STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315448	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ESTATES REHAB AND SENIOR LIVING CENTER	303 BANK AVE RIVERTON, NJ 08077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS C/O # NJ 169224, 169762, 173961, 175384, 176014 Standard Survey 09/06/2024 Census: 48 Sample Size: 17 + 2 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interviews, medical record review, and review of other pertinent facility documentation, it was determined that the facility failed to follow professional standards of practice for documenting [NJ Ex Order 26.4(b)(1)] on the Electronic Treatment Administration Record (TAR). This deficient practice was identified for 1 of 1 resident reviewed for [NJ Exec Order] care (Resident #15). This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical	F 658	1.) The nurse who failed to document treatment administration for Resident #15 was re-educated on importance of signing Resident #15's Treatment Administration Record (TAR) immediately after completion of the treatment. The facility□s [NJ Ex Order 26.4b1] reassessed Resident #15 to ensure the prescribed treatments have been effective. 2.) Residents receiving wound treatments have the potential to be affected by the deficient practice. 3.) The Director of Nursing (DON) or designee educated licensed nursing staff on importance of accurate and timely signing of the TAR following treatment	10/1/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/26/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315448	A. BUILDING _____ B. WING _____	C 09/06/2024

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F 658	Continued From page 1 nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated Title 45. Chapter 11. New Jersey Board of Nursing Statutes 45:11-23. Definitions " b. The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribe by a licensed or otherwise legally authorized physician or dentist. Diagnosing in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis. Treating means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen. Human response means those signs, symptoms and processes which denote the individual's health need or reaction to an actual or potential health problem. According to the Admission Record (AR), Resident #15 was admitted to the facility with diagnoses which included but were not limited to,	F 658	delivery. A daily report of missed treatment documentation will be generated by the DON or designee, and immediate follow-up will be conducted with the assigned nurse. 4.) The DON or designee will audit five (5) charts weekly for four (4) weeks, then five (5) charts monthly for two (2) months to ensure that TAR documentation is completed appropriately. Audit findings will be submitted to the monthly Quality Assurance and Performance Improvement (QAPI) Committee for three (3) months in order to determine if further interventions are needed. 5.) Completion date: 10/01/2024.	

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NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) .

A review of Resident #15's most recent Quarterly Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4(b)(1) revealed that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4 out of 15, which indicated the resident's was NJ Ex Order 26.4(b)(1)

A review of the "Order Summary Report (OSR)" Active Orders as of NJ Ex Order 26.4(b)(1) included but were not limited to the following Physician's Orders (POS):

-NJ Ex Order 26.4(b)(1) every shift for monitoring.

-NJ Ex Order 26.4(b)(1) with NJ Ex Order 26 , apply NJ Ex Order 26.4(b)(1) daily every day shift for NJ Ex Order 26.4(b)(1)

-NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1), apply NJ Ex Order 26.4(b)(1) and cover with NJ Ex Order 26.4(b) daily every day shift for NJ Ex Order 26.4(b)(1).

The surveyor reviewed Resident #15's NJ Ex Order 26. TAR on 09/04/2024, and it revealed blank spaces for the following treatment orders on NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) for day shift:

-NJ Ex Order 26.4(b)(1) every shift for monitoring.

-NJ Ex Order 26.4(b)(1) with NJ Ex Order 26

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NJ Ex Order 26.4(b) apply NJ Ex Order 26.4(b)(1) daily every day shift for NJ Ex Order 26.4(b)(1)

-NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1), apply NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) daily every day shift for NJ Ex Order 26.4(b)(1).

The surveyor reviewed Resident #15's NJ Ex Order 26 progress notes (PNs) which revealed no documentation that the treatment orders were administered on NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1).

During an interview with the surveyor on 09/05/2024 at 1:04 PM, in the presence of the survey team and the U.S. FOIA (b) (6) the U.S. FOIA (b) (6) stated that the expectation for nurses after performing treatments was that they document in the Electronic Medical Record (EMR) on the TAR. The U.S. FOIA further stated that if there were blank spaces on the TAR there should be a reason documented to why the treatment was not given. The U.S. FOIA stated a blank space on the TAR would have indicated that the treatment was not done.

On 09/06/2024 at 9:10 AM, the U.S. FOIA brought the surveyor an audit report titled "Medication Administration Audit Report" (MAAR) for Resident #15 with schedule date of NJ Ex Order 26.4(b)(1) - NJ Ex Order 26.4(b)(1). The MAAR revealed the following:

- An order for NJ Ex Order 26.4(b)(1) every shift for monitoring with a scheduled date of NJ Ex Order 26.4(b) at 07:00 revealed an administration date of NJ Ex Order 26.4(b)(1) at 16:02 and documented time of NJ Ex Order 26.4(b)(1) at 16:02.

-An order to NJ Ex Order 26.4(b)(1) with NJ Ex Order 26

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F 658		F 658		

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NJ Ex Order 26.4(b) apply NJ Ex Order 26.4(b)(1) and cover with NJ Ex Order 26.4(b)(1) every day shift for NJ Ex Order 26.4(b)(1) with a scheduled date of NJ Ex Order 26.4(b)(1) at 07:00 revealed an administration date of NJ Ex Order 26.4(b)(1) at16:02 and documented time of NJ Ex Order 26.4(b)(1) at 16:02.

-An order to NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1), apply NJ Ex Order 26.4(b)(1) daily every day shift for NJ Ex Order 26.4(b)(1) with a scheduled date of NJ Ex Order 26.4(b)(1) at 07:00 revealed an administration date of NJ Ex Order 26.4(b)(1) at 16:02 and documented time of NJ Ex Order 26.4(b)(1) at 16:02.

- An order for NJ Ex Order 26.4(b)(1) every shift for monitoring with a scheduled date of NJ Ex Order 26.4(b) at 07:00 revealed an administration date of NJ Ex Order 26.4(b)(1) at 15:40 and documented time of NJ Ex Order 26.4(b)(1) at 15:41.

- An order to NJ Ex Order 26.4(b)(1) with NJ Ex Order 26 NJ Ex Order 26.4b, apply NJ Ex Order 26.4(b)(1) and cover with daily every day shift for NJ Ex Order 26.4(b)(1) with a scheduled date of NJ Ex Order 26.4(b)(1) at 07:00 revealed an administration date of NJ Ex Order 26.4(b)(1) at15:39 and documented time of NJ Ex Order 26.4(b)(1) at 15:41.

- An order to NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1), apply NJ Ex Order 26.4(b)(1) daily every day shift for NJ Ex Order 26.4(b)(1) with a scheduled date of NJ Ex Order 26.4(b)(1) at 07:00 revealed an administration date of NJ Ex Order 26.4(b)(1) at 15:39 and documented time of NJ Ex Order 26.4(b)(1) at 15:41.

During an interview with the surveyor on 09/06/2024 at 9:12 AM, in the presence of the survey team and the U.S. FOIA (b) (6) the U.S. FOIA (b) (6)) stated there were no blank spaces in the TAR that was given to the surveyor because the

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F 658	Continued From page 5 U.S. FOIA spoke with the nurse assigned to Resident #15 on NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) on day shift. U.S. FOIA further stated the nurse told the U.S. FOIA that the treatments for Resident #15 were completed on NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) on day shift and the nurse had forgotten to sign the TAR. The U.S. FOIA confirmed that the standard of care was that the nurses were to sign the TAR after treatments were completed. A review of facility policy titled " Charting and Documentation" with revised date of 01/2024, revealed under "Policy Interpretation and Implementation","2. The following information is to be documented in the resident medical record: b. Medications administered c. Treatments or services performed 3. Documentation in the medical record will be objective, complete, and accurate. 5. Documentation of the procedures and treatments will include care-specific details, including: a. The date and time the procedure/treatment was provided; b. The name and title of the individual(s) who provided the care." NJAC 8:39-29.2(d)	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695		10/1/24

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F 695	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to A.) follow a physician order for PRN (as needed) NJ Ex Order 26.4 use for 1 of 2 residents reviewed for NJ Ex Order 26.4(b)(1) and B.) failed to implement infection control measures for the handling and storage of NJ Ex Order 26.4(b)(1) for 2 of 2 residents reviewed for NJ Exec Order 26.4b1 Care, (Resident #18 and Resident # 5). This deficient practice was evidenced by the following: A. During the initial tour of the unit on 09/03/2024 at 06:55 PM, Surveyor #1 observed NJ Ex Order 26.4(b) dated NJ Ex Or sitting on top of the NJ Ex Order 26.4(b) uncovered and exposed in Resident #18's room. A review of Resident #18' Electronic Medical Record (EMR) on NJ Ex Order 26.4(b)(1) at 11:07 AM revealed the following: According to the Admission Record, Resident #18 was admitted to the facility with diagnoses including but not limited to: NJ Ex Order 26.4(b)(1) A review of the most recent Minimum Data Set (MDS), an assessment tool used to facilitate care dated NJ Ex Order 26.4(b)(1) revealed Resident #18 had NJ Ex Order 26.4(b)(1). The MDS further revealed under section NJ E no to NJ Ex Order 26.4(b)(1) while a resident. A review of an Order Summary Report with Active Orders as of NJ Ex Order 26.4(b)(1) revealed a physician order with start date of NJ Ex Order 26.4(b)(1) to Administer	F 695	1.) Resident #18's physician has been notified of the deficiency, and a care plan revision has been implemented to reflect the physician's order. All NJ Ex Order 26.4(b)(1) equipment in Resident #18's room has been properly cleaned, dated, and stored according to infection control guidelines. The NJ Ex Order 26.4(b)(1) in Resident #5's room was immediately cleaned, air-dried, and stored in a NJ Ex Order 26.4(b)(1) after each use, per policy. Resident #5's care plan has been reviewed to ensure that all NJ Ex Order 26.4(b)(1) interventions are correctly implemented and documented. 2.) Residents who receive respiratory treatments including oxygen administration and nebulizer treatments have the potential to be affected by the deficient practice. 3.) All nursing staff received re-education by the Director of Nursing (DON) or designee on the facility's respiratory care policies, including: Proper oxygen administration protocols, specifically addressing PRN orders; correct procedures for handling, cleaning, and storing respiratory equipment such as nebulizer masks; infection control guidelines related to respiratory care and equipment handling; importance of accurate and timely documentation of oxygen saturation and respiratory treatments in the Electronic Medical Record (EMR). All residents receiving oxygen therapy or nebulizer treatments had a review of their care plans to ensure the care plan matches the physician's	

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F 695	Continued From page 7 NJ Ex Order 26.4(b)(1)) as needed for NJ Ex Order 26.4(b)(1)), [redacted] A review of the Medication Administration Records (MAR) revealed a physician order for Administer NJ Ex Order 26.4(b)(1) as needed for [redacted] Under the Hours column indicated [redacted] and PRN. A further review of the MARS for [redacted] did not include documentation that the resident required [redacted] A review of the NJ Ex Order 26.4(b)(1)) Summary revealed that on the following dates Resident #18 used [redacted] with a [redacted]. In [redacted] through [redacted] through [redacted]. In NJ Ex Order 26.4(b)(1) [redacted] through [redacted] through [redacted]. In NJ Ex Order 26.4(b)(1). A review of the Nursing Progress notes from [redacted] did not include documentation that Resident #18 had [redacted] A review of Resident #18's care plan revealed a focus area of [Resident name] has [redacted] r/t (related to) NJ Ex Order 26.4(b)(1) [redacted] Hx (history) of [redacted] with a Date Initiated: [redacted] and Revision on: [redacted]. Under the Goal section the resident will have no [redacted] of NJ Ex Order 26.4(b)(1)	F 695	order. 4.) The nursing management team will conduct three (3) observational audits per week x 4 weeks, then three (3) per month x two (2) months to ensure PRN oxygen orders are followed correctly. Nursing management team will conduct three (3) observational audits per week x 4 weeks, then three (3) per month x two (2) months to ensure respiratory equipment in resident rooms is cleaned, dated, and stored properly. Audit findings will be submitted to the monthly Quality Assurance and Performance Improvement (QAPI) Committee in order to determine if further interventions are needed. 5.) Completion date: 10/01/2024.	

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through the review date. Interventions included but were not limited to: Monitor for s/sx of NJ Ex Order 26.4(b)(1) and report to MD PRN: NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) . SETTINGS: NJ Ex Order 26.4(b)(1) (SPECIFY: NJ Ex Order 26.4(b)(1)

A review of a facility policy on 09/05/2024 at 09:26 AM, titled Oxygen Administration with reviewed/revised date of 4/2024 revealed under the Preparation section 1. Verify that there is a physician's order for this procedure. Under the documentation section Under the Documentation section 5. The reason for p,r,n, administration. 6. All assessment data obtained before, during and after the procedure. 9. The signature and title of the person recording the data.

During an interview with Surveyor #1 on 09/05/2024 at 12:15 PM, Licensed Practical Nurse (LPN #1) was asked What is the facility procedure/policy for storing NJ Ex Order 26.4(b)(1) equipment such as NJ Ex Order 26. or NJ Ex Order 26.4(b) when not in use. LPN #1 responded it should be stored NJ Ex Order 26 NJ Ex Order 26.4(b)(1). It is changed I want to say every 3 days, but I am not sure, they do it on overnight shift.

B. On 09/04/2024 at 09:27 AM, Surveyor #2 observed Resident #5 seated in their wheelchair in their room. Resident #5"s NJ Ex Order 26.4(b)(1) was observed on the bedside table. Resident #5 stated he/she had NJ Ex Order 26.4(b)(1) last night. The NJ Ex Order was on top of the NJ Ex Order 26.4(b)(1) and was NJ Ex Order 26.4(b)(1) while not in use.

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According to the Admission Record, Resident #5 was admitted to the facility with the following but not limited to diagnoses: NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) [redacted]).

A review of the MDS, an assessment tool, dated NJ Ex Order 26.4(b)(1), revealed Resident #5 had a Brief Interview for Mental Status score of [redacted]/15, indicating NJ Ex Order 26.4(b)(1). Resident #5 was NJ Ex Order 26.4(b)(1). Section O of the MDS revealed Resident #5 received NJ Ex Order 26.4(b)(1) while a resident at the facility.

A review of the Order Summary Report with active orders as of NJ Ex Order 26.4(b)(1) revealed that Resident #5 had the following physician order: NJ Ex Order 26.4(b)(1) [redacted] every 12 hours related to NJ Ex Order 26.4(b)(1) [redacted] NJ Ex Order 26.4(b)(1) after use. Order Date NJ Ex Order 26.4(b)(1)."

According to the NJ Ex Order 26.4(b) - NJ Ex Order 26.4(b)(1) Medication Administration Record, Resident #5 received NJ Ex Order 26.4(b)(1) [redacted] every 12 hours on [redacted] through [redacted] at 0900 and 2100.

A review of the comprehensive care plan revealed that Resident #5 had the following care

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plan Focus: "[resident name] has NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1), Revision on: NJ Ex Order 26.4(b)(1). The following was revealed under Interventions/Tasks: "Administer NJ Ex Order 26.4(b)(1) as ordered. Monitor for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)."

On 09/05/2024at 09:06 AM Surveyor #2 went to Resident #5's room. Resident #5 was not in their room on this observation. The NJ Ex Order 26.4(b)(1) was observed on the bed side table and was stored in NJ Ex Order 26.4(b)(1) while not in use.

On 09/05/2024 at 12:17 PM Surveyor #2 entered Resident #5's room after knocking. Resident #5 was out of the room at this time. The surveyor observed the NJ Ex Order 26.4(b)(1) on bedside table and in a plastic bag while not in use.

B. On 09/04/2024 at 09:27 AM, Surveyor #2 observed Resident #5 seated in their wheelchair in their room. Resident #5's NJ Ex Order 26.4(b)(1) was observed on the bedside table. Resident #5 stated he/she had NJ Ex Order 26.4b1 last night. The NJ Ex Order was on top of the NJ Ex Order 26.4(b)(1) and was NJ Ex Order 26.4(b)(1) while not in use.

According to the Admission Record, Resident #5 was admitted to the facility with the following but not limited to diagnoses: NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4 [redacted], and NJ Ex Order 26.4(b)(1) [redacted]

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	315448	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ESTATES REHAB AND SENIOR LIVING CENTER	303 BANK AVE RIVERTON, NJ 08077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 11 NJ Ex Order 26.4(b)(1)). A review of the MDS, an assessment tool, dated NJ Ex Order 26.4(b)(1), revealed Resident #5 had a Brief Interview for Mental Status score of NJ E/15, indicating NJ Ex Order 26.4(b)(1). Resident #5 was NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1). Section O of the MDS revealed Resident #5 received NJ Ex Order 26.4(b)(1) while a resident at the facility. A review of the Order Summary Report with active orders as of NJ Exec Order 26.4b1 revealed that Resident #5 had the following physician order: "NJ Ex Order 26.4(b)(1) every 12 hours related to NJ Ex Order 26.4(b)(1) after use. Order Date: NJ Ex Order 26.4(b)(1)." According to the NJ Ex Order 26.4(b)(- NJ Ex Order 26.4(b)(1, Medication Administration Record, Resident #5 received NJ Ex Order 26.4(b)(1) every 12 hours on NJ Ex O through NJ Ex Order 26.4(b) at 0900 and 2100. A review of the comprehensive care plan revealed that Resident #5 had the following care plan Focus: "[resident name] has NJ Ex Order 26.4(b)(1) r/t (related to) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), Revision on NJ Ex Order 26.4(b)(1). The following was revealed under Interventions/Tasks: "Administer NJ Ex Order 26.4(b)(1) as ordered. Monitor for effectiveness and side effects. Revision on:	F 695		

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F 695	Continued From page 12	F 695		

NJ Ex Order 26.4(b)(1) ."

On 09/05/2024 at 09:06 AM, Surveyor #2 went to Resident #5's room. Resident #5 was not in their room on this observation. The NJ Ex Order 26.4(b)(1) was observed on the bed side table and was NJ Ex Order 26.4(b)(1) while not in use.

On 09/05/2024 at 12:17 PM, Surveyor #2 entered Resident #5's room after knocking. Resident #5 was out of the room at this time. The surveyor observed the NJ Ex Order 26.4(b)(1) on bedside table and in a NJ Ex Order 26.4(b)(1) while not in use.

On 09/05/2024 at 2:26 PM, Surveyor #2 conducted an interview with Licensed Practical Nurse (LPN #3). The surveyor asked LPN #3 what the facility practice was for residents after they had a received NJ Ex Order 26.4(b)(1). LPN #3 told the surveyor, " After a resident receives a NJ Ex Order 26.4(b)(1), we (nurses) go back and check the resident's NJ Ex Order 26.4(b)(1), NJ Ex Order 26. and NJ Ex Order 26.4(b)(1) after the treatment." LPN #3 further stated, "The NJ Ex Order 26.4(b)(1) is cleaned after the procedure with soap and water or a sanitizing wipe, air dried and then it should be stored in a plastic bag on the NJ Ex Order 26.4(b) . That is completed for each use."

On 09/05/2024 at 01:22 PM, Surveyor #2 conducted an interview with the facility U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) . The surveyor asked what the facility policy was for NJ Ex Order 26.4(b)(1) after treatment and when not in use between treatments. The U.S. FOIA told the surveyors, "The policy/practice is to clean the mask with a wipe. After it is cleaned, we store it in NJ Ex Order 26.4(b)(1) between uses." The surveyor then asked the

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F 695	Continued From page 13 U.S. FOIA what the expectation would be for the NJ Ex Order 26.4(b)(1) was between treatments. The U.S. FOIA stated, "Our expectation is that it would be NJ Ex Order 26.4(b)(1) between treatments to make sure it does not get contaminated which could potentially cause contamination to the resident." A review of the facility policy titled Nebulizer Administration, reviewed/revised 07/2024, revealed the following under the Purpose heading: The purpose of this procedure is to provide guidelines for safe nebulizer administration. The following was revealed under the heading Steps in the Procedure: 18. Rinse nebulizer, mouthpiece, and "T" piece with tap water and let air dry. a. Date and place supplies in a treatment bag. NJAC 8:39- 27.1 (a)	F 695		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve	F 727		10/1/24

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F 727	Continued From page 14 as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and review of Nurse Staffing Report sheets, it was determined that the facility failed to ensure a Registered Nurse (RN) worked 7 days a week for at least 8 consecutive hours a day for 2 of 7 weekends reviewed. This deficient practice was evidenced by the following: 09/05/24 12:55 PM A review of the Facility Assessment with last reviewed date of 8/7/2024 revealed under the Staffing Plan the following: Day RN blank (no numerical indicator) LPN 2 CNA 1 to 8 residents Evening RN 0-1 LPN 2 CNA 1-10 residents Night RN 0-1 LPN 2 CNA 3 (no ratio provided) A review of the Nurse Staffing Report for the week of 12/3/2023 through 12/9/2023 revealed that on Satuday 12/9/2023 had all zeros for Day, Evening, and Night shift under RN column. A review of the Nurse staffing Report for the week of 08/25/2024 through 08/31/2024 revealed that on 08/31/2024 there were zero's for Day, Evening, and Night shift under the RN column. A review of the daily nursing schedule for 12/9/2023 revealed there was no RN on the	F 727	1.) The facility could not retroactively correct the deficient practice due to passage of time. A staffing oversight committee has been created to monitor RN staffing levels weekly. The committee will audit staffing reports and schedules weekly, x 3 months, to ensure compliance with regulatory requirements. A backup plan has been implemented for RN coverage in the event of an unplanned absence (e.g., call-outs). This plan includes a rotating on-call list of RNs, including the DON, who can fill in if there is a sudden vacancy in the shift. 2.) All residents have the potential to be affected by the deficient practice. 3.) Nursing and Human Resources (HR) staff were re-educated on the facility's staffing requirements, focusing on the importance of having Registered Nurse (RN) coverage for 8 consecutive hours daily, including weekends. 4.) Any gaps or potential issues will be addressed immediately. The results of the weekly staffing audits and reviews will be presented to the Quality Assurance and Performance Improvement (QAPI) committee on a monthly basis. The QAPI committee will review these findings and make recommendations for further improvements if necessary. 5.) Completion Date: 10/01/2024	

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F 727	Continued From page 15	F 727		

schedule. The Human Resources/Staffing confirmed there was no RN on the schedule.

A review the daily nursing schedule showed an RN was scheduled on 08/31/2024. When asked why there was a zero on the Nurse Staffing Report submitted to the survey team, Humand Resources/Staffing checked the RN punch card. The punchcard indicated she called out (did not come to work).

During an interview with the surveyor on 09/06/2024 at 12:08 PM, the U.S. FOIA (b) (6) [redacted] said yes, when asked if there was a Registered Nurse (RN) in the building on a daily basis.

During an interview with the sureveyor on 09/06/2024 at 12:22 PM, the U.S. FOIA (b) (6) [redacted] said yes we always have an RN on duty every day.
The surveyor requested a copy of the nursing daily schedule for 12/9/2023 and 08/31/2024.

A review of a facility policy titled Staffing with a reviewed/revised date of 12/2023 under the Policy & Procedure section:

The purpose of this policy is to ensure that our facility provides adequate and appropriate staffing levels to meet the needs of residents, in compliance with federal, state, and local regulations. The policy is designed to ensure high-quality care, promote resident safety and well-being, and create a supportive working environment for staff.

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F 727	Continued From page 16 This policy applies to all staff involved in direct resident care, including but not limited to Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Nursing Assistants (CNAs), and other healthcare professionals and support staff employed or contracted by the facility. Under 2. Staffing Categories Registered Nurses (RNs): RNs will be available 8 hours a day to provide clinical oversight, care planning, and assessment. A designated RN will serve as the Director of Nursing (DON). NJAC 8:39-25.2(h)	F 727		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756		10/1/24

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F 756	Continued From page 17 minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to respond to the U.S. FOIA (b) (6) medication regimen review recommendations (MRR) in a timely manner. This deficient practice was identified for 2 out of 5 residents (Resident #5 and Resident #50) reviewed for unnecessary medications. This deficient practice was evidenced by the following: 1. On 09/04/2024 at 09:33 AM, the surveyor observed Resident #5 in their room during the initial tour of the facility Resident #5 was NJ Ex Order and NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) According to the Admission Record, Resident #5 was admitted to the facility with the following but not limited to diagnoses: NJ Ex Order 26.4(b)(1), NJ Ex Order 26. , NJ Ex Order 26.4(b)(1), and NJ Ex Order	F 756	1.) The order for NJ Ex Order 26.4(b)(1) for Resident #5 was updated on NJ Ex Order 26.4 to reflect administration at 9:00 AM per the Consultant Pharmacist (CP)□s recommendation. A comprehensive review of Resident #5□s medication regimen was conducted to ensure all Medication Regimen Review (MRR) recommendations have been addressed and implemented. Resident #50□s physician was immediately notified about the outstanding recommendations for NJ Ex Order 26.4(b)(1) levels and the need for NJ Ex Order 26.4b1 . Orders for these labs were placed, and they were scheduled for completion. 2.) All residents who take medications have the potential to be affected by the deficient practice 3.) The Pharmacy Consultant Policy and	

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F 756	Continued From page 18 NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1)). A review of the Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4(b)(1), revealed that Resident #5 had a Brief Interview for Mental Status score of NJ E/15, indicating NJ Ex Order 26.4(b)(. Section N revealed that Resident #5 received a daily NJ Ex Order 26.4(b)(1) daily NJ Ex Order 26.4(b)(1) and daily NJ Ex Order 26.4(b)(1) medication. A review of the Order Summary Report with orders active as of: NJ Ex Order 26.4(b)(1), revealed the following physician order for Resident #5: NJ Ex Order 26.4(b)(1)) Give 1 tablet 1 time a day for NJ Ex Order 2 . Oder Date: NJ Ex Order 26.4(b)(1). 09/04/2024 at 11:01 AM, during a review of the past 6 months of the CP MRR the following recommendation was observed for Resident #5 during the recommendations created between NJ Ex and NJ Ex Order 26.4(b)(1) MRR: "NJ Ex Order 26.4(b)(1) can be administered without regards to meals. Please update time to 9 AM." A review of the Medication Administration Records (MAR) for NJ Ex Order 26.4(b - NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b - NJ Ex Order 26.4(b 4, NJ Ex Order 26.4(b - NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b - NJ Ex Order 26.4(b)(1 revealed that Resident #5 had the following active order for NJ Ex Order 26 , NJ Ex Order 26 , and NJ Ex Order 26 : NJ Ex Order 26.4(b)(1) Oral Tablet Delayed Release NJ Ex Order 26.4(b)(1) Give 1 tablet 1 time a day for NJ Ex Order 26.4(b)(1) . Start Date: NJ Ex Order 26.4(b)(1). Review of the NJ Ex Order 26.4(b)(1) -	F 756	Procedure was updated to specify that recommendations made by the consultant pharmacist (CP) will be reviewed and implemented by nursing within 5 business days. Nursing staff and unit managers were in-serviced on the importance of timely response to CP recommendations and the updated workflow for handling MRRs. Physicians were re-educated on the requirement to provide timely documentation of agreement or disagreement with CP recommendations. 4.) The Director of Nursing (DON) will conduct monthly audits for (3) months to review the timeliness of MRR implementation for all residents. Any delays will be addressed immediately, and corrective actions will be taken. The Quality Assurance Performance Improvement (QAPI) committee will review all audit findings related to MRR recommendations on a monthly basis. 5.) Completion Date: 10/01/2024	

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F 756	Continued From page 19 NJ Ex Order 26.4(b)(1) MAR revealed the following order: NJ Ex Order 26.4(b)(1) Give 1 tablet 1 time a day for NJ Ex Order 26.4(b)(1) at 0900. Order Date: NJ Ex Order 26.4(b)(1). 2. On 09/03/2024 at 07:00 PM during the initial tour of the facility, the surveyor observed Resident #50 lying in bed in the lowest position. Resident #50 was asleep at the time and had a NJ Ex Order 26.4(b)(1)) applied to their NJ Ex Order 26.4(b)(1). A review of the Admission Record revealed that Resident #50 was admitted to the facility with the following but not limited to diagnoses: NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). A review of the MDS, an assessment tool dated NJ Ex Order 26.4(b)(1), revealed Resident #50 had a Brief Interview for Mental Status score of NJ/15, indicating NJ Ex Order 26.4(b)(1). On 09/04/2024 at 11:42 AM, the surveyor reviewed the past 6 months of MRR by the facility CP. On NJ Ex Order 26.4(b)(1) the CP made the following physician/practitioner recommendation: NJ Ex Order 26.4(b)(1) levels are recommended periodically while being maintained on NJ Ex Order 26.4(b)(1) Baseline NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)), and then periodically are recommended as well. NJ Ex Order 26.4(b)(1) tests are recommended before NJ Ex Order 26.4(b)(1) Review of the recommendation sheet revealed that the practitioner responded on NJ Ex Order 26.4(b)(1) as indicated by their date and signature on the CP recommendation sheet.	F 756		

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F 756	Continued From page 20	F 756		

Review of the electronic medical record revealed that Resident #50 had not been ordered any laboratory studies since [NJ Ex Order 26.4(b)(1)]. The practitioner did not indicate on the response whether they agreed or disagreed with the CP recommendation. When interviewed concerning whether a physician/prescriber should document a rationale if they disagree with the CP recommendation the facility U.S. FOIA (b) (6) told the surveyor, "Typically a physician should write something if they disagree."

During an interview with the facility [U.S. FOIA (b) (6)] and U.S. FOIA (b) (6) on 09/05/2024 at 01:09 PM, the [U.S. FOIA] told the survey team that the "[U.S. FOIA]" is responsible for monthly pharmacist reports and physician notification. Nursing recommendations from the CP are handled by the [U.S. FOIA] unit managers and staff nurses. The [U.S. FOIA] further stated, "The [U.S. FOIA] is responsible to ensure that the recommendations are completed in a timely manner." When the surveyor asked the [U.S. FOIA] what they considered a timely manner the [U.S. FOIA] told the surveyors, "I would expect a timely manner to be a couple days depending on the order, a week maximum. A recommendation made in May should be completed in May."

The surveyor reviewed the facility policy titled Pharmacy Consultant Policy & Procedure, revised 07/2024. The following was observed under the heading OBJECTIVES:

6. To have the pharmacist find and identify apparent irregularities or potential drug therapy problems i.e. drug interactions with medication and food, laboratory services needed, and recommended drug therapeutic levels. The

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F 756	Continued From page 21 following was revealed under the heading PROCEDURE: 8. The pharmacist will provide the DON with Pharmacy recommendation reports on an on-going basis each month. The DON will act upon these recommendations by bringing them to the attention of the attending physician and ensuring any changes are implemented in a timely manner. NJAC 8:39-29.3(a)(1)	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		10/1/24

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	315448	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ESTATES REHAB AND SENIOR LIVING CENTER	303 BANK AVE RIVERTON, NJ 08077

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F 761	Continued From page 22 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly label, store, and date medication in accordance with manufacturer recommendations. This deficient practice was observed in 1 of 2 medication carts (B/C cart) inspected during the medication storage and labeling task and was evidenced by the following: On 9/6/24 at 10:59 AM, in the presence of Licensed Practical Nurse (LPN #2), the surveyor inspected cart B/C. In the third drawer on the left side of the cart the surveyor observed a brown sticky substance stuck to the bottom of the drawer. In addition, while inspecting the remainder of the cart the surveyor found seven and a half loose tablets. Lastly upon controlled substance reconciliation the surveyor located a lorazepam liquid being stored on the medication cart. Inspection of the lorazepam medication container revealed a pharmacy sticker with the word "refrigerate" as well as on the manufactured box instructions to "store at cold temperature. Refrigerate at two degrees to eight degrees Celsius or thirty six to forty six degrees Fahrenheit. At that time, LPN #2 stated she was aware of the sticky substance and had tried to remove it but was unsuccessful. LPN #2 also stated she had checked the medication cart at the start of her shift but did not see the loose tablets. LPN #2 further stated the lorazepam liquid should be stored in the refrigerator and that the lorazepam had probably been delivered by the pharmacy the night before.	F 761	1.) The medication cart was switched out with a clean, spare medication cart that was in storage. The loose tablets were disposed of per facility policy in the medication destruction container. The improperly stored lorazepam liquid was removed from the cart and placed in the locked medication refrigerator according to manufacturer guidelines. The pharmacy was contacted to replace the medication. 2.) All residents have the potential to be affected by the deficiency. 3.) A new cleaning protocol has been implemented for medication carts to ensure that spills or residues are cleaned immediately. In addition, housekeeping will perform a deep clean on medication carts on a monthly basis. Nursing staff have been re-educated on the proper storage and handling of medications, including: Ensuring medications requiring refrigeration are promptly stored in a locked medication refrigerator, maintaining cleanliness of the medication cart and ensuring no loose tablets are present, and reporting and addressing any spills immediately. 4.) The Director of Nursing (DON) or unit manager (UM) will conduct one (1) observational audit of medication carts weekly for (3) months to ensure compliance with storage and cleanliness protocols. The results of these audits will be reviewed monthly during the facility□s Quality Assurance and Performance	

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F 761	Continued From page 23 On 9/6/24 at 11:18 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated the lorazepam should have been stored in the locked frigerator in the medication room. The U.S. FOIA (b) (6) acknowledged the loose tablets found in the cart and stated every shift was responsible to make sure there were no loose medications and that there should be no spills of liquids in the cart, that the cart should be need and clean. The (b) (9) acknowledged the third drawer down on left side of med cart had visible brown spillage and should be cleaned immediately. The loose tablets should be disposed of in the drug disposal bottle located on the medication cart. Lastly the U.S. FOIA (b) (6) stated she would call the provider pharmacy and have the lorazepam replaced. On 9/6/24 at 12:16 PM, the surveyor interviewed the U.S. FOIA (b) (6) who stated if there were a spill it should be wiped immediately, and maintenance should be contacted for further cleaning if needed. The carts should not look visibly dirty and should be kept neat and organized, any loose tablets should be placed in the mediation destruction container. The U.S. FOIA (acknowledged lorazepam should stored in the refrigerator in the locked box. A review of the facility's "Storage of Medications" policy dated revised 1/2024 included... The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner... Medications requiring refrigeration must be stored in a refrigerator located in a refrigerator located in the drug room at the nurses' station or other secured	F 761	Improvement (QAPI) meetings to identify any trends or areas needing further improvement. Identified issues will be addressed immediately, and corrective actions will be implemented as necessary. 5.) Completion Date: 10/01/2024	

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F 761	Continued From page 24 location... NJAC 8:39-29.4(h)	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 9/4/2024 from 8:14 to 9:04 AM, the surveyors, accompanied by the U.S. FOIA (b) (6)) observed the following in the kitchen:	F 812	1.) The dented can was immediately removed from the dry storage area and discarded; the exposed frozen puree moldings in the walk-in freezer were discarded immediately, and the improper storage practice was corrected; the expired coriander was discarded immediately by the Food Service Director (FSD) during the inspection. The unlabeled takeout container found in the resident pantry refrigerator was discarded	10/1/24

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F 812	Continued From page 25 1. On an upper shelf in the dry storage room, a can of Pizza Sauce with Basil had a dent on the upper seam of the can. The [U.S. FOIA] stated to the surveyors that it will be moved to designated dented can area. 2. A quarter pan in the walk-in freezer was placed on top of cardboard boxes. The quarter pan contained frozen puree moldings for lunch, according to the [U.S. FOIA] The pan was covered with plastic wrap. The plastic wrap was torn, and the puree moldings were exposed to the air. 3. In the walk-in refrigerator in the kitchen, a one eighth pan on a middle shelf contained fresh coriander, according to the [U.S. FOIA] The coriander was dated "8/16/24." The coriander was brown on appearance and wilted. The [U.S. FOIA] removed the coriander to the trash. On 9/05/2024 from 9:44 to 9:53 AM, the surveyors, accompanied by the Licensed Practical Nurse (LPN #2), observed the following in the designated resident pantry: 1. A red [NJ Ex Order 2] cloth bag in the refrigerator contained an unidentified food in a black plastic take out style container with a clear plastic lid. The bag and container had no name or date labeled on it. When interviewed, LPN #2 stated, "That should have been labeled and dated by nursing. I'm removing it from the refrigerator." LPN #2 further stated, "I think it came in last night because I did not see it yesterday. On interview LPN #2 confirmed that nursing staff was responsible for labeling and dating foods provided/received from out of the facility.	F 812	by LPN #2 immediately after being identified. 2.) Residents potentially affected by the deficiency include any resident that dines in the facility. 3.) Administrator, FSD and Director of Nursing (DON) conducted a mandatory training session for all kitchen and nursing staff on food safety standards, proper food storage practices, and the importance of labeling and dating foods. 4.) Dietician and or administrator will conduct weekly inspections of the kitchen, walk-in refrigerators/freezers, and nursing units for (3) months to ensure compliance with food safety protocols. Audits will be documented, and findings will be reported to the Food Service Director, Reginal Food Service Director and nursing management for immediate corrective actions if necessary. Findings will be submitted for (3) months to the monthly Quality Assurance Performance Improvement (QAPI) committee who will determine further interventions as needed. 5.) Completion Date: 10/01/2024	

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F 812	Continued From page 26 A review of the facility policy titled Food Receiving and Storage, reviewed/revised 12/2023, revealed the following: 2. When food is delivered to the facility it will be inspected for safe transport, quality, and dents before being accepted and stored. 3. Dented cans shall be separated and discarded from general food stock. 4. Should cans become dented during the course of regular operations, they shall be removed and placed in a designated area at the moment they are identified. 8. All foods stored in the refrigerator or freezer will be covered, labeled, and dated. 13. Food items and snacks kept on the nursing units must be maintained as indicated below: b. All foods belonging to residents must be labeled with the resident's name, the item, and the date. A review of the facility policy titled Monitoring of Cooler/Freezer Temperature, date reviewed/revised: 3/24/2024, The following was revealed under Policy Explanation and Compliance Guidelines: 11. Refrigerated foods shall be labeled, dated, and monitored so that it is used by the use by date, frozen, or discarded, whichever is applicable. NJAC 18:39-17.2(g)	F 812		
F 880 SS=D	Infection Prevention & Control	F 880		10/1/24

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F 880	Continued From page 27 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 28 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, review of the medical record and review of other facility documentation, it was determined that the facility failed to: a.) ensure appropriate infection control practices were maintained during NJ Ex Order 26.4(b)(1); and b.) implement NJ Ex Order 26.4(b)(1)) for a resident with NJ Ex Order 26.4(b)(1). This deficient practice was identified for 1 of 1 resident (Resident #15) reviewed for NJ Ex Order 26.4(b)(1) and was evidenced by the following:	F 880	1.) The facility immediately retrained the Licensed Practical Nurse (LPN #2) involved in Resident #15's NJ Ex Order 26.4(b)(1) on proper NJ Ex Order 26.4(b)(1) procedures, including changing gloves between steps, hand hygiene, and the use of NJ Ex Order 2 and gloves as per infection control protocols. Signage indicating the need for NJ Ex Order 26.4(b)(1)) was immediately placed outside Resident	

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F 880	Continued From page 29 1. During the initial tour on 09/03/2024 at 6:42 PM, the surveyor observed Resident #15 lying in bed, which had a NJ Ex Order 26.4(b)(1) attached to the end of the bed. Resident #15 was NJ Ex Order 26.4b1 regarding NJ Ex Order 26.4 and NJ Ex Order 26 care. According to the Admission Record (AR), Resident #15 was admitted to the facility with diagnoses which included but were not limited to, NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1), and NJ Exec Or), and NJ Exec Order 26.4b1 A review of Resident #15's most recent Quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated the resident's NJ Exec Order 26.4b was NJ Ex Order 26.4(b)(1). The MDS further revealed under section "M" that Resident #15 was at risk for NJ Ex Order 26.4(b)(1). The MDS did not indicate that resident had a NJ Ex Order 26.4(b at that time. A review of the "Order Summary Report (OSR)" Active Orders as of NJ Exec Order 26.4b1 included but were not limited to the following Physician's Orders (POS): -Cleanse NJ Ex Order 26.4(b)(1) with NJ Ex Order 26 , apply NJ Ex Order 26.4(b)(1) daily every day shift for NJ Ex Order 26.4(b)(1) -Cleanse NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1), apply NJ Ex Order 26.4(b)(1) and cover with NJ Ex Order 26.4(b) daily every day shift for NJ Ex Order 26.4(b)(1)	F 880	#15□s door. An NJ Exec Order 26. cart containing appropriate personal protective equipment (PPE) (NJ Ex Order 26 gloves, NJ Ex Order 26.4(b)(1)) was stationed at the room. 2.) Residents who receive wound care have the potential to be affected by the deficient practice. 3.) Clinical staff received infection control re-education with a focus on: Proper wound care techniques, including the use of gloves, hand hygiene, and the correct sequence of steps when handling dressings, and implementation of Enhanced Barrier Precautions (EBP) for residents with open wounds or those at risk of transmitting infections. The infection preventionist was re-educated on the facility EBP policy. 4.) The Director of Nursing (DON) or Infection Preventionist (IP) will observe one (1) wound treatment administration per week for (2) months to ensure proper infection control practices are followed. The DON or designee will conduct a weekly audit x 4 weeks to ensure that EBP is implemented for all residents with an open wound. The results of these audits will be discussed during weekly Quality Assurance and Performance Improvement (QAPI) meetings to identify any trends or recurring issues. Immediate corrective actions will be taken as needed. 5.) Completion Date: 10/01/2024	

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F 880	Continued From page 30 NJ Ex Order 26.4(b)(1) Miscellaneous: Apply to NJ Ex Order 26.4 [redacted] every day shift for NJ Ex Order 26.4(b)(1) [redacted] On 09/04/2024 at 11:01 AM, the surveyor observed no signage on Resident #15's door that indicated resident was on NJ Ex Orde [redacted] On 09/04/2024 at 1:55 PM, the surveyor observed Licensed Practical Nurse (LPN #2) perform NJ Ex Order 26.4(b)(1) on Resident #15. The surveyor observed that LPN #2 did not wear a gown during NJ Ex Order 26.4(b)(1) [redacted]. The surveyor observed that LPN#2 did not change gloves after NJ Ex Order 26.4(b) [redacted] from Resident #15's NJ Ex Order 26.4(b)(1) [redacted]. LPN #2 then proceeded to NJ Ex Order 26.4(b)(1) [redacted] with same gloves used to remove NJ Ex Order 26.4(b)(1) [redacted]. LPN #2 opened NJ Ex Orde [redacted] packaging and dated NJ Ex Order 26.4(b [redacted] with same gloves used to remove NJ Ex Order 26.4(b)(1) [redacted]. On 09/04/2024 at 1:57 PM, the surveyor observed LPN #2 apply NJ Ex Order 26.4(b)(1) [redacted] to Resident #15's NJ Ex Order 26.4(b)(1) [redacted]. The surveyor observed that LPN #2 did not change gloves or perform hand hygiene prior to or after NJ Ex Order 26.4(b [redacted]. On 09/04/2024 at 1:59 PM, the surveyor observed LPN #2 remove a NJ Ex Order 26.4(b)(1) [redacted] from Resident#15's NJ Ex Order 26.4(b)(1) [redacted] without NJ Ex Order 26.4(b) [redacted] and did not perform hand hygiene prior to removing NJ Ex Order 26.4(b [redacted] or after removal of NJ Ex Order 26.4(b) [redacted] LPN #2 then proceeded to put NJ Ex Order 26.4(b)(1) [redacted] on Resident #15's NJ Ex Order 26.4(b)(1) [redacted] and then NJ Ex Order 26. [redacted] with NJ Ex Order 2 [redacted] with same gloves used to remove NJ Ex Order 26.4(b)(1) [redacted]. LPN #2 then NJ Ex Order 26.4(b)(1) [redacted] and placed	F 880		

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F 880	Continued From page 31 [redacted] on resident's [redacted] with same gloves used to remove [redacted]. During an interview with the surveyor on 09/04/2024 at 2:02 PM, LPN #2 stated that they forgot to change gloves after removing [redacted] and before [redacted]. LPN #2 further stated that gloves should have been removed and hand hygiene performed after removal of [redacted] and before [redacted] During an interview with the surveyor on 09/05/2024 at 10:03 AM, the [redacted] stated that [redacted] were instituted if a resident had a [redacted] or a [redacted] The [redacted] stated that when a resident was placed on [redacted] staff were made aware by signage on resident door and an [redacted] cart would be located outside of resident room. The [redacted] further stated that if a resident had an [redacted], the expectation was that staff would wear gowns, gloves, and goggles when providing [redacted]. The [redacted] stated that Resident #15 was not placed on [redacted] because resident did not require [redacted]). The [redacted] further stated that standard precautions were implemented for [redacted] if resident did not have a [redacted] On 09/05/2024 at 12:04 PM, the surveyor observed a white four drawer cart outside of resident #15's room. The cart consisted of [redacted] gloves, disinfectant, [redacted], and gloves inside of it. The surveyor observed no signage near resident's door indicating that Resident #15 was on [redacted]	F 880		

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F 880	Continued From page 32 During an interview with the surveyor on 09/05/2024 at 12:04 PM, the [redacted] confirmed placing white four drawer cart outside of Resident #15's room. The [redacted] further stated that no signage for [redacted] was placed because the resident did not have an [redacted] in their [redacted]. During an interview with the surveyor on 09/05/2024 at 1:04 PM, in the presence of the survey team and the [redacted] the [redacted] stated he was unsure of when [redacted] would be indicated for residents. The [redacted] stated that staff would be made aware of any resident being on [redacted] during daily huddles. The [redacted] further stated that the expectation was that an [redacted] cart and signage should be outside of resident room that is on [redacted]. The [redacted] stated that staff should be wearing [redacted] gloves, [redacted] and if appropriate [redacted] when providing [redacted]. A review of a facility policy titled " Enhanced Barrier Precautions" with revised date of 03/2024 revealed under "Policy Statement", "To minimize the transmission of germs transferring from residents to staff hands and clothing, staff will wear gown and gloves when providing care to residents that require significant physical contact and are at high risk of acquiring or spreading Multidrug Resistance Organisms (MDRO)." Under "Policy Interpretation and Implementation" revealed "1. Enhanced barrier precautions will be applied to: c. Residents with a chronic wound, regardless of their MDRO status. 2. High-contact resident care activities include: h. Performing wound care (for example, any skin opening requiring a dressing)." Under "Procedure" revealed, "1. Signage will be displayed outside of	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315448	A. BUILDING _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ESTATES REHAB AND SENIOR LIVING CENTER	303 BANK AVE RIVERTON, NJ 08077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 33	F 880		

resident rooms specifying the type of PPE needed and will clarify high -contact resident care activities.

A review of a facility policy titled "Wound Care" with revised date of 04/2024 revealed under "Steps in the Procedure", "5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 6. Put on gloves."

A review of a facility policy titled " Infection Control (IC) Guidelines for all Nursing Procedures" with revised date of 08/2024, under "General Guidelines", "7. Employees must wash their hands for twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: e. After handling items potentially contaminated with blood, body fluids, or secretions; 8. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: e. Before handling clean or soiled dressings, gauze pads, etc.; f. Before moving from a contaminated body site to a clean body site during resident care; h. After handling used dressings, contaminated equipment."

NJAC 8:39-19.4 (a) (1) (n)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030301	A. BUILDING: _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ESTATES REHAB AND SENIOR LIVING C	303 BANK AVE RIVERTON, NJ 08077

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiecncy and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisisons of the New Jersey Admiistrative Code, Title 8, Chapter 43E, enforcement of Licensure.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: C/O # NJ 169224, 173961 Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for week of Complaint staffing from 11/19/2023 to 11/25/2023, the facility was deficient in CNA staffing for residents for residents on 6 of 7 day shifts, deficient in total staff for residents on 2 of 7 evening shifts, and deficient in total staff for residents on 1 of 7 overnight shifts, Complaint staffing from 12/03/2023 to 12/09/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts, and deficient in total staff for	S 560	1.) Human Resources (HR) has been re-educated regarding the state-mandated staffing ratios and the importance of meeting minimum staffing levels at all times. This re-education was completed on 09/10/2024. In addition, prior to the next work week, schedules will be reviewed to ensure that CNA assignments are sufficiently staffed based on our current census. Any known vacancies will be promptly addressed. 2.) Residents who reside in this facility have the potential to be impacted by the deficient practice. 3.) The facility has increased recruitment efforts, including outreach to local CNA schools, job fairs, and online platforms.	10/1/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030301	A. BUILDING: _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 1 residents on 2 of 7 evening shifts, Complaint staffing from 05/19/2024 to 05/25/2024, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts, Complaint staffing from 06/30/2024 to 07/06/2024, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts, Complaint staffing from 07/28/2024 to 08/03/2024, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts, from 08/18/2024 to 08/31/2024, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.	S 560	The facility will offer sign-on bonuses and referral bonuses to incentivize CNAs to join the facility and refer qualified candidates. 4.) The unit manager (UM) and HR will conduct daily morning huddles to review staffing levels and ensure that state-mandated CNA-to-resident ratios are met. Any anticipated shortages will be addressed immediately. In addition, HR will conduct daily audits to ensure compliance with CNA staffing ratios for each shift. Any discrepancies will be addressed immediately, and results will be reported to the Administrator and Director of Nursing (DON). Staffing levels will be reviewed monthly for (3) months at the facility's Quality Assurance and Performance Improvement (QAPI) meetings. Trends in staffing, recruitment, and retention will be analyzed, and adjustments will be made as necessary to ensure compliance. 5.) Completion Date: 10/01/2024	

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	030301	A. BUILDING: _____ B. WING _____	C 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ESTATES REHAB AND SENIOR LIVING C	303 BANK AVE RIVERTON, NJ 08077

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S 560	Continued From page 2	S 560		

1. For the week of Complaint staffing from 11/19/2023 to 11/25/2023, the facility was deficient in CNA staffing for residents for residents on 6 of 7 day shifts, deficient in total staff for residents on 2 of 7 evening shifts, and deficient in total staff for residents on 1 of 7 overnight shifts as follows:

-11/19/23 had 2 CNAs for 49 residents on the day shift, required at least 6 CNAs.
-11/21/23 had 4 CNAs for 48 residents on the day shift, required at least 6 CNAs.
-11/21/23 had 4 total staff for 48 residents on the evening shift, required at least 5 total staff.
-11/22/23 had 2 CNAs for 47 residents on the day shift, required at least 6 CNAs.
-11/23/23 had 2 CNAs for 47 residents on the day shift, required at least 6 CNAs.
-11/24/23 had 2 CNAs for 47 residents on the day shift, required at least 6 CNAs.
-11/24/23 had 4 total staff for 47 residents on the evening shift, required at least 5 total staff.
-11/25/23 had 5 CNAs for 47 residents on the day shift, required at least 6 CNAs.
-11/25/23 had 2 total staff for 47 residents on the overnight shift, required at least 3 total staff.

2. For the week of Complaint staffing from 12/03/2023 to 12/09/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts, and deficient in total staff for residents on 2 of 7 evening shifts as follows:

-12/03/23 had 4 CNAs for 48 residents on the day shift, required at least 6 CNAs.
-12/04/23 had 5 CNAs for 48 residents on the day shift, required at least 6 CNAs.
-12/05/23 had 4 CNAs for 47 residents on the day

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	030301	A. BUILDING: _____ B. WING _____	C 09/06/2024

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RIVERVIEW ESTATES REHAB AND SENIOR LIVING C	303 BANK AVE RIVERTON, NJ 08077

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S 560	Continued From page 3	S 560		

shift, required at least 6 CNAs.
-12/06/23 had 4 CNAs for 47 residents on the day shift, required at least 6 CNAs.
-12/08/23had 4 CNAs for 46 residents on the day shift, required at least 6 CNAs.
-12/08/23 had 2 total staff for 46 residents on the evening shift, required at least 5 total staff.
-12/09/23 had 5 CNAs for 46 residents on the day shift, required at least 6 CNAs.
-12/09/23 had 4 total staff for 46 residents on the evening shift, required at least 5 total staff.

3. For the week of Complaint staffing from 05/19/2024 to 05/25/2024, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows:

-05/19/24 had 3 CNAs for 47 residents on the day shift, required at least 6 CNAs.
-05/20/24 had 5 CNAs for 47 residents on the day shift, required at least 6 CNAs.
-05/24/24 had 5 CNAs for 46 residents on the day shift, required at least 6 CNAs.

4. For the week of Complaint staffing from 06/30/2024 to 07/06/2024, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows:

-06/30/24 had 4 CNAs for 47 residents on the day shift, required at least 6 CNAs.
-07/01/24 had 5 CNAs for 47 residents on the day shift, required at least 6 CNAs.
-07/03/24 had 5 CNAs for 47 residents on the day shift, required at least 6 CNAs.
-07/05/24 had 5 CNAs for 47 residents on the day shift, required at least 6 CNAs.

5. For the week of Complaint staffing from 07/28/2024 to 08/03/2024, the facility was

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ESTATES REHAB AND SENIOR LIVING C	303 BANK AVE RIVERTON, NJ 08077

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S 560	Continued From page 4 deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -07/28/24 had 5 CNAs for 47 residents on the day shift, required at least 6 CNAs. -07/29/24 had 4 CNAs for 46 residents on the day shift, required at least 6 CNAs. -07/31/24 had 5 CNAs for 46 residents on the day shift, required at least 6 CNAs. 6. For the 2 weeks of staffing prior to survey from 08/18/2024 to 08/31/2024, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: -08/18/24 had 5 CNAs for 49 residents on the day shift, required at least 6 CNAs. -08/22/24 had 5 CNAs for 49 residents on the day shift, required at least 6 CNAs. -08/24/24 had 5 CNAs for 48 residents on the day shift, required at least 6 CNAs. -08/25/24 had 5 CNAs for 48 residents on the day shift, required at least 6 CNAs. -08/29/24 had 5 CNAs for 47 residents on the day shift, required at least 6 CNAs. -08/30/24 had 5 CNAs for 47 residents on the day shift, required at least 6 CNAs. -08/31/24 had 5 CNAs for 49 residents on the day shift, required at least 6 CNAs. During an interview with the surveyor on 09/06/2024 at 9:20 AM, the Human Resiurce/Staffing was asked Are you aware of the minimum staffing requirements for CNA's? The Human Resource/Staffing replied Yes, Days 1-8, Evening 1-10 and nights 1-14 to 1-16. It is 6 CNA's on days, 5 on evening, and 3-4 on nights. When asked do you meet the required	S 560		

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S 560	Continued From page 5 amount and she replied yes. A review of a facility policy titled Staffing with reviewed/revised dat of 12/2023 revealed under the Policy & Procedure: The purpose of this policy is to ensure that our facility provides adequate and appropriate staffing levels to meet the needs of residents, in compliance with federal, state, and local regulations. The policy is designed to ensure high-quality care, promote resident safety and well-being, and create a supportive working environment for staff. 1. Staffing Levels The facility will meet federal, state, and local staffing requirements. Staffing ratios will be reviewed and adjusted based on the acuity and care needs of residents, ensuring that there are enough licensed and unlicensed personnel to provide high-quality care. 3. Staff-to-Resident Ratios The facility will maintain a minimum staff-to-resident ratio of 1:8 during daytime shifts, 1:10 during evening shifts, and 1:14 during night shifts.	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315448 Y1	A. Building B. Wing Y2	11/3/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ESTATES REHAB AND SENIOR LIVING CENTER	303 BANK AVE RIVERTON, NJ 08077

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0658	Correction	ID Prefix	F0695	Correction	ID Prefix	F0727	Correction
Reg. #	483.21(b)(3)(i)	Completed	Reg. #	483.25(i)	Completed	Reg. #	483.35(b)(1)-(3)	Completed
LSC		10/01/2024	LSC		10/01/2024	LSC		10/01/2024
ID Prefix	F0756	Correction	ID Prefix	F0761	Correction	ID Prefix	F0812	Correction
Reg. #	483.45(c)(1)(2)(4)(5)	Completed	Reg. #	483.45(g)(h)(1)(2)	Completed	Reg. #	483.60(i)(1)(2)	Completed
LSC		10/01/2024	LSC		10/01/2024	LSC		10/01/2024
ID Prefix	F0880	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		10/01/2024	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/6/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
030301	A. Building B. Wing	11/3/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ESTATES REHAB AND SENIOR LIVING CENTER	303 BANK AVE RIVERTON, NJ 08077

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 10/01/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
9/6/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315448	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ESTATES REHAB AND SENIOR LIVING CENTER	**303 BANK AVE** **RIVERTON, NJ 08077**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Riverview Estates was found to be in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/05/2024 and 09/06//2024, Riverview Estates was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Riverview Estates is a single story Type II Protected building with a basement that was built in January 1972. The facility is divided into 4 smoke zones. Emergency secondary power was provided by a 55 KW natural gas powered generator. The sprinkler system had a diesel powered fire pump.	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.	K 353		11/1/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/26/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315448	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ESTATES REHAB AND SENIOR LIVING CENTER	**303 BANK AVE** **RIVERTON, NJ 08077**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 1 a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/6/24 in the presence of the U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6) [redacted]), it was determined the facility failed ensure fire sprinkler system sprinkler heads were maintained in accordance with NFPA 101: 2012 edition, Sections 9.7.5, 19.3.5.1 and, NFPA 25: 2011 edition. This deficient practice had the potential to affect all 48 residents and was evidenced by: Observations during a tour of the facility between 12:05 PM and 1:50 PM, revealed the following: 1. In the resident room 107 bathroom, the sprinkler assembly was coming down 1-inch from the drywall ceiling producing a 1/2-inch space around the pipe. 2. In the nurses station bathroom, the sprinkler escutcheons was coming off the sprinkler and bent. 3. In the soiled utility room, the escutcheon plate and sprinkler head were coming down 3/4 of an inch, leaving a space around the pipe. 4. In the hall ceiling just before the kitchen, there	K 353	Sprinkler System 1. Deficient practice found in individual's Room 107 was fixed by maintenance, who leveled sprinkler pipe to close gap in ceiling on 9/25/2024. The escutcheons were ordered on 9/20/24 and are in the building. Installation was completed on 10/31/2024 by contractor. Sprinkler company installed escutcheons in boiler room and nursing station bathroom on 10/31/2024. Sprinklers repaired by maintenance were inspected on same date by the contractor. Fire wool was immediately ordered for the Kitchen, soiled utility room, and laundry ceiling gaps on 9/6/24 and were placed on 9/20/24. 2. All residents have the potential to be affected by the deficient practice. 3. The U.S. FOIA (b) (6) [redacted]) was educated on the requirements to maintain sprinkler head system coverage compliance by Chief Compliance Officer. 4. MD will conduct facility wide audit monthly for three (3) months to ensure any gaps in the ceiling are sealed around	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315448	A. BUILDING **01** B. WING _____	**09/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ESTATES REHAB AND SENIOR LIVING CENTER	**303 BANK AVE** **RIVERTON, NJ 08077**

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K 353	Continued From page 2 was a 1/2-inch space around the sprinkler escutcheon. 5. In the kitchen, there were 3 wall mounted air conditioning units that each had wires going through the drop ceiling with space around them to allow the passage of smoke and hot gasses. 6. In the laundry room, there was a sprinkler above the dryers with a 2-inch cut out from the sprinkler to the ceiling grid and a sprinkler with foam on the operational part of the sprinkler that would impede proper operation. There was a U shaped cut out around a sprinkler above the washing machine. 7. In the boiler room, there were 4 of 4 sprinklers with no escutcheon plates and two of them had 3/4-inch space around the sprinkler head in the ceiling. In interviews at the time of the observations, the U.S. FOIA and U.S. FC confirmed the findings. The facility U.S. FOIA (b) (6) was informed of the deficient practice during the Life Safety Code exit conference at 3:27 PM. NJAC 8:39-31.2(e) NFPA 13, 25	K 353	the sprinkler heads. Any issues found will be fixed immediately. An audit completed during rounds of the sprinkler head system coverage will be done monthly and provided to the quarterly QAPI. If noticed they will be fixed immediately. Audit findings will be submitted to the quarterly Quality Assurance Performance Improvement (QAPI) meeting for three (3) quarters for review and determine if further interventions are needed. 5. Completion Date: 11/01/2024	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core	K 363		10/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315448	A. BUILDING **01** B. WING _____	**09/06/2024**

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K 363	Continued From page 3 wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/6/24 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), it was determined the facility failed to ensure corridor doors resisted the passage of smoke for 7 of 16	K 363	K-363 1. All residents can be affected by this deficient practice. 2. The Adjustment of hinges has been completed to allow clearance of the	

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	315448	A. BUILDING **01** B. WING _____	**09/06/2024**

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K 363	Continued From page 4 doors observed in accordance with NFPA 101: 2012 edition, Sections 8.3.3, 8.5, 19.3.2, 19.3.6.3, 19.3.6.3.3 and NFPA 80: 2010 edition. The deficient practice had the potential to affect all 48 residents and was evidenced by the following: Observations during a tour of the facility between 12:05 PM and 1:50 PM, revealed the following: 1. The resident room 122 corridor door hit the door frame and would not latch when pulled into its frame. The [redacted] and [redacted] each repeated the test with the same results. 2. The resident room 136 corridor door did not close all the way into its frame and latch when pulled into its frame. 3. The resident room 137 corridor door did not close to latch when pulled into its frame. The [redacted] and [redacted] each repeated the test with the same results. 4. The resident room 135 corridor door did not close to latch when pulled into its frame. 5. The resident room 133 corridor door did not close to latch when pulled into its frame and bounced back open. 6. The double corridor smoke doors #5 had a 1/4-inch space between the meeting edges of the door leaves running vertically from the bottom to the top of the leaves. 7. One of the two kitchen to dining room doors (door closest to the cooking line) did not close into its frame. The door stopped 5-inches open when opened to 90 degrees and released. The	K 363	identified door frame so it latches into closed position for the residents rooms. An Astragal was immediately ordered for the gap in smoke door #5 to meet requirements for compliance and was installed on 9/25/2024. The automatic closer arm was adjusted to close fully between the kitchen and dining room. 3. The Director of Maintenance In-serviced staff on door closure issues and notification to place work orders in the TELS work order system on 9/23/24. The Director of Maintenance will conduct facility wide -audits monthly X3 months to ensure doors close properly. Any issues found will be fixed immediately. 4. Audit findings will be submitted to the quarterly Quality Assurance Performance Improvement meeting X3 quarters for review and determine if further interventions are needed. 5. Completion Date: 10/15/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315448	A. BUILDING **01** B. WING _____	**09/06/2024**

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K 363	Continued From page 5 U.S. FOIA repeated the test with the same results. In an interview at the time, the U.S. FOIA and U.S. FO confirmed the observations. The facility U.S. FOIA (b) (6) was informed of the deficient practice during the Life Safety Code exit conference at 3:27 PM. NJAC 8:39-31.2(e)	K 363		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315448	A. Building 01 - MAIN BUILDING 01 B. Wing	11/3/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ESTATES REHAB AND SENIOR LIVING CENTER	303 BANK AVE RIVERTON, NJ 08077

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 11/01/2024	ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 10/15/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/6/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO