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 ___	**10/30/2023**

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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/09/2021 Baptist Home 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. Baptist Home is a single story Type II Protected building that was built in January 1972. The facility is divided into 4 smoke zones.	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 10/24/2023 in the presence of facility management, it was determined that the facility failed to provide two (2) illuminated exit signs to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following:	K 293	1. All residents have the potential to be affected by this deficient practice. 2. Two illuminated exit signs were installed on 12/4/2023 above the doors leading back into the building in the outside enclosed courtyard. The Maintenance Director was educated on 10/24/23 for the requirement to clearly identify the exit access path to reach an	12/4/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/22/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 293	Continued From page 1	K 293		

Reference:
NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants.

NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination.
Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2

Reference: New Jersey Uniform Construction Code 5:23:
International Building Code,
1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge."

2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign."

Provider's plan of correction (K 293):

exit discharge door with illuminated exit signs.
3. DOM/Designee will conduct monthly audits x3 months in the outside courtyard to ensure that this requirement is met. Findings will be submitted to the Administrator. Any incorrect findings will be corrected immediately.
4. Audit findings will be submitted to the quarterly QAA Committee Meeting x3 quarters to review and determine if further interventions are needed.

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 ____	**10/30/2023**

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 293	Continued From page 2 On 10/24/2023 during the survey entrance at approximately 9:25 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building with one outside enclosed center courtyard that Resident, Staff and Visitors could use. Starting at approximately 9:55 AM, in the presence of the facility's Corporate Maintenance Director (CMD) and MD, a tour of the building was conducted. Along the tour of the facility, at approximately 12:31 PM, an inspection of the outside enclosed (surrounded by the building) courtyard was performed. The surveyor observed no evidence of two (2) illuminated exit signs to clearly identify the exit access route to reach an exit above the two (2) exit access doors in the enclosed courtyard. At this time, the CMD pointed to the plastic signs attached to the doors. The surveyor informed the CMD that the signs need to be illuminated. The CMD confirmed the findings at the time of observations. On 10/24/2023 during the Life Safety Code survey exit, at approximately 2:58 PM, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress	K 293		

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K 293	Continued From page 3 Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c)	K 293		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 10/24/2023, in the	K 321	1. All residents have the potential to be affected by this deficient practice.	12/4/23

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K 321	Continued From page 4 presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 10/24/2023 during the survey entrance, at approximately 9:25 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building with a basement. Starting at approximately 9:55 AM in the presence of the facility's Corporate Maintenance Director (CMD) and MD a tour of the building was conducted. During the building tour the surveyor observed the following hazardous area that failed to have smoke resisting door, 1) At approximately 10:40 AM, an inspection inside the basement level Medical supply storage room was performed. The surveyor observed inside the room multiple combustible cardboard boxes. The room was larger then 50 square feet. The surveyor observed the corridor door had no means to self-close the door into its frame. This left an approximately 38 inch opening to the corridor.	K 321	2. An automatic self-closing door device was installed immediately to the medical supply storage room. 3. A complete audit of all closets and storage rooms over 50 square feet containing combustible materials was conducted on 10/24/23, to ensure that fire rated doors to hazardous areas are separated by smoke resisting partitions. The maintenance director was educated on date on the requirement to ensure that fire rated doors to hazardous areas are separated by smoke resisting partitions. All managers were also educated on 10/25/23 to immediately report to the maintenance department if there is ever an issue with a defective or missing automatic self-closer in hazardous areas. 4. DOM/Designee shall audit all rooms monthly x3 months which require self-closures to ensure proper standards are being met and submit findings to facility administrator. Any incorrect findings will be immediately corrected. 5. Audit findings will be submitted to the quarterly QAA Committee Meeting x3 quarters to review and determine if further interventions are needed.	

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K 321	Continued From page 5 With this corridor door not closing into its frame all the way, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. A review of an emergency evacuation diagram posted in the area identified to pass the Medical supply storage room is the primary and/ or secondary egress route in the event of a fire. The CMD and MD confirmed the findings at the time of observations. On 10/24/2023 during the Life Safety Code survey exit at approximately 2:58 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8	K 341		12/4/23

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K 341	Continued From page 6	K 341		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and review of facility provided documentation on 10/24/2023, in the presence of the facility management, it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 1 of 1 outside enclosed courtyards in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9

The deficient practice was evidenced by the following:

On 10/24/2023 during the survey entrance, at approximately 9:25 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.

A review of the facility provided lay-out identified the facility is a single-story building with one outside enclosed center courtyard and a basement.

Starting at approximately 9:55 AM, in the presence of the facility's Corporate Maintenance Director (CMD) and MD, a tour of the building was conducted. Along the tour of the facility, at approximately 12:31 PM, an inspection of the outside enclosed (surrounded by the building) courtyard was performed.

1. All residents have the potential to be affected by this deficient practice.
2. A vendor was immediately contacted to install an audio and visual alarm tied into the fire alarm system and service has been scheduled for to be completed by 12/4/23.
3. The Maintenance Director was educated on 10/24/23 on the requirement to provide fire alarm notification by audible and visible signals for enclosed courtyards.
4. DOM/Designee will perform audits monthly x3 months to ensure the fire alarm notification by audible and visible signals for enclosed courtyards is working properly and submit findings to the administrator. Any incorrect findings will be immediately corrected.
5. Audit findings will be submitted to the quarterly QAA Committee Meeting x3 quarters for review and determine if further interventions are needed.

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K 341	Continued From page 7 The surveyor observed no evidence of an audio and visual alarm that is tied into the buildings fire alarm and detection system. At this time, the surveyor asked the CMD, "do Residents come out here?" The CMD told the surveyor, yes. The CMD confirmed the finding at the time of observation. Later, at approximately 1:24 PM, during a second tour of the outside enclosed courtyard with the facility Administrator, the surveyor asked the Administrator, "Do you have an audio and visual alarm tied into the buildings fire alarm system?" The Administrator looked around and told the surveyor, "no." The CMD and Administrator confirmed the findings at the time. During the Life Safety Code survey exit at approximately 2:58 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39-31.2(a) NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9	K 341		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in	K 351		12/4/23

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K 351	Continued From page 8 accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 10/24/2023, in the presence of facility management it was determined that the Facility failed to properly install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice is evidenced by the following, On 10/24/2023 during the survey entrance, at approximately 9:25 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building with thirty (30)	K 351	1. All residents have the potential to be affected by this deficient practice. 2. Ceiling tiles were immediately installed/replaced in the following areas; Medical records storage room, Business office, Contractor room, Commercial Laundry room The Director of Maintenance was educated on 10/24/23 for the requirement to properly install sprinklers and provide proper fire sprinkler coverage. 3. The Maintenance Director will conduct facility-wide audits monthly x3 months to ensure all ceiling tiles are properly maintained and provide proper fire sprinkler coverage. Audit findings will be given to the Administrator. Any improper findings will be corrected immediately. 4. Audit findings will be submitted to the quarterly QAA committee meeting x3 quarters for review and determine if further interventions are needed.	

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K 351	Continued From page 9	K 351		

Resident sleeping rooms and a basement.

Starting at approximately 9:55 AM, in the presence of the facility's Corporate Maintenance Director (CMD) and MD, a tour of the building was conducted.
Along the tour, the surveyor observed the following locations that failed to provide proper fire sprinkler coverage:

Basement level:
1) At approximately 10:00 AM, inside the Business office, the surveyor observed the drop ceiling grid were missing one (1) 2' by 4' ceiling tile and one 2' by 2' ceiling tile.
With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system.

2) At approximately 10:15 AM, inside the Medical Records storage room, the surveyor observed the drop ceiling grid were missing one (1) 2' by 2' ceiling tile. With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system.

3) At approximately 10:19 AM, inside the room being utilized by the Contractor, the surveyor observed the drop ceiling grid were missing one (1) 2' by 4' ceiling tile. With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system.

4) At approximately 10:37 AM, inside the Commercial Laundry room by the washing machines, the surveyor observed the drop ceiling grid were missing one (1) 1' by 2' ceiling tile.

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K 351	Continued From page 10 With the opening in the ceilings, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. The CMD and MD confirmed the findings at the time of observations. During the Life Safety Code survey exit at approximately 2:58 PM, the surveyor informed the Administrator of the deficiency. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 364 SS=E	Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This REQUIREMENT is not met as evidenced by: Based on observations, interview and review of	K 364	1. All residents have potential to be	12/4/23

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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 364	Continued From page 11 facility provided documentation on 10/24/2023, in the presence of facility management, it was determined that the facility failed to prohibit transfer grills in corridor doors on resident sleeping units. This deficient practice was evidenced by the following: On 10/24/2023 during the survey entrance at approximately 9:25 AM, a request was made to the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also asked, "how many Resident sleeping rooms are in the facility?" The MD told the surveyor that there are thirty (30) Resident sleeping rooms. A review of the facility provided lay-out identified the facility is a single-story building with 8 Resident sleeping rooms on the "A-Wing", 10 Resident sleeping rooms on the "B-Wing" and 12 Resident sleeping rooms on the "C-Wing." along with common areas and offices. Starting at approximately 9:55 AM, in the presence of the facility's Corporate Maintenance Director (CMD) and MD, a tour of the building was conducted. Along the tour of the facility the surveyor observed the following: 1) At approximately 12:15 PM,the surveyor observed the Residents shower room on B-Wing had a 32 inch by 12 inch open transfer grill. 2) At approximately 12:42 PM,the surveyor observed the Residents shower room on A-Wing had a 32 inch by 12 inch open transfer grill.	K 364	affected by this deficient practice. 2. Both “A-wing” and “B-wing” shower room transfer grills were immediately covered by a plank of plywood, completely sealing the 32” by 12” transfer grill. The Maintenance Director was educated on 10/24/23 for the prohibition of transfer grills in corridor doors on resident sleeping units. 3. DOM/Designee will conduct a facility-wide audit monthly x3 months of all corridor doors in residents sleeping units to ensure that transfer grills are not in corridor doors. Audit findings will be given to the Administrator. Any improper findings will be corrected immediately. 4. Audit findings will be submitted to the quarterly QAA committee meeting x3 quarters for review and determine if further interventions are needed.	

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 ______	**10/30/2023**

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 364	Continued From page 12 The CMD and MD confirmed the findings during the tour of the facility at the time of the inspections. During the Life Safety Code survey exit at approximately 2:58 PM, the surveyor informed the Administrator of the deficiency. NJAC 8:39 - 31.2 (e).	K 364		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 10/24/2023, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for one (1) of four (4) smoke barrier walls inspected as evidenced by the following: On 10/24/2023, during the survey entrance at approximately 9:25 AM, a request was made to	K 372	1. All residents are at risk to be affected by this deficient practice. 2. The 6'x2' penetration above the double doors near Administrator's office was fixed on 11/20/23. The Maintenance Director was educated on 10/24/23 for the requirement to maintain the integrity of all smoke barrier partitions for smoke barrier walls.	12/4/23

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	**10/30/2023**

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 372	Continued From page 13 the Administrator and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building with four (4) smoke barrier walls in the facility. Starting at approximately 9:55 AM, in the presence of the facility's Corporate Maintenance Director (CMD) and MD, an inspection above the corridor ceiling tiles of 4 smoke barrier walls was performed. The surveyor observed the following smoke barrier wall failed to maintain the 1/2 hour fire rated construction as required by code in the following locations: 1. At approximately 11:55 AM, the surveyor observed above the ceiling tiles of the corridor double smoke doors near the Administrators office, one (1) approximately 6" by 2" penetration with 6 gray wires and 1 blue wire running through the smoke barrier wall. This penetration was observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The CMD and FMD confirmed the findings at the time of observations. During the Life Safety Code survey exit at approximately 2:58 PM, the surveyor informed the Administrator of the deficiency.	K 372	3. DOM/Designee will conduct a facility-wide audit monthly x3 months to maintain the integrity of all smoke barrier partitions for smoke barrier walls. Audit findings will be given to the Administrator. Any improper findings will be corrected immediately. 4. Audit findings will be submitted to the quarterly QAA Committee meeting x3 quarters for review and determine if further interventions are needed.	

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 ______	**10/30/2023**

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 372	Continued From page 14 Fire Safety Hazard. NJAC 8:39- 31.2(e).	K 372		

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	12/29/2023

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 K0293	Correction Completed 12/04/2023	ID Prefix Reg. # NFPA 101 LSC K0321	Correction Completed 12/04/2023	ID Prefix Reg. # NFPA 101 LSC K0341	Correction Completed 12/04/2023
ID Prefix Reg. # NFPA 101 LSC K0351	Correction Completed 12/04/2023	ID Prefix Reg. # NFPA 101 LSC K0364	Correction Completed 12/04/2023	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 12/04/2023
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	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	
10/30/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO