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

PRINTED: 09/29/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
315225		B. WING _	B. WING		08/11/2022		
NAME OF PROVIDER OR SUPPLIER RIVERFRONT REHABILITATION AND HEALTHCARE CENTER				5	STREET ADDRESS, CITY, STATE, ZIP CODE 5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109		
(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		K	000			
	TYPE OF SURVEY: Renovation Project: I Lobby and Administra	Phase 3 renovation of the					
	New Jersey Departme Survey and Field Ope Riverfront Rehab. and found to be in noncon requirements for parti Medicare/Medicaid at Safety from Fire, and National Fire Protection Life Safety Code (LSC Health Care Occupant Riverfront Rehabilitation a three story type II of January 1986.	cipation in 242 CFR 483.90(a), Life the 2012 Edition of the on Association (NFPA) 101, C), Chapter 19 EXISTING ncies. ion and Healthcare Center is onstruction building built in					
K 351 SS=D	formal notification by Licensing Division has Sprinkler System - Ins		K	351			8/25/22
	construction type, are approved automatic s accordance with NFP. Installation of Sprinkle In Type I and II construe measures are permitt	nospitals where required by protected throughout by an prinkler system in A 13, Standard for the					
. A D O D A T O D \ / I	DIDECTORIC OR BROWINER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITI F		(X6) DATE

Electronically Signed

08/19/2022

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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	315225 B. WING			08/11/20			
NAME OF PROVIDER OR SUPPLIER RIVERFRONT REHABILITATION AND HEALTHCARE CENTER				510	REET ADDRESS, CITY, STATE, ZIP CODE 01 NORTH PARK DRIVE ENNSAUKEN, NJ 08109		
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K 351	or local regulations p In hospitals, sprinkler closets of patient slee of the closet does no sprinkler coverage co required by NFPA 13 Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19 19.4.2, 19.3.5.10, 9.7 This REQUIREMENT by: Based on observation facility provided docu this facility did not pro required by CMS reg environment to all are requirements of 1) N Section 19.3.5.1, 9.7 Protection Association Sprinkler Systems 20 2) As required by the Construction Code N I-2 (health care) use This deficient practice sprinkler rooms adjace lobby and was evider Reference #1: Nation Association (NFPA) 1 Installation of Sprinkl Installation Requirem -8.8.4.1.1 Unobstruct -8.8.4.1.1.1 Under und distance between the ceiling shall be a min	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 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		TAG CROSS-REFERENCED TO THE APPROPR		e e eted n to ng the ill	

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NAME OF PROVIDER OR SUPPLIER RIVERFRONT REHABILITATION AND HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109				
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K 351	Special detailed required occupancy section 40 Automatic sprinkler scompartments contains shall be equipped thrifire sprinkler system if 903.3.1.1. The smoked equipped with approving the survey enterproximately 9:05 Automatic sprinklers 903.3.2. During the survey enterproximately 9:05 Automatic sprinkle sprinkl	rm Construction Code, irements based on use and 17 group I-2, [F] 407.5 system. Smoke ning patient sleeping units oughout with an automatic in accordance with Section in accordance wi	K	351				

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K 351	Continued From page 3		K 3	351				
	The DOM confirmed to observation.	he finding at the time of						
		s informed of the surveyor's rvey exit on 8/11/2022 at						
	Fire Safety Hazard. NJAC 8:39 -31.2(a)							