PRINTED: 04/30/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G <b>01</b>		(X3) DATE SURVEY COMPLETED		
		315225	B. WING _			12/16/2022		
	ROVIDER OR SUPPLIER  ONT REHABILITATION	I AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
E 000	Initial Comments		E 0	00				
K 000	conducted by Healt LLC on behalf of the		К 0	00				
	New Jersey Departs Survey and Field O found to be in nonce requirements for pa Medicare/Medicaid Safety from Fire, an National Fire Protect	rticipation in at 42 CFR 483.90(a), Life at the 2012 Edition of the ction Association (NFPA) 101, SC), Chapter 19 EXISTING						
K 200 SS=F	a three-story buildir composed of Type I facility is divided int generator does app as per the Maintena occupied beds are	ation and Healthcare Center, and that was built in 1982. It is all protected construction. The consistency eight smoke zones. The proximately 50% of the building ance Director. The current 157 of 182. equirements - Other	K 2	00		1/30/23		
	List in the REMARK 18.2 and 19.2 Mear are not addressed be deficient. This inforr applicable Life Safe	equirements - Other (S section any LSC Section as of Egress requirements that by the provided K-tags, but are mation, along with the sty Code or NFPA standard included on Form CMS-2567.						
ABORATORY	I DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATUF	RE	TITLE		(X6) DATE		

Electronically Signed 12/30/2022

Facility ID: NJ60415

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		PLE CONSTRUCTION G <b>01</b>	(X3) DATE SURVEY COMPLETED
315225			B. WING	····	12/16/2022
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
K 200	Continued From page	e 1	K 20	00	
	by: Based on observation failed to ensure that the annually in accordant Code (2012 edition) practice had the poter residents.  Findings include:  Observations of the fraction of the fractio	Based on observation and interview, the facility failed to ensure that the fire doors were inspected annually in accordance with NFPA 101 Life Safety Code (2012 edition) 7.2.1.15. This deficient practice had the potential to affect all 157 residents.  Findings include:  Observations of the facility's fire doors on 12/09/22 from 11:00 AM to 1:30 PM, revealed the door lacked the required inspection tags required to be placed on the doors after completed inspections. The Maintenance Director was present at the time of observation and confirmed the doors were not inspected. The Maintenance Director advised that he did not know that the fire doors had to be inspected annually by a qualified person who had knowledge of the fire doors and		Immediate Corrective Action  The facility fire door assemblies will inspected by a qualified person by 1/30/23.  Method to Assess Others  All facility fire door assemblies were accounted for.  No Residents were affected by this practice.  All residents have the potential to be affected by this practice.  Systematic Process  Maintenance Department has been educated on fire safety and the nee all fire doors to be inspected.  The Maintenance Department will continue to perform annual inspectit the facility fire door assemblies as puthe facility slife safety program.  Quality Assurance  Maintenance Director/Designee will Quarterly audits x4 after that to ensithat door inspection is completed annually. Maintenance Director will	e ed for ons of part of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BU		PLE CONSTRUCTION G <b>01</b>	(X3) DATE SURVEY COMPLETED		
		315225	B. WING		12/16/2022		
	ROVIDER OR SUPPLIER  ONT REHABILITATION A	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION		
K 200	Continued From page	2	K 20	present audits to quarterly QAPI me x4 Quarters.	eeting		
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101			23	1/30/23		
	Doors in an exit pass or horizontal exit, smorth area enclosure are sectored position, unless device complying with closes all such doors compartment or entire * Required manual fir * Local smoke detects smoke passing through smoke detection syst * Automatic sprinkler * Loss of power.  18.2.2.2.7, 18.2.2.2.8 This REQUIREMENT by:  Based on observation failed to maintain the three stairway exit door was device in accordance Code (2012 Edition) Selficient practice had residents.  Findings include:  Observation on 12/09 that the stairway door device. At the time of	Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:  * Required manual fire alarm system; and  * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and  * Automatic sprinkler system, if installed; and  * Loss of power.  18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8  This REQUIREMENT is not met as evidenced by:  Based on observation and interview, the facility failed to maintain the means of egress for one of three stairway exit doors on the 2nd floor. The stairway exit door was missing a self-closing device in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 19.2.2.2.7. This deficient practice had the potential to affect 17 residents.		Immediate Corrective Action  The facility fire door assemblies will inspected by a qualified person by 1/30/23.  Method to Assess Others  All facility fire door assemblies were accounted for.  No Residents were affected by this practice.  All residents have the potential to be affected by this practice.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 01 315225 B. WING 12/16/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5101 NORTH PARK DRIVE** RIVER FRONT REHABILITATION AND HEALTHCARE CENTER PENNSAUKEN, NJ 08109 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 223 Continued From page 3 K 223 NJAC 8:39-31.2(e) Systematic Process Maintenance Department has been educated on fire safety and the need for all fire doors to be inspected. The Maintenance Department will continue to perform annual inspections of the facility fire door assemblies as part of the facility's life safety program. **Quality Assurance** Maintenance Director/Designee will do Quarterly audits x4 after that to ensure that door inspection is completed annually. Maintenance Director will present audits to quarterly QAPI meeting x4 Quarters. K 311 Vertical Openings - Enclosure K 311 1/30/23 SS=E CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility Immediate Corrective Action

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
315225			B. WING _			12/16/2022		
	ROVIDER OR SUPPLIER  ONT REHABILITATION A	AND HEALTHCARE CENTER	,	REET ADDRESS, CITY, STATE, ZIP CODE 101 NORTH PARK DRIVE ENNSAUKEN, NJ 08109	•			
(X4) ID PREFIX TAG	,	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
K 311	failed to maintain the three stairway exit do stairway exit door wa indicated the fire ratir with NFPA 101 Life S Sections 19.3.1.1. Th potential to affect 17  Findings include:  Observation on 12/09 stairway exit door loc missing the label indi door. At the time of th Maintenance Director	Observation on 12/09/22 at 1:06 PM, revealed the stairway exit door located on the 2nd floor, was missing the label indicating the fire rating of the door. At the time of the observation, the Maintenance Director verified the label was missing from the stairway door.  NJAC 8:39-31.1 (c)		311	Stairway exit doors will be labeled with fire rating attached to it.  Method to Assess Others  No Residents were affected by this practice.  All residents have the potential to be affected by this practice.  All other stairwell doors Have been inspected to ensure the presence of a rated label.  Systematic Process  Maintenance Department has been educated on fire safety and the need for all fire doors to be fire rated and labele on the door.  The Maintenance Director will continue perform annual inspections of the facility stairwell doors to ensure the presence a fire rated label as part of the facility's safety program.  Quality Assurance  Maintenance Director will do monthly audits x4 after that to ensure all fire do have been rated appropriately.  Maintenance Director will present audit to quarterly QAPI meeting x2 Quarters	fire or d e to fity of life		

NAME OF PROVIDER OR SUPPLIER  RIVER FRONT REHABILITATION AND HEALTHCARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  5101 NORTH PARK DRIVE  PENNSAUKEN, NJ 08109  PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	12/16/2022 (X5) COMPLETION DATE
RIVER FRONT REHABILITATION AND HEALTHCARE CENTER  5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
DEFICIENCY)	
K 345 Continued From page 5 K 345 Fire Alarm System - Testing and Maintenance K 345	1/30/23
SS=F CFR(s): NFPA 101  Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.  9,6.1.3, 9,6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure smoke detection sensitivity testing was completed of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. This had the potential to affect all 157 residents.  Findings include:  Observation of the facility smoke detectors on 12/09/22 from 12:30 PM to 3:00 PM, revealed smoke detectors located in the corridors and other concealed areas throughout the building.  Review of the facility fire alarm "Inspection and Testing Form" dated 07/26/22, provided by the Director of Maintenance, revealed no documented reference to a smoke detection sensitivity test.  During an interview on 12/09/22 at 3:15 PM, the Director of Maintenance verified that the fire alarm sensitivity testing was not completed on the fire alarm system.  K 345  FIRMAINTENTIAL TOP A 72  This Alarm System - Testing and Maintenance and prevail and maintained in accordance with an approved program complying with the requirements of NFPA 72, National Fire Alarm and Signaling Code. Records of System acceptance, maintenance and testing are readily available.  Immediate Corrective Action  Sensitivity testing was performed by a 3rd party vendor.  All facility smoke detectors were accounted for.  No Residents were affected by this practice.  All residents have the potential to be affected by this practice.  Systematic Process  Maintenance Department has been educated on fire safety and the need for sensitivity testing for all smoke detectors throughout the building.  The Maintenance Director will continue to	

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		315225	B. WING _			12/	12/16/2022	
NAME OF P	ROVIDER OR SUPPLIER		,	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
RIVER FR	ONT REHABII ITATION A	ND HEALTHCARE CENTER		51	01 NORTH PARK DRIVE			
KIVEKTK	THE THEATTHCARE CENTER		PI	ENNSAUKEN, NJ 08109				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION		
K 345	Continued From page NJAC 8:39-31.2(e)	6	K3	345	coordinate on an ongoing basis with a third-party fire alarm system vendor to perform biennial smoke detector sensitivity testing as part of the facility life safety program.  Quality Assurance  Maintenance Director/Designee will do bi-annual audits x4 after that to ensure sensitivity testing is completed Biennia Maintenance Director will present audit to quarterly QAPI meeting x4 Quarters	s o e allly. ts		

#### POST-CERTIFICATION REVISIT REPORT

FOST-CERTIFICATION REVISIT REFORT												
PROVIDER / SUPPLIER / CLIA / MULTIPLE CONST									DATE O	F REVISIT		
IDENTIFICATION NUMBER 315225 A. Building 01 - B. Wing				COOPER F	RIVER W	/EST				V0	2/9/202	3 ,,,,
11 0							CTDEE	TARRESC CITY	V OTATE 715	Y2		. Y3
NAME OF	FACILITY RONT REHABIL	ΙΤΛΤΙΩΝΙ Λ	ND HEALTHOA	DE CENTE	D			T ADDRESS, CIT' ORTH PARK DRI\		CODE		
KIVLKII	CONT INCLIABLE	ITATIONA	INDTILALITICA	INL CLIVIL	IX			AUKEN, NJ 0810				
program, corrected provision	to show those d and the date su	eficiencies ch correcti	previously repo ve action was ac	rted on the ccomplished	CMS-25 d. Each	67, Statem deficiency	nent of E should	Deficiencies and be fully identifie	Plan of Cor d using eithe	ent Amendments rection, that have er the regulation o of each requirem	r LSC	
ITEI	И		DATE	ITEM				DATE	ITEM			DATE
Y4			Y5	Y4				Y5	Y4			Y5
ID Prefix Reg. # LSC	NFPA 101 		Correction  Completed 01/30/2023	ID Prefix Reg. # LSC	NFPA 10	01		Correction Completed 01/30/2023	ID Prefix Reg. # LSC	NFPA 101 K0311		Correction Completed 01/30/2023
ID Prefix			Correction	ID Prefix				Correction	ID Prefix			Correction
Reg.#	NFPA 101		Completed	Reg.#				Completed	Reg. #			Completed
LSC	K0345		01/30/2023	LSC					LSC			
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FOLLOWILD TO SURVEY COMPLETED ON			CHECK FOR ANY LINCORRECTED DEFICIENCIES, WAS A SLIMMARY OF									

12/16/2022

UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

YES NO