| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315225 | A. BUILDING **01**<br>B. WING _____ | **12/16/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **RIVER FRONT REHABILITATION AND HEALTHCARE CENTER** | **5101 NORTH PARK DRIVE**<br>**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 |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 12/09/22. The facility was found to be in compliance with 42 CFR 483.73 | E 000 | | |
| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/09/22 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 Occupancy<br><br>Riverfront Rehabilitation and Healthcare Center, a three-story building that was built in 1982. It is composed of Type II protected construction. The facility is divided into eight smoke zones. The generator does approximately 50% of the building as per the Maintenance Director. The current occupied beds are 157 of 182. | K 000 | | |
| K 200 SS=F | Means of Egress Requirements - Other<br>CFR(s): NFPA 101<br><br>Means of Egress Requirements - Other<br>List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.<br>18.2, 19.2 | K 200 | | 1/30/23 |

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

Electronically Signed | 12/30/2022

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| K 200 | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>Findings include:<br><br>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 how they operate.<br><br>Use NJAC 8:39-31.1(c), 31.2(e) | K 200 | Immediate Corrective Action<br><br>The facility fire door assemblies will be inspected by a qualified person by 1/30/23.<br><br>Method to Assess Others<br><br>All facility fire door assemblies were accounted for.<br><br>No Residents were affected by this practice.<br><br>All residents have the potential to be affected by this practice.<br><br>Systematic Process<br><br>Maintenance Department has been educated on fire safety and the need for all fire doors to be inspected.<br><br>The Maintenance Department will continue to perform annual inspections of the facility fire door assemblies as part of the facility□s life safety program.<br><br>Quality Assurance<br><br>Maintenance Director/Designee will do Quarterly audits x4 after that to ensure that door inspection is completed annually. Maintenance Director will | |

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| | 315225 | A. BUILDING **01**<br>B. WING _____ | **12/16/2022** |

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| K 200 | Continued From page 2 | K 200 | present audits to quarterly QAPI meeting x4 Quarters. | |
| K 223 SS=E | Doors with Self-Closing Devices<br>CFR(s): NFPA 101<br><br>Doors with Self-Closing Devices<br>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:<br>* Required manual fire alarm system; and<br>* Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and<br>* Automatic sprinkler system, if installed; and<br>* Loss of power.<br>18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8<br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>Findings include:<br><br>Observation on 12/09/22 at 1:06 PM, revealed that the stairway door was missing a self-closing device. At the time of the observation, the Maintenance Director verified the self-closing device was missing from the stairway door. | K 223 | Immediate Corrective Action<br><br>The facility fire door assemblies will be inspected by a qualified person by 1/30/23.<br><br>Method to Assess Others<br><br>All facility fire door assemblies were accounted for.<br><br>No Residents were affected by this practice.<br><br>All residents have the potential to be affected by this practice. | 1/30/23 |

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| **RIVER FRONT REHABILITATION AND HEALTHCARE CENTER** | **5101 NORTH PARK DRIVE**<br>**PENNSAUKEN, NJ 08109** |

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| K 223 | Continued From page 3<br><br>NJAC 8:39-31.2(e) | K 223 | Systematic Process<br><br>Maintenance Department has been educated on fire safety and the need for all fire doors to be inspected.<br><br>The Maintenance Department will continue to perform annual inspections of the facility fire door assemblies as part of the facility's life safety program.<br><br>Quality Assurance<br><br>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 SS=E | Vertical Openings - Enclosure<br>CFR(s): NFPA 101<br><br>Vertical Openings - Enclosure<br>2012 EXISTING<br>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<br>If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility | K 311 | Immediate Corrective Action | 1/30/23 |

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| | 315225 | A. BUILDING **01**<br>B. WING _____ | **12/16/2022** |

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| **RIVER FRONT REHABILITATION AND HEALTHCARE CENTER** | **5101 NORTH PARK DRIVE**<br>**PENNSAUKEN, NJ 08109** |

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|---|---|---|---|---|
| K 311 | Continued From page 4<br>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 label that indicated the fire rating of the door in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 19.3.1.1. This deficient practice had the potential to affect 17 residents.<br><br>Findings include:<br><br>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.<br><br>NJAC 8:39-31.1 (c)<br>NJAC 8:39-31.2 (e) | K 311 | Stairway exit doors will be labeled with the fire rating attached to it.<br><br>Method to Assess Others<br><br>No Residents were affected by this practice.<br><br>All residents have the potential to be affected by this practice.<br><br>All other stairwell doors Have been inspected to ensure the presence of a fire rated label.<br><br>Systematic Process<br><br>Maintenance Department has been educated on fire safety and the need for all fire doors to be fire rated and labeled on the door.<br><br>The Maintenance Director will continue to perform annual inspections of the facility stairwell doors to ensure the presence of a fire rated label as part of the facility's life safety program.<br><br>Quality Assurance<br><br>Maintenance Director will do monthly audits x4 after that to ensure all fire doors have been rated appropriately. Maintenance Director will present audits to quarterly QAPI meeting x2 Quarters | |

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| K 345 | Continued From page 5 | K 345 | | |
| K 345 SS=F | Fire Alarm System - Testing and Maintenance<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Testing and Maintenance<br>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.<br>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>Findings include:<br><br>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.<br><br>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.<br><br>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 | Immediate Corrective Action<br><br>Sensitivity testing was performed by a 3rd party vendor.<br><br>Method to Assess Others<br><br>All facility smoke detectors were accounted for.<br><br>No Residents were affected by this practice.<br><br>All residents have the potential to be affected by this practice.<br><br>Systematic Process<br><br>Maintenance Department has been educated on fire safety and the need for sensitivity testing for all smoke detectors throughout the building.<br><br>The Maintenance Director will continue to | 1/30/23 |

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| K 345 | Continued From page 6<br>NJAC 8:39-31.2(e) | K 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's life safety program.<br><br>Quality Assurance<br><br>Maintenance Director/Designee will do bi-annual audits x4 after that to ensure sensitivity testing is completed Biennially. Maintenance Director will present audits to quarterly QAPI meeting x4 Quarters. | |

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 |
|---|---|---|
| 315225 Y1 | A. Building 01 - COOPER RIVER WEST<br>B. Wing Y2 | 2/9/2023 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RIVER FRONT REHABILITATION AND HEALTHCARE CENTER | 5101 NORTH PARK DRIVE<br>PENNSAUKEN, NJ 08109 |

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 | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed |
| LSC K0200 | 01/30/2023 | LSC K0223 | 01/30/2023 | LSC K0311 | 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 | |
| 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 |
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| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
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| 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 | |
|---|---|
| 12/16/2022 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |