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

|                          | DF DEFICIENCIES<br>CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ` ′                 |     | CONSTRUCTION   | (X3) DATE<br>COMF | SURVEY<br>PLETED           |
|--------------------------|---|--|---------------------|-----|--|-------------------|----------------------------|
|                          |   | 315225   | B. WING_            |     |  |                   | C<br>/ <b>31/2022</b>      |
|                          | ROVIDER OR SUPPLIER  DNT REHABILITATION A   | ND HEALTHCARE CENTER   |                     | 51  | TREET ADDRESS, CITY, STATE, ZIP CODE  101 NORTH PARK DRIVE  ENNSAUKEN, NJ 08109                                      | 1 077             | 31/2022                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | x   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                   | (X5)<br>COMPLETION<br>DATE |
| F 000                    | INITIAL COMMENTS  |  | F                   | 000 |  |                   |                            |
|                          | •   | 50, NJ153795, NJ155485,<br>157, NJ149169, NJ150827,<br>5888  |                     |     |  |                   |                            |
|                          | Census: 156   |  |                     |     |  |                   |                            |
|                          | Sample Size: 14   |  |                     |     |  |                   |                            |
|                          | The facility is not in corequirements of 42 C Long Term Care Faci complaint survey.   | FR Part 483, Subpart B, for  |                     |     |  |                   |                            |
|                          | Survey dates: 07/30/2   | 2022 to 07/31/2022   |                     |     |  |                   |                            |
| F 609<br>SS=D            |   |  | F 6                 | 509 |  |                   | 9/16/22                    |
|                          |   | se to allegations of abuse,<br>or mistreatment, the facility   |                     |     |  |                   |                            |
|                          | involving abuse, neglimistreatment, includir source and misappro are reported immedia hours after the allegathat cause the allegative serious bodily injury, the events that cause abuse and do not rest the administrator of the officials (including to adult protective service for jurisdiction in long | that all alleged violations ect, exploitation or ng injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to be facility and to other the State Survey Agency and the state Survey Agency and the state serious in elaw through established |                     |     |  |                   |                            |
| ARODATORY                | <br>  | SUPPLIER REPRESENTATIVE'S SIGNATURI  | <br>=               |     | TITI F   |                   | (X6) DATE                  |

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

08/25/2022

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

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.

**Electronically Signed** 

| ,                        |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |  | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|---|---------------------|--|--|-------------------------------|--|
|                          |   | 315225  | B. WING _           |  |  | C<br><b>7/31/2022</b>         |  |
|                          | ROVIDER OR SUPPLIER   | N AND HEALTHCARE CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP COI<br>5101 NORTH PARK DRIVE<br>PENNSAUKEN, NJ 08109  | •  | 773172022                     |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE   | ' STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)   | N SHOULD BE<br>E APPROPRIATE   | (X5)<br>COMPLETION<br>DATE    |  |
| F 609                    | S483.12(c)(4) Rep investigations to the designated repression accordance with Survey Agency, wincident, and if the appropriate correct This REQUIREMED by: Complaint Intake Based on interview policy review, the of unknown origin was immediately rand State Survey sampled resident origin. Findings included: Review of a facility Mistreatment, Neg Misappropriation of 07/01/2022, reveal | ort the results of all ne administrator or his or her entative and to other officials in tate law, including to the State ithin 5 working days of the alleged violation is verified tive action must be taken. ENT is not met as evidenced #NJ150827  vs, record review, and facility facility failed to ensure an injury to the resident's eported to the Administrator Agency for 1 (Resident ) of 1 reviewed for injury of unknown | F 6                 | I: Immediate Action: a) Facility staff were re-in se identifying injury of unknown timely notification to the Adm State survey agency. b) Resident medical recreviewed, noted no untoward related to the c) Resident no longer in the state survey medical recreviewed no longer in the state survey medical recreviewed no longer in the state survey medical recreviewed no longer in the state survey medical recreated to the longer in the st | rviced on origin and inistrator and ord was deffects he facility, service on of unknown eing affected were |                               |  |
|                          | in the resident's color indicative of abuse findings and/or color supervisor. If the enot available (i.e.   supervisor should The policy also indicated that allegations/vioneglect, exploitation injuries from an unmisappropriation of  | proyees - In changes are noted on dition, which may be a, immediately report their neerns to their direct supervisor is meaning] off shift), the nursing also be notified immediately." dicated, "The facility will ensure plations involving abuse, on or mistreatment, including alknown source and of resident's property, are ely but not later than 2 hours  |                     | unknown origin were identified noted that proper documental reporting was in place.  3) All patients currently in ho   | ed and it was ation and use were one noted.  viewed Policy njury of be in                                  |                               |  |

| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI   | , ,       |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | ` '     | PLE CONSTRUCTION  G  | (X3) DATE SURVEY<br>COMPLETED  |                            |
|--|-----------|---|---|---------|--|--|----------------------------|
| RIVERFRONT REHABILITATION AND HEALTHCARE CENTER    SUMMARY STATEMENT OF DEFICIENCIES   PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE)   PREFIX   PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE A |           |   | 315225  | B. WING |  |  |                            |
| REFERENT REHABILITATION AND HEALTHCARE CENTER   PENNSAUKEN, NJ 08109   | NAME OF P | ROVIDER OR SUPPLIER   |   |         | STREET ADDRESS, CITY, STATE, ZIP CODE  |  | 113112022                  |
| PENNSAUKEN, NJ 08109   PENNSAUKEN, NJ 08109   PENNSAUKEN, NJ 08109   PROPRIET   PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   REACH CORRECTIVE ACTION SHOULD BE COMMELT OR CROSS-REFERENCED TO THE APPROPRIATE   CAMPICAL OR LSC IDENTIFYING INFORMATION)   PREFIX   REACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   CAMPICAL OR LSC IDENTIFY OR LS   | D11/5050  |   |   |         | 5101 NORTH PARK DRIVE  |  |                            |
| FREENT TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 609  Continued From page 2 after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not results [sic] in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protection service where State law provides for jurisdiction in long term care facilities) in accordance with State Law through established procedures." The policy also revealed, "The results of all investigation will be reported to the administrator or his or her designated representative and other officials in accordance with State law, including the State Survey Agency, withing 5 working days of the incident."  Review of an "Admission Record" revealed Resident had a Brief Interview for Mental Status (BIMS) score of injury of unknown origin to the Administrator of the facility and to other officials in accordance with State law, including primary had diagnoses including primary had a Brief Interview for Mental Status (BIMS) score of injury of unknown origin to the Administrator and State survey agency IV. QA Monitoring a) An audit tool was created to monitor and track any injury of unknown origin to the Administrator and State survey agency IV. QA Monitoring a) An audit tool was created to monitor and track any injury of unknown origin to the Administrator and State survey agency IV. QA Monitoring a) An audit tool was created to monitor and track any injury of unknown origin to the Administrator of the facility and to accordance with State Law through established procedures." The policy and track any injury of unknown origin to the Administrator of the facility and to the reportion, with the policy for reporting of injury of unknown origin to the Administrator of the State Survey Agency and adult protection service where State Survey Agency and adult protection servi | RIVERFRO  | ON I REHABILITATION A   | ND HEALTHCARE CENTER  |         | PENNSAUKEN, NJ 08109   |  |                            |
| after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not results [sic] in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protection service where State law provides for jurisdiction in long term care facilities) in accordance with State Law through established procedures." The policy also revealed, "The results of all investigation will be reported to the administrator or his or her designated representative and other officials in accordance with State law, including the State Survey Agency, withing 5 working days of the incident."  Review of an "Admission Record" revealed Resident had a Brief Interview for Mental Status (BIMS) score of , indicating the resident was have a serious bodily injury, or not later than 24 hours if the events that cause the allegation do not injury of unknown origin to the Administrator and States survey agency IV. QA Monitoring a) An audit tool was created to monitor and track any injury of unknown origin to the Administrator and State survey agency IV. QA Monitoring a) An audit tool was created to monitor and track any injury of unknown origin to the Administrator and States survey agency IV. QA Monitoring a) An audit tool was created to monitor and track any injury of unknown origin to the Administrator and States survey agency IV. QA Monitoring a) An audit tool was created to monitor and track any injury of unknown origin to the Administrator and States survey agency IV. QA Monitoring a) An audit tool was created to monitor and track any injury of unknown origin to the Administrator and States survey agency IV. QA Monitoring a) An audit tool was created to monitor and track any injury of unknown origin to ensure spectures. The Administrator and States survey agency IV. QA Monitoring a) An audit tool was created to monitor and track any inj | PREFIX    | (EACH DEFICIENC)  | Y MUST BE PRECEDED BY FULL  | PREFIX  | (EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP   | OULD BE  | (X5)<br>COMPLETION<br>DATE |
| resident required limited assistance of one person with bed mobility, transfer, toilet use, personal hygiene, and dressing.  A review of a "Care Plan," revealed Resident was at risk for Interventions included inspecting the daily during care. The care plan was dated as closed due to discharge. The care plan   | F 609     | after the allegation is cause the allegation is serious bodily injury, of the events that cause involve abuse and do bodily injury, to the act and to other officials (Survey Agency and a State law provides for care facilities) in accordance through established prevealed, "The results reported to the admin designated represent accordance with State Survey Agency, within incident."  Review of an "Admiss Resident had diag primary  Review of a significant (MDS), dated had a Brief Interview score of indicating resident required limit person with bed mobile personal hygiene, and A review of a "Care Pwas at risk for Interventions included care. The care plan we are involved that the care plan we care. | made, if the events that hovolve abuse or result in or not later than 24 hours if the allegation do not not results [sic] in serious diministrator of the facility including to the State dult protection service where right in jurisdiction in long term redance with State Law rocedures." The policy also so fall investigation will be istrator or his or her ative and other officials in elaw, including the State and 5 working days of the sion Record" revealed noses including hoses including hoses including has a manner of the mose including has been assistance of one lity, transfer, toilet use, didressing.  It inspecting the for daily during has dated as closed | F 60    | Education on facility policy for repinjury of unknown origin to the Administrator and State survey at IV. QA Monitoring  a) An audit tool was created to me and track any injury of unknown oproper reporting as indicated.  b) QA audits on residents with injuensure proper investigation and rewill be conducted by the DON/deweekly x 4 weeks then monthly x months followed by quarterly x2 c) All results of the audits will be to | gency onitor origin and uries, to eporting, signee 2 quarters. brought |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |              |   | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|--|--|---|--------------|---|-------------------------------|----------------------------|--|
|  |  | 315225   | B. WING                                 |              |   |                               | 31/2022                    |  |
|  | ROVIDER OR SUPPLIER  | ND HEALTHCARE CENTER   |   | 5101 NORTH F | ESS, CITY, STATE, ZIP CODE PARK DRIVE EN, NJ 08109  | 1 011                         | 51/2022                    |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                      |              | PROVIDER'S PLAN OF CORRECTION<br>EACH CORRECTIVE ACTION SHOULD E<br>DSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |  |
| F 609  | at 2:53 P Practical Nurse (LPN of the resid were no signs of . The note rev was asked about the "I woke up like this." would continue to mo condition. There was the was report  The resident no longe time of the survey. Re dated at: resident expired in th  During an interview of Assistant Director of LPN #6 no longer wo #1 stated there was r regarding the cause of face once it was door She stated Resident have a condition potentially the cause stated it was her expi contact the supervisor indicated that an invei initiated immediately, investigation would b agency within 24 hour  During an interview of the Administrator stat feel the on Re related to abuse. He suspicion of abuse, the | ry "Nursing Note" dated M, revealed Licensed ) #6 noted to the ent's . There on palpation and no ealed that when Resident The note indicated the nurse onitor for any changes in no indication in the note that ted to anyone.  er resided in the facility at the eview of a "Nursing Note," 2:53 PM, revealed the e facility.  on 07/31/2022 at 4:44 PM, Nursing (ADON) #1 stated rked for the facility. ADON no further investigation of the to the resident's umented on the nurse's note. was already known to that could have been of the ADON #1 ectation for the nurse to or to report the estigation would then be ADON #1 indicated the e reported to the state urs.  on 07/31/2022 at 4:46 PM, ted the facility staff did not sident was | F                                       | 609          |   |                               |                            |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPL<br>A. BUILDING  | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED  |                 |  |
|--|---|--|---------------------|--|-----------------|--|
|  |   | 315225   | B. WING             |  | C<br>07/31/2022 |  |
|  | ROVIDER OR SUPPLIER  DNT REHABILITATION A   | ND HEALTHCARE CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5101 NORTH PARK DRIVE<br>PENNSAUKEN, NJ 08109   |                 |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)   | BE COMPLETION   |  |
| F 610<br>SS=D  | of 24-hour and 5-day  The Director of Nursifor an interview.  New Jersey Administ Investigate/Prevent/C  CFR(s): 483.12(c)(2)   | n of events and submission reports.  Ing (DON) was unavailable rative Code: 8:39-9.4(f) Correct Alleged Violation -(4)   | F 610               |  | 9/16/22         |  |
|  | neglect, exploitation, must:  §483.12(c)(2) Have eviolations are thorough \$483.12(c)(3) Prevent neglect, exploitation, investigation is in prospect of the secondary of the seco | at further potential abuse, or mistreatment while the gress.  the results of all administrator or his or her native and to other officials in the law, including to the State of 5 working days of the leged violation is verified the action must be taken.  The is not met as evidenced to the leged violation is verified to action must be taken.  The is not met as evidenced to the leged violation is verified to action must be taken.  The is not met as evidenced to the leged violation is verified to action must be taken.  The is not met as evidenced to the resident's to the resident's to the resident's to the resident's to the resident reviewed for the resident revie |                     | I: Immediate Action: a) Facility staff were re-in serviced on identifying injury of unknown origin ar conducting/completing proper investigation (incident report). b) Resident 's medical record was reviewed, noted no untoward effects related to the |                 |  |

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` '                 | PLE CONSTRUCTION  G   |  | ATE SURVEY<br>OMPLETED     |
|--------------------------|--|---|---------------------|---|--|----------------------------|
|                          |  | 315225  | B. WING _           |   |  | C<br>07/31/2022            |
| NAME OF P                | ROVIDER OR SUPPLIER  | 1   | <del></del>         | STREET ADDRESS, CITY, STATE, ZIP CO   | •  | 3113112022                 |
| NAME OF T                | NOVIDER OR GOLF EIER   |   |                     | 5101 NORTH PARK DRIVE   | DE   |                            |
| RIVERFRO                 | ONT REHABILITATION   | AND HEALTHCARE CENTER   |                     |   |  |                            |
|                          |  |   |                     | PENNSAUKEN, NJ 08109  |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIE  | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY  | ON SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLETION<br>DATE |
| F 610                    | Continued From pa  | nge 5   | F6                  | c) Resident no longer in t  |  |                            |
|                          | Findings included:   | noliny titled "Abuse  |                     | expired under care  | service on   |                            |
|                          | Mistreatment, Negli Misappropriation of 07/01/2022, reveal Procedure: All Empin the resident's coindicative of abuse findings and/or consupervisor. If the enot available (i.e. [Isupervisor should a The policy also indicative of abuse findings and/or consupervisor. If the enot available (i.e. [Isupervisor should a The policy also indicated that allegations/vioneglect, exploitation injuries from an unimisappropriation of reported immediate after the allegation cause the allegation serious bodily injurithe events that cau involve abuse and bodily injury, to the and to other official Survey Agency and State law provides care facilities) in activities and through established revealed, "The resireported to the addidesignated representation of the stabilished representation of the stabilished revealed, "The resireported to the addidesignated representation of the stabilished representation of the stabilished revealed, "The resireported to the addidesignated representation of the stabilished representation of the stabilished revealed, "The resireported to the addidesignated representation of the stabilished representation of the stabilished revealed, "The resireported to the addidesignated representation of the stabilished revealed, "The resireported to the addidesignated representation of the stabilished revealed, "The resireported to the addition of the stabilished revealed, "The resireported to the addition of the stabilished revealed, "The resireported to the addition of the stabilished revealed, "The resireported to the addition of the stabilished revealed," The resireported to the addition of the stabilished revealed, "The resireported to the addition of the stabilished revealed," The resireported to the addition of the stabilished revealed, "The resireported to the addition of the stabilished revealed," The resireported to the addition of the stabilished revealed, "The resireported to the addition of the stabilished revealed," The resireported to the addition of the stabilished revealed, "The resireported to the | policy titled, "Abuse, ect, Exploitation, and f Resident's Property" revised ed, "Section IV: Identification. ployees - If changes are noted ndition, which may be immediately report their cerns to their direct mployee's direct supervisor is meaning] off shift), the nursing also be notified immediately." Ideated, "The facility will ensure lations involving abuse, in or mistreatment, including known source and for resident's property, are ely but not later than 2 hours its made, if the events that in involve abuse or result in lay, or not later than 24 hours if see the allegation do not do not results [sic] in serious administrator of the facility in secondance with State Law disprocedures." The policy also alts of all investigation will be ininistrator or his or her entative and other officials in late law, including the State thing 5 working days of the |                     | II. Identification of Others:  1) All residents with injuries origin have the potential of b  2) All residents with injuries or reviewed and anyone with in unknown origin were identified noted that proper documental reporting was in place.  3) All patients currently in hot assessed for any in the life in | reing affected were hjury of ed and it was ation and ruse were one noted. eviewed Policy reatment, sappropriation on IV restigation of found to be in ervice or completing of for any to monitor own origin and t report) as th injuries, to and reporting, N/designee |                            |
|                          | incident."  Review of an "Adm  | ission Record" revealed   |                     | <ul> <li>c) All results of the audits will<br/>to the QAPI committee meet<br/>quarterly.</li> </ul>   | -  |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ` ′               | PLE CONSTRUCTION  G  |                                 | E SURVEY<br>IPLETED        |
|---|---|--|---------------------|--|---------------------------------|----------------------------|
|   |   | 315225   | B. WING             |  | 0.7                             | C<br><b>7/31/2022</b>      |
|   | ROVIDER OR SUPPLIER   | N AND HEALTHCARE CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>5101 NORTH PARK DRIVE<br>PENNSAUKEN, NJ 08109 |                                 | 131/2022                   |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICI  | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENC          | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 610   | Review of a signif (MDS), dated had a Brief Interviscore of , indicate resident required person with bed in personal hygiene,  A review of a "Carwas at risk for Interventions inclusions at risk for Interventions inclusions at 2:5:  Practical Nurse (Lower enosigns of the reward of the reward as asked about "I woke up like this would continue to condition. There were the was regulated resident expired in During an interview." | diagnoses including , and cicant change Minimum Data Set , revealed Resident ew for Mental Status (BIMS) ing the resident was . The MDS indicated the limited assistance of one nobility, transfer, toilet use, and dressing.  The Plan, revealed Resident daily during an was dated as closed of discharge. The care plan dated as to when it was initiated.  The revealed Licensed Licensed (Licensed Licensed License | F6                  | 10   |                                 |                            |

|                          | DF DEFICIENCIES CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '               | PLE CONSTRUCTION  G  | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|---|---------------------|--|----------------------------|
|                          |   | 315225  | B. WING             |  | C<br>07/31/2022            |
|                          | ROVIDER OR SUPPLIER  DNT REHABILITATION A   | ND HEALTHCARE CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109                         | 1 07/31/2022               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETION              |
| F 610                    | LPN #6 no longer wo #1 stated there was regarding the cause of once it was door. She stated Resident have a condition potentially the cause stated it was her expression contact the supervision indicated that an investing time and interview of the Administrator state feel the confidence on Research and the staff to initiate the included investigation of 24-hour and 5-day. The Director of Nursifor an interview.  New Jersey Administ Quality of Care CFR(s): 483.25  § 483.25 Quality of care is a function and the staff to all treatments facility residents. Bas assessment of a residents received accordance with profit. | rked for the facility. ADON no further investigation of the to the resident's umented on the nurse's note.  was already known to that could have been of the ADON #1 ectation for the nurse to or to report the ADON #1 indicated the e reported to the state urs.  on 07/31/2022 at 4:46 PM, ted the facility staff did not sident was stated if there was a ne expectation would be for e abuse protocol, which of events and submission reports.  on (DON) was unavailable rative Code: 8:39-13.4(c) | F 68                |  | 9/16/22                    |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|--|---|--|---|-------------------------------|----------------------------|
|                          |  | 315225   | B. WING _                               |  |   | 07/3                          | 31/2022                    |
| NAME OF PI               | ROVIDER OR SUPPLIER  | <u> </u>   |   | STREET ADDRESS, CITY, STATE, ZIP CODI  | <b>'</b><br>E   | 0170                          | 71/2022                    |
|                          |  |  |   | 5101 NORTH PARK DRIVE  |   |                               |                            |
| RIVERFRO                 | ONT REHABILITATION A   | ND HEALTHCARE CENTER   |   | PENNSAUKEN, NJ 08109   |   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)  | I SHOULD BE   | I                             | (X5)<br>COMPLETION<br>DATE |
| F 684                    | Continued From page  | ≥ 8  | F 6                                     | 84   |   |                               |                            |
|                          | by:  | is not met as evidenced  |   |  |   |                               |                            |
|                          | Based on record revieur policy review, the factor necessary care and the astronomy care and the sampled residents residents residents record and the sampled residents recorded and the sample sample samples recorded and the samples recorded and th | reatments were documented lance with accepted practice and physician's taxonic and Resident (a) of 3 viewed for medication of 2 viewed for (b) Specifically, the facility:  and and istently documented as potential |   | I: Immediate Action:  a) Facility staff were re-in serve properly documenting in the Madministration record, making medications and treatments a b) An ad hoc QAPI on same we completed and ongoing c) Current Medication Administrecord for residents and reviewed, no negative findings and medications were signed appropriately.  II. Identification of Others:  1) All residents receiving med treatments have the potential affected.  2.) An audit of the Medication Administration Record for all rewho are currently in house was | Medication I sure all Ire signed Ivas  stration I were Is, all care  lications a of being | ind                           |                            |
|                          | (MDS), dated<br>had an active diagnos<br>the MDS, the residen<br>Mental Status (BIMS)<br>resident was  | t had a Brief Interview for score of , indicating the . Additionally, the  |   | and it was noted that proper documentation was in place, r signatures were noted. 3.) No other issues were identified. III. Systemic changes: a) DON and Administrator rev and Procedure: Medication Adam Documentation Policies, I  | no missino<br>tified.<br>riewed Pol<br>dministrati<br>Procedure                           | g<br>licy<br>ion              |                            |
|                          | MDS indicated the re therapy, a resident.  Review of a "Care Plarevealed Resident related to   | care while   |   | and found to be in compliance b.) Nursing Staff received Inse Education on facility policy for proper documentation and sig all medications administered a rendered in The Medication A Record.  | ervice<br>r ensuring<br>gnatures fo<br>and care   | or                            |                            |

|                          |  | IDENTIFICATION NUMBER:  |                     | (X2) MULTIPLE CONSTRUCTION  A. BUILDING   |   |              | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|---------------------|---|---|--------------|-------------------------------|--|
|                          |  | 315225  | B. WING _           |   |   | C<br>07/31/  | /2022                         |  |
|                          | ROVIDER OR SUPPLIER  ONT REHABILITATION A  | ND HEALTHCARE CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5101 NORTH PARK DRIVE<br>PENNSAUKEN, NJ 08109  | E   |              |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)   | SHOULD BE   | -            | (X5)<br>COMPLETION<br>DATE    |  |
| F 684                    | Review of Resident "Medication Administ revealed staff were to care existe with and monitori There we documented to indicate was the 7:00 AM to 3:00 F 11:00 PM (3-11) shift 3-11 shift. In addition documented to indicate provided on 09/22/20 AM (11-7) shift, on 09 3-11 shifts, and on 09 During an interview of Licensed Practical Number of the resident was to make sure the sure the sure them there may be a missed but asserted and residents were and as needed.  During an interview of LPN #4 revealed residents were and as needed.  During an interview of LPN #4 revealed residents were and as needed. | d suctioning as necessary are every shift.  I's September 2021 ration Record (MAR)" o suction the resident's very shift and provide very shift by cleansing the remaining | F 6                 | IV. QA Monitoring a) An audit tool was created to and track documentation in the Administration Record complex compliance b) QA audits of the Medication Administration Record will be to ensure documentation and are complete for all patients be DON/designee weekly x 4 were weekly x 2 months c) All results of the audits will to the QAPI committee meeting. | ne Medical<br>etion/<br>n<br>conducte<br>signature<br>by the<br>eks then<br>be brough | l<br>d<br>es |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X: |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | IPLE CONSTRUCTION NG  |                                   | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|---------------------|---|-----------------------------------|-------------------------------|--|
|  |  | 315225   | B. WING _           |   |                                   | C<br>07/31/2022               |  |
|  | ROVIDER OR SUPPLIER  ONT REHABILITATION  | N AND HEALTHCARE CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP C<br>5101 NORTH PARK DRIVE<br>PENNSAUKEN, NJ 08109 |                                   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                             | (EACH DEFICIE  | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENCE   | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 684  | During an interview care and cared for who had cared for who had buring an interview Registered Nurse she provided worked and had not had not been buring an interview Assistant Director care physician's orders indicated there had care was been buring an interview the Administrator i was an issue the final improved. Acceptives were bein 2. a) Review of an (MDS), dated had active diagnos (disorder land), and Review of a "Care Review of a "Car | w on 07/31/2022 at 10:00 AM, had provided for any resident she had a  w on 07/31/2022 at 9:05 AM, Unit Manager (RM) #1 revealed care when she ot seen any cleaned or had buildup.  w on 07/31/2022 at 4:38 PM, of Nursing (ADON) #1 stated was provided according to and as needed. The ADON d not been any reports of a not being provided. The had been an issue with the had been and it cording to the Administrator, and provided.  w on 07/31/2022 at 12:09 PM, andicated signing of the MAR acility was working on, and it cording to the Administrator, and provided.  admission Minimum Data Set sees that included ar of the  in the difference of the cordinate of the  in the difference of the  in the difference of the cordinate of the  in the difference of the cordinate of the  in the difference of the cordinate of the  in the difference of the  in the | F6                  | 84  |                                   |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |                     |  | TE SURVEY<br>MPLETED           |                            |
|--|--|--|---------------------|--|--------------------------------|----------------------------|
|  |  | 315225   | B. WING _           |  |                                | C<br><b>17/31/2022</b>     |
|  | ROVIDER OR SUPPLIER  | N AND HEALTHCARE CENTER  |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>5101 NORTH PARK DRIVE<br>PENNSAUKEN, NJ 08109   |                                |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICI   | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE |
| F 684  | problems was to a medications as or Mareview of the Administration Remedications where the medications where t | intervention for these care plan administer the resident's dered.  "Medication cord (MAR)" revealed Resident were not documented to have das ordered on the following  00 AM: The scheduled dose of milliliters one time a day mot initialed as administered.  00 PM: The scheduled dose of milligrams (mg) at was not initialed as  00 PM: The scheduled dose of tablet mg by mouth at was not initialed as  00 PM: The scheduled dose of tablet mg by mouth two was not initialed as  00 PM: The scheduled dose of tablet mg by mouth two was not initialed as  00 PM: The scheduled dose of tablet mg by mouth two was not initialed as | F                   | 884  |                                |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '                 | IPLE CONSTRUCTION  |                                | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|---------------------|--|--------------------------------|-------------------------------|--|
|   |  | 315225   | B. WING _           |  |                                | C<br>07/31/2022               |  |
|   | ROVIDER OR SUPPLIER  DNT REHABILITATION A  | ND HEALTHCARE CENTER   |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>5101 NORTH PARK DRIVE<br>PENNSAUKEN, NJ 08109 |                                | 1113112022                    |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'         | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 684   | Review of a quarterly dated , resident on resident of the review of the resident of the resident of the review of the resident of the review of the resident of the prevention of resident | ident s "Admission facility readmitted the with diagnoses including  Minimum Data Set (MDS), vealed the resident had a ental Status (BIMS) score of                | F                   | DEFICIENC'   | Y)                             |                               |  |
|   | Licensed Practical No<br>electronic MAR (eMA<br>after each medication  | on 07/30/2022 at 10:57 AM,<br>curse (LPN) #1 stated the<br>curse (LPN) #1 stated the<br>curse if stated in administration, because if<br>gned, it looked as if the |                     |  |                                |                               |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | l ` '               | IPLE CONSTRU | (X3) DATE SURVEY<br>COMPLETED  |  |                                       |  |
|---|--|---|---------------------|--------------|--|--|---------------------------------------|--|
|   |  | 315225  | B. WING _           |              |  | C<br><b>07/31/2022</b>                         |                                       |  |
|   | ROVIDER OR SUPPLIER  DNT REHABILITATION A  | ND HEALTHCARE CENTER  |                     | 5101 NORT    | DRESS, CITY, STATE, ZIP CODE<br>TH PARK DRIVE<br>JKEN, NJ 08109  | <u>,                                      </u> | · · · · · · · · · · · · · · · · · · · |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG |              | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE            |  |
| F 684   | Registered Nurse Un stated the eMAR sho medication was admi medications were giv  An interview with the (ADON) on 07/31/202 expectation was for the policy to be followed the eMAR after every administered.  An interview with the at 12:09 PM revealed residents' eMARs we were administered. The facility had been work medication administration and Deprocedures, and Informedication Administration occur manner. Medications within a two-hour time hour before or after the policy also indications administration administration and procedures administration occur manner. Medications within a two-hour time hour before or after the policy also indications administration administration administration administration and procedures administration a | iven.  n 07/31/2022 at 9:05 AM, it Manager (RM) #1 uld be signed after each nistered to show the en as ordered.  Assistant Director of Nursing 22 at 4:38 PM revealed the ne medication administration and that staff document in medication was  Administrator on 07/31/2022 It was expected that all re signed after medications he Administrator stated the king with nursing on ation and signing the MARs.  Dicy titled, "Medication occumentation Policies, rmation," dated 07/01/2022, licy of this facility to ensure | F                   | 84           |  |  |                                       |  |

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|        | FOF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/G<br>IDENTIFICATION NUMB   |                     |   | CONSTRUCTION   | (X3) DATE S<br>COMPLI |                          |
|--------|--|---|---------------------|---|--|-----------------------|--------------------------|
|        |  |   |                     | D WING                                  |  | C                     |                          |
|        |  | 060415  |                     | B. WING                                 |  | 07/3                  | 31/2022                  |
|        | ROVIDER OR SUPPLIER  ONT REHABILITATION A  | ND HEALTHCARE C   | 5101 NORT           | RESS, CITY, STA<br>T <b>H PARK DRIV</b> | E  |                       |                          |
|        | (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY TAG REGULATORY OR LSC IDENTIFYING INFORM                          |   |                     | KEN, NJ 0810                            | 9  |                       |                          |
| PREFIX | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FU  |                     | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)  | BE                    | (X5)<br>COMPLETE<br>DATE |
| S 000  | Initial Comments   |   |                     | S 000                                   |  |                       |                          |
|        | Complaint Intake #NJ<br>Census: 156<br>Sample Size: 14<br>TYPE OF SURVEY: 0  |   |                     |   |  |                       |                          |
|        | all the standards in th  | ubstantial compliance w<br>e New Jersey Administ<br>s for Licensure of Long-  | rative              |   |  |                       |                          |
|        | including a completion<br>and ensure that the p<br>to correct deficiencies<br>action in accordance   | nit a plan of correction,<br>n date for each deficien<br>lan is implemented. Fai<br>may result in enforcen<br>with provisions of New<br>Code Title 8, Chapter<br>sure Regulations.  | ilure<br>nent       |   |  |                       |                          |
| S 560  | 8:39-5.1(a) Mandator   | y Access to Care  |                     | S 560                                   |  |                       | 9/16/22                  |
|        | (a) The facility shall confederal, State, and longer regulations.  |   |                     |   |  |                       |                          |
|        | by:<br>Complaint Intake #NJ  |   |                     |   | I: Immediate Action:     A) Staffing coordinator was immediate.  | ely                   |                          |
|        | and New Jersey Depa<br>memo, dated 09/19/2<br>facility failed to mainta<br>staff-to-resident ratios<br>Jersey State Law. Thi<br>14 day shifts reviewed | facility document reviewantment of Health (NJD) 021, it was determined ain direct care as mandated by New is was evident for 14 out and 2 out of 14 night e potential to affect all | OH)<br>the<br>ut of |   | re in-serviced on staffing ratio requirements.  II. Identification of Others:  A)All residents have the potential to be affected however no resident was dire affected by this.  III. Systemic changes:  A)DON or LNHA/Designee will review open positions and applications plus | ectly                 |                          |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed

08/25/22

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New Jersey Department of Health

|               | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/<br>IDENTIFICATION NUMB  |                              |                 | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED  |
|---------------|--|---|------------------------------|-----------------|--|--------------------------------|
|               |  | 060415  |                              | B. WING         |  | C<br>07/31/2022                |
| NAME OF P     | ROVIDER OR SUPPLIER  |   | STREET ADD                   | RESS, CITY, STA | TE, ZIP CODE   |                                |
| RIVERFR       | ONT REHABILITATION A   | ND HEALTHCARE C   |                              | H PARK DRIV     |  |                                |
| (X4) ID       | SUMMARY STA  | ATEMENT OF DEFICIENCIES   | PENNSAU                      | KEN, NJ 08109   | PROVIDER'S PLAN OF CORRECTION  | N (X5)                         |
| PREFIX<br>TAG | (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FU<br>SC IDENTIFYING INFORMATI  |                              | PREFIX<br>TAG   | (EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)   | BE COMPLETE                    |
| S 560         | Continued From page  | : 1   |                              | S 560           |  |                                |
|               | "Compliance with N.J Annotated) 30:13-18, requirements for nurs New Jersey Governor 112, codified at N.J.S established minimum nursing homes. The feffective on 02/01/202 One certified nurse air for the day shift.  One direct care staff residents for the even fewer than half of all scertified nurse aides, member shall be sign | 21: d to every eight resider member to every 10 ing shift, provided that staff members shall be   | tutes the 020 c which in nts |                 | results of any interviews weekly to loc opportunities to hire.  B)The Administrator and Director of Nurses will continue to utilize all poss means to increase the facility staff. The will include continued timely interview fairs, reaching out to agencies for supplemental staff, setting up booths nursing schools utilization of all possil avenues to increase staffing in the factorial IV. QA Monitoring A)LNHA/Designee will review staffing schedules weekly for 3 months.  B)Findings of review will be presented LNHA at quarterly QAPI meeting. | ible his s, job at ble cility. |
|               | direct care staff memle certified nurse aide an aide duties.  A review of the "Nurse completed by the faci 07/17/2022 through 0 staff-to-resident ratios minimum requirement.  The facility was defici residents on 14 of 14   | e shift, provided that ear our shall sign in to work and perform certified number Staffing Report," lity for the weeks of 7/30/2022, revealed a that did not meet the ts as listed below.  The content in CNA staffing for day shifts, as follows: CNAs for 148 residents | k as a<br>rse                |                 |  |                                |

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| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  S101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S 560  Continued From page 2  - 07/18/2022 had 16 CNAs for 147 residents on the day shift, required 18 - 07/19/2022 had 15 CNAs for 144 residents on the day shift, required 18 - 07/20/2022 had 13 CNAs for 144 residents on the day shift, required 18 - 07/20/2022 had 13 CNAs for 144 residents on  | (X3) DATE SURVEY<br>COMPLETED |  |  |
|--|-------------------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER  RIVERFRONT REHABILITATION AND HEALTHCARE C  STREET ADDRESS, CITY, STATE, ZIP CODE  5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S 560  Continued From page 2  - 07/18/2022 had 16 CNAs for 147 residents on the day shift, required 18 - 07/19/2022 had 15 CNAs for 144 residents on the day shift, required 18 - 07/19/2022 had 15 CNAs for 144 residents on the day shift, required 18   |                               |  |  |
| RIVERFRONT REHABILITATION AND HEALTHCARE C    SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   S 560   Continued From page 2   - 07/18/2022 had 16 CNAs for 147 residents on the day shift, required 18   - 07/19/2022 had 15 CNAs for 144 residents on the day shift, required 18   - 07/19/2022 had 15 CNAs for 144 residents on the day shift, required 18   - 07/19/2022 had 19 CNAs for 144 residents on the day shift, required 18   - 07/19/2022 had 19 CNAS for 144 residents on the day shift, required 18   - 07/19/2022 had 19 CNAS for 144 residents on the day shift, required 18   - 07/19/2022 had 19 CNAS for 144 residents on the day shift, required 18   - 07/19/2022 had 19 CNAS for 144 residents on the day shift, required 18   - 07/19/2022 had 19 CNAS for 144 residents on the day shift, required 18   - 07/19/2022 had 19 CNAS for 144 residents on the day shift, required 18   - 07/19/2022 had 19 CNAS for 144 residents on the day shift, required 18   - 07/19/2022 had 19 CNAS for 144 residents on the day shift, required 18   - 07/19/2022 had 19 CNAS for 144 residents on the day shift, required 18   - 07/19/2022 had 19 CNAS for 144 residents on the day shift, required 18   - 07/19/2022 had 19 CNAS for 144 residents on the day shift, required 18   - 07/19/2022 had 19 CNAS for 144 residents on the day shift had |                               |  |  |
| RIVERFRONT REHABILITATION AND HEALTHCARE C  PENNSAUKEN, NJ 08109  (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S 560 Continued From page 2  - 07/18/2022 had 16 CNAs for 147 residents on the day shift, required 18  - 07/19/2022 had 15 CNAs for 144 residents on the day shift, required 18   |                               |  |  |
| PENNSAUKEN, NJ 08109  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S 560 Continued From page 2  - 07/18/2022 had 16 CNAs for 147 residents on the day shift, required 18  - 07/19/2022 had 15 CNAs for 144 residents on the day shift, required 18   |                               |  |  |
| PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S 560  Continued From page 2  - 07/18/2022 had 16 CNAs for 147 residents on the day shift, required 18  - 07/19/2022 had 15 CNAs for 144 residents on the day shift, required 18   |                               |  |  |
| - 07/18/2022 had 16 CNAs for 147 residents on the day shift, required 18 - 07/19/2022 had 15 CNAs for 144 residents on the day shift, required 18  | LETE                          |  |  |
| the day shift, required 18 - 07/19/2022 had 15 CNAs for 144 residents on the day shift, required 18  |                               |  |  |
| the day shift, required 18 - 07/21/2022 had 15 CNAs for 143 residents on the day shift, required 18 - 07/22/2022 had 16 CNAs for 143 residents on the day shift, required 18 - 07/23/2022 had 16 CNAs for 143 residents on the day shift, required 18 - 07/24/2022 had 16 CNAs for 150 residents on the day shift, required 19 - 07/25/2022 had 16 CNAs for 150 residents on the day shift, required 19 - 07/25/2022 had 16 CNAs for 150 residents on the day shift, required 19 - 07/26/2022 had 16 CNAs for 150 residents on the day shift, required 19 - 07/27/2022 had 18 CNAs for 152 residents on the day shift, required 19 - 07/28/2022 had 18 CNAs for 152 residents on the day shift, required 19 - 07/28/2022 had 15 CNAs for 152 residents on the day shift, required 19 - 07/30/2022 had 15 CNAs for 152 residents on the day shift, required 19 - 07/30/2022 had 12 CNAs for 152 residents on the day shift, required 19 In addition, the facility was deficient in staff for two of 14 night shifts as follows: - 07/24/2022 had a total of ten direct care staff for 150 residents for the night shift, required 11 - 07/25/2022 had a total of nine direct care staff for 150 residents for the night shift, required 11  During an interview on 07/31/2022 at 12:09 PM, the Administrator revealed he knew the facility would receive a staffing deficiency and was trying to keep the facility staffed. The Administrator   |                               |  |  |

#### STATE FORM: REVISIT REPORT

|                                  | STATE FORM. RE        | VISII REPORT                          |                 |  |
|----------------------------------|-----------------------|---------------------------------------|-----------------|--|
|                                  | MULTIPLE CONSTRUCTION |                                       | DATE OF REVISIT |  |
| O60415 Y1                        | 9/16/2022             |                                       |                 |  |
| NAME OF FACILITY STREET ADDRESS, |                       | STREET ADDRESS, CITY, STATE, ZIP CODE |                 |  |
| RIVER FRONT REHABILITATION       | AND HEALTHCARE CENTER | 5101 NORTH PARK DRIVE                 |                 |  |
|                                  |                       | PENNSAUKEN, NJ 08109                  |                 |  |
|                                  |                       |                                       |                 |  |

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                              | DATE                   | ITEM      |  | DATE       | ITEM      |      | DATE       |
|-----------------------------------|------------------------|-----------|--|------------|-----------|------|------------|
| Y4                                | Y5                     | Y4        |  | Y5         | Y4        |      | Y5         |
| ID Prefix S0560                   | Correction             | ID Prefix | C  | Correction | ID Prefix |      | Correction |
| 8:39-5.1(a)                       | Completed              | Reg. #    | C  | Completed  | Reg.#     |      | Completed  |
| LSC                               | 09/16/2022             | LSC       |  |            | LSC       |      | -          |
| ID Prefix                         | Correction             | ID Prefix | C  | Correction | ID Prefix |      | Correction |
| Reg. #                            | Completed              | Reg. #    | c  | Completed  | Reg. #    |      | Completed  |
| LSC                               |                        | LSC       |  |            | LSC       |      | -          |
| ID Prefix                         | Correction             | ID Prefix | C  | Correction | ID Prefix |      | Correction |
| Reg. #                            | Completed              | Reg. #    | c  | Completed  | Reg. #    |      | Completed  |
| LSC                               |                        | LSC       |  |            | LSC       |      | -          |
| ID Prefix                         | Correction             | ID Prefix | C  | Correction | ID Prefix |      | Correction |
| Reg. #                            | Completed              | Reg. #    | C  | Completed  | Reg. #    |      | Completed  |
| LSC                               |                        | LSC       |  |            | LSC       |      | -          |
| ID Prefix                         | Correction             | ID Prefix | C  | Correction | ID Prefix |      | Correction |
| Reg. #                            | Completed              | Reg. #    | C  | Completed  | Reg. #    |      | Completed  |
| LSC                               |                        | LSC       |  |            | LSC       |      | _          |
|                                   |                        |           |  |            |           |      |            |
| REVIEWED BY STATE AGENCY          | REVIEWED BY (INITIALS) | DATE      | SIGNATURE OF SURV                            | /EYOR      |           | DATE |            |
| REVIEWED BY CMS RO                | REVIEWED BY (INITIALS) | DATE      | TITLE  |            |           | DATE |            |
| FOLLOWUP TO SURVEY C<br>7/31/2022 | OMPLETED ON            |           | DR ANY UNCORRECTED DECRETED DEFICIENCIES (CM |            |           |      | s 🗆 no     |

Page 1 of 1 EVENT ID: XWPG12

|                                    |   | PUS 1                                   | -CERI                    | IFICATIO                             | NKEVI                             | OII KE                        | -PURI                        |   |                |                  |
|------------------------------------|---|---|--------------------------|--------------------------------------|-----------------------------------|-------------------------------|------------------------------|---|----------------|------------------|
|                                    | R / SUPPLIER / CLIA /   | MULTIPLE CONS                           | STRUCTION                |                                      |                                   |                               |                              |   | DATE O         | F REVISIT        |
|                                    | CATION NUMBER   | A. Building                             |                          |                                      |                                   |                               |                              |   | 0/40/00        | 22               |
| 315225                             | Y1  | B. Wing                                 |                          |                                      | _                                 |                               |                              | Y2  | 9/16/20        | 22 <sub>Y3</sub> |
| NAME OF                            | FACILITY  |   |                          |                                      | STREET AD                         | DRESS, CIT                    | Y, STATE, ZIF                | CODE                                      |                |                  |
| RIVER F                            | RONT REHABILITATION   | I AND HEALTHC                           | ARE CENTE                | R                                    | 5101 NORTH                        | H PARK DRI                    | VΕ                           |   |                |                  |
|                                    |   |   |                          |                                      | PENNSAUK                          | EN, NJ 0810                   | 9                            |   |                |                  |
| program,<br>corrected<br>provision | ort is completed by a qual<br>to show those deficienci<br>d and the date such corre<br>number and the identific<br>by report form). | es previously rep<br>ctive action was a | orted on the accomplishe | CMS-2567, State<br>d. Each deficienc | ement of Defic<br>by should be fu | iencies and<br>ully identifie | Plan of Cor<br>d using eithe | rection, that have<br>er the regulation o | been<br>or LSC |                  |
| ITE                                | M   | DATE                                    | ITEM                     |                                      | D                                 | ATE                           | ITEM                         |   |                | DATE             |
| Y4                                 |   | Y5                                      | Y4                       |                                      |                                   | Y5                            | Y4                           |   |                | Y5               |
|                                    |   |   |                          |                                      |                                   |                               |                              |   |                |                  |
| ID Prefix                          | F0609   | Correction                              | ID Prefix                | F0610                                | Со                                | rrection                      | ID Prefix                    | F0684                                     |                | Correction       |
|                                    |   |   |                          |                                      |                                   |                               |                              |   |                |                  |
| Reg.#                              | 483.12(c)(1)(4)   | Completed                               | Reg. #                   | 483.12(c)(2)-(4)                     | Co                                | mpleted                       | Reg. #                       | 483.25                                    |                | Completed        |
| LSC                                |   | 09/16/2022                              | LSC                      |                                      | 09/                               | 16/2022                       | LSC                          |   |                | 09/16/2022       |
|                                    |   | <del>_</del>                            | +                        |                                      |                                   |                               |                              |   |                |                  |
|                                    |   |   |                          |                                      |                                   |                               |                              |   |                |                  |
| ID Prefix                          |   | Correction                              | ID Prefix                |                                      | Co                                | rrection                      | ID Prefix                    |   |                | Correction       |
| Reg. #                             |   | Completed                               | Reg. #                   |                                      | Co                                | mpleted                       | Reg.#                        |   |                | Completed        |
| LSC                                |   |   | LSC                      |                                      |                                   | mpictou                       | LSC                          |   |                | Completed        |
|                                    |   | _                                       | LSC                      |                                      |                                   |                               | LSC                          |   |                |                  |
|                                    |   |   |                          |                                      |                                   |                               |                              |   |                |                  |
| ID Prefix                          |   | Correction                              | ID Prefix                |                                      | Со                                | rrection                      | ID Prefix                    |   |                | Correction       |
|                                    |   | _                                       |                          |                                      |                                   |                               |                              |   |                |                  |
| Reg.#                              |   | Completed                               | Reg. #                   |                                      | Co                                | mpleted                       | Reg. #                       |   |                | Completed        |
| LSC                                |   |   | LSC                      |                                      |                                   |                               | LSC                          |   |                |                  |
|                                    |   |   |                          |                                      |                                   |                               | -                            |   |                |                  |
|                                    |   |   |                          |                                      | _                                 |                               |                              |   |                |                  |
| ID Prefix                          |   | Correction                              | ID Prefix                |                                      | Со                                | rrection                      | ID Prefix                    |   |                | Correction       |
| Reg. #                             |   | Completed                               | Reg. #                   |                                      | Со                                | mpleted                       | Reg.#                        |   |                | Completed        |
| LSC                                |   |   | LSC                      |                                      |                                   | 1                             | LSC                          | -   |                |                  |
|                                    |   | _                                       | LSC                      |                                      |                                   |                               | LSC                          |   |                |                  |
|                                    |   |   |                          |                                      |                                   |                               |                              |   |                |                  |

**REVIEWED BY** REVIEWED BY DATE SIGNATURE OF SURVEYOR DATE STATE AGENCY (INITIALS) DATE TITLE DATE **REVIEWED BY** REVIEWED BY CMS RO (INITIALS) CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF FOLLOWUP TO SURVEY COMPLETED ON UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

ID Prefix

Reg.#

LSC

Correction

Completed

Form CMS - 2567B (09/92) EF (11/06)

**ID Prefix** 

Reg. #

7/31/2022

LSC

**ID** Prefix

Reg. #

LSC

Correction

Completed

YES NO

Correction

Completed