STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING _____ B. WING _____	C 07/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERFRONT REHABILITATION AND HEALTHCARE CENTER	**5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaints #NJ149050, NJ153795, NJ155485, NJ154063, NJ00149157, NJ149169, NJ150827, NJ151895, and NJ155888 Census: 156 Sample Size: 14 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey. Survey dates: 07/30/2022 to 07/31/2022	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours 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 result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		9/16/22

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

Electronically Signed | 08/25/2022

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F 609	Continued From page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ150827 Based on interviews, record review, and facility policy review, the facility failed to ensure an injury of unknown origin [redacted] to the resident's [redacted] was immediately reported to the Administrator and State Survey Agency for 1 (Resident [redacted]) of 1 sampled resident reviewed for injury of unknown origin. Findings included: Review of a facility policy titled, "Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident's Property" revised 07/01/2022, revealed, "Section IV: Identification. Procedure: All Employees - If changes are noted in the resident's condition, which may be indicative of abuse, immediately report their findings and/or concerns to their direct supervisor. If the employee's direct supervisor is not available (i.e. [meaning] off shift), the nursing supervisor should also be notified immediately." The policy also indicated, "The facility will ensure that allegations/violations involving abuse, neglect, exploitation or mistreatment, including injuries from an unknown source and misappropriation of resident's property, are reported immediately but not later than 2 hours	F 609	I: Immediate Action: a) Facility staff were re-in serviced on identifying injury of unknown origin and timely notification to the Administrator and State survey agency. b) Resident [redacted] medical record was reviewed, noted no untoward effects related to the [redacted] c) Resident [redacted] no longer in the facility, expired under [redacted] care service on [redacted] II. Identification of Others: 1) All residents with injuries of unknown origin have the potential of being affected 2) All residents with injuries were reviewed and anyone with injury of unknown origin were identified and it was noted that proper documentation and reporting was in place. 3) All patients currently in house were assessed for any [redacted], none noted. III. Systemic changes: a) DON and Administrator reviewed Policy and Procedure: reporting of injury of unknown origin and found to be in compliance. b)Nursing Staff received Inservice	

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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 [redacted] had diagnoses including [redacted] primary [redacted], and [redacted]. Review of a significant change Minimum Data Set (MDS), dated [redacted], revealed Resident [redacted] had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating the resident was [redacted]. The MDS indicated the 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 [redacted] was at risk for [redacted]. Interventions included inspecting the [redacted] for [redacted] daily during care. The care plan was dated as closed [redacted] due to discharge. The care plan problem was not dated as to when it was initiated.	F 609	Education on facility policy for reporting 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 and proper reporting as indicated. b) QA audits on residents with injuries, to ensure proper investigation and reporting, will be conducted by the DON/designee weekly x 4 weeks then monthly x 2 months followed by quarterly x2 quarters. c) All results of the audits will be brought to the QAPI committee meetings quarterly	

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F 609	Continued From page 3	F 609		

A review of a late entry "Nursing Note" dated [redacted] at 2:53 PM, revealed Licensed Practical Nurse (LPN) #6 noted [redacted] to the [redacted] of the resident's [redacted]. There were no signs of [redacted] on palpation and no [redacted]. The note revealed that when Resident [redacted] was asked about the [redacted], the resident stated, "I woke up like this." The note indicated the nurse would continue to monitor for any changes in condition. There was no indication in the note that the [redacted] was reported to anyone.

The resident no longer resided in the facility at the time of the survey. Review of a "Nursing Note," dated [redacted] at 2:53 PM, revealed the resident expired in the facility.

During an interview on 07/31/2022 at 4:44 PM, Assistant Director of Nursing (ADON) #1 stated LPN #6 no longer worked for the facility. ADON #1 stated there was no further investigation regarding the cause of the [redacted] to the resident's face once it was documented on the nurse's note. She stated Resident [redacted] was already known to have a [redacted] condition that could have been potentially the cause of the [redacted]. ADON #1 stated it was her expectation for the nurse to contact the supervisor to report the [redacted]. She indicated that an investigation would then be initiated immediately. ADON #1 indicated the investigation would be reported to the state agency within 24 hours.

During an interview on 07/31/2022 at 4:46 PM, the Administrator stated the facility staff did not feel the [redacted] on Resident [redacted] was related to abuse. He stated if there was a suspicion of abuse, the expectation would be for the staff to initiate the abuse protocol, which

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F 609	Continued From page 4 included investigation of events and submission of 24-hour and 5-day reports. The Director of Nursing (DON) was unavailable for an interview.	F 609		
F 610 SS=D	New Jersey Administrative Code: 8:39-9.4(f) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ150827 Based on interviews, record review, and facility policy review, the facility failed to ensure an injury of unknown origin [redacted] to the resident's [redacted]) was investigated for possible abuse for 1 (Resident [redacted] of 1 sampled resident reviewed for injury of unknown origin.	F 610	I: Immediate Action: a) Facility staff were re-in serviced on identifying injury of unknown origin and conducting/completing proper investigation (incident report). b) Resident [redacted]'s medical record was reviewed, noted no untoward effects related to the [redacted]"	9/16/22

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F 610	Continued From page 5 Findings included: Review of a facility policy titled, "Abuse, Mistreatment, Neglect, Exploitation, and Misappropriation of Resident's Property" revised 07/01/2022, revealed, "Section IV: Identification. Procedure: All Employees - If changes are noted in the resident's condition, which may be indicative of abuse, immediately report their findings and/or concerns to their direct supervisor. If the employee's direct supervisor is not available (i.e. [meaning] off shift), the nursing supervisor should also be notified immediately." The policy also indicated, "The facility will ensure that allegations/violations involving abuse, neglect, exploitation or mistreatment, including injuries from an unknown source and misappropriation of resident's property, are reported immediately but not later than 2 hours 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	F 610	c) Resident [redacted] no longer in the facility, expired under [redacted] care service on [redacted]. II. Identification of Others: 1) All residents with injuries of unknown origin have the potential of being affected 2) All residents with injuries were reviewed and anyone with injury of unknown origin were identified and it was noted that proper documentation and reporting was in place. 3) All patients currently in house were assessed for any [redacted] none noted. III. Systemic changes: a) DON and Administrator reviewed Policy and Procedure: Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident's property/ Section IV Identification procedure), investigation of injury of unknown origin and found to be in compliance. b)Nursing Staff received Inservice Education on facility policy for completing investigation (incident report) for any injury of unknown origin IV. QA Monitoring a) An audit tool was created to monitor and track any injury of unknown origin and proper investigation (incident report) as indicated. b) QA audits on residents with injuries, to ensure proper investigation and reporting, will be conducted by the DON/designee weekly x 4 weeks then monthly x 2 months c) All results of the audits will be brought to the QAPI committee meetings quarterly.	

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F 610	Continued From page 6 Resident [redacted] had diagnoses including [redacted] primary [redacted], and [redacted] Review of a significant change Minimum Data Set (MDS), dated [redacted], revealed Resident [redacted] had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating the resident was [redacted]. The MDS indicated the 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 [redacted] was at risk for [redacted]. Interventions included inspecting the [redacted] for [redacted] daily during care. The care plan was dated as closed [redacted] due to discharge. The care plan problem was not dated as to when it was initiated. A review of a late entry "Nursing Note" dated [redacted] at 2:53 PM, revealed Licensed Practical Nurse (LPN) #6 noted [redacted] to the [redacted] of the resident's [redacted]. There were no signs of [redacted] on palpation and no [redacted]. The note revealed that when Resident [redacted] was asked about the bruise, the resident stated, "I woke up like this." The note indicated the nurse would continue to monitor for any changes in condition. There was no indication in the note that the [redacted] was reported to anyone. The resident no longer resided in the facility at the time of the survey. Review of a "Nursing Note," dated [redacted] at 2:53 PM, revealed the resident expired in the facility. During an interview on 07/31/2022 at 4:44 PM, Assistant Director of Nursing (ADON) #1 stated	F 610		

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F 610	Continued From page 7 LPN #6 no longer worked for the facility. ADON #1 stated there was no further investigation regarding the cause of the [redacted] to the resident's [redacted] once it was documented on the nurse's note. She stated Resident [redacted] was already known to have a [redacted] condition that could have been potentially the cause of the [redacted] ADON #1 stated it was her expectation for the nurse to contact the supervisor to report the [redacted]. She indicated that an investigation would then be initiated immediately. ADON #1 indicated the investigation would be reported to the state agency within 24 hours. During an interview on 07/31/2022 at 4:46 PM, the Administrator stated the facility staff did not feel the [redacted] on Resident [redacted] was related to abuse. He stated if there was a suspicion of abuse, the expectation would be for the staff to initiate the abuse protocol, which included investigation of events and submission of 24-hour and 5-day reports. The Director of Nursing (DON) was unavailable for an interview. New Jersey Administrative Code: 8:39-13.4(c)	F 610		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		9/16/22

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F 684	Continued From page 8 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ149050 and #NJ154063 Based on record review, interviews, and facility policy review, the facility failed to ensure necessary care and treatments were documented as provided in accordance with accepted standards of nursing practice and physician's orders for 2 (Resident [redacted] and Resident [redacted]) of 3 sampled residents reviewed for medication administration and for 1 (Resident [redacted] of 2 sampled residents reviewed for [redacted] care and [redacted] Specifically, the facility: - failed to ensure [redacted] and [redacted] were consistently documented as conducted to prevent potential [redacted] complications for Resident [redacted] - failed to ensure medication administration was consistently documented as conducted to prevent potential medication errors for Resident [redacted] and [redacted] Findings included: 1. Review of an admission Minimum Data Set (MDS), dated [redacted], revealed Resident [redacted] had an active diagnosis of [redacted]. Per the MDS, the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating the resident was [redacted]. Additionally, the MDS indicated the resident received [redacted] therapy, [redacted], and [redacted] care while a resident. Review of a "Care Plan," dated [redacted], revealed Resident [redacted] had a [redacted] related to [redacted].	F 684	I: Immediate Action: a) Facility staff were re-in serviced on properly documenting in the Medication administration record, making sure all medications and treatments are signed. b) An ad hoc QAPI on same was completed and ongoing c) Current Medication Administration record for residents [redacted] and [redacted] were reviewed, no negative findings, all care and medications were signed appropriately. II. Identification of Others: 1) All residents receiving medications and treatments have the potential of being affected. 2.) An audit of the Medication Administration Record for all residents who are currently in house was conducted and it was noted that proper documentation was in place, no missing signatures were noted. 3.) No other issues were identified. III. Systemic changes: a) DON and Administrator reviewed Policy and Procedure: Medication Administration and Documentation Policies, Procedures and found to be in compliance. b.) Nursing Staff received Inservice Education on facility policy for ensuring proper documentation and signatures for all medications administered and care rendered in The Medication Administration Record.	

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F 684	Continued From page 9 Interventions included suctioning as necessary and providing [redacted] care every shift. Review of Resident [redacted]'s September 2021 "Medication Administration Record (MAR)" revealed staff were to suction the resident's [redacted] every shift and provide [redacted] care every shift by cleansing the site with [redacted], changing the [redacted] and monitoring the [redacted]. There were no nurses' initials documented to indicate the resident's [redacted] was [redacted] on 09/25/2021 on the 7:00 AM to 3:00 PM (7-3) shift and 3:00 PM to 11:00 PM (3-11) shift, and on 09/26/2021 on the 3-11 shift. In addition, there were no initials documented to indicate [redacted] care was provided on 09/22/2021 on the 11:00 PM to 7:00 AM (11-7) shift, on 09/25/2021 on the 7-3 and 3-11 shifts, and on 09/26/2021 on the 3-11 shift. During an interview on 07/30/2022 at 10:57 AM, Licensed Practical Nurse (LPN) #1 revealed the priority for a resident who had a [redacted] was to make sure the [redacted] was patent and [redacted] the resident as needed. LPN #1 stated there may be a missed signature on the MARs, but asserted [redacted] care was completed and residents were [redacted] in a timely manner and as needed. During an interview on 07/30/2022 at 2:47 PM, LPN #4 revealed residents with a [redacted] had physician's orders to [redacted] and clean the [redacted], and asserted the nurses would follow the physician's orders. LPN #4 was not aware of any missed [redacted] care or [redacted] and stated residents with [redacted] would have to be [redacted] to	F 684	IV. QA Monitoring a) An audit tool was created to monitor and track documentation in the Medical Administration Record completion/ compliance b) QA audits of the Medication Administration Record will be conducted to ensure documentation and signatures are complete for all patients by the DON/designee weekly x 4 weeks then monthly x 2 months c) All results of the audits will be brought to the QAPI committee meetings quarterly	

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F 684	Continued From page 10 keep their [redacted] clear. During an interview on 07/31/2022 at 10:00 AM, LPN #8 stated she had provided [redacted] care and [redacted] for any resident she had cared for who had a [redacted]. During an interview on 07/31/2022 at 9:05 AM, Registered Nurse Unit Manager (RM) #1 revealed she provided [redacted] care when she worked and had not seen any [redacted] that had not been cleaned or had [redacted] buildup. During an interview on 07/31/2022 at 4:38 PM, Assistant Director of Nursing (ADON) #1 stated [redacted] care was provided according to physician's orders and as needed. The ADON indicated there had not been any reports of [redacted] care not being provided. The ADON stated there had been an issue with nursing staff signing the MAR, but asserted the actual care was being provided. During an interview on 07/31/2022 at 12:09 PM, the Administrator indicated signing of the MAR was an issue the facility was working on, and it had improved. According to the Administrator, services were being provided. 2. a) Review of an admission Minimum Data Set (MDS), dated [redacted], revealed Resident [redacted] had active diagnoses that included [redacted] (disorder of the [redacted]), [redacted] in the [redacted]), [redacted], and [redacted]. Review of a "Care Plan," dated [redacted], revealed Resident [redacted] was care planned for	F 684		

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F 684	Continued From page 11 problems including [redacted] status. A planned intervention for these care plan problems was to administer the resident's medications as ordered. A review of the [redacted] "Medication Administration Record (MAR)" revealed Resident [redacted] medications were not documented to have been administered as ordered on the following dates: - 09/25/2021 at 9:00 AM: The scheduled dose of [redacted] mg/[redacted] milliliters (ml), [redacted] mg [redacted] one time a day for [redacted] (prevention) was not initialed as administered. - 09/26/2021 at 9:00 PM: The scheduled dose of [redacted] milligrams (mg) at bedtime for [redacted] was not initialed as administered. - 09/26/2021 at 9:00 PM: The scheduled dose of [redacted] tablet [redacted] mg by mouth at bedtime for [redacted] was not initialed as administered. - 09/26/2021 at 9:00 PM: The scheduled dose of [redacted] tablet [redacted] mg by mouth two times a day for [redacted] was not initialed as administered. - 09/26/2021 at 9:00 PM: The scheduled dose of [redacted] mg, two capsules by mouth three times a day for [redacted] was not initialed as administered. - The scheduled doses of [redacted] solution [redacted] mg/[redacted] ml, [redacted] orally via [redacted] every 6 hours for [redacted] were not initialed as administered on 09/23/2021 at 6:00 AM; 09/24/2021 at 6:00 AM; 09/25/2021 at 6:00 AM, 12:00 PM, and 6:00 AM; and 09/26/2021 at 6:00 AM.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING _____ B. WING _____	C 07/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERFRONT REHABILITATION AND HEALTHCARE CENTER	5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109

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F 684	Continued From page 12 2. b) A review of Resident [redacted]s "Admission Record" revealed the facility readmitted the resident on [redacted] with diagnoses including [redacted]. Review of a quarterly Minimum Data Set (MDS), dated [redacted], revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] indicating the resident was [redacted] intact. Review of a "Care Plan," dated as revised on [redacted], revealed the resident had [redacted] related to [redacted] and [redacted] and indicated staff should administer medication as ordered. A review of the [redacted] "Medication Administration Record (MAR)" revealed the following physician-ordered medications were not initialed as administered to Resident [redacted] on 10/24/2021: - [redacted] milligrams (mg), one tablet one time a day for [redacted] - [redacted] mg, one tablet one time a day for the prevention of [redacted] - [redacted] mg, one capsule one time a day for [redacted]. - [redacted] mg, one tablet one time a day for essential [redacted]. During an interview on 07/30/2022 at 10:57 AM, Licensed Practical Nurse (LPN) #1 stated the electronic MAR (eMAR) should always be signed after each medication administration, because if the eMAR was not signed, it looked as if the	F 684		

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	315225	A. BUILDING _____ B. WING _____	C 07/31/2022

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RIVERFRONT REHABILITATION AND HEALTHCARE CENTER	5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109

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F 684	Continued From page 13	F 684		

medication was not given.

During an interview on 07/31/2022 at 9:05 AM, Registered Nurse Unit Manager (RM) #1 stated the eMAR should be signed after each medication was administered to show the medications were given as ordered.

An interview with the Assistant Director of Nursing (ADON) on 07/31/2022 at 4:38 PM revealed the expectation was for the medication administration policy to be followed and that staff document in the eMAR after every medication was administered.

An interview with the Administrator on 07/31/2022 at 12:09 PM revealed it was expected that all residents' eMARs were signed after medications were administered. The Administrator stated the facility had been working with nursing on medication administration and signing the MARs.

Review of a facility policy titled, "Medication Administration and Documentation Policies, Procedures, and Information," dated 07/01/2022, revealed, "It is the policy of this facility to ensure that Medication Administration and Documentation occurs in a timely and accurate manner. Medications are to be administered within a two-hour time frame (i.e. [such as] one hour before or after the medication order time." The policy also indicated the licensed nurse "Documents administration of medication in the eMAR [electronic Medication Administration Record] immediately following administration."

New Jersey Administrative Code: § 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060415	A. BUILDING: _____ B. WING _____	C 07/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERFRONT REHABILITATION AND HEALTHCARE C	5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Intake #NJ155485 Census: 156 Sample Size: 14 TYPE OF SURVEY: Complaint Survey The facility is not in substantial compliance with all the standards in the New Jersey Administrative Code 8:39, Standards for Licensure of Long-Term Care Facilities. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ155485 Based on interviews, facility document review, and New Jersey Department of Health (NJDOH) memo, dated 09/19/2021, it was determined the facility failed to maintain direct care staff-to-resident ratios as mandated by New Jersey State Law. This was evident for 14 out of 14 day shifts reviewed and 2 out of 14 night shifts reviewed. This had the potential to affect all residents.	S 560	I: Immediate Action: A) Staffing coordinator was immediately re in-serviced on staffing ratio requirements. II. Identification of Others: A)All residents have the potential to be affected however no resident was directly affected by this. III. Systemic changes: A)DON or LNHA/Designee will review open positions and applications plus	9/16/22

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

Electronically Signed | 08/25/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060415	A. BUILDING: _____ B. WING _____	C 07/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERFRONT REHABILITATION AND HEALTHCARE C	5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109

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S 560	Continued From page 1 Findings included: Reference: NJDOH memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One certified nurse aid to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties. A review of the "Nurse Staffing Report," completed by the facility for the weeks of 07/17/2022 through 07/30/2022, revealed staff-to-resident ratios that did not meet the minimum requirements as listed below. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts, as follows: - 07/17/2022 had 12 CNAs for 148 residents on the day shift, required 18	S 560	results of any interviews weekly to look for opportunities to hire. B)The Administrator and Director of Nurses will continue to utilize all possible means to increase the facility staff. This will include continued timely interviews, job fairs, reaching out to agencies for supplemental staff, setting up booths at nursing schools utilization of all possible avenues to increase staffing in the facility. IV. QA Monitoring A)LNHA/Designee will review staffing schedules weekly for 3 months. B)Findings of review will be presented by LNHA at quarterly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060415	A. BUILDING: _____ B. WING _____	C 07/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERFRONT REHABILITATION AND HEALTHCARE C	5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109

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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 - 07/21/2022 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 12 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 17 CNAs for 150 residents on the day shift, required 19 - 07/28/2022 had 18 CNAs for 152 residents on the day shift, required 19 - 07/29/2022 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 indicated it was difficult to maintain staff.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER Y1	MULTIPLE CONSTRUCTION Y2	DATE OF REVISIT Y3
060415	A. Building B. Wing	9/16/2022

NAME OF FACILITY	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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/16/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
7/31/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315225	A. Building B. Wing	9/16/2022

NAME OF FACILITY	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 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 F0609 Reg. # 483.12(c)(1)(4) LSC	Correction Completed 09/16/2022	ID Prefix F0610 Reg. # 483.12(c)(2)-(4) LSC	Correction Completed 09/16/2022	ID Prefix F0684 Reg. # 483.25 LSC	Correction Completed 09/16/2022
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
7/31/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO