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 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER FRONT 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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS C/O # NJ 156940, 158956, 159495, 165279, 166140, 166158, 166263, 166628, 166926, 170093, 170632, 174097 Standard Survey 08/14/2024 Census: 163 Sample Size: 32 + 2 Closed Records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550		9/25/24

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

Electronically Signed | 08/29/2024

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F 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, and review of other facility documentation, it was determined that the facility failed to ensure the transport of a NJ Ex Order 26.4b1 resident was provided in a manner to promote the dignity and respect of the resident. This deficient practice was identified for 1 of 32 residents reviewed for dignity, (Resident #27) and was evidenced by the following: A review of a facility policy titled Resident Rights, Created: 2/2024, revealed the following under Policy Explanation and Compliance Guidelines: 10. All residents will be treated equally regardless	F 550	1. Resident□s Affected a. Resident #27 was immediately turned around to face forward during transport. The staff LPN #2 was immediately reeducated on how to properly transport residents in a [redacted] chair or wheelchair to maintain dignity and safety. 2. Identification of Others a. All other residents requiring the use of geri-chairs or wheelchairs have the potential to be affected. b. An audit will be completed to identify all residents who use wheelchairs and geri-chairs to ensure they are transported	

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F 550	Continued From page 2 of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression. 11. The facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents. The following was revealed under the heading Resident rights: The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. On 08/05/2024 11:23 AM, during the initial tour of the facility, the surveyor observed Resident #27 seated in a [redacted] chair. A female staff was observed to transport Resident #27 from the [redacted] dining/activity room and past the nursing station by pulling the [redacted]-chair from behind and not pushing Resident #27 facing forward. The surveyor interviewed Licensed Practical Nurse (LPN #2). The surveyor asked LPN #2 how a [redacted] resident should be properly transported. LPN #2 responded by stating that she was sorry. A review of the Electroinic Medical Record on 08/06/2024 at 09:26 AM, revealed the following: A review of the Admission Record revealed that Resident #27 was admitted to the facility with the following but not limited to diagnoses: [redacted]. A review of the comprehensive Minimum Data	F 550	appropriately. 3. Systemic Changes a. All clinical staff were reeducated on how to properly transport residents who are in a wheelchair or a geri-chair to ensure dignity and safety are maintained. b. The resident□s right policy was reviewed and found to be appropriate. 4. Monitoring of Systemic Change a. The Director of Nursing will round on all nursing units 3x/week for 60 days and then submit to Quality Assurance and Performance Improvement (QAPI) committee for compliance x 2 months; to ensure residents dignity and safety are maintained while being transported in a geri-chair or wheelchair. Person Responsible: Director of Nursing or Designee	

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F 550	Continued From page 3 Set (MDS), an assessment tool, dated [NJ Ex Order 26.4b1] [redacted] revealed Resident #27 had a Brief Interview for Mental Status score of [NJ Exec Or] [redacted], which indicated U.S. FOIA (b)(6) [redacted]. Section GG revealed that Resident #27 had [NJ Exec Order 26.4b1] [redacted]. On 08/13/2024 at 02:20 PM, the surveyor conducted an interview with the facility administration which included the U.S. FOIA (b)(6) [redacted]. When asked how to properly transport a [NJ Ex Order 26.4b1] resident, the [U.S. FOIA (b)] [redacted] told the surveyors, "The resident should be transported from behind so that the staff and resident are moving forward in the same direction to see where you are going and for dignity issues."	F 550		
F 584 SS=D	NJAC 4.1(a)(12) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584		9/26/24

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F 584	Continued From page 4 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: C/O # NJ 156940 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain the facility in a clean and sanitary environment. This deficient practice was identified for 2 of 3 units, (Pavilion 2 and Pavilion 3) and was evidenced by the following: 1. On 08/13/2024 at 10:40 AM, a review of a facility policy titled Complete Room Cleaning dated 06/2024, revealed under the purpose	F 584	"Safe/Clean/ Homelike Environment " A) All housekeeping Staff were in re-educated by Director of Housekeeping on the proper method to clean a medication cart, a room, door jams, corners and IV poles. B) All medication carts were thoroughly cleaned, and hair knots were removed from the bottom of all med carts. C) Laminate on the door of room #126 was properly affixed to the door. D) All IV poles were inspected and	

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F 584	Continued From page 5 section; The complete room cleaning schedule insures {sic} (ensures)that each resident room is discharge-cleaned on a monthly basis. Under the Patient Room section 3. Starting in a clockwise rotation from patient room door; clean polish, scrub, scrape, dust, disinfect, sweep, wipe and mop everything in the room including: ... Check all the corners, ceiling and floors, Remove buildup on floor, dust mop and damp mop entire room. Under the Bathrooms section: ... Toilet: scrub and disinfect toilet bowl. Use cleanser on interior of bowl only. Remove all stains and buildup. Remove all buildup from the floor around the bowl, door frame, corners and edges. Dust mop the entire floor. Make sure vent in the bathroom is cleaned. Damp mop the entire floor. During the initial tour of the facility on the 2nd floor on 08/05/2024, the surveyor observed the following: + at 11:11 AM, in room 224 floor the surveyor feet stuck to floor. + at 11:14 AM room 221 had debris on floor. During a subsequent tour of the 2nd floor on 08/07/2024 at 12:12 PM, the surveyor observed the following: + room 229 floor with debris, hair knot by wheel at bottom of the bed, floor near door where the jam meets floor with dark spots, + room 228 dark marks on floor where the door jam and floor meet. + surveyor shoes stuck to the floors in rooms 229 and 228. + room 226 dark marks floor and where the door jam and floor meet. + hair knot observed on the floor outside room 225 in hallway.	F 584	thoroughly cleaned E) Rooms 224, 221, 229, 228, 226, 225, 227, 222, 223, 220, 221, 219, 218, 217, and 216 were all thoroughly cleaned and sanitized. " Residents in rooms 224, 221, 229, 228, 226, 225, 227, 222, 223, 220, 221, 219, 218, 217, and 216 were affected. " All residents have the potential to be affected. " Director of Housekeeping or Designee to 1) Audit 10 resident rooms for cleanliness weekly for one month and monthly for 2 months. Director of Maintenance or Designee to report findings to monthly QAPI meeting for 3 months 2) Audit 2 medication carts for cleanliness weekly for 4 weeks and then monthly for 2 months. Director of Maintenance or Designee to report findings to monthly QAPI meeting for 3 months. 3) Audit 4 IV poles for cleanliness weekly for 4 weeks and then monthly for 2 months. Director of Maintenance or designee to report findings to monthly QAPI meeting for 3 months.	

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F 584	Continued From page 6 On 08/07/2024 at 12:23 PM, the hallway 2nd floor high hall was observed with various colored debris marks on the floor between rooms 227 and 229. + room 222 corner of wall upon entering on left missing baseboard, cracked paint. + corners where door jams meet floor rooms 222, 223, 221, 220 219, 218, 217, 216, all have debris and dark marks. + floor room 218 upon entering with dark marks and w/c wheel trails. + medication cart high hall 2nd floor wheels with hair wrapped around wheels. + room 227 in the bathroom, floor where the baseboard and floor meet have dark stains, on left side of toilet when looking at it, on the floor is discolored and stains along base of toilet and inside toilet bowl. During an interview with the surveyor on 08/07/2024 at 12:24 PM, a family member said they are supposed to clean the rooms every day. They only mop the floors, don't sweep before mopping. Look at the stuff on the floors. The family member said they only mop floor in bathroom, they don't clean toilet. On 08/12/2024 at 12:00 PM, medication cart high hall 2nd floor wheel stills have hair wrapped on wheels. On 08/12/2024 at 09:06 AM, observed laminate board on door to room 126 peeling off. During an interview with the surveyor on 08/13/2024 at 09:44 AM, the U.S. FOIA (b)(6) [redacted]) was asked what the process was for cleaning resident	F 584		

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F 584	Continued From page 7	F 584		

rooms. The [redacted] responded first they knock on door, empty trash, sweep rooms (dry sweep) with dustpan and broom, wipe on top and bottoms of all surface areas, also clean top of lights. Then they go to the bathroom, clean toilet, sink and mirrors, check make sure toilet paper and paper towels are inside the holder not on back of toilet. They finish with wet mop rooms and bathroom. The [redacted] also said they check privacy curtains to make sure they are clean of spills or stains. When asked how often this is done, he said this is done daily.

The [redacted] said I usually have 2 housekeepers on each floor and 1 porter on day shift. On evening we have 2 floor techs, and they are responsible for day rooms and scrub the hallways, and empty soiled linen and trash.
The surveyor asked what about the corners of the room. The [redacted] replied that is also part of the daily cleaning. When asked who is responsible to clean the hallways, the [redacted] said the evening floor techs. The housekeeper or floor tech are responsible to clean marks off the floors. The [redacted] went on to say that hallways are cleaned daily, and twice weekly halls are scheduled to be scrubbed. The surveyor questioned what scrubbed means and he said we run the floor machine is what scrubbing means.

The surveyor asked how often room carbs (carbolization which is the process of deep cleaning a room) done. The [redacted] replied 1 room on each floor daily including weekends. This includes pulling all dressers, beds away from the wall, cleaning behind everything, top of lights, wipe call bell and phone lines are cleaned, wiping remotes (done daily as well) dust TV, picture frames, bed frames, mattresses, window frames

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F 584	Continued From page 8 and windowsills and windows. The surveyor asked who is responsible to clean the medication carts. The [redacted] responded Housekeeping is responsible to clean the medication carts. We have a spare, we clean that one, nursing then switches cart and then we take the dirty cart and clean it. Yes, that includes wheels and drawers, scrape anything left in there and when it is clean we leave for nursing to switch back. That is done monthly. During an interview with the surveyor on 08/13/2024 at 01:15 PM, the Housekeeping Assistant (HKA #1) said rooms are clean daily. The process is to sweep floor, mop floor, clean toilet, clean sink, dust top of dressers, lights, wipe bed down including mattress every day. When questioned about carbolizations, how often is this done. The Housekeeper replied do one room a day so done monthly. 2. On 08/05/2024 at 10:35 AM Resident #101 was observed lying in bed on the initial tour of the facility. [redacted] observed to be off at this time of observation. The surveyor observed what appeared to be [redacted] to be spilled on the floor and on the base of [redacted]. On 08/07/2024 at 08:26 AM Resident #101 was observed lying in bed with the head of the bed (HOB) slightly elevated. [redacted] is not on this observation. The [redacted] remains covered with an unidentified tan colored	F 584		

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F 584	Continued From page 9 substance on the base [NJ Ex Order 26.4b1]. On 08/08/2024 at 08:24 AM Resident #101was observed lying in bed with HOB elevated. [NJ Exec Order 26] [NJ Ex Order 26] is turned off and [NJ Ex Order 26.4b1] is present. [NJ Ex Order 26.4b1] and floor are stained/covered with an unidentified tan/brown substance that resembles [NJ Ex Order 26.4b1], as seen on previous observations. On 08/12/2024 at 11:10 AM Resident #101was observed lying in bed and receiving [NJ Ex Order 26.4b1] was hung at this time. [NJ Ex Order 26.4b1] is covered with an unidentified tan/brown substance that is dried onto the base. Appears to be dried [NJ Ex Order 26.4b1] that spilled. On 08/13/2024 at 08:35 AM Resident #101 was observed lying in bed with HOB elevated. [NJ Exec Order] [NJ Ex Order 26.4b1] is covered with what appears to be [NJ Ex Order 26.4b1]. The surveyor conducted an interview with the [NJ Exec Order 26.4b1] assigned to Resident #101's room. When asked who was responsible for cleaning of [NJ Ex Order 26.4b1] the house keeping assistant (HKA #2) stated that housekeeping staff were responsible for the maintenance/cleaning of [NJ Ex Order 26.4b1] in the facility. HKA #2 agreed that the [NJ Ex Order 26.4b1] needed cleaning and agreed that [NJ Ex Order 26.4b1] had been spilled on the [NJ Ex Order 26.4b1]. On 08/13/2024 at 09:45 AM the surveyors conducted an interview with the facility [ ]. When asked who was responsible for the cleaning of IV poles the [NJ Exec Order 26] responded, "We are responsible to clean the IV poles. They are	F 584		

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F 584	Continued From page 10 scheduled once a week to be cleaned but they can be cleaned daily if need be." On 08/13/2024 at 02:26 PM during an interview with facility [redacted] confirmed housekeeping/environmental services was responsible for cleaning IV poles as well as the person making the spill.	F 584		
F 656 SS=D	NJAC 8:39-31.4(a) Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		10/2/24

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F 656	Continued From page 11 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives, timelines, and interventions to meet resident's medical and nursing needs for 1 out of 4 residents investigated for NJ Ex Order 26.4b1. A review of a facility policy reviewed on 08/08/2024 at 11:05 AM, titled, "Care Plan," dated June 2024, revealed the following statement, "It is the policy of [facility name] that all residents admitted to the facility will have adequate person-centered care plans that provide for all their needs in a timely manner." Under "Procedures," #1. Baseline Care Plans for all new	F 656	1. Residents Affected a. Resident #372 was not negatively affected by the deficient practice. Resident #372's care plan was updated on 8/7/24 to reflect the presence of a NJ Exec Order 26.4b1 2. Identification of Others a. All other residents requiring a tracheostomy have the potential to be affected. b. An audit of all residents with a tracheostomy was conducted to ensure all tracheostomies are reflected in the resident's care plan. 3. Systemic Changes a. The policy and Procedure on Care Plans was reviewed by the Administrator	

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F 656	Continued From page 12 admissions will be initiated within 48 hours of admission. Under #2. They will include initial goals, MD orders, medications, treatments, dietary orders, therapy orders, social service and PASARR recommendations. The deficient practice was evidenced by the following: On 08/05/2024 at 10:13 AM, the surveyor observed Resident #372 in his/her room, lying in bed with a NJ Exec Order 26.4b1 [redacted] with [redacted] A review of Resident #372's Electronic Medical Record on 08/06/2024 at 09:31 AM, revealed the following: A review of Resident #372's Admission Record revealed that he/she had a diagnosis of [redacted] A review of the resident physician orders revealed orders for the care and treatment of the NJ Exec Order 26.4b1 A review of Resident #372's most recent comprehensive Minimum Data Set (MDS), an assessment tool to facilitate resident care dated NJ Ex Order 26.4b1 under Section O-Special Treatments, Procedures, and Programs, indicated that Resident #372 required [redacted] therapy, NJ Ex Order 26.4b1, and NJ Exec Order 26.4b1. A review of Resident # 372's care plan did not include the required care and maintenance for the	F 656	and Director of Nursing has been reviewed and was found appropriate. b. All clinical staff responsible for updating any aspect of the resident's care plan were reeducated on the importance of initiating, reviewing and revising care plans to reflect the status of all residents, including tracheostomy care and maintenance. 4. Monitoring of Systemic Change a. Audits will be conducted for all tracheostomy residents weekly x 4 weeks, monthly x 2 months, and then presented to Quality Assurance and Performance Improvement (QAPI) committee for compliance x 2 months to ensure residents have a care plan for tracheostomy care and maintenance. Person Responsible: Director of Nursing or Designee	

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F 656	Continued From page 13 resident's NJ Ex Order 26.4b1. During an interview with the surveyor on 08/07/2024 at 09:10 AM, Registered Nurse/Unit Manager (RN/UM #1), stated that there was no care plan for the NJ Ex Order 26.4b1 for Resident #372. RN/UM #1 added that it was ultimately her responsibility to assure that a care plan was in place.	F 656		
F 658 SS=D	8:39-11.2 (e) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, review of the Electronic Medical Record (EMR), and review of other facility documentation, it was determined that the facility failed to ensure a resident had a Physician Order (PO) for transfer to the hospital. This deficient practice was identified for 2 of 2 residents reviewed for hospitalizations (Resident # 126 and Resident # 137) and was evidenced by the following: On 08/14/2024 at 9:52 AM, a review of the facility's "Transfer or Discharge, Emergency" policy dated revised June 2024, included, Should it become necessary to make an emergency transfer or discharge to a hospital... Notify the resident's attending physician; place order for transfer per attending physician/NP (nurse	F 658	1. Residents Affected a. Physician orders were obtained for resident #126 and #137 transfers to the NJ Ex Order 26.4b1 2. Identification of Others a. All other residents being transferred to the hospital have the potential to be affected. b. An audit of all residents transferred to the hospital in the past 3 months was conducted to ensure all residents transferred to the hospital have a physician□s order. 3. Systemic Changes a. The policy and Procedure on emergency transfers was reviewed by the Administrator and Director of Nursing has	10/2/24

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F 658	Continued From page 14 practitioner)/PA...(physician assistant) On 08/06/2024 at 11:42 AM, a review of the Electronic Medical Record (EMR) revealed the following: 1. A review of the Admission record revealed Resident #126 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted]. A review of a facility progress note (PN) dated NJ Ex Order 26.4b1 revealed Resident #126 was observed sitting in the chair with NJ Exec Order 26.4b1 [redacted] 911 was called and Resident #126 left with Emergency Medical Services to the local NJ Ex Order 26.4b1. A further review of the EMR did not include a physician order to transfer Resident #126 to the NJ Ex Order 26.4b1 During an interview with the surveyor on 08/14/2024 at 09:10 AM, the U.S. FOIA (b)(6) [redacted]) said there was no order to transfer Resident #126 to the hospital. The surveyor asked should there have been an order and she replied, "Yes." 2. On 8/13/24 at 8:47 AM, the surveyor reviewed the medical record for Resident #137, a NJ Exec Order 26.4b1 resident. A review of the Admission Record reflected the resident was admitted to the facility with diagnoses which included injury of the NJ Exec Order 26.4 [redacted]	F 658	been reviewed and was found appropriate. b. All LPNs and RNs were reeducated on placing a physician□s order into the electronic medical record (EMR) for all residents transferring to the hospital. c. The Director of Nursing or Designee will check to ensure that the physician order for transfer to the hospital is present in the Electronic Medical Record when a resident transfers from the facility. 4. Monitoring of Systemic Change a. Audits of the medical record of 5 residents transferred to the hospital will be conducted weekly x 4 weeks, monthly x 2 months, and submitted to the monthly Quality Assurance and Performance Improvement (QAPI) committee monthly x 2 months; to ensure all residents have a physician□s order when transferred to the hospital. b. The DON/designee will be responsible for ensuring all residents transferred to the hospital have a physician□s order checked weekly and findings to be reviewed for compliance at the monthly Quality Assurance and Performance Improvement (QAPI) committee x 3 months. Person Responsible: Director of Nursing or Designee	

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F 658	Continued From page 15 NJ Exec Order 26.4b1. A review of the Progress Notes (PN), Health Status Note, dated NJ Exec Order 26.4b1, the resident was observed with NJ Exec Order 26.4b1. The US FOIA (b)(6) was contacted and ordered resident to be NJ Ex Order 26.4b1. A review of the Medication Review Report for NJ Exec Order 26.4b1 did not reveal a physician's order for the resident to be NJ Ex Order 26.4b1 on NJ Exec Order 26.4 On 8/14/24 at 8:42 AM, the surveyor interviewed the U.S. FOIA (b) who stated there should be a physician's order for a resident to be transferred to the NJ Ex Order 26.4b1. The U.S. FOIA (b) acknowledged there was no order for Resident #137 to be transferred to the NJ Ex Order 26.4b1 in the resident's medical record.	F 658		
F 693 SS=D	NJAC 8:39-11.2(b); 27.1(a) Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the	F 693		10/2/24

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F 693	Continued From page 16 resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to follow physician orders specifically to change the [redacted] NJ Exec Order 26.4b1 [redacted] r) every 24 hours for 1 of 3 residents reviewed for [redacted], (Resident #54). This deficient practice was evidenced by the following: On 08/12/2024 at 12:10 PM, a review of a facility policy titled Enteral Tubes with a last revised date of 06/3/2024, revealed under the Procedure section: 16. Rinse Thoroughly with tap water and place in a labeled dry plastic bag to remain at bedside. *Change syringe and bag every 24 hours. During the initial tour of [redacted] on 08/05/2024 at 10:58 AM, Resident # 54's [redacted] was observed on the bed side table. The bottled had the residents name and was dated [redacted] A review of the Electronic Medical Record on 08/06/2024 at 09:29 AM, revealed the following: Resident #54 was admitted with diagnoses	F 693	1. Residents Affected a. The NJ Ex Order 26.4b1 for Resident #54 were changed immediately and dated correctly and will continue to be changed daily as per facility policy. 2. Identification of Others a. All other residents requiring enteral feedings have the potential to be affected. b. An audit was conducted for all residents receiving enteral feedings to ensure they have a piston, and syringe changed every 24 hours. 3. Systemic Changes a. The facility's policy and procedure on enteral feeding was reviewed by the Administrator and Director of Nursing and was found to be appropriate. b. All LPNs and RNs were reeducated on the importance of changing the piston and syringe of all residents receiving enteral feedings. 4. Monitoring of Systemic Change a. Audits will be conducted for the presence of a properly dated piston/syringe for all residents with enteral feedings weekly x 4 weeks, monthly x 2 months, and submitted monthly to the monthly Quality Assurance and	

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F 693	Continued From page 17 including but not limited to: NJ Exec Order 26.4b1 [redacted] A review of the most recent Quarterly Minimum Data Set, an assessment tool, dated NJ Exec Order 26.4b1 revealed under section K Resident #54 had a NJ Exec Order 26.4b1 and had a NJ Exec Order 26.4b1 under Nutritional Approaches. A review of the Physician Order Summary included a physician order with a start date of NJ Exec Order 26.4b1 to change NJ Ex Order 26.4b1 (Name and date bottle/package) every night shift. A review of the Medication Administration Record for NJ Ex Order 26.4b1 revealed the aforementioned order. Under the dates NJ Ex Order 26.4b1 signatures that the order was completed were observed. During an interview with the surveyor on 08/12/2024 at 09:23 AM, the Registered Nurse/Unit Manager (RN/UM #1) was asked what was the facility process for the use of NJ Ex Order 26.4b1 RN/UM #1 replied they are changed daily in the evening, usually 11-7 shift which is night. They are used to NJ Ex Order 26.4b1 through the NJ Exec Order 26 [redacted]. It is important to change every 24 hours for infection control. The surveyor asked what was meant by infection control and she said you could be entering bacteria directly into blood stream of the resident. It is also used to check residual as well. The surveyor also asked where this would be documented, and she responded on the TAR (Treatment Administration Record). RN/UM #1 went on to say if there are initials on the TAR it means it was changed and completed. They are signing for that.	F 693	Performance Improvement (QAPI) committee x 2 months to ensure they have a changed piston and syringe every 24 hours. Person Responsible: Director of Nursing/Designee	

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F 693	Continued From page 18 On 08/12/2024 at 09:32 AM, the surveyor reviewed the evidence of the NJ Ex Order 26.4b1 with RN/UM #1 and confirmed that on NJ Ex Order 2 it had not been changed for 2 days even though it was signed out as having been done. During an interview with the surveyor on 08/12/2024 at 11:05 AM, the US FOIA (b)(6) was asked what was the process for the use of NJ Ex Order 26.4b1. The US FOIA (b)(6) replied, to provide fluids or nutrition to the patient. They are supposed to be changed every 24 hours. It is an infection control issue. The surveyor questioned what was meant by infection control issue. The U.S. FOIA (b) responded "Make sure that anything going right into their (residents) body is safe and not introduce NJ Exec Order 26.4b1 When asked where this would be documented, the US FOIA (b)(6) replied, "It should be on the TAR." On 08/12/2024 at 11:09 AM, the surveyor reviewed the evidence with the US FOIA (b)(6) who confirmed it NJ Ex Order 26.4b1) should have been changed.	F 693		
F 695 SS=D	NJAC 8:39-27.1(a) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		10/2/24

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F 695	Continued From page 19 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the Electronic Medical Record (EMR) and review of other facility documentation, it was determined that the facility failed to ensure a resident who used [redacted] therapy at night, had a Physician Order. This deficient practice was identified for 1 of 4 residents reviewed for [redacted] (Resident #117) and was evidenced by the following: During the initial tour of the facility on 08/05/2024 at 10:29 AM, the surveyor observed [redacted] next to the resident in bed. The [redacted] was not dated. Resident #117 said he/she uses it at night. There was no observed [redacted] outside the room. On 08/08/2024 at 01:10 PM, a review of a facility policy titled Oxygen Administration with a revised date of January 2024, revealed under the Policy section: "Oxygen administration will be carried out only with a physician order." A review of the EMR on 08/05/2024 at 12:00 PM, revealed the following: According to the Admission Record Resident #117 was admitted to the facility with diagnoses including but not limited to: [redacted] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate resident care, dated [redacted] revealed Resident #117 had a Brief Interview for	F 695	1. Residents Affected a. The [redacted] order for resident #117 was immediately placed in the electronic medical record (EMR) and will continue to be monitored to ensure medical necessity or further order changes. A. Identification of Others a. All other residents administered oxygen have the potential to be affected. b. Audits were completed for all residents receiving oxygen to ensure they have a physician's order. B. Systemic Changes a. The facility's policy and procedure on oxygen administration was reviewed by the Administrator and Director of Nursing and was found to be appropriate. b. All LPNs and RNs were reeducated on receiving a physician□s order prior to administering oxygen to residents. C. Monitoring of Systemic Change a. Audits will be conducted on all residents on oxygen therapy weekly x 4 weeks, monthly x 2 months, and submitted monthly to the monthly Quality Assurance and Performance Improvement (QAPI) committee x 2 months for compliance to ensure they have physician orders for oxygen administration. b. A checklist for all admissions and residents with new orders for oxygen therapy will be reviewed by the Director of Nursing and Unit managers in morning meeting to ensure that a physician order	

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F 695	Continued From page 20 Mental Status score of [redacted], indicating Resident #117 was [redacted]. The MDS indicated under section [redacted] that Resident #117 used [redacted] upon admission and while a resident. A review of the Wts. (weights)/Vitals tab in the EMR included documentation of [redacted] under the Method section [redacted]. A review of the Order Summary Report with Active Orders as of [redacted], did not include a physician order for Resident #117 to [redacted]. A review of the comprehensive Care Plan revealed a Focus area of [resident name] has potential for [redacted] /t (related to) [redacted] symptoms Created on: [redacted]. Interventions included but were not limited to: [redacted] Created on: [redacted] During an interview with the surveyor on 08/12/2024 at 11:31 AM, Licensed Practical Nurse (LPN #1) was asked what was the facility policy regarding [redacted] use. LPN #1 responded, "We need a physician order for [redacted] We look at records to make sure [redacted] and definitely get an order." During an interview with the surveyor on 08/13/2024 at 11:31 AM, Registered Nurse/Unit Manager (RN/UM #1) was asked what was the facility policy regarding [redacted] use. RN/UM #1	F 695	and care plan is in place. Person Responsible: Director of Nursing/Designee	

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F 695	Continued From page 21 responded, "It depends on the medical condition determined by the physician and the physician orders." The surveyor asked RN/UM #1 if [NJ Exec Order 26] use required a physician order. RN/UM #1 said, "If in emergency no. If standard use continuously, there would be a sign on the door and a physician order for the [NJ Exec Order 26.4b1] On 08/13/2024 at 11:36 AM, RN/UM #1 told the surveyor, "I was told in the past he/she has used [NJ Exec Order 26] before." The surveyor asked RN/UM #1 to look at the resident's orders. RN/UM #1 then told the surveyor, "No, I do not see a physician order for [NJ Exec Order 26]." The surveyor also reviewed with RN/UM #1 that Resident #117 told the surveyor he/she wore [NJ Exec Order 26.4b] every night. The surveyor also reviewed with the RN/UM #1 that the nurses are documenting pulse [NJ Exec Order 26.4b1]. RN/UM #1 looked at the EMR and saw the documentation for the pulse [NJ Exec Order 26.4b1] and said, "I see that." During an interview with the surveyor on 08/13/2024 02:40 PM, the facility [U.S. FOIA (b)(6)] was asked what the facility policy was regarding [NJ Ex Order 26.4b1]. The [US FOIA (b)] said they have to have an order from MD (physician) with amount of [NJ Ex Order 26.4] needed, whether prn (as needed) or continuous, how given either [NJ Exec Orde] or [NJ Ex Order 26.4b1], and a care plan. NJAC 8:39-27.1(a)	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent	F 698		10/2/24

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F 698	Continued From page 22 with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and other facility documentation, it was determined that the facility failed to complete the [NJ Exec Order 26] communication book for a resident on [NJ Exec Order 26.4b] (Resident #94). This deficient practice was identified for 1 of 1 residents reviewed for [NJ Exec Order 26.4b]. The evidence was as follows: On 8/16/2024 at 12:00 PM the surveyor reviewed the facility's "Dialysis Management (Hemodialysis) policy with a revised date of 6/2024 included... If Dialysis is provided at off-site Dialysis Center...Assure facility completed Dialysis communication form accompanies resident to dialysis on treatment days, to communicate resident information and coordinate care between Dialysis center and facility...Dialysis center personnel to complete Dialysis communication form and return and return to the facility... Upon return from Dialysis Center, review information provided on Dialysis communication form... On 8/7/24 at 11:18 AM the surveyor observed the Resident #94 in a wheelchair in their room. The resident stated they went to [NJ Exec Order 26] on Tuesday, Thursday and Saturday and further stated he/she would bring a communication binder back and forth from the [NJ Exec Order 26.4b] center that contained his/her records. The surveyor reviewed the medical record for	F 698	1. Residents Affected a. A new book was created for resident #94, communication sheets were reviewed with [NJ Ex Order 26.4b1] ensure no recommendations were missed. 2. Identification of Others a. All other residents receiving dialysis in the facility have the potential to be affected. b. An audit was conducted for all residents receiving dialysis to ensure dialysis communication sheets were completed. 3. Systemic Changes a. The facility's policy and procedure for dialysis management was reviewed by the Administrator and Director of Nursing and was found to be appropriate. b. On 08/13/2024 LPNs and RNs were reeducated by DON and IP Nurse on ensuring all dialysis residents have a complete dialysis communication sheet prior to scheduled dialysis appointment. 4. Monitoring of Systemic Change a. Audits for all residents receiving dialysis will be conducted weekly x 4 weeks, monthly x 2 months, and presented to the Quality Assurance and Performance Improvement (QAPI) committee x 2 months for compliance to ensure dialysis communication sheets are completed. Person Responsible: Director of Nursing/Designee	

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F 698	Continued From page 23 Resident #94 on 08/06/2024 at 11:43 AM. A review of the Admission Record reflected that the resident was admitted to the facility with diagnoses that included [redacted]. A review of the Order Summary Report included a physician's order (PO) dated [redacted], for [redacted] every Tuesday, Thursday, and Saturday; 10:45 AM- 2:30 PM return time, wheelchair transport. A review of the most recent comprehensive Minimum Data Set (MDS) dated [redacted] reflected the resident had a brief interview for mental status score of [redacted], which indicated a [redacted]. A further review of the MDS indicated the resident had received [redacted] treatments while in the facility. On 8/12/2024 at 11:07 AM, the surveyor interviewed the residents Licensed Practical Nurse (LPN #1) who stated Resident #94 received [redacted] on Tuesday, Thursday, and Saturday, and that the facility communicated with the [redacted] center using a communication book the resident would transport with them. LPN #1 further explained the facility nurse would fill out the top portion with the resident's vital signs and the [redacted] center fills out the bottom portion. A review of Resident # 94's [redacted] communication book which included forms dated [redacted] and observed the following: On [redacted] the [redacted] center did not complete	F 698		

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F 698	Continued From page 24 their portion of the Nurse Communication Record. On [NJ Ex Order 26.4] the facility did not complete their portion of the Nurse Communication Record. , On 8/12/2024 at 11:26 AM the surveyor interviewed the resident's Registered Nurse Unit Manager (RN/UM #1) who stated that in [NJ Ex Order] the resident returned back from [NJ Ex Order 26.4b1] without their communication book from [NJ Ex Order 26.4b1] so a new communication book/binder was created beginning [NJ Ex Order 26.4b1]. At that time the surveyor and the RN/UM #1 reviewed the resident's [NJ Ex Order 26.4] communication book and she confirmed two of the five forms provided were not completed in their entirety. RN/UM #1 stated the sending nurse was responsible to complete the top portion of the form and the [NJ Ex Order 26.4] nurse would complete the bottom portion of the form. RN/UM #1 further stated the nurse who received the resident after [NJ Exec Order 26.4] was responsible for reviewing the form and should call the [NJ Ex Order 26.4] center if the form was not completed. On 8/13/2024 at 2:22 PM, the survey team met with the facility administration. The [U.S. FOIA (b)(6)]) stated the nurses were responsible to ensure the [NJ Ex Order 26.4] communication form was completed in its entirety and sent with the resident to [NJ Ex Order 26.4]. Then upon the return to the facility from [NJ Ex Order 26.4] the nurse should review the form for any treatments provided or recommendations. If the form was not completed from the [NJ Ex Order 26.4] center, then the nurse should have reached out to the [NJ Ex Order 26.4b1] to have the form completed. NJAC 8:39-27.1(a)	F 698		

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F 725	Continued From page 25	F 725		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint # NJ 158956, 166158, 170632 Based on interview, and review of other facility documentation, it was determined the facility failed to ensure there was sufficient nursing staff on a 24-hour basis to provide nursing care to the residents. This deficient practice was evidenced	F 725	1. DON and Administrator looked over staffing patterns and hired more regular staff and contacted agencies to ensure that we will have adequate staff to meet resident's needs. 2. All residents have the potential to be affected.	10/2/24

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F 725	Continued From page 26 by the following: A review of the provided "Facility Assessment" dated March 2024 included ...our approach to ensure adequate staff based on our resident population and their needs for care ... for Certified Nurse Aides 1:8 Residents for days, 1:10 evenings, 1:14 nights, one Restorative Aide day shift weekdays and one Restorative Aide Day shift weekends. During resident Council meeting on 08/08/2024 at 11:00 AM, a resident stated nights are short staffed, and wait time is long. Only two were on 2nd floor last night. 2 of 5 residents stated they have waited 4 to 5 hours for an aide. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the following weeks weeks revealed the facility was deficient in CNA staffing for residents as follows: 1. For the 2 weeks of staffing prior to survey from 07/21/2/2024 to 08/03/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: The facility provided less than half the required CNA staffing for resident care on 4 day shifts. -07/21/24 had 14 CNAs for 168 residents on the day shift, required at least 21 CNAs. -07/22/24 had 16 CNAs for 168 residents on the day shift, required at least 21 CNAs. -07/23/24 had 16 CNAs for 168 residents on the day shift, required at least 21 CNAs. -07/24/24 had 12 CNAs for 168 residents on the	F 725	3. The following measures have been put in place to prevent the deficiency from recurring: a) Advertisement / Job postings for CNA open positions have been posted on social media websites with a generous sign on bonus for new hires and referral bonus for employees. b) Incentives are also offered to CNAs to work extra shifts. c) Tables are being set up by job fairs letting people know that the facility is hiring CNAs. d) The facility continues to reach out to CNAs schools to advise them of our hiring programs and training of new graduates. e) The facility is contracted with several staffing agencies to assist with staffing needs. 4. Administrator or designee will review staffing schedule with DON and staffing coordinator weekly to monitor staffing ratios for 2 months. Results of monitoring will be submitted to QAPI committee for 3 months for review and modification of plan as needed to remain in compliance.	

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F 725	Continued From page 27 day shift, required at least 21 CNAs. -07/25/24 had 16 CNAs for 170 residents on the day shift, required at least 21 CNAs. -07/26/24 had 15 CNAs for 170 residents on the day shift, required at least 21 CNAs. -07/27/24 had 13 CNAs for 170 residents on the day shift, required at least 21 CNAs. -07/28/24 had 12 CNAs for 173 residents on the day shift, required at least 22 CNAs. -07/29/24 had 13 CNAs for 171 residents on the day shift, required at least 21 CNAs. -07/29/24 had 10 total staff for 171 residents on the overnight shift, required at least 12 total staff. -07/30/24 had 15 CNAs for 168 residents on the day shift, required at least 21 CNAs. -07/31/24 had 16 CNAs for 165 residents on the day shift, required at least 21 CNAs. -08/01/24 had 13 CNAs for 164 residents on the day shift, required at least 20 CNAs. -08/02/24 had 13 CNAs for 164 residents on the day shift, required at least 20 CNAs. -08/03/24 had 11 CNAs for 163 residents on the day shift, required at least 20 CNAs. 2. For the week of Complaint staffing from 07/30/2023 to 08/05/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -07/30/23 had 5 CNAs for 163 residents on the day shift, required at least 20 CNAs. -07/31/23 had 16 CNAs for 163 residents on the day shift, required at least 20 CNAs. -08/01/23 had 19 CNAs for 163 residents on the day shift, required at least 20 CNAs. -08/04/23 had 18 CNAs for 159 residents on the day shift, required at least 20 CNAs. -08/05/23 had 18 CNAs for 159 residents on the	F 725		

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F 725	Continued From page 28 day shift, required at least 20 CNAs. 3. For the week of Complaint staffing from 08/13/2023 to 08/19/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -08/13/23 had 13 CNAs for 160 residents on the day shift, required at least 20 CNAs. -08/18/23 had 17 CNAs for 159 residents on the day shift, required at least 20 CNAs. 4. For the week of Complaint staffing from 08/27/2023 to 09/02/2023, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -08/27/23 had 9 CNAs for 157 residents on the day shift, required at least 20 CNAs. -08/28/23 had 16 CNAs for 157 residents on the day shift, required at least 20 CNAs. -09/01/23 had 18 CNAs for155 residents on the day shift, required at least 19 CNAs. 5. For the week of Complaint staffing from 12/31/2023 to 01/06/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 2 of 7 evening shifts as follows: -12/31/23 had 10 CNAs for 155 residents on the day shift, required at least 19 CNAs. -01/01/24 had 11 CNAs for 155 residents on the day shift, required at least 19 CNAs. -01/01/24 had 14 total staff for 155 residents on the evening shift, required at least 15 total staff. -01/02/24 had 14 CNAs for 155 residents on the day shift, required at least 19 CNAs. -01/03/24 had 16 CNAs for 155 residents on the	F 725		

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F 725	Continued From page 29	F 725		

day shift, required at least 19 CNAs.
-01/04/24 had 17 CNAs for 155 residents on the day shift, required at least 19 CNAs.
-01/05/24 had 11 CNAs for 155 residents on the day shift, required at least 19 CNAs.
-01/06/24 had 12 CNAs for 155 residents on the day shift, required at least 19 CNAs.
-01/06/24 had 14 total staff for 155 residents on the evening shift, required at last 15 total staff.

6. For the week of Complaint staffing from 01/21/2024 to 01/27/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, and deficient in total staff for residents on 2 of 7 evening shifts as follows:

-01/21/24 had 10 CNAs for 162 residents on the day shift, required at least 20 CNAs.
-01/21/24 had 15 total staff for 162 residents on the evening shift, required at least 16 total staff.
-01/22/24 had 7 CNAs for 162 residents on the day shift, required at least 20 CNAs.
-01/23/24 had 14 CNAs for 161 residents on the day shift, required at least 20 CNAs.
-01/24/24 had 15 CNAs for 161 residents on the day shift, required at least 20 CNAs.
-01/25/24 had 16 CNAs for 161 residents on the day shift, required at least 20 CNAs.
-01/26/24 had 16 CNAs for 161 residents on the day shift, required at least 20 CNAs.
-01/26/24 had 15 total staff for 161 residents on the evening shift, required at least 16 total staff.
-01/27/24 had 16 CNAs for 158 residents on the day shift, required at least 20 CNAs.

7. For the week of Complaint staffing from 05/25/2024 to 06/01/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents

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F 725	Continued From page 30 on 1 of 7 overnight shifts as follows: -05/26/24 had 18 CNAs for 166 residents on the day shift, required at least 21 CNAs. -05/27/24 had 12 CNAs for 165 residents on the day shift, required at least 21 CNAs. -05/27/24 had 9 total staff for 165 residents on the overnight shift, required at least 12 total staff. -05/28/24 had 16 CNAs for 165 residents on the day shift, required at least 21 CNAs. -05/29/24 had 16 CNAs for 165 residents on the day shift, required at least 21 CNAs. -05/30/24 had 15 CNAs for 165 residents on the day shift, required at least 21 CNAs. -05/31/24 had 16 CNAs for 165 residents on the day shift, required at least 21 CNAs. -06/01/24 had 15 CNAs for 165 residents on the day shift, required at least 21 CNAs. On 8/14/24 at 10:34 AM, the surveyor interviewed the facility US FOIA (b)(6) who stated she was aware of the staffing requirements for Certified Nurse Aides in New Jersey. The US FOIA stated one CNA to 10 residents on dayshift, one CNA to 10 residents on the evening shift and one CNA to 20 residents on the night shift. The US FOIA stated she did her best and believed they were meeting the minimum staffing requirements a majority of the time. During an interview with the US FOIA (b)(6) on 08/13/2024 at 02:44 PM, the surveyor reviewed the Facility Assessment and asked the US FOIA (b) what was the facility's staffing pattern for nurses? The US FOIA (b)(6) explained the following: PAV (Pavilion) 1 DAY 2 nurses EVE 2 nurses	F 725		

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F 725	Continued From page 31 NIGHT 2 nurse PAV 2 DAY 2 nurses EVE 2 nurse NIGHT 1 nurse PAV 3 DAY 2 nurses EVE 2 nurses NIGHT 1 nurse.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755		10/2/24

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F 755	Continued From page 32 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Cross Reference F867 Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to ensure: a) a discontinued and expired medication [redacted] was removed from active inventory b) maintain an accurate accountability for controlled substances within the medication administration cart c) a controlled medication that was expired was removed from an automated medication dispensing system. This deficient practice was identified for 1 of 3 medication carts, and 1 of 1 automated medication dispensing system reviewed during the medication storage task. A review of the facility policy, "Medication Administration" (Reviewed 06/24) revealed the following: ...Check the expiration date on medication label. A review of an undated facility policy, "6.0 Inventory Control of Drugs" revealed the following: Controlled drugs are inventoried and documented under proper conditions with regard to security and state/federal regulations.	F 755	1. Residents Affected a. Resident #8 had the potential to be affected. b. [redacted] had not yet been administered from the medication backup system , they were immediately removed and destroyed. c. The expired medication was immediately removed from the medication cart. 2. Identification of Others a. All other residents have the potential to be affected. b. Audits were conducted of the medication carts and medication backup system from the last 3 months to ensure expired medications were removed. 3. Systemic Changes a. All LPNs and RNs were reeducated 8/13/24 on checking the medication carts for expired medications. b. All RN supervisors were reeducated on 8/16/24 checking the medication backup system narcotics for expiration dates when completing the daily count. c. The Director of Nursing will review the medication backup system report biweekly to check for expiration dates 4. Monitoring of Systemic Change a. All unit managers will check their	

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F 755	Continued From page 33 ...Schedule II medications are counted by the oncoming nurse and the outgoing nurse at least once (1) a day or at the change of each shift and documented on a Controlled Drug Count Verification (Shift Count Sheet for Narcotics). A review of the facility policy, "4.0 Schedule II Controlled Substance Medication" (Revised 10/01/18) revealed the following: ...An inventory count of all CDS (controlled dangerous substances) medications stored on each nursing unit shall be performed at each change of shift by both the incoming and outgoing nurse. Both nurses are responsible for the count and must sign the inventory count form. This deficient practice was evidenced by the following: 1. On 08/07/2024 at 11:23 AM, during a medication cart inspection of the [redacted] in the presence of Licensed Practical Nurse (LPN #1), the surveyor noted a bingo card (unit dose medication blister packaged onto a multiple-dose card) that contained [redacted] (mg) that was ordered for Resident #8 had expired on [redacted]. When interviewed at that time, LPN #1 stated that the resident received the medication this morning. LPN #1 further stated that he had not seen the expiration date. On 08/07/2024 at 11:56 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM #1) who stated that staff should check medications before the medication pass to make sure that they were not expired. On 08/08/2024 at 12:48 PM, the surveyor	F 755	medication carts for expired medications weekly x 4 weeks, monthly x 2 months, and results submitted to the monthly Quality Assurance and Performance Improvement (QAPI) for compliance x 2 months. b. The 11p-7a RN supervisors and IP Nurse/designee will check the medication backup system daily for expired narcotics when counting. c. The daily pharmacy report will be reviewed by the Director of Nursing for expiring backup narcotics weekly x 4 weeks, monthly x 2 months, and results submitted to the monthly Quality Assurance and Performance Improvement (QAPI) for compliance x 2 months and then reviewed at the quarterly QAPI meeting. d. The Consultant Pharmacy environmental rounds reports will be reviewed for expired medications on the carts monthly, and results submitted to the monthly Quality Assurance and Performance Improvement (QAPI) for compliance x 2 months and then reviewed at the quarterly QAPI meeting. Person Responsible: Director of Nursing/Designee	

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conducted a telephone interview with the U.S. FOIA (b)(6) who stated that nursing should look at the expiration date on the medication prior to administration. The [redacted] stated that she expected nursing to look through their carts each time that they handled medications. The [redacted] stated that as a [redacted], part of her role was to check the bingo cards during cart inspection.

On 08/08/2024 at 1:33 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that the expiration date should have been on the back of the blister pack and the nurse should have looked at the expiration date prior to administration.

The surveyor reviewed the unsampled resident's electronic health record and noted an order for NJ Exec Order 26.4b1 [redacted] The discontinued medication remained within the resident's active inventory of medications through NJ Ex Order 26.4b1, until surveyor inquiry.

2. On 08/07/2024 at 11:34 AM, the surveyor reviewed the NJ Exec Order 26.4b1 [redacted]) Book in the presence of LPN #1 for the Pavilion Two Unit Short Hall Medication Cart. The surveyor reviewed the "NJ Exec Order 26.4b Count Record" for U.S. FOIA (b)(6) [redacted] and noted that LPN #1, who was scheduled to work the 7 AM to 3 PM shift, had already signed his name in the space provided for the Offgoing Nurse Signature for the 3 PM to 11 PM shift. When the surveyor asked why he signed the NJ Exec Order 26.4b1 Count Record" prior to performing a NJ Exec Order 26.4b count of all controlled medications within the medication cart with the Oncoming Nurse he

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stated, "So I do not forget."

On 08/07/2024 at 11:56 AM, the surveyor interviewed RN/UM #1 of Pavilion Two who stated that the purpose of the narcotic count was for the incoming and outgoing nurses to document that they were in agreement that the count was correct. The RN/UM #1 stated that it was not acceptable to sign out for the outgoing shift before the count was completed. LPN #1 was present at that time, and stated that he was mistaken.

On 08/08/2024 at 12:48 PM, the surveyor conducted a telephone interview with the U.S. FOIA (b)(6)) who stated that the 7 AM to 3 PM nurse absolutely should not have signed out as the outgoing nurse on the 3 PM to 11 PM shift because they did not count with the incoming nurse. The U.S. FOIA stated that the whole idea was to make sure that the narcotic count was okay. The U.S. FO stated, "It is not okay to pre-sign."

On 08/08/2024 at 1:33 PM, the surveyor interviewed the U.S. FOIA (b) who stated that the process for the narcotic count was to sign to verify what you see at that point, because things change. The U.S. FOIA (b) stated that both the incoming and outgoing nurses should count what they have in the medication cart together and then sign afterward. The U.S. FOIA (b) further stated, "We should never pre-sign for anything."

3. On 08/07/2024 at 12:13 PM, the surveyor observed the U.S. FOIA (b) and RN/UM #1 as they performed a cycle count of back up controlled medications stored within the automated medication dispensing system. The U.S. FOIA (b) stated

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F 755	Continued From page 36 that the U.S. FOIA (b)(6)) performed a cycle count daily. During the inventory count, the U.S. FOIA (b) stated that NJ Exec Order 26.4b1 , expired on NJ Exec Order 26.4b1 The U.S. FOIA (b) stated that the expired medication should have been identified during the daily cycle count. The U.S. FOIA (b) stated the pharmacy also should have known the medication was expired. The U.S. FOIA (b) stated that the efficacy (ability to produce a desired or intended result) would be compromised if the medication were administered. The U.S. FOIA (b) further stated that the NJ Exec Order 26.4b1 should have been removed from the automated dispensing system on NJ Exec Order 26.4b1 , as the facility went by the first day of the month. On 08/08/2024 at 12:48 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that there should not have been U.S. FOIA (b)(6) in the automated medications dispensing system. The U.S. FC stated that the staff should have checked the expiration dates when they did the counts. The U.S. FC stated that the potency of the NJ Exec Order 26.4b1 would have been affected if it were expired and the resident may have received less medication if the patch were administered. The U.S. FC stated, "There is no excuse for expired medications, they should be checking those things."	F 755		
F 756 SS=E	NJAC 8:39-29.4(g); 29.7 (c); 29.1(e) Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		9/25/24

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F 756	Continued From page 37 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756		

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F 756	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record, and review of pertinent facility records it was determined that the facility failed to follow through on recommendations made by the [redacted] during their monthly medication regimen review (MRR) in a consistent and timely manner. This deficient practice was identified for 2 of 5 residents reviewed for unnecessary medications, (Resident #55 and Resident #89) and was evidenced by the following: The surveyor reviewed the facility policy on 08/13/2024 at 10:45 AM, titled Medication Regimen Review Policy NO: ROP-32, Reviewed: 6/2/2024. The following was revealed under POLICY: It is the facilities policy to provide a Medication regimen review (MRR) for all residents admitted to the nursing facility. The following was revealed under Policy Explanation and Compliance Guidelines: 1. Medication Regimen Review (MRR) is a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication. The review includes preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team. 4. The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and the reports must be acted upon. c. The attending physician must document in the	F 756	1. Residents Affected a. The medications for residents #55 and #89 were discontinued immediately as recommended by the physician on the medication regimen review. b. A medication error report was completed for residents #55 and #89. 2. Identification of Others a. All other residents with pharmacy consultant recommendations have the potential to be affected by the deficient practice. 3. Systemic Changes a. The facility's policy and procedure for medication regimen review was reviewed by the Administrator and Director of Nursing and was found to be appropriate. b. The unit managers were reeducated on the importance of completing the medication regimen review in a timely manner and following the physician□s recommendations. c. The Director of Nursing will distribute the monthly reports with a return date. 4. Monitoring of Systemic Change a. The Director of Nursing/designee will ensure that each unit□s report displays corrections or needed documentation is returned by the assigned due date, this will be ongoing. b. The Director of Nursing will audit all medication regimen reviews monthly x 3 months to ensure completion and submit results to the Quality Assurance and Performance Improvement (QAPI) committee for compliance x 2 months. Person Responsible: Director of	

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F 756	Continued From page 39 resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. 7. Upon completion of the MRR, the facility designee and/or physician, will respond to the recommendations in a timely manner. 10. Each resident's drug regimen remains free of unnecessary drugs. An unnecessary drug is any drug when used: a. In excessive doses, including duplicate therapy. b. For excessive duration. c. Without adequate monitoring. d. Without adequate indications for its use. e. In the presence of adverse consequences which indicate the dose should be reduced or discontinued. 1.On 08/06/2024 at 08:43 AM Resident #55 was observed lying in bed and asleep. Resident #55 did not respond to the surveyor voice. A review of the Electronic Medical Record on 08/06/2024 at 12:01 PM revealed the following: According to the Admission Record Resident #55 had the following but not limited to diagnoses: NJ Exec Order 26.4b1 [redacted] A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4b1 [redacted] revealed that Resident #55 had a Brief	F 756	Nursing/Designee	

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F 756	Continued From page 40 Interview for Mental Status score of [NJ Exec Orde] indicating [NJ Ex Order 26.4b1]. Section N of the MDS revealed Resident #55 received [NJ Exec Order 26.4b1] [redacted] A review of the Order Summary Report revealed that Resident #55, as of [NJ Exec Order 26.4b1] had the following active order: [NJ Ex Order 26.4b1] [redacted]." A review of the [NJ Ex Order 26.4b1] Medication Administration Record (MAR) revealed Resident #55 had not received [NJ Exec Order 26.4b1] during the month of [NJ Exec Order 26.4b1]. A review of the CP MRR "Note To Attending Physician/Prescriber" MRR Date: [NJ Ex Order 26.4b1] revealed the following CP recommendation: "Recommend discontinuing PRN (as necessary) [NJ Ex Order 26.4b1] The resident has not used medication > (greater than) 60 days." A review of the Physician/Prescriber Response revealed that the physician/prescriber "Agreed: and was signed and dated '[NJ Ex Order 26]." A review of the Consultant Pharmacist's Medication Regimen Review document for recommendations created between [NJ Ex Order 26.4b1] revealed the following recommendation: "Recommend discontinuing PRN [NJ Ex Order 26.4b1] The resident has not used medication for > 60 days." Under the "Follow-Through" heading the following was documented: "Note written to physician" 2. On 08/06/2024 at 09:07 AM, Resident #89 was	F 756		

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observed lying in bed with the head of the bed elevated. Resident #89 was asleep, and no [redacted] behaviors were exhibited on this observation.

A review of the Medical Record on 08/06/2024 at 10:37 AM revealed the following:

A review of the Admission Record revealed Resident #89 had the following but not limited to diagnoses: NJ Exec Order 26.4b1 [redacted].

A review of Resident #89's comprehensive MDS, dated NJ Ex Order 26.4b1, revealed that Resident #89 had a Brief Interview for Mental Status score of [redacted] indicating NJ Exec Order 26.4b1. Section N of the MDS revealed that Resident #89 received a NJ Exec Order 26.4b1 [redacted] daily.

A review of the Order Summary Report with Active Orders As Of: NJ Exec Order 26.4b1, revealed Resident #89 had the following physician/practitioner order: 'NJ Exec Order 26.4b1 [redacted]".

A review of Resident #89's comprehensive care plan revealed a care plan Focus: "I am on [redacted]) Created on: NJ Ex Order 26.4b1." The following was revealed under Interventions: "Ask physician to review medication for possible dose reduction every three months Created on:

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NJ Ex Order 26.4b1 and "Administer medication as ordered and monitor for side effects. Report to MD as appropriate. Created on: NJ Ex Order 26.4b1"

A review of Resident #89's MAR for NJ Ex Order 26.4b1 revealed that Resident #89 received NJ Exec Order 26.4b1) for the dates of NJ Ex Order 26.4b1 . A review of Resident #89's NJ Ex Order 26.4b1 MAR revealed that Resident #89 received NJ Exec Orde (MAR was provided to surveyor on 8/8/2024).

On 08/08/2024 at 11:33 AM the surveyor conducted a review of the CP MRR for the past 6 month period. Review of the Consultant Pharmacist's Medication Regimen Review for recommendations created between NJ Ex Order 26.4b1 revealed the following recommendation for Resident #89: "Resident has been on NJ Exec Order 26.4b1 . Please re-evaluate continuous need and consider discontinuing. Has the NJ Exec Order 26 resolved?" Under the "Follow-Through heading the following documentation was observed: "Note written to physician."

A review of the Note To Attending Physician/Prescriber MRR Date: NJ Ex Order 26.4b1 revealed the following: "Resident has been on U.S. FOIA (b)(6) . Please re-evaluate continuous need and consider discontinuing. Has the NJ Exec Order 26 resolved?" The following was documented under Physician/Prescriber Response: "Agree" signed and dated NJ Ex Order 26 ."

A review of Resident #89's progress notes dated

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F 756	Continued From page 43 NJ Ex Order 26.4b1 did not reveal any documentation concerning the discontinuation of the Lasix medication. On 08/13/2024 at 08:53 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM #1) who was assigned to the unit that Resident #55 and #89 resided. The surveyor asked LPN/UM #1 to describe the facility process for responding to the CP MRR. LPN/UM #1 told the surveyor "The physician recommendations are given to the doctors in a folder monthly. They respond to them and sign them and then they are given back to me. I (UM/LPN #1) take care of the monthly nursing recommendations. It is up to the physicians to handle and agree or disagree with the CP monthly medication regimen reviews." During a follow-up interview with LPN/UM #1 on 08/14/2024 at 09:02 AM, the surveyor asked LPN/UM #1 if she had ever been responsible for discontinuing physician orders recommended by the CP. LPN/UM #1 replied, "I've never had to discontinue an order from the physician side. I/we (nursing) are only responsible for nursing recommendations. The physician is responsible for carrying out their own recommendations concerning consultant pharmacy recommendations." On 08/14/2024 at 09:52 AM, the surveyor conducted an interview with the facility U.S. FOIA (b)(6) The surveyor asked the U.S. FOIA (b)(6) what the facility process was concerning the CP MRR. The NJ Exec Orde told the surveyor, "The physician will discontinue the order, or they will provide nursing with a verbal order to discontinue a CP recommendation if they agree with the	F 756		

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F 756	Continued From page 44 recommendation. That applies to physicians and nurse practitioners." For Resident #89 the [NJ Ex Order 2] order should have been discontinued on [NJ Ex Order 2] [redacted] Concerning Resident #55 Yes, the [NJ Ex Order 26.4b1] should have been discontinued according to the physician checking "Agree" and signing and dating. I agree that there is a breakdown in the MRR process, and I take that seriously."	F 756		
F 812 SS=E	NJAC 8:39-29.3(a)(1) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous foods and maintain	F 812	" All residents have the potential to be affected. " 1) Dented can of mushrooms was	9/25/24

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F 812	Continued From page 45 sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: The surveyor reviewed a facility policy on 08/05/2024 at 12:02 PM, titled [company name] Dining Services Food Storage, undated. The following was revealed under Canned Fruits: Dented or bulging cans shall be placed on Damaged Goods Shelf and returned for credit. The following was revealed under Canned Vegetables: Dented or bulging cans shall be placed on Damaged Goods Shelf and returned for credit. The surveyor reviewed a facility policy on 08/05/2024 at 12:02 PM, titled [facility name] Dining Services Pots and Pans - Sanitizing Solution, undated. The following was revealed under the heading SANITATION OF EQUIPMENT: NOTE: Allow all items to air dry. Towels shall never be used for drying. When items are dry, store in proper storage area. On 08/11/2024 at 12:26 PM, the facility provided the surveyor with a copy of the facility policy for refrigerators in the pantries, Reviewed 2/2024. The policy revealed the following under the heading POLICY: The facility recognizes the importance of ensuring that all foods are held at a safe temperature to ensure the safety of its residents. All refrigerators on the units will be monitored daily for correct temperatures. The policy did not address the monitoring of freezer temperatures. On 8/5/2024 from 9:26 to 10:05 AM, the surveyors, accompanied by the facility US FOIA (b)(6) [redacted] observed the following in	F 812	immediately removed by FSD and placed in designated dented can area 2) All 5 pans that were stored in an inverted position and were found to be wet nesting were immediately removed by FSD and sent to be rewashed and sanitized. 3)Dietary employees were re-educated on removing any dented cans from the pantry and immediately placing them in dented can area. Staff were also re-educated on not stacking pans while they dry so that wet nesting does not occur. 4) Thermometers were placed in all pantry freezers 5) Refrigerator in the Pantry Policy was updated to include the monitoring of freezer temperatures 6) Unit Managers were re-educated on updated Refrigerator in the Pantry Policy and immediately started to monitor freezer temperatures daily. " 1) Food Service Director or Designee to audit pantry for dented cans weekly for one month and then monthly for 2 months. All findings are to be reported by FSD or Designee at monthly QAPI meeting for 3 months. 2) Food Service Director or Designee to audit pot washing room to ensure that no wet nesting is occurring weekly for one month and then monthly for 2 months. All findings are to be reported by FSD or Designee at monthly QAPI meeting for 3 months. 3) Director of Nursing or Designee to check freezers to ensure proper temperature checks are being done weekly for one month and then monthly	

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F 812	Continued From page 46 the kitchen: 1. In the dry storage room a can of mushrooms on a multi-tiered rack had a significant dent on the seam. The [US FOIA (b)] removed the can of mushrooms to the designated dented can area with the other dented cans that were removed for dents. 2. A stack of five (5) deep/full pans on a middle rack of the pot and pan storage rack were stored in the inverted position. The surveyor picked up the top pan with their hand and observed a clear, watery substance on the bottom surface of the pan beneath. Further observation revealed that the additional three (3) pans in the stack also were covered with a wet watery substance, a process known as wet nesting (occurs when wet dishes or pots and pans are stacked, preventing them from drying, and creating conditions that are ripe for microorganisms to grow). The [US FOIA (b)] removed the stack of five (5) pans from the pot/pan storage rack to be rewashed and sanitized. On 08/08/2024 from 12:57 to 1:17 PM, the surveyors, accompanied by Unit Manager/Licensed Practical Nurse (UN/LPN #1) observed the following on the PAV1 (pavilion 1) pantry: 1. The surveyor reviewed the PAV1 Pantry Food Refrigerator Temperature Log, dated "Aug 2024.". The log revealed that the Refrigerator range for foods was "32-40 degrees Fahrenheit" and "Freezer: -10 to 0 F." Observation of the interior of the pantry freezer determined there was no internal thermometer in the freezer and no temperatures were recorded for the Aug 2024	F 812	for 2 months. DON to report findings at monthly QAPI meeting for 3 months.	

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F 812	Continued From page 47 PAV1 Pantry freezer on the temperature log only refrigerator temperatures. On interview the UM/LPN # stated that she was not aware that the freezer required a thermometer and that the temperature needed to be monitored." UM/LPN # told the facility Infection Preventionist who was walking by that the unit needs a thermometer for the PAV 1 freezer in the presence of the surveyor. On 08/08/2024 from 1:20 to 1:30 PM, the surveyor, accompanied by LPN/UM #1 observed the following in the PAV3 (pavilion 3 pantry): 1. The temperature log, as described above for PAV1 had no freezer temperatures recorded for the dates 8/1 thru 8/8/2024. Observation of the freezer revealed no internal thermometer was present to monitor the freezer temperature. On interview LPN/UM #1 stated, "I was not aware that we had to do the freezer as well as the refrigerator. It makes perfect sense. I will get a thermometer." NJAC 18:39-17.2(g)	F 812		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input	F 867		9/25/24

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F 867	Continued From page 48 from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing:	F 867		

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F 867	Continued From page 49 (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or	F 867		

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F 867	Continued From page 50 problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Cross Reference F755 Based on observation, interview, and review of pertinent facility records, it was determined that the facility Quality Assessment and Performance Improvement (QAPI) committee failed to utilize the Facility Performance Improvement Plan (PIP) to follow the facility process to measure and utilize data for checking medication carts three times weekly for expired medications. This deficient practice was evidenced by the following: On 08/13/2024 at 09:51 AM, the surveyor reviewed the facility policy titled Quality Assurance Performance Improvement, Date Reviewed/Revised: 9/14/23. The following was revealed under Purpose: Our Quality Assurance	F 867	1) Members of the QAPI committee were re-educated on the need to provide data to show whether a QAPI is effective. A new QAPI was started to ensure that expired medications are being removed from the medication carts 2) All residents have the potential to be affected 3) All LPNs and RNs were re-educated on checking medication carts for expired medications. 4)Director of Nursing or Designee will check all medication carts for expired medications weekly x 4 weeks, monthly x 2 months. All Findings are to be submitted to the QAPI committee for compliance Director of Nursing or Designee to submit	

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F 867	Continued From page 51 and Performance Improvement Program (QAPI) represent our facility's commitment to continuous quality improvement. The program ensures a systematic performance evaluation, problem analysis, and implementation of improvement strategies to achieve our performance goals. The following was revealed at II. Guidelines for Governance and Leadership: a. Nursing and Facility Administration are responsible and accountable for developing, leading, and closely monitoring a QAPI program. Under an additional Policy heading on page 3 of 7 of the QAPI policy the following was revealed: 5. The QAPI Team oversight responsibilities shall include, but are not limited to the following: "Utilize facility data to identify opportunities to improve systems and care. Data may include, but is not limited to; grievance logs, medical record review, skilled care claims, fall log, pressure ulcer log, treatment logs, staffing trends, incident and accident reports, quality measures, survey outcomes, etc. 1. On 08/13/2024 at 10:50 AM, the surveyors, while reviewing the facilities QAPI policy and procedure and QAPI plan asked the facility administration to provide the surveyors with 3 current QAPI's that the facility was addressing. After receiving the binder, the surveyors observed that in February of 2024 the facility identified via pharmacy reports that expired medications were a major concern. Root cause analysis identified 1.) expired medications on carts and medication rooms were found during inspection by the consultant pharmacist (CP). 2. Nurses were not	F 867	QAPI on checking medication carts for expired medications with data to show effectiveness of QAPI to QAPI meeting for 3 months.	

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F 867	Continued From page 52 checking medication carts for expired medications. Goals & Objectives were defined as: 1.) To have all expired meds out of medication carts and stock rooms. 2. Educate all Licensed Practical Nurses about checking carts for expired medications. Responsible team members were identified as US FOIA (b)(6) [redacted] Estimated and Completion date were "ongoing." Education was identified as being "on going." The Comments section of the February 2024 QAPI Action Plan noted that "Education will be ongoing and that medication carts will be checked periodically for expired medications three (3) times per week. A copy of the April 2024 QAPI plan revealed that "Pharmacy reports have expired medications as a major concern." Root Cause Analysis revealed the following: 1.) "Expired medications on carts, medication rooms were found during inspection." and 2.) "Charge nurses are not checking carts for expired medications." In the Action Items section, the QAPI plan revealed 1. LPN staff will be educated on dating and disposing of medications. and 2. All carts will be checked periodically for expired medications." Start date was listed as 2/2024 and responsible team members were US FOIA (b)(6) [redacted]. Estimated and Actual Completion Date were identified as "ongoing." The following was documented in the Comments section of the plan: "Education will be ongoing. Labeling is still a concern with compliance at 77% which is up from March" Also in the Comments section, it was stated that "Checks will be done regularly. 4/24 - Currently all expired medications are out of med rooms and carts." The surveyors did not observe any data collection forms in the facility QAPI binder associated with the data collection for the expired medication QAPI plan	F 867		

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F 867	Continued From page 53 for February or April of 2024. At this point the surveyors requested from the facility U.S. FOIA (b)(6) and/or [redacted] copies of data collection for the QAPI plan for expired medication cart medications that was revealed via consultant pharmacist reports. On 08/13/2024 at 01:09 PM, during an interview with the facility U.S. FOIA (b)(6) told the surveyors that they do not have any data collected for the expired medication QAPI plan for February or April of 2024 and that they cannot provide the surveyor with any data from the 2/2024 QAPI Action Plan related to pharmacy reports that have expired meds as a major concern. The DON further told the surveyor that the reason they did not have any audits is because the QAPI plan did not work, and they are coming up with a new one. On 08/13/2024 at 02:32 PM, the facility told the surveyor when asked where the facility obtained a rate of 77% compliance on the April 2024 QAPI plan the DON told the surveyor that" It's possible that the data reported came from the monthly CP visit."	F 867		
F 880 SS=D	NJAC 8:39-33.1(c) 33.2(a)(b)(d) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		10/2/24

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F 880	Continued From page 54	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 55 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of pertinent facility documentation, it was determined that the facility failed to a.)properly store and maintain both sterile and non-sterile medical supplies in a safe and sanitary manner and b.) ensure that laundry staff used the appropriate personal protective equipment while handling items that were likely contaminated with infectious bodily fluids. This deficient practice was identified for 2 of 2 medication storage rooms reviewed for the medication storage task and 1 of 1 laundry staff and was evidenced by the following: On 08/07/2024 at 9:41 AM, during the inspection of the Pavilion Three Medication Storage Room, in the presence of Licensed Practical Nurse Unit Manager (LPN/UM #1) the surveyor observed: three enema kits, two packages of heel booties, and a box of wound treatment supplies which included: a half filled box of fifty count 4 x 4	F 880	" 1)a-No residents were affected " b-All items that were found under the sink in the [NJ Exec Order 26.4b1] Medication Storage room were immediately disposed of. c-Maintenance sealed bottom of sink in [NJ Exec Order 26.4b1] Medication Storage Room so that it can no longer be opened. d-The one-liter bag of 0.45% [NJ Exec Order 26.4b1]) that was found in the [NJ Exec Order 26.4b1] Medication room was immediately disposed of. e-The apron put on by laundry staff was disposed of and disposable gowns were provided. 2) a-Maintenance Director immediately checked all sinks to ensure that they were sealed b-Infection Preventionist Nurse immediately checked all medication rooms to ensure that there are no opened	

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F 880	Continued From page 56 gauze pads, a fifteen count box of border gauze dressings, two rolls of gauze, and a roll of paper tape that were stored beneath the handwashing sink. LPN/UM #1 stated that Central Supply stocked the supply room and placed the items under the sink. LPN/UM #1 stated that she never checked under the sink and did not know that the supplies were there. LPN/UM #1 further stated that the issue with the items being stored under the sink was contamination. On 08/07/2024 at 12:45 PM, during the inspection of the Pavilion Two Medication Room in the presence of the Registered Nurse/Unit Manager (RN/UM #1), the surveyor observed a one liter bag of 0.45% sodium chloride injection (Intravenous fluid solution) and noted that the outer plastic packaging was previously opened and remained in storage. The RN/UM #1 stated that the effectiveness of the medication could be compromised. On 08/08/2024 at 10:15 AM, the surveyor interviewed the U.S. FOIA (b)(6) in the presence of the survey team. The [redacted] stated that he did not know the facility policy for storing items beneath the handwashing sink. The [redacted] stated that the wound treatment supplies would no longer be sterile or usable if it were to become wet beneath the sink. The [redacted] stated that if either the enema kits or heel booties got wet they would become contaminated and could not be used. The [redacted] stated that the facility did not have a policy that pertained to the prohibited storage of medical supplies beneath the sink. On 08/08/2024 at 12:36 PM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that she placed items from central	F 880	or unpackaged items. c-Director of Housekeeping immediately checked laundry room to ensure that there was no more aprons or non-disposable PPE. 3) a-Laundry staff were re-educated on the proper PPE to wear while sorting soiled linens, proper hand washing (washing hands after removing gloves) and wearing disposable gowns while handling soiled linens. b- Maintenance staff were re-educated to ensure that all sinks are sealed to ensure that there is nothing underneath. c- All RNs and LPNs re-educated to dispose of any opened or unpackaged items in the Medication Rooms. " 4) a-Infection Preventionist or Designee to audit all sinks once a month for 3 months to ensure that all sinks are sealed and that nothing can be stored underneath. Results of this audit to be reported at monthly QAPI meeting for 3 months. b-Infection Preventionist or Designee to monitor all Medication rooms to ensure that all supplies are properly stored and sealed to ensure that they do not become contaminated weekly for one month and then monthly for 2 months. All findings to be reported at monthly QAPI meeting . c-Infection Preventionist or Designee to monitor laundry room to ensure staff are wearing proper PPE while sorting soiled linen and that proper handwashing is being done when gloves are removed. Monitoring is to be done weekly for one month and then monthly	

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	315225	A. BUILDING _____ B. WING _____	C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER FRONT 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 880	Continued From page 57 supply in the medication storage rooms in the cabinets and storage bins. The [redacted] stated she would never store anything under the sink because if it happened to leak, she did not want the leakage to reach the stock. The [redacted] stated, "We are not allowed to place anything under the sink because it was a rule put into place by both the former and current administrators, and was an infection control issue." The [redacted] stated that the nurses have access to the area and put things away. The [redacted] further stated that the cabinets beneath the sinks should be fixed, and not opened. On 08/08/2024 at 1:33 PM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted] who stated that it was unsanitary and we risked our dressings no longer being sterile if fluids were on on the wound treatment supplies and they went into someone's wound. The [redacted] stated that nothing should be stored under the handwashing sink. At that time, the [redacted] further stated that a liter of IV fluids should not have been placed back into storage after it was opened, as the package should have remained sterile and not opened until ready for usage. On 08/12/2024 at 01:12 PM, a review of a facility policy titled Linen Handling Policy with a reviewed date of 6/3/2024 revealed under 3: Personal Protective Equipment (PPE) for laundry Staff Practice hand hygiene before and after removing PPE. Wear tear resistant gloves when handling and laundering soiled linens.	F 880	for 2 months. Findings are to be reported at monthly QAPI meeting.	

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F 880	Continued From page 58 If there is a risk of splashing (e.g. hand-washing laundry) Laundry staff should also wear gowns or aprons and face protection... On 08/12/2024 at 09:37 AM, the surveyor observed the following in the facility laundry area: Observed a laundry staff wearing a surgical mask under her nose and gloves while emptying soiled laundry from plastic bags into soiled laundry bins. When the surveyor asked what she was required to wear when sorting soiled laundry, she replied, "I have to wear gloves, mask, and cover (apron) to keep clothes clean." The surveyor asked the laundry staff if she was wearing a cover and she responded, "No, I wasn't wearing the cover when the surveyor came in." The surveyor questioned the laundry staff member as to what the purpose of wearing the cover was and the laundry staff replied, "Not messing with your clothes." The laundry staff then put the apron on in the presence of the surveyor. The surveyor then asked about the dryer. The staff removed the cover/apron and draped it over the dirty laundry bin, removed her gloves and proceeded to open the dryer lint door. The staff did not perform hand hygiene after removing her gloves. During an interview with the [redacted]) on 08/08/2024 at 10:19 AM, the surveyor questioned what surveillance you perform in the laundry department. The [redacted] replied, "I am here at 5am daily. I go through the laundry and make sure we have enough linen. I look to make sure everything is ok." When asked what facility policy was regarding handling of	F 880		

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F 880	Continued From page 59 soiled linen, the [U.S.F] said, "I am not familiar with the laundry policy regarding soiled linens." During an interview with the surveyor on 08/13/2024 at 09:44 AM, the [U.S. FOIA (b)(6)] was questioned as to what the laundry staff are to wear while sorting soiled linens. The [U.S. FOIA (b)(6)] replied, "They are supposed to be covered up with gown, gloves, and mask." The surveyor asked what gown he meant. The [U.S. FOIA (b)(6)] said, "They normally wear yellow gowns. I have never seen anybody wear the apron." Gowns are back there and provided for them. NJAC 8:39-19.4 NJAC 8:39-19.4 (a)(1)	F 880		

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RIVER FRONT REHABILITATION AND HEALTH	5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109

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H 000	Initials Comments The facility is not in compliance with N.J.A.C. Title 8 Chapter 43E- General Licensure Procedures and Standards Applicable To All Licensed Facilities.	H 000		
H5790	8:43E-13.4(d) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record. This REQUIREMENT is not met as evidenced by: C/O # NJ166263 Based on interviews, review of the Electronic Medical Record (EMR), as well as other pertinent facility documentation, it was determined that the facility failed to maintain a completed copy of the New Jersey Universal Transfer Form (NJUTF) as part of the medical record. This deficient practice was identified for 3 of 3 residents reviewed for hospitalizations (Resident # 126, Resident # 137, and Resident # 369) and was evidenced by the following: Reference : New Jersey Hospital Association "Provider Resources" Section 6:	H5790	1. Residents Affected a. Residents #126, #137, and #369 universal transfer sheets were not located after a thorough review of medical records. Any transfers to the [NJ Ex Order 26.4b] for these residents will have a Universal Transfer Form as per facility protocol. 2. Identification of Others a. All other residents transferring to the hospital have the potential to be affected. b. An audit was conducted of the medical records for residents transferred to the hospital in the past 3 months for a universal transfer sheet. 3. Systemic Changes	10/2/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 08/29/24

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H5790	Continued From page 1 The NJ Universal Transfer Form (UTF) must be used by all licensed healthcare facilities and programs when a patient is transferred from one care setting to another. On 08/13/2024 at 09:15 AM, a review of a facility policy titled Universal Transfer Form (UTF) with a last reviewed date of 02-2024, revealed under the Universal Transfer Form section (d): A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer form sent with a resident when a resident is transferred as part of the resident's medical record. 1. A review of the Admission record revealed Resident #126 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted]. A review of a facility progress note (PN) dated NJ Ex Order 26.4b1 revealed Resident #126 was observed sitting in the chair with NJ Exec Order 26.4b1 [redacted] 911 was called and Resident #126 left with Emergency Medical Services to the local NJ Ex Order 26.4b1 A further review of the EMR did not include a copy of the UTF that was sent with Resident #126 to the NJ Ex Order 26.4b1. On 08/12/2024 at 09:18 AM, Surveyor #1 reviewed Resident #126's hard copy chart on the unit. Observation of the hard copy chart did not include a copy of UTF for the above transfer to NJ Ex Order 26.4b1 dates. During an interview with the Surveyor #1 on 08/12/2024 at 11:40 AM, Registered Nurse/Unit Manager (RN/UM #1) told Surveyor #, "I looked for the UTF for NJ Ex Order 26.4b1 and could not find it."	H5790	a. On 08/12/2024 all LPNs and RNs were reeducated by Director of Nursing and IP Nurse on completing the NJ universal transfer form in electronic medical records system for all residents being transferred to the hospital. 4. Monitoring of Changes a. All residents transferred to the hospital for the next 3 months will have their medical records reviewed to ensure a completed and thorough Universal Transfer Form. Results of this audit will be presented to Monthly Quality Assurance and Performance Improvement (QAPI) committee for x 3 months. Person Responsible: Director of Nursing/Designee	

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H5790	Continued From page 2 When asked by the surveyor if a copy of the UTF should be retained in the medical record RN/UM #1 replied, "Yes we are to keep copies for the residents record." 2. A review of the Admission record revealed Resident #137 was admitted to the facility with diagnoses which included a NJ Exec Order 26.4b1 [redacted] A review of a facility progress note (PN) dated NJ Ex Order 26.4b1 revealed Resident #137 was observed with U.S. FOIA (b)(6) [redacted] 911 was called and the resident was transported by Emergency Medical Services to a local NJ Ex Order 26.4b1 [redacted] A further review of the EMR did not include a copy of the UTF that was sent with Resident #137 to the NJ Ex Order 26.4b1 [redacted] On 8/13/2024 at 11:35 AM, the Surveyor #2 reviewed the resident's hard chart on the unit, which did not include a copy of the UTF for the above referenced date. On 8/13/24 at 11:47 AM, Surveyor #2 along with the DON reviewed the resident's hard chart. The DON acknowledged she could not find the UTF on the resident's chart either and further stated there should be a copy placed on the chart. On 8/14/24 at 11:50 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM #2) and together reviewed the resident's hard chart looking for the UTF and were unable to locate one. LPN/UM #2 stated the nurse should make a copy of the UTF and place it on the medical chart.	H5790		

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H5790	Continued From page 3 3. According to the facility "Admission Record," Resident #369 was re-admitted to the facility with diagnoses including but not limited to, NJ Exec Order 26.4b1 [redacted] A review of the PN dated NJ Exec Order 26.4b1 indicated Resident #369 was NJ Exec Order 26.4b1 and sent to the NJ Ex Order 26.4b1 emergently. A review of the closed medical record revealed a New Jersey Universal Transfer Form dated NJ Exec Order 26.4b1 that was incomplete. The following required information (Items 1-29 must be completed) were blank: #6, # 8, #10, #11, #12, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #25, #26, #27, #29.	H5790		
S 000	Initial Comments C/O # NJ158956, 166158, 170632 The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiecncy and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisisons of the New Jersey Admiistrative Code, Title 8, Chapter 43E, enforcement of Licensure.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable	S 560		10/2/24

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S 560	Continued From page 4 Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ 158956, 166158, 170632 Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. From 07/21/2/2024 to 08/03/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts. From 06/25/2023 to 07/01/2023, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts. From 07/30/2023 to 08/05/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts. From 08/13/2023 to 08/19/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts. 08/27/2023 to 09/02/2023, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts. From 12/31/2023 to 01/06/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 2 of 7 evening shifts. From 01/21/2024 to 01/27/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, and deficient in total staff for residents on 2 of 7 evening shifts. From 05/25/2024 to 06/01/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts. This deficient practice was evidenced by the	S 560	□ Mandatory Access to Care 1. Administrator and Director of Nursing looked over staffing patterns and hired more regular staff and contacted staffing agencies to ensure that we will have adequate staff to meet resident's needs. 2. All residents have the potential to be affected. 3. The following measures have been put in place to prevent the deficiency from recurring: a) Advertisement / Job postings for CNA open positions have been posted on social media websites with a generous sign on bonus for new hires and referral bonus for employees. b) Incentives are also offered to CNAs to work extra shifts. c) Tables are being set up by job fairs letting people know that the facility is hiring CNAs. d) The facility continues to reach out to CNAs schools to advise them of our hiring programs and training of new graduates. e) The facility is contracted with several staffing agencies to assist with staffing needs. 4. Administrator or designee will review staffing schedule with DON and staffing coordinator weekly to monitor staffing ratios for 2 months. Results of monitoring will be submitted to QAPI	

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S 560	Continued From page 5 following: 1. Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "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 2/01/21: One Certified Nurse Aide (CNA) 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 CNAs, and each direct staff member shall be signed in to work as a CNA 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 CNA and perform CNA duties. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the following weeks weeks revealed the facility was deficient in CNA staffing for residents as follows: 1. For the 2 weeks of staffing prior to survey from 07/21/2/2024 to 08/03/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows:	S 560	committee for 3 months for review and modification of plan as needed to remain in compliance.	

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S 560	Continued From page 6 The facility provided less than half the required CNA staffing for resident care on 4 day shifts. -07/21/24 had 14 CNAs for 168 residents on the day shift, required at least 21 CNAs. -07/22/24 had 16 CNAs for 168 residents on the day shift, required at least 21 CNAs. -07/23/24 had 16 CNAs for 168 residents on the day shift, required at least 21 CNAs. -07/24/24 had 12 CNAs for 168 residents on the day shift, required at least 21 CNAs. -07/25/24 had 16 CNAs for 170 residents on the day shift, required at least 21 CNAs. -07/26/24 had 15 CNAs for 170 residents on the day shift, required at least 21 CNAs. -07/27/24 had 13 CNAs for 170 residents on the day shift, required at least 21 CNAs. -07/28/24 had 12 CNAs for 173 residents on the day shift, required at least 22 CNAs. -07/29/24 had 13 CNAs for 171 residents on the day shift, required at least 21 CNAs. -07/29/24 had 10 total staff for 171 residents on the overnight shift, required at least 12 total staff. -07/30/24 had 15 CNAs for 168 residents on the day shift, required at least 21 CNAs. -07/31/24 had 16 CNAs for 165 residents on the day shift, required at least 21 CNAs. -08/01/24 had 13 CNAs for 164 residents on the day shift, required at least 20 CNAs. -08/02/24 had 13 CNAs for 164 residents on the day shift, required at least 20 CNAs. -08/03/24 had 11 CNAs for 163 residents on the day shift, required at least 20 CNAs. 2. For the week of Complaint staffing from 07/30/2023 to 08/05/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows:	S 560		

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S 560	Continued From page 7 -07/30/23 had 5 CNAs for 163 residents on the day shift, required at least 20 CNAs. -07/31/23 had 16 CNAs for 163 residents on the day shift, required at least 20 CNAs. -08/01/23 had 19 CNAs for 163 residents on the day shift, required at least 20 CNAs. -08/04/23 had 18 CNAs for 159 residents on the day shift, required at least 20 CNAs. -08/05/23 had 18 CNAs for 159 residents on the day shift, required at least 20 CNAs. 3. For the week of Complaint staffing from 08/13/2023 to 08/19/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -08/13/23 had 13 CNAs for 160 residents on the day shift, required at least 20 CNAs. -08/18/23 had 17 CNAs for 159 residents on the day shift, required at least 20 CNAs. 4. For the week of Complaint staffing from 08/27/2023 to 09/02/2023, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -08/27/23 had 9 CNAs for 157 residents on the day shift, required at least 20 CNAs. -08/28/23 had 16 CNAs for 157 residents on the day shift, required at least 20 CNAs. -09/01/23 had 18 CNAs for155 residents on the day shift, required at least 19 CNAs. 5. For the week of Complaint staffing from 12/31/2023 to 01/06/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 2 of 7 evening shifts as follows: -12/31/23 had 10 CNAs for 155 residents on the	S 560		

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RIVER FRONT REHABILITATION AND HEALTH	5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109

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S 560	Continued From page 8 day shift, required at least 19 CNAs. -01/01/24 had 11 CNAs for 155 residents on the day shift, required at least 19 CNAs. -01/01/24 had 14 total staff for 155 residents on the evening shift, required at least 15 total staff. -01/02/24 had 14 CNAs for 155 residents on the day shift, required at least 19 CNAs. -01/03/24 had 16 CNAs for 155 residents on the day shift, required at least 19 CNAs. -01/04/24 had 17 CNAs for 155 residents on the day shift, required at least 19 CNAs. -01/05/24 had 11 CNAs for 155 residents on the day shift, required at least 19 CNAs. -01/06/24 had 12 CNAs for 155 residents on the day shift, required at least 19 CNAs. -01/06/24 had 14 total staff for 155 residents on the evening shift, required at last 15 total staff. 6. For the week of Complaint staffing from 01/21/2024 to 01/27/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, and deficient in total staff for residents on 2 of 7 evening shifts as follows: -01/21/24 had 10 CNAs for 162 residents on the day shift, required at least 20 CNAs. -01/21/24 had 15 total staff for 162 residents on the evening shift, required at least 16 total staff. -01/22/24 had 7 CNAs for 162 residents on the day shift, required at least 20 CNAs. -01/23/24 had 14 CNAs for 161 residents on the day shift, required at least 20 CNAs. -01/24/24 had 15 CNAs for 161 residents on the day shift, required at least 20 CNAs. -01/25/24 had 16 CNAs for 161 residents on the day shift, required at least 20 CNAs. -01/26/24 had 16 CNAs for 161 residents on the day shift, required at least 20 CNAs. -01/26/24 had 15 total staff for 161 residents on the evening shift, required at least 16 total staff.	S 560		

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S 560	Continued From page 9 -01/27/24 had 16 CNAs for 158 residents on the day shift, required at least 20 CNAs. 7. For the week of Complaint staffing from 05/25/2024 to 06/01/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -05/26/24 had 18 CNAs for 166 residents on the day shift, required at least 21 CNAs. -05/27/24 had 12 CNAs for 165 residents on the day shift, required at least 21 CNAs. -05/27/24 had 9 total staff for 165 residents on the overnight shift, required at least 12 total staff. -05/28/24 had 16 CNAs for 165 residents on the day shift, required at least 21 CNAs. -05/29/24 had 16 CNAs for 165 residents on the day shift, required at least 21 CNAs. -05/30/24 had 15 CNAs for 165 residents on the day shift, required at least 21 CNAs. -05/31/24 had 16 CNAs for 165 residents on the day shift, required at least 21 CNAs. -06/01/24 had 15 CNAs for 165 residents on the day shift, required at least 21 CNAs. On 8/14/2024 at 10:34 AM, the surveyor interviewed the facility Staffing Coordinator (SC) who stated she was aware of the staffing requirements for Certified Nurse Aides in New Jersey. The SC stated one CNA to 10 residents on dayshift, one CNA to 10 residents on the evening shift and one CNA to twenty residents on the night shift. The SC stated she did her best and believed they were meeting the minimum staffing requirements a majority of the time.	S 560		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation	S1405		10/2/24

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S1405	Continued From page 10 a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure that newly hired employees had completed a health history and received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment, or within thirty days if a Registered Nurse (RN) completed an assessment upon employment, for 8 out of 10 newly hired employee files reviewed. On 08/08/2024 at 01:15PM, a review of the facility's untitled policy related to newly hired employees, updated 01/2024, included, "all new	S1405	1. Residents Affected a. No residents were negatively affected by the deficient practice. 2. Identification of Others a. All residents have the potential to be affected by new employees not receiving health physicals. b. An audit was conducted for all current employees to ensure they have a completed health physical. 3. Systemic Changes a. The IP nurse was reeducated on the facility's procedure for new employee physicals. b. An audit tool was created to track the	

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S1405	Continued From page 11 employees will complete a screening health history which will be completed and reviewed by a physician within 30 days of hire." The policy did not include that the examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant must be completed within two weeks prior to employment or upon employment, or within thirty days if a Registered Nurse (RN) completed an assessment upon employment. This deficient practice was evidenced by the following: On 08/08/2024 at 9:40 AM, the surveyor reviewed the employee health files of ten random newly hired employees since the last recertification survey date of [NJ Ex Order 26.4b1] which revealed the following: -Employee #1, with a hire date of [NJ Exec Order 26.4b1], had an RN assessment completed, but there was no date to indicate when the exam was conducted. Further review revealed the physician signed the physical examination form on [NJ Exec Order 26.4b1] which was 10 days after the employee's hire date. -Employee #2, with a hire date of [NJ Exec Order 26.4b], did not have a physical examination form in their employee health file. -Employee #3, with a hire date of [NJ Exec Order 26.4b1] had a physical examination form which was incomplete and not signed by the physician. -Employee #5, with a hire date of [NJ Exec Order 26.4b], had an RN assessment completed, but there was no date to indicate when the exam was conducted. Further review revealed the physician signed the physical examination form on [NJ Exec Order 26.4b], which	S1405	completion of employee physicals upon hire. 4. Monitoring of Changes a. Audits will be conducted for 5 new hires weekly x 4 weeks, monthly x 2 months, and presented to Quality Assurance and Performance Improvement (QAPI) committee x 2 months for compliance to ensure all new employees have completed health physicals. Person Responsible: Director of Nursing/Designee	

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S1405	Continued From page 12 was four months before the employee's hire date. -Employee #6, with a hire date of [NJ Exec Order 26.4b], did not have a physical examination form in their employee health file. -Employee #7, with a hire date of [NJ Exec Order 26.4b] did not have a physical examination form in their employee health file. -Employee #8, with a hire date of [NJ Exec Order 26.4b], had an RN assessment completed on [NJ Exec Order 26.4b], which was eight days after the employee's hire date. Further review revealed the physician signed the physical examination form, but there was no date to indicate when the exam was conducted. -Employee #9, with a hire date of [NJ Exec Order 26.4b], had an RN assessment and a physician physical examination completed on [NJ Exec Order 26.4b] which was 13 days after the employee's hire date. During an interview with the surveyor on 08/08/2024 at 10:00 AM, the Infection Preventionist (IP) confirmed that the health files the surveyor received were the complete health files, but if anything was missing, it could be in the employees' personnel files. The IP further stated that he was responsible for conducting the Registered Nurse (RN) assessments for new hires during orientation. The IP then stated that the physician should conduct their physical examination upon the employee's hire, or within 30 days if an RN assessment was completed. The IP explained that it was important for newly hired employees to receive a physical examination within the required time frames to ensure the employee can do the work they are assigned.	S1405		

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S1405	Continued From page 13 During the same interview, the surveyor informed the IP of the surveyor's findings, and the IP confirmed the following: -For Employee #1, the IP should have documented the date the RN assessment was completed. -For Employee #2, the employee should have had a physical examination, but that it might be in the employee's personnel file. -For Employee #3, the physical examination should have been completed in the required timeframe. -For Employee #5, the physical examination should have been completed within two weeks prior to employment. -For Employee #6, the employee should have had a physical examination, but that it might be in the employee's personnel file. -For Employee #7, the employee should have had a physical examination, but that it might be in the employee's personnel file. -For Employee #8, the RN assessment should have been done upon hire and the physician should have documented the date the physical examination was completed. -For Employee #9, the RN assessment should have been done upon hire and the physical examination should have been done two weeks prior to employment or within 30 days of the RN assessment. During an interview with the surveyor on 08/08/2024 at 10:18 AM, Human Resources (HR) verified the missing physical examination forms were not in the employees' personnel files. During an interview with the surveyor on 08/08/2024 at 10:38 AM, the Director of Nursing (DON) stated the IP was responsible for ensuring the newly hired employees had an RN	S1405		

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S1405	Continued From page 14 assessment completed during orientation and a physical examination completed by a physician within 30 days of the RN assessment. The DON further stated that it was important for newly hired employees to receive a physical examination within the required time frames to ensure the employee is healthy enough to perform job duties without harming themselves or the residents. During the same interview, the surveyor informed the DON of the surveyor's findings and the DON confirmed that the IP should have included the date the RN assessment was completed, the physician should have signed and dated the physical examinations within 30 days of the RN assessment, and that all health files should have been complete, including the employee's physical examination forms.	S1405		
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin	S1410		10/2/24

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S1410	Continued From page 15 skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility records, it was determined that the facility failed to ensure that a new employee received the Mantoux tuberculin (TB) skin test (a test to determine the presence of tuberculin bacteria), also called a PPD, as required for 6 of 10 newly hired employee files reviewed. On 08/08/2024 at 01:00 PM, a review of the facility's untitled policy related to newly hired employees, updated 01/2024, included, "all new employees will receive a two-step Mantoux (PPD) testing upon hire unless they have documentation of a positive Mantoux history and/or a copy of a recent chest x-ray documenting negative active tuberculosis." A review of the facility's Infection Prevention and Control Program policy, revised 07/05/22, included under the section titled Monitoring Employee Health and Safety, "pre-employment screening for infections required by law or regulation (such as TB)." The deficient practice was evidenced by the following: On 08/08/2024 at 9:40 AM, the surveyor reviewed	S1410	1. Residents Affected a. No residents were negatively affected by the deficient practice. 2. Identification of Others a. All residents have the potential to be affected by new employees not having tuberculin testing upon hire. b. An audit was conducted for all current employees to ensure they have completed tuberculin testing. 3. Systemic Changes a. The IP nurse was reeducated on the facility's procedure for new employee tuberculin testing. b. An audit tool was created to track the completion of employee two-step tuberculin testing upon hire. 4. Monitoring of Changes a. Audits will be conducted for 5 new hires weekly x 4 weeks, monthly x 2 months, and presented to Quality Assurance and Performance Improvement (QAPI) committee x 2 months for compliance to ensure all new employees have completed tuberculin testing. Person Responsible: Director of Nursing/Designee	

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S1410	Continued From page 16 the employee health files of ten random newly hired employees since the last recertification survey date of [NJ Ex Order 26.4b1] which revealed the following: -Employee #3, with a hire date of [NJ Exec Order 26.4b], had an Employee Tuberculosis (Mantoux) Screening form in their file, but it was not filled out in the sections designated for 1st Step PPD and 2nd Step PPD. -Employee #4, with a hire date of [NJ Exec Order 26.4b], did not have an Employee Tuberculosis (Mantoux) Screening form, which would have included the employee's PPD information. -Employee #5, with a hire date of [NJ Exec Order 26.4b], had an Employee Tuberculosis (Mantoux) Screening form in their file, but it was not filled out in the sections designated for 1st Step PPD and 2nd Step PPD. -Employee #8, with a hire date of [NJ Exec Order 26.4b], had an Employee Tuberculosis (Mantoux) Screening form in their file, but it was not filled out in the sections designated for 1st Step PPD and 2nd Step PPD. -Employee #9, with a hire date of [NJ Exec Order 26.4b], had an Employee Tuberculosis (Mantoux) Screening form in their file, but the date for the 1st Step PPD was not filled out. -Employee #10, with a hire date of [NJ Exec Order 26.4b], did not have an Employee Tuberculosis (Mantoux) Screening form, which would have included the employee's PPD information. During an interview with the surveyor on 08/08/2024 at 10:00 AM, the Infection	S1410		

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S1410	Continued From page 17 Preventionist (IP) confirmed that the health files the surveyor received were the complete health files, but that if anything was missing, it could be in the employees' personnel files. The IP further stated that he was responsible for administering PPDs to newly hired employees upon employment and that it was important for the newly hired employees to receive a PPD within the required time frame to ensure the employee did not have tuberculosis. During the same interview, the surveyor informed the IP of the surveyor's findings, and the RN/IP confirmed the following: -For Employee #3, the PPD should have been administered in the required time frame. -For Employee #4, the employee should have had a PPD documented in the health file, but that it might be in the employee's personnel file. -For Employee #5, the PPD should have been administered in the required time frame. -For Employee #8, the PPD should have been administered in the required time frame. -For Employee #9, the first step PPD should have had an administration date documented on the form. -For Employee #10, the employee should have had a PPD documented in the health file, but that it might be in the employee's personnel file. During an interview with the surveyor on 08/08/2024 at 10:18 AM, Human Resources (HR) verified the missing Employee Tuberculosis (Mantoux) Screening form were not in the employees' personnel files. During an interview with the surveyor on 08/08/2024 at 10:38 AM, the Director of Nursing (DON) stated the IP was responsible for administering newly hired employees' first step	S1410		

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S1410	Continued From page 18 PPD during orientation and that it was important to administer PPD within the required time frame because, "tuberculosis is a communicable disease, and we want to prevent the spread to residents or staff." During the same interview, the surveyor informed the DON of the surveyor's findings, and the DON confirmed that the IP should have ensured that all PPDs were administered to newly hired employees within the required time frame, and that all health files should have been complete, including the employee's PPD information.	S1410		
S2120	8:39-31.1(c) Mandatory Physical Environment (c) Fire safety maintenance and retrofit of long-term care facilities shall comply with the Uniform Fire Safety Code (N.J.A.C. 5:18) as adopted by the New Jersey Department of Community Affairs. The New Jersey Uniform Fire Safety Code may be obtained from the Fire Safety Element of the Department of Community Affairs, P.O. Box 809, Trenton, New Jersey 08625-0809.	S2120		10/20/24

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S2120	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on interview and record review on 8/13/24 in the presence of the Director of Maintenance (DM) it was determined the facility failed to ensure the quarterly local fire inspections were performed in accordance with the New Jersey Uniform Fire Safety Code, N.J.A.C. 5:70. This deficient practice had the potential to affect 163 residents and was evidenced by: Record review between 9:30 AM and 12:30 PM, revealed 3 of the past 4 quarterly local fire inspection reports required by the New Jersey Uniform Fire Safety Code were not provided. Only the Quarterly report for 11/27/23 was provided. In an interview at the time, the MD stated the documents in the maintenance book were all they had. The Administrator, Vice President of Environmental, Maintenance Technician and DM were informed of the deficient practice at 4:40 PM during the Life Safety Code exit conference.	S2120	"" A-Director of Maintenance was re-educated on the importance of ensuring that quarterly local fire inspections are done to ensure resident safety. B-Reached out to local fire inspectors/Fire Marshall to come to perform quarterly fire inspection " No residents were affected " All residents have the potential to be affected " Director of Maintenance or Designee to ensure compliance. " Director of Maintenance or Designee to ensure that local fire inspection is completed and will report findings for 3 months to monthly QAPI meeting.	
S2460	8:39-31.8(c)(8) Mandatory Physical Environment (c) All residents shall have, in their rooms: 8. Night lights;	S2460		9/26/24

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S2460	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/13/24 in the presence of the Vice President of Environmental (VPE), Maintenance Technician (MT) and Director of Maintenance (DM), it was determined the facility failed to ensure 12 of 12 resident rooms observed were provided with operational night lights. This deficient practice had the potential to affect all 163 residents and was evidenced by the following: An observation of the facility's resident rooms between 12:30 PM and 3:50 PM revealed rooms 107, 109, 119, 126, 208, 216, 221, 230, 312, 319, 325, and 329 had night light fixtures that were not operational. In an interview at the time, the VPE, MT, and DM confirmed the observations. The facility Administrator was informed of the findings during the Life Safety Code exit conference at 4:40 PM.	S2460	"" A- Administrator re-educated Director of Maintenance on the importance of ensuring that all residents have operational night lights in their rooms to ensure resident safety. B- Light bulbs changed in affected rooms so that night lights work C-Director of Maintenance or Designee to audit all resident night lights weekly for one month and then monthly for 2 months after to ensure that they are operational. " Residents in rooms 107, 109, 119, 126, 208, 216, 221, 230, 312, 319, 325, and 329 were affected " All residents have the potential to be affected " Director or Maintenance or Designee to ensure compliance " Findings are to be brought monthly to the Administrator by the Director of Maintenance or Designee. " Director of Maintenance or Designee to report findings at monthly QAPI meetings.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
315225 Y1	Y2	10/21/2024 Y3

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 F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 09/26/2024	ID Prefix F0725 Reg. # 483.35(a)(1)(2) LSC	Correction Completed 10/02/2024	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	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	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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
8/14/2024	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315225 Y1	A. Building B. Wing Y2	10/21/2024 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0584	Correction	ID Prefix F0656	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	09/25/2024	LSC	09/26/2024	LSC	10/02/2024
ID Prefix F0658	Correction	ID Prefix F0693	Correction	ID Prefix F0695	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(g)(4)(5)	Completed	Reg. # 483.25(i)	Completed
LSC	10/02/2024	LSC	10/02/2024	LSC	10/02/2024
ID Prefix F0698	Correction	ID Prefix F0725	Correction	ID Prefix F0755	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.35(a)(1)(2)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	10/02/2024	LSC	10/02/2024	LSC	10/02/2024
ID Prefix F0756	Correction	ID Prefix F0812	Correction	ID Prefix F0867	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.75(c)(d)(e)(g)(2)(i)(ii)	Completed
LSC	09/25/2024	LSC	09/25/2024	LSC	09/25/2024
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/02/2024	LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
8/14/2024	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060415 (Y1)	A. Building B. Wing (Y2)	10/21/2024 (Y3)

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix H5790 Reg. # 8:43E-13.4(d) LSC	Correction Completed 10/02/2024	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	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	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 8/14/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060415 Y1	A. Building B. Wing Y2	10/21/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S1405	Correction	ID Prefix S1410	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-19.5(a)	Completed	Reg. # 8:39-19.5(b)(1)	Completed
LSC	10/02/2024	LSC	10/02/2024	LSC	10/02/2024
ID Prefix S2120	Correction	ID Prefix S2460	Correction	ID Prefix	Correction
Reg. # 8:39-31.1(c)	Completed	Reg. # 8:39-31.8(c)(8)	Completed	Reg. #	Completed
LSC	10/20/2024	LSC	09/26/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/14/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060415 Y1	A. Building B. Wing Y2	10/21/2024 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S1405	Correction	ID Prefix S1410	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-19.5(a)	Completed	Reg. # 8:39-19.5(b)(1)	Completed
LSC	10/02/2024	LSC	10/02/2024	LSC	10/02/2024
ID Prefix S2120	Correction	ID Prefix S2460	Correction	ID Prefix	Correction
Reg. # 8:39-31.1(c)	Completed	Reg. # 8:39-31.8(c)(8)	Completed	Reg. #	Completed
LSC	10/20/2024	LSC	09/26/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/14/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING 01 B. WING _____	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER FRONT 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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 8/09/24 and 8/13/24. River Front Rehabilitation and Healthcare Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Riverfront Rehabilitation and Healthcare Center, a three-story building that was built in 1982. It is composed of Type II protected construction. The facility is divided into eight smoke zones. The generator is a 88 kW internally located diesel powered generator. The generator does approximately 50% of the building as per the [redacted] in 2022. The current occupied beds are 163 of 180.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 08/13/24 in the presence of the [redacted]	K 211	A-Second floor Bridgeway stairwell exit serving the second and third floor corridors to the first floor egress were	10/11/24

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

Electronically Signed | 08/27/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING 01 B. WING _____	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 211	Continued From page 1 and US FOIA (b)(6)), it was determined that the facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency in accordance with NFPA 101: 2012 edition, Section 7.1.10.1, and 7.7. This deficient practice had the potential to affect all 163 resident and was evidenced by the following: An observation at 2:02 PM, revealed the 2nd floor bridgeway exit stairwell serving the 2nd and 3rd floor corridors to the first floor was littered with garbage from the second to 1st floor egress enclosure producing multiple trip hazards. The ceiling was hanging down with portions missing above the 2nd floor landing in the stairwell enclosure. At the first floor landing, the stairwell exit door was blocked from opening outward by a stack of mattresses 7-feet high and other stored items in the 1st floor exit passage corridor to the exterior exit door. This deficient practice blocked exit egress out of the stairwell and egress from the stairwell to the exterior exit. There was no sprinkler protection in the stairwell enclosure from the second floor to the 1st floor. In an interview at the time, the US FOIA (b)(6) confirmed the observation. An observation at 3:05 PM of the first floor end of corridor exit at the bridgeway, revealed the space from this first floor corridor exit to the same shared (with the bridgeway stairwell exit pathway) exterior exit was used for storage of multiple combustible boxes and equipment open to the path of exit egress travel.	K 211	immediately cleaned and cleared of all garbage. B-The ceiling above the second floor landing in the stairwell enclosure with portions missing to be fixed. C-At the first floor landing the stairwell exit door was immediately cleared of all items in the first floor exit passage corridor to the exterior exit door allowing for full exit egress from the stairwell to the exterior exit. D-Sprinkler to be added in the stairwell enclosure from the second to the first floor E-All storage, combustible boxes and equipment was immediately removed from the path of exit egress travel on the first floor end of corridor exit at the breezeway (with the bridgeway stairwell exit pathway). F- On 08/26/24 US FOIA (b)(6) [redacted] were in serviced by the Administrator on the importance of ensuring that the means of egress was continuously maintained free of all obstructions or impediments to full instant use in case of fire or other emergency to ensure resident safety. " All residents have the potential to be affected. " Director of Maintenance or Designee and Director of Housekeeping or Designee will ensure compliance. " Breezeway will be checked by Director of Housekeeping or Designee for cleanliness and any possible obstruction to ensure full exit egress to first floor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING **01** B. WING _____	**08/14/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER FRONT 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
K 211	Continued From page 2 In an interview at the time, the US FOIA (b)(6) confirmed the observation. During the Life Safety Code exit conference on 8/13/24 at 4:40 PM, the US FOIA (b)(6) were informed of the findings.	K 211	exterior exit weekly for one month and then monthly for the next 2 months. Findings will be reported monthly by Director of Housekeeping or Designee at the monthly QAPI meeting. "	
K 222 SS=F	NJAC 8:39-31.2 (e) Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is	K 222		9/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING **01** B. WING _____	**08/14/2024**

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

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K 222	Continued From page 3 constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/13/24 in the presence of the[U.S. FOIA (b)(6) redacted], it was determined that the facility failed to ensure all staff was trained or provided with a key to readily unlock clinical needs door-locking arrangements in	K 222	" All residents have the potential to be affected " Lock was immediately removed from exterior fence enclosure and replaced by a non-locking latch " On 08/26/2024 [US FOIA (b)(6) redacted]	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING 01 B. WING	08/14/2024

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

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K 222	Continued From page 4 accordance with NFPA 101: 2012 edition, Section 19.2.2.2.5 and 19.2.2.2.6. This deficient practice had the potential to affect all 163 residents and was evidenced by the following: An observation at 3:07 PM of the first floor dining room exterior exit discharge, revealed an exterior fenced-in enclosure with a gate leading to the public way that was secured with a keyed lock. In an interview at the time the U.S. FOIA (b)(6) confirmed the observation and did not have the key available with them. In an interview at the time, the U.S. FOIA asked the [redacted] if she had the key. The nursing unit manager stated that activities had the key. The activities person was not present with the key. No policy and procedure was provided for staff training on the policy and procedure of how the locked gate is to be opened in the event of an emergency. During the Life Safety Code exit conference on 8/13/24 at 4:40 PM, the US FOIA (b)(6) [redacted] were informed of the findings.	K 222	US FOIA (b)(6) were in serviced to ensure that all doors in a required means of egress is not equipped with a latch or a lock that requires the use of a tool or key from the egress side unless necessary for specific clinical needs or due to a security threat. " Director of Maintenance or Designee will check all doors in means of egress to ensure that they are not equipped with a latch or lock that requires the use of a tool or key from the egress side unless necessary for specific clinical needs or due to a security threat weekly x 4 weeks and then monthly x 2 months. " Director of Maintenance or Designee will report findings to Administrator. Administrator will report findings at monthly QAPI committee.	
K 345 SS=F	NJAC 8:39-31.2 (e) Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National	K 345		9/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING 01 B. WING _____	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER FRONT 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
K 345	Continued From page 5 Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview, and record review on 8/9/24 and 8/13/24 in the presence of the US FOIA (b)(6) [redacted], it was determined the facility failed to ensure smoke detection sensitivity testing of the smoke detectors were completed every alternate year in accordance with NFPA 70: 2011 Edition and NFPA 72 National Fire Alarm and Signaling Code: 2010 Edition, Section 14.4.5.3.2. This deficient practice had the potential to affect 163 residents and was evidenced by the following: Record review on 8/9/24 between 9:33 AM and 2:00 PM of the facility's last 3 fire alarm system inspection and testing reports dated 7/1/24, 2/1/24 and 7/18/23 provided by the U.S. FOIA [redacted], revealed the reports had no reference to smoke detector sensitivity testing. No other documents were provided. In an interview on 8/13/24 at 12:25 PM, surveyor asked the U.S. FOIA [redacted] for a written record of the last fire alarm sensitivity testing. The U.S. FOIA [redacted] stated that the documents provided were all the documents he had and no further documents were provided. Observations on 8/13/24 from 12:45 AM to 3:50 PM, revealed smoke detectors were located in resident rooms, corridors and other concealed areas throughout the building. During the exit conference on 8/13/24 at 4:40 PM,	K 345	" Smoke detection sensitivity testing on the smoke detectors was completed on 07/01/2024 by contracted vendor that comes to ensure compliance. " All residents have the potential to be affected " On 08/26/2024 US FOIA (b)(6) [redacted] were re-educated on the importance of ensuring that smoke detection sensitivity testing on smoke detectors are done every alternate year. " Director of Maintenance or Designee to ensure compliance and will report to Administrator any obstacles to future compliance. " Administrator to report findings at monthly QAPI meeting.	

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	315225	A. BUILDING 01 B. WING _____	08/14/2024

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K 345	Continued From page 6 the U.S. FOIA (b)(6) [redacted] were informed of the findings. This deficient practice was cited at the previous standard survey on 12/16/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 8/9/24 and 8/13/24 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined the facility	K 353	"" 1)On 08/26/2024 US FOIA (b)(6) [redacted] s in serviced by the Administrator on the need for the facility to ensure that fire sprinkler report repairs are completed, that sprinkler heads are	10/11/24

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K 353	Continued From page 7 failed ensure fire sprinkler system report repairs were completed, sprinkler heads were maintained and the ceiling was resistant to the passage of smoke in accordance with NFPA 101: 2012 edition, Sections 8.3.5,8.5, 8.5.6, 9.7, 9.7.5 and 19.3.5.1, NFPA 25: 2011 edition and NFPA 72: 2010 edition. This deficient practice had the potential to affect 163 residents and was evidenced by: Record review on 8/9/24 between 9:30 AM and 2:20 PM revealed the last annual fire sprinkler system inspection dated 11/14/23 stated in the comments " A-28: Tampers on (2) 4" butterfly valves for stairwell did not send signal to panel" there was no documentation that the tamper switches were repaired and send a signal to the panel. In an interview at the time the [redacted] confirmed the observation and stated he would call the sprinkler service. No further documents were provided. Observations on 8/13/24 between 12:45 PM and 3:50 PM, revealed the following: 1. The 3rd floor supply room had a space in the ceiling tile around the sprinkler head. 2. The 3rd floor soiled utility room was missing a ceiling tile exposing 12-inch x 12-inch penetration in sheetrock wall above drop ceiling. 3. The 2nd floor housekeeping closet sprinkler had no escutcheon. 4. The staff bathroom at the 2nd floor nurses station had a 2-foot x 4-foot ceiling tile missing.	K 353	maintained and that the ceiling is resistant to smoke to ensure resident safety. 2) tampers on (2) 4 butterfly valves for stairwell to be repaired to send signal to the panel. 3) Space in the 3rd floor supply room ceiling tile around the sprinkler head was filled in with escutcheon. 4) Missing ceiling tile in the third floor soiled utility room was replaced. 12 x 12 inch penetration in sheetrock above drop ceiling was filled in with sheetrock. 5) Escutcheon placed around closet sprinkler in 2nd floor housekeeping closet. 6) 2 foot x 4 foot ceiling tile replaced in 2nd floor staff bathroom. 7) Ceiling tile replaced in 1st floor storage room labeled payroll. 8) 1-inch space in the ceiling tile around the sprinkler head in the maintenance shop was filled in with an escutcheon. 9) 4-foot x 4 foot section of drop ceiling missing around sprinkler in the personal laundry room was filled in with ceiling tiles. 10) Escutcheon was replaced in sprinkler head and ceiling tile replaced from the sprinkler to the ceiling grid in the area at the end of the kitchen hall. 11) Drop ceiling placed in the open space in the kitchen housekeeping closet and escutcheon replaced around the sprinkler head. " All residents have the potential to be affected " Director of Maintenance or Designee to ensure compliance " Director of Maintenance or Designee to check all fire system reports and ensure that all fire system report repairs	

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K 353	Continued From page 8 5. The 1st floor storage room labeled payroll had a ceiling tile missing. 6. The maintenance shop had a 1-inch space in the ceiling tile around the sprinkler head. 7. The personal laundry room had a 4-foot x 4-foot section of drop ceiling missing around a sprinkler. 8. The end of the kitchen hall area ceiling had a sprinkler with no escutcheon and a space cut out of ceiling tile from the sprinkler to the ceiling grid. 9. The kitchen housekeeping closet had no drop ceiling with a sprinkler head in the open space. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observations. The facility U.S. FOIA (b)(6) were informed of the deficient practice during the Life Safety Code exit conference at 4:40 PM. NJAC 8:39-31.2(e) NFPA 25	K 353	are completed and that all sprinkler systems are maintained and that all ceilings are resistant to smoke weekly for one monthly and then monthly for 2 more months. Results are to be reported by Director of Maintenance or Designee at monthly QAPI meeting.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors	K 363		10/11/24

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K 363	Continued From page 9 to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/13/24 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure corridor doors closed and latched into their frame in accordance with NFPA 101: 2012 edition, Section 19.3.6.3, 19.3.2.1, 19.3.2.1.3, 19.3.5.9, 19.3.7.6, 19.3.7.8, 19.3.7.9 and NFPA 80: 2010 Edition. This	K 363	"Corridor-Doors " 1) On 08/26/24 the Administrator In serviced the US FOIA (b)(6) [redacted] on the importance of ensuring that corridor doors close and latch into their frames to ensure resident safety. 2) Third floor MDS office was fixed to so that it is able to close into its frame when opened to 90 degrees and released.	

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K 363	Continued From page 10 deficient practice had the potential to affect all 163 residents and was evidenced by the following: An observation of the facility between 12:45 PM and 3:50 PM, revealed corridor doors did not close into their frames and/or latch for the following doors: 1. The 3rd floor MDS office door did not close into its frame when opened to 90 degrees and released. 2. Room 319 door hit on bottom and did not latch. 3. The 3rd floor bathroom door next to shower room hit the door frame and did not close into its frame. 4. The 3rd floor infection control office had boxes of combustibles stored inside the room and did not have a self-closing mechanism on the door. 5. The 3rd floor locker room had no latch on the corridor door. 6. The 3rd floor medical records room had boxes with combustibles and did not have a self-closing mechanism on the door. 7. The 2nd floor double doors to the dining room had self closing devices and were observed in the closed position with an astragal on one door leaf holding the other door leaf open allowing the passage of smoke. The doors were opened to 90 degrees and released and the door leaf with the astragal closed first holding the other door leaf open when it was closed.	K 363	3) Room 319 door fixed so that it no longer hits on the bottom and now latches 4) 3rd floor bathroom door next to shower was fixed so that it no longer hits the door frame and now closes properly into its frame. 5) All boxes of combustible items removed from 3rd floor infection control office. Self-closing mechanism placed on the door. 6) Latch placed on the corridor door of the third-floor locker room 7) Self-closing mechanism placed on the door of the third floor Medical Records room. All combustibles were removed. 8) Door self-closer on the double doors of the second floor dining room were fixed to ensure that the double doors allowed for the astragals to close properly when shut. 9) The door to the 1rst floor locker room (by the nurse□s station) was fixed to ensure that it did not hit the door frame and latches properly when opened to 90 degrees and released. 10) The door to the first floor soiled utility room (by room 115) was fixed to ensure that it does not hit the door frame and latches properly when opened to 90 degrees and released. 11) The right door leaf from the first floor service hall double smoke doors was fixed so that it doesn□t stay in an open position of ¿ of an inch from closing into its proper position. 12) All combustibles were removed from1rst floor storage room labeled Payroll and self-closing mechanism was placed on the door.	

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K 363	Continued From page 11 8. The 1st floor locker room (by nurses station) door it hit the door frame and did not close into its frame and latch when open to 90 degrees and released. 9. The 1st floor soiled utility room (by room 115) door it hit the door frame and did not close into its frame and latch when open to 90 degrees and released. 10. The 1st floor service hall double smoke doors had the right door leaf staying in an open position 3/4 of an inch from closing into it's proper position, allowing the passage of smoke. 11. The 1st floor storage room labeled Payroll contained combustibles and had no self-closing mechanism on the door. 12. A kitchen corridor door had signage stating "Door must be closed at all times" had a self-closing mechanism and was staying in an open position 1-inch from its door frame. 13. The second door to the laundry room was held open by hitting the floor, it had no self-closing mechanism and did not latch. The door tests were repeated for the aforementioned doors by the U.S. FOIA (b)(6) with the same results. In an interview at the time, the U.S. FOIA (b)(6) confirmed the corridor door observations. During the exit conference on 8/13/24 at 4:40 PM, the U.S. FOIA (b)(6) were informed of the findings.	K 363	13) The self-closing mechanism on the kitchen corridor door labeled Door must be closed at all times was repaired to ensure that it doesn□t stay in an opened position. 14) The second door to the laundry room was fixed so that it no longer held open when it hit the floor. In addition, a working latch and a self-closing mechanism were added to the door. " All Residents have the potential to be affected " Director of Maintenance or Designee to ensure compliance " Director of Maintenance or Designee to audit all doors to ensure that they properly latch into their frames monthly for 3 months. Audit findings are to be brought by the Director of Maintenance or designee to the monthly QAPI meeting	

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K 363	Continued From page 12 NJAC 8:39-31.2 (e) NFPA 80	K 363		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/13/24 in the presence of the [redacted] it was determined the facility failed to ensure residents bathroom exhaust fans were maintained in operational condition in accordance with NFPA 101:2012 edition, Sections 19.5.2.1, 9.2. This deficient practice had the potential to affect 163 residents and was evidenced by the following: Observations during a facility tour between 12:45 PM and 3:50 PM, revealed 7 of 8 resident room bathrooms did not have windows and the exhaust fans did not operate. The MT tested the fans at the surveyor request. The non-operational exhaust fans were located in rooms: 107, 126, 208, 230, 221, 329 and 319. In an interview at the time, the [redacted]	K 521	"" 1) On 08/26/2024 [redacted] was in serviced by the Administrator on ensuring that the resident□s bathroom□s exhaust fans are maintained in operational condition to ensure resident comfort. 2) Bathroom exhaust in rooms 107, 126, 208, 230, 221, 329 and 319 fixed on October 4, 2024. 3) Director of Maintenance or Designee to check 10 resident exhaust fans daily for 12 weeks to ensure that they are in working order to ensure resident comfort. " Residents in rooms 107, 126, 208, 230, 221, 329 and 319 have been affected All residents have the potential to be affected " Director of Maintenance or Designee to ensure compliance.	10/4/24

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K 521	Continued From page 13 confirmed the observations. During the exit conference on 8/13/24 at 4:40 PM, the U.S. FOIA (b)(6) [redacted] were informed of the findings.	K 521	" Director of Maintenance or Designee to report findings of above audits to monthly QAPI committee and then to quarterly QA meeting.	
K 531 SS=F	NJAC 8:39-31.2 (e) Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on record review and interview on 8/13/24, in the presence of the U.S. FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure firefighters emergency operation tests were performed monthly with written record for 2 of 2 elevators in accordance	K 531	Elevators " On 08/26/2024 Administrator In-Serviced US FOIA (b)(6) [redacted] on ensuring that firefighters emergency operation tests are completed monthly with written records for 2 of 2 elevators for	9/25/24

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K 531	Continued From page 14 with NFPA 101; 2012 Edition, Sections 19.5.3, 9.4, 9.4.2, 9.4.3, 9.4.6, and ASME/ANSI A17.3 These deficient practices had the potential to affect all 163 residents and was evidenced by: Record review between 9:30 AM and 12:45 PM revealed there was no complete record of the monthly firefighters service requirements including firefighters service Phase 1 key recall and smoke detector automatic recall and firefighters Phase 2 emergency in car operation tests performed with written record for the last 12 months. The facility "Elevator Monthly Fire Service Test Log" provided was incomplete. It only listed dates from January 2024 to August 2024. It did not indicate which elevator car was being tested, there was no data for what was tested, no indication if it passed or failed and had no initials of person performing test. No log was provided for December, November, October, September and August of 2023. In an interview at the time, the [redacted] confirmed the recorded document and stated that was the document they had and that he had only been at the facility since May 2024. Elevator #2 serves 3 levels and #1 serves 3 levels. The [redacted] were informed of the findings at the Life Safety Code exit conference at 4:40 PM on 6/19/24. N.J.A.C. 8:39-31.2 (e), 5:70-2.5	K 531	phase 1 key recall and smoke detector auto recall and Firefighters Phase 2 emergency in car operation to ensure resident safety. All elevator repairs are completed by Gotham elevator company. Currently all elevators are functioning properly. " All Residents have the potential to be affected. Monthly firefighters emergency operations tests completed to ensure resident safety. " Director of Maintenance or Designee to audit elevator tests monthly for 3 months. Findings of elevator tests to be brought to Administrator monthly. " Director of Maintenance or Designee to ensure compliance. " Director of Maintenance or Designee to report findings of audits at monthly QAPI committee meeting.	
K 918 SS=F	Electrical Systems - Essential Electric Syste	K 918		10/11/24

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K 918	Continued From page 15 CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observations, record review and	K 918	"" All Residents have the potential to be	

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K 918	Continued From page 16 interview on 8/9/24 and 8/13/24 in the presence of the[redacted], it was determined the facility failed to ensure the emergency power generator was exercised at 30% or greater of its nameplate KW rating during the monthly load tests or that a 90 minute annual load bank test was performed. The facility failed to measure and record that the time to transfer power from the primary utility source to the generator was within 10 seconds, the facility failed to provide emergency back up lighting in the transfer switch room, the facility failed to provide a remote emergency generator shut off and failed to document the monthly and weekly generator tests and inspections for 5 of the last 12 months in accordance with NFPA 101: 2012 edition, NFPA 99: 2012 edition, Sections 6.4.4, 6.5.4, 6.6.4, and NFPA 110: 2010 edition, Sections 7.3, 7.3.1, 7.3.2, 8.4, 8.4.1, 8.4.2, 8.4.2.3. This deficient practice had the potential to affect 163 residents and was evidenced by: Record review between 9:33 AM and 2:00 PM of the monthly emergency power generator logs for each of the last 12 months from July 2024 to August 2023 revealed the following: 1. The facility did not record the percentage of the emergency power system nameplate kilowatt rating that the generator was exercised to determine if the load met the 30% of the rating requirement or performed a 90 minute annual load bank test. 2. The facility did not record the transfer time from the normal utility power source to the alternate power source being tested to determine the time was within 10 seconds or provide a	K 918	affected " On 08/26/2024 the Administrator in serviced the[redacted] on the importance of ensuring that the Facility must make sure that the generator or alternate power source and alternate equipment is capable of providing service within 10 seconds. If the 10 second criteria is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches to ensure resident safety. In addition, monthly and weekly generator tests must be documented/recorded to resident safety. " Director of Maintenance to: 1) ensure that 90-minute annual load bank test was performed on the generator and ensured that generator or alternate power source and associated equipment is capable of supplying service within 10 seconds by the compliance date. 2) Install operational lighting as well as emergency back up lighting in the transfer switch room by the compliance date. 3) Remote emergency generator shut off switch installed on 08/22/2024 directly outside generator room. " Director of Maintenance or Designee to audit that the generator or alternate power source is capable of providing service within 10 seconds weekly for 1 month and then monthly for 2 months. " Director of Maintenance or Designee is to report findings at monthly QAPI meeting and then at quarterly QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING **01** B. WING _____	**08/14/2024**

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

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K 918	Continued From page 17 process to annually confirm this capability to the life safety and critical branches. 3. The facility did not record the monthly generator load tests for the months of December, November, October, September and August of 2023. 4. The facility did not record the weekly generator inspections for the months of December, November, October, September and August of 2023. In an interview at the time, the [redacted] confirmed the record review findings. An observation on 8/13/24 at 2:37 PM revealed the transfer switch room had no operational lighting and no back up emergency lighting provided. In an interview at the time, the [redacted] confirmed the observation. An observation on 8/13/24 at 2:45 PM, revealed the emergency power generator did not have a remote emergency shut off device provided. In an interview at the time, the [redacted] confirmed the observation. The facility [redacted] were informed of the deficient practices during the Life Safety Code exit conference on 8/13/24 at 4:40 PM. NJAC 8:39-31.2(e)	K 918		

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K 923	Continued From page 18	K 923		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.	K 923		10/2/24

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	315225	A. BUILDING 01 B. WING _____	08/14/2024

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K 923	Continued From page 19 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/13/24, in the presence of the NJ Exec Order 26.4b1 [redacted] it was determined that the facility failed to ensure oxidizing gases were not stored with flammables, separated from combustibles by 5 feet (if sprinklered), in 2 of 2 oxygen storage rooms in accordance with NFPA 99: 2012 edition, Section 11.3, 11.3.2.3 (2). These deficient practices had the potential to affect all 163 residents and were evidenced by: An observation at 1:02 PM of the 3rd floor oxygen storage room, revealed a rack with full oxygen cylinders stored directly next to plastic storage container with drawers that had boxes on top with combustible supplies. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observation. An observation at 3:07 PM of the 1st floor oxygen storage room, revealed a rack with full oxygen cylinders stored directly next to a stack of 7 boxes and a rack full of diaper supplies, all combustible. In an interview at the time, the U.S. FOIA (b)(6) confirmed the observation. The U.S. FOIA (b)(6) [redacted] were informed of the findings at 4:40 PM during the Life Safety Code exit conference. N.J.A.C. 8:39-31.2 (e) NFPA 99	K 923	"" A) On 08-26-2024, Administrator in serviced US FOIA (b)(6) [redacted] that the facility must ensure oxidizing gases are not stored with flammables, separated from combustibles by 5 feet (if sprinklered) to ensure resident safety. B) On third floor oxygen storage room, all plastic storage boxes and combustible supplies that were stored nearby were removed to ensure resident safety. C) All oxygen from first floor supply room was removed and put in and separate room that holds no combustible items to ensure resident safety. All residents have the potential to be affected " Director of Maintenance or Designee to audit all oxygen supply rooms monthly for 3 months to ensure that all oxidizing gases are not stored with flammables and are separated by 5 feet from combustibles to ensure resident safety. " Director of Maintenance or Designee to report findings monthly to Administrator. " Director of Maintenance or Designee to report findings of audit at monthly QAPI Committee meeting and then at Quarterly QA meeting.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315225 Y1	A. Building 01 - COOPER RIVER WEST B. Wing Y2	10/21/2024 Y3

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	ID Prefix	Correction	DATE Y5
Reg. #	NFPA 101	Completed	
LSC	K0211		10/11/2024
Reg. #	NFPA 101	Completed	
LSC	K0222		09/25/2024
Reg. #	NFPA 101	Completed	
LSC	K0345		09/01/2024
Reg. #	NFPA 101	Completed	
LSC	K0353		10/11/2024
Reg. #	NFPA 101	Completed	
LSC	K0363		10/11/2024
Reg. #	NFPA 101	Completed	
LSC	K0521		10/04/2024
Reg. #	NFPA 101	Completed	
LSC	K0531		09/25/2024
Reg. #	NFPA 101	Completed	
LSC	K0918		10/11/2024
Reg. #	NFPA 101	Completed	
LSC	K0923		10/02/2024

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 8/14/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO