STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING _____ B. WING _____	C 07/30/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ145796, NJ142317, NJ145807, NJ146081, NJ145021 Census: 158 Sample Size: 7 This facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 584 SS=E	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 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;	F 584		9/14/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/20/2021

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F 584	Continued From page 1 §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: Complaint Intake NJ146081 Based on observations, record reviews, document review, and interviews, it was determined that the facility failed to ensure ceiling lights were working down the even numbered side of the [redacted]-floor hallway. This affected eight resident rooms (Rooms [redacted], [redacted]) and 18 residents. Findings included: 1. Resident [redacted] was admitted to the facility on [redacted] with diagnoses that included [redacted]. The quarterly Minimum Data Set (MDS), dated [redacted], revealed a Brief Interview for Mental Status (BIMS) of [redacted], indicating no [redacted]. Resident [redacted] supervised for activities of daily living (ADLs). On 07/28/2021 at 4:30 PM, Resident [redacted] was	F 584	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. The lights in rooms [redacted] have been fixed 7/31/2021. Random audits will be completed to ensure that all lights are functioning properly. Current staff will be educated on the process of reporting needed repairs via TELS (Equipment Lifecycle System). Maintenance staff was educated in the importance of ensuring all lights are in proper working order. Director of Maintenance or Designee will perform weekly random audits x 4, then	

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F 584	Continued From page 2 interviewed at bedside. Resident [redacted] stated the resident was moved to the current resident room on [redacted]. Resident [redacted] stated that the day the resident moved into the current room, the resident met with the Nursing Home Administrator (NHA). Resident #1 informed the NHA of several items in the room that needed repair, including the ceiling light that did not work. The resident asked the surveyor to test the lights, and the lights did not turn on. On 07/29/2021 at 2:38 PM, the Director of Maintenance (DM) was interviewed. The DM stated that he used The Equipment Lifecycle System (TELS) for tracking maintenance requests. He stated that all staff have access to TELS if a work ordered needed to be entered. The DM stated it was his goal to complete repairs within one to two days, unless a part needed to be ordered. He stated he was not aware of any request to look at a ceiling light that was out for Resident [redacted]. The DM observed the ceiling light was out and assumed it was in relationship to recent facility remodeling that was happening in the hallway. On 07/29/2021 at 3:43 PM, the Nursing Home Administrator (NHA) was interviewed. The NHA stated he recalled meeting with Resident [redacted] the day the resident changed rooms. He acknowledged the concerns raised by Resident [redacted], including the ceiling light not working, and stated he sent a text message to the DM. The NHA stated that he felt a text from the NHA would hold more weight then entering the work order in TELS. Upon further investigation on [redacted] at 8:45 AM, an observation was made that the ceiling lights were not in working order for the even	F 584	monthly thereafter for 3 months to ensure lights are in good functioning order. Results of these audits will be presented and reviewed at monthly QAPI meetings.	

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F 584	Continued From page 3 numbered rooms down the hallway. The room numbers included Rooms [redacted] The two alert and oriented residents who lived in Room [redacted] were briefly interviewed and confirmed the lights had been out for months. The DM stated he was not aware of the lights being out. A review of the work orders entered into TELS during the month of [redacted] was reviewed. There were no work orders in TELS for any repairs to ceiling lights.	F 584		
F 600 SS=D	New Jersey Administrative Code § 8:39-31.2(e) Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Complaint Intake NJ145021 Based on record review, interviews, document review, and facility policy review, it was determined that the facility failed to keep a resident free from physical abuse. Resident [redacted]	F 600	Resident [redacted] was immediately assessed and found to have no physical injury, no s/s of distress or discomfort noted. Resident does not recall incident. Care plan was updated with new interventions, [redacted] services provided.	9/14/21

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F 600	Continued From page 4 was experiencing behaviors including kicking and hitting and the end of the resident's [redacted] were tied together. This affected 1 (Resident [redacted]) of 3 residents reviewed for abuse. Findings included: 1. Resident [redacted] was admitted to the facility on [redacted] with diagnoses that included [redacted]. The annual Minimum Data Set (MDS), dated [redacted] indicated a Brief Interview for Mental Status (BIMS) score of [redacted], indicating [redacted]. Resident [redacted] needed extensive assistance of one person for all activities of daily living (ADLs). Resident [redacted] had a care plan, dated [redacted] and revised on [redacted] that indicated Resident [redacted] had a history of being [redacted] and [redacted]. A review of a Facility Reported Event (FRE) sent to the New Jersey Department of Public Health (NJDOH) on 04/16/2021, revealed the following: On [redacted], staff reported to administration that the resident's [redacted] were tied together. Prior to the event, the care plan and interventions for use of physical restraints were self-releasing Velcro seatbelt related to safety. The facility initiated an investigation, identified staff, and immediately suspended the staff pending the investigation. Appropriate parties were notified. The resident was assessed for pain and injury. The care plan was reviewed and updated with immediate intervention. Based on the investigation, the facility substantiated the allegation of abuse. The facility obtained statements from staff and housekeeping contractors that witnessed the resident's sleeves tied together. The facility terminated staff and	F 600	All current residents with [redacted] behaviors will be reviewed for appropriate interventions and have their care plans updated accordingly. DON/designee will re-educate current staff from all departments on abuse prevention and managing residents with challenging behaviors. DON/Designee will complete weekly random audits x4 and monthly x3 of current residents with [redacted] behaviors to ensure no abuse has occurred and appropriate interventions are in place and on the care plan. Results of these audits will be presented and reviewed at monthly QAPI meetings.	

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F 600	Continued From page 5	F 600		

removed the housekeeping contractors from the facility for failing to report.

On 04/16/2021, the facility reported an occurrence that happened on [redacted]. The facility reported the [redacted] of Resident [redacted]s [redacted] were tied together. The resident was assessed for pain and/or bruising. The resident did not recall the event. The facility suspended four employees pending investigation.

A review of the facility's report, dated [redacted], revealed four employees were suspended due to the failure to report the incident. According to the written report, four employees stated knowing about the sleeves being tied, but did not report it. Resident [redacted] was having a particularly bad day with episodes of kicking and hitting staff. Licensed Practical Nurse (LPN) #2 indicated Resident [redacted] was being kept in the nurses' station due to [redacted] and [redacted]y as evidenced by kicking, slapping, and biting. Two housekeepers (HK) #3 and #7, a Temporary Nursing Assistant (TNA) #4, and LPN #2 were terminated. The facility was unable to determine who tied Resident #3's [redacted], however LPN #2 was the suspected perpetrator. HK #3, HK #7, and TNA #4 observed the tied [redacted] on Resident [redacted] and failed to report.

On 07/30/2021 at 11:10 AM, the housekeeping supervisor (HS) was interviewed. The HS stated he was out of the facility during the incident and had only recently returned. He was not aware of the details of the occurrence.

On 07/30/2021 at 1:15 PM, the Social Worker (SW) was interviewed. The SW interviewed Resident [redacted] after the occurrence and the resident did not recall the occurrence at all. The SW

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F 600	Continued From page 6	F 600		

stated Resident [redacted] can be both [redacted] and [redacted].

On 07/30/2021 at 2:47 PM, Housekeeper #3 was called for an interview, and this surveyor left a voice mail message. The call was never returned.

On 07/30/2021 at 3:46 PM, LPN #2 was called for an interview. LPN #2 sent a text message to this surveyor stating that she was no longer an employee of the facility and any information needed should be obtained from the facility.

On 07/30/2021 at 4:00 PM, Temporary Nurse Aide (TNA) #4 was interviewed. TNA #4 stated LPN #2 asked her to get some supplies and when she returned, TNA #4 observed the [redacted] of Resident [redacted] were tied together. She stated she did not see anyone physically tie the [redacted]. TNA #4 admitted to not telling anyone. She stated she put down the requested supplies and quickly went on to complete the rounds of her resident group. She stated she knew it was wrong not to report the observation.

On 07/30/2021 at 5:00 PM, the Nursing Home Administrator (NHA) was interviewed. The NHA stated the facility initiated all the proper measures once informed of the occurrence. He stated they immediately suspended the suspected employees and those who did not report the occurrence. Both employees and residents were interviewed. Additional abuse and reporting training was initiated. The incident happened just prior to when the new Director of Nursing began her employment. The NHA stated the occurrence became part of the facility QAPI (Quality Assurance Performance Improvement) plan.

Education files indicated that the two

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F 600	Continued From page 7 housekeepers, LPN #2, and TNA #4 had gone through abuse training that included being a mandatory reporter upon orientation and annually. The facility policy on abuse prevention program, dated 2001 and revised December 2016, read, in part, 4. Require staff training/orientation program that includes such topics as abuse prevention, identification and reporting of abuse, stress management, and handling [redacted] or [redacted] behavior.	F 600		
F 604 SS=D	New Jersey Administrative Code § 4.1 (a)(5) Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for	F 604		9/14/21

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F 604	Continued From page 8 purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Complaint Intake NJ145021 Based on record review, interviews, document review, and facility policy review, it was determined that the facility failed to keep a resident free from the use of a physical restraint. Resident [redacted] was experiencing behaviors including kicking and hitting and the end of the resident's [redacted] were tied together. This affected 1 (Resident [redacted]) of 1 resident reviewed for the use of physical restraints. Findings included: 1. Resident [redacted] was admitted to the facility on 12/06/2018 with diagnoses that included [redacted]. The annual Minimum Data Set (MDS), dated [redacted] indicated a Brief Interview for Mental Status (BIMS) score of [redacted], indicating severe cognitive impairment. Resident [redacted] needed extensive assistance of one person for all activities of daily living (ADLs). Resident [redacted] had a care plan, dated [redacted] and revised on [redacted], that indicated Resident [redacted] had a history of being [redacted] abusive. A review of a Facility Reported Event (FRE) sent to the New Jersey Department of Public Health (NJDOH) on 04/16/2021, revealed the following:	F 604	Resident [redacted] was immediately assessed, no injury noted, no s/s of distress or discomfort noted. Care plan was updated with new interventions. [redacted] services provided; resident does not recall incident. Random audits of current residents with [redacted] behaviors, including kicking and hitting will be reviewed to ensure restraints are not being used. DON/designee will re-educate current staff on restraint policy and managing residents with challenging behaviors. DON/Designee will complete weekly random audits x4 and monthly x3 of current residents with [redacted] ensure restraints are not in use. Results of these audits will be presented and reviewed at monthly QAPI meetings for improvement.	

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F 604	Continued From page 9 On [redacted], staff reported to administration that the resident's [redacted] were tied together. Prior to the event, the care plan and interventions for use of physical restraints were [redacted] related to safety. The facility initiated an investigation, identified staff, and immediately suspended the staff pending the investigation. Appropriate parties were notified. The resident was assessed for pain and injury. The care plan was reviewed and updated with immediate intervention. Based on the investigation, the facility substantiated the allegation of abuse. The facility obtained statements from staff and housekeeping contractors that witnessed the resident's [redacted] tied together. The facility terminated staff and removed the housekeeping contractors from the facility for failing to report. On 04/16/2021, the facility reported an occurrence that happened on [redacted]. The facility reported the [redacted] of Resident [redacted]'s [redacted] was tied together. The resident was assessed for pain and/or bruising. The resident did not recall the event. The facility suspended four employees pending investigation. A review of the facility's report, dated [redacted], revealed four employees were suspended due to the failure to report the incident. According to the written report, four employees stated knowing about the [redacted] being tied, but did not report it. Resident [redacted] was having a particularly bad day with episodes of kicking and hitting staff. Licensed Practical Nurse (LPN) #2 indicated Resident [redacted] was being kept in the nurses' station due to [redacted] as evidenced by kicking, slapping, and biting. Two housekeepers (HK) #3 and #7, a Temporary Nursing Assistant (TNA) #4, and LPN #2 were terminated. The	F 604		

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facility was unable to determine who tied Resident [redacted]'s [redacted] however LPN #2 was the suspected perpetrator. HK #3, HK #7, and TNA #4 observed the tied [redacted] on Resident [redacted] and failed to report.

On 07/30/2021 at 11:10 AM, the housekeeping supervisor (HS) was interviewed. The HS stated he was out of the facility during the incident and had only recently returned. He was not aware of the details of the occurrence.

On 07/30/2021 at 1:15 PM, the Social Worker (SW) was interviewed. The SW interviewed Resident [redacted] after the occurrence and the resident did not recall the occurrence at all. The SW stated Resident [redacted] can be both [redacted] and [redacted].

On 07/30/2021 at 2:47 PM, Housekeeper #3 was called for an interview, and this surveyor left a voice mail message. The call was never returned.

On 07/30/2021 at 3:46 PM, LPN #2 was called for an interview. LPN #2 sent a text message to this surveyor stating that she was no longer an employee of the facility and any information needed should be obtained from the facility.

On 07/30/2021 at 4:00 PM, Temporary Nurse Aide (TNA) #4 was interviewed. TNA #4 stated LPN #2 asked her to get some supplies and when she returned, TNA #4 observed the [redacted] of Resident [redacted] were tied together. She stated she did not see anyone physically tie the [redacted] TNA #4 admitted to not telling anyone. She stated she put down the requested supplies and quickly went on to complete the rounds of her resident group. She stated she knew it was wrong not to report the observation.

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F 604	Continued From page 11 On 07/30/2021 at 5:00 PM, the Nursing Home Administrator (NHA) was interviewed. The NHA stated the facility initiated all the proper measures once informed of the occurrence. He stated they immediately suspended the suspected employees and those who did not report the occurrence. Both employees and residents were interviewed. Additional abuse and reporting training was initiated. The incident happened just prior to when the new Director of Nursing began her employment. The NHA stated the occurrence became part of the facility QAPI (Quality Assurance Performance Improvement) plan. The facility policy on abuse prevention program, dated 2001 and revised December 2016, read, in part, 4. Require staff training/orientation program that includes such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior.	F 604		
F 607 SS=E	New Jersey Administrative Code § 8:39-4.1(a)(6) Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced	F 607		9/14/21

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(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 607	Continued From page 12 by: Complaint Intake NJ145021 Based on record review, document review, interviews, and facility policy review, it was determined that the facility staff failed to timely report an allegation of physical abuse. Four staff members (Two housekeepers (HK) #3 and #7, a Temporary Nursing Assistant (TNA) #4, and Licensed Practical Nurse #2) observed that the ends of Resident [redacted] had been tied together and failed to report the observation. This affected 1 (Resident [redacted]) of 3 residents reviewed for abuse reporting. Findings included: 1. Resident [redacted] was admitted to the facility on [redacted] with diagnoses that included [redacted]. The annual Minimum Data Set (MDS), dated [redacted], indicated a Brief Interview for Mental Status (BIMS) score of [redacted] indicating severe cognitive impairment. Resident [redacted] needed extensive assistance of one person for all activities of daily living (ADLs). Resident [redacted] had a care plan, dated [redacted] and revised on [redacted], that indicated Resident [redacted] had a history of being [redacted] abusive. A review of a Facility Reported Event (FRE) sent to the New Jersey Department of Public Health (NJDOH) on 04/16/2021, revealed the following: On [redacted], staff reported to administration that the resident's [redacted] were tied together. Prior to the event, the care plan and interventions for use of physical restraints; [redacted] related to safety. The facility initiated an investigation, identified staff, and immediately	F 607	Staff members (two housekeepers) #3 & #7, a Temporary Nursing Assistant (TNA)#4, and a Licensed Practical Nurse#2 were immediately suspended pending investigation and subsequently employment was terminated. Resident [redacted] was assessed, no injuries noted, no apparent distress or s/s of pain observed, [redacted] services provided, and care plan updated with appropriate interventions. Current residents with [redacted] behaviors will be reviewed to ensure if any abuse has occurred it is reported timely. DON/designee will re-educate current staff during orientation on the abuse reporting policy and time requirements. DON/Designee will complete weekly random audits x4 and monthly x3 of current residents with [redacted] behaviors to ensure that if any abuse has occurred it has been reported timely. Results of these audits will be presented and reviewed at monthly QAPI meetings for improvement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING _____ B. WING _____	C 07/30/2021

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F 607	Continued From page 13 suspended the staff pending the investigation. Appropriate parties were notified. The Resident was assessed for pain and injury, The care plan was reviewed and updated with immediate intervention. Based on the investigation, the facility substantiated the allegation of abuse. The facility obtained statements from staff and housekeeping contractors that witnessed the resident's [redacted] tied together. The facility terminated staff and removed the housekeeping contractors from the facility for failing to report. On 04/16/2021, the facility reported an occurrence that happened on [redacted]. The facility reported the sleeves of Resident [redacted] was tied together. The resident was assessed for pain and/or bruising. The resident did not recall the event. The facility suspended four employees pending investigation. A review of the facility's report, dated [redacted], revealed four employees were suspended due to the failure to report the incident. According to the written report, four employees stated knowing about the [redacted] being tied, but did not report it. Resident [redacted] was having a particularly bad day with episodes of kicking and hitting staff. Licensed Practical Nurse (LPN) #2 indicated Resident [redacted] was being kept in the nurses' station due to [redacted] as evidenced by kicking, slapping, and biting. Two housekeepers (HK) #3 and #7, a Temporary Nursing Assistant (TNA) #4, and Licensed Practical Nurse #2 were terminated. The facility was unable to determine who tied Resident [redacted], however LPN #2 was the suspected perpetrator. HK #3, HK #7, and TNA #4 observed the tied sleeves on Resident [redacted] and failed to report.	F 607		

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On 07/30/2021 at 2:47 PM, Housekeeper #3 was called for an interview, and this surveyor left a voice mail message. The call was never returned.

On 07/30/2021 at 3:46 PM, LPN #2 was called for an interview. LPN #2 sent a text message to this surveyor stating that she was no longer an employee of the facility and any information needed should be obtained from the facility.

On 07/30/2021 at 4:00 PM, Temporary Nurse Aide (TNA) #4 was interviewed. TNA #4 stated LPN #2 asked her to get some supplies and when she returned, TNA #4 observed the [redacted] of Resident [redacted] were tied together. She stated she did not see anyone physically tie the [redacted]. TNA #4 admitted to not telling anyone. She stated she put down the requested supplies and quickly went on to complete the rounds of her resident group. She stated she knew it was wrong not to report the observation.

On 07/30/2021 at 5:00 PM, the Nursing Home Administrator (NHA) was interviewed. The NHA stated the facility initiated all the proper measures once informed of the occurrence. He stated they immediately suspended the suspected employees and those who did not report the occurrence. Both employees and residents were interviewed. Additional abuse and reporting training was initiated. The incident happened just prior to when the new Director of Nursing began her employment. The NHA stated the occurrence became part of the facility QAPI (Quality Assurance Performance Improvement) plan.

Education files indicated that the two housekeepers, LPN #2, and TNA #4 had gone through abuse training that included being a mandatory reporter upon orientation and

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F 607	Continued From page 15 annually. The education stated any allegation of abuse, witnessed or suspected, should be reported immediately to a supervisor or management. The facility policy on abuse prevention program, dated 2001 and revised December 2016, read, in part, 4. Require staff training/orientation program that includes such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. 7. Investigate and report any allegations of abuse within timeframes as required by federal requirements.	F 607		
F 804 SS=E	New Jersey Administrative Code § 8:39-5.1(a) Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Complaint Intake NJ146081 Based on observations, interviews, and document review, it was determined that the facility failed to ensure food was served at palatable temperatures. This affected 3 (Resident [redacted], Resident [redacted] and Resident [redacted]) of 7 residents reviewing for food served at a palatable temperature.	F 804	Resident [redacted] are now being served food at palatable temperatures. All residents have the potential to be affected. Monthly dietary meetings are being formed to ensure residents needs are being catered to. Random test trays will be completed to ensure the food is served at palatable temperatures. Dietary staff will be educated on	9/14/21

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F 804	Continued From page 16 Findings included: 1. On 07/29/2021 at 10:45 AM, the food temperature logs for the month of July 2021 were reviewed. The food temperature logbook indicated that food was within appropriate temperatures on the steam table prior to serving. Based on complaints of room trays being served at cold temperatures from Resident [redacted], Resident [redacted] and Resident [redacted], test trays to the [redacted] floor revealed the following: On 07/29/2021 at 11:30 AM, Dietary Aide (DA) #1 checked the temperatures the food on the tray line before the lunch meal was served. The temperatures were as follows: - Beef and peppers -168 Fahrenheit (F) - Rice - 152 F - Peas - 204 F - Pureed turkey - 192 F - Mashed potatoes - 185 F - Pureed peas - 188 F - Gravy - 175 F - Ground turkey - 185 F - Egg noodles - 199 F A test tray was requested and assembled. The tray was the first to be placed on the meal delivery cart. The meal delivery cart left the kitchen at 12:17 PM. The trays were received on the 1st floor unit at 12:19 PM. The certified nursing assistants (CNAs) started to pass out the room trays. The CNAs informed the Assistant Food Service Director (AFSD) that all trays had been passed. The test tray temperatures at 12:31 PM were as follows: - Beef and peppers - 126 F - Peas - 108 F - Cold canned pears - 52 F - Coffee - 133 F	F 804	appropriate temperatures for palatability. Director of Dietary or Designee will perform weekly random audits x 4, then monthly thereafter for 3 months to ensure food temperatures are being met for palatability. Results of these audits will be presented and reviewed at monthly QAPI meetings.	

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F 804	Continued From page 17	F 804		

At 12:35 PM, the AFSD stated the policy was to serve the cold food below 45 degrees F and the hot food should be served above 135 degrees F. He stated the plates are on a warmer and the bases are warmed as well. The AFSD stated being concerned at how low the temperatures would get if the CNAs were not immediately available to pass the trays. He was surprised by how fast the temperatures dropped. An observation of the dome cover revealed a significant crack that could compromise the integrity of the system to hold in heat. The AFSD stated a need to go through all the dome lids to see if others had cracks or were somehow compromised.

A review of the February 2021 Resident Council minutes indicated 25 resident surveys were distributed with 24 being returned. Eleven of the returned surveys indicated less then optimal food temperatures.

A review of the March 2021 Resident Council minutes indicated 30 resident surveys were distributed with 22 returned. A specific number was not indicated, but there were responses that food was served at less-than-optimal temperatures.

The April 2021 Resident Council minutes revealed an in-person meeting was held. When dietary concerns were brought up at that meeting, the minutes indicated a separate food service meeting was going to be conducted. No minutes from that meeting could be located.

Dietary was not noted in the May and June 2021 Resident Council meeting minutes.

A review of the July 2021 Resident Council

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F 804	Continued From page 18 meeting minutes revealed a complaint that, "the food is always cold." The activities department had all new staff. The new Activities Director (AD), interviewed on 07/29/2021 at approximately 4:30 PM, was not aware of the facility's procedure for passing along grievances. New Jersey Administrative Code § 8:39-17.4(a)(2)	F 804		
F 914 SS=D	Bedrooms Assure Full Visual Privacy CFR(s): 483.90(e)(1)(iv)(v) §483.90(e)(1)(iv) Be designed or equipped to assure full visual privacy for each resident; §483.90(e)(1)(v) In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Complaint Intake NJ146081 Based on observations, document review, and interviews, it was determined that the facility failed to ensure a privacy curtain was free from damage and offered complete visual privacy. This affected 1 (Resident [redacted]) of 3 residents reviewed for environmental concerns. Findings included: 1. Resident [redacted] was admitted to the facility on [redacted] with diagnoses that included [redacted]	F 914	The privacy curtain in resident [redacted]s room was replaced with a new privacy curtain that wraps around the entire bed, providing complete privacy. All residents have the potential to be affected. Random audits will be completed in residents room to inspect and ensure privacy curtains all are in good condition and wrap completely around the bed to ensure resident privacy. Current staff will be educated on the process of reporting damaged privacy curtains via TELS (Equipment Lifecycle System). Director of Maintenance or Designee will	9/14/21

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F 914	Continued From page 19 [redacted]. The quarterly Minimum Data Set (MDS), dated [redacted], revealed a Brief Interview for Mental Status (BIMS) of [redacted] indicating no [redacted] impairment. Resident [redacted] was supervised for activities of daily living (ADLs). On 07/28/2021 at 4:30 PM, Resident [redacted] was interviewed at bedside. Resident [redacted] stated they moved to their current room on [redacted] Resident [redacted] stated the day the resident moved into the current room; the resident met with the Nursing Home Administrator (NHA). Resident #1 informed the NHA of several items in the room that needed repair, including the cubicle curtain. The resident pointed out the curtain had holes in the mesh part of the top of the curtain, and approximately three feet of curtain was not attached to the hooks. This part of the curtain was up against the back wall of the room. All eye holes in the curtain were being held up with the hooks that were available in the ceiling track. The curtain was not long enough to provide full privacy around the bed of Resident [redacted]. On 07/29/2021 at 12:47 PM, a new cubicle curtain was observed to be hanging up in the room for Resident [redacted]. Resident [redacted] stated someone had come in the previous night to change the curtain. The curtain had 25 eye holes and the ceiling rack only offered 23 hooks. The curtain was observed to be in good condition but was too short to wrap around the Resident's bed. Therefore, it would not provide adequate privacy. On 07/29/2021 at 2:38 PM, the Director of Maintenance (DM) was interviewed. The DM stated that he used The Equipment Lifecycle System (TELS) for tracking maintenance	F 914	perform weekly random audits x4 and then monthly x3 to inspect the privacy curtains for damage and ensure they wrap completely around the resident bed. Results of these audits will be presented and reviewed at monthly QAPI meetings.	

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F 914	Continued From page 20	F 914		

requests. He stated that all staff have access to TELS if a work ordered needed to be entered. The DM stated it was his goal to complete repairs within one to two days unless a part needed to be ordered. He stated he was not aware of any request to replace a cubicle curtain for Resident [redacted] The DM observed the cubicle curtain that was too short to provide complete privacy. He stated, "this curtain is not long enough to wrap around this bed. It needs to be long enough to go all the way around the bed."

On 07/29/2021 at 3:43 PM, the Nursing Home Administrator (NHA) was interviewed. The NHA stated he recalled meeting with Resident [redacted] the day the resident changed rooms. He acknowledged the concerns raised by Resident [redacted], including the damaged cubicle curtain, and stated he sent a text message to the DM. The NHA stated that he felt a text from the NHA would hold more weight than entering the work order in TELS.

On 07/30/2021 at 11:10 AM, the Housekeeping Supervisor (HS) was interviewed. The HS stated there was supposed to be a deep cleaning done on every room, every month, but he could not confirm the last time the cubicle curtain in Resident [redacted]'s room was inspected for damage and taken down to be laundered.

A review of the work orders entered into TELS during the month of [redacted] was reviewed. There were no work orders in TELS for any repairs to Resident [redacted]s room.

New Jersey Administrative Code § 8:39-31.8(c)5

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	060415	A. BUILDING: _____ B. WING _____	C 07/30/2021

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

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S1570	8:39-21.1(k) Mandatory Laundry Services (k) The facility shall have a system to identify each resident's clothing and a procedure to locate and/or minimize loss of clothing. This REQUIREMENT is not met as evidenced by: Complaint Intake NJ145796 Based on record review, interviews, and facility policy review, it was determined that the facility failed to ensure resident's clothing was inventoried and labeled. This affected 1 (Resident [redacted]) of 3 residents reviewed for misappropriation of personal property. Findings included: 1. Resident [redacted] was admitted to the facility on [redacted] with diagnoses that included [redacted] The quarterly Minimum Data Set (MDS) dated [redacted] indicated the resident had a Brief Interview for Mental Status (BIMS) of [redacted], indicating severe cognitive impairment. Resident [redacted] was independent with ambulation and bed mobility. Due to [redacted], Resident [redacted] was completely dependent for bathing and grooming. Resident #4 had a behavior care plan, dated [redacted], that indicated Resident [redacted] takes personal clothes and belongings and places them in other residents' rooms. The intervention was to monitor the resident closely during acute episodes of behavior to keep the resident and others safe. Due to the resident's [redacted], Resident [redacted] was	S1570	Resident [redacted] s clothing has been properly labeled. All residents have the potential to be affected. Random audits will be done to ensure residents clothing are properly labeled. Laundry and front desk will be properly educated on the procedure for labeling clothing upon admission. Director of Housekeeping/Laundry or Designee will perform weekly random audits x 4, then monthly thereafter x3 to ensure proper labeling. Results of these audits will be presented and reviewed at monthly QAPI meetings.	9/14/21

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

Electronically Signed | 08/20/21

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S1570	Continued From page 1 unable to be interviewed. On 07/29/2021 at 11:06 AM, Resident [redacted] responsible party (RP) was interviewed via telephone. The RP stated that when Resident [redacted] was moved into the facility, personal belongings were not labeled. The RP stated prior to the lock down due to COVID 19, the RP would visit Resident [redacted] daily. The RP would look for Resident [redacted]'s clothing and other personal belongs and return them to their proper place. The RP stated when the facility opened back up to in-person visits, it was first observed that Resident [redacted] was not wearing clothing that belonged to the resident. The RP spoke with a representative from the laundry department, and a few of Resident [redacted]'s items were located. The RP stated that Resident [redacted] would take personal belongings to other resident rooms and try to give belongings away. The RP felt that if the facility had properly labeled Resident [redacted]'s belongings upon admission, the problem could have been avoided. On 07/29/2021 at 3:02 PM, the Social Worker (SW) was interviewed. The SW stated that when a report of missing clothing or belongings was received, she sent out an email to all the department heads. There was also follow-up in the morning stand up meeting. When there was missing clothing, the SW would follow up with the housekeeping/laundry supervisor to get the status of the missing clothing. The SW stated if clothing could not be found, the family/resident would be reimbursed. Regarding Resident [redacted], the SW stated the resident liked to hang up clothing in the hallway as if it was being hung out to dry on a clothesline. The SW continued to reveal Resident [redacted] also liked to give belongings to other residents. The SW stated that during COVID-19 when the facility was not allowed to have visitors,	S1570		

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S1570	Continued From page 2 it was the facility's responsibility to safeguard Resident [redacted]'s belongings, and they "did not do a good job". The SW stated the facility had implemented a quality assurance plan to prevent this incident in the future and to develop a better system for labeling clothing and belongings. On 07/29/2021 at 3:43 PM, the Nursing Home Administrator (NHA) was interviewed. The NHA stated the facility staff did their best to locate Resident [redacted]'s belongings. The NHA stated it was difficult since Resident [redacted] liked to give personal items away to other residents. The floor where Resident [redacted] resided was dedicated to all residents with [redacted] On 07/30/2021 at 11:10 AM, the housekeeping supervisor (HS) was interviewed. The HS stated he had recently returned to the facility and was still trying to catch up. He did not now about the missing clothing for Resident [redacted]. The facility policy, titled Personal Property, originally dated 2001 and revised 09/2012 and 03/2021, indicated in part, 4. A representative of the admitting office will advise the resident, prior to or upon admission, as to the types and amount of personal clothing and possessions that the resident may keep in his or her room. 5. The resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished.	S1570		