PRINTED: 06/09/2022 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		315225	B. WING			C 07/30/2021	
NAME OF PI	ROVIDER OR SUPPLIER	0.0220		STREET ADDRESS, CITY, STATE, ZIP CO	I ODE	07/30/2021	_
RIVERFRO	ONT REHABILITATION A	ND HEALTHCARE CENTER		5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIA		1
F 000	INITIAL COMMENTS	3	F 0	000			
	Complaint #: NJ145 NJ146081, NJ14502 Census: 158 Sample Size: 7	796, NJ142317, NJ145807, 1					
5.504	Long Term Care Factoring Complaint Survey.	FR Part 483, Subpart B, for lilities based on this				0144494	
	Safe/Clean/Comforta CFR(s): 483.10(i)(1)-	ble/Homelike Environment (7)	F 5	84		9/14/21	
	§483.10(i) Safe Envir The resident has a ri- comfortable and hom but not limited to rece supports for daily living	ght to a safe, clean, nelike environment, including eiving treatment and					
	homelike environmer use his or her persor possible. (i) This includes ensureceive care and service.	clean, comfortable, and nt, allowing the resident to nal belongings to the extent uring that the resident can vices safely and that the efacility maximizes resident					
	independence and do	poes not pose a safety risk. exercise reasonable care for resident's property from loss					
	, , , ,	keeping and maintenance o maintain a sanitary, orderly, rior;					
	§483.10(i)(3) Clean be in good condition;	ped and bath linens that are					
LABORATORY	 DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	 RE	TITLE		(X6) DATE	_

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.

Electronically Signed

08/20/2021

	F CORRECTION	IDENTIFICATION NUMBER:		E CONSTRUCTION	COMPLETED
		315225	B. WING		C 07/30/2021
	ROVIDER OR SUPPLIER ONT REHABILITATION	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109	·
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F 584	resident room, as sp §483.10(i)(5) Adequal levels in all areas; §483.10(i)(6) Comformation levels. Facilities initian 1990 must maintain 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Complaint Intake N Based on observation document review, and determined that the lights were working side of the floor resident rooms (Room for the following included: 1. Resident was with diagram with diagram for the following included: 1. Resident for some for the following included: 2. Resident for some for the following included: 3. Resident for some for the following included: 4. Resident for some for the following included: 5. Status (BIMS) of for some for the following included: 4. Resident for some for the following included: 5. Status (BIMS) of for some for the following included: 5. Status (BIMS) of for some for the following included: 5. Status (BIMS) of for some for the following included: 6. Status (BIMS) of for some for the following included: 6. Status (BIMS) of for some for the following included: 7. Resident for the following included: 8. Status (BIMS) of for some for the following included: 8. Status (BIMS) of for some for the following included: 8. Status (BIMS) of for some for the following included: 8. Status (BIMS) of for some for the following included: 8. Status (BIMS) of for some for the following included: 8. Status (BIMS) of for some for the following included: 9. Status (BIMS) of for some for the following included: 9. Status (BIMS) of for some for the following included: 9. Status (BIMS) of for some for the following in	e closet space in each pecified in §483.90 (e)(2)(iv); attemption and comfortable lighting ortable and safe temperature ally certified after October 1, a temperature range of 71 to e maintenance of comfortable of the image of	F 584	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submis of this Plan of Correction is not an admission that a deficiency exists of one was cited correctly. This Plan of Correction is submitted meet requirements established by sand federal law. The lights in rooms 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 TELS (Equipment Lifecycle System Maintenance staff was educated in importance of ensuring all lights are proper working order. Director of Maintenance or Designe perform weekly random audits x 4, to	the sion r that to tate via b. the in e will

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F 584	interviewed at bedsi resident was moved on Resident moved resident moved resident met with the (NHA). Resident #1 items in the room the ceiling light that asked the surveyor lights did not turn or On 07/29/2021 at 2: Maintenance (DM) stated that he used System (TELS) for trequests. He stated TELS if a work orde The DM stated it was within one to two dabe ordered. He state request to look at a Resident The DM stated it was out and assuming recent facility remove the hallway. On 07/29/2021 at 3: Administrator (NHA) stated he recalled in day the resident chall acknowledged the cestated he sent a tex NHA stated that he hold more weight th TELS. Upon further investion of the sident investion of the servation of the sident investion.	de. Resident stated the to the current resident room ident stated that the day into the current room, the e Nursing Home Administrator informed the NHA of several at needed repair, including did not work. The resident to test the lights, and the n. 38 PM, the Director of was interviewed. The DM The Equipment Lifecycle racking maintenance that all staff have access to red needed to be entered. It is his goal to complete repairs ys, unless a part needed to ed he was not aware of any ceiling light that was out for M observed the ceiling light ed it was in relationship to deling that was happening in the was interviewed. The NHA neeting with Resident the interviewed was interviewed. The NHA neeting with Resident the inglight not working, and the message to the DM. The felt a text from the NHA would en entering the work order in	F 58-	monthly thereafter for 3 months to lights are in good functioning order. Results of these audits will be presund reviewed at monthly QAPI medical services.	ented

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NAME OF P	ROVIDER OR SUPPLIER	7.722	Ī	STREET ADDRESS, CITY, STATE, ZIP COL	I	07/30/2021
RIVERFR	ONT REHABILITATION A	ND HEALTHCARE CENTER		5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109		
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F 584	residents who lived in interviewed and conf for months. The DM sthe lights being out. A review of the work during the month of were no work orders ceiling lights. New Jersey Administ	with the hallway. The room froms The two alert and oriented in Room were briefly remed the lights had been out stated he was not aware of orders entered into TELS was reviewed. There in TELS for any repairs to	F5			0/44/04
F 600 SS=D	Exploitation The resident has the neglect, misappropria and exploitation as d includes but is not lin corporal punishment, any physical or chem treat the resident's m §483.12(a) The facilit §483.12(a)(1) Not us physical abuse, corporativoluntary seclusion This REQUIREMENT by: Complaint Intake NJ Based on record revireview, and facility podetermined that the firm	m Abuse, Neglect, and right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. by must- e verbal, mental, sexual, or oral punishment, or is not met as evidenced 145021 ew, interviews, document	F6	Residen was immediatel and found to have no physica s/s of distress or discomfort r Resident does not recall incic plan was updated with new in services provided	al injury, no noted. dent. Care nterventions,	9/14/21

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED
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		315225	B. WING		0	7/30/2021
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F 600	was experiencing be hitting and the end of were tied together. of 3 residents review Findings included: 1. Resident was with diagram was assistance activities of daily livicare plan, dated what indicate that indicate of the New Jersey D (NJDOH) on 04/16/2 On was assistance of physical review of a Facility to the New Jersey D (NJDOH) on 04/16/2 On was assistance of physical reversion of the event, the for use of physical reversion of the event, the for use of physical reversion of the event, the resident was assistance of physical reversion of the event, the for use of physical reversion of the event, the for use of physical reversion of the event, the for use of physical reversion. Approon The resident was as The care plan was rimmediate intervent investigation, the for allegation of abuse, statements from state contractors that with	ehaviors including kicking and of the resident's This affected 1 (Resident veed for abuse. admitted to the facility on gnoses that included veed a Brief Interview for Mental e of the facility on gnoses that included veed a Brief Interview for Mental e of the facility on gnoses that included veed a Brief Interview for Mental e of the facility on gnoses that included veed a Brief Interview for Mental e of the facility on gnoses that included veed a Brief Interview for Mental e of the facility on gnoses that included veed and revised on icated Resident that a gnose of the facility of the facility of the facility extraints were self-releasing ed to safety. The facility eation, identified staff, and ded the staff pending the priate parties were notified. It is sessed for pain and injury. Eviewed and updated with	F 60	All current residents with behaviors will be review appropriate interventions and had care plans updated accordingly DON/designee will re-educated staff from all departments on all prevention and managing resident challenging behaviors. DON/Designee will complete we random audits x4 and monthly current residents with behaviors to ensure no abuse to occurred and appropriate intervare in place and on the care plan Results of these audits will be pand reviewed at monthly QAPI.	ave their // current buse dents with reekly x3 of mas rentions an.	

	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ATE SURVEY OMPLETED
		315225	B. WING _		، ا	C 07/30/2021
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109		3770072021
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F 600	removed the housel facility for failing to r On 04/16/2021, the occurrence that hap facility reported the were tied together. for pain and/or bruis recall the event. The employees pending A review of the facility revealed four employees pending A review of the facility revealed four employees be failure to report written report, four eabout the sleeves be resident was hawith episodes of kick Licensed Practical Nesident was be due to select was unable to Resident #3's suspected perpetrat #4 observed the tied failed to report. On 07/30/2021 at 1's supervisor (HS) was he was out of the failure details of the occurrence was resident select was after the desident select was after the desident select was after the control of the failure the details of the occurrence was resident select was after the control of the failure the details of the occurrence was resident select was after the control of the failure the details of the occurrence was resident select was after the control of the failure the details of the occurrence was resident select was after the control of the failure the details of the occurrence was resident select was after the control of the failure the details of the occurrence was resident select was resident select the control of the failure the details of the occurrence was resident select the control of the failure the details of the occurrence was resident select the control of the failure the details of the occurrence was resident select the control of the failure the details of the occurrence was resident select the control of the failure the details of the occurrence was resident select the control of the failure the details of the occurrence was resident select the control of the failure the details of the occurrence was resident select the control of the failure the details of the occurrence was resident select the control of the failure the contr	facility reported an pened on The of Resident s The resident was assessed sing. The resident did not e facility suspended four investigation. Ity's report, dated yees were suspended due to the incident. According to the employees stated knowing eing tied, but did not report it. ving a particularly bad day king and hitting staff. Nurse (LPN) #2 indicated ing kept in the nurses' station and year evidenced by the did not report it. ving a particularly bad day king and hitting staff. Nurse (LPN) #2 indicated ing kept in the nurses' station and year evidenced by the did not report it. ving a particularly bad day king and hitting staff. Nurse (LPN) #2 indicated ing kept in the nurses' station and year evidenced by the determine who tied year terminated. The of determine who tied year to however LPN #2 was the or. HK #3, HK #7, and TNA on Resident and and turned. He was not aware of	F6			

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED				
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NAME OF PROVIDER O		AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109	CODE	1 07730/2021	
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On 07/3 called for voice m On 07/3 an intersurveyor employed needed On 07/3 Aide (TI LPN #2 she return Resider did not TNA #4 she put went or group. So report the conce in immedia employed occurred interview training prior to her employed assurant and the conce in	on/2021 at 2:4 or an interview ail message. on/2021 at 3:4 view. LPN #2 or stating that the eof the facility should be obtained. TNA #4 was in asked her to gradmitted to red to complete the stated should be observation. on/2021 at 5:0 trator (NHA) he facility inition of the ately suspended and those hees he	an be both and and are with a surveyor left a and and and and and and and and and a	F	500			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (A. BUILDING (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (DATE SURVEY COMPLETED		
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	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109)E	01/00/2021
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housekeepers, LPN: through abuse training mandatory reporter to annually. The facility policy on dated 2001 and revision part, 4. Require staff that includes such to identification and reposition and	#2, and TNA #4 had gone ng that included being a upon orientation and abuse prevention program, sed December 2016, read, in training/orientation program pics as abuse prevention, porting of abuse, stress andling orientative Code § 4.1 (a)(5)				0/4 4/04
CFR(s): 483.10(e)(1) §483.10(e) Respect of the resident has a riand dignity, including §483.10(e)(1) The rigphysical or chemical purposes of disciplinarequired to treat the consistent with §483.12 The resident has the neglect, misapproprisand exploitation as dincludes but is not lincorporal punishment any physical or chemical the resident's misappropriation of the resident	and Dignity. ght to be treated with respect g: ght to be free from any restraints imposed for e or convenience, and not resident's medical symptoms, .12(a)(2). right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from , involuntary seclusion and nical restraint not required to nedical symptoms. ty must- e that the resident is free	F 6	04		9/14/21
	CORRECTION ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page housekeepers, LPN standard through abuse training mandatory reporter use annually. The facility policy on dated 2001 and revise part, 4. Require staff that includes such to identification and repermanagement, and has lead to be the form of the facility policy on dated 2001 and revise part, 4. Require staff that includes such to identification and repermanagement, and has lead to be free from CFR(s): 483.10(e)(1) Separation of the facility of	CONTREHABILITATION AND HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 behavior. 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).	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 behavior. 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	ROUIDER OR SUPPLIER ONT REHABILITATION AND HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 that includes such topics as abuse prevention, identification and reporting of abuse, stress management, and handling behavior. 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F 604	purposes of disciplir are not required to to symptoms. When the indicated, the facility alternative for the led document ongoing restraints. This REQUIREMENT by: Complaint Intake N Based on record reverview, and facility purposed that the resident free from the Resident was extincluding kicking and resident's affected 1 (Resident for the use of physical for the use of the u	ne or convenience and that reat the resident's medical e use of restraints is must use the least restrictive ast amount of time and re-evaluation of the need for IT is not met as evidenced J145021 view, interviews, document policy review, it was facility failed to keep a lease of a physical restraint. It is periencing behaviors do hitting and the end of the least restraints. admitted to the facility on gnoses that included lead a Brief Interview for Mental er of least restraint in modificating leading indicating leading and the end of the least restraints.	F 604	Resident was immediately assess no injury noted, no s/s of distress or discomfort noted. Care plan was up with new interventions. services provided; resident does not incident. Random audits of current residents behaviors, includicted behaviors, includicted behaviors, includicted behaviors, includicted behaviors, includicted behaviors are not being used DON/designee will re-educate currestaff on restraint policy and managing residents with challenging behaviors DON/Designee will complete weekly random audits x4 and monthly x3 of current residents with ensure restraints are not in use. Results of these audits will be presedent reviewed at monthly QAPI meet for improvement.	dated recall with ding o . nt g

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		MPLETED
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	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109		7770072021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 604	On staff that the resident's Prior to the event, the for use of physical related initiated an investigation. Appropring The resident was as The care plan was reimmediate intervention investigation, the fact allegation of abuse. Statements from staff contractors that with tied together. The faremoved the housek facility for failing to recommend the was tied together. The facility reported the was tied together. The facility pending investigation. A review of the facility revealed four employ the failure to report to written report, four eabout the seident was have with episodes of kick Licensed Practical Nesident was being due to kicking, slapping, and (HK) #3 and #7, a Technology and the seident was being due to kicking, slapping, and (HK) #3 and #7, a Technology and the seident was being due to kicking, slapping, and (HK) #3 and #7, a Technology and the seident was being due to kicking, slapping, and (HK) #3 and #7, a Technology and the seident was being due to kicking, slapping, and (HK) #3 and #7, a Technology and the seident was being due to kicking, slapping, and (HK) #3 and #7, a Technology and the seident was being due to kicking, slapping, and (HK) #3 and #7, a Technology and the seident was being due to kicking, slapping, and (HK) #3 and #7, a Technology and the seident was being due to kicking, slapping, and (HK) #3 and #7, a Technology and the seident was being due to kicking, slapping, and (HK) #3 and #7, a Technology and the seident was being due to kicking, slapping, and (HK) #3 and #7, a Technology and the seident was being due to kicking, slapping, and (HK) #3 and #7, a Technology and the seident was being due to kicking, slapping, and (HK) #3 and #7, a Technology and the seident was being due to kicking, slapping, and the seident was being due to kicking, slapping, and the seident was being due to kicking, slapping, and the seident was being due to kicking, slap	were tied together. e care plan and interventions estraints were ed to safety. The facility tion, identified staff, and ded the staff pending the oriate parties were notified. sessed for pain and injury. eviewed and updated with on. Based on the cility substantiated the The facility obtained if and housekeeping essed the resident's cility terminated staff and deeping contractors from the eport. facility reported an one resident was assessed for The resident did not recall y suspended four employees in. ty's report, dated weeping tied, but did not report it. ving a particularly bad day	F6	504		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY MPLETED
		315225	B. WING		0.	C 7/30/2021
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 604	facility was unable to Resident 's suspected perpetrate #4 observed the tied failed to report. On 07/30/2021 at 11 supervisor (HS) was he was out of the fact had only recently refet the details of the occurrence of the details of the occurrence Resident after the did not recall the occurrence was an interview. LPN #2 surveyor stating that employee of the faci needed should be of On 07/30/2021 at 2: called for an interview. LPN #2 surveyor stating that employee of the faci needed should be of On 07/30/2021 at 4: Aide (TNA) #4 was in LPN #2 asked her to she returned, TNA #4 Resident were tied in ot see anyone provided the returned was anyone provided to she put down the retwent on to complete went on to complete	however LPN #2 was the brown HK #3, HK #7, and TNA on Resident and and arrended. The HS stated collity during the incident and urned. He was not aware of currence. 15 PM, the Social Worker and the resident currence and the resident currence at all. The SW and be both and and arrended was never returned. 47 PM, Housekeeper #3 was w, and this surveyor left a The call was never returned. 46 PM, LPN #2 was called for a sent a text message to this she was no longer an ality and any information obtained from the facility. 50 PM, Temporary Nurse interviewed. TNA #4 stated a get some supplies and when a 4 observed the sent telling anyone. She stated she obtysically tie the sent telling anyone. She stated quested supplies and quickly the rounds of her resident ne knew it was wrong not to	F 61	04		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	C	X3) DATE SURVEY COMPLETED
		315225	B. WING _			C 07/30/2021
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109	<u>l</u>	01/30/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 604	Administrator (NHA) stated the facility initionce informed of the immediately suspendemployees and those occurrence. Both eminterviewed. Addition training was initiated prior to when the new her employment. The became part of the facility policy on dated 2001 and revisionart, 4. Require staff that includes such to identification and rep	200 PM, the Nursing Home was interviewed. The NHA stated all the proper measures occurrence. He stated they ded the suspected who did not report the uployees and residents were all abuse and reporting. The incident happened just w Director of Nursing began with NHA stated the occurrence	F	504		
F 607 SS=E	Develop/Implement A CFR(s): 483.12(b)(1) \$483.12(b) The facili implement written po \$483.12(b)(1) Prohib neglect, and exploita misappropriation of r \$483.12(b)(2) Establ to investigate any su \$483.12(b)(3) Include paragraph \$483.95,	trative Code § 8:39-4.1(a)(6) Abuse/Neglect Policies 0-(3) ty must develop and dicies and procedures that: bit and prevent abuse, tion of residents and esident property, ish policies and procedures	F	507		9/14/21

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING _	COMPLETED	
		315225	B. WING		C 07/30/2021
	ROVIDER OR SUPPLIER ONT REHABILITATION	AND HEALTHCARE CENTER	5	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 607	by: Complaint Intake N Based on record revinterviews, and facil determined that the report an allegation members (Two house Temporary Nursing Licensed Practical Nends of Resident together and failed affected 1 (Residen for abuse reporting. Findings included: 1. Resident was with dia The annual Minimum with dia The annual Minimum with dia Status (BIMS) score severe cognitive implexensive assistance activities of daily livicare plan, dated method to the New Jersey E (NJDOH) on 04/16/20 On method to the New Jersey E (NJDOH) on 04/16/20 On method to the Prior to the event, the for use of physical related to severe together the resident's prior to the event, the related to severe together the related to severe together the related to severe together the resident's prior to the event, the related to severe together the related to severe the re	view, document review, ity policy review, it was facility staff failed to timely of physical abuse. Four staff sekeepers (HK) #3 and #7, a Assistant (TNA) #4, and Nurse #2) observed that the had been tied to report the observation. This to report the observation. This to report the observation of 3 residents reviewed admitted to the facility on gnoses that included indicating pairment. Resident indicating pairment. Resident indicating pairment. Resident indicating pairment of pairment indicating pairment indicating pairment indicating pairment. Resident indicating pairment indicating pairment indicating pairment indicating pairment of pairment indicating pairment of pairment indicating pairment of Public Health 2021, revealed the following: if reported to administration were tied together. The care plan and interventions	F 607	Staff members (two housekeepers) #7, a Temporary Nursing Assistant (TNA)#4, and a Licensed Practical Nurse#2 were immediately suspend pending investigation and subseque employment was terminated. Resid was assessed, no injuries noted, no apparent distress or s/s of pain obsequence pending investigation and subsequence pending investigation and subsequence pending investigation and subsequence pending investigation apparent distress or s/s of pain obsequence pending distress or s/s of pain obsequence pending distress or s/s of pain obsequence pending pe	ded ently ent ent erved, eare e if any mely. ent e nts. ents. y f

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315225 B. WING				30/2021		
	ROVIDER OR SUPPLIER DNT REHABILITATION A	ND HEALTHCARE CENTER		5101 NORTH	DRESS, CITY, STATE, ZIP CODE H PARK DRIVE KEN, NJ 08109	1 011	50/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 607	suspended the staff p Appropriate parties w was assessed for pai was reviewed and up intervention. Based of facility substantiated of facility obtained state housekeeping contra- resident's tied terminated staff and r contractors from the f On 04/16/2021, the facility reported the sl was tied together. The pain and/or bruising. the event. The facility pending investigation A review of the facility revealed four employ the failure to report the written report, four en about the seident was have with episodes of kicki Licensed Practical Nu Resident was bein due to kicking, slapping, and (HK) #3 and #7, a Tel (TNA) #4, and Licens terminated. The facility who tied Resident	rending the investigation. rere notified. The Resident in and injury, The care plant dated with immediate on the investigation, the the allegation of abuse. The ments from staff and ctors that witnessed the did together. The facility emoved the housekeeping facility for failing to report. The resident was assessed for The resident did not recall suspended four employees The resident did not report it. Ing a particularly bad day ing and hitting staff. The resident was assessed for The resident was assessed for The resident did not report it. Ing a particularly bad day ing and hitting staff. The resident was assessed for The resident did not report it. Ing a particularly bad day ing and hitting staff. The resident was assessed for The resident did not report it. Ing a particularly bad day ing and hitting staff. The resident was assessed for The resident did not report it. Ing a particularly bad day ing and hitting staff. The resident was assessed for The active was assessed for The resident was assessed f	F	607				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	315225 B. WING				3 0/2021		
	ROVIDER OR SUPPLIER ONT REHABILITATION A	ND HEALTHCARE CENTER		51	REET ADDRESS, CITY, STATE, ZIP CODE 01 NORTH PARK DRIVE ENNSAUKEN, NJ 08109	, 0.,	00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	On 07/30/2021 at 2:4 called for an interview voice mail message. On 07/30/2021 at 3:4 an interview. LPN #2 surveyor stating that employee of the facilineeded should be obout on 07/30/2021 at 4:0 Aide (TNA) #4 was in LPN #2 asked her to she returned, TNA #4 Resident were tied did not see anyone plant and the put down the requent on to complete the group. She stated she report the observation on 07/30/2021 at 5:0 Administrator (NHA) stated the facility initial once informed of the immediately suspend employees and those occurrence. Both empinterviewed. Additional training was initiated. prior to when the new her employment. The became part of the facility and the facility initial and prior to when the new her employment. The became part of the facility indication files	7 PM, Housekeeper #3 was and this surveyor left a The call was never returned. 6 PM, LPN #2 was called for sent a text message to this she was no longer and ty and any information tained from the facility. 0 PM, Temporary Nurse terviewed. TNA #4 stated get some supplies and when to observed the factorial of the diagram of the diagra	F	607			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315225	B. WING _		C 07/30/2021	
	VIDER OR SUPPLIER	ND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109	, 07.	33/2321
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
ar at ree m The date path id mage ree as N. SS=E C. \$4 cc. \$4 cc. \$4 cc. \$4 cc. \$5 cc. \$6 cc.	buse, witnessed or seported immediately nanagement. he facility policy on a lated 2001 and revise art, 4. Require staff in at includes such top lentification and reportangement, and ha ggressive resident be port any allegations is required by federal lew Jersey Administrative Value/Appear (FR(s): 483.60(d)(1)(483.60(d))(1)(483.60(d))(1)(1)(483.60(d))(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1	con stated any allegation of suspected, should be to a supervisor or abuse prevention program, ed December 2016, read, in training/orientation program pics as abuse prevention, orting of abuse, stress indling verbally or physically ehavior. 7. Investigate and sof abuse within timeframes I requirements. Trative Code § 8:39-5.1(a) ar, Palatable/Prefer Temp (2) drink as and the facility provides-repared by methods that ue, flavor, and appearance; and drink that is palatable, and appetizing is not met as evidenced 146081 This, interviews, and document ined that the facility failed to ged at palatable fected 3 (Resident 7, ident 7) of 7 residents	F 6		are needs	9/14/21

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		315225	B. WING _			l	C 30/2021	
	ROVIDER OR SUPPLIER ONT REHABILITATION A	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109		1 07/30/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 804	Findings included: 1. On 07/29/2021 at temperature logs for reviewed. The food to indicated that food w temperatures on the Based on complaints at cold temperatures and Resident and Resident revealed the following: On 07/29/2021 at 11: checked the temperatures were a Beef and peppers - Rice - 152 F - Peas - 204 F - Pureed turkey - 192 - Mashed potatoes - Pureed peas - 188 - Gravy - 175 F - Ground turkey - 185 - Egg noodles - 199 I A test tray was requestray was the first to be delivery cart. The meditchen at 12:17 PM. the 1st floor unit at 12 nursing assistants (Croom trays. The CNA Food Service Directors)	10:45 AM, the food the month of July 2021 were emperature logbook as within appropriate steam table prior to serving. If of room trays being served from Resident test trays to the floor g: If of service trays trays the floor g: If of service trays trays trays trays trays the food on the tray meal was served. The service floor floo	F	304	appropriate temperatures for palatabilit Director of Dietary or Designee will perform weekly random audits x 4, the monthly thereafter for 3 months to ensit food temperatures are being met for palatability. Results of these audits will be presente and reviewed at monthly QAPI meeting.	n ure		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		315225	B. WING		0	C 7/30/2021		
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	5	TREET ADDRESS, CITY, STATE, ZIP CODE 101 NORTH PARK DRIVE ENNSAUKEN, NJ 08109	1 -			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 804	At 12:35 PM, the AF serve the cold food bhot food should be she stated the plates bases are warmed a being concerned at how fast the temperature observation of the dosignificant crack that integrity of the system stated a need to got see if others had cracompromised. A review of the Februminutes indicated 25 distributed with 24 be returned surveys indicated surveys indicated with 22 rewas not indicated, but food was served at lettemperatures. The April 2021 Residerevealed an in-persodietary concerns well the minutes indicated meeting was going to from that meeting collisters was not note Resident Council meeting was not note Resid	SD stated the policy was to below 45 degrees F and the erved above 135 degrees F. are on a warmer and the s well. The AFSD stated now low the temperatures is were not immediately trays. He was surprised by atures dropped. An ome cover revealed a could compromise the mit to hold in heat. The AFSD chrough all the dome lids to cks or were somehow Lary 2021 Resident Council is resident surveys were ening returned. Eleven of the icated less then optimal food in the 2021 Resident Council is resident surveys were entertured. A specific number seturned. A specific number seturned. A specific number seturned. A specific number seturned was held. When the brought up at that meeting, do a separate food service of the conducted. No minutes and be located. In the May and June 2021	F 804					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		315225	B. WING			C 07/30/2021	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CC 5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109	DDE	07/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 914 SS=D	meeting minutes reversioned is always cold." The activities departinew Activities Director 07/29/2021 at approximate approximate approximate of the facility's grievances. New Jersey Administ (2) Bedrooms Assure Function (2) Bedrooms Assure Function (2) \$483.90(e)(1)(iv) Be assure full visual prival (2) \$483.90(e)(1)(iv) In function (31, 1992, exceed must have ceiling extend around the bearing in combination (2) Bedrooms Assure Function (3) September 10, 10, 10, 10, 10, 10, 10, 10, 10, 10,	ment had all new staff. The or (AD), interviewed on kimately 4:30 PM, was not a procedure for passing along strative Code § 8:39-17.4(a) All Visual Privacy (viv)(v) designed or equipped to racy for each resident; facilities initially certified after ept in private rooms, each g suspended curtains, which ed to provide total visual on with adjacent walls and an with adjacent walls and the remined that the facility wacy curtain was free from complete visual privacy. This		The privacy curtain in resid room was replaced with a nocurtain that wraps around the providing complete privacy, have the potential to be affer Random audits will be compresidents room to inspect an privacy curtains all are in go	ent s ew privacy he entire bed, All residents hoteted.	9/14/21	
	Findings included: 1. Resident was a	admitted to the facility on		and wrap completely around ensure resident privacy. Current staff will be educate process of reporting damag	ed on the		
		noses that included		curtains via TELS (Equipme System). Director of Maintenance or I	ent Lifecycle		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IPLE CONSTRUCTION NG	L COMPLE			
		315225	B. WING _			07/30/2021	
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109			07/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTION CROSS-REFERENCE CROSS-REFER	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE	
F 914	quarterly Minimum Direction revealed Status (BIMS) of impairment supervised for activity. On 07/28/2021 at 4:3 interviewed at bedsig moved to their current Resident stated the into the current room Nursing Home Adminiformed the NHA of that needed repair, in The resident pointed the mesh part of the approximately three attached to the hook was up against the bholes in the curtain whooks that were avaicurtain was not long privacy around the bound of the curtain was observed room for Resident someone had come change the curtain. In and the ceiling rack of curtain was observed was too short to wrantherefore, it would not	ata Set (MDS), dated a Brief Interview for Mental indicating no a Resident was ies of daily living (ADLs). BO PM, Resident was de. Resident stated they not room on the day the resident moved at the resident met with the instrator (NHA). Resident #1 several items in the room including the cubicle curtain. Out the curtain had holes in top of the curtain was not so. This part of the curtain ack wall of the room. All eye were being held up with the lable in the ceiling track. The enough to provide fulled of Resident stated in the previous night to the curtain had 25 eye holes only offered 23 hooks. The data be in good condition but to around the Resident's bed. Out provide adequate privacy. BO PM, Resident stated in the previous night to the curtain had 25 eye holes only offered 23 hooks. The data be in good condition but to around the Resident's bed. Out provide adequate privacy.	FS	completely around the Results of these aud	nspect the privacy and ensure they wra		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		315225	B. WING			C 07/30/2021		
	ROVIDER OR SUPPLIER	AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, Z 5101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109	ZIP CODE	07/30/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE CROSS-REFERENCED	NOF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE		
F 914	requests. He stated to TELS if a work order The DM stated it was within one to two day ordered. He stated he request to replace a The DM observed too short to provide of "this curtain is not lor this bed. It needs to way around the bed." On 07/29/2021 at 3:4 Administrator (NHA) stated he recalled meday the resident characknowledged the complete of the stated he sent a text NHA stated that he fellold more weight that TELS. On 07/30/2021 at 11 Supervisor (HS) was there was supposed on every room, every confirm the last time Resident was and taken down to be a review of the work during the month of were no work orders Resident so room.	that all staff have access to ed needed to be entered. It is shis goal to complete repairs or unless a part needed to be e was not aware of any cubicle curtain for Resident id the cubicle curtain that was complete privacy. He stated, and enough to wrap around it is be long enough to go all the ended rooms. He was interviewed. The NHA eeting with Resident aged cubicle curtain, and message to the DM. The elt a text from the NHA would an entering the work order in enterviewed. The HS stated to be a deep cleaning done or month, but he could not the cubicle curtain in was inspected for damage	F	914				

New Jersey Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		000445		B. WING		C 07/30/2021	
		060415				07/30/	2021
	ROVIDER OR SUPPLIER ONT REHABILITATION A	ND HEALTHCARE C	101 NORT	RESS, CITY, STA H PARK DRIV (EN, NJ 08109	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
\$1570	each resident's clothin and/or minimize loss of the second review. This REQUIREMENT by: Complaint Intake NJ1 Based on record review policy review, it was of failed to ensure reside inventoried and labeled inventoried and labeled of personal property. Findings included: 1. Resident was an with diagram with diagram with diagram with diagram with ambuse to the second with a minuse to the seco	ave a system to identify and and a procedure to loo of clothing. is not met as evidenced 45796 ew, interviews, and facility letermined that the facility ent's clothing was ed. This affected 1 (Residue of the facility of	dent in	\$1570	Resident s clothing has been proplabeled. All residents have the potentiable affected. Random audits will be done to ensure residents clothing are properly labeled. Laundry and front desk will be properleducated 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 ensure proper labeling. Results of these audits will be present and reviewed at monthly QAPI meeting.	perly all to	/14/21
	Due to the resident's	, Resident wa	as				

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

TITLE (X6) DATE

Electronically Signed STATE FORM 6899 If continuation sheet 1 of 3 Z75H11

08/20/21

PRINTED: 06/09/2022 FORM APPROVED

New Jersey Department of Health

STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		060415	B. WING		C 07/30/202 ′	1
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
DIVEDED.	ONT DELLA DIL ITATIONI A	5101 NOR	TH PARK DRIV	E		
RIVERFR	ONT REHABILITATION A	PENNSAU	KEN, NJ 0810	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COM	X5) PLETE ATE
S1570	was moved into the fawere not labeled. The down due to COVID Resident daily. The Resident s's clothing belongs and return the The RP stated when to in-person visits, it was not belonged to the resident representative from the few of Resident repr	of AM, Resident was interviewed via ated that when Resident acility, personal belongings a RP stated prior to the lock 19, the RP would visit and other personal em to their proper place. The facility opened back up was first observed that wearing clothing that ent. The RP spoke with a ne laundry department, and is items were located. The ent would take personal esident rooms and try to give a RP felt that if the facility Resident is belongings problem could have been 2 PM, the Social Worker 1. The SW stated that when othing or belongings was	S1570	DEFICIENCY)		
	reimbursed. Regardir stated the resident lik hallway as if it was be clothesline. The SW of also liked to give be residents. The SW states	ng Resident , the SW ed to hang up clothing in the eing hung out to dry on a continued to reveal Resident belongings to other ated that during COVID-19				

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New Jersey Department of Health

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE S101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S1570 Continued From page 2 S1570 STREET ADDRESS, CITY, STATE, ZIP CODE S101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109 C(COM CRACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S1570			
RIVERFRONT REHABILITATION AND HEALTHCARE C S101 NORTH PARK DRIVE PENNSAUKEN, NJ 08109)/2021		
RIVERFRONT REHABILITATION AND HEALTHCARE C PENNSAUKEN, NJ 08109 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S1570 Continued From page 2 S1570 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMDETED TO THE APPROPRIATE DEFICIENCY)			
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) S1570 Continued From page 2 PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S1570 S1570 PREFIX TAG S1570 S1570			
Government i i i i i i i i i i i i i i i i i i i	(X5) COMPLETE DATE		
If was the facility's responsibility to safeguard			
Resident 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 seed the section of the stated it was difficult since Resident like to give personal items away to other residents. The floor where Resident with section of the stated to all residents with continuous continuous did not now about the missing clothing for Resident still trying to catch up. He did not now about the missing clothing for Resident. 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.			