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 01/14/2021

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 #: NJ142174, NJ140792, NJ139779, NJ140462, NJ138263 Census: 163 Sample Size: 9 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 573 SS=B	Right to Access/Purchase Copies of Records CFR(s): 483.10(g)(2)(i)(ii)(3) §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media;	F 573		3/1/21

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

Electronically Signed | 02/04/2021

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 01/14/2021

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 573	Continued From page 1 and (C)Postage, when the individual has requested the copy be mailed. §483.10(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law. This REQUIREMENT is not met as evidenced by: Complaint #: NJ140462 Based on record review, interviews, facility policy review, and Centers for Medicare and Medicaid Services (CMS) publication it was determined the facility failed to provide a copy of the resident's medical record within 10 working days for 2 of 3 residents (Residents [redacted] and [redacted]) reviewed medical records requests. Findings included: Reference: CMS publication, "COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers," dated 12/01/2020, retroactive as of 03/01/2020, indicated: Clinical Records. Pursuant to section 1135(b)(5) of the Act, CMS is modifying the requirement at 42 CFR §483.10(g)(2)(ii) which requires long-term care (LTC) facilities to provide a resident a copy of their records within two working days (when requested by the resident). Specifically, CMS is modifying the timeframe requirements to allow	F 573	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. F573-B What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice Resident [redacted] and [redacted] have received their requested medical records How you will identify other residents having the potential to be affected by the	

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 01/14/2021

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 573	Continued From page 2 LTC facilities ten working days to provide a resident's record rather than two working days. 1. Resident [redacted] was admitted on [redacted] with diagnoses to include [redacted] A review of the annual Minimum Data Set (MDS) dated [redacted] revealed Resident [redacted] had a Brief Interview of Mental Status score of [redacted], which indicated [redacted] cognition. A review of a Medical Record Request for Resident [redacted] indicated records requested were for physician notes, meeting notes of [redacted] (after the meeting), fall, assessment notes from the fall and after the fall. The request was signed by an illegible signature, with a date that appeared as [redacted] On 01/11/2021 at 3:07 PM, an interview was conducted with Resident [redacted]'s Responsible Party (RP). The RP stated he/she had requested Resident [redacted]s medical records in [redacted] and had not received them as of this date. The RP stated Resident [redacted] was discharged from the facility [redacted] and the RP was told the paperwork would be ready at that time also, but it was still not given to him/her. On 01/11/2021 at 5:07 PM, an interview was conducted with the Medical Record Coordinator (MRC). The MRC stated according to her emails, Resident [redacted]s RP requested the medical records on [redacted]. The MRC sent the medical records request to the legal department for approval on [redacted] and received approval on [redacted]. The MRC stated she was unable to	F 573	same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the deficient practice. Facility audited request for medical records to ensure requested were received. No further deficient practice noted. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. Medical Records Coordinator was educated on the facility's policy "Third Party Disclosures of Protected Health Information" related to receiving request for medical records and the time allotted to send medical records. Facility has implemented a new medical records log to track request for medical records. The Medical Records Coordinator was educated on the use of the new facility log. How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The NHA will audit the medical records log weekly x 4, then monthly x3 to ensure compliance. Results of the audits will be presented in monthly QAPI meeting to ensure compliance and reassessed for further	

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 01/14/2021

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 573	Continued From page 3 find verification that the medical records had been sent to the RP. The MRC indicated she did not retain receipts from the mail carrier, and she had not kept a log of requested medical records. On 01/12/2021 at 4:35 PM, an interview was conducted with the Social Worker (SW). The SW stated a conference was conducted on [redacted] with Resident [redacted] the RP, the Administrator, and Director of Nursing present. The SW stated at the end of the meeting, she filled out a medical record request for the RP and had Resident [redacted] sign the request. On 01/13/2021 at 9:37 AM, an interview was conducted with the Administrator who stated he would have kept a record or log of requested records and expected the MRC to have kept a log. The Administrator stated going forward, they were redoing the process for medical record requests to be in keeping with the guidelines. 2. Resident [redacted] was admitted to the facility on [redacted] with diagnoses to includ [redacted]. The resident expired on [redacted]. On 01/13/2021 at 12:03 PM, an interview was conducted with the MRC who stated according to her emails, she received a medical record request for Resident [redacted] s records on [redacted] The records were sent for legal approval on [redacted] and they were approved on [redacted]. The MRC stated that due to the large file, more time was needed. The MRC stated she sent the file again to legal and it was approved on [redacted] and the file was due to go out this afternoon, but the MRC wanted her Administrator to approve the file first. The MRC stated she was	F 573	action.	

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 01/14/2021

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 573	Continued From page 4 unaware there was a time frame for records to be sent out, but she was going to keep a log going forward. On 01/13/2021 at 9:37 AM, an interview was conducted with the Administrator who stated he would have kept a record or log of requested records and expected the MRC to have kept a log. The Administrator stated going forward, they were redoing the process for medical record requests to be in keeping with the guidelines. A review of the facility's policy titled, "Third Party Disclosures of Protected Health Information," dated as revised on 02/2020, noted: Procedure I. B. d. Request should be produced for the resident legal representative within two working days of the request. New Jersey Administrative Code § 8:39-35.2(h)	F 573		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580		3/1/21

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 01/14/2021

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 580	Continued From page 5 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint #: NJ140462 Based on record review, interviews, and facility policy review, it was determined the facility failed to notify the Responsible Party of a fall for 1 of 3 residents (Resident [redacted] reviewed for falls. Findings included:	F 580	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	

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 01/14/2021

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 580	Continued From page 6 1. Resident [redacted] was admitted on [redacted] with diagnoses to include [redacted]. A review of the annual Minimum Data Set (MDS) dated [redacted] revealed Resident [redacted] had a Brief Interview of Mental Status score of [redacted], which indicated moderately impaired cognition. Resident [redacted] required limited one-person staff assistance for bed mobility, dressing, personal hygiene, and extensive one-person staff assistance for toilet use and bathing. A review of a progress note dated [redacted] at 10:17 PM by Unit Manager #1 (UM), revealed Resident [redacted] was noted to be on the floor, found by Certified Nurse Assistant (CNA #15). The resident was assessed from head to toe, with no complaints of pain or discomfort. Range of motion was conducted in all extremities, the skin was intact, and first aid was not necessary. [redacted] checks were initiated immediately and the physician on call was notified. There was no documentation indicating the responsible party had been notified. A review of an incident report dated [redacted] revealed under Agencies/People Notified: the name of a physician with the date and time of notification. There was no documentation indicating the responsible party had been notified. On 01/11/2021 at 3:07 PM, an interview was conducted with Resident [redacted]s Responsible Party (RP). The RP stated he/she found out on [redacted] about Resident [redacted]s fall on when the resident phoned the RP	F 580	meet requirements established by state and federal law. F580-E What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident [redacted] was discharged on [redacted] How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents who fall have the potential to be affected by the deficient practice. Residents who have fallen in the last 30 days medical records have been reviewed to ensure the responsible party has been notified. No further deficient practice noted. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. The Educator or designate employee will re-educate the licensed nurses on the facility's policy "Response to Falls" related to the notification of responsible party post fall. Residents who have fallen medical records will be reviewed in morning	

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 01/14/2021

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 580	Continued From page 7 about the fall. On 01/12/2021 at 9:25 AM, an interview was conducted with UM #1. The UM stated Resident [redacted] had a fall on [redacted], and she had been the nurse on the unit at the time. The UM stated she had called the physician on call, but at the time she thought Resident [redacted] was his/her own RP since he/she was alert and oriented, and she did not call the family. The UM stated she had informed the Director of Nursing (DON) that she did not call the family and the DON had indicated he would take care of it. On 01/12/2021 at 10:26 AM, an interview was conducted with the DON. The DON stated he did not know of Resident [redacted]'s fall until [redacted] because the resident did not suffer an injury or go to the hospital. The DON stated he found out about the fall on [redacted] when he called the facility and talked to the supervisor. The DON stated the UM did not call the family, but he did expect staff to notify the family and document it, or pass it on to the next shift, that the family needed to be called. Review of the facility "Response to Falls" policy, revised on 03/2020, indicated under Procedure: I. E. The Licensed Nurse will notify the responsible party of the fall and any resulting interventions and /or treatments.	F 580	clinical meeting to ensure the responsible party has been notified. How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The Director of Nursing, Unit Manager or designated employee will audit 100% of medical records of residents who have fallen to ensure responsible party has be notified, weekly x4, monthly x 3. Results of audits will be presented in quarterly Quality Assurance meeting to ensure compliance and reassessed for further action.	
F 658 SS=D	New Jersey Administrative Code § 8:39-5.1(a) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658		3/1/21

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 01/14/2021

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 658	Continued From page 8 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint #: NJ139779 Based on interview and record review it was determined the facility failed to follow physician's orders for the administration of medications for 1 of 3 residents (Resident [redacted] reviewed for medication administration. Findings included: 1. Resident [redacted] was admitted to the facility on [redacted] with diagnoses that included [redacted]). The admission Minimum Data Set (MDS) assessment dated [redacted] revealed Resident [redacted] had a Brief Interview for Mental Status (BIMS) of [redacted] indicating [redacted]. Resident [redacted] was admitted needing extensive assistance for all Activities of Daily Living (ADLs) and was discharged on [redacted] needing only supervision. A review of Resident [redacted]s Controlled Substance Administration Record revealed the following: [redacted] (an [redacted]) [redacted] milligrams (mg); 1 tablet by mouth every [redacted] hours as needed for [redacted]. On [redacted] the record indicated the medication was given at 2:00 PM and again at 5:30 PM. On [redacted], the record documented the medication was given at 6:00 AM and 9:00 AM. This was not every [redacted] hours as per physician's	F 658	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. F658-D What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident [redacted] was discharged from the facility on [redacted] How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents on controlled substances have the potential to be affected by the deficient practice. All residents on prn controlled substances for the last 30 days, MARs have been audited to ensure physician orders for administration were followed. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not	

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 01/14/2021

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 658	Continued From page 9 orders. [redacted] (an [redacted]) [redacted] mg; 1 tablet by mouth [redacted] times a day as needed. On [redacted], the record indicated the medication was given at 2:00 AM, 6:00 AM, 10:00 AM, 2:00 PM, and 10:08 PM. This was five times, instead of three times per day as per the physician's orders) On [redacted], the record indicated the medication was given at 1:14 AM, 6:17 AM, 11:05 AM, and 4:00 PM. [redacted] times, instead of [redacted] times as per the physician's orders. On [redacted], a pill was wasted at 10:06 PM and on [redacted], a pill was wasted at 1:30 PM. On 01/12/2021 at 1:50 PM, the Administrator, Director of Nursing (DON), Assistant DON, and the Infection Preventionist nurse (ICP) were interviewed. The ICP stated she would have to review Resident [redacted]'s closed record however, she agreed the [redacted] appeared to have been given prior to the four-hour prescribed time and the [redacted] had been given more than the prescribed [redacted] times per day. On 01/12/2021 at 5:49 PM, the Regional Nurse was interviewed. The Regional Nurse stated it appeared as though there had been several medication errors. She stated the facility had been doing audits on resident charts who were still in house. The Regional Nurse stated the facility needed to audit closed charts, too.	F 658	recur. The Educator, DON and designated employee will reeducate licensed nurses on the facility policy on Administering Medications as related to following physician orders. How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Director of Nursing, Unit Managers will audit 10% of resident on prn controlled substances MARS including closed records weekly x4, then monthly x 3 to ensure physician orders were followed. Results of audits will be presented in quarterly QAPI meeting to ensure compliance and reassessed for further action.	
F 689 SS=G	New Jersey Administrative Code § 8:39-29.2(d) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		3/1/21

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 01/14/2021

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 689	Continued From page 10 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint #: NJ140462 Based on record review, interviews, observations, and facility policy review, the facility failed to investigate to determine the causative factors of falls to prevent the falls and/or reduce risk for falls for 1 of 3 residents (Resident [redacted]) reviewed for falls. Resident [redacted] had multiple falls, with one fall that resulted in a [redacted] Findings included: 1. The admission history form indicated Resident [redacted] was admitted to the facility on [redacted] with diagnoses that included [redacted]. The quarterly Minimum Data Set (MDS) assessment, dated [redacted] indicated the resident had [redacted] and the Brief Interview for Mental Status (BIMS) score [redacted]. Resident [redacted] was completely dependent for all Activities of Daily Living (ADLs). The MDS indicated Resident [redacted] needed extensive assistance of one person to transfer. A review of the facility's incident reports beginning [redacted] revealed the following falls for Resident [redacted] - [redacted] at 10:00 AM - [redacted] at 6:45 PM - [redacted] at 8:48 AM - [redacted] at 2:56 PM	F 689	What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. Residents [redacted] expired on [redacted] How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. Residents with falls in the last 60 days incident reports and care plans will be reviewed to ensure thy have been investigated to determine causative factors of fall. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. The Educator and designated employee will reeducate the licensed nurses on the facility's policies on Falls Management Program and Investigating and Reporting Accidents and Incidents. Fall Incident reports will be reviewed in clinical morning meeting by the IDT team to review to help determine causative factor and ensure care plans were updated.	

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 01/14/2021

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 689	Continued From page 11 - [redacted] at 12:08 PM - [redacted] at 3:43 PM - [redacted] at 6:44 AM - [redacted] at 3:45 AM - [redacted] at 10:00 PM - [redacted] at 9:00 AM - [redacted] at 2:31 PM - [redacted] at 2:46 PM The incident report for the fall on [redacted] at 10:00 AM revealed the facility did not complete an investigation of how the fall occurred or how the facility was going to prevent future falls with goals and interventions. The report revealed the resident was found on the floor. The incident report indicated, "Resident is high risk for falls secondary to history [redacted], history of [redacted]." Resident [redacted] was not taken to the hospital. There were no new interventions indicated on the incident report or in the medical record. The incident report for the fall on [redacted] at 6:45 PM revealed the nurse was requested, by the certified nursing assistant (CNA), to assist the roommate. The privacy curtain was drawn when the CNA heard a noise. Upon entering the room, the nurse observed Resident [redacted] on the floor. The nurse immediately assessed Resident [redacted] and observed [redacted] to the [redacted].The resident was able to perform active range of motion (AROM) and [redacted] was within normal limits (WNL). The physician was made aware and ordered a [redacted] to rule out a [redacted]. The facility did not complete an investigation of how the fall occurred or how they were going to prevent future falls. Resident [redacted] was not taken to the hospital. There were no new interventions indicated on the incident report or in	F 689	How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The Director of Nursing, Unit Managers will audit 100% of fall incident reports weekly x4, monthly x3 to ensure the report has been investigated and causative factor determined. Results of audits will be presented in monthly QAPI meeting to ensure compliance and reassessed for further action	

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 01/14/2021

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 689	Continued From page 12 the medical record. The incident report for the fall dated [redacted] at 8:48 AM, revealed Resident [redacted] was found on the floor next to his/her wheelchair. Resident [redacted] was found leaning on the dresser. A nursing note indicated, "Patient was transferred from floor to wheelchair and continued assessment was completed and [redacted] was noted." The nursing note did not reveal where the [redacted] and [redacted] were noted. Resident [redacted] was transferred to the hospital for evaluation. A nursing note on [redacted] at 1:45 PM indicated Resident [redacted] returned from the hospital with a [redacted] The [redacted] was stabilized in a [redacted] On 01/13/2021 at 10:42 AM, the Rehabilitation Director (RD) was interviewed. The RD stated prior to [redacted], Resident [redacted] was in a standard wheelchair that had an [redacted] system, a [redacted], a [redacted] and [redacted]. The RD stated Resident [redacted] was picked up for physical and occupational therapy following the [redacted] and the [redacted] The main goal of therapy was to assist Resident [redacted] with [redacted]. On 01/13/2021 at 1:30 PM, CNA #12 was interviewed. CNA #12 stated Resident [redacted] knew how to release the [redacted]. Resident [redacted] moved around a lot and they never knew when to expect a fall. CNA #12 did not recall receiving updated information about interventions to keep Resident [redacted] safe and prevent falls. On 01/13/2021 at 1:38 PM, CNA #16 was interviewed. CNA #16 stated Resident [redacted] was unpredictable and would fall on any shift.	F 689		

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 01/14/2021

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 689	Continued From page 13	F 689		

Resident [redacted] would often bend over, thinking there was something on the floor that needed to be picked up. CNA #16 did not recall receiving updated information about interventions to keep Resident [redacted] safe and prevent falls.

On 01/13/2021 at 2:25 PM, the Infection Preventionist (ICP) nurse was interviewed. At the time of the [redacted] and [redacted] falls, the ICP was the Director of Nursing (DON). The ICP stated during that time, the facility was going through a lot as it related to COVID-19 outbreaks, and they were looking for a unit manager for the unit where Resident [redacted] resided. She stated that a follow up investigation was completed, but she could not locate it. Since she could not locate the actual investigation, she could not confirm a root cause analysis had been completed. In addition, she was unable to verbalize the causative factors of the resident's multiple falls. She continued by stating that she was normally organized, but during that time she was working nursing shifts on the floor and papers were just stacking up in her office.

A review of Resident [redacted]'s plan of care (POC) revealed following the fall with a [redacted] on [redacted], the resident's POC for falls was not updated until [redacted]

The facility's Fall Management Program Policy No-NP-292 dated 02/2020, indicated in part: Policy: The facility will provide the highest quality in the safest environment for the residents residing in the facility. The facility has developed a Fall Management Program that strives to prevent resident falls through meaningful assessments, interventions, education, and reevaluation.

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 01/14/2021

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 689	Continued From page 14 New Jersey Administrative Code § 8:39-27.1(a)	F 689		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility policy review, it was determined the facility failed to ensure staff wore hair restraints in the kitchen for four (Dietary Aid (DA) #1, DA #2, DA #3, and Cook #1) of four kitchen staff observed. This had the potential to affect 154 of 163 residents who receive food from the kitchen. Findings included: 1. On 01/11/2021 at 4:10 PM, this surveyor observed four staff members in the kitchen not wearing hairnets/hair restraints. Dietary Aide (DA) #1 had shoulder length braids and was not wearing a hair restraint. DA #2 had braids that	F 812	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. F812 - F What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient	3/1/21

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 01/14/2021

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 812	Continued From page 15 were the length of her back and was not in a hairnet. DA #3 had short hair and was not wearing a hairnet. Cook #1 had short hair and a beard. He was not wearing a hairnet, beard net, or a mask. On 01/11/2021 at 4:20 PM, the Certified Dietary Manager (CDM) was interviewed. He stated, "There is no excuse for it and I'm not even going to try to make one up." "I dropped the ball because I didn't even notice (as he walked through the kitchen)." The CDM explained it was part of their daily check to observe that dietary staff were in their uniform, and that included hairnets and beard nets. The CDM stated, "we check, but we do not have to enforce all that often." On 01/11/2021 at 4:45 PM, the Administrator (Admin) was interviewed. The Admin stated he spent a lot of time in the kitchen and was surprised by the observation. The CDM confirmed the observation with the Admin. On 01/11/2021 at 4:54 PM, the Admin and this surveyor observed the kitchen staff again. DA #1 had on a hairnet with his shoulder length braids hanging out from under the hairnet. DA #2 had on a hairnet over the top of her head with her braids hanging out from under her hairnet. Cook #1 had on a hairnet, but no beard net. The Admin confirmed the observation. The Riverfront Dress Code Policy, dated 02/01/2019, read in part: For Dietary Personnel, "Effective hair restraints must be worn when working with or around food (hairnet, clean covering, or cap.)" New Jersey Administrative Code § 8:39-17.2(g)	F 812	practice. The dietary kitchen staff were immediately educated on wearing hair restraints in the kitchen How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the deficient practice. The Dietary Manager will re-educate the dietary staff on the policy “Staff Attire” as related to hair restraints What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. The NHA or designate will audit the kitchen 2x weekly x4, monthly x3 to ensure dietary employees are wearing the appropriate hair restraints. Results of audits will be presented in monthly QAPI meeting to ensure compliance and reassessed for further action	

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 01/14/2021

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 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		3/1/21

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 01/14/2021

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 880	Continued From page 17 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, facility policy review, and review of the New Jersey Department of Health (NJDOH) Executive Directive No. 20-026-1, revised 01/06/2021, it was determined the facility failed to ensure kitchen staff wore face masks for source control for four (Dietary Aid (DA) #1, DA #2, DA #3, and Cook #1) of four kitchen staff observed. This deficient practice occurred during the COVID-19 pandemic and had the potential to affect all residents. Findings included:	F 880	This Directed 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. F880 - F What corrective actions(s) will be	

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 01/14/2021

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 880	Continued From page 18 Reference: NJDOH Executive Directive No. 20-026-1, revised 01/06/2021, indicated the following: 3. Cohorting, PPE (personal protective equipment) and Training Requirements in Every Phase: i. Facilities shall implement universal source control for everyone in the facility. 1. On 01/11/2021 at 4:10 PM, this surveyor observed four staff members in the kitchen not wearing masks. Dietary Aide (DA) #1, DA #2, DA #3 were not wearing face mask. Cook #1 was wearing a face shield but was not wearing face mask. On 01/11/2021 at 4:20 PM, the Certified Dietary Manager (CDM) was interviewed. He stated, "There is no excuse for it and I'm not even going to try to make one up." "I dropped the ball because I didn't even notice (as he walked through the kitchen)." The CDM explained it was part of their daily check to observe that dietary staff were in their uniform and that included face masks. The CDM stated, "we check, but we do not have to enforce all that often." On 01/11/2021 at 4:45 PM, the Nursing Home Administrator (NHA) was interviewed. The NHA stated he spent a lot of time in the kitchen and was surprised by the observation. The CDM confirmed the observation with the NHA. New Jersey Administrative Code § 8:39-5.1 (a)	F 880	accomplished for those residents found to have been affected by the deficient practice. No resident was found to have been affected by the deficient practice. The dietary kitchen staff were immediately educated on the use of proper PPE in the kitchen. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the deficient practice. The Infection Preventionist will re-educate the dietary staff on wearing the appropriate PPE. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. The facility shall provide in – service training to appropriate staff as follows: • Module 1 - Infection Prevention & Control Program (Topline staff & IP) • CDC cov1D-19 Prevention Messages for Front Line Long-Term Care Staff: Keep Covid-19 Out! (All staff) youtube.be/7srwrF9MGdw • CDC cov1D-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for Covid-19 (All staff)	

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 01/14/2021

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 880	Continued From page 19	F 880	https://youtu.be/YYTATw9yav4 Conduct a Root Cause Analysis The NHA or designate will audit the kitchen 2x weekly x4, monthly x3 to ensure dietary employees are wearing the appropriate PPE. Results of audits will be presented in monthly QAPI meeting to ensure compliance and reassessed for further action	