STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			COMPLETED	
	062018				07/09/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
AI ARIS	HEALTH AT RIVERTO	1777 I AW	RENCE STR			
ALAINIO	IILALIII AI RIVERTO	RAHWAY,	NJ 07065			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	WITH THE STAND. ADMINISTRATIVE STANDARDS FOR TERM CARE FACII SUBMIT A PLAN O INCLUDING A CON DEFICIENCY AND IMPLEMENTED. FA DEFICIENCIES MA ENFORCEMENT A WITH THE PROVIS	MPLETION DATE, FOR EACH ENSURE THAT THE PLAN IS ALLURE TO CORRECT AY RESULT IN CTION IN ACCORDANCE SIONS OF THE NEW TRATIVE CODE, TITLE 8, IFORCEMENT OF				
S 560	8:39-5.1(a) Mandat	·	S 560			8/12/21
		comply with applicable local laws, rules, and				
	by: Based on observati pertinent facility dod determined the faci required minimum or ratios as mandated This deficient practi following:  Reference: NJ State 112. An Act concern nursing homes and Revised Statutes. Be It Enacted by Assembly of the Sta	on, interview, and review of cumentation, it was lity failed to maintain the direct care staff-to-resident by the state of New Jersey. It is requirement, CHAPTER and staffing requirements for supplementing Title 30 of the of New Jersey: C.30:13-18 and General atte of New Jersey: C.30:13-18 and control of the control of		How the corrective action will be accomplished for those residents for have been affected by the deficient practice The facility is utilizing sign on bonu working with different CNA schools offering OT, posting jobs on indeed referral bonuses and utilization of vin order to fill any staffing gaps, and ensure state required ratios are meaniterviews with residents pertaining days in which ratios were not met, result in any complaints or concern appropriate care was not rendered	t ses, s, d, waivers d et. g to did not as that	

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

TITLE

(X6) DATE

**Electronically Signed** 

07/16/21

PRINTED: 09/30/2021 FORM APPROVED

INCW OCI	sey Department of I	Icaliii				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		062018	B. WING		07/0	9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
		1777 LAW	RENCE ST	REET		
ALARIS	HEALTH AT RIVERTO	RAHWAY,	NJ 07065			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETE DATE
S 560	Continued From pa	ige 1	S 560	How the facility will identify other re	esidents	
	1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant			having the potential to be affected same deficient practice All residents have the potential to affected by the deficient practice.	by the	
	maintain the followi -to-resident ratios: (1) one certifie	(C.26:2H-1 et seq.) shall ng minimum direct care staff d nurse aide to every eight		What measures will be put into pla systemic changes made to ensure deficient practice would not recur	that the	
	residents for the ev	by shift; care staff member to every 10 rening shift, provided that no Il staff members shall be		The facility is utilizing sign on bonumering with different CNA schools offering OT, posting jobs on indee referral bonuses and utilization of	s, d,	
	certified nurse aide shall be signed in to	s, and each staff member o work as a certified nurse orm certified nurse aide duties;		in order to fill any staffing gaps, ar ensure state required ratios are m The DON or designee will do a sta	ıd et.	
	and (3) one direct of	care staff member to every 14 ght shift, provided that each		ratio review every 2 weeks to ensuratios are met x 90 days.		
	certified nurse aide aide duties	ember shall sign in to work as a and perform certified nurse		How the facility will monitor its corrections to ensure that the deficient practice is being corrected and will	t	
	b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.			recur The results of the biweekly staffing review will be reviewed in the quar meeting x 90 days, and will be re-evaluated thereafter.		
	(2) If the applic subsection a. of this a whole number of certified nurse aide required direct care rounded to the next the resulting ratio, o is fifty-one hundred					
		ations shall be based on the r the day in which the shift				

AND DIAM OF CODDECTION . 'IDENTIFICATION NUMBER		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	062018	B. WING		07/0	9/2021
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ALARIS HEALTH AT RIVERTON	V	RENCE STF NJ 07065	REET		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE
affect any minimum soursing homes as macommissioner of Hecare staff, including of restrict the ability of a staffing levels, at any established minimum.  On 06/29/21, 06/30/2 07/06/21, 07/07/21, at the surveyors observed Nursing Aides (CNA) and third floors of the The surveyor reviews Schedule from 06/29.  On Tuesday, 06/29/2 (number of residents 7:00 AM - 3:00 PM si Aide) CNA's. 68 divice resident's (not met) 3:00 PM - 11:00 PM si (met) 11:00 PM - 7:00 AM si (met)  The facility did not more requirements on the On Wednesday, 6/30 68.  7:00 AM - 3:00 PM si met) 3:00 PM - 11:00 PM si met)	ection shall be construed to staffing requirements for ay be required by the ealth for staff other than direct certified nurse aides, or to a nursing home to increase y time, beyond the n  21, 07/01/21, 07/02/21, and 07/08/21, and 07/08/21, and 07/09/21, wed six to eight Certified by sworking on the second	S 560			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		062018	B. WING		07/0	9/2021
	PROVIDER OR SUPPLIER HEALTH AT RIVERTO	N 1777 LAW	DRESS, CITY, S RENCE STR NJ 07065	STATE, ZIP CODE REET		
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S 560	Continued From pa	ge 3	S 560			
	requirements on the the 3:00 PM - 11:00 On Thursday, 7/01/269. 7:00 AM - 3:00 PM met) 3:00 PM - 11:00 PM (not met) 11:00 PM - 7:00 AM (not met) The facility did not requirements on the 3:00 PM - 11:00 PM 7:00 AM shift. On Friday, 07/02/21 7:00 AM - 3:00 PM met) 3:00 PM - 11:00 PM (not met) 11:00 PM - 7:00 AM (met) The facility did not requirements on the 3:00 PM - 11:00 PM (mot met) 11:00 PM - 7:00 AM (met) The facility did not requirements on the the 3:00 PM - 11:00 On Saturday, 07/03	21 the facility's census was shift 8 CNA's. 69/8 = 8.6 (not 1 shift 5 CNA's. 69/5 = 13.8 If shift 4 CNA's 69/4 = 17.25 If shift 4 CNA's 69/4 = 17.25 If shift, and the 11:00 PM - 1 the facility's census was 69. shift 8 CNA's. 69/8 = 8.6 (not 1 shift 5 CNA's. 69/6 = 11.5 If shift 5 CNA's 69/5 = 13.8 If shif				
	met) 3:00 PM - 11:00 PM (not met)	shift 8 CNA's. 69/8 = 8.6 (not 1 shift 6 CNA's. 69/6 = 11.5 1 shift 5 CNA's 69/5 = 13.8				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		062018	B. WING		07/0	9/2021
	PROVIDER OR SUPPLIER  HEALTH AT RIVERTO	N 1777 LAW	DRESS, CITY, S RENCE STR NJ 07065	STATE, ZIP CODE REET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S 560	The facility did not requirements on the the 3:00 PM - 11:00  On Sunday, 07/04/27:00 AM - 3:00 PM met) 3:00 PM - 11:00 PM (not met) 11:00 PM - 7:00 AM (not met)  The facility did not requirements on the 11:00 PM shift, an shift.  On Monday, 07/05/65. 7:00 AM - 3:00 PM met) 3:00 PM - 11:00 PM met) 11:00 PM - 7:00 AM (not met)  The facility did not requirements on the 3:00 PM - 11:00 PM 7:00 AM shift.  On Tuesday, 07/06/65. 7:00 AM - 3:00 PM met) 3:00 PM - 11:00 PM 7:00 AM shift.	meet the mandatory staffing e 7:00 AM - 3:00 PM shift and	S 560			

` ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	062018		B. WING		07/0	9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ALARIS	HEALTH AT RIVERTO	)N	RENCE STF NJ 07065	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE
S 560	Continued From pa	ge 5	S 560			
		meet the mandatory staffing e 7:00 AM - 3:00 PM shift and ) PM shift.				
	was 64. 7:00 AM - 3:00 PM 3:00 PM - 11:00 PM (not met)	'/07/21 the facility's census shift CNA's. 64/8 = 8 (met) // shift CNA's. 64/5 = 12.8 // shift CNA's 64/4 = 16 (not				
		meet the mandatory staffing e 3:00 PM - 11:00 PM shift and ) AM shift.				
	On Thursday, 07/08/21 the facility's census was 65. 7:00 AM - 3:00 PM shift 6 CNA's. 65/6 = 10.8 (not met) 3:00 PM - 11:00 PM shift 5 CNA's. 65/5 = 13 (not met) 11:00 PM - 7:00 AM shift 5 CNA's 65/5= 13 (met)					
		meet the mandatory staffing e 7:00 AM - 3:00 PM shift and ) PM shift.				
	7:00 AM - 3:00 PM 3:00 PM - 11:00 PM (not met)	, the facility's census was 65. shift CNA's. 65/8 = 8 (met) // shift 5 CNA's. 65/4 = 16.25 // shift 5 CNA's 65/4= 16.25				
		meet the daily staffing e 3:00 PM - 11:00 PM shift and ) AM shift.				
	On 07/08/21 at 9:50	3 AM, the surveyor interviewed				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		062018	B. WING		07/0	9/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ALARIS	HEALTH AT RIVERTO	)N	/RENCE STR , NJ 07065	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
S 560	a Certified Nurse Ai who stated that she since 2008. CNA #7:00 AM - 3:00 PM the 3:00 PM - 11:00 #1 stated that wher 3:00 PM shift there working on the third we could have eigh assignment." CNA: 10 residents on her stated that when sh PM shift, that she, a would usually have assignments. CNA overtime work if the to help provide care.  On 07/08/21 at 10:0 interviewed CNA #2 further stat was the 7:00 AM - 3 nine to 11 residents stated that she would usually have assignments. CNA work that she had worke CNA #2 further stat was the 7:00 AM - 3 nine to 11 residents stated that she would not 11:00 PM shift to 11 residents on his shift as well.  On 07/08/21 at 10:0 interviewed the 7:00 PM - 11:00 PM #1 stated that he work three years. LPN # on the second floor 3:00 PM - 11:00 PM #1 stated that on the CNA's would usuall on their assignments.	ide (CNA #1) on the third floor had worked at the facility 1 stated that she worked the shift during the weekdays and 0 PM shift on weekends. CNA in she worked the 7:00 AM - were usually three CNA's difloor and, "on any given day at to 12 residents are our #1 stated that today, she had r assignment. CNA #1 further he worked the 3:00 PM - 11:00 along with the other CNA's more residents on their #1 stated that she picked up ere was a CNA that called out	S 560			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	062018		B. WING		07/0	9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ALARIS	HEALTH AT RIVERTO	N .	RENCE STR	REET		
(VA) ID	SHIMMADV STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	)NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
S 560	Continued From pa	ge 7	S 560			
	unit and had a high more medical issue more staff was allow needed. LPN #1 fur 11:00 PM shift would working on each floeight to ten residen  On 07/08/21 at 10:10 interviewed the CN stated she had working and regularly worked CNA #3 stated that AM - 3:00 PM shift residents on her as stated that she would 3:00 PM - 11:00 PM short staffed and not that when she working was allowed to the control of the control o	second floor was the sub-acute er acuity (residents that have es and need more care) so cated to that floor when other stated that the 3:00 PM - 1d have three to four CNA's por that would provide care to ts on their assignment.  11 AM, the surveyor A #3 on the second floor who ked at the facility for 13 years and the 7:00 AM - 3:00 PM shift. When she worked the 7:00 she would have eight to ten signment. CNA #3 further ald pick up overtime on the 1d shift when the facility was seeded help. CNA #3 stated and the 3:00 PM - 11:00 PM et et no 12 residents on her				

AND DIAN OF CORRECTION . IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		062018	B. WING		07/0	9/2021
	PROVIDER OR SUPPLIER HEALTH AT RIVERTO	N 1777 LAW	DRESS, CITY, S /RENCE STF , NJ 07065	STATE, ZIP CODE REET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
S 560	residents on their a On 07/08/21 at 10:3 interviewed the Bus who stated that one included scheduling BOM stated that the was eight resident's the 7:00 AM - 3:00 CNA's assignment shift, and 15 reside the 11:00 PM - 7:00 stated that if there v increased, she wou facility if they wante call a sister facility t provide care for the On 07/08/21 at 12:1 interviewed the Adn the survey team wh required staffing rat CNA's assignment shift, ten resident's the 3:00 PM - 11:00	ssignments.  31 AM, the surveyor siness Office Manager (BOM) of her job responsibilities graffing for the facility. The extate required staffing ratio is on a CNA's assignment on PM shift, ten resident's on a on the 3:00 PM - 11:00 PM into on a CNA's assignment on AM shift. The BOM manager was a call out or the census and ask staff working at the od to work overtime or would to obtain more staffing to	S 560			

				STATE F	ORM: RE	VISIT REPORT				
	R / SUPPLIER CATION NUMB		MULTIPLE CON A. Building	ISTRUCTION					DATE OF	REVISIT
062018		Y1	B. Wing					Y2	9/1/2021	Y3
NAME OF FACILITY ALARIS HEALTH AT RIVERTON					STREET ADDRESS, CITY, STATE, ZIP CODE 1777 LAWRENCE STREET RAHWAY, NJ 07065					
corrective	e action was a	ccomplis	shed. Each def	iciency should	be fully ident	reviously reported that ified using either the r efix codes shown to th	egulation or LSC ہ	provision r	number ar	nd the
ITEN	M		DATE	ITEM		DATE	ITEM			DATE
Y4			Y5	Y4		Y5	Y4			Y5
ID Prefix	S0560		Correction	ID Prefix		Correction	ID Prefix		C	orrection
Reg.#	8:39-5.1(a)		Completed	Reg. #		Completed	Reg.#		С	ompleted
LSC			08/12/2021	LSC			LSC			ompiotod
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		С	orrection
D #			-	D #			D- " #			
Reg. #			Completed	Reg. #		Completed	Reg. #			ompleted
LSC			_	LSC			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		C	orrection
Reg. #			Completed	Reg. #		Completed	Reg. #		С	ompleted
LSC			<del>-</del> -	LSC			LSC			
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		С	orrection
Reg. #			- Completed	Reg. #		Completed	Reg. #			ompleted
LSC			- Completed	LSC		Completed	LSC			ompleted
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		C	orrection
Reg. #			Completed	Reg. #		Completed	Reg. #		С	ompleted
LSC			<del>-</del> -	LSC			LSC			
REVIEWE	ED BY	REVIE	WED BY	DATE	SIGNATI	JRE OF SURVEYOR		T	DATE	
STATE AC		(INITIA			John	O. JONALION				
REVIEWE CMS RO	D BY	REVIEN (INITIA	WED BY LS)	DATE	TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 7/9/2021					CORRECTED DEFICIEN ICIENCIES (CMS-2567)		II IT) (O	YES	□ NO	

Page 1 of 1 EVENT ID: VP4H12