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	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Front Rehabilitation and Healthcare Center	5101 North Park Drive Pennsauken, NJ 08109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40039 Based on observation and interview, and review of other facility documentation, it was determined that the facility failed to ensure the transport of a non-ambulatory resident was provided in a manner to promote the dignity and respect of the resident. This deficient practice was identified for 1 of 32 residents reviewed for dignity, (Resident #27) and was evidenced by the following: A review of a facility policy titled Resident Rights, Created: 2/2024, revealed the following under Policy Explanation and Compliance Guidelines: 10. All residents will be treated equally regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression. 11. The facility will ensure that all staff members are educated on the rights of residents and the responsibility of the facility to properly care for its residents. The following was revealed under the heading Resident rights: The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. On 08/05/2024 11:23 AM, during the initial tour of the facility, the surveyor observed Resident #27 seated in a Geri-chair. A female staff was observed to transport Resident #27 from the Pavilion 3 dining/activity room and past the nursing station by pulling the Geri-chair from behind and not pushing Resident #27 facing forward. The surveyor interviewed Licensed Practical Nurse (LPN #2). The surveyor asked LPN #2 how a non-ambulatory resident should be properly transported. LPN #2 responded by stating that she was sorry. A review of the Electroinic Medical Record on 08/06/2024 at 09:26 AM, revealed the following: A review of the Admission Record revealed that Resident #27 was admitted to the facility with the following but not limited to diagnoses: Contracture (unspecified joint), vascular dementia, and major depressive disorder. (continued on next page)

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.

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

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Front Rehabilitation and Healthcare Center	5101 North Park Drive Pennsauken, NJ 08109

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the comprehensive Minimum Data Set (MDS), an assessment tool, dated June 28, 2024, revealed Resident #27 had a Brief Interview for Mental Status score of 3/15, which indicated severe cognitive impairment. Section GG revealed that Resident #27 had impairment on side to both the lower and upper extremity. On 08/13/2024 at 02:20 PM, the surveyor conducted an interview with the facility administration which included the Director of Nursing DON), the Licensed Nursing Home Administrator (LNHA), and the [NAME] President of Clinical Services. When asked how to properly transport a non-ambulatory resident, the DON told the surveyors, The resident should be transported from behind so that the staff and resident are moving forward in the same direction to see where you are going and for dignity issues. NJAC 4.1(a)(12)

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NAME OF PROVIDER OR SUPPLIER River Front Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5101 North Park Drive Pennsauken, NJ 08109	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34423 C/O # NJ 156940 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain the facility in a clean and sanitary environment. This deficient practice was identified for 2 of 3 units, (Pavilion 2 and Pavilion 3) and was evidenced by the following: 1. On 08/13/2024 at 10:40 AM, a review of a facility policy titled Complete Room Cleaning dated 06/2024, revealed under the purpose section; The complete room cleaning schedule insures {sic} (ensures)that each resident room is discharge-cleaned on a monthly basis. Under the Patient Room section 3. Starting in a clockwise rotation from patient room door; clean polish, scrub, scrape, dust, disinfect, sweep, wipe and mop everything in the room including: . Check all the corners, ceiling and floors, Remove buildup on floor, dust mop and damp mop entire room. Under the Bathrooms section: . Toilet: scrub and disinfect toilet bowl. Use cleanser on interior of bowl only. Remove all stains and buildup. Remove all buildup from the floor around the bowl, door frame, corners and edges. Dust mop the entire floor. Make sure vent in the bathroom is cleaned. Damp mop the entire floor. During the initial tour of the facility on the 2nd floor on 08/05/2024, the surveyor observed the following: + at 11:11 AM, in room [ROOM NUMBER] floor the surveyor feet stuck to floor. + at 11:14 AM room [ROOM NUMBER] had debris on floor. During a subsequent tour of the 2nd floor on 08/07/2024 at 12:12 PM, the surveyor observed the following: + room [ROOM NUMBER] floor with debris, hair knot by wheel at bottom of the bed, floor near door where the jam meets floor with dark spots, + room [ROOM NUMBER] dark marks on floor where the door jam and floor meet. + surveyor shoes stuck to the floors in rooms [ROOM NUMBERS]. + room [ROOM NUMBER] dark marks floor and where the door jam and floor meet. + hair knot observed on the floor outside room [ROOM NUMBER] in hallway. On 08/07/2024 at 12:23 PM, the hallway 2nd floor high hall was observed with various colored debris marks on the floor between rooms [ROOM NUMBERS]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: River Front Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 5101 North Park Drive Pennsauken, NJ 08109	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	+ room [ROOM NUMBER] corner of wall upon entering on left missing baseboard, cracked paint. + corners where door jams meet floor rooms 222, 223, 221, 220 219, 218, 217, 216, all have debris and dark marks. + floor room [ROOM NUMBER] upon entering with dark marks and w/c wheel trails. + medication cart high hall 2nd floor wheels with hair wrapped around wheels. + room [ROOM NUMBER] in the bathroom, floor where the baseboard and floor meet have dark stains, on left side of toilet when looking at it, on the floor is discolored and stains along base of toilet and inside toilet bowl. During an interview with the surveyor on 08/07/2024 at 12:24 PM, a family member said they are supposed to clean the rooms every day. They only mop the floors, don't sweep before mopping. Look at the stuff on the floors. The family member said they only mop floor in bathroom, they don't clean toilet. On 08/12/2024 at 12:00 PM, medication cart high hall 2nd floor wheel stills have hair wrapped on wheels. On 08/12/2024 at 09:06 AM, observed laminate board on door to room [ROOM NUMBER] peeling off. During an interview with the surveyor on 08/13/2024 at 09:44 AM, the Director Environmental Services and Laundry (DEVS) was asked what the process was for cleaning resident rooms. The DEVS responded first they knock on door, empty trash, sweep rooms (dry sweep) with dustpan and broom, wipe on top and bottoms of all surface areas, also clean top of lights. Then they go to the bathroom, clean toilet, sink and mirrors, check make sure toilet paper and paper towels are inside the holder not on back of toilet. They finish with wet mop rooms and bathroom. The DEVS also said they check privacy curtains to make sure they are clean of spills or stains. When asked how often this is done, he said this is done daily. The DEVS said I usually have 2 housekeepers on each floor and 1 porter on day shift. On evening we have 2 floor techs, and they are responsible for day rooms and scrub the hallways, and empty soiled linen and trash. The surveyor asked what about the corners of the room. The DEVS replied that is also part of the daily cleaning. When asked who is responsible to clean the hallways, the DEVS said the evening floor techs. The housekeeper or floor tech are responsible to clean marks off the floors. The DEVS went on to say that hallways are cleaned daily, and twice weekly halls are scheduled to be scrubbed. The surveyor questioned what scrubbed means and he said we run the floor machine is what scrubbing means. The surveyor asked how often room carbs (carbolization which is the process of deep cleaning a room) done. The DEVS replied 1 room on each floor daily including weekends. This includes pulling all dressers, beds away from the wall, cleaning behind everything, top of lights, wipe call bell and phone lines are cleaned, wiping remotes (done daily as well) dust TV, picture frames, bed frames, mattresses, window frames and windowsills and windows. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER River Front Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5101 North Park Drive Pennsauken, NJ 08109	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor asked who is responsible to clean the medication carts. The DEVS responded Housekeeping is responsible to clean the medication carts. We have a spare, we clean that one, nursing then switches cart and then we take the dirty cart and clean it. Yes, that includes wheels and drawers, scrape anything left in there and when it is clean we leave for nursing to switch back. That is done monthly. During an interview with the surveyor on 08/13/2024 at 01:15 PM, the Housekeeping Assistant (HKA #1) said rooms are clean daily. The process is to sweep floor, mop floor, clean toilet, clean sink, dust top of dressers, lights, wipe bed down including mattress every day. When questioned about carbolizations, how often is this done. The Housekeeper replied do one room a day so done monthly. 40039 2. On 08/05/2024 at 10:35 AM Resident #101 was observed lying in bed on the initial tour of the facility. Tube feeding (TF) was observed to be off at this time of observation. The surveyor observed what appeared to be tan/brown tube feed formula to be spilled on the floor and on the base of the IV pole. On 08/07/2024 at 08:26 AM Resident #101 was observed lying in bed with the head of the bed (HOB) slightly elevated. TF is not hung or infusing on this observation. The IV pole base remains covered with an unidentified tan colored substance on the base of the IV pole. On 08/08/2024 at 08:24 AM Resident #101was observed lying in bed with HOB elevated. Enteral pump is turned off and no tube feed is present. Base of IV pole and floor are stained/covered with an unidentified tan/brown substance that resembles an enteral feed, as seen on previous observations. On 08/12/2024 at 11:10 AM Resident #101was observed lying in bed and receiving intravenous fluids. No TF was hung at this time. IV pole base is covered with an unidentified tan/brown substance that is dried onto the base. Appears to be dried tube feed formula that spilled. On 08/13/2024 at 08:35 AM Resident #101 was observed lying in bed with HOB elevated. Tube feeding of Jevity 1.5 (an enteral formula to provide nutrition to residents that are unable to eat by mouth). IV pole base is covered with what appears to be dried enteral feeding. The surveyor conducted an interview with the Housekeeping Assistant assigned to Resident #101's room. When asked who was responsible for cleaning of IV poles the house keeping assistant (HKA #2) stated that housekeeping staff were responsible for the maintenance/cleaning of IV poles in the facility. HKA #2 agreed that the IV pole needed cleaning and agreed that enteral formula had been spilled on the IV pole base. On 08/13/2024 at 09:45 AM the surveyors conducted an interview with the facility Director of Environmental Services and Laundry (DEVS). When asked who was responsible for the cleaning of IV poles the DEVS responded, We are responsible to clean the IV poles. They are scheduled once a week to be cleaned but they can be cleaned daily if need be. On 08/13/2024 at 02:26 PM during an interview with facility administration the DON and LNHA confirmed housekeeping/environmental services was responsible for cleaning IV poles as well as the person making the spill. NJAC 8:39-31.4(a)

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River Front Rehabilitation and Healthcare Center	5101 North Park Drive Pennsauken, NJ 08109

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41442 Based on observation, interview, record review, and review of other facility documentation, it was determined the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives, timelines, and interventions to meet resident's medical and nursing needs for 1 out of 4 residents investigated for Respiratory Care. A review of a facility policy reviewed on 08/08/2024 at 11:05 AM, titled, Care Plan, dated June 2024, revealed the following statement, It is the policy of [facility name] that all residents admitted to the facility will have adequate person-centered care plans that provide for all their needs in a timely manner. Under Procedures, #1. Baseline Care Plans for all new admissions will be initiated within 48 hours of admission. Under #2. They will include initial goals, MD orders, medications, treatments, dietary orders, therapy orders, social service and PASARR recommendations. The deficient practice was evidenced by the following: On 08/05/2024 at 10:13 AM, the surveyor observed Resident #372 in his/her room, lying in bed with a tracheostomy, (an opening surgically created through the neck into the trachea (windpipe) to allow air to fill the lungs) with 5 liters of continuous oxygen inhalation therapy infusing. A review of Resident #372's Electronic Medical Record on 08/06/2024 at 09:31 AM, revealed the following: A review of Resident #372's Admission Record revealed that he/she had a diagnosis of Multiple Sclerosis, Paraplegia, Tracheostomy, and Chronic Respiratory Failure with Hypoxia. A review of the resident physician orders revealed orders for the care and treatment of the tracheostomy. A review of Resident #372's most recent comprehensive Minimum Data Set (MDS), an assessment tool to facilitate resident care dated 07/18/2024, under Section O-Special Treatments, Procedures, and Programs, indicated that Resident #372 required Oxygen therapy, Suctioning, and Tracheostomy Care. A review of Resident # 372's care plan did not include the required care and maintenance for the resident's tracheostomy. During an interview with the surveyor on 08/07/2024 at 09:10 AM, Registered Nurse/Unit Manager (RN/UM #1), stated that there was no care plan for the respiratory care for Resident #372. RN/UM #1 added that it was ultimately her responsibility to assure that a care plan was in place. 8:39-11.2 (e)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 34423 Based on interview, review of the Electronic Medical Record (EMR), and review of other facility documentation, it was determined that the facility failed to ensure a resident had a Physician Order (PO) for transfer to the hospital. This deficient practice was identified for 2 of 2 residents reviewed for hospitalization s (Resident # 126 and Resident # 137) and was evidenced by the following: On 08/14/2024 at 9:52 AM, a review of the facility's Transfer or Discharge, Emergency policy dated revised June 2024, included, Should it become necessary to make an emergency transfer or discharge to a hospital . Notify the resident's attending physician; place order for transfer per attending physician/NP (nurse practitioner)/PA .(physician assistant) On 08/06/2024 at 11:42 AM, a review of the Electronic Medical Record (EMR) revealed the following: 1. A review of the Admission record revealed Resident #126 was admitted to the facility with diagnoses including but not limited to: Conversion Disorder with Seizures or Convulsions. A review of a facility progress note (PN) dated 11/5/2023 revealed Resident #126 was observed sitting in the chair with both eyes rolled up and unresponsive. 911 was called and Resident #126 left with Emergency Medical Services to the local hospital. A further review of the EMR did not include a physician order to transfer Resident #126 to the hospital. During an interview with the surveyor on 08/14/2024 at 09:10 AM, the Director Of Nursing (DON) said there was no order to transfer Resident #126 to the hospital. The surveyor asked should there have been an order and she replied, Yes. 39460 2. On 8/13/24 at 8:47 AM, the surveyor reviewed the medical record for Resident #137, a hospitalized resident. A review of the Admission Record reflected the resident was admitted to the facility with diagnoses which included injury of the cervical (neck) spinal cord, muscle weakness and difficulty walking. A review of the Progress Notes (PN), Health Status Note, dated 8/3/24 at 8:14 PM, the resident was observed with SOB (shortness of breath) and skin pale in color. The NP (Nurse Practitioner) was contacted and ordered resident to be sent out [to the hospital] via 911. A review of the Medication Review Report for August 2024 did not reveal a physician's order for the resident to be sent to the hospital on 8/3/24. On 8/14/24 at 8:42 AM, the surveyor interviewed the DON who stated there should be a physician's order for a resident to be transferred to the hospital. The DON acknowledged there was no order for Resident #137 to be transferred to the hospital in the resident's medical record. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-11.2(b); 27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 34423 Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to follow physician orders specifically to change the piston set (a device intended for medical purposes that consists of a calibrated hollow barrel and a movable plunger) every 24 hours for 1 of 3 residents reviewed for Tube Feeding, (Resident #54). This deficient practice was evidenced by the following: On 08/12/2024 at 12:10 PM, a review of a facility policy titled Enteral Tubes with a last revised date of 06/3/2024, revealed under the Procedure section: 16. Rinse Thoroughly with tap water and place in a labeled dry plastic bag to remain at bedside. *Change syringe and bag every 24 hours. During the initial tour of Pavilion 2 on 08/05/2024 at 10:58 AM, Resident # 54's piston set was observed on the bed side table. The bottled had the residents name and was dated 8/3/24. A review of the Electronic Medical Record on 08/06/2024 at 09:29 AM, revealed the following: Resident #54 was admitted with diagnoses including but not limited to: Multiple Sclerosis, Gastrostomy (G Tube), Dysphagia (difficulty swallowing). A review of the most recent Quarterly Minimum Data Set, an assessment tool, dated 05/24/2024, revealed under section K Resident #54 had a swallowing disorder and had a feeding tube under Nutritional Approaches. A review of the Physician Order Summary included a physician order with a start date of 02/23/2022 to change piston set every shift (Name and date bottle/package) every night shift. A review of the Medication Administration Record for August 2024 revealed the aforementioned order. Under the dates 08/04 and 08/05 signatures that the order was completed were observed. During an interview with the surveyor on 08/12/2024 at 09:23 AM, the Registered Nurse/Unit Manager (RN/UM #1) was asked what was the facility process for the use of piston sets. RN/UM #1 replied they are changed daily in the evening, usually 11-7 shift which is night. They are used to flush water and give hydration through the G tube. It is important to change every 24 hours for infection control. The surveyor asked what was meant by infection control and she said you could be entering bacteria directly into blood stream of the resident. It is also used to check residual as well. The surveyor also asked where this would be documented, and she responded on the TAR (Treatment Administration Record). RN/UM #1 went on to say if there are initials on the TAR it means it was changed and completed. They are signing for that. On 08/12/2024 at 09:32 AM, the surveyor reviewed the evidence of the irrigation set dated 8/3/24 with RN/UM #1 and confirmed that on 08/05 it had not been changed for 2 days even though it was signed out as having been done. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 08/12/2024 at 11:05 AM, the Director of Nursing (DON) was asked what was the process for the use of piston sets. The DON replied, to provide fluids or nutrition to the patient. They are supposed to be changed every 24 hours. It is an infection control issue. The surveyor questioned what was meant by infection control issue. The DON responded Make sure that anything going right into their (residents) body is safe and not introduce foreign bacteria into GI (gastrointestinal) system. When asked where this would be documented, the DON replied, It should be on the TAR. On 08/12/2024 at 11:09 AM, the surveyor reviewed the evidence with the DON who confirmed it (the piston set) should have been changed. NJAC 8:39-27.1(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 34423 Based on observation, interview, review of the Electronic Medical Record (EMR) and review of other facility documentation, it was determined that the facility failed to ensure a resident who used Oxygen therapy at night, had a Physician Order. This deficient practice was identified for 1 of 4 residents reviewed for Respiratory Care (Resident #117) and was evidenced by the following: During the initial tour of the facility on 08/05/2024 at 10:29 AM, the surveyor observed oxygen tubing next to the resident in bed. The tubing was not dated. Resident #117 said he/she uses it at night. There was no observed oxygen sign outside the room. On 08/08/2024 at 01:10 PM, a review of a facility policy titled Oxygen Administration with a revised date of January 2024, revealed under the Policy section: Oxygen administration will be carried out only with a physician order. A review of the EMR on 08/05/2024 at 12:00 PM, revealed the following: According to the Admission Record Resident #117 was admitted to the facility with diagnoses including but not limited to: Hypertensive heart Disease. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate resident care, dated 08/03/2024, revealed Resident #117 had a Brief Interview for Mental Status score of 13/15, indicating Resident #117 was cognitively intact. The MDS indicated under section O that Resident #117 used oxygen upon admission and while a resident. A review of the Wts. (weights)/Vitals tab in the EMR included documentation of Pulse Ox (noninvasive test that measures the oxygen saturation level in the blood) under the Method section Oxygen via Nasal Cannula. A review of the Order Summary Report with Active Orders as of 08/13/2024, did not include a physician order for Resident #117 to use oxygen at bedtime. A review of the comprehensive Care Plan revealed a Focus area of [resident name] has potential for altered respiratory status/difficulty breathing r/t (related to) COPD, respiratory/cold symptoms Created on: 08/14/2023. Interventions included but were not limited to: OXYGEN SETTINGS: O2 via nasal cannula @ 2L/min (liters per minute) at bedtime Created on: 05/08/2024 During an interview with the surveyor on 08/12/2024 at 11:31 AM, Licensed Practical Nurse (LPN #1) was asked what was the facility policy regarding oxygen use. LPN #1 responded, We need a physician order for oxygen. We look at records to make sure liters and definitely get an order. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 08/13/2024 at 11:31 AM, Registered Nurse/Unit Manager (RN/UM #1) was asked what was the facility policy regarding oxygen use. RN/UM #1 responded, It depends on the medical condition determined by the physician and the physician orders. The surveyor asked RN/UM #1 if oxygen use required a physician order. RN/UM #1 said, If in emergency no. If standard use continuously, there would be a sign on the door and a physician order for the oxygen. On 08/13/2024 at 11:36 AM, RN/UM #1 told the surveyor, I was told in the past he/she has used oxygen before. The surveyor asked RN/UM #1 to look at the resident's orders. RN/UM #1 then told the surveyor, No, I do not see a physician order for oxygen. The surveyor also reviewed with RN/UM #1 that Resident #117 told the surveyor he/she wore oxygen every night. The surveyor also reviewed with the RN/UM #1 that the nurses are documenting pulse ox's on oxygen. RN/UM #1 looked at the EMR and saw the documentation for the pulse ox's on nasal cannula and said, I see that. During an interview with the surveyor on 08/13/2024 02:40 PM, the facility Director of Nursing (DON) was asked what the facility policy was regarding oxygen use. The DON said they have to have an order from MD (physician) with amount of oxygen needed, whether prn (as needed) or continuous, how given either nasal cannula or via mask, and a care plan. NJAC 8:39-27.1(a)

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	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Front Rehabilitation and Healthcare Center	5101 North Park Drive Pennsauken, NJ 08109

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39460 Based on observation, interview, review of medical records and other facility documentation, it was determined that the facility failed to complete the dialysis communication book for a resident on dialysis (Resident #94). This deficient practice was identified for 1 of 1 residents reviewed for dialysis. The evidence was as follows: On 8/16/2024 at 12:00 PM the surveyor reviewed the facility's Dialysis Management (Hemodialysis) policy with a revised date of 6/2024 included . If Dialysis is provided at off-site Dialysis Center .Assure facility completed Dialysis communication form accompanies resident to dialysis on treatment days, to communicate resident information and coordinate care between Dialysis center and facility .Dialysis center personnel to complete Dialysis communication form and return and return to the facility . Upon return from Dialysis Center, review information provided on Dialysis communication form . On 8/7/24 at 11:18 AM the surveyor observed the Resident #94 in a wheelchair in their room. The resident stated they went to dialysis on Tuesday, Thursday and Saturday and further stated he/she would bring a communication binder back and forth from the dialysis center that contained his/her records. The surveyor reviewed the medical record for Resident #94 on 08/06/2024 at 11:43 AM. A review of the Admission Record reflected that the resident was admitted to the facility with diagnoses that included chronic kidney disease; dependence on renal dialysis; and type II diabetes mellitus. A review of the Order Summary Report included a physician's order (PO) dated 5/13/24, for hemodialysis every Tuesday, Thursday, and Saturday; 10:45 AM- 2:30 PM return time, wheelchair transport. A review of the most recent comprehensive Minimum Data Set (MDS) dated [DATE], reflected the resident had a brief interview for mental status score of 15 out of 15, which indicated a fully intact cognition. A further review of the MDS indicated the resident had received dialysis treatments while in the facility. On 8/12/2024 at 11:07 AM, the surveyor interviewed the residents Licensed Practical Nurse (LPN #1) who stated Resident #94 received dialysis on Tuesday, Thursday, and Saturday, and that the facility communicated with the dialysis center using a communication book the resident would transport with them. LPN #1 further explained the facility nurse would fill out the top portion with the resident's vital signs and the dialysis center fills out the bottom portion. A review of Resident # 94's dialysis communication book which included forms dated 8/1/24, 8/3/24, 8/6/24, 8/8/24, and 8/10/24 and observed the following: On 8/1/24 the dialysis center did not complete their portion of the Nurse Communication Record. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/3/24 the facility did not complete their portion of the Nurse Communication Record. , On 8/12/2024 at 11:26 AM the surveyor interviewed the resident's Registered Nurse Unit Manager (RN/UM #1) who stated that in July 2024 the resident returned back from dialysis without their communication book from dialysis, so a new communication book/binder was created beginning August 2024. At that time the surveyor and the RN/UM #1 reviewed the resident's dialysis communication book and she confirmed two of the five forms provided were not completed in their entirety. RN/UM #1 stated the sending nurse was responsible to complete the top portion of the form and the dialysis nurse would complete the bottom portion of the form. RN/UM #1 further stated the nurse who received the resident after dialysis was responsible for reviewing the form and should call the dialysis center if the form was not completed. On 8/13/2024 at 2:22 PM, the survey team met with the facility administration. The Director of Nursing (DON) stated the nurses were responsible to ensure the dialysis communication form was completed in its entirety and sent with the resident to dialysis. Then upon the return to the facility from dialysis the nurse should review the form for any treatments provided or recommendations. If the form was not completed from the dialysis center, then the nurse should have reached out to the dialysis center to have the form completed. NJAC 8:39-27.1(a)

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NAME OF PROVIDER OR SUPPLIER River Front Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5101 North Park Drive Pennsauken, NJ 08109	

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39460 Complaint # NJ 158956, 166158, 170632 Based on interview, and review of other facility documentation, it was determined the facility failed to ensure there was sufficient nursing staff on a 24-hour basis to provide nursing care to the residents. This deficient practice was evidenced by the following: A review of the provided Facility assessment dated [DATE] included .our approach to ensure adequate staff based on our resident population and their needs for care . for Certified Nurse Aides 1:8 Residents for days, 1:10 evenings, 1:14 nights, one Restorative Aide day shift weekdays and one Restorative Aide Day shift weekends. During resident Council meeting on 08/08/2024 at 11:00 AM, a resident stated nights are short staffed, and wait time is long. Only two were on 2nd floor last night. 2 of 5 residents stated they have waited 4 to 5 hours for an aide. A review of New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the following weeks weeks revealed the facility was deficient in CNA staffing for residents as follows: 1. For the 2 weeks of staffing prior to survey from 07/21/2/2024 to 08/03/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: The facility provided less than half the required CNA staffing for resident care on 4 day shifts. -07/21/24 had 14 CNAs for 168 residents on the day shift, required at least 21 CNAs. -07/22/24 had 16 CNAs for 168 residents on the day shift, required at least 21 CNAs. -07/23/24 had 16 CNAs for 168 residents on the day shift, required at least 21 CNAs. -07/24/24 had 12 CNAs for 168 residents on the day shift, required at least 21 CNAs. -07/25/24 had 16 CNAs for 170 residents on the day shift, required at least 21 CNAs. -07/26/24 had 15 CNAs for 170 residents on the day shift, required at least 21 CNAs. -07/27/24 had 13 CNAs for 170 residents on the day shift, required at least 21 CNAs. -07/28/24 had 12 CNAs for 173 residents on the day shift, required at least 22 CNAs. -07/29/24 had 13 CNAs for 171 residents on the day shift, required at least 21 CNAs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-07/29/24 had 10 total staff for 171 residents on the overnight shift, required at least 12 total staff. -07/30/24 had 15 CNAs for 168 residents on the day shift, required at least 21 CNAs. -07/31/24 had 16 CNAs for 165 residents on the day shift, required at least 21 CNAs. -08/01/24 had 13 CNAs for 164 residents on the day shift, required at least 20 CNAs. -08/02/24 had 13 CNAs for 164 residents on the day shift, required at least 20 CNAs. -08/03/24 had 11 CNAs for 163 residents on the day shift, required at least 20 CNAs. 2. For the week of Complaint staffing from 07/30/2023 to 08/05/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -07/30/23 had 5 CNAs for 163 residents on the day shift, required at least 20 CNAs. -07/31/23 had 16 CNAs for 163 residents on the day shift, required at least 20 CNAs. -08/01/23 had 19 CNAs for 163 residents on the day shift, required at least 20 CNAs. -08/04/23 had 18 CNAs for 159 residents on the day shift, required at least 20 CNAs. -08/05/23 had 18 CNAs for 159 residents on the day shift, required at least 20 CNAs. 3. For the week of Complaint staffing from 08/13/2023 to 08/19/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -08/13/23 had 13 CNAs for 160 residents on the day shift, required at least 20 CNAs. -08/18/23 had 17 CNAs for 159 residents on the day shift, required at least 20 CNAs. 4. For the week of Complaint staffing from 08/27/2023 to 09/02/2023, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -08/27/23 had 9 CNAs for 157 residents on the day shift, required at least 20 CNAs. -08/28/23 had 16 CNAs for 157 residents on the day shift, required at least 20 CNAs. -09/01/23 had 18 CNAs for155 residents on the day shift, required at least 19 CNAs. 5. For the week of Complaint staffing from 12/31/2023 to 01/06/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 2 of 7 evening shifts as follows: -12/31/23 had 10 CNAs for 155 residents on the day shift, required at least 19 CNAs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-01/01/24 had 11 CNAs for 155 residents on the day shift, required at least 19 CNAs. -01/01/24 had 14 total staff for 155 residents on the evening shift, required at least 15 total staff. -01/02/24 had 14 CNAs for 155 residents on the day shift, required at least 19 CNAs. -01/03/24 had 16 CNAs for 155 residents on the day shift, required at least 19 CNAs. -01/04/24 had 17 CNAs for 155 residents on the day shift, required at least 19 CNAs. -01/05/24 had 11 CNAs for 155 residents on the day shift, required at least 19 CNAs. -01/06/24 had 12 CNAs for 155 residents on the day shift, required at least 19 CNAs. -01/06/24 had 14 total staff for 155 residents on the evening shift, required at last 15 total staff. 6. For the week of Complaint staffing from 01/21/2024 to 01/27/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, and deficient in total staff for residents on 2 of 7 evening shifts as follows: -01/21/24 had 10 CNAs for 162 residents on the day shift, required at least 20 CNAs. -01/21/24 had 15 total staff for 162 residents on the evening shift, required at least 16 total staff. -01/22/24 had 7 CNAs for 162 residents on the day shift, required at least 20 CNAs. -01/23/24 had 14 CNAs for 161 residents on the day shift, required at least 20 CNAs. -01/24/24 had 15 CNAs for 161 residents on the day shift, required at least 20 CNAs. -01/25/24 had 16 CNAs for 161 residents on the day shift, required at least 20 CNAs. -01/26/24 had 16 CNAs for 161 residents on the day shift, required at least 20 CNAs. -01/26/24 had 15 total staff for 161 residents on the evening shift, required at least 16 total staff. -01/27/24 had 16 CNAs for 158 residents on the day shift, required at least 20 CNAs. 7. For the week of Complaint staffing from 05/25/2024 to 06/01/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -05/26/24 had 18 CNAs for 166 residents on the day shift, required at least 21 CNAs. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: River Front Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 5101 North Park Drive, Pennsauken, NJ 08109	

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-05/27/24 had 12 CNAs for 165 residents on the day shift, required at least 21 CNAs. -05/27/24 had 9 total staff for 165 residents on the overnight shift, required at least 12 total staff. -05/28/24 had 16 CNAs for 165 residents on the day shift, required at least 21 CNAs. -05/29/24 had 16 CNAs for 165 residents on the day shift, required at least 21 CNAs. -05/30/24 had 15 CNAs for 165 residents on the day shift, required at least 21 CNAs. -05/31/24 had 16 CNAs for 165 residents on the day shift, required at least 21 CNAs. -06/01/24 had 15 CNAs for 165 residents on the day shift, required at least 21 CNAs. On 8/14/24 at 10:34 AM, the surveyor interviewed the facility Staffing Coordinator (SC) who stated she was aware of the staffing requirements for Certified Nurse Aides in New Jersey. The SC stated one CNA to 10 residents on dayshift, one CNA to 10 residents on the evening shift and one CNA to 20 residents on the night shift. The SC stated she did her best and believed they were meeting the minimum staffing requirements a majority of the time. During an interview with the Director of Nursing (DON) on 08/13/2024 at 02:44 PM, the surveyor reviewed the Facility Assessment and asked the DON what was the facility's staffing pattern for nurses? The DON explained the following: PAV (Pavilion) 1 DAY 2 nurses EVE 2 nurses NIGHT 2 nurse PAV 2 DAY 2 nurses EVE 2 nurse NIGHT 1 nurse PAV 3 DAY 2 nurses EVE 2 nurses NIGHT 1 nurse.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37547 Cross Reference F867 Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to ensure: a) a discontinued and expired medication (pantoprazole, used to treat gastroesophogeal reflux disease /GERD, a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach) was removed from active inventory b) maintain an accurate accountability for controlled substances within the medication administration cart c) a controlled medication that was expired was removed from an automated medication dispensing system. This deficient practice was identified for 1 of 3 medication carts, and 1 of 1 automated medication dispensing system reviewed during the medication storage task. A review of the facility policy, Medication Administration (Reviewed 06/24) revealed the following: .Check the expiration date on medication label. A review of an undated facility policy, 6.0 Inventory Control of Drugs revealed the following: Controlled drugs are inventoried and documented under proper conditions with regard to security and state/federal regulations. .Schedule II medications are counted by the oncoming nurse and the outgoing nurse at least once (1) a day or at the change of each shift and documented on a Controlled Drug Count Verification (Shift Count Sheet for Narcotics). A review of the facility policy, 4.0 Schedule II Controlled Substance Medication (Revised 10/01/18) revealed the following: .An inventory count of all CDS (controlled dangerous substances) medications stored on each nursing unit shall be performed at each change of shift by both the incoming and outgoing nurse. Both nurses are responsible for the count and must sign the inventory count form. This deficient practice was evidenced by the following: 1. On 08/07/2024 at 11:23 AM, during a medication cart inspection of the Short Hall Medication Cart on the Pavilion Two Unit in the presence of Licensed Practical Nurse (LPN #1), the surveyor noted a bingo card (unit dose medication blister packaged onto a multiple-dose card) that contained pantoprazole 40 milligrams (mg) that was ordered for Resident #8 had expired on 08/01/24. When interviewed at that time, LPN #1 stated that the resident received the medication this morning. LPN #1 further stated that he had not seen the expiration date. On 08/07/2024 at 11:56 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM #1) who stated that staff should check medications before the medication pass to make sure that they were not expired. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/08/2024 at 12:48 PM, the surveyor conducted a telephone interview with the Consultant Pharmacist (CP) who stated that nursing should look at the expiration date on the medication prior to administration. The CP stated that she expected nursing to look through their carts each time that they handled medications. The CP stated that as a CP, part of her role was to check the bingo cards during cart inspection. On 08/08/2024 at 1:33 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the expiration date should have been on the back of the blister pack and the nurse should have looked at the expiration date prior to administration. The surveyor reviewed the unsampled resident's electronic health record and noted an order for pantoprazole 40 mg give 1 (one) tablet orally one time a day for GERD was ordered on 05/24/22 and was discontinued on 03/03/24. The discontinued medication remained within the resident's active inventory of medications through 08/07/24, until surveyor inquiry. 2. On 08/07/2024 at 11:34 AM, the surveyor reviewed the Narcotic (a controlled substance used to dull the senses and relieve pain) Book in the presence of LPN #1 for the Pavilion Two Unit Short Hall Medication Cart. The surveyor reviewed the Narcotic Count Record for August 2024 and noted that LPN #1, who was scheduled to work the 7 AM to 3 PM shift, had already signed his name in the space provided for the Offgoing Nurse Signature for the 3 PM to 11 PM shift. When the surveyor asked why he signed the Narcotic Count Record prior to performing a narcotic count of all controlled medications within the medication cart with the Oncoming Nurse he stated, So I do not forget. On 08/07/2024 at 11:56 AM, the surveyor interviewed RN/UM #1 of Pavilion Two who stated that the purpose of the narcotic count was for the incoming and outgoing nurses to document that they were in agreement that the count was correct. The RN/UM #1 stated that it was not acceptable to sign out for the outgoing shift before the count was completed. LPN #1 was present at that time, and stated that he was mistaken. On 08/08/2024 at 12:48 PM, the surveyor conducted a telephone interview with the Consultant Pharmacist (CP) who stated that the 7 AM to 3 PM nurse absolutely should not have signed out as the outgoing nurse on the 3 PM to 11 PM shift because they did not count with the incoming nurse. The CP stated that the whole idea was to make sure that the narcotic count was okay. The CP stated, It is not okay to pre-sign. On 08/08/2024 at 1:33 PM, the surveyor interviewed the DON who stated that the process for the narcotic count was to sign to verify what you see at that point, because things change. The DON stated that both the incoming and outgoing nurses should count what they have in the medication cart together and then sign afterward. The DON further stated, We should never pre-sign for anything. 3. On 08/07/2024 at 12:13 PM, the surveyor observed the DON and RN/UM #1 as they performed a cycle count of back up controlled medications stored within the automated medication dispensing system. The DON stated that the Registered Nurse Supervisor and the Infection Preventionist (IP) performed a cycle count daily. (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the inventory count, the DON stated that eight of eight Fentanyl (an opioid pain reliever) 50 microgram/hour (mcg/hr) patches, expired on 07/20/24. The DON stated that the expired medication should have been identified during the daily cycle count. The DON stated the pharmacy also should have known the medication was expired. The DON stated that the efficacy (ability to produce a desired or intended result) would be compromised if the medication were administered. The DON further stated that the expired Fentanyl patches should have been removed from the automated dispensing system on 07/01/24, as the facility went by the first day of the month. On 08/08/2024 at 12:48 PM, the surveyor interviewed the Consultant Pharmacist (CP) who stated that there should not have been expired Fentanyl patches in the automated medications dispensing system. The CP stated that the staff should have checked the expiration dates when they did the counts. The CP stated that the potency of the Fentanyl patches would have been affected if it were expired and the resident may have received less medication if the patch were administered. The CP stated, There is no excuse for expired medications, they should be checking those things. NJAC 8:39-29.4(g); 29.7 (c); 29.1(e)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315225	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
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F 0756

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40039

Based on observation, interview, review of the medical record, and review of pertinent facility records it was determined that the facility failed to follow through on recommendations made by the consultant pharmacist (CP) during their monthly medication regimen review (MRR) in a consistent and timely manner. This deficient practice was identified for 2 of 5 residents reviewed for unnecessary medications, (Resident #55 and Resident #89) and was evidenced by the following:

The surveyor reviewed the facility policy on 08/13/2024 at 10:45 AM, titled Medication Regimen Review Policy NO: ROP-32, Reviewed: 6/2/2024. The following was revealed under POLICY: It is the facilities policy to provide a Medication regimen review (MRR) for all residents admitted to the nursing facility. The following was revealed under Policy Explanation and Compliance Guidelines:

1. Medication Regimen Review (MRR) is a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication. The review includes preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team.

4. The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and the reports must be acted upon.

c. The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

7. Upon completion of the MRR, the facility designee and/or physician, will respond to the recommendations in a timely manner.

10. Each resident's drug regimen remains free of unnecessary drugs. An unnecessary drug is any drug when used:

a. In excessive doses, including duplicate therapy.

b. For excessive duration.

c. Without adequate monitoring.

d. Without adequate indications for its use.

e. In the presence of adverse consequences which indicate the dose should be reduced or discontinued.

(continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.On 08/06/2024 at 08:43 AM Resident #55 was observed lying in bed and asleep. Resident #55 did not respond to the surveyor voice. A review of the Electronic Medical Record on 08/06/2024 at 12:01 PM revealed the following: According to the Admission Record Resident #55 had the following but not limited to diagnoses: Osteoarthritis of left knee, diabetes mellitus, encounter for attention to colostomy, and acquired absence of left toe. A review of the comprehensive Minimum Data Set (MDS), an assessment tool dated June 14, 2024, revealed that Resident #55 had a Brief Interview for Mental Status score of 15/15 indicating intact cognition. Section N of the MDS revealed Resident #55 received antidepressant, anticoagulant, opioid and hypoglycemic medications daily. A review of the Order Summary Report revealed that Resident #55, as of 8/14/2024 had the following active order: Dicyclomine HCl (hydrochloric acid) Oral Tablet 20MG (milligram) (Dicyclomine HCl) Give 1 tablet by mouth every 12 hours as needed for Abdominal pain Order Status: Active Order Date: 01/19/2024. A review of the July 2024 and August 2024 Medication Administration Record (MAR) revealed Resident #55 had not received Dicyclomine HCl oral tablet during the month of July or August 2024. A review of the CP MRR Note To Attending Physician/Prescriber MRR Date: 6/24/2024 revealed the following CP recommendation: Recommend discontinuing PRN (as necessary) Dicyclomine. The resident has not used medication > (greater than) 60 days. A review of the Physician/Prescriber Response revealed that the physician/prescriber Agreed: and was signed and dated 7/2/24. A review of the Consultant Pharmacist's Medication Regimen Review document for recommendations created between 6/23/2024 and 6/24/2024 revealed the following recommendation: Recommend discontinuing PRN Dicyclomine. The resident has not used medication for > 60 days. Under the Follow-Through heading the following was documented: Note written to physician 2. On 08/06/2024 at 09:07 AM, Resident #89 was observed lying in bed with the head of the bed elevated. Resident #89 was asleep, and no maladaptive behaviors were exhibited on this observation. A review of the Medical Record on 08/06/2024 at 10:37 AM revealed the following: A review of the Admission Record revealed Resident #89 had the following but not limited to diagnoses: Chronic Obstructive Pulmonary Disease (a type of progressive lung disease), morbid obesity, hypertensive heart disease (high blood pressure), atherosclerotic heart disease, and paranoid schizophrenia. A review of Resident #89's comprehensive MDS, dated [DATE], revealed that Resident #89 had a Brief Interview for Mental Status score of 15/15 indicating intact cognition. Section N of the MDS revealed that Resident #89 received a diuretic (promotes increased production of urine) daily. A review of the Order Summary Report with Active Orders As Of: 08/14/2024, revealed Resident #89 had the following physician/practitioner order: Lasix Oral Tablet 40 MG (Furosemide) Give 1 tablet by mouth one time a day for edema Order Status: Active Order Date: 10/04/2023. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #89's comprehensive care plan revealed a care plan Focus: I am on diuretic therapy (Lasix) r/t (related to): HTN (hypertension) Created on: 05/24/2023. The following was revealed under Interventions: Ask physician to review medication for possible dose reduction every three months Created on: 05/24/2023 and Administer medication as ordered and monitor for side effects. Report to MD as appropriate. Created on: 05/24/2023. A review of Resident #89's MAR for 7/1/2024 - 7/31/2024 revealed that Resident #89 received Lasix Oral Tablet 40 MG daily at 0800 (8:00 AM) for the dates of 7/1/2024 through 7/31/2024. A review of Resident #89's 8/1/2024 - 8/31/2024 MAR revealed that Resident #89 received Lasix Oral Tablet 40 MG daily from 8/1/2024 through 8/8/2024 (MAR was provided to surveyor on 8/8/2024). On 08/08/2024 at 11:33 AM the surveyor conducted a review of the CP MRR for the past 6 month period. Review of the Consultant Pharmacist's Medication Regimen Review for recommendations created between 6/23/2024 and 6/24/2024 revealed the following recommendation for Resident #89: Resident has been on Lasix for edema since 10/5/2023. Please re-evaluate continuous need and consider discontinuing. Has the edema resolved? Under the Follow-Through heading the following documentation was observed: Note written to physician. A review of the Note To Attending Physician/Prescriber MRR Date: 6/24/2024 revealed the following: Resident has been on Lasix for edema since 10/5/2023. Please re-evaluate continuous need and consider discontinuing. Has the edema resolved? The following was documented under Physician/Prescriber Response: Agree signed and dated 7/2/24. A review of Resident #89's progress notes dated 7/2/2024 and 7/3/2024 did not reveal any documentation concerning the discontinuation of the Lasix medication. On 08/13/2024 at 08:53 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM #1) who was assigned to the unit that Resident #55 and #89 resided. The surveyor asked LPN/UM #1 to describe the facility process for responding to the CP MRR. LPN/UM #1 told the surveyor The physician recommendations are given to the doctors in a folder monthly. They respond to them and sign them and then they are given back to me. I (UM/LPN #1) take care of the monthly nursing recommendations. It is up to the physicians to handle and agree or disagree with the CP monthly medication regimen reviews. During a follow-up interview with LPN/UM #1 on 08/14/2024 at 09:02 AM, the surveyor asked LPN/UM #1 if she had ever been responsible for discontinuing physician orders recommended by the CP. LPN/UM #1 replied, I've never had to discontinue an order from the physician side. I/we (nursing) are only responsible for nursing recommendations. The physician is responsible for carrying out their own recommendations concerning consultant pharmacy recommendations. On 08/14/2024 at 09:52 AM, the surveyor conducted an interview with the facility Director of Nursing (DON). The surveyor asked the DON what the facility process was concerning the CP MRR. The DON told the surveyor, The physician will discontinue the order, or they will provide nursing with a verbal order to discontinue a CP recommendation if they agree with the recommendation. That applies to physicians and nurse practitioners. For Resident #89 the Lasix order should have been discontinued on 7/2 or 7/3/2024. Concerning Resident #55 Yes, the Dicyclomine should have been discontinued according to the physician checking Agree and signing and dating. I agree that there is a breakdown in the MRR process, and I take that seriously. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NJAC 8:39-29.3(a)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40039 Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: The surveyor reviewed a facility policy on 08/05/2024 at 12:02 PM, titled [company name] Dining Services Food Storage, undated. The following was revealed under Canned Fruits: Dented or bulging cans shall be placed on Damaged Goods Shelf and returned for credit. The following was revealed under Canned Vegetables: Dented or bulging cans shall be placed on Damaged Goods Shelf and returned for credit. The surveyor reviewed a facility policy on 08/05/2024 at 12:02 PM, titled [facility name] Dining Services Pots and Pans - Sanitizing Solution, undated. The following was revealed under the heading SANITATION OF EQUIPMENT: NOTE: Allow all items to air dry. Towels shall never be used for drying. When items are dry, store in proper storage area. On 08/11/2024 at 12:26 PM, the facility provided the surveyor with a copy of the facility policy for refrigerators in the pantries, Reviewed 2/2024. The policy revealed the following under the heading POLICY: The facility recognizes the importance of ensuring that all foods are held at a safe temperature to ensure the safety of its residents. All refrigerators on the units will be monitored daily for correct temperatures. The policy did not address the monitoring of freezer temperatures. On 8/5/2024 from 9:26 to 10:05 AM, the surveyors, accompanied by the facility Food Service Director (FSD), observed the following in the kitchen: 1. In the dry storage room a can of mushrooms on a multi-tiered rack had a significant dent on the seam. The FSD removed the can of mushrooms to the designated dented can area with the other dented cans that were removed for dents. 2. A stack of five (5) deep/full pans on a middle rack of the pot and pan storage rack were stored in the inverted position. The surveyor picked up the top pan with their hand and observed a clear, watery substance on the bottom surface of the pan beneath. Further observation revealed that the additional three (3) pans in the stack also were covered with a wet watery substance, a process known as wet nesting (occurs when wet dishes or pots and pans are stacked, preventing them from drying, and creating conditions that are ripe for microorganisms to grow). The FSD removed the stack of five (5) pans from the pot/pan storage rack to be rewashed and sanitized. On 08/08/2024 from 12:57 to 1:17 PM, the surveyors, accompanied by Unit Manager/Licensed Practical Nurse (UN/LPN #1) observed the following on the PAV1 (pavilion 1) pantry: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The surveyor reviewed the PAV1 Pantry Food Refrigerator Temperature Log, dated [DATE]. The log revealed that the Refrigerator range for foods was 32-40 degrees Fahrenheit and Freezer: -10 to 0 F. Observation of the interior of the pantry freezer determined there was no internal thermometer in the freezer and no temperatures were recorded for the [DATE] PAV1 Pantry freezer on the temperature log only refrigerator temperatures. On interview the UM/LPN # stated that she was not aware that the freezer required a thermometer and that the temperature needed to be monitored. UM/LPN # told the facility Infection Preventionist who was walking by that the unit needs a thermometer for the PAV 1 freezer in the presence of the surveyor. On 08/08/2024 from 1:20 to 1:30 PM, the surveyor, accompanied by LPN/UM #1 observed the following in the PAV3 (pavilion 3 pantry): 1. The temperature log, as described above for PAV1 had no freezer temperatures recorded for the dates 8/1 thru 8/8/2024. Observation of the freezer revealed no internal thermometer was present to monitor the freezer temperature. On interview LPN/UM #1 stated, I was not aware that we had to do the freezer as well as the refrigerator. It makes perfect sense. I will get a thermometer. NJAC 18:39-17.2(g)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 40039 Cross Reference F755 Based on observation, interview, and review of pertinent facility records, it was determined that the facility Quality Assessment and Performance Improvement (QAPI) committee failed to utilize the Facility Performance Improvement Plan (PIP) to follow the facility process to measure and utilize data for checking medication carts three times weekly for expired medications. This deficient practice was evidenced by the following: On 08/13/2024 at 09:51 AM, the surveyor reviewed the facility policy titled Quality Assurance Performance Improvement, Date Reviewed/Revised: 9/14/23. The following was revealed under Purpose: Our Quality Assurance and Performance Improvement Program (QAPI) represent our facility's commitment to continuous quality improvement. The program ensures a systematic performance evaluation, problem analysis, and implementation of improvement strategies to achieve our performance goals. The following was revealed at II. Guidelines for Governance and Leadership: a. Nursing and Facility Administration are responsible and accountable for developing, leading, and closely monitoring a QAPI program. Under an additional Policy heading on page 3 of 7 of the QAPI policy the following was revealed: 5. The QAPI Team oversight responsibilities shall include, but are not limited to the following: Utilize facility data to identify opportunities to improve systems and care. Data may include, but is not limited to; grievance logs, medical record review, skilled care claims, fall log, pressure ulcer log, treatment logs, staffing trends, incident and accident reports, quality measures, survey outcomes, etc. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. On 08/13/2024 at 10:50 AM, the surveyors, while reviewing the facilities QAPI policy and procedure and QAPI plan asked the facility administration to provide the surveyors with 3 current QAPI's that the facility was addressing. After receiving the binder, the surveyors observed that in February of 2024 the facility identified via pharmacy reports that expired medications were a major concern. Root cause analysis identified 1.) expired medications on carts and medication rooms were found during inspection by the consultant pharmacist (CP). 2. Nurses were not checking medication carts for expired medications. Goals & Objectives were defined as: 1.) To have all expired meds out of medication carts and stock rooms. 2. Educate all Licensed Practical Nurses about checking carts for expired medications. Responsible team members were identified as DON (Director of Nursing), ADON (Assistant Director of Nursing), and LPN (Licensed Practical Nurse). Estimated and Completion date were ongoing. Education was identified as being on going. The Comments section of the February 2024 QAPI Action Plan noted that Education will be ongoing and that medication carts will be checked periodically for expired medications three (3) times per week. A copy of the April 2024 QAPI plan revealed that Pharmacy reports have expired medications as a major concern. Root Cause Analysis revealed the following: 1.) Expired medications on carts, medication rooms were found during inspection. and 2.) Charge nurses are not checking carts for expired medications. In the Action Items section, the QAPI plan revealed 1. LPN staff will be educated on dating and disposing of medications. and 2. All carts will be checked periodically for expired medications. Start date was listed as 2/2024 and responsible team members were DON, ADON, LPN. Estimated and Actual Completion Date were identified as ongoing. The following was documented in the Comments section of the plan: Education will be ongoing. Labeling is still a concern with compliance at 77% which is up from March Also in the Comments section, it was stated that Checks will be done regularly. 4/24 - Currently all expired medications are out of med rooms and carts. The surveyors did not observe any data collection forms in the facility QAPI binder associated with the data collection for the expired medication QAPI plan for February or April of 2024. At this point the surveyors requested from the facility DON and/or Licensed Nursing Home Administrator copies of data collection for the QAPI plan for expired medication cart medications that was revealed via consultant pharmacist reports. On 08/13/2024 at 01:09 PM, during an interview with the facility DON and ADON, the DON told the surveyors that they do not have any data collected for the expired medication QAPI plan for February or April of 2024 and that they cannot provide the surveyor with any data from the 2/2024 QAPI Action Plan related to pharmacy reports that have expired meds as a major concern. The DON further told the surveyor that the reason they did not have any audits is because the QAPI plan did not work, and they are coming up with a new one. On 08/13/2024 at 02:32 PM, the facility told the surveyor when asked where the facility obtained a rate of 77% compliance on the April 2024 QAPI plan the DON told the surveyor that It's possible that the data reported came from the monthly CP visit. NJAC 8:39-33.1(c) 33.2(a)(b)(d)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37547 Based on observation, interviews, and review of pertinent facility documentation, it was determined that the facility failed to a.)properly store and maintain both sterile and non-sterile medical supplies in a safe and sanitary manner and b.) ensure that laundry staff used the appropriate personal protective equipment while handling items that were likely contaminated with infectious bodily fluids. This deficient practice was identified for 2 of 2 medication storage rooms reviewed for the medication storage task and 1 of 1 laundry staff and was evidenced by the following: On 08/07/2024 at 9:41 AM, during the inspection of the Pavilion Three Medication Storage Room, in the presence of Licensed Practical Nurse Unit Manager (LPN/UM #1) the surveyor observed: three enema kits, two packages of heel booties, and a box of wound treatment supplies which included: a half filled box of fifty count 4 x 4 gauze pads, a fifteen count box of border gauze dressings, two rolls of gauze, and a roll of paper tape that were stored beneath the handwashing sink. LPN/UM #1 stated that Central Supply stocked the supply room and placed the items under the sink. LPN/UM #1 stated that she never checked under the sink and did not know that the supplies were there. LPN/UM #1 further stated that the issue with the items being stored under the sink was contamination. On 08/07/2024 at 12:45 PM, during the inspection of the Pavilion Two Medication Room in the presence of the Registered Nurse/Unit Manager (RN/UM #1), the surveyor observed a one liter bag of 0.45% sodium chloride injection (Intravenous fluid solution) and noted that the outer plastic packaging was previously opened and remained in storage. The RN/UM #1 stated that the effectiveness of the medication could be compromised. On 08/08/2024 at 10:15 AM, the surveyor interviewed the Infection Preventionist (IP) in the presence of the survey team. The IP stated that he did not know the facility policy for storing items beneath the handwashing sink. The IP stated that the wound treatment supplies would no longer be sterile or usable if it were to become wet beneath the sink. The IP stated that if either the enema kits or heel booties got wet they would become contaminated and could not be used. The IP stated that the facility did not have a policy that pertained to the prohibited storage of medical supplies beneath the sink. On 08/08/2024 at 12:36 PM, the surveyor interviewed the Central Supply Director (CSD), who stated that she placed items from central supply in the medication storage rooms in the cabinets and storage bins. The CSD stated she would never store anything under the sink because if it happened to leak, she did not want the leakage to reach the stock. The CSD stated, We are not allowed to place anything under the sink because it was a rule put into place by both the former and current administrators, and was an infection control issue. The CSD stated that the nurses have access to the area and put things away. The CSD further stated that the cabinets beneath the sinks should be fixed, and not opened. On 08/08/2024 at 1:33 PM, the surveyor interviewed the Director of Nursing (DON) who stated that it was unsanitary and we risked our dressings no longer being sterile if fluids were on on the wound treatment supplies and they went into someone's wound. The DON stated that nothing should be stored under the handwashing sink. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At that time, the DON further stated that a liter of IV fluids should not have been placed back into storage after it was opened, as the package should have remained sterile and not opened until ready for usage. 34423 On 08/12/2024 at 01:12 PM, a review of a facility policy titled Linen Handling Policy with a reviewed date of 6/3/2024 revealed under 3: Personal Protective Equipment (PPE) for laundry Staff Practice hand hygiene before and after removing PPE. Wear tear resistant gloves when handling and laundering soiled linens. If there is a risk of splashing (e.g. hand-washing laundry) Laundry staff should also wear gowns or aprons and face protection . On 08/12/2024 at 09:37 AM, the surveyor observed the following in the facility laundry area: Observed a laundry staff wearing a surgical mask under her nose and gloves while emptying soiled laundry from plastic bags into soiled laundry bins. When the surveyor asked what she was required to wear when sorting soiled laundry, she replied, I have to wear gloves, mask, and cover (apron) to keep clothes clean. The surveyor asked the laundry staff if she was wearing a cover and she responded, No, I wasn't wearing the cover when the surveyor came in. The surveyor questioned the laundry staff member as to what the purpose of wearing the cover was and the laundry staff replied, Not messing with your clothes. The laundry staff then put the apron on in the presence of the surveyor. The surveyor then asked about the dryer. The staff removed the cover/apron and draped it over the dirty laundry bin, removed her gloves and proceeded to open the dryer lint door. The staff did not perform hand hygiene after removing her gloves. During an interview with the Infection Preventionist (IP) on 08/08/2024 at 10:19 AM, the surveyor questioned what surveillance you perform in the laundry department. The IP replied, I am here at 5am daily. I go through the laundry and make sure we have enough linen. I look to make sure everything is ok. When asked what facility policy was regarding handling of soiled linen, the IP said, I am not familiar with the laundry policy regarding soiled linens. During an interview with the surveyor on 08/13/2024 at 09:44 AM, the Director of Environmental Services and Laundry (DEVS) was questioned as to what the laundry staff are to wear while sorting soiled linens. The DEVS replied, They are supposed to be covered up with gown, gloves, and mask. The surveyor asked what gown he meant. The DEVS said, They normally wear yellow gowns. I have never seen anybody wear the apron. Gowns are back there and provided for them. NJAC 8:39-19.4 NJAC 8:39-19.4 (a)(1)