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	01/15/2026

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility policy review, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to offer three of eight residents (Residents (R) 80, R17, and R86) reviewed for pneumonia vaccinations, and/or their representatives, the opportunity for the residents to be vaccinated in accordance with nationally recognized standards out of 61 residents sampled. This practice had the potential to increase the risk for residents to contract pneumonia. In addition, the facility policy did not reflect current CDC recommendations. 1. Review of R80's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the facility admitted the resident on 02/21/22. The resident was over the age of 65 at the time of his/her admission. Review of R80's EMR titled Immunization located under the Immun (Immunization) tab, indicated that the resident received the Pneumovax 23 vaccine on 09/05/23. There was no evidence in the clinical record that the resident and/or his/her representative were given the opportunity to receive the PCV20 or the PCV21. 2. Review of R17's EMR titled admission Record located under the Profile tab, indicated the facility admitted the resident on 11/13/19. The resident turned [AGE] years of age while living at the facility.Review of R17's EMR titled Immunization located under the Immun tab, indicated that the resident received the Pneumovax23 vaccine on 09/05/23. There was no evidence in the clinical record that the resident and/or his/her representative were given the opportunity to receive the PCV20 or the PCV21. 3. Review of R86's EMR titled admission Record located under the Profile tab, indicated that the facility admitted the resident on 02/26/21. The resident turned [AGE] years of age while living at the facility. Review of R86's EMR titled Immunization located under the Immun tab, indicated that the resident received the Pneumovax23 vaccine on 10/04/23. There was no evidence in the clinical record that the resident and/or his/her representative were given the opportunity to receive the PCV20 of the PCV21. During an interview on 01/15/26 at 11:16 AM, the Regional Nurse Consultant and the Infection Preventionist (IP) went through the EMRs for R20, R17, and R86 and both verified that the three residents had received only the Pneumovax23 and did not receive the PCV13 vaccine. Review of the CDC website titled PneumoRecs VaxAdvisor App (Application) for Vaccine Providers dated 01/15/25 indicated . Administer PCV15, PCV20, or PCV21 for all adults 50 years or older . Who have never received any pneumococcal conjugate vaccine . Whose previous vaccination history is unknown . Based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they have received both . PCV13 [but not PCV15, PCV20, or PCV21] at any age and . PPSV23 at or after the age of [AGE] years old. NJAC 8:39-(i)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. Building B. Wing	01/15/2026

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on interviews, record reviews, and review of the facility's policy, the facility failed to ensure one of one resident (Residents (R) 17), out of a survey sample of 61, was afforded the right to participate in their care planning process. This failure placed the residents at risk of not being aware of the goals and outcomes of their care and for their care plan not to be person centered.Findings include:Review of R17's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the facility admitted the resident on 11/13/19.Review of R17's EMR titled social services Progress Notes dated 05/23/25, located under the Prog (Progress) Notes tab, revealed that the resident attended a care conference. There was no further evidence in the clinical record that indicated the resident was invited to subsequent care conferences after this date.Review of a document provided by the facility titled IDT [Interdisciplinary Team] Meeting Information, dated 08/20/25, failed to show that R17 was invited to his/her care conference. Review of R17's EMR titled quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) dated 11/07/25, located under the MDS tab, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which revealed the resident was cognitively intact. Review of a document provided by the facility titled IDT Meeting Information, dated 11/20/25, failed to show that R17 was invited to his/her care conference.During an interview on 01/12/26 at 9:41 AM, R17 stated that he/she had not been invited to care plan meetings for a while.During an interview on 01/14/26 at 9:08 AM, the Social Services Director (SSD) stated there was a period of time that the EMR was not working, and the facility had used paper copies of the care conferences. During an interview on 01/14/26 at 12:22 PM, the SSD provided the documents for the IDT meetings. The SSD stated that he/she would notify the residents verbally, if the residents were their own responsible party, to invite them to their care conferences. SSD confirmed there was no evidence on the IDT Meeting documents that showed R17 was invited to his/her care conference or that the resident participated in his/her care conference. The regional nurse consultant was also present during this interview. Review of a facility policy titled Care Plans, Comprehensive Person-Centered, dated 09/25, indicated . Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to.participate in the planning process.participate in establishing the expected goals and outcomes of care. participate in determining the type, amount, frequency and duration of care. NJAC 8:39-4.1(a)3NJAC 8:39-11.2(e)

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	01/15/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and review of the facility's abuse policy, the facility failed to ensure one of 42 sampled residents (Resident # 62) was free from resident-to-resident abuse from Resident # 52. This resulted in harm when Resident # 52 hit Resident # 62 causing a swollen lip and two teeth being knocked out. Findings include: 1.Review of the admission Record located under the Profile tab in the Electronic Medical Record (EMR) identified Resident # 62 was admitted on [DATE], with diagnoses that included muscle wasting and atrophy; other specified mental disorder due to known physiological condition; generalized anxiety disorder; and major depressive disorder.Review of the Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 11/07/25, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicating Resident # 62 was moderately cognitively impaired.2.Review of the admission Record located under the Profile tab in the EMR identified Resident # 52 was admitted on [DATE], with diagnoses that included schizoaffective disorder, bipolar type; recurrent depressive disorder; and anxiety disorder.Review of the Quarterly MDS located under the MDS tab in the EMR with an ARD of 12/05/25, revealed a BIMS score of two out of 15 which indicated Resident # 52 was significantly cognitively impaired.Review of the Facility Reported Incident Investigation provided by the facility and dated 11/20/25, revealed a Certified Nursing Assistant (CNA)11 witnessed Resident # 52 and Resident # 62 seated at the nurses' station talking. Resident # 62 touched Resident # 52's shoulder which prompted Resident # 52 to stand and strike Resident # 62 in the face. Resident # 62 suffered a swollen upper lip and had two front teeth knocked out. The residents were immediately separated. One to one supervision was implemented for Resident # 52 prior to being transferred to the CRISIS emergency room for an evaluation. Upon return, Resident # 52 remained on one-to-one monitoring until it was removed on 01/12/26.During an interview on 01/13/26 at 1:03 PM, Resident # 62 stated they remembered the incident and that he/she lost teeth. Resident # 62 denied being afraid of any resident including the assailant stating, Everyone here, in my nursing home, are my friends, they love me and take care of me.During an interview on 01/14/26 at 3:22 PM, Resident # 52 stated they had not had any incidents with other residents, I haven't hit anyone. Resident # 52 denied striking Resident # 62 in the face.During an interview on 01/14/26 at 3:11 PM, CNA # 11 (witness) stated, Resident # 52 and Resident # 62 usually sat together at the nurses station talking. Resident # 52 said he/she thought Resident # 62 hit him/her so he/she hit Resident # 62 back.During an interview on 01/13/26 at 1:14 PM, Licensed Practical Nurse (LPN #4), stated that Resident # 52 was generally calm, had no previous behaviors, and We just keep his/her routine the same and he/she does well. During an interview on 01/13/26 at 3:23 PM, the Social Services Director (SSD #1) stated that neither resident had behavior concerns prior to the incident. During an interview on 01/15/26 at 11:00 AM, the Psychiatric Nurse Practitioner (PNP #1) stated they had kept Resident # 52 on the one-to-one supervision to ensure he/she did not become aggressive with a resident again. Resident # 52 was removed from one-to-one supervision on 01/12/26.During an interview on 01/14/26 at 8:47 AM, the Physician's Assistant (PA #1), revealed he/she was the PA for both residents. Resident # 52 had no prior behaviors and has had none since the stated incident. Resident # 62 was assessed the next day, by PA #1, and had no recollection of the incident, denied being afraid of anyone, and denied having any pain.Review of the facility's Abuse Prevention and Reporting policy and procedure, with a revision date of 05/20/23, and a review date of 09/14/23, revealed Residents of [name redacted] will be protected from abuse, neglect, mistreatment, or misappropriation of property in accordance with State and Federal Regulations. NJAC 8:39-4.1(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	01/15/2026

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure that one of one resident (Resident (R) 41) reviewed for vision out of a total sample of 61 residents had an appointment made for cataract removal. This failure had the potential for the resident's vision to decline. Findings include:Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/21/25, located in the EMR under the MDS tab revealed R41 was admitted to the facility on [DATE]. The Brief Interview for Mental Status (BIMS) revealed a score of 14 out of 15 indicating R41 was cognitively intact. Review of R41's Physician Orders located in the EMR under the Orders tab revealed R41 was seen on 05/27/25, by an Optometrist and an order was written to schedule R41 for Cataract surgery at an outside facility.Review of R41's Progress Notes located in the EMR under the Progress Notes tab revealed the Unit Secretary had documented a phone call on 06/01/25, to an outside facility to schedule a cataract removal surgery for R41. The appointment was denied due to R41's weight of 374 pounds (lbs.). There was no evidence of any other attempts to locate another outside facility that could accommodate R41's cataract surgery.During an interview on 01/12/26 at 1:30 PM, R41 reported he/she could not see, and needed to see the Doctor. During an interview on 01/12/26 at 2:40 PM with Licensed Practical Nurse (LPN) revealed I have been calling other facilities, ever since he/she was denied at the one facility and no one will accept him/her. When asked about documentation, he/she stated, I don't actually make the calls the Unit Secretary does. During an interview on 01/12/26 at 4:40 PM with the Director of Nursing (DON) revealed he/she was unaware an appointment was needed for R41.The Unit Secretary was on vacation during the survey and unable to be contacted. NJAC 8:39-27.1(a)