STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315235	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health and Rehabilitation Center LLC	325 Jersey Street Trenton, NJ 08611

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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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following:On 04/15/2026 from 9:27AM to 10:41AM, the surveyor observed the following in the kitchen in the presence of the Food Service Director (FSD):In the Stand Up/Cold Prep refrigerator, a partially empty jar of applesauce observed with no opened date or use by date. The FSD acknowledged it should be dated. On the floor beside the ice machine, debris was observed on the floor. In the dry storage room, the surveyor observed two boxes containing single-serve cereal bowls stacked directly on the floor. The FSD acknowledged the boxes should not be on the floor and relocated the boxes to the shelf unit. In the dry storage room, three boxes containing single-serve cereal bowls were not labeled with a received by date. The FSD acknowledged the received by date was missing from the boxes.In the dry storage room, an opened box of enriched macaroni product was observed with no opened date or use by date. In the walk-in refrigerator in an uncovered cardboard box of green and red bell peppers, four green peppers at the top of the box were observed to be discolored and mottled. The FSD stated they would dispose of them. In the walk-in freezer doorway, a used disposable glove was observed on the floor.In the walk-in freezer a box containing plastic bag of burger patties was observed opened to air with no opened date or use by date. Below the countertops a meat patty was observed on the floor against the wall.Components of the meat slicer including the blade cover and the tray on which the meat rests when slicing were observed on the table open to air on top of oven mitts. The FSD stated she was unsure if they needed to be covered with the slicer and then placed them under the cover with the meat slicer. On 04/17/2026 at 10:33 AM in the fourth-floor pantry refrigerator, the surveyor observed 2 cartons of milk that were frozen to the back of the refrigerator. The fourth-floor Unit Manager (UM) #1 stated that these items should not be frozen to the refrigerator. Licensed Practical Nurse (LPN) # 1 used a utensil to remove the milk cartons from the back of the refrigerator. The surveyor observed the cartons to have expiration dates of April 1 and April 7. LPN #1 confirmed the cartons of milk were expired and disposed of them. On 04/17/2026 at 11:04 AM, in the third-floor pantry freezer an unknown brown substance was observed on the bottom and on the door of the freezer. In the cabinet one white colored bin was observed with light brown colored particles at the bottom. On the shelf an unlabeled and undated take-out container was observed. On the same day at 11:11 AM, in an interview, LPN #2 stated that the take out containers were another staff member's food. LPN #2 further stated that the take out container should have been labeled and in the refrigerator. LPN #2 stated that the refrigerator is emptied once a week and unsure of how often it is cleaned. On 4/17/2026 at 11:13 with the permission of the resident and in the presence of LPN #2 the surveyor observed a resident's personal refrigerator. The surveyor observed that there was no thermometer in the refrigerator. When asked by LPN #2, the resident indicated that they had taken the thermometer out of the refrigerator and placed it in a drawer. At the same time, a temperature log with the month November written on it, was observed attached to the side of the resident's refrigerator. LPN #2 acknowledged that the temperature logs were not being completed. On the same date at 11:19 AM (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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	during an interview, UM #2 confirmed that only one resident in the facility had a personal refrigerator. UM #2 stated that nursing staff are responsible for maintaining and recording the temperature log of the refrigerator. On 04/17/2026 at 11:37 AM the surveyor observed a dark brown substance inside the ice machine, along top of the machine. On 04/21/2026 at 9:41 AM during an interview the Director of Nursing (DON) stated that housekeeping should be cleaning the pantry monthly and all staff should monitor daily for old or expired food items. On the same date and time during an interview the Licensed Nursing Home Administrator (LNHA) stated that staff should not store their personal food items in the pantry. A review the policy titled, Receiving revision date 2/2023, revealed under number 5, All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation. The facility was unable to provide a policy specific to labeling and dating but did provide a Labeling and dating in-service provided to new hires with no date. The in-service titled Labeling and Dating Inservice, under the section Guidelines for Labeling and Dating revealed, All foods should be dated upon receipt before being stored. A review of the policy titled Food Storage: Dry Goods revision date 2/2023, revealed under the section Procedures number 1, All items will be stored on shelves at least 6 inches above the floor. The policy further revealed under number 6, Storage areas will be neat, arranged for easy identification and date marked as appropriate.A review of the policy titled Food Storage: Cold Foods revision date 2/2026, revealed under the section Procedures number 5, All food will be stored wrapped or in covered containers, labeled and dated.A review of the policy titled Resident Refrigerators revised 08/27/2024 revealed in the section, Policy explanation and Compliance Guidelines under number 2, Maintenance or Designee shall record refrigerator temperatures weekly on a temperature log attached to the refrigerator. The policy further states A thermometer shall remain in the refrigerator.A pantry policy was requested but not provided by the facility. NJAC 8:39-17.2(g)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation and interview, it was determined that the facility failed to maintain the residents' living environment in a clean, sanitary, and homelike manner for 2 of 4 units (Second and Fourth Floor). The deficient practice was evidenced by the following: During the initial tour on 04/15/2026 at 9:30 AM, surveyor #1 observed the following: room [ROOM NUMBER]: A chair in the bathroom had a brown stain on the seat. room [ROOM NUMBER]: The bathroom wall had large scuff marks that penetrated through the drywall. room [ROOM NUMBER]: A foul odor was present, and the unmade bed had stained sheets and pillowcases. 3rd Floor Shower Room: A patch in the tiled wall had not been retiled. Additionally, the floor molding was peeling off and was held in place with tattered blue tape, which was also peeling. During follow-up rounds on 04/20/2026 at 10:50 AM, surveyor # 1 observed: room [ROOM NUMBER]: A foul odor remained, and the bed was made with visible stains on the top blanket. room [ROOM NUMBER]: The same chair remained in the bathroom with the same brown stain; an open, half-used roll of toilet paper was sitting on the chair. During an interview on 04/17/2026 at 11:35 AM with Surveyor #1, a Certified Nurse Aide (CNA) stated that residents' bedding is changed every other day unless it requires more frequent changing. During an interview on 04/20/2026 at 11:00 AM with Surveyor #1, a housekeeper (HK) stated they enter rooms several times a day to clean, specifically to sterilize the room, clean the bathroom, and empty the trash. When asked about the stained chair in room [ROOM NUMBER], the HK stated, It would be my responsibility to clean the chair if I saw it. During an interview on 04/20/2026 at 11:04 AM with Surveyor #1, the Director of Environmental Services (DES) stated that resident rooms are cleaned daily, including wiping high-touch areas, cleaning bathrooms, and sweeping/mopping floors. The DES noted that if furniture or surfaces are dirty, they should be cleaned. During an interview on 04/20/2026 with Surveyor #1, the Maintenance Assistant Director (MAD) stated that resident rooms and common areas are rounded on at least monthly. The MAD stated that concerns are typically fixed immediately and that holes should be patched with sheetrock and repainted. The MAD also confirmed the shower room patch should have been retiled and the floor molding should have been repaired rather than taped. On 04/15/2026 at 10:00 AM during tour of the low side of the second floor, Surveyor #1 observed the following: a dresser in room [ROOM NUMBER] with the wood veneer peeling exposing particle board, (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	paint was peeling off of the wall under the window exposing the drywall in room [ROOM NUMBER], the sink in the low side shower room had multiple black and gray strands of hair in it. During an interview on 04/21/2026 at 9:46 AM, the Licensed Nursing Home Administrator stated that the bedside dresser in room [ROOM NUMBER] and the paint in room [ROOM NUMBER] were resolved yesterday. He furthered that the issues required quicker attendance. A review of the facility policy titled Safe and Homelike Environment revealed: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. N.J.A.C. 8:39-31.4(f)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to accurately account for the administration, disposition, and reconciliation of 3 controlled medications for 3 sampled resident (Resident #47, Resident #58 and Resident #69) identified upon inspection of 2 of 3 medication carts (second floor low-side cart and high-side cart). The evidence was as follows: On 4/15/2026 at 10:47 AM, the surveyor in the presence of the Licensed Practical Nurse (LPN) inspected the second-floor high end medication cart. A review of the narcotics located in the secured and locked narcotic box revealed Resident 58's Chain-of-Custody Record (a declining inventory record) for methadone 100 mg (milligram) oral solution, a medication used to treat opioid use disorder, did not match. The bag contained 7 bottles, six contained medication and one was empty. The Chain-of-custody Record had not been completed to indicate any doses had been administered. A further review of the narcotic box revealed Resident #69's buprenorphine/naloxone 8/2 mg (milligram) film, a medication used to treat opioid use disorder, did not match the Individual Patient's Controlled Drug Record. The medication box contained two films and the declining inventory sheet indicated there should be three films remaining. The LPN stated she had administered the medications earlier and she had forgotten to sign the declining inventory sheets. The LPN further stated the declining inventory sheet should be signed after the medication had been administered. On 4/15/2026 at 11:03 AM, the surveyor in the presence of the Registered Nurse (RN) inspected the second-floor low-end medication cart. A review of the narcotics located in the secured and locked narcotic box and the declining inventory sheet, revealed Resident #47's tramadol 50mg tablets count was incorrect. Resident #47's medication order was for two tablets of tramadol 50mg to make a total dose of tramadol 100mg. The number of tablets remaining in the blister pack was nine. The declining inventory sheet also revealed there should be nine tablets remaining, this would not be possible if the dose required two tablets for accurate medication administration. At that time the RN acknowledged that the count could not be correct that if two tablets were administered at each dose, then the balance could not be an odd number of tablets such as nine, unless one tablet had been wasted. A review of the reverse side of the declining inventory revealed two tablets had been wasted and the RN again confirmed the count was not correct. The RN further stated she had not administered tramadol to Resident #47 that day. On 4/16/2026 at 12:30 PM, the surveyor interviewed the second-floor Licensed Practical Nurse Unit Manager (LPN/UM) who confirmed the nurses should have signed the declining inventory sheets when they removed the medications from the packaging and once administered, they should sign in the electronic medical record (EMR). When asked about the tramadol for Resident #47 he stated he was aware and had brought the information to the Director of Nursing (DON). On 4/20/2026 at 12:41 PM, the surveyor interviewed the DON and the Assistant Director of Nursing (ADON) who stated the nurses should sign out the controlled medications when they are removed from the packaging and once administered then sign off in the EMR. The DON and ADON confirmed the nurses had not followed the facility policy. The DON further stated they were currently investigating Resident #47's tramadol administration and discrepancy in documentation. A review of the facility's undated Controlled Substance Administration and Accountability policy included All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. scheduled II controlled substances dispensed from the pharmacy for a patient-specific are recorded on the Controlled Drug Record supplied with the medication or other designated form as per facility policy. NJAC 8:39- 29.2(d), 29.7(c)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, it was determined that the facility failed to provide the Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN), Form CMS-10055, to 1 of 3 residents (Resident # 56) reviewed under Beneficiaries Task. The deficient practice was evidenced by the following: A review of Resident # 56's Electronic Medical Record revealed the resident was admitted with Medicare A as the primary payer source. A review of the Beneficiary Notification Review completed by the facility revealed that Resident # 56's Medicare Part A skilled services episode start date was 09/04/2025. The last covered day of Part A service was 12/1/2025. A review of the Beneficiary Notification Review revealed that the SNF ABN, Form CMS 10055 was not provided to the resident. No explanation was provided on the SNF Beneficiary Notification Review form. On 04/20/2026 at 10:43 AM during an interview with the surveyor, the facility's Business Manager said that the Social Worker at the time, did not know they had to issue a SNF ABN form. She said that originally yes was checked on the SNF Beneficiary Notification Review form but it was changed to no when it was discovered the Social Worker never sent the the SNF ABN form. A review of the facility policy titled, Advance Beneficiary Notices dated 05/07/2025 revealed under, Explanation and Compliance Guidelines that The current CMS-approved version of the forms shall be used at the time of issuance to the beneficiary (resident or resident representative). Contents of the form shall comply with related instructions and regulations regarding the use of the form. a. For Part A items and services, the facility shall use the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), Form CMS-10055.N.J.A.C. S 8:39-4.1 (a) 8

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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. Based on observation, interview, record review and review of other pertinent facility documents, it was determined that the facility failed to implement care consistent with the resident's care plan by failing to order and implement Enhanced Barrier Precautions (EBP). This deficient practice was observed for 1 of 1 resident (Resident #3) reviewed for Tube Feeding. The deficient practice was evidenced by the following:On 04/15/2026 at 12:12 PM during initial tour, Resident #3 was observed lying in their bed attached to an enteral feed pump (a device used to deliver liquid nutrition directly into a person's stomach or small intestine through a tube). At that time, the surveyor observed no EBP signage outside the resident's doorway. At the same time the surveyor observed Resident #3s identification sign at the top of the doorway with no colored mark next to his/her name. On 4/16/2026 at 1:27 PM the surveyor observed no EBP signage outside of the room of Resident #3. No evidence was observed to indicate Resident #3 was on EBP. On 4/17/2026 at 10:51 AM, the surveyor observed and EBP sign to the right of Resident #3's doorway and a red dot visible on the identification sign at the top of the doorway. A review of Resident #3's Electronic Medical Record (EMR) revealed Resident #3's diagnoses that included but not limited to, Gastrostomy Status (Tube placed in stomach for feeding) and Dysphagia (Difficulty swallowing food or liquids). A review of Resident #3's EMR revealed no orders for Enhanced Barrier Precautions. A review of Resident #3's care plan revealed a Focus for Enhanced Barrier Precaution initiated on 02/17/2026. The focus revealed a goal of infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities r/t peg tube.On 04/16/2026 at 1:30 PM during an interview with the Unit Manager (UM) stated, staff know that residents are on EBP by the EBP signage outside of the resident's doorway and by a small colored mark next to the resident's identification signage at the top of the doorway. The UM indicated that she was unaware what the policy was for a resident care planned for EBP with no EBP order. On 4/17/2026 at 10:51 AM during a follow up interview with the UM, stated that if a resident is care planned for EBP they should have an order and a sign outside of the resident's doorway with the colored marking next to the resident identification sign.On 4/17/2026 at 1:03PM during an interview, the Infection Preventionist (IP) stated that residents with gastrostomy tubes should be on EBP. The IP further stated that once a resident is care planned for EBP, they should have an order placed. The IP stated that she was responsible for ensuring EBP orders are entered into the computer system. On 04/21/2026 at 9:41AM during an interview the Assistant Director of Nursing (ADON) stated that both the DON and IP will review resident orders and care plans to ensure accuracy. The ADON further stated the importance of ensuring that residents under EBP have the appropriate orders to maintain patient safety and for infection prevention purposes.A review of the policy titled Enhanced Barrier Precautions revised on 09/09/2025, revealed under number 2 Initiation of Enhanced Barrier Precautions under section b. An order for enhanced barrier precautions will be obtained for residents with any of the following: . indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes.) NJAC 8:39-27.1 (a)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide pain management that met professional standards of practice related to pain management. Specifically, by giving pain medication outside of the window of administration. This deficient practice was identified for 1 of 1 resident (Resident # 106) investigated for pain. The deficient practice was evidenced by the following: On 04/15/2026 9:43 AM the surveyor spoke to Resident #106 who stated that they received pain medication late. A review of Resident #106's admission Minimum Data Set (MDS) an assessment tool dated 03/20/26 reflected that they received routine pain medication. A review of Resident #106's electronic medical record (EMR) revealed a diagnosis of but not limited to muscle weakness and a lack of coordination. A review of Resident #106's physician's orders located in the EMR revealed an order for Acetaminophen Extra Strength Tablet 500 MG (milligrams) 2 tablets to be given by mouth twice a day for arthritis pain, and tramadol 50 MG (milligrams) 2 tablets to be given by mouth four times a day. A review of the Medication Administration Audit for March and April 2026 revealed the Acetaminophen Extra Strength Tablet tablets were administered on the following dates and times: 03/19/2026 scheduled for 06:00 PM and given at 07:14 PM03/21/2026 scheduled for 06:00 PM and given at 07:05 PM04/06/2026 scheduled for 06:00 PM and given at 07:11 PM04/08/2026 scheduled for 06:00 PM and given at 08:51 PM A review of the Medication Administration Audit for March and April 2026 revealed the tramadol tablets were administered on the following dates and times: 04/04/2026 scheduled for 12:00 PM and given at 01:35 PM04/05/2026 scheduled for 12:00 PM and given at 01:46 PM04/06/2026 scheduled for 06:00 PM and given at 07:11 PM04/07/2026 scheduled for 12:00 AM and given at 05:48 AM 04/08/2026 scheduled for 06:00 PM and given at 08:52 PM04/12/2026 scheduled for 12:00 AM and given at 06:55 AM04/13/2026 scheduled for 12:00 PM and given at 02:20PM During an interview with the surveyor on 04/16/2026 at 10:26 AM, the Unit Manager stated that medications can be administered one hour before and one hour after the scheduled time. The nurse should then document that the medication was administered at the time of administration. During an interview with the surveyor on 04/21/2026 at 10:29 AM, the Director of Nursing and the Assistant Director of Nursing acknowledged that Resident #106 received his/her pain medication late. A review of the facility policy titled, Pain Management, with an implemented date of 10/01/2023, reflected that the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. NJAC 8:39-27.1(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that all medications used in the facility were labeled and stored in accordance with professional standards of practice to preserve their integrity. This deficient practice was observed in 1 of 2 medication storage areas (first floor nursing office) inspected and was evidenced by the following: On 4/20/2026 at 12:29 PM, the surveyor in the presence of the Director of Nursing (DON), inspected the first-floor medication storage room. There was no medication refrigerator located in that room, the DON stated there was a refrigerator used to store medications located in the first-floor nursing office. On 4/20/2026 at 12:35 PM, the surveyor in the presence of the DON, Assistant Director of Nursing (ADON) and the Infection Preventionist (IP) inspected the refrigerator in the first-floor nursing office. During inspection of the medication room refrigerator the surveyor observed an open, undated multi-use vial of Tuberculin Purified protein derivative (PPD) 5 TU/0.1ml (5 tuberculin units/0.1 milliliter), labeled house stock. At that time the IP stated the vial of PPD should have been dated when it was opened and that once it was opened it was only good for 30 days, then it should be discarded. Both the DON and the ADON confirmed the vial should have been dated when opened. A review of the facility's Labeling of Medications and Biologicals policy dated reviewed/revised 11/12/2024 included All medications and biologicals will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices.Labels for multi-use vials must include: a. The date the vial was initially opened or accessed (needle punctured) b. All opened or accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. NJAC 8:39-29.4(h)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, it was determined that the facility failed to ensure standardized recipes were utilized to ensure food was prepared to conserve nutritive value and flavor. This deficient practice was identified for 2 of 2 observed lunch meals prepared and the evidence was as follows:On 04/16/2026 at 11:50 AM, Resident #9 stated that they were unsatisfied with the food they were served. Resident #9 stated that they did not receive the food listed on their ticket and the portions were small.On 04/17/2026 at 11:10 AM during the resident council meeting, 5 out of 5 members in attendance stated that the food was not appealing and was not palatable. On 4/16/2026 at 12:02 PM during an interview, the Food Service Director (FSD) stated the menu is a set daily menu with a main entree and alternate entree. The FSD further stated that the computer system generates the resident's meal ticket based on their diet order. The FSD stated that any changes or any alternate are requested by the resident's nurse. The surveyor reviewed the week 3, Week at a Glance menu provided by the facility. The surveyor observed the main lunch meal for 04/17/2026 was lemon butter baked fish filet with roasted red skin potatoes, broccoli florets, dinner roll/bread and deluxe fruit salad. The alternate entree was smothered turkey patty, seasoned rice and roasted beets. On 04/17/2026 at 12:46 PM the surveyor received a sample lunch tray with both the main entree and the alternate lunch options. The alternate, smothered turkey patty meal did not contain the roasted beets listed on the menu but had a substitution of broccoli florets. At the same date and time, the surveyor placed a small portion of the fish filet onto a spoon to taste. The surveyor observed a small black curled hair in the piece of fish. At the same date and time, two surveyors tasted the smothered turkey patty and were unable to consume. The surveyors noted that the flavor profile did not meet the expected standards of palatability. On 04/17/2026 at 1:16 PM in an interview with the FSD, she confirmed that there was a hair in the fish entree. The FSD further stated that there should not be hair in the food. On the same date and time, the FSD stated that she had not tasted the smothered turkey patty. The FSD tasted the food upon the surveyors request and the FSD stated that she thought it was good. The FSD further stated that the turkey patty is premade, and the gravy is from a powder that water is added. The facility did not provide a policy related to the flavor or preparation of foods.NJAC 8:39-17.2(a); 17.4(a)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315235	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health and Rehabilitation Center LLC	325 Jersey Street Trenton, NJ 08611

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, it was determined that the facility failed to ensure that infection control practices were followed to prevent the potential spread of infection for a resident on contact isolation. This deficient practice was evidenced for 1 of 10 residents (Resident # 65) reviewed under the Infection Control Task. The deficient practice was evidenced by the following: A review of Resident # 65's EMR revealed under orders that he/she has an E.Coli/UTI (a bacterial infection in the urinary tract). The order clarifies that the precaution type is contact. The order was started on 4/16/2026.A review of Resident # 65's Care Plan located in the EMR revealed the resident was on isolation contact precautions.A review of Resident # 65's Care Plan located in the EMR revealed Resident # 65 had Methicillin-resistant Staphylococcus aureus (a type of staph that can be resistant to several antibiotics). The Care Plan was last reviewed 02/06/2026.A review of Resident # 65's Care Plan revealed an intervention for but not limited to, Contact isolation wear gowns and masks when changing contaminated linens, Place soiled linens in bags marked biohazard. Give antibiotic therapy as ordered, instruct visitors to wear disposable gloves and gown when in residents room and to wash hands before leaving room.On 04/17/2026 at 10:53 AM while outside the room, the surveyor observed a sign that read, For All Staff Contact Precautions in addition to standard precautions. Further the sign read, Before entering room/care zone Perform Hand Hygiene, Put on a gown, Wear gloves in accordance with standard precautions.On that date and time, the surveyor observed CNA (Certified Nurses Aide) # 1 walk into the room and speak to Resident # 65. She did not apply a gown or gloves. Upon exiting the room, the surveyor asked if she needed to wear a gown in that room. She replied that she did not have to wear a gown unless she was doing care. During the interview, another CNA, CNA # 2 also entered the room without a gown and began placing supplies on the bedside table in the room. When she exited the room, she informed the surveyor that they [staff] must wear a gown when they are hands on with the resident.On the same date at 10:58 AM during an interview with the surveyor, the Licensed Practical Nurse/Unit Manager told the surveyor that the staff only wears personal protective equipment (PPE) when they are doing hands-on care.On 04/17/2026 at 12:29 PM during an interview with the surveyor, the Infection Preventionist confirmed that Resident # 65 was on Contact Isolation. When the surveyor asked what staff should do when entering that room, the Infection Preventionist replied, that for contact, there is a bin for that room, and it will have PPE. She clarified that before staff go into the room they have to wear it.A review of the facility policy titled, Transmission-Based (Isolation) Precautions dated 05/16/2023 revealed, d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination.N.J.A.C. S 8:39-19.4(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315235	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health and Rehabilitation Center LLC	325 Jersey Street Trenton, NJ 08611

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, it was determined that the facility failed to maintain an environment free of pests. The deficient practice was identified by observation of a live pest on 1 of 4 floors (2nd Floor) in the facility. The deficient practice was evidenced by the following: On 04/16/2026 at 10:40 AM while touring the 2nd floor in the hallway near the nurses station, the surveyor observed a brown insect crawling across the wall near the hand rail. At that time, the Licensed Practical Nurse/Unit Manager (LPN/UM) also observed the insect when the surveyor brought it to his attention. He then used a disposable glove to dispose of the insect. The LPN/UM informed the surveyor that he will document the occurrence in the Pest Control Log. On 04/20/2026 at 12:55 PM during an interview with the surveyor, the Licensed Nursing Home Administrator (LNHA) said that pest control services are scheduled biweekly. Further, he said they have had the company come in to make a more in-depth treatment. When the surveyor asked if there is an ongoing issue with insects, the LNHA said they try to follow-up with residents in their rooms. He said when we become aware of rooms, pest control treats those specific rooms. A review of the facility-provided invoices from the pest control company for March of 2026, revealed that the facility has been treated for cockroaches. A review of the facility policy titled, Pest Control Program dated 04/02/2025 revealed that, It is the guideline of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents. The policy defined an Effective pest control program as, measures to eradicate and contain common household pests (e.g., bed bugs, lice, roaches, ants, mosquitos, flies, mice and rats). N.J.A.C. S 8:39-31.5