



Certified End Page

RIVERTON REHABILITATION AND HEALTHCARE CENTER

STATE LICENSE NUMBER: 124102

SURVEY EXIT DATE: 12/09/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395171	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
NAME OF PROVIDER OR SUPPLIER: RIVERTON REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 803 N WAHNETA STREET ALLENTOWN, PA 18103		
STATE LICENSE NUMBER: 124102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 124102 Component 01 Main Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on December 9, 2024, it was determined that Riverton Rehabilitation and Healthcare Center was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a three story, Type II (222), fire resistive building, with unused attic spaces, that is fully sprinklered.</p>	K 0000		

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

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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K 0222 SS=E		K 0222		
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K 0222 SS=E	Continued from page 2 NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door	K 0222	The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To maintain compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. 1. The Maintenance Director corrected the 1st floor exit door, near main employee lounge, to ensure delayed egress operates correctly. 2. The Maintenance Director/Designee will conduct an initial audit to verify doors with delayed egress operate correctly. 3. Nursing Home Administrator or Designee will re-educate the Maintenance Director on proper functions of delayed egress doors.	Completion Date: 12/31/2024 Status: APPROVED Date: 12/23/2024

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K 0222 SS=E	Continued from page 3 assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:	K 0222	4. The Maintenance Director/Designee will conduct weekly audits for four weeks and then monthly for two months thereafter to verify that doors with delayed egress operate correctly. This plan of correction will be reviewed at the monthly Quality Assurance Performance Improvement meeting and changes will be made as needed.	

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K 0222 SS=E	Continued from page 4 Based on observation and interview, it was determined the facility failed to maintain a delayed egress door, in one location, affecting one of three floors, within this component. Findings include: 1. Observation on December 9, 2024, at 11:45 a.m., revealed the 1st floor exit door, near main employee lounge, failed to open when tested. Door signs states door will open within 15 seconds. Exit interview with the Facility Administrator, Director of Plant Operations, and Facilities Manager, on December 9, 2024, at 1:30 p.m., confirmed door egress deficiency.	K 0222		
K 0321 SS=E		K 0321		

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K 0321 SS=E	Continued from page 6 This REQUIREMENT is not met as evidenced by:	K 0321	4. The Maintenance Director/Designee will conduct weekly audits for four weeks and then monthly for two months thereafter to verify that fire barrier doors latch appropriately. This plan of correction will be reviewed at the monthly Quality Assurance Performance Improvement meeting and changes will be made as needed.	

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K 0321 SS=E	Continued from page 7 Based on observation and interview, it was determined the facility failed to maintain one hazardous area enclosure, affecting one of three floors, within this component. Findings include: 1. Observation on December 9, 2024, at 12:00 p.m., revealed the 1st floor Mechanical Room door failed to latch into frame when tested. Exit interview with the Facility Administrator, Director of Plant Operations, and Facilities Manager, on December 9, 2024, at 1:30 p.m., confirmed the door failed to latch.	K 0321		
K 0355 SS=E		K 0355		

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K 0355 SS=E	Continued from page 8 NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:	K 0355	The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To maintain compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. 1. The Maintenance Director inspected the 2 identified fire extinguishers to ensure compliance. 2. The Maintenance Director/Designee will conduct an initial audit to verify that facility fire extinguisher inspections are current. 3. Nursing Home Administrator or Designee will re-educate the Maintenance Director on facility fire extinguisher inspection compliance.	Completion Date: 12/31/2024 Status: APPROVED Date: 12/23/2024

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K 0355 SS=E	Continued from page 9	K 0355	4. The Maintenance Director/Designee will conduct weekly audits for four weeks and then monthly for two months thereafter to verify that facility fire extinguisher inspections are current. This plan of correction will be reviewed at the monthly Quality Assurance Performance Improvement meeting and changes will be made as needed.	

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K 0355 SS=E	Continued from page 10 Based on observation and interview, it was determined the facility failed to maintain portable fire extinguishers monthly inspections, in two locations, affecting one of eight smoke compartments within this component. Findings Include: 1. Observation on December 9, 2024, between 11:55 a.m., and 11:56 a.m., revealed the following: a. 11:55 a.m., 1st floor, Electrical room, fire extinguisher was missing 5 of 11 monthly inspections for 2024. b. 11:56 a.m., 1st floor, Corridor fire extinguisher, near electrical room, lacked monthly inspection for November 2024. Exit interview with the Facility Administrator, Director of Plant Operations, and Facilities Manager, on December 9, 2024, at 1:30 p.m., confirmed the lack of the monthly inspections.	K 0355		

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K 0363 SS=E		K 0363		
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K 0363 SS=E	Continued from page 12 NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 0363	The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To maintain compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. 1. The Maintenance Director corrected the 2nd floor country kitchen doors to ensure they latch appropriately. 2. The Maintenance Director/Designee will conduct an initial audit to verify that country kitchen doors latch appropriately. 3. Nursing Home Administrator or Designee will re-educate the Maintenance Director on proper latching of dining room doors.	Completion Date: 12/31/2024 Status: APPROVED Date: 12/23/2024

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K 0363 SS=E	Continued from page 13 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 0363	4. The Maintenance Director/Designee will conduct weekly audits for four weeks and then monthly for two months thereafter to verify that country kitchen doors latch appropriately. This plan of correction will be reviewed at the monthly Quality Assurance Performance Improvement meeting and changes will be made as needed.	

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K 0363 SS=E	<p>Continued from page 14</p> <p>Based on observation and interview, it was determined the facility failed to maintain corridor openings, in one location, affecting one of the floors, within this component.</p> <p>Findings include:</p> <p>1. Observation on December 9, 2024, at 12:30 p.m., revealed the 2nd floor, Country Kitchen doors, which have a self-closure and tied to the fire alarm, failed to latch into frame when released from hold open device.</p> <p>Exit interview with the Facility Administrator, Director of Plant Operations, and Facilities Manager, on December 9, 2024, at 1:30 p.m., confirmed the doors failed to latch when tested.</p>	K 0363		



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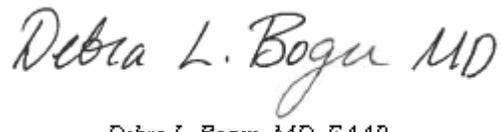
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K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 124102 Component 02 Multipurpose Room</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on December 9, 2024, at Riverton Rehabilitation and Healthcare Center, it was determined there were no deficiencies identified under the requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a one story, Type II (000), unprotected, noncombustible building, that is fully sprinklered.</p>	K 0000		

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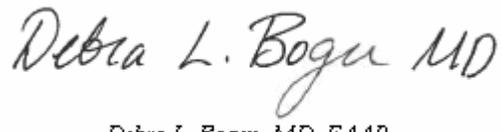
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395171	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>03</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/09/2024
NAME OF PROVIDER OR SUPPLIER: RIVERTON REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 803 N WAHNETA STREET ALLENTOWN, PA 18103		
STATE LICENSE NUMBER: 124102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 124102 Component 03 Administration Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on December 9, 2024, at Riverton Rehabilitation and Healthcare Center, it was determined there were no deficiencies identified under the requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a three story, Type II (111), protected, noncombustible building, that is fully sprinklered.</p>	K 0000		

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

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.



Certified End Page

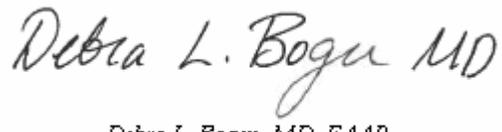
RIVERTON REHABILITATION AND HEALTHCARE CENTER

STATE LICENSE NUMBER: 124102

SURVEY EXIT DATE: 12/09/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

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