STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __--_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on December 30, 2024, it was determined that Riverside Health and Rehab Center had deficiencies that have the potential for minimal harm as related to the requirements of 42 CFR 483.73.	E 0000		
E 0030 SS=C		E 0030		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __--_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
E 0030 SS=C	Continued from page 1 483.73(c)(1) Names and Contact Information §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers.	E 0030	NHA/Designee will educate the Maintenance Director/Designee on the Emergency Preparedness Plan requirements regarding Names and Contact Information. The current resident roster and physicians names and contact information will be put in the EPP binder and be update weekly by the Receptionist/Designee. NHA/Designee will audit the EPP names and contacts on weekly x 4 weeks.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/17/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __--_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
E 0030 SS=C	Continued from page 2 *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.	E 0030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __--_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
E 0030 SS=C	Continued from page 3 (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by:	E 0030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __--_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
E 0030 SS=C	Continued from page 4 Based on a review of the facility's Emergency Preparedness (EP) Plan, it was determined the facility failed to include names and contact information. Findings include: 1. Interview and documentation review on December 30, 2024, at 8:45 a.m., revealed the EP Plan did not include updated and accurate names and contact information for residents and residents physicians contact information. Interview with the Facility Administrator and Maintenance Director on December 30, 2024, at 1:30 p.m., confirmed the EP Communication Plan lacked accurate residents and physicians contact information.	E 0030		
E 0037 SS=C		E 0037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __--_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
E 0037 SS=C	Continued from page 5 483.73(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:	E 0037	Preparation and submission does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness set forth in the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirements under state and the federal laws. The NHA will be educated on the Emergency Preparedness Training Program annual tabletop exercise requirement. The facility will conduct a tabletop exercise of the Emergency Preparedness Program.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/17/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __--_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
E 0037 SS=C	Continued from page 6 (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.	E 0037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __--_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
E 0037 SS=C	Continued from page 7 (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness	E 0037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __--_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
E 0037 SS=C	Continued from page 8 training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and	E 0037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __--_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
E 0037 SS=C	Continued from page 9 cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by:	E 0037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __--_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
E 0037 SS=C	Continued from page 10 Based on a review of the facility's Emergency Preparedness (EP) Plan, it was determined the facility failed to maintain documentation of staff training and testing. Findings include: 1. Interview and documentation review on December 30, 2024, at 8:55 a.m., revealed the facility failed to provide documentation for: Section (iii) Maintain documentation of all emergency preparedness training and Section (iv) Demonstrate staff knowledge of emergency procedures for Emergency Preparedness Training Program. The facility could not provide documentation of an annual table top exercise of the Emergency Preparedness program. Interview with the Facility Administrator and Maintenance Director on December 30, 2024, at 1:30 p.m., confirmed the above listed EP training and testing deficiency.	E 0037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __--_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
E 0037 SS=C	Continued from page 11	E 0037		

Certified End Page

RIVERSIDE HEALTH & REHAB CENTER

STATE LICENSE NUMBER: 185402

SURVEY EXIT DATE: 12/30/2024

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
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)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: 01 B. WING:	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET** **MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	INITIAL COMMENT Facility ID# 185402 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on December 30, 2024, it was determined that Riverside Health and Rehab 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). This is a one-story, Type V (III), protected wood frame building, without a basement, that is fully sprinklered.	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0100 SS=C	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:	K 0100	The Maintenance Director/Maintenance staff will be educated on the requirements of the 2016 Act 48-Care Facility Carbon Monoxide Alarms Standards Act. All carbon monoxide alarms will have their batteries replaced along with a log will be maintained to record the alarms' location and the date of the annual battery replacement. The facility will perform all the required testing and cleaning of the battery-operated alarms on a monthly basis. A log will be maintained at the facility. All current staff will be educated on the carbon monoxide evacuation and alarm protocols. Any new employees will be trained on the carbon monoxide evacuation and alarm protocols during their general orientation.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/16/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0100 SS=C	Continued from page 2 Based on documentation review and interview, it was determined that the facility failed to maintain battery operated carbon monoxide alarms in accordance with the 2016 Act 48-Care Facility Carbon Monoxide Alarms Standards Act in three instances, affecting the entire facility. Findings include: 1. Observation on December 30, 2024, revealed the following carbon monoxide deficiencies: a) 9:20 a.m., the facility failed to perform the required annual battery replacement, of the battery-operated carbon monoxide alarms; b) 9:25 a.m., the facility failed to perform the required testing and cleaning, of the battery-operated carbon monoxide alarms; c) 9:30 a.m., The facility failed to provide documentation of Carbon Monoxide Evacuation and Alarm protocols.	K 0100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0100 SS=C	Continued from page 3 Interview with the Facility Administrator and Maintenance Director on December 30, 2024, at 1:30 p.m., confirmed the carbon monoxide alarm deficiencies.	K 0100		
K 0291 SS=F	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:	K 0291	The Maintenance Director/Maintenance staff will be educated on the NFPA regulation requiring emergency lighting to being tested monthly for 30 seconds and 90 minutes and annually for 90 minutes. NHA/Designee will audit the emergency lighting monthly testing monthly x 2 months.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/16/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0291 SS=F	Continued from page 4 Based on document review and interview, it was determined the facility failed to maintain emergency lighting in one instance, affecting the entire facility. Findings include: 1. Documentation review on December 30, 2024, at 9:00 a.m., revealed the facility lacked documentation for an annual 90-minute test and monthly 30 second testing for the emergency lights. Interview with the Facility Administrator and Maintenance Director on December 30, 2024, at 1:30 p.m., confirmed the facility lacked documentation for the annual 90-minute test and monthly testing for the emergency lights at the time of survey.	K 0291		
K 0321 SS=E		K 0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0321 SS=E	Continued from page 5 NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)	K 0321	NHA/Designee will educate the Maintenance Director/Maintenance staff on the NFPA requirements for hazardous area - corridors. The penetration in the ceiling of the janitor's closet in the Memory Care Unit was fixed on 1/8/25. A visual inspection of all of the facility's janitor's closets will be completed to ensure no more penetrations are present.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/16/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0321 SS=E	Continued from page 6 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain hazardous area enclosures in one instance, affecting one of eight smoke compartments. Findings include: 1. Observation on December 30, 2024, at 11:45 a.m., revealed there was a penetration in the ceiling of the Janitor's closet in the Memory Care Unit. Interview with the Facility Administrator and the Maintenance Director on December 30, 2024, at 1:30 p.m., confirmed the listed hazardous area enclosure deficiency.	K 0321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0324 SS=E	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by:	K 0324	NHA/Designee will educate the Maintenance Director/Maintenance staff on the NFPA 101 cooking facilities standard for ventilation control and fire protection. Maintenance staff will ensure the gas fired oven on wheels is tethered securely to the wall. NHA will audit the completion of the tethered oven to the wall. The hood cleaning is schedule for February 2,2025. The Maintenance Director/Designee will conduct monthly fire suppression system visual inspections. The NHA/Designee will audit the monthly inspections x3 monthly. The semi-annual fire suppression system inspections were performed on April 16,2024 and October 8, 2024. The inspection reports are on file at the facility.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/16/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0324 SS=E	Continued from page 8 Based on observation and interview, it was determined the facility failed to properly install and maintain equipment protected by the kitchen hood extinguishing system in four instances, affecting one of eight smoke compartments. Findings Include: 1. Observation on December 30, 2024, at 9:45 a.m., revealed a gas-fired oven on wheels, in the main kitchen, was not provided with an approved method that would ensure the appliance was returned to an approved design location after it had been moved for maintenance and cleaning, as required by section 12.1.2.3 and 12.1.2.3.1 of NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Interview with the Facility Administrator and Maintenance Director on December 30, 2024, at 1:30 p.m., confirmed the gas-fired cooking appliance was not tethered in a way so it could not be moved from the ventilation hood and gas	K 0324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0324 SS=E	Continued from page 9 connection. 2. Based on documentation review, observation, and interview, it was determined the facility failed to maintain the kitchen hoods in three instances, affecting one of eight smoke compartments. Findings include: 1. Document review and observation on December 30, 2024, revealed the following cooking facility deficiencies: a) 8:45 a.m., the facility failed to perform one of the two required semi-annual hood cleanings; b) 8:47 a.m., facility failed to perform one of the two required semi-annual fire suppression system inspections; c) 11:30 a.m., the facility failed to document the required monthly fire suppression system visual inspections. Interview with the Facility Administrator and the Maintenance Director on December 30, 2024, at	K 0324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0324 SS=E	Continued from page 10 1:30 p.m., confirmed the above listed deficiencies.	K 0324		
K 0345 SS=F	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 0345	The sensitivity test of the smoke alarms is scheduled to be completed in April 2025. The semiannual visual fire alarm inspection was completed on October 31, 2024, and one is scheduled for April 2025. The Maintenance Director/Maintenance staff we be educated on the NFPA requirements of a 2-year smoke detector sensitivity test and the semiannual visual fire alarm inspection.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/17/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0345 SS=F	Continued from page 11 Based on document review and interview, it was determined the facility failed to maintain the fire alarm system in two instances, affecting the entire facility. Findings include: 1. Document review and observation on December 30, 2024, revealed the following fire alarm system deficiencies: a) 8:40 a.m., review of documentation revealed the facility failed to provide documentation verifying a sensitivity test of smoke detectors was performed within the previous two years; b) 8:45 a.m., review of documentation reveled the facility failed to conduct a semiannual visual fire alarm inspection. Interview with the Facility Administrator and Maintenance Director on December 30, 2024, at	K 0345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: 01 B. WING:	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET** **MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0345 SS=F	Continued from page 12 1:30 p.m., confirmed the facility could not provide documentation for a semiannual fire alarm inspection and a two-year sensitivity test, at the time of the survey.	K 0345		
K 0353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	The NHA/Designee will educate the Maintenance Director/Maintenance staff on the NFPA requirements of the semiannual automatic sprinkler system inspection. The semiannual sprinkler system was conducted on February 26, May 21, August 26 and November 18, 2024. Inspections are on file at the facility.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/17/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0353 SS=E	Continued from page 13 Based on observation, document review, and interview, it was determined the facility failed to maintain the automatic sprinkler system in three instances, affecting the entire facility. Findings include: 1. Document review on December 30, 2024, at 9:23 a.m., revealed the facility failed to provide documentation for the semiannual automatic sprinkler system inspection. Interview with the Facility Administrator and Director of Maintenance on December 30, 2024, at 1:30 p.m., confirmed the facility lacked the documentation for a semiannual sprinkler system inspection. 2. Observation on December 30, 2024, revealed the following automatic sprinkler system deficiencies: a) 9:47 a.m., the sprinkler head behind the dryer room in the laundry was covered in lint and dust;	K 0353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0353 SS=E	Continued from page 14 b) 10:42 a.m., a sprinkler head on the overhang at main entrance was covered in dust. Interview with the Facility Administrator and Director of Maintenance on December 30, 2024, at 1:30 p.m., confirmed the above listed sprinkler system deficiencies.	K 0353		
K 0355 SS=F	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	NHA/Designee will educate the Maintenance Director/Maintenance staff on the NFPA requirements for portable fire extinguishers inspections. NHA/Designee will audit all the facility's fire extinguishers to ensure the monthly inspections are completed.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/16/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0355 SS=F	Continued from page 15 Based on observation and interview, it was determined the facility failed to maintain portable fire extinguishers in one instance, affecting the entire facility. Findings include: 1. Observation on December 30, 2024, at 9:30 a.m., revealed the facility failed to perform the required monthly inspections of the fire extinguishers throughout the entire facility. Interview with the Facility Administrator and Maintenance Director on December 30, 2024, at 1:30 p.m., confirmed the above portable fire extinguisher deficiency.	K 0355		
K 0363 SS=E		K 0363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: 01 B. WING:	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET** **MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0363 SS=E	Continued from page 16 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	NHA/Designee will educate the Maintenance Director/Maintenance staff NFPA requirements corridors - doors. Maintenance has repaired the Patient laundry door, room 507 and the Soiled Utility on the 800 hall. Maintenance staff will conduct a weekly audit of all corridor doors to make sure all doors latch properly.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/16/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0363 SS=E	Continued from page 17 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0363 SS=E	Continued from page 18 Based on observation and interview, it was determined the facility failed to maintain corridor doors in three instances, affecting three of eight smoke compartments. Findings include: 1. Observation on December 30, 2024, revealed the following corridor doors would not latch in their frame when tested: a) 9:45 a.m., the door to Patient Laundry in the 400 Hallway; b) 10:00 a.m., the door to room 507; c) 10:10 a.m., the door to Soiled Utility in the 800 hallway, would not latch due to tape covering the striker plate. Interview with the Facility Administrator and Maintenance Director on December 30, 2024, at 1:30 p.m., confirmed the listed corridor door deficiencies.	K 0363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0363 SS=E	Continued from page 19	K 0363		
K 0712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:	K 0712	NHA/Designee will educate the Maintenance Director/Maintenance staff/Designee on the fire drill policy. Fire drills will be conducted monthly by the Maintenance Director/Designee at varying times to ensure that each sift has a fire drill quarterly. NHA will audit the fire drills monthly x 3 months.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/16/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0712 SS=F	Continued from page 20 Based on documentation review and interview, it was determined the facility failed to perform eleven of twelve required fire drills, affecting the entire facility. Findings include: 1. Review of documentation on December 30, 2024, at 8:30 a.m., revealed the facility lacked fire drill documentation for the first shift, first quarter, second shift, first quarter, and all three shifts for the second, third, and fourth quarters of the year. Interview with the Facility Administrator and Maintenance Director on December 30, 2024, at 1:30 p.m., confirmed the facility lacked documentation for the drills performed in the previous twelve months.	K 0712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0712 SS=F	Continued from page 21	K 0712		
K 0918 SS=E	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained	K 0918	NHA/Designee will educate the Maintenance Director/Maintenance staff on the weekly NFPA generator inspection requirements and the 3-year, 4-hour load testing. The 3 year, 4-hour load testing is scheduled on 1/23/2025. NHA/Designee will audit the weekly generator inspections monthly x 3 months.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/16/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0918 SS=E	Continued from page 22 and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0918 SS=E	Continued from page 23 Based on document review and interview, it was determined the facility failed to maintain and inspect the emergency generator in three instances, affecting the entire facility. Findings include: 1. Document review on December 30, 2024, at 8:20 a.m., revealed the facility could not provide documentation of the following tests and inspections: a) Weekly visual inspections for December 2024; b) Weekly battery electrolyte level or battery voltage for December 2024; c) A 4-hour load test performed within the last 3 years. Interview with the Facility Administrator and the Maintenance Director on December 30, 2024, at 1:30 p.m., confirmed the lack of emergency generator documentation.	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __01_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0918 SS=E	Continued from page 24	K 0918		

Certified End Page

RIVERSIDE HEALTH & REHAB CENTER

STATE LICENSE NUMBER: 185402

SURVEY EXIT DATE: 12/30/2024

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
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)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: 02 B. WING:	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET** **MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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	INITIAL COMMENT Facility ID# 185402 Component 02 Riverside Care Center MIU Addition Based on a Medicare/Medicaid Recertification Survey completed on December 30, 2024, at Riverside Health and Rehab Center, it was determined was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy of the Life Safety Code. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a one-story, Type V (III), protected wood frame building, without a basement, that is fully sprinklered.	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: 02 B. WING:	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET** **MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0100 SS=C	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:	K 0100	The Maintenance Director/Maintenance staff will be educated on the requirements of the 2016 Act 48-Care Facility Carbon Monoxide Alarms Standards Act. All carbon monoxide alarms will have their batteries replaced along with a log will be maintained to record the alarms' location and the date of the annual battery replacement. The facility will perform all the required testing and cleaning of the battery-operated alarms on a monthly basis. A log will be maintained at the facility. All current staff will be educated on the carbon monoxide evacuation and alarm protocols. Any new employees will be trained on the carbon monoxide evacuation and alarm protocols during their general orientation.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/16/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __02_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0100 SS=C	Continued from page 2 Based on documentation review and interview, it was determined that the facility failed to maintain battery operated carbon monoxide alarms in accordance with the 2016 Act 48-Care Facility Carbon Monoxide Alarms Standards Act in three instances, affecting the entire facility. Findings include: 1. Observation on December 30, 2024, revealed the following carbon monoxide deficiencies: a) 9:20 a.m., the facility failed to perform the required annual battery replacement, of the battery-operated carbon monoxide alarms; b) 9:25 a.m., the facility failed to perform the required testing and cleaning, of the battery-operated carbon monoxide alarms; c) 9:30 a.m., The facility failed to provide documentation of Carbon Monoxide Evacuation and Alarm protocols. Interview with the Facility Administrator and	K 0100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: 02 B. WING:	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET** **MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0100 SS=C	Continued from page 3 Maintenance Director on December 30, 2024, at 1:30 p.m., confirmed the carbon monoxide alarm deficiencies.	K 0100		
K 0291 SS=F	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:	K 0291	The Maintenance Director/Maintenance staff will be educated on the NFPA regulation requiring emergency lighting to being tested monthly for 30 seconds and 90 minutes and annually for 90 minutes. NHA/Designee will audit the emergency lighting monthly testing monthly x 2 months.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/16/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __02_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0291 SS=F	Continued from page 4 Based on document review and interview, it was determined the facility failed to maintain emergency lighting in one instance, affecting the entire facility. Findings include: 1. Documentation review on December 30, 2024 at 9:00 a.m., revealed the facility lacked documentation for an annual 90-minute test and monthly 30 second testing for the emergency lights. Interview with the Facility Administrator and Maintenance Director on December 30, 2024, at 1:30 p.m., confirmed the facility lacked documentation for the annual 90-minute test and monthly testing for the emergency lights at the time of survey.	K 0291		
K 0345 SS=F		K 0345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __02_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0345 SS=F	Continued from page 5 NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 0345	The sensitivity test of the smoke alarms is scheduled to be completed in April 2025. The semiannual visual fire alarm inspection was completed on October 31, 2024, and one is scheduled for April 2025. The Maintenance Director/Maintenance staff we be educated on the NFPA requirements of a 2-year smoke detector sensitivity test and the semiannual visual fire alarm inspection.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/17/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __02_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0345 SS=F	Continued from page 6 Based on document review and interview, it was determined the facility failed to maintain the fire alarm system in two instances, affecting the entire facility. Findings include: 1. Document review and observation on December 30, 2024, revealed the following fire alarm system deficiencies: a) 8:40 a.m., review of documentation revealed the facility failed to provide documentation verifying a sensitivity test of smoke detectors was performed within the previous two years; b) 8:45 a.m., review of documentation reveled the facility failed to conduct a semiannual visual fire alarm inspection. Interview with the Facility Administrator and Maintenance Director on December 30, 2024, at 1:30 p.m., confirmed the facility could not provide	K 0345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: 02 B. WING:	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET** **MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0345 SS=F	Continued from page 7 documentation for a semiannual fire alarm inspection and a two-year sensitivity test, at the time of the survey.	K 0345		
K 0353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	The NHA/Designee will educate the Maintenance Director/Maintenance staff on the NFPA requirements of the semiannual automatic sprinkler system inspection. The semiannual sprinkler system was conducted on February 26, May 21, August 26 and November 18, 2024. Inspections are on file at the facility.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/17/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: 02 B. WING:	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET** **MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0353 SS=F	Continued from page 8 Based on document review and interview, it was determined the facility failed to maintain the automatic sprinkler system in one instance, affecting the entire facility. Findings include: 1. Document review on December 30, 2024, at 9:23 a.m., revealed the facility failed to provide documentation for the semiannual automatic sprinkler system inspection. Interview with the Facility Administrator and Director of Maintenance on December 30, 2024, at 1:30 p.m., confirmed the facility lacked the documentation for the semi-annual sprinkler system inspection.	K 0353		
K 0355 SS=F		K 0355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: 02 B. WING:	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET** **MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0355 SS=F	Continued from page 9 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	NHA/Designee will educate the Maintenance Director/Maintenance staff on the NFPA requirements for portable fire extinguishers inspections. NHA/Designee will audit all the facility's fire extinguishers to ensure the monthly inspections are completed.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/16/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: 02 B. WING:	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET** **MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0355 SS=F	Continued from page 10 Based on observation and interview, it was determined the facility failed to maintain portable fire extinguishers in one instance, affecting the entire facility. Findings include: 1. Observation on December 30, 2024, at 9:30 a.m., revealed the facility failed to perform the required monthly inspections of the fire extinguishers throughout the entire facility. Interview with the Facility Administrator and Maintenance Director on December 30, 2024, at 1:30 p.m., confirmed the above portable fire extinguisher deficiency.	K 0355		
K 0712 SS=F		K 0712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: 02 B. WING:	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET** **MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0712 SS=F	Continued from page 11 NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:	K 0712	NHA/Designee will educate the Maintenance Director/Maintenance staff/Designee on the fire drill policy. Fire drills will be conducted monthly by the Maintenance Director/Designee at varying times to ensure that each sift has a fire drill quarterly. NHA will audit the fire drills monthly x 3 months.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/16/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __02_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0712 SS=F	Continued from page 12 Based on documentation review and interview, it was determined the facility failed to perform eleven of twelve required fire drills, affecting the entire facility. Findings include: 1. Review of documentation on December 30, 2024, at 8:30 a.m., revealed the facility lacked fire drill documentation for the first shift, first quarter, second shift, first quarter, and all three shifts for the second, third, and fourth quarters of the year. Interview with the Facility Administrator and Maintenance Director on December 30, 2024, at 1:30 p.m., confirmed the facility lacked documentation for the drills performed in the previous twelve months.	K 0712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __02_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0918 SS=E	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918	NHA/Designee will educate the Maintenance Director/Maintenance staff on the weekly NFPA generator inspection requirements and the 3-year, 4-hour load testing. The 3 year, 4-hour load testing is scheduled on 1/23/2025. NHA/Designee will audit the weekly generator inspections monthly x 3 months.	Completion Date: **02/03/2025** Status: **APPROVED** Date: **01/16/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: __02_____ B. WING: _____	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0918 SS=E	Continued from page 14	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395719	A. BLDG: 02 B. WING:	12/30/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIVERSIDE HEALTH & REHAB CENTER STATE LICENSE NUMBER: **185402**	**100 8TH STREET** **MCKEESPORT, PA 15132**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 0918 SS=E	Continued from page 15 Based on document review and interview, it was determined the facility failed to maintain and inspect the emergency generator in three instances, affecting the entire facility. Findings include: 1. Document review on December 30, 2024, at 8:20 a.m., revealed the facility could not provide documentation of the following tests and inspections: a) Weekly visual inspections for December 2024; b) Weekly battery electrolyte level or battery voltage for December 2024; c) A 4-hour load test performed within the last 3 years. Interview with the Facility Administrator and the Maintenance Director on December 30, 2024, at 1:30 p.m., confirmed the lack of emergency generator documentation.	K 0918		

Certified End Page

RIVERSIDE HEALTH & REHAB CENTER

STATE LICENSE NUMBER: 185402

SURVEY EXIT DATE: 12/30/2024

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
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