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RIVERSIDE NURSING AND REHABILITATION CENTER	**325 JERSEY STREET TRENTON, NJ 08611**

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F 000	INITIAL COMMENTS Survey Date: 12/29/22 Census: 118 Sample: 3 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be not in compliance with 42 CFR §483.80 infection control regulations as it relates to the implementation of the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		2/20/23

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

Electronically Signed | 01/19/2023

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conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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F 880	Continued From page 2 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to: a) utilize appropriate personal protective equipment (PPE) for two staff members on 1 of 3 units; b) failed to post facility information about the COVID-19 outbreak; c) failed to perform handwashing appropriately 3 of 3 visitors and 1 of 1 staff, observed during the screening process; d) failed to follow the facility screening process for COVID-19 for 1 of 3 visitors; e) failed to disinfect and sanitize the equipment used in the COVID-19 screening process for 3 of 3 visitors in accordance with the facility protocol and Centers for Disease Control and Prevention (CDC) guidelines for infection control to mitigate the spread of COVID-19; and, f) failed to utilize appropriate PPE for 3 of 5 rooms on 1 of 3 units to prevent the potential spread of infection in accordance with the facility policy and acceptable standards of practice. This deficient practice was evidenced by the following: 1. During an interview with the surveyor on 12/28/2022 at 10:10 AM, the third-floor Licensed Practical Nurse (LPN) stated there are Covid-19 positive residents on the unit. Each room is identified with a plastic curtain. All staff is required to wear an N95 respirator with a surgical mask over the N95 in the facility. She stated that the staff needed to wear a gown, gloves, goggles,	F 880	1. The identified areas of infection control and prevention have been addressed. 2. Education on-going for appropriate use of PPE; notification of facility outbreak has been posted; hand hygiene education is on-going for staff and visitors who enter the Facility; reception screening process has been amended to include disinfection/sanitizing of all touched equipment. 3. Receptionist educated on screening process for all persons who enter the Facility to include hand hygiene, visitor instructions and disinfection/ sanitizing of all touched equipment. Audit conducted to ensure proper signage placed for notification of outbreak. On-going staff education for appropriate use of PPE. 4. Audits for appropriate PPE use, placement of signage, entry screening process for all staff and visitors, will be conducted by the Infection Preventionist (or designee) daily x one week; weekly x 4 weeks; monthly x 3 months with results reported to QAPI monthly.	

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F 880	Continued From page 3 and an N95 respirator mask with a surgical mask over the N95 when entering residents' rooms who are Covid-19 positive. When exiting the rooms, staff must remove the surgical mask, gown, and gloves and replace the surgical mask over the N95. During the tour of the high side of the third floor on 12/28/2022 at 10:25 AM, the surveyor observed a Certified Nursing Assistant (CNA #1) wearing two surgical masks under a KN95 in the hallway. At that time, the surveyor interviewed the CNA, who stated that what he was wearing was not supposed to be worn in the facility. He said staff must wear an N95 with a surgical mask over the N95. He stated he knew it was wrong, but he had worn his masks that way because he moved too quickly in and out of the rooms. He said he was trained on PPE and how to use it appropriately. He stated he was educated on applying an N95 and the proper use of the masks and would wear them properly. During meal tray delivery on the high side of the third floor on 12/28/2022 at 12:05 PM, the surveyor observed a CNA #2 wearing an N95 with a surgical mask, eye protection, gloves, and a plastic gown enter room 320, an isolation room with a lunch tray. The CNA exited the room and did not remove the plastic gown, gloves, or surgical mask or perform hand hygiene after leaving the room. The surveyor then observed CNA #2 removing a lunch tray from the food cart and enter room 324, another isolation room. She exited the room without doffing the PPE. At that time, the surveyor interviewed CNA #2, who stated she did not know if she had to doff (remove) her PPE when exiting rooms, when passing lunch trays, and would have to ask the	F 880	Directed Plan of Correction I. Directed Plan of Correction Statement: During an infection survey that ended on 12/29/2022, the center received a deficiency of F880. II. Root Cause Analysis - After careful review, it has been determined that the root cause was related to employees who had previously been education, did not follow the protocols. Upon multiple interviews with employee's, contributing factors included employees rushing to get tasks completed, nervousness related to being watched and then becoming flustered, as well as human nature in which employees forgot the steps in which they had previously been trained. III. Directed In-Servicing Training: Evidence of Completion will be submitted by 2/20/23 on the following: 1. Nursing Home Infection Preventionist Training Course; Module 1 – Infection Prevention and Control Program. Training provided to topline staff and infection preventionist. 2. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 out! Training provided to front line staff. 3. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Sparkling Surfaces. Training provided to front line staff. 4. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff:	

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F 880	Continued From page 4 nurse on the unit. The CNA walked to the nurse's station and the nurse instructed her that she had to don (put on) and doff PPE when entering and exiting rooms during meal tray delivery. During an interview with the surveyor on 12/28/2022 at 2:00 PM, the Infection Control Preventionist stated that the staff was educated on the proper use of an N95 and when to don and doff PPE. She further noted that CNA #2 should have removed her gown, gloves, and surgical mask when exiting the room. She further stated that (CNA #1) should have known better and that wearing a surgical mask underneath an N95 would not create a correct seal. A review of the facility's Personal Protective Equipment (PPE) competency dated and signed on 9/6/2022 indicated that both CNA #1 and #2 were appropriately trained on how to don and doff PPE. A review of the Don and Doff PPE with sequence in-service sign-in sheet dated 9/6/2022 indicated that both CNA #1 and CNA #2 had signed that they received the in-service. A review of the facility's policy Coronavirus Disease (Covid-19) using Personal Protective Equipment dated September 2022 indicated personnel who enter the room of a resident with suspected or confirmed SARS-CoV-2 infection adhere to standard precautions and use an approved N95. A review of the facility's Infection Control Policy: Outbreak Plan dated 3/22/2021 indicated that the staff would be educated on exposure risks, symptoms, and prevention of the infectious	F 880	Clean Hands. Training provided to front line staff. 5. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Closely Monitor Residents. Training provided to front line staff. 6. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPD Correctly for COVID-19. Training provided to front line staff. 7. Nursing Home Infection Preventionist Training Course; Module 5 – Outbreaks. Training provided to topline staff and infection preventionist. 8. Nursing Home Infection Preventionist Training Course; Module 11B – Environmental Cleaning and Disinfection. Training provided to all staff including topline staff and infection preventionist. 9. Nursing Home Infection Preventionist Training Corse; Module 7 – Hand Hygiene. Training provided to all staff including topline staff and infection preventionist. 10. Nursing Home Infection Preventionist Training Course; Module 6A – Principles of Standard Precautions. Training provided to all staff including topline staff and infection preventionist. 11. Nursing Home Infection Preventionist Training Course; Module 6B – Principles of Transmission Based Precautions. Training provided to all staff including topline staff and the infection preventionist. 12. Nursing Home Infection Preventionist Training Course; Module 11A – Reprocessing Reusable Resident Care Equipment. Training provided to topline	

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F 880	Continued From page 5 disease, with special emphasis on reviewing the basic infection prevention and control, use of PPE, and other infection prevention such as hand washing. The Outbreak response plan further indicated that the staff would be re-educated on donning and doffing of PPE, respiratory protection plan would be conducted. During an outbreak, the staff will adhere to the standard and transmission-based precautions, including the use of facemasks, gowns, gloves, and eye protection for confirmed or suspected cases. 2. According to U.S. CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 9/23/22 included, " ...Ensure everyone is aware of recommended IPC practices in the facility. "Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias). These alerts should include instructions about current IPC recommendations. Dating these alerts can let help ensure people know that they reflect current recommendations: Visitation: However, facilities should adhere to local, territorial, tribal, state, and federal regulations related to visitation; Counsel patients and their visitor(s) about the risks of an in-person visit; "Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy. "Visitors should be instructed to only visit the patient room. They should minimize their time	F 880	staff and infection preventionist. Date of Completion 2/20/23	

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spent in other locations in the facility..."

According to the U.S. CDC Hand Hygiene in Healthcare Settings, Hand Hygiene Guidance, page last reviewed 1/30/20 included, "... Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications:

Immediately before touching a patient,
Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices,
Before moving from work on a soiled body site to a clean body site on the same patient,
After touching a patient or the patient's immediate environment....."

According to the U.S. CDC Clinical Questions about COVID-19: Questions and Answers, updated 9/26/22 included, " ...Cleaning and Disinfection of Environmental Surfaces. Surfaces can become contaminated with microorganisms and potential pathogens. However, many of these surfaces are generally not directly associated with the transmission of infections to either healthcare workers or patients. The transfer of pathogens from environmental surfaces is largely due to hand contact with the surface (e.g., frequently touched surfaces). Touch contamination may lead to cross-contamination of patient care items, and other environmental surfaces, self-contamination, and possible infection after touching one's face or mouth. Both hand hygiene and the cleaning and disinfection of environmental surfaces are fundamental practices to reduce the incidence of healthcare-associated infections ...."

On 12/29/22 at 10:45 AM, the surveyor entered

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the facility entrance (lobby/reception) and was instructed by the Receptionist to use the kiosk (automated temperature screening machine to read body temperature as well as store information regarding COVID-19 screening questions). There were no signs posted about the facility's COVID-19 outbreak information to notify staff and visitors.

During an interview on 12/29/22 at 11:04 AM with the surveyor, the Receptionist stated that the facility was on COVID outbreak. The Receptionist could not say what date the COVID-19 outbreak started and how many staff and residents tested positive.

On that same date and time, the surveyor asked the Receptionist why there were no posted signs to alert the visitors and staff about the facility's COVID-19 outbreak information indicating how many staff or residents tested positive for COVID-19 when they should enter the facility, information to those who enter to monitor for signs and symptoms of COVID-19, and appropriate actions to take if signs or symptoms occur. The Receptionist did not respond.

On 12/29/22 at 11:08 AM, the surveyor observed Visitor#1 (V#1) enter the facility entrance, who did not perform hand hygiene before and after using the kiosk. There was an alcohol-based hand rub (ABHR) container at the reception desk; V#1 immediately walked away from the kiosk. V#1 declined to be interviewed.

At that time, the surveyor interviewed the Receptionist. The Receptionist stated that V#1 visits Resident #1 "almost" every day and that the facility was familiar with V#1. The Receptionist

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acknowledged that V#1 did not perform hand hygiene before and after the use of the kiosk and that the kiosk was not disinfected. The Receptionist immediately ran after V#1 with a container of ABHR.

Upon return of the Receptionist to the reception desk, V#2 entered the facility entrance, did not perform hand hygiene before and after the use of the kiosk, and the kiosk was not disinfected; V#2 immediately walked away. The Receptionist stated that V#2 visits Resident #2 frequently. The Receptionist let V#2 leave the reception desk without performing hand hygiene.

On that same date and time, the Receptionist stated that it was his responsibility to ensure that all staff and visitors followed the protocol to perform hand hygiene before and after using the kiosk and to wear an appropriate mask.

On 12/29/22 at 11:17 AM, the surveyor observed V#3 enter the facility and was instructed by the Receptionist to use the kiosk for COVID-19 screening. The Receptionist asked V#3 for a reason for the visit, and V#3 responded that she was scheduled for a physical examination because she was a new employee. V#3 did not perform hand hygiene before and after the use of the kiosk, and the kiosk was not disinfected.

On that same date and time, the surveyor interviewed V#3. V#3 informed the surveyor that she was a new employee to start on 01/03/23 as an OTA (Occupational Therapist Assistant). The surveyor asked V#3 about hand hygiene and why she did not perform hand hygiene when the kiosk voice command and instructions prompted her to perform hand hygiene, and V#3 did not respond.

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At that same time, the surveyor interviewed the Receptionist. The Receptionist acknowledged that V#1, #2, and #3 did not perform hand hygiene before and after the use of the kiosk. The Receptionist stated he should have stopped the three visitors from leaving the reception desk and ensured they followed the protocol to perform hand hygiene. He also acknowledged that he should have disinfected the kiosk after each use, especially since the three visitors did not perform hand hygiene.

Then, the surveyor observed the Receptionist immediately disinfect the kiosk after the surveyor's inquiry. Afterward, the surveyor observed the Receptionist use the telephone and computer without performing hand hygiene after disinfecting the kiosk.

At this time, the surveyor asked the Receptionist if he should perform hand hygiene after disinfecting the kiosk. The Receptionist stated, "No one told me that I should do hand hygiene after disinfecting the kiosk." He further stated that Staff Development educated him about infection control, which included hand hygiene. However, performing hand hygiene after disinfecting frequently touched surfaces like the kiosk was not discussed.

On 12/29/22 at 11:36 AM, the surveyor interviewed a Licensed Practical Nurse/Staff Development (LPN/SD). The LPN/SD informed the surveyor that she was responsible for staff education and helped the Infection Preventionist (IP) with regard to infection control which included PPE use, hand hygiene, and other infection control issues. The LPN/SD stated that as per

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facility protocol, staff and visitors must follow the posted information upon entry to the facility using appropriate PPE and hand hygiene which can also be found using the kiosk. The LPN/SD further stated that the IP was not at the facility because she was on vacation.

Furthermore, in the presence of the survey team, the surveyor asked the LPN/SD how visitors knew there was an outbreak in the facility when it started and how many tested positive for COVID-19. The LPN/SD stated that the facility utilized the automated system via text message to the staff, residents, and family representatives (listed on the resident's contact list) to notify them of the facility's outbreak and information about the date and how many tested positive for COVID-19. The surveyor then asked the LPN/SD about other visitors not included in the resident's list of responsible parties to contact and how they would get the information when they entered the facility to visit. The LPN/SD stated that because of HIPAA (Health Insurance Portability and Accountability Act of 1996 is a Federal Law that protects patient (or resident) sensitive health information from being disclosed without the patient's consent or knowledge; for example, the patient's name and birthdate), the above information will not be provided to other visitors who were not on the contact list when they enter the facility.

In addition, the LPN/SD was unaware of the CDC guidelines about posting COVID-19 information at the facility entrance and in strategic places that do not include residents' sensitive health information. The LPN/SD further stated that she was "not sure" if it was in their facility policy and procedure to post signs in the entrance and

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strategic places in the facility COVID-19 information about the date an outbreak started and how many staff and residents tested positive to alert staff and visitors and that she would get back to the surveyor.

On 12/29/22 at 12:26 PM, the Licensed Nursing Home Administrator (LNHA) provided a copy of the Update on COVID-19 as of 12/28/22, which included information about the COVID-19 outbreak date and how many staff and residents tested positive that was addressed to the team and family and friends. The LNHA stated that this "should have been posted" in the facility lobby area to notify all staff (team), family, and friends that enter the facility to alert them of the COVID-19 outbreak. The LNHA did not provide additional information why this was not posted until the surveyor's inquiry.

On 12/29/22 at 12:59 PM, the surveyor notified the LNHA of the above regarding staff not performing appropriate hand hygiene and not disinfecting the kiosk after each use; The LNHA did not refute the findings. The surveyor asked the LNHA to provide a copy of the visitor log for today, and she said she would get back to the surveyor.

On 12/29/22 at 01:08 PM, the surveyor received a copy of the visitor logs from the LNHA. The surveyor and the LNHA reviewed the visitors' log and could not find V#1's information to show that she did the screening for COVID-19. The LNHA stated that it was the Receptionist's responsibility to ensure visitors and staff follow the screening process, including answering the screening COVID-19 questions in the kiosk that will register the staff and visitors' names in the log that was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315235	A. BUILDING _____ B. WING _____	C 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE NURSING AND REHABILITATION CENTER	325 JERSEY STREET TRENTON, NJ 08611

(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 DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12	F 880		

provided to the surveyor.

On 12/29/22 at 01:34 PM, the surveyor followed up with the LNHA about the requested policy and protocol for screening visitors and staff. The LNHA stated that it should be the same as the previously provided copy of Visitation instructions. The LNHA did not provide additional documents and information to dispute the above findings.

A review of the facility's Handwashing/Hand Hygiene Policy that the LNHA provided with a revised date of August 2019 showed that all personnel shall follow handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The facility policy also included that residents, family members, or visitors will be encouraged to practice hand hygiene through the use of fact sheets, pamphlets, or other written materials provided at the time of admission or posted throughout the facility and to perform hand hygiene after handling contaminated equipment.

The undated policy titled "Visitation Instructions" that the LNHA provided showed that staff and visitors are required to perform hand hygiene upon entry and after touching any surfaces.

3. During the initial tour of the 2nd-floor unit on 12/28/22 at 09:47 AM, upon stepping off the elevator, the surveyor observed two security officers sitting in the hallway. One security officer was wearing an N95 mask that was not properly secured around his head; the bottom strap of the N95 mask was hanging down below his chin and not properly secured around the back of his head. The surveyor interviewed the security officer about the proper use of the N95, which he was

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F 880	Continued From page 13	F 880		

aware of, and upon the surveyor's inquiry, he properly secured the N95.

On that same date and time, the surveyor observed five rooms that had a "Red Zone" sign affixed to the outside of the doors; 3 of the 5 "Red Zone" rooms had a plastic curtain hanging over the doors, but two of the rooms on the high side did not. The signs read standard/droplet/contact precautions; "The following PPE is required: N95 mask must be changed between each room, surgical mask over N95 must be changed, gown or equivalent, goggles or face shield, gloves, and surgical masks can be worn in the hallways."

The surveyor observed plastic bins in the hallway outside 2 of the 5 rooms on the low side, but no plastic bins were set up outside the doors of the three resident rooms on the high side where the three "Red Zone" signs were posted.

The plastic bins contained PPE gowns, surgical masks, eye protection, and gloves, but there were no N95 masks available in the bins with the other PPE.

On 12/28/22 at 10:25 AM, the surveyor interviewed a Certified Nurse Assistant (CNA) who stated that there were times when they did not have enough PPE on the unit, especially N95 masks and that the masks were kept locked at the nurse's station. The CNA stated there is PPE in the central supply when staff is available to bring it to the unit. The CNA added, "but things are definitely improving."

On the same day and time, the surveyor toured with the Unit Manager Licensed Practical Nurse (LPN), who stated that the "Red Zone" signs and

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	315235	A. BUILDING _____ B. WING _____	C 12/29/2022

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F 880	Continued From page 14	F 880		

the plastic curtains hanging on the outside of the doors in the unit were the Covid-19 positive residents and the plastic bins contained the PPE to put on before entering the room. The surveyor showed the plastic bins available outside 2 of the room doors on the low side. On the high side, the three doors that displayed the "Red Zone" signs did not have plastic bins set up outside the doors. There were also no plastic bins in the high-side hallway, and there were no N95's in any of the five plastic bins placed outside the 5 "Red Zone" rooms.

The LPN further stated it was her first day but confirmed there should be plastic bins outside each room, and all the PPE should be available in the plastic bins. The LPN stated she would speak with the DON to have the plastic bins and N95 masks put in place.

On 12/28/22 at 11:00 AM, the surveyor interviewed Staffing Coordinator (SC), who stated she was the backup to the Infection Preventionist (IP) because the IP was on vacation. The SC confirmed that PPE should be readily available, and N95 masks should be available in the carts if there is signage outside the doors.

In the review of the Infection Prevention and Control policy - PPE for standard and droplet precautions-PPE is used to prevent contact of the COVID-19 virus. PPE that may be used to provide care, including N95 respirators, surgical or procedural masks, gloves, and gowns for standard precautions and to prevent the spread to other residents.

Signs will be posted on the door signifying an isolation status, and an isolation cart will be set

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	315235	A. BUILDING _____ B. WING _____	C 12/29/2022

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RIVERSIDE NURSING AND REHABILITATION CENTER	**325 JERSEY STREET TRENTON, NJ 08611**

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F 880	Continued From page 15 up outside the patient's room. Staff will perform handwashing prior to leaving the room. NJAC 8:39-19.4(a)(2)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061112	A. BUILDING: _____ B. WING _____	C 12/29/2022

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documents, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift and evening shift as mandated by the State of New Jersey. The facility was deficient in Certified Nursing Assistants (CNA) staffing for residents on 12 of 14 day shifts and deficient in CNAs on 1 of 14 evening shifts as follows: Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	1. Staffing reviewed for the referenced dates/shifts. No residents were negatively affected. 2. All residents have potential to be affected. 3. Daily review of staffing by DON (or designee) to ensure compliance with NJSA 30:13-18 minimum staffing requirements for nursing homes for day and evening shifts. Call-out policy reviewed. Agency engaged as needed. 4. The DON (or designee) to have weekly meetings to determine upcoming schedules to anticipate staffing needs and	2/20/23

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

Electronically Signed | 01/19/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061112	A. BUILDING: _____ B. WING _____	C 12/29/2022

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S 560	Continued From page 1 Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 12/11/2022 through 12/17/2022, and 12/18/2022 through 12/24/2022, the staffing-to-resident ratio did not meet the minimum requirements and is documented below: -12/11/22 had 15 CNAs for 126 residents on the day shift, required 16 CNAs. -12/12/22 had 15 CNAs for 126 residents on the day shift, required 1 6 CNAs. -12/13/22 had 15 CNAs for 126 residents on the day shift, required 16 CNAs. -12/14/22 had 15 CNAs for 126 residents on the day shift, required 16 CNAs. -12/15/22 had 15 CNAs for 126 residents on the day shift, required 16 CNAs. -12/16/22 had 15 CNAs for 127 residents on the day shift, required 16 CNAs.	S 560	will report findings to the Administrator x 4 weeks; monthly x 3 months with results reported to QAPI. QAPI meets monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061112	A. BUILDING: _____ B. WING _____	C 12/29/2022

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S 560	Continued From page 2 -12/17/22 had 13 CNAs for 127 residents on the day shift, required 16 CNAs. -12/18/22 had 11 CNAs for 125 residents on the day shift, required 16 CNAs. -12/19/22 had 13 CNAs for 125 residents on the day shift, required 16 CNAs. -12/21/22 had 14 CNAs for 121 residents on the day shift, required 15 CNAs. -12/22/22 had 14 CNAs for 121 residents on the day shift, required 15 CNAs. -12/24/22 had 12 CNAs for 119 residents on the day shift, required 15 CNAs. -12/24/22 had 5 CNAs to 13 total staff on the evening shift, required 6 CNAs. On 12/29/22 at 09:44 AM, the surveyor interviewed the facility Staffing Coordinator (SC). The SC told the surveyor the required ratios for Certified Nursing Assistants (CNA). The SC spoke to the facility utilizing agency and per diem staff if needed. The surveyor asked the SC if she felt they had enough staff and she responded, "I think it can be better, I'm just being honest". NJAC 8:39-5.1 (a)	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315235 (Y1)	A. Building B. Wing (Y2)	3/1/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE NURSING AND REHABILITATION CENTER	325 JERSEY STREET TRENTON, NJ 08611

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 02/20/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 12/29/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061112		3/1/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE NURSING AND REHABILITATION CENTER	325 JERSEY STREET TRENTON, NJ 08611

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 02/20/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
12/29/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO