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 11/29/2019

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

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F 000	INITIAL COMMENTS COMPLAINT#: NJ120614, NJ120615, NJ130164 CENSUS: 101 SAMPLE SIZE: 3	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: C#: NJ120614, NJ120615, NJ130164 Based on interview, review of medical records (MR) and other pertinent facility documentation, it was determined that facility staff failed to implement and follow their abuse policies and procedure when on [redacted], the housekeeping staff aggressively pushed the resident into the resident's room to prevent the resident from being disruptive. This deficient practice was for 1 of 3 sampled residents (Resident #2) reviewed for incidents and accidents and was evidenced by the following:	F 607	1. Resident #2 no longer lives at the facility. 2. All facility residents have the potential to be harmed by this behavior. A review of facility residents shows that other Residents have not been exposed to such behavior. 3. All facility staff will be re-trained on the policy of how to react in order to safeguard a resident from abuse, mistreatment, or neglect; this training will include stopping what they are doing, ensuring the resident□s safety, and	1/1/20

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

Electronically Signed | 01/02/2020

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F 607	Continued From page 1 On 1/21/2019, the New Jersey Department of Health (NJDOH), Long-Term Care Complaints Program received a Facility Reporting Event (FRE) of an alleged staff to resident abuse with an event date of [redacted] The facility indicated in the Investigative Summary that the conclusion to their investigation indicated that the allegation of abuse was substantiated by the facility's internal investigation. Review of the MR were as follows: According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS) score [redacted], which indicated that the resident had [redacted] impairment. The MDS also indicated that Resident #2 required extensive two-person physical assistance with transfers, and Activities of Living (ADLs). Review of a facility's incident report (IR) dated [redacted] at 11:56 a.m., showed under "Resident Description:" Resident was questioned as to how he/she fell.... In addition, the IR indicated the resident was questioned as to how he/ she fell. However, the resident indicated to get out of the resident's room. The IR also indicated the resident was asked several times but did not indicate how [redacted] fell. Further review of the IR showed 911 initiated and the resident was sent to the emergency room (ER) evaluation. Review of the Progress Notes (PN) dated [redacted] at 12:24 p.m., showed the Licensed Practical Nurse (LPN #1) was alerted by CNA #1 that Resident #2 was on the floor. The PN also revealed that the resident was observed in the left lateral position, [redacted] was noted on the floor and	F 607	immediately reporting the occurrence to their supervisor as per policy. 4. An audit by the Director of Nursing or designee will be done as QAPI monthly for (4) months and then quarterly thereafter for one year to ensure that facility staff are following the above stated policy and to ensure that residents feel safe. 10% of residents will be evaluated with each QAPI. The results of the audit will be reported to the Administrator at QA meeting.	

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F 607	Continued From page 2 the resident had a [redacted] to the [redacted] with swelling surrounding the site. Review of a second PN dated [redacted] at 2:17 p.m., the resident returned to the facility with [redacted] to the [redacted] and denied any [redacted] or [redacted] During a post survey phone interview with CNA #1, on [redacted] at 8:51 a.m., the CNA stated that during handing out lunchtime trays she heard the housekeeper asked Resident #2 to move and then pushed the resident into his/her room, the CNA then heard a noise and the housekeeper said the resident fell out of [redacted] wheelchair. In addition, the CNA indicated she did not intervene because she thought the housekeeper was a nursing staff and knew the resident. During a post survey phone interview with the Unit Manager/ Registered Nurse (RN #1), on [redacted] at 11:02 a.m., the RN stated the following day after the incident he/she reviewed the facility's camera with the Administrator and Director of Nursing (DON) which showed Resident #2 going down the hall in his/her wheel chair knocking over items in the hall way which appeared to be the linen carts, then went into his/her room while staff picked up the linen carts. The RN further indicated that the resident then come out of his/ her room again and went towards the opposite direction when the housekeeper went after Resident #2 and attempted to push the wheelchair forward, the resident then became resistant and placed his/her feet on the floor preventing the wheel chair from moving. The housekeeper then turned the chair around and tilted the chair backwards pulling the resident into his/her room. A few	F 607		

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F 607	Continued From page 3	F 607		

minutes later the housekeeper came out of Resident #2's room and went towards the nursing station, and the nurse LPN #1 then went to Resident #2's room. RN #1 further explained that the camera did not record voices so she was unable to hear what was being said, also, the cameras were only in the hallways not in the resident's rooms. Again, nothing observed that the resident was pushed out of the chair?

During a post survey phone interview with the Licensed Practical Nurse (LPN #1) on 12/4/19 at 11:02 a.m., LPN #1 stated she heard a commotion and when she went to resident #2's room the resident was on the floor. The LPN also indicated that she was told by the housekeeper that the resident threw [redacted] on the floor and the resident was not able to get out of the chair independently and required total assistance.

During a post survey phone interview on 12/19/19 at 12:48 p.m., the District Manager (DM) of the Housekeeping company stated the housekeeping staff are not allowed to touch the residents and the staff receive training twice a year on resident's rights and abuse. The DM also stated that the housekeeper no longer worked for the company, the same day the incident occurred at the facility the housekeeper was escorted out of the facility and was let go from the company.

The housekeeping staff no longer works at the facility since the day of the incident. The surveyor attempted to reach the housekeeper involved in the alleged altercation but was unable to reach the housekeeper.

The surveyor also attempted to contact the agency CNA who witnessed the housekeeper

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F 607	Continued From page 4 aggressively wheeling the resident in the wheelchair but was unable to reach the CNA. The facility staff and contracted staff were in service on the facility's abuse policy on [redacted] and [redacted] Review of the facility's policy presented by the Administrator titled "Abuse Policy" Revised: 11/2016, included the following: Under "Prevention of Resident Abuse" (The facility) will endeavor to provide an environment that prohibits the incident of resident abuse.... Supervisory staff is trained to detect inappropriate staff behavior....Under "Definition of abuse:" Abuse is the willful infliction of injury, unreasonable confinement, intimidating, or punishment with resulting physical harm, pain or mental anguish.... Also, verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enable through use of technology. Purpose: 1. To ensure the residents at (the facility) are free from abuse by anyone, including: Staff, Visitors, Other residents.... 3. To provide safe and secure environment for those who reside at (the facility).... Any employee who knowingly or negligently brings harm or injury to a resident will be suspended pending the outcome of the investigation and their employment may be terminated .... Review of a second facility's policy presented by the Director of Nursing (DON) titled "Abuse In-Service" revised 1/2019, revealed under Purpose: To prevent abuse, neglect, an adverse	F 607		

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F 607	Continued From page 5 event, and/or mistreatment of residents.... Under "Procedure:" Any employee who is suspected of or accused of abusing a resident will be immediately suspended, pending investigation. Even if the resident is confused or the allegation is unlikely, the same action is taken.... Under "Types of Abuse:" Physical Abuse: .... It includes, but is not limited to; hitting, slapping, pulling, shoving.... Under "Reporting Abuse and Neglect:" If an employee suspects or witnesses abuse, mistreatment, neglect, they are to do the following; If observed or witnessed, stop what you are doing, ensure the resident's safety, and immediately report occurrence to your immediate supervisor, DON, and/ or Administrator.... The facility's staff failure to intervene to prevent an alleged altercation resulted in physical harm to Resident #2 and placed all other residents with a similar incident at risk for harm. N.J.A.C: 8:39-4.1 (a) 5	F 607		