| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E SURVEY PLETED | |
|--|---|--|---|--|------------------------|--|
| | | 061112 | B. WING | | C 12/06/2021 | |
| | PROVIDER OR SUPPLIER | EHABILITATION C 325 JEF | NDDRESS, CITY, RSEY STREET DN, NJ 08611 | | | |
| X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLE DATE | |
| S 000 | | n compliance with the lew Jersey Administrative | S 000 | | | |
| | Long Term Care F submit a plan of co completion date, for that the plan is imp deficiencies may r accordance with th Jersey Administrat | 9, Standards for Licensure of acilities. The facility must prrection, including a preach deficiency and ensure blemented. Failure to correct esult in enforcement action in the Provisions of the New tive Code, Title 8, Chapter 43E censure Regulations. | | | | |
| S 560 | (a) The facility sha | tory Access to Care Il comply with applicable d local laws, rules, and | S 560 | | 1/21/22 | |
| | by: Based on interview on 12/6/2021, it wa failed to ensure sta maintain the requir ratios as mandated for 23 of 49 shifts of practice had the po- Findings include: Reference: New J (NJDOH) memo, of with N.J.S.A. (New 30: 13-18, new min for nursing homes Governor singed in | ENT is not met as evidenced vs and facility document review as determined that the facility affing ratios were met to red minimum staff-to-resident d by the state of New Jersey reviewed. This deficient otential to affect all residents. | | S560 Mandatory Access to Care (Staffing) Element One Director of Nursing, Administrator, Staffing Coordinator and/or Designee will continue to recruit and advertise to satisfy the staffing regulation to ensure that quality of care is provided to the residents This will be done by rounding, observation, auditing, communication with residents and families through daily interaction, care conferences and resident council. Element Two All residents have the potential to be | | |

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

TITLE

(X6) DATE

12/31/21

STATE FORM

Electronically Signed

6899

If continuation sheet 1 of 4

| New | ersev | Dena | artment | of | Health |
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| ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---|---|--|--|
| | 061112 | B. WING | B. WING | | | |
| PROVIDER OR SUPPLIER | EHABILITATION C 325 JER | SEY STREET | | | | |
| (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH | OULD BE | (X5) COMPLETE DATE | |
| established minimu nursing homes. The effective on 02/01/2 One Certified Nurs residents for the day member to every te shift provided that is shall be CNAs and be signed into work shall perform nurse care staff member night shift, provided member shall sign perform CNA duties 1.Week from 09/12 facility was deficier on 6 of 7 day shifts staff on 1 of 7 even staff for residents of follows: On 09/12/21 had 1 the day shift, requin On 09/15/21 had 1 the day shift, requin On 09/15/21 had 1 the day shift, requin On 09/15/21 had 1 | um staffing requirements in ne following ratio (s) were 2021: e Aide (CNA) to every eight ay shift. One direct care staff en residents for the evening no fewer of all staff members each direct staff member sha < as a certified nurse aide and e aide duties: and One direct to every 14 residents for the d that each direct care staff in to work as a CNA and s. 2/2021 to 09/18/2021, the nt in CNA staffing for residents of deficient in CNAs to total hing shifts, and deficient in tota on 1 of 7 overnight shifts as 2 CNAs for 123 residents on red 16 CNAs. total staff for 123 residents on red 16 CNAs. 2 CNAs for 120 residents on red 16 CNAs. 2 CNAs for 120 residents on red 15 CNAs. CNAs to 14 total staff on the ired 7 CNAs. 4 CNAs for 120 residents on | 1 5 al | affected by this practice Element Three Rates have been significantly i for C.N.A.s Incentives and sign on bonuse Ads updated to reflect increase Job Fairs Banners are put by the facility that we need more staff. The call out policy has been re the staff have been reeducated Staffing policy updated to refler mandate. Contract / relationships with ag fill open slots. Element Four The DON, Administrator, Staffi Coordinator and/or Designee to weekly meetings to determine schedules to anticipate needs. Facility will increase sending n agencies 2x per week. Curren week. | s added. es. to advertise viewed and t ct staffing jencies to ng o have upcoming eeds list to tly at 1x per | | |
| | TOF DEFICIENCIES OF CORRECTION ROVIDER OR SUPPLIER DE NURSING AND RI SUMMARY STA (EACH DEFICIENC REGULATORY OR L Continued From participation and the stablished minimur nursing homes. The effective on 02/01/2 One Certified Nurs residents for the dar member to every the shift provided that is shall be CNAs and be signed into work shall perform nurse care staff member night shift, provided member shall sign perform CNA dutie 1.Week from 09/12 facility was deficien on 6 of 7 day shifts staff on 1 of 7 even staff for residents of follows: On 09/12/21 had 1 the day shift, requin On 09/15/21 had 3 the overnight shift, requin On 09/15/21 had 1 the day shift, requin On 09/15/21 had 1 | OF CORRECTION IDENTIFICATION NUMBER: 061112 061112 ROVIDER OR SUPPLIER STREET A SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every ten residents for the evening shift provided that no fewer of all staff members shall be CNAs and each direct staff member shall be Signed into work as a certified nurse aide and shall perform nurse aide duties: and One 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. 1.Week from 09/12/2021 to 09/18/2021, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts, deficient in CNAs to total staff or 1 of 7 evening shifts, and deficient in tota staff for residents on 1 of 7 overnight shifts as follows: On 09/12/21 had 12 CNAs for 123 residents on the day shift, required 16 CNAs. | TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPA A. BUILDING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, 325 JERSEY STREET TRENTON, NJ 08611 NOT DE NURSING AND REHABILITATION C STREET ADDRESS, CITY, 325 JERSEY STREET TRENTON, NJ 08611 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 1 S 560 established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: S 560 One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every ten residents for the evening shift provided that no fewer of all staff members shall be form nurse aide duties: and One 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. 1.Week from 09/12/2021 to 09/18/2021, the facility was deficient in CNAs taffing for residents on 6 of 7 day shifts, deficient in CNAs to total staff or residents on 1 of 7 overnight shifts as follows: 0n 09/12/21 had 12 CNAs for 123 residents on the day shift, required 16 CNAs. On 09/13/21 had 9 CNAs for 123 residents on the day shift, required 15 CNAs. On 09/15/21 had 12 CNAs for 120 residents on the day shift, required 15 CNAs. On 09/15/21 had 12 CNAs for 120 residents on the day shift, required 15 CNAs. On 09/15/21 had 14 CNAs for 120 residents on the day shift, required 15 CNAs. | COP DEPRICIENCIES (X1) PROVIDERSUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: OPTIDE STREET ADDRESS, CITY, STATE, ZIP CODE DE NURSING AND REHABILITATION C 325 JERSEY STREET TRENTON, NJ 08611 DE NURSING AND REHABILITATION C 325 JERSEY STREET TRENTON, NJ 08611 DE NURSING AND REHABILITATION C 325 JERSEY STREET TRENTON, NJ 08611 DE NURSING AND REHABILITATION C 325 JERSEY STREET TRENTON, NJ 08611 DE NURSING AND REHABILITATION C 35 560 SUMMARY STATEMENT OF DEFICIENCIES (EACH ORRECTIVE ACTION BH (EACH ORRECTIVE ACTION (BH OR SHIT, HEQUICH TO EACH (EACH ORRECTIVE ACTION (BH ACH AND ACTION BH (EACH ORRECTIVE ACTION | ICTO DEFICIENCIES OF CORRECTION (X1) PROVIDERSUPPLIERICLA IDENTIFICATION NUMBER: (X2) MULTIFLE CONSTRUCTION A BUILDING: (X3) DATE: COMPI ROVIDER OR SUPPLIER STREET ADDRESS, GLTY, STATE, ZIP CODE 22 JERSEY STREET TRENTON, NJ 08611 SUMMARY STATEMENT OF DEFICIENCIES (EACH ECRICENCY WIST PRECEDED BY FULL REQUITIONY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTION (EACH ECRICENCY WIST PRECEDED BY FULL REQUITIONY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTION (EACH ECRICENCY WIST PRECEDED BY FULL REQUITIONY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTION (EACH ECRICENCY WIST PRECEDED BY FULL REQUITIONY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF CORRECTION (EACH ECRICENCY WIST PRECEDED BY FULL REQUITION AND REAL SUMMARY STATEMENT OF DEFICIENCIES (EACH ECRICENC WIST BY PROVIDER'S PLAN OF CORRECTION (EACH ECRICENC WIST BY ENCLOSE (EACH ECRICENCENCY OF LSC IDENTIFYING INFORMATION) Continued From page 1 \$ 560 Contract from page 1 \$ 560 S faility wist actified nurse actified nurse actified nurse shall be CNAs and each direct care staff member to very 14 residents for the evening shift provided that each direct care staff member to very 14 residents for the actifity wist increase sending needs. Facility was deficient in CNA statiton the day shift, required 16 CNAs. On 09/12 | |

HP0D11

If continuation sheet 2 of 4

| New Jer | sey Department of H | lealth | | | FURM | APPROVED |
|--------------------------|--|--|-------------------------------|--|---------|--------------------------|
| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: | E CONSTRUCTION | | E SURVEY PLETED |
| | 061112 | | B. WING | | | C 06/2021 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | |
| RIVERSI | DE NURSING AND RE | -HABILITATION C | SEY STREET | | | |
| | | TRENTO | N, NJ 08611 | | 071011 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| S 560 | Continued From pa | ige 2 | S 560 | | | |
| | the day shift, requir | ed 15 CNAs. | | | | |
| | facility was deficien on 13 of 14 day shi total staff on 2 of 14 On 11/21/21 had 14 the day shift, requir On 11/22/21 had 14 the day shift, requir On 11/24/21 had 13 the day shift, requir On 11/25/21 had 14 the day shift, requir On 11/25/21 had 6 evening shift, requir On 11/26/21 had 10 the day shift, requir On 11/27/21 had 8 day shift, required 7 On 11/27/21 had 8 day shift, required 7 On 11/27/21 had 7 evening shift, required 7 On 11/28/21 had 9 day shift, required 7 On 11/29/21 had 11 the day shift, required 7 On 11/29/21 had 11 the day shift, requir On 12/01/21 had 13 the day shift, requir On 12/02/21 had 14 the day shift, requir On 12/03/21 had 15 the day shift, requir On 12/03/21 had 15 the day shift, requir On 12/03/21 had 15 the day shift, requir | 4 CNAs for 115 residents on red 15 CNAs. 3 CNAs for 115 residents on red 15 CNAs. 2 CNAs for 115 residents on red 15 CNAs. 2 CNAs for 115 residents on red 15 CNAs. 0 CNAs to 13 total staff on the red 7 CNAs. 0 CNAs for 119 residents on red 15 CNAs. CNAs for 119 residents on the 15 CNAs. CNAs for 119 residents on the red 8 CNAs. CNAs for 119 residents on the 15 CNAs. I CNAs for 119 residents on red 15 CNAs. I CNAs for 119 residents on red 15 CNAs. I CNAs for 121 residents on red 16 CNAs. 5 CNAs for 121 residents on | | | | |

HP0D11

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE | (X3) DATE SURVEY COMPLETED | | |
|--|----------------------|---|------------------|--|--------------------------------|------------------------|--|
| 061112 | | IDENTIFICATION NUMBER. | A. BUILDING: _ | | | | |
| | | B. WING | | | C 06/2021 | | |
| AME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | ATE, ZIP CODE | | | |
| IVERSI | DE NURSING AND RI | EHABILITATION C 325 JER | SEY STREET | | | | |
| (X4) ID | | TRENTC | DN, NJ 08611 | PROVIDER'S PLAN OF (| | (XE) | |
| PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC | ON SHOULD BE HE APPROPRIATE | (X5) COMPLE DATE | |
| S 560 | Continued From pa | age 3 | S 560 | | | | |
| | | ted the aforementioned num staffing requirement for | | | | | |
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| DEPAR | IMENT OF HEALTH | AND HUMAN SERVICES | | | | APPROVED |
|--------------------------|----------------------------------|--|---------------------|--|-------|----------------------------|
| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | | . 0938-0391 |
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | • • | IPLE CONSTRUCTION | CON | TE SURVEY MPLETED |
| | | 315235 | B. WING | | | C / 06/2021 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | 00/2021 |
| RIVERSI | DE NURSING AND RE | EHABILITATION CENTER | | 325 JERSEY STREET TRENTON, NJ 08611 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMEN | TS | F 00 | 00 | | |
| | COMPLAINT # NJ | 148877 | | | | |
| | CENSUS: 121 | | | | | |
| | SAMPLE SIZE: 3 | | | | | |
| | | | | | | |
| | REQUIREMENTS SUBPART B, FOR | N COMPLIANCE WITH THE OF 42 CFR, PART 483, LONG TERM CARE D ON THIS COMPLAINT | | | | |
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| | | | | | | |
| | | DER/SUPPLIER REPRESENTATIVE'S SIG | SNATURE | TITLE | | (X6) DATE |
| Electror | nically Signed | | | | | 12/31/2021 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 02/27/2023

STATE FORM: REVISIT REPORT

| | MULTIPLE CONSTRUCTION | | | DATE OF REVI | SIT |
|---|-----------------------|---------------------------------------|----|--------------|-----|
| IDENTIFICATION NUMBER | A. Building | | | | |
| 061112 _{Y1} | B. Wing | | Y2 | 1/24/2022 | 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 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 | DATE | ITEM | | DATE | ITEM | | DATE |
|-----------------------|---------------------------|-------------|--------------------------------|------------|-----------|------|------------|
| Y4 | Y5 | Y4 | | Y5 | Y4 | | Y5 |
| ID Prefix S0560 | Correction | ID Prefix | | Correction | ID Prefix | | Correction |
| Reg. # | Completed | Reg. # | | Completed | Reg. # | | Completed |
| LSC | 01/21/2022 | LSC | | - | LSC | | |
| ID Prefix | Correction | ID Prefix | | Correction | ID Prefix | | Correction |
| Reg. # | Completed | Reg. # | | Completed | Reg. # | | Completed |
| LSC | | LSC _ | | - | LSC | | |
| ID Prefix | Correction | ID Prefix _ | | Correction | ID Prefix | | Correction |
| Reg. # | Completed | Reg. # | | Completed | Reg. # | | Completed |
| LSC | | LSC _ | | - | LSC | | |
| ID Prefix | Correction | ID Prefix _ | | Correction | ID Prefix | | Correction |
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| LSC | | LSC _ | | - | LSC | | |
| ID Prefix | Correction | ID Prefix _ | | Correction | ID Prefix | | Correction |
| Reg. # | Completed | Reg. # | | Completed | Reg. # | | Completed |
| LSC | | LSC _ | | - | LSC | | |
| REVIEWED BY | REVIEWED BY | DATE | SIGNATURE OF | SUBVEYOR | | DATE | |
| | (INITIALS) | | SIGNALURE UP | JURVETUR | | DATE | |
| REVIEWED BY CMS RO | REVIEWED BY (INITIALS) | DATE | TITLE | | | DATE | |
| FOLLOWUP TO SURVE | Y COMPLETED ON | | FOR ANY UNCORRECTED DEFICIENCI | | | | s 🗆 no |