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 10/25/2022

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) COMPLETE DATE
S 000	Initial Comments TYPE OF SURVEY: Initial inspection of an addition of 10 licensed beds. This would increase the licensed bed count from 131 to 141. SURVEY DATE: 10/25/22 THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. No deficiencies were noted during the inspection of the ten (10) additional beds residing within these Resident Rooms: 316, 317, 318, 325, 326, 327, 328, 329, and 421 The above noted areas may not be occupied until formal notification by the Certificate of Need and Licensing Division has been received.	S 000		

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

Electronically Signed | 11/01/22

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 10/25/2022

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 000	INITIAL COMMENTS TYPE OF SURVEY: Initial inspection of an addition of 10 licensed beds. This would increase the licensed bed count from 131 to 141. SURVEY DATE: 10/25/22 The facility was found to be in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. No deficiencies were noted during the inspection of the ten (10) additional beds residing within these Resident Rooms: 316, 317, 318, 325, 326, 327, 328, 329, and 421 The above noted areas may not be occupied until formal notification by the Certificate of Need and Licensing Division has been received. Further, if certifying the beds for Medicare/Medicaid, reimbursement will not occur until formal notification from CMS for the approval to occupy the beds.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/01/2022

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.