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 _____	08/29/2019

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 STANDARD SURVEY: 8/29/19 CENSUS: 103 SAMPLE SIZE: 28 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		9/30/19

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

Electronically Signed | 09/23/2019

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 _____	08/29/2019

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 584	Continued From page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to maintain resident rooms and care equipment in a clean and sanitary condition. This deficient practice was identified in 3 of 3 nursing units and was evidenced by the following: On 08/22/19 at 11:21 AM, during the initial tour of the Third floor unit, the surveyor observed the following: In room 323, there was a strong odor of urine. Resident #7's nightstand was missing a handle on the bottom drawer. During an interview at the time of observation, Resident #7 stated that he/she had been having problems with flushing the bathroom toilet for four months. The resident stated the toilet did not flush properly, and that he/she reported it to maintenance staff. The resident stated that maintenance had worked on the toilet, but the toilet was still not flushing properly. At that time, the surveyor checked the	F 584	F584 1. Room [redacted] floor was stripped, waxed & sealed. Resident # 7's room (room [redacted]) drawer handle replaced. Toilet removed, obstruction (TV remote) removed and new toilet installed. Room [redacted] Base of Bedside table cleaned. Bathroom in room [redacted] toilet was cleaned and burned out bulbs replaced. Room [redacted] broken furniture removed and replaced, missing handles replaced. Toilet paper holders replaced in all rooms. Stained ceiling tiles in all bathrooms replaced. Central Bathroom on [redacted] floor window blinds replaced. Feeding pump cleaned. 2. All residents have the potential to be affected by environmental conditions. 3. All Housekeeping, Nursing and Activities staff in-serviced to note items needing attention in Maintenance log.	

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 _____	08/29/2019

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 584	Continued From page 2 toilet by flushing it, and observed as water backed up near the toilet seat and took approximately two minutes to drain down the water. In room [redacted], there was dirt and a dried yellow-colored substance of unknown origin on the base of a resident's bedside table. In room [redacted] the bedside table was missing the edging, exposing the substrate beneath. The top drawer of the night stand was missing the handle. The bottom drawer of the television stand was missing the handle. In room [redacted] the handle on the nightstand drawer was missing. On 08/23/19 at 09:02 AM, the surveyor interviewed the resident in [redacted] regarding the night stand. The resident stated he/she did not usually open the drawer because staff obtained belongings from drawer for him/her and that he/she was not sure how they to opened the drawer. In the bathroom, in resident rooms [redacted], and [redacted], there were no toilet tissue holders. The toilet tissue was stored on the back of the toilet. On 08/22/19 at 2:10 PM, the surveyor interviewed the Maintenance Director regarding the above. He stated that he rounded on the [redacted] floor in May 2019 and that no one informed him of the broken equipment/areas. On 08/23/19 at 9:05 AM, the surveyor accompanied the Licensed Practical Nurse Unit Manager (LPN/UM) to the resident rooms, who acknowledged the above observations. The LPN/UM stated she was not aware of the missing cabinet handles. She stated that staff were	F 584	Condition of toilet paper dispensers added to Quarterly Room Inspection Logs. The Administrator or designee will randomly inspect one room per floor per week for three months using the Maintenance Inspection Worksheet. IV & Tube Feeding Poles have been added to Housekeeping room cleaning schedule 4. Results of Monthly Audits will be reported to the QA committee at Quarterly QA Meeting with a goal of meeting at least a 90% completion rate. Completion date September 30, 2019	

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 _____	08/29/2019

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 584	Continued From page 3	F 584		

supposed to report or document in the maintenance log, any broken resident equipment. The LPN/UM stated that they kept the maintenance log at the nurses' station and that staff were supposed to document on the log.

A review of the Maintenance log dated 6/19/19 through 8/22/19 did not reflect that the above areas/equipment were documented.

On 08/23/19 at 9:10 AM, the surveyor reviewed the Maintenance log book with the LPN/UM, which revealed there was no documentation on the log regarding the above areas. The LPN/UM stated that maintenance staff might have removed the completed log book.

On 08/23/19 at 9:20 AM, the surveyor accompanied the LPN/UM to room [redacted] bathroom, where she flushed the toilet and noted the water started to rise up near the seat of the bowel. The LPN/UM confirmed that the resident had informed her of the flushing problem and that the toilet was "snaked" this week. At that time, the resident, who was seated in the wheelchair in the room, stated again, "the problem had been ongoing for four months." The LPN/UM stated she did not know how long the toilet flushing problem had been going on.

On 08/23/19 at 1:02 PM, the surveyor noted that room [redacted] had an odor of urine. At 1:09 PM, the surveyor returned to the room, accompanied by the nurse assigned to room [redacted]. The nurse stated that the odor was "urine" and that one of the two residents that share that room used the bathroom independently and that might be the reason for the smell of urine in the room. The nurse was not aware of any intervention to

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 _____	08/29/2019

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 584	Continued From page 4 address the odor of urine in the room. On 08/23/19 at 1:16 PM, the surveyor, in the presence of the housekeeper, returned to room [redacted]. Upon surveyor inquiry regarding the smell, the housekeeper responded, "it's a pissy [urine] smell." The housekeeper further stated that the urine odor is a recurring issue and has been occurring for a while. The housekeeper added that one of the residents in the room urinates on the floor and the bed. The housekeeper stated that he cleans room [redacted] two to three times a day because of the odor and believed the source of the odor was more related to the bed than the floor. The surveyor reviewed the maintenance policy statement, dated 12/2009, which indicated the maintenance department is responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times. During a meeting with the facility administration on 08/29/19 at 10:30 AM, the Director of Nursing stated that Resident #7 did not urinate on the floor and acknowledged that room [redacted] required special cleaning attention. On 08/22/19 at 11:40 AM, during the initial tour of the [redacted] floor unit, the surveyor observed the following: In room 212/214's shared bathroom, the toilet paper was on the back of the toilet tank. The toilet bowl and rim of bowl were soiled with feces. One light bulb above the sink was out. In room [redacted] shared bathroom, there was a 2 x 2 feet stained ceiling tile.	F 584		

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 _____	08/29/2019

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 584	Continued From page 5 In room [redacted], there was a 2 x 2 feet stained ceiling tile. In room [redacted], there were two 2 x 2 feet stained ceiling tiles. In the central bathroom, two windows had broken blinds. In the resident hallway bathroom, near room [redacted], the toilet paper was not in the holder but on the back of the toilet tank. In the residents' bathroom, located on the subacute unit near the physical therapy room, there was a 2 x 2 feet stained ceiling tile. In room [redacted], there was a heavily stained ceiling tiles near the bathroom. In room [redacted] shared bathroom, the toilet tissue holder was broken. The toilet tissue was placed between the hand rails. In room [redacted] shared bathroom, the toilet tissue holder was broken. The ceiling tiles in the bathroom were heavily stained. In room [redacted], there were heavily stained ceiling tiles in the bathroom. On 08/22/19 at 12 PM, the surveyor showed the above areas to the Registered Nurse Unit Manager who acknowledged the stained ceiling tiles but had no explanation for their condition. On 08/22/19 at 12:40 PM, in room [redacted], the surveyor observed that there was dirt and a	F 584		

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 _____	08/29/2019

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 584	Continued From page 6 tan-colored dried substance splattered on the base of the feeding pump pole and on the floor next to the pole. On 08/23/19 at 11:00 AM, the surveyor made the same observation in the presence of a LPN, who could not speak to why the pole and the floor were not cleaned. NJAC 8:39 - 31.4 (a)	F 584		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide an account of the [redacted] provided to a resident in accordance with professional standards of practice, every shift from 6/1/19 to 7/18/19. This deficient practice was identified for Resident #54, 1 of 3 residents reviewed for [redacted] and was evidenced by the following: On 08/22/19 at 12:40 PM, during the initial tour of the facility, the surveyor observed Resident #54 seated in a high back wheelchair alert and [redacted] The surveyor observed a [redacted] next to the bed which was not in use. A review of the Admission Record reflected Resident #54 was admitted to the facility on	F 658	F658 1. Resident #54 has had their [redacted] orders and administration reviewed for accuracy and corrected by discontinuing the first order and keeping the second order; resident has also been seen by a physician. 2. Other residents receiving [redacted] have been evaluated for accuracy concerning their [redacted] order and administration and corrections made as needed. 3. Nursing staff will be in-serviced on the necessity of following accuracy with orders for resident [redacted], including cancelling discontinued orders and following through with new orders so that	9/30/19

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 _____	08/29/2019

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 658	Continued From page 7 [redacted] with medical diagnoses that included, [redacted] A review of the Significant Change Minimum Data Set (MDS), an assessment tool dated [redacted] revealed the resident had a Brief Interview of Mental Status (BIMS) of [redacted] The functional assessment on the MDS reflected the resident required total care from staff for bed mobility, bathing and eating. On 08/23/19 at 10:49 AM, the surveyor reviewed the physician's order summary report with active orders on 08/23/19. The order summary revealed an order dated 05/22/19 for [redacted] The surveyor reviewed the Progress Notes which revealed a Nutritional Note dated 06/27/19. The Nutritional Note indicated the [redacted] On 08/23/19 at 11:00 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who was assigned to care for the resident. LPN #1 stated that the [redacted] The surveyor and the nurse reviewed the resident's [redacted] which indicated the [redacted] LPN #1 stated he did not know why the machine	F 658	only the current [redacted] order is displayed. The 24-hour chart check program has been updated to include reviews of [redacted] orders every 24 hours on all units with notification of any change in [redacted] orders being sent by nursing supervisor doing 24-hour chart checks to unit manager and DON. Unit Manager verifies proper order on the MAR to ensure no duplicate or contrary [redacted] 4. An audit will be conducted weekly for three months by the unit manager or their designee to verify accuracy of all [redacted]. The Unit Manager will report the results of the audit to the Director of Nursing. The results of the audit will be reported to the QA Committee at Quarterly QA Meeting.	

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 _____	08/29/2019

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 658	Continued From page 8 was set at [redacted] On 08/26/19 at 12:00 PM, the surveyor interviewed LPN #2 who stated the [redacted]. Together the surveyor and LPN #2 reviewed the electronic Medication Administration Record (EMAR) for June and July 2019, which revealed an order for the [redacted] was signed by LPN #2, and another order for [redacted] also signed by LPN #2. LPN #2 stated she thought the amount was for [redacted] and could not explain why she signed that she administered [redacted] and [redacted] at the same time. The surveyor and the Registered Nurse Unit Manager (RN/UM) went into the resident's room and reviewed the [redacted] which reflected the [redacted] On 08/27/19 at 9:44 AM, the surveyor met with the Advanced Practice Nurse (APN) and the Dietitian. The APN stated the resident was receiving [redacted]. The surveyor and the APN reviewed a dietitian progress note dated 06/27/19, indicating an increase in [redacted]. The surveyor and the APN along with the dietitian reviewed the resident's chart, which revealed a written order dated 06/07/19, indicating to [redacted] The APN confirmed the order was from her. The surveyor, the Dietitian and the APN reviewed the EMAR for June 2019 and July 2019 which reveale [redacted] Both orders were signed by nurses from 06/08/19 to 07/18/19. The APN had no explanation as to why the two orders were	F 658		

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 _____	08/29/2019

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 658	Continued From page 9 signed by the nurses. A review of the 06/2019 EMAR revealed that the day shift (7 AM-3 PM) nurses signed they [redacted] per shift from 06/9/19 to 06/30/19. The evening shift (3 PM-11 PM) documented they [redacted] per shift from 06/09/19 to 06/30/19. The night shift (11 PM-7 AM) documented they [redacted] per shift from 06/09/19 to 06/30/19. A review of the 07/2019 EMAR revealed that the nurses signed that they [redacted] per shift from 07/01/19 to 07/18/19. They also signed that they [redacted] daily from 06/01/19 to 06/30/19. The nurses who signed the EMAR did not provide further explanation for their documentation for the conflicting documentation. On 08/27/19 at 12:33 PM, the surveyor interviewed the Regional Clinical Consultant RN who stated that the 24 chart checks should have identified the double orders and discontinued one of the orders. On 08/28/19 at 9:57 AM, the surveyor and the unit LPN medication nurse reviewed the MARS for June 2019 and July 2019. She stated she did not realize that there were two different orders with [redacted] from 06/08/19 to 07/18/19. She also acknowledged she signed the EMAR for both orders from 06/08/19 through 07/18/19. When questioned about their process for the use of [redacted], the LPN did not provide an explanation. On 08/28/19 at 10:30 AM, the MDS Coordinator Registered Nurse stated she had a meeting with	F 658		

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 _____	08/29/2019

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 658	Continued From page 10 the APN and the Dietitian on 07/18/19 and they decided t [redacted] and that on 07/18/19 she discontinued the order for [redacted] because the resident had congestion. She acknowledged that the [redacted] noted on the [redacted] by the surveyor on 8/23/19 was wrong because she discontinued the [redacted] on 07/18/19 but failed to document in the resident's medical record. The facility could not provide further information regarding the [redacted] On 08/28/19 at 11:00 AM, the surveyor reviewed an undated document labeled, Charting, Documentation, Daily Chart Reviews Policy, which revealed that all services provided to the resident shall be documented in the residents medical record. On 08/28/19 at 2:43 PM, the surveyor informed the Administrator and the Director of Nurses of the findings. On 08/29/19 at 10:00 AM, the surveyor interviewed the RN/UM who stated that 24-hour chart checks were done by the nigh shift nurse daily and that the night shift supervisor ensured that the nurses completed the chart checks. On 08/29/19 at 10:10 AM, the surveyor met with the Administration team and the Regional Clinical Consultant RN who stated that nurses were signing for both orders simultaneously and could not determine what feeding amount the resident was receiving. NJAC 8:39-27.1 (a)	F 658		

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 _____	08/29/2019

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 684	Continued From page 11	F 684		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the medical record and other facility documentation, it was determined that the facility failed to assess, monitor and administer recommended wound treatment in a timely manner to a resident's skin injury. This deficient practice was identified for Resident #74, 1 of 2 residents reviewed for skin conditions and was evidenced by the following: During the initial tour conducted on 08/22/19 at 9:45 AM, the surveyor observed Resident #74 seated in a wheelchair inside his/her room. When interviewed, the resident stated he/she smoked and went outside four times a day to smoke cigarettes. The resident also stated he/she recently sustained a skin injury to the hand when he/she scraped his/her hand against the door frame while exiting the door from the smoking area. The resident added the skin injury was healed. The surveyor observed the site of the injury to the left hand, which was healed. The surveyor reviewed the Admission Record	F 684	F684 1. Resident #74 had their [redacted] evaluated by a physician. Area is healed and there are no further clinical concerns. 2. All Residents with skin treatment orders were reviewed to ensure that those orders were followed. 3. 3. Nurses will be in-serviced on the standard of practice of initiating wound treatment physician orders without delay and based upon a standard of clinical timeliness. Nurses were also in-serviced on proper assessment and documentation of wounds on incident reports. Based on improvements made in the 24-hour chart checks, nurses on 3rd shift who review new orders for wound treatments will verify that they have been placed on the MAR or TAR and 24-hour sheet and initiated without delay. The report of this process will be delivered to the DON who logs the 24-hour chart checks. The DON	9/30/19

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 _____	08/29/2019

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 684	Continued From page 12 which reflected that Resident #74 was admitted to the facility with diagnoses that included; [redacted] According to the most recent Minimum Data Set (MDS), an assessment tool dated [redacted] Resident #74 scored [redacted]. A review of an untitled document provided by the facility, dated 05/17/19 at 3:08 PM and revised on 05/21/19 at 4:40 PM, revealed the nurse received a call from the Receptionist's desk and was informed the resident's [redacted]. The document reflected that the nurse arrived on the [redacted] floor and found the resident had [redacted] According to the document, the nurse [redacted]. The nurse also notified the Advance Practice Nurse (APN) about the incident. A review of a Progress Note (PN), dated 05/17/19 at 5:08 PM, reflected Resident #74 sustained a [redacted] According to this note, the nurse cleansed the resident's [redacted] The surveyor reviewed PNs from 05/17/19 through 05/26/19, which did not reflect any documentation or mention of the resident's [redacted]	F 684	or designee reviews the 24-hour chart check form and notes the area designated for new wound assessments and treatments. The DON or designee will review all wound assessments on Incident Reports at morning meeting. 4. The DON or designee will audit 30% of wound assessments weekly x (4) weeks and then monthly thereafter based on the 24-hour chart checks and 24-hour sheets to ensure that they are being transferred to the MAR/TAR properly and are being done accordingly. The DON or designee will audit from the new 24-hour chart check form. The results of the audit will be reported to the QA Committee at Quarterly QA Meeting.	

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 _____	08/29/2019

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 684	Continued From page 13 A review of a document titled, "Statement Form," dated 05/17/19 and un-timed, revealed that Resident #74 reported to the nurse he/she [redacted] on the doorway while entering the building from smoke break. A review of a "[redacted] Care Consultation Report," dated 05/20/19, revealed Resident #74 was evaluated by the [redacted] care consultant for a [redacted]. The recommendation made by the consultant was to apply [redacted] to the resident's [redacted], and to cover the area with a gauze dressing daily. There was no documentation to show that this treatment was done as recommended. A review of the Daily Report sheets provided by the LPN/UM from 05/18/19 through 05/24/19 did not reflect any documentation about Resident #74's [redacted]. A review of the PNs from 05/18/19 through 05/26/19 also did not reflect any documentation about the resident's [redacted]. A review of an Order Summary Report (OSR), dated 05/22/19, revealed a pending order for [redacted] to be applied to the resident's [redacted], every day shift. The order also indicated for the [redacted] to be [redacted] A review of the corresponding Treatment Administration Record" (TAR) for May 2019 showed the treatment order for Resident #74's [redacted] did not start until 05/24/19, four days after recommendation.	F 684		

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 _____	08/29/2019

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 684	Continued From page 14	F 684		

A review of another OSR, dated 05/28/19, reflected a subsequent order for [redacted] to be administered by mouth two times a day for [redacted] for 9 days.

A review of a PN, dated 05/27/19 at 9:94 PM, reflected the resident was being treated with [redacted] for treatment due to [redacted] on the [redacted].

A review of another PN dated 05/29/19 at 10:28 PM reflected the resident received [redacted]

During an interview conducted by the surveyor on 08/27/19 at 11:14 AM, the Registered Nurse (RN) stated Resident #74's [redacted] might have came from the resident's inability to keep his/her [redacted].

During an interview on 08/27/19 1:30 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated the resident's [redacted] was reported to her on 05/17/19, and that the nurse initiated an incident investigation.

On 08/28/19 at 9:37 AM, the surveyor interviewed the unit LPN who was first notified of the resident's injury. She stated she took the resident back to the [redacted] floor nursing unit and applied [redacted] and placed a dressing on to the resident's [redacted] on the day of the incident. The LPN stated she also notified the APN. The LPN stated that it was the facility's policy to monitor a resident following an accident and to document their assessment in the progress notes. The LPN stated she was off from work for about five days following the resident's incident, and that she

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 _____	08/29/2019

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 684	Continued From page 15	F 684		

found the resident's [redacted] to the touch when she returned back to work. The LPN added she notified the APN who then ordered the [redacted].

During a follow-up interview on 08/28/19 at 9:55 AM, the LPN/UM stated that nurses were responsible for documenting their assessments in the Progress Note and on the 24-hour report sheet. The LPN/UM added that nurses were also responsible for notifying the doctor about any changes in a resident's condition. The LPN/UM stated that doctors and APNs were also supposed to document their assessments in the resident chart. The LPN/UM confirmed that Resident #74 was seen by the [redacted] Care Consultant on 05/20/19 with a recommendation for [redacted] treatment, and that the [redacted] was not obtained until 05/24/19 which was when the treatment to the resident's [redacted] was started. She could not explain why there was a delay in treatment of the resident's injury. The LPN/UM also did not provide answers as to why there was no subsequent documentation in the medical record after the resident's injury.

On 08/28/19 at 11:15 AM, the surveyor interviewed the APN regarding the resident's injury and subsequent infection of the area. She stated that a nurse notified her about Resident #74's [redacted] injury on 05/17/19, and that she did assess the resident's [redacted]. The APN added she was not always on site and relied on nurses to report changes. She confirmed she did not document her assessments on the resident's record. The APN added, "I guess if it was not documented, it was not done."

When interviewed on 08/28/19 at 3:35 PM, in the

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 _____	08/29/2019

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 684	Continued From page 16 presence of the Administrator, the Director of Nursing (DON) stated he was new to the facility and was not sure of the facility's policy on documentation following an accident. The DON stated he also could not comment on the facility's policy on how soon a medication order or treatment should be administered. The DON added it is standard of practice for nurses to follow physician orders and administer treatment as soon as possible. The DON stated it was also a standard of practice for nurses to monitor the resident's [redacted] and document their assessment in the resident chart. When asked why there was a delay in the application of [redacted], the DON stated he could not give an explanation. When asked, why there was no documentation in the resident's medical record by the nurses or APN regarding the skin injury, the DON did not offer any explanation. A review of the facility's Pressure Ulcer/Skin Breakdown-Clinical Protocol, dated October 2010, revealed the following: During resident visits, the physician will evaluate and document in the progress of [redacted] healing-especially for those with complicated, extensive, or non-healing [redacted]. A review of the "Unit Manger's Job Description" identified the Unit Manager as being delegated the administrative authority, responsibility, and accountability necessary for carrying out assigned duties, to ensure that all nursing services personnel are following their respective job descriptions. Review nurses' notes to ensure that they are informative and descriptive of the nursing care being provided. NJAC 8:39-27.1 (a)	F 684		

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 _____	08/29/2019

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 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to identify and remove expired medical supplies from the medication room. This deficient practice was identified in 1 of 3 medication rooms inspected and was evidenced by the following: On 08/26/19 at 9:23 AM, the surveyor inspected	F 761	F761 1. Medication rooms were inspected for expired, opened, contaminated or unsealed medical supplies and glucometer control solution and all expired, opened, contaminated or unsealed medical supplies and glucometer control solution were removed.	9/30/19

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 _____	08/29/2019

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 761	Continued From page 18 the [redacted] floor medication room in the presence of a Licensed Practical Nurse (LPN) and observed the following: 1. One box of high/low glucometer control solution (a solution that mimics blood and is used to test the accuracy of the blood glucose meter) with a package open date of 12/02/18. 2. One liter of normal saline solution with the outer sealed missing. 3. One peripherally inserted catheter dressing kit that was opened. 4. One 10 cc syringe of Normal saline not in sealed packaging and mixed with other sealed syringes. 5. One 100 cc Normal saline solution intravenous (IV) bag with an expiration date of 04/19. 6. One 20 gauge safety IV catheter with an expiration date of 11/18. On 08/26/19 at 10:15 AM, the surveyor interviewed the unit LPN and asked about the person responsible for checking medical supply items in the medication room. The LPN stated that the 11 PM-7 AM shift staff were responsible for checking and removing expired items. On 08/26/19 at 10:25 AM, the surveyor interviewed the employee who was responsible for stocking the medication room with over the counter medications. The employee stated that she was responsible for checking expiration dates when she removed the items from the stockroom and before she delivered them to the units, and that nursing staff was responsible for checking the items in units medication rooms. On 08/26/19 at 2:00 PM, the surveyor reviewed the Medication Use, Medication Storage policy	F 761	2. All residents have the potential to be affected by expired, opened, contaminated or unsealed medical supplies and glucometer control solution 3. Nurses will be in-serviced on the importance of monitoring for expired, opened, contaminated, or unsealed medical supplies and removing them from nursing service areas. They will also be in-serviced on not using glucometer control solution past the expiration date. A new Expired/Opened/Contaminated/Unsealed Biologicals Form and protocol has been created whereby the 3rd shift supervisor or her designee will review medication rooms, treatment and medication carts x 2 weekly to inspect for expiring, opened, contaminated or unsealed biologicals and glucometer control solution and to remove them according to the standard of practice. These bi-weekly reviews will be delivered to the DON or designee, reviewed, and logged. 4. The ADON or designee will audit medications rooms, treatment and medication carts weekly x 4 and then monthly thereafter to determine if there are any errors in finding expired, opened, contaminated, or unsealed biologicals or expired glucometer control solution by the 3rd shift supervisor in her routine review. The results of the audit will be reported to the QA Committee at Quarterly QA Meeting. Completion date September 30, 2019	

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 _____	08/29/2019

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 761	Continued From page 19 dated 02/2009 and revised annually. The policy indicated that expired, discontinued and/or contaminated medications will be removed from the medication storage areas and disposed of in accordance with facility policy. The policy did not show who was responsible for checking the items. On 08/28/19 1:30 PM , the surveyor reviewed the policy titled; Quality Control for glucometer and dated 08/2006. The policy indicated to not use a glucometer control solution if three months had passed since the date it was opened. The glucometer found in the medication room drawer had been open for eight months. When asked if the solution was in use, the nurse did not provide further information. NJAC 8:39-29.4	F 761		
F 880 SS=D	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	F 880		9/30/19

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 _____	08/29/2019

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 20	F 880		

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment 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.

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 _____	08/29/2019

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 21 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of 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 record review, it was determined that the facility failed to follow proper infection control practices by wearing appropriate protective equipment while caring for or handling items for a resident on contact isolation precautions. This deficient practice was identified for Resident #83, 1 of 5 residents reviewed for isolation precautions and was evidenced by the following: On 08/22/19 at 10:17 AM, the surveyor observed an isolation cart and a stop sign located outside of Resident # 83's room, near the door. The cart contained gloves, masks, and gowns. A review of the Admission Record showed Resident # 83 was admitted to the facility on [redacted] with medical diagnoses that included; [redacted] A review of the 5-day Minimum Data Set (MDS),	F 880	F880 1. Resident #83 was seen by a physician and reviewed for infection control violations with corrections being made as necessary. Resident's care plan was updated to reflect contact precautions and wearing gloves and gowns while in resident room. 2. All Residents under infection control precaution contact isolation - were reviewed for accuracy of isolation procedures to ensure that any staff making contact with the resident or their environment are wearing gowns and gloves. 3. Nursing staff will be in-serviced on the necessity of following the CDC directives on contact isolation which includes wearing gown and gloves any time there is a possibility that they may make contact with the resident or their environment and that personal protective equipment must be discarded prior to exiting patient s room. Under a new system, Unit Managers or	

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 _____	08/29/2019

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 22 an assessment tool dated [redacted], showed the resident had a Brief Interview of Mental Status of [redacted]. The MDS also reflected that Resident #83 was [redacted] The MDS showed the resident required two person physical assistance for bed mobility, transfer, dressing, and toilet use. On 08/22/19 at 10:54 AM, the surveyor approached the resident's room and noted the resident's door was closed. The surveyor knocked on the door and the resident's Certified Nurses Aide (CNA) opened the door. The CNA was wearing gloves but no gown. When interviewed, the CNA stated the resident had "an [redacted]." The surveyor asked if a gown was necessary and the CNA stated "not to go in the room, only when care was being provided." The surveyor asked the CNA if Resident #83 was [redacted] and the CNA replied, "no." On 08/22/19 at 10:59 AM, the surveyor interviewed the resident's primary nurse, a Licensed Practical Nurse (LPN) regarding the isolation precautions. The LPN stated the resident was on isolation for a [redacted] and that full protective equipment must be worn (gloves and gown) anytime someone entered the resident's room. The LPN stated, "that is contact isolation precautions." On 08/23/19 at 9:36 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated the resident was on contact isolation precautions.	F 880	their designee and nursing supervisors will verify with staff working with residents on contact isolation the policy of gowning and gloving any time there is the potential for coming into contact with the resident or their environment. The fact that resident is on contact precaution will be added to staff assignment sheets and 24-hour sheets where nurses and CNAs will sign at least once for each resident on contact precaution to indicate their awareness of the contact precaution and their training on the topic. 4. The Unit Managers or designee will do an audit weekly x 4 weeks and then monthly thereafter on any residents on contact precaution to verify proper use of gowns and gloves and signatures on staff assignment sheets and 24-hour sheets at least once for each staff member working with any particular resident. These audits will be delivered to the DON. The results of the audit will be reported to the QA Committee at Quarterly QA Meeting.	

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 _____	08/29/2019

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 23 On 08/26/19 at 12:45 PM, the surveyor reviewed the physician orders which reflected an order to start [redacted]) two times per day for [redacted] on 08/21/19. There was also an order for contact isolation for [redacted]. The August 2019 Medication Administration Record (MAR) also reflected an active order for contact isolation precaution for [redacted] in the [redacted] every shift. A review of the resident's nursing care plan did not reflect the facility addressed contact isolation or infection in the care plan. On 08/28/19 at 10:40 AM, the surveyor observed a CNA in the isolation room wearing a pair of gloves and no gown. The surveyor observed as she CNA gathered a soiled [redacted] and placed in the trash bag. When the surveyor inquired about wearing a gown in the isolation room, the CNA stated, "do I have to wear a gown also?" The CNA then left the resident's room, donned an isolation gown and re-entered the room. On 08/28/19 at 11:32 AM, the surveyor interviewed the Assistant Director of Nursing, (ADON) who was also the Infection Control Nurse. The ADON stated that if a resident had an [redacted], staff only had to wear a pair of gloves, and that the gown was not necessary, even to empty the [redacted]. When asked about the policy for residents who were [redacted], the ADON stated, "that is different." The ADON stated that full personal protective equipment (gown and gloves) must be worn and the resident would be on contact	F 880		

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 _____	08/29/2019

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 24 isolation. On 08/28/19 at 12:15 PM, the surveyor reviewed the policy titled, "Isolation-Categories of Transmission Based Precautions," and dated 10/2018. The policy reflected for staff to "wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment." The policy also indicated for staff to don Personal Protective Equipment upon room entry and properly discarding before exiting the patient room to contain pathogens.	F 880		
F 908 SS=D	NJAC 8:39-19.4 Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/28/19, it was determined that the facility failed to ensure that the building's mechanical equipment was maintained in a safe operating condition. This deficient practice was evidenced by the following: During a tour of the facility's Laundry room, in the presence of the Maintenance Director at 11:30 AM, the surveyor observed that the area and equipment behind 3 clothes dryers was covered with a thick accumulation of lint. The lint covered the top surface of the dryers, all of the plumbing/pipes for the automatic sprinkler heads, gas supply, and the exterior surfaces of the	F 908	F908 1. All lint was removed from the area behind the dryer. 2. All Residents have the potential to affected by a lint buildup. 3. The cleaning vendor will be notified of the deficient finding and tasked with retraining their staff to insure proper cleaning of all lint from areas behind the dryers. The Maintenance Director or designee will inspect the quality of the work the day following all professional cleaning. The Inspection will be	9/30/19

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 _____	08/29/2019

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 908	Continued From page 25 exhaust ducts. The surveyor noted that the presence of accumulated lint in this area and heat from the dryers was unsafe and could cause fire. This finding was acknowledged by the Maintenance Director in an interview during the observation. Also, during this interview he stated that the area above and behind the dryers were cleaned every three months by a contracted vendor and the area should have been cleaned better. The surveyor observed that a vendor's service sticker affixed to exhaust ducts indicated that this area was last cleaned on 06/07/19. However, the facility was unable to provide any additional documentation that indicated facility oversight or work verification of the vendor to ensure that this area was cleaned. The facility's Administrator was verbally informed of this finding during the Life Safety Code exit conference on 8/28/19 at 2:30 PM. NJAC 8:39-31.2(e)	F 908	documented accordingly. 4. The area behind the dryer will be inspected monthly by the Maintenance Director or designee to monitor lint buildup and cleaned as necessary. The results of all Inspections will be documented appropriately and will be reported to the QA Committee at Quarterly QA Meeting.	