STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Front Rehabilitation and Healthcare Center	5101 North Park Drive Pennsauken, NJ 08109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # : 185875 Based on observations, interviews, record reviews, and policy reviews, the facility failed to ensure that resident rights were respected for residents who smoke and/or desire to go outside the facility. Findings include:1. Review of the 01/2025 policy titled Smoking Policy - Residents revealed This facility has established and maintains safe resident smoking practices. Policy Interpretation and Implementation 1. Prior to, and upon admission, residents are informed of the facility's smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences.2. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. Electronic cigarettes are permitted in designated areas only. Smoking is not allowed inside the facility under any circumstances.3. Oxygen use is prohibited in smoking areas.4. Metal containers, with self-closing cover devices, are available in smoking areas.5. Ashtrays are emptied only into designated receptacles.6. Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes:a. current level of tobacco consumption;b. method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc.);c. desire to quit smoking; andd. ability to smoke safely with or without supervision (per a completed Say' Smoking Evaluation).e. Smoking Agreement between the facility and the resident. During the Resident Group Interview on 09/03/25 at 1:00 PM with 11 residents (Resident (R) 12, R17, R18, R19, R20, R21, R22, R23, R24, R25, and R26) who were identified as alert and oriented, it was stated that no one is allowed to go outside unless you're a smoker and that is only three times a day for twenty minutes. The residents said non-smokers can go outside twice a day during an activity for thirty minutes. All other times, the door to the enclosed patio is locked and has to have a code. a. Review of R21's admission Record, located under the Profile tab in the electronic medical record (EMR) revealed the resident was admitted on [DATE] with diagnoses that included anxiety disorder and depression. Review of the 05/08/25 Smoking Evaluation, provided by the Administrator, revealed R21 preferred to smoke in the morning, afternoon, and evening. R21 was assessed to require no supervision. A care plan, dated 06/25/25, noted the resident liked to smoke and would be monitored for compliance. b. Review of R23's admission Record, located under the Profile tab in the EMR revealed the resident was admitted on [DATE] with diagnoses that included muscle wasting and atrophy and major depressive disorder. Review of the 02/10/25 Smoking Evaluation, provided by the Administrator, revealed R23 preferred to smoke in the morning, afternoon, and evening. R23 was assessed to require no supervision. A care plan, dated 06/16/25, noted the resident liked to smoke and would be monitored for compliance. c. Review of R32's admission Record, located under the Profile tab in the EMR revealed the resident was admitted on [DATE] and had diagnoses including peripheral vascular disease and adjustment disorder with depressed mood. Review of the 01/21/25 Smoking Evaluation, provided by the Administrator, revealed R32 preferred to smoke in the morning, afternoon, and evening. R32 was assessed to require no supervision. A care plan, dated 11/16/22, noted the resident liked to smoke and would be monitored for compliance. d. Review of R33's admission Record, located under the Profile tab in the EMR revealed the resident was admitted on [DATE] with diagnoses that included diffuse traumatic brain injury, depression, and anxiety disorder. Review of the 12/02/24 Smoking Evaluation, provided by the Administrator, revealed R33 liked to smoke in the morning and afternoon. R33 was assessed to require a smoking apron and someone to light and extinguish his cigarettes. Observation of the smoke break on 09/04/25 at 4:00 PM revealed two staff from the Activity Department were responsible for handing the residents their cigarette and lighting it. The residents were permitted two cigarettes, in twenty minutes. At the twenty minute timer, the Activity Director clapped her hands and stated, That's it, everybody inside. During an interview on 09/04/25 at 4:05 PM, R32 stated, It would be nice to have three cigarettes. We only get two. I tried to ask for more [cigarette] but they don't pay attention. One more [cigarette] at 7:30 PM or 8:00 PM would be great. During an interview on 09/04/25 at 4:07 PM, R33 stated, I would like more[cigarettes], but they don't let us. During an interview on 09/04/25 at 4:09 PM, R21 stated, I would like more than three smoke breaks, more than twenty minutes. We can only have two cigarettes in twenty minutes. It's like you have to rush just to smoke, it's not relaxing at all. I would like to have a cigarette before I go to bed to be calm and relaxed. During an interview on 09/04/25 at 4:12 PM, R23 stated, I would like more[cigarettes], more time, not to be so fast. During an interview on 09/04/25 at 4:21 PM, the Pavillion 1 Unit Manager (PAV1UM) said there is always two activity staff on the patio and a nurse to help monitor. During an interview on 09/04/25 at 4:15 PM

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: 185875 and 182189Based on observation, interviews, record review, and policy review, the facility failed to ensure the residents' environment remained clean, comfortable, and homelike for three of the three floors (first, second, and third floors). Specifically, the facility failed to provide overall facility cleanliness; clean and repair resident wheelchairs, electric wheelchairs, and geri chairs; repair scraped and scuffed air conditioning units; clean ceiling vents; clean and repair rusty and dirty door jams; provide ceiling vent covers in the shower rooms; and provide window screens that were without rips and tears. Findings include:Review of the facility's 11/2024 Maintenance Rounds Policy and Procedure, provided by the MD, read It is the policy of this facility to utilize a maintenance inspection checklist in order to assure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. l. The Director of Maintenance Services will perform routine inspections of the physical plant using the Maintenance Checklist. 2. The Administrator, or designee, will perform random inspections of the physical plant using the Maintenance Checklist. 3. All opportunities will be corrected immediately by maintenance personnel. 4. The facility shall establish quality/compliance thresholds as a benchmark for QA (Quality Assurance) purposes. 5. Data recorded of the Maintenance Checklist will be compared to established thresholds, and action plans will be generated as needed. 6. All Maintenance Checklists will be filed in the Director of Maintenance's office and retained for a minimum of three years. Review of the facility's 11/2024 Cleaning and Disinfection of Environmental Surfaces Policy and Procedure, provided by the ED revealed Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSTIA [OSHA] (Occupational Safety and Health Administration) Bloodborne Pathogens Standard. Review of the 11/2024 facility Cleaning and Disinfecting Residents' Rooms Policy and Procedure, provided by the ED, revealed The purpose of this procedure is to provide guidelines for cleaning and disinfecting residents' rooms. 1. Observations of the third floor on 09/04/25 at 11:33 AM, revealed the following:The Pavillion 3 Unit Manager (PAVIIIUM) said there were 57 residents on the third floor.a. Observations of the two hallways noted broken room number signs outside resident rooms; unidentified spills, drips, and general unclean walls. b. The floor in R11's room was very sticky. The resident's family member (FM1) said, It's often like that, I just try to ignore it.c. There was an approximately 6-inch diameter hole in the wall near the air conditioning unit. The window screen had holes along the bottom of the screen which could allow pests inside. The overbed table had the edging falling off three of the four sides. The dresser doors and end table doors were broken and hanging.d. Two Geri chairs, an electric wheelchair, and a wheelchair had armrests which were worn, torn, and generally dirty.e. The end cap on the radiator across from room [ROOM NUMBER] was missing.f. R34's Geri chair had no padding on the entire length of the right arm. The wood and screws were exposed. The seat of the Geri chair was observed to have a large patch of xx missing, approximately 7x8 inches. When asked about the chair, the Activity Director (AD), providing drinks and snacks to the residents, stated, (R34) picks it. The AD was not able to state if any alternatives to picking at the arm rest or seat had been implemented for R34. Observations of the second floor on 09/04/25 at 12:16 PM, revealed the following:a. The shower table was dirty on the edges and had a mesh tube running the length of the table that was noted to have a heavy build up of dark dirt and grime.b. There was no ceiling vent cover above the shower table.c. The air conditioning unit, in R14's room, was noted to have a rusty grate and emitted little cool air. Two individual fans were noted to have a buildup of dust and dirt on the blades and covers.During a Group Interview on 09/03/25 at 1:00 PM with eleven alert and oriented residents (Resident (R) 12, R17, R18, R19, R20, R21, R22, R23, R24, R25, and R26), the following verbalizations were made:a. The equipment, including wheelchairs and shower chairs, is dirty.b. Resident bathrooms and walls need to be cleaned.c. Shower room walls and curtains need to be cleaned.d. There are many flies in the facility and ants near the nurses' stations. On 09/05/25 at 9:27 AM, a tour of the facility was conducted with two surveyors, the Maintenance Director (MD), Environmental Director (ED), Regional [NAME] President of Environmental Services, and the Administrator to identify the above concerns to the management staff. Following the facility tour on 09/05/25 at 10:20 AM, the ED stated, When I came, 10 months ago, there was no system in place to clean rooms, floors, halls, etc. The discoloration on the walls is most likely splatter from spraying bleach. Following the facility tour on 09/05/25 at 10:30 AM, the MD stated, This is my fourth week in the facility, I appreciate the extra eyes. We can get this all fixed in time. Review of the undated Hallway Duty List

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # 2587860 and 187900Based on review of facility policy, record review, and interviews, the facility failed to ensure timely reporting of allegations of potential exploitation and/or abuse to the State Agency for four Sampled Residents (Resident (R) R1, R2, R15 and R16) out of a total sample of 34 residents. This failure created the potential for this and other residents to experience further exploitation and/or abuse. Findings include:Review of the facility's Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property Policy dated most recently reviewed in 09/2024 read, in pertinent part, It is the policy of the facility to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion misappropriation of resident property, or exploitation; and G. Reporting and Response: The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property , are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. 1. Review of R1's admission Record, dated 09/05/25 and found in the electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included dementia and history of falls. Review of R1's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 06/06/25 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of four out of 15 (which indicated the resident was severely cognitively impaired). The document indicated Family Member (FM1) was the resident's Responsible Party (RP). Review of R1's Progress Notes, dated 07/02/25 and found in the EMR under the Notes Tab, 30 Day discharge: Resident (R1) and family served 30-day discharge notice due to non-payment. Letter mailed via mail and certified mail to (Resident and FM2's address). Letter also mailed to Ombudsman, DOH (Department of Health) and Provider. Resident to be discharged on 07/31/25. Review of R1's Progress Notes, dated 07/18/25 and found in the EMR under the Notes Tab, Administrator and Business Office Manager met with (Resident's Family Member (FM2)), to discuss (R1's) discharge from the facility. It was once again explained to (FM2) that due to non-payment of monies due to facility (R1) received a 30-day discharge notice. It was reiterated that the Facility has tried to work with the family on several occasions, but family continues to refuse to disclose where assets were spent and have not paid off remaining balance. (FM2) was unable to provide answers to those questions and stated that he would try to provide us with additional information at the beginning of the following week. (FM2) was reminded that there is less than 2 weeks remaining before his grandmother is scheduled to be discharged . Review of R1's Progress Notes, dated 07/31/25 and found in the EMR under the Notes Tab, revealed Administrator and BOM (Business Office Manager) met today with FM1, FM2, as well as representatives from the State of NJ (New Jersey) Ombudsman's Office. Attorney for the Ombudsman's Office joined via telephone. All issues and barriers for discharge were discussed. The meeting concluded with 3 choices for the family. 1) pay the facility monies owed as well as the difference between the resident's income and facility rates and the resident can stay. 2)Find another safe accepting facility for the resident to discharge to. 3)Take the resident home. (FM1) stated that she will be in touch with the facility early next week (Monday or Tuesday) to let them know her final decision. Review of R1's Progress Notes, dated 08/06/25 and found in the EMR under the Notes Tab, revealed, Facility has not yet heard from the family about (FM1) their final decision as far as resident discharge status. Administrator and BOM left message for (Ombudsman) to inform them that the facility has not yet heard back from the family and asked for guidance from Ombudsman on how to proceed. Review of R1's progress notes revealed R1's RP (FM1) refused to provide information to show where R1's assets were as of the 09/05/25 complaint investigation exit date. Entries dated 07/15/25, 07/21/25, 07/22/25, 07/28/25 and 07/30/25, revealed FM1 abruptly ended the call or hung up on facility staff members who were attempting to reach out to FM1 on those dates to discuss R1's care and ability to remain in the facility. Review of R1's Progress Notes, dated 08/26/25 and found in the EMR under the Notes Tab, revealed, Social service director (SSD) and Social Worker (SW) issued (a second) 30-day discharge notice to resident on unit. Witnessed by UM (Unit Manager) as well. Review of R1's Progress Notes, dated 09/04/25 and found in the EMR under the Notes Tab, revealed, At approximately 12:35pm Administrator called NJ DOH, NJ LTC Ombudsman and local Pennsauken police to report possible financial exploitation of (R1's) by her family

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # : 2587860 and 187900 Based on review of facility policy, record review, and interviews, the facility failed to ensure a thorough investigation was completed related to allegations of potential exploitation and/or abuse two sampled residents (Resident (R) R1and R2) out of a total sample of 34 residents. This failure created the potential for these and other residents to experience further exploitation and/or abuse.Findings include: Review of the facility's Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property Policy dated most recently reviewed in 09/2024 read, in pertinent part, It is the policy of the facility to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion misappropriation of resident property, or exploitation; and E. Investigation: When an incident or suspected incident of abuse is reported, the Administrator or designee will investigate the incident with assistance of appropriate personnel. The investigation will include: i. Who was involved ii. Residents' Statements iii. Resident roommate statements (if applicable) iv. Involved staff and witness statements of events v. A description of the resident's behavior and environment at the time of the incident vi. Injuries present including a resident assessment vii. Observation of resident and staff behaviors during the investigation viii. Environmental considerations; and Investigation of injuries of unknown origin of suspicious injuries must be immediately investigated to rule out abuse. 1. Review of R1's admission Record, dated 09/05/25 and found in the electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included dementia and history of falls. Review of R1's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 06/06/254 and found in the EMR under the MDS tab, indicated a Brief Interview for Mental Status (BIMS) score of four out of 15 (which indicated the resident was severely cognitively impaired). The document indicated Family Member (FM1) was the resident's Responsible Party (RP). Review of R1's Progress Notes, dated 07/02/25 and found in the EMR under the Notes Tab, 30 Day discharge: Resident (R1) and family served 30-day discharge notice due to non-payment. Letter mailed via mail and certified mail to (Resident and FM1's address). Letter also mailed to Ombudsman, DOH (Department of Health) and Provider. Resident to be discharged on 7/31/25. Review of R1's progress notes revealed R1's RP (FM1) refused to provide information to show where R1's assets were as of the 09/05/25 complaint investigation exit date. Entries dated 07/15/25, 07/21/25, 07/22/25, 07/28/25 and 07/30/25, revealed FM1 abruptly ended the call or hung up on facility staff members who were attempting to reach out to FM1 on those dates to discuss R1's care and ability to remain in the facility. Review of R1's Progress Notes, dated 09/04/25 and found in the EMR under the Notes Tab, revealed, At approximately 12:35pm Administrator called NJ DOH, NJ LTC Ombudsman and local Pennsauken police to report possible financial exploitation of (R1's) by her family. Review of the facility's records revealed an investigation of potential abuse/exploitation related to the concerns about R1's family potentially exploiting her by mismanaging her money/assets was not initiated until 09/04/25 when the surveyors requested information related to an investigation into the concerns. During an interview with the Administrator on 09/03/25 at 3:17 PM, she confirmed she had been aware of concerns related to R1's family potentially misappropriating her funds/exploiting her since sometime in June of 2025. She confirmed an investigation into the potential exploitation of R1 by her family members had never been initiated. During an interview with the Business Office Manager (BOM), the [NAME] President of Clinical, the Regional Nurse Consultant, and the Administrator on 09/04/25 at 11:40 AM, The [NAME] President of Clinical and the Regional Nurse Consultant indicated they understood the potential exploitation/financial abuse of R1 by FM1 should have been identified and investigated by the facility prior to 09/04/25 when the surveyors brought the concerns to their attention. 2. Review of R2's admission Record, dated 09/05/25 and found in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included dementia, cerebral ischemia and Chronic Obstructive Pulmonary Disease. Review of R2's quarterly MDS assessment with an ARD of 07/18/25 and found in the EMR under the MDS tab, indicated a BIMS score of zero out of 15 which indicated the resident was severely cognitively impaired. Review of R2's Progress Notes, dated 06/29/25 10:00 AM, entered into the resident's record on 06/30/25 at 3:34 PM, and found in the EMR under the Notes Tab, indicated Aide (Certified Nursing Assistant (CNA6) stated that the resident refused care and out of nowhere the resident started swinging his backscratcher at her. Writer went to resident's room to speak with

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # 179036Based on record review, interviews, and policy review, the facility failed to develop a comprehensive care plan for one of two residents (Resident (R) 8) sampled for the use of a Life Vest, (a wearable defibrillator). Findings include: Review of the admission Record located under the Profile tab in the electronic medical record (EMR) revealed R8 was initially admitted on [DATE] and discharged to home on [DATE]. R8 had diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, hypertensive heart disease with heart failure, chronic atrial fibrillation, unspecified, and chronic diastolic (congestive) heart failure. Review of the Physician Orders located under the Orders tab in the EMR revealed R8 received an order for a Life Vest on 09/19/24. The order noted Change life vest battery every day shift. Life vest manufacturer [NAME] 1-8005433267serial # 58020305. Check [NAME] monitor for function and placement. Review of the 09/19/24 Comprehensive Care Plan located under the Care Plan tab in the EMR revealed The resident has altered cardiovascular status r/t (related to) CHF (congestive heart failure), afib (atrial fibrillation) use of life vest. The goal was identified as The resident will be free from complications of cardiac problems through the review date. The interventions listed Assess for shortness of breath and cyanosis every (specify). Encourage low fat, low salt intake. The care plan failed to address the cleanliness of the Life Vest, personal hygiene when utilizing a Life Vest, responding to alarms, and when to notify the resident's physician in the comprehensive care plan for R8 who utilized a Life Vest, a wearable defibrillator. Review of the Treatment Administration Records (TAR) for the months of 09/24, 10/24, 11/24, and 12/24, located under the Orders tab in the EMR, revealed the nursing staff were changing the battery every day and monitoring the [NAME] for function and placement every shift. During an interview with the Minimum Data Set Coordinator (MDSC) on 09/05/25 at 2:16 PM, the MDSC stated, We all work on the care plans, but I did not complete (R8's). During an interview with the Director of Nurses (DON) on 09/05/25 at 2:16 PM, the DON stated, I was not employed at that time, I cannot answer. During an interview on 09/05/25 at 2:30 PM, the Pavilion I Unit Manager (PAV1UM) stated, I do the care plans. I remember (R8). I don't know why (R8's) care plan did not address the specifics of the Life Vest. We changed the battery every day. Review of the Life Vest Policy and Procedure, dated 11/2024, provided by the Regional Nurse Consultant revealed Nursing home staff must provide safe and competent care for residents utilizing the LifeVest wearable defibrillator. This includes ensuring proper use, monitoring, and maintenance of the device, as well as providing education to staff and residents to prevent complications and ensure effective operation.Daily Care/Device Inspection identified Check the LifeVest daily for proper positioning, cleanliness, and secure fit. Inspect electrode pads and battery connections to ensure the device is functioning. Assist residents in maintaining hygiene without compromising the LifeVest's functionality. When removed for bathing, ensure the device is promptly re-worn as instructed by the manufacturer.Ensure spare, fully charged batteries are available. Replace the battery per the manufacturer's instructions to avoid interruptions in monitoring. Responding to Alarms/Non-Emergency Alarms: If the LifeVest issues a non-emergency alert (e.g., low battery, poor connection), address the issue following the manufacturer's troubleshooting steps. Document any actions taken and notify, the resident's physician if necessary. Emergency Alarms (Shock Delivery): If the LifeVest delivers a shock:I. Monitor the resident's condition immediately. 2. Call 9l1 and notify the physician for further assessment. 3. Record the event in the residents' medical chart, including the time, observed symptoms, and response to the shock. NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Front Rehabilitation and Healthcare Center	5101 North Park Drive Pennsauken, NJ 08109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Complaint # : 178254 and 179036 Based on observations, record review, and interviews, the facility failed to ensure the ceiling vents, ice machine vent, and equipment were kept clean and/or in good repair. The failure had the potential to affect 149 of 153 residents who received meals prepared in the facility kitchen. Findings include:During an inspection of the kitchen on 09/04/25 at 8:45 AM, along with the Dietary Director (DD), the following was observed:a. Three of the insulated food carts were checked for door closure. Two failed to latch and a third cart had no latch on one of the doors.b. The ceiling vent located at the end of the prep table, next to the oven/stove, had a heavy buildup of a black substance.c. The ceiling vent above the prep table had a heavy buildup of a black substance.d. The vent on the outside of the ice machine had a black substance that came off one. The vent on outside of ice machine had black substance that came off on my finger when touched.f. The tray line table, equipped with rollers to allow the trays to move easily, had missing rollers. The table was observed to have a piece of cardboard taped to the sides of the table with duct tape. The duct tape was identified to be tattered and rolled on the edges, making it an uncleanable surface.g. The prep table, located behind the plate warmer, was observed with significant rust on the legs, shelf, and edges of the table.h. A portable stand fan, located next to the oven, was observed blowing on prep table, The fan had no front cover, the blades were exposed, and had a build up of dust and grime. During an interview on 09/04/25 at 8:58 AM, the DD stated, That's a good question, when asked whose responsibility it was to clean the vents. During a tray line observation on 09/04/25 at 12:00 PM, the above conditions were identified to the Regional Food Service Director (RFSD). The RFSD was unable to clarify who was responsible for cleaning the vents, fixing the rollers on the tray table, removing the rust from the prep tables, cleaning the fan and putting a front on the fan to cover the blades. Review of a cleaning schedule, dated Week of 8/25-8/30, provided by the RFSD and the DD on 09/05/25 at 12:02 PM, revealed there were no cleaning job for the vents, ice machine, or the floor fan. The RFSD said they were going to have the Maintenance Director (MD) fix the latches on the insulated food carts. There was no evidence that the insulated food carts had been identified to require repairs prior to 09/05/25. A Policy and Procedure for kitchen cleaning was not provided prior to the exit on 09/05/25 at 3:30 PM. NJAC 8:39-17.2(g)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # : 185875 Based on record review, observations, staff interviews, and review of facility policy, the facility failed to ensure an effective pest control program within the facility. Flies were observed in multiple areas of the building during the complaint investigation process. This failure created the potential for cross contamination related to the fly infestation. A total of 34 residents were reviewed in the sample. Findings include:Review of the facility's Pest Control Policy dated 11/2024 revealed, Our facility shall maintain an effective pest control program. 1. This facility maintains an ongoing pest control program to ensure that the building is kept free of insects and rodents. Review of the facility's pest control logs, dated 06/01/25 through 09/05/25, revealed multiple entries indicating flies and/or cockroaches/water bugs had been reported on all three of the facility units during that time period. During the initial tour of the facility on 09/02/25 from 11:00 AM - 11:30 AM, at least 15 flies were observed flying about on the third floor unit, a very large dead roach was observed laying upside down in the entry to room [ROOM NUMBER] on the second floor unit, at least 10 flies were observed flying about on the second floor unit, and four flies were observed flying about on the first floor unit.During a tour of the facility on 09/03/25 from 10:10 AM - 10:45 AM, two flies were observed flying about and around the non-interviewable resident in room [ROOM NUMBER]-B.During a tour of the facility with the Maintenance Director (MD), the Director of Housekeeping and Laundry, the [NAME] President of Environmental Services and the Administrator on 09/05/25 from 10:30 AM - 11:20 AM, multiple flies were observed flying about on all three floors of the facility.During the group interview conducted with 11 residents, including the Resident Council President and Resident Council [NAME] President, on 09/03/25 at 1:00 PM, the group unanimously indicated flies were an ongoing problem in the building and the residents stated they also frequently saw large black water bugs in the facility in common areas as well as their individual rooms. One resident stated she/he had just seen a large black water bug in his room the previous night. Three residents confirmed they had seen flies in the building on the day of the interview. The residents further indicated ants were sometimes a problem on the second floor unit around the nurse's desk. All of the residents confirmed the pests were bothersome to them.During an interview with Certified Nursing Assistants (CNA)3 and CNA4 on 09/03/25 at 4:45 PM, both confirmed they had recently seen ants around the second floor nurse's desk. During an interview with the Director of Housekeeping and Laundry and the [NAME] President of Environmental Services on 09/05/25 at 1:33 PM, both confirmed the observation of multiple flies on all three units of the facility during the tour conducted on 09/05/25. The Director of Housekeeping and Laundry confirmed he had received recent reports of flies in the facility and stated he was aware of sightings of water bugs in the facility. He stated all facility staff was expected to document sightings of pests in the pest control books kept on each unit and he stated the pest control company was in the facility every Friday. He stated the pest control company provided pest control based on reports of pests received during the week prior to each visit.During an interview with the Administrator on 09/05/05 at 2:00 PM, she stated her expectation was the facility should be free of pests. N.J.A.C. S 8:39-31.5