STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING _____ B. WING _____	10/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERFRONT 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 0640 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to complete and transmit Minimum Data Set (MDS) assessments in accordance with the Resident Assessment Instrument (RAI) 3.0 Manual guidelines. This deficient practice was identified for 3 of 35 residents reviewed for resident assessment (Residents #1, #2 and #108). This deficient practice was evidenced by: 1.) On 10/5/2020 at 9:00 AM, the surveyor reviewed the Admission Record (AR) for Resident #1 which revealed that Resident #1 was admitted to the facility with [DIAGNOSES REDACTED]. Further review of the AR revealed that Resident #1 was discharged to home on 04/20/2020. The surveyor reviewed the Minimum Data Set (MDS) assessment history assessment tool, which included all of the completed MDSs for the resident. The MDS assessment history revealed that there was no Discharge Assessment-return not anticipated (DRNA-MDS) completed for the resident's discharge date of [DATE]. 2.) On 10/5/2020 at 9:45 AM, the surveyor reviewed the AR for Resident #2 which revealed that Resident #2 was admitted to the facility with [DIAGNOSES REDACTED]. The surveyor reviewed the MDS assessment history assessment tool, which included all of the completed MDSs for the resident. The MDS assessment history revealed that there was no DRNA-MDS completed for the resident's discharge date of [DATE]. 3. On 10/07/2020 at 9:02 PM, the surveyor reviewed the AR for Resident #108 which revealed that Resident #108 was admitted to the facility with [DIAGNOSES REDACTED]. According to the Census section of the Electronic Medical Record (EMR), Resident #108 was discharged from the facility on 08/06/20. At that time, the facility completed a DRNA-MDS. The surveyor reviewed the MDS assessment history assessment tool, which included all of the completed MDSs for the resident. The MDS assessment history revealed that there was no Entry MDS completed when Resident#108 was admitted to the facility on [DATE]. During an interview with the surveyor on 10/05/20 at 10:52 AM, the lead Registered Nurse MDS Coordinator (CRC), who had been employed since September, stated that the discharge assessments for Resident #1 and Resident #2 were not completed and that she was not employed by the facility at the time these assessments were supposed to be completed. During an interview with the surveyor on 10/06/20 at 09:55 AM, the Licensed Practical Nurse MDS Coordinator (LPN MDS Coordinator) stated that the lead CRC would do the schedule for the MDS. I did not take over the scheduling till August and even then, the CRC would check to assure the schedule was done correctly. The LPN MDS Coordinator stated that she was not sure why there were missing discharge assessments for Resident #1 and Resident #2. She stated, We have a MDS Consultant Company that looks over our Casper Report. (A reporting application which enables facilities to connect electronically to the National Reporting Database). I'm not sure they check the schedule, but they check our coding accuracy. I don't know why they were missed. During a follow-up interview with the surveyor on 10/06/20 at 10:10 AM, the LPN MDS Coordinator stated she was familiar with Resident #108. She stated that the resident went home and then returned to the facility. The LPN MDS Coordinator stated that there should have been an Entry MDS completed upon the resident's return to the facility. During a follow-up interview with the surveyor on 10/06/20 at 11:00 AM, the CRC stated that an Entry MDS should have been completed for Resident #108. During an interview with the surveyor on 10/06/20 at 12:49 PM, the Infection Control Regional Nurse stated, I am not sure why the MDS assessments were missed. During an interview with the surveyor on 10/06/20 at 2:03 PM, the Administrator stated that the MDS Consultant Company reviewed the Casper reports to check for compliance but was not sure if they were checking every single one. He added that the consulting company was able to check for missing or late assessments. During a telephone interview with the surveyor on 10/06/20 at 02:14 PM, the MDS Consulting Company (CC) Supervisor stated that the company started with the facility in June 2020. The Supervisor from the CC stated that the company looks over quality measures and assured that coding for the MDS was done accurately. We don't run the missing assessments from the Casper report. We don't have access to the Casper Reports. So we would not know if an assessment was missing. We're working on trying to clean this up and think it was a problem during Covid pandemic. We are now getting systems in place so this can be corrected. The facility's untitled policy dated 10/20 reflected that it was the facilities policy to complete the Resident Assessment Instrument (RAI) process according to the requirements and standards of the latest published RAI manual. The policy indicated that the Nurse Assessment Coordinator would schedule and open all appropriate MDSs (Admission, Quarterly, Annual, Significant Change, Significant Correction, Discharges, Entry's and Medicare Assessments) in a timely manner according to the RAI manual schedule and standards. The MDSs will be filled out accurately, after proper collection of data, in a timely manner according to the RAI manual standards. The policy also indicated that periodic checks will be performed to ensure that the MDS is opened, filled out and transmitted timely and accurately according to the RAI requirements. The Center for Medicare/Medicaid Services (CMS) - Resident Assessment Instrument (RAI) 3.0 Manual (updated October 2019) Version 1.17.1. reveals: page 2-11: Entry is a term used for both an admission and a reentry and requires completion of an Entry tracking record. Entry and Discharge Reporting MDS assessments are tracking records that include a select number of items from the MDS used to track residents and gather important quality data at transition points, such as when they enter a nursing home, leave a nursing home, or when a resident's Medicare Part A stay ends, but the resident remains in the facility. Entry/Discharge reporting includes Entry tracking record, OBRA Discharge assessments, Part A PPS Discharge assessment, and Death in Facility tracking record. page 2-14: OBRA-Required Tracking Records and Assessments are Federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. These assessments are coded on the MDS 3.0 in items A0310A (Federal OBRA Reason for Assessment) and A0310F (Entry/discharge reporting). They include: Tracking records: Entry and Death in facility and Assessments: - Admission (comprehensive) - Quarterly - Annual (comprehensive) - Discharge (return not anticipated or return anticipated) page 2-21: For a resident who goes in and out of the facility on a relatively frequent basis and return is expected within the next 30 days, the resident may be discharged with return anticipated. This status requires an Entry tracking record each time the resident returns to the facility and an OBRA Discharge assessment each time the resident is discharged . N.J.A.C. 8:39-11.1
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review and review of other pertinent facility documentation it was determined that the facility failed to provide the necessary respiratory care for changing oxygen tubing for 4 of 4 resident's reviewed (Resident #61, #80, #86 and #136) and was evidenced by the following: 1.) The Admission Record (AR) dated 10/5/2020 indicated that Resident #61 was admitted to the facility with the [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) an assessment tool dated 7/26/2020, indicated that Resident #61 was cognitively intact and required limited assistance with activities of daily living (ADL's). The MDS further reflected that the resident received oxygen

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING _____ B. WING _____	10/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERFRONT 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 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) (O2), suctioning and [MEDICAL CONDITION] care. On 10/02/20 at 10:26 AM during the initial tour of the Pavilion II nursing unit, the surveyor observed the resident's suction tubing was labeled with a date of 07/31/2020, the O2 corrugated tubing that was used to deliver O2 to the resident's [MEDICAL CONDITION] (the surgical formation of an opening into the trachea through the neck especially to allow the passage of air) was dated 09/3/2020 and the O2 humidification bottle was not dated. Resident #61 was unable to be interviewed because he/she was out to an appointment. On 10/02/20 10:40 PM, the surveyor reviewed the Order Summary Record (OSR) for Active Orders as of 10/5/20. The OSR did not reveal a physician's orders [REDACTED]. The surveyor reviewed the October 2020 Treatment Administration Record (TAR). The October 2020 TAR did not reveal that Resident #61's oxygen tubing or respiratory tubing was to be changed. On 10/05/20 at 09:38 AM, the surveyor observed Resident #61 resting in bed with eyes closed. The corrugated O2 tubing and O2 tubing that was attached to the corrugated tubing was dated 09/03/2020. The O2 humidification bottle was undated. During an interview with the surveyor on 10/05/20 at 09:50 AM, the Licensed Practical Nurse (LPN) stated that she had been employed in the facility for only two weeks and was not educated on how often respiratory supplies and tubing were supposed to be changed. I think daily, but not sure. On 10/05/20 at 10:12 AM, the Licensed Practical Nurse Unit Manager (LPN UM) accompanied the surveyor to Resident #61's room and was interviewed at that time. The LPN UM stated that all the respiratory tubing should be dated and changed weekly. I'm not sure why it's dated 09/03/2020 because we had a Respiratory Therapist (RT) who comes in weekly to see the residents with [MEDICAL CONDITION]'s and they should have changed the tubing. The LPN UM also added that she is not sure who the RT was because it's a contract company and there were different RTs every week. During an interview with the surveyor on 10/05/20 at 10:17 AM, the Director of Nursing (DON) who stated that it was the nursing staff's responsibility to change all the respiratory tubing weekly on 11-7 and not the responsibility of the RT that comes in weekly. The DON added, If a nurse saw that the tubing was out of date or not dated, they should change the tubing and date accordingly. The DON confirmed that there should be a physician's orders [REDACTED]. 2.) The AR dated 10/5/2020, indicated that Resident #80 was admitted with the [DIAGNOSES REDACTED]. The quarterly MDS dated [DATE], indicated that the resident had severe cognitive impairment and required complete care with all aspect of ADLs. The MDS further reflected that the resident received O2. On 10/02/20 at 9:47 AM, during tour of the Pavilion II nursing unit, the surveyor observed Resident #80 sitting up in bed with O2 on at 2 liters via (by way of) nasal cannula, a device consisting of a light-weight tube which on one end splits into two prongs which are placed in the nostrils and from which a mixture of air and oxygen flows). The O2 tubing was undated and unlabeled. The resident was unable to be interviewed at this time due to poor/impaired cognition. On 10/05/20 at 09:29 AM, the surveyor observed Resident #80 sitting up in the bed with O2 on at 2 liters via nasal cannula. The O2 tubing observed was undated. The OSR for Active Orders as of 10/05/20 revealed two physician orders. One order was dated 05/23/2020 and indicated that the O2 tubing was to be changed on night shift on Wednesday and the other order dated 06/24/2020 indicated that the O2 tubing was to be changed every Thursday morning for oxygen therapy. The October 2020 TAR indicated that the O2 tubing was to be changed on Thursday, 10/01/2020 at 6:00 AM. The October 2020 TAR did not reflect that the nurse signed on 10/01/20 to indicate that the O2 tubing was changed. During a follow up interview with the surveyor on 10/05/20 at 12:10 PM, the DON stated that there should be a physician order [REDACTED]. The nurse should sign the TAR to indicate that he/she did in fact change the tubing. The DON added that it was the responsibility of the RN UM on the 11 PM - 7 AM shift to assure that the process was being done. The DON also confirmed that there should be only one order to change the O2 tubing in the medical record. On 10/05/20 at 12:28 PM, the DON provided the surveyor with a undated facility form titled, 11-7 M-F Supervisor Duties which reflected that the supervisor on the 11 PM-7 AM shift was to ensure that nurses changed the oxygen/nebulizer/[MEDICAL CONDITION] supplies. The surveyor attempted to conduct a telephone interview with the Registered Nurse Supervisor on the 11 PM - 7 AM shift; with no answer. The surveyor left a message. 3.) The AR dated 10/05/2020 indicated that Resident #86 was admitted to the facility with the [DIAGNOSES REDACTED]. The quarterly MDS dated [DATE] indicated that the resident was cognitively intact, required supervision with ADLs. The MDS further reflected that the resident received O2. On 10/02/20 at 9:58 AM, the surveyor observed Resident #86 sitting on the side of the bed. Resident #86 stated that the O2 tubing on the portable O2 tank and the O2 tubing on the concentrator were never changed. The Surveyor observed that the O2 tubing on the portable O2 tank and the concentrator were not labeled or dated. The OSR for Active Orders as of 10/05/20 revealed a physician order [REDACTED]. The October 2020 TAR indicated that the O2 tubing was to be changed on 10/01/2020 at 6:00 AM. The October 2020 TAR did not reflect that the nurse signed on 10/01/20 to indicate that the O2 tubing was changed. On 10/05/20 09:31 AM, the surveyor observed the resident sitting up in bed. The surveyor observed that the O2 tubing that was attached to the portable O2 tank on the wheelchair and the O2 tubing that was attached to the oxygen concentrator were undated. The resident stated that he/she does not remember the last time the O2 tubing was changed. The surveyor observed that the nebulizer tubing sitting on the bed was undated and the plastic bag that stores the nebulizer tubing was dated 09/10/2020. The resident was interviewed at this time and stated that the staff does not change the O2 tubing unless the resident reminds them. He/she added that the nebulizer tubing was changed last week but that they never changed the bag that the tubing was stored in, so his/her clean tubing had to go back into a dirty bag. 4.) The AR dated 10/5/2020 indicated that Resident #136 was admitted to the facility with the [DIAGNOSES REDACTED]. The annual MDS dated [DATE] reflected that Resident #136 had severe cognitive impairment and required total assistance with ADL's. The MDS indicated that the resident received O2 and required suctioning and [MEDICAL CONDITION] care. On 10/02/20 at 10:08 AM, the surveyor observed Resident #136 in bed with O2 on via [MEDICAL CONDITION]. The surveyor observed that the corrugated O2 tubing was dated 09/03/20. The resident was non-verbal and tracking the surveyor with eyes. The resident was not able to be interviewed due to severe cognitive impairment. On 10/05/20 at 09:24 AM, the surveyor observed Resident #136 in bed and was non-verbal. The corrugated O2 tubing observed was dated 09/03/20 and the O2 tubing coming from the concentrator attached to the corrugated tubing was not dated. The O2 humification bottle was dated 10/05/2020. On 10/05/20 at 10:24 AM, the LPN UM accompanied the surveyor to Resident #136's room and was interviewed at that time. The LPN UM stated that all respiratory tubing should be changed weekly and then dated. The LPN UM then confirmed that the O2 tubing coming from the O2 concentrator was not changed weekly according to the date that that was on the O2 tubing. The OSR for Active Orders as of 10/05/20 did not reveal a physician's orders [REDACTED]. The October 2020 TAR did not reveal that Resident 136's oxygen tubing or respiratory tubing was to be changed. The facility policy dated 3/20 and titled, Oxygen Administration indicated under Infection Control A.) that all oxygen tubing for humidifiers, nebulizers, masks, tracheostomies and cannulas used to deliver oxygen: -Are for single resident use only. -will be changed weekly and when visibly soiled, or as indicated by state regulation. B.) Oxygen items will be stored in a plastic bag at the residents bedside to protect equipment from dust and dirt when not in use. NJAC 8:39-25.2 (b), 3, 4
F 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to act on or respond to, comments made by the Consultant Pharmacist (CP) in a timely manner. This deficient practice was identified for 2 of 6 residents reviewed (Residents #21 and # 26) for medications. This deficient practice was evidenced by: 1. According to the Admission Record (AR) dated 10/09/20, Resident #21 was admitted to the facility with medical [DIAGNOSES REDACTED]. The annual Minimum Data Set (MDS) and assessment tool dated 09/24/2020, reflected that Resident #21 was cognitively intact and required limited assist with activities of daily living (ADL's). The MDS also indicated that the resident was taking routine [MEDICAL CONDITION] medications. The surveyor reviewed the medical record of Resident #21 for PRN (as needed) [MEDICAL CONDITION] medications. The Electronic Medical Record revealed a physician order [REDACTED]. The physician order [REDACTED]. The July 2020 Medication Administration Record [REDACTED]. The September 2020 MAR indicated [REDACTED]. The October 2020 MAR indicated [REDACTED]. A review of the CP's Therapeutic Suggestions dated 07/12/20 revealed a recommendation that A duration must be specified for PRN (as needed) psychoactive medications. First order is limited to only 14 days, but if rationale documented by prescriber to continue order, then next duration may be longer, i.e. 30, 60 or 90 days. Please update order for [MEDICATION NAME] per CMS regulations. The document did not reflect a signature from the physician that the pharmacist recommendation was reviewed. A review of the CP's Monthly Report dated 08/17/20 revealed a recommendation that Regarding the comment made on 07/12/2020: A duration must be specified for PRN psychoactive medications. First order is limited to only 14 days, but if rationale documented by prescriber to continue order, then next duration may be longer, i.e. 30,60 or 90 days. Please update order for [MEDICATION NAME] per CMS regulations. **The Pharmacy Consult was not addressed. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING _____ B. WING _____	10/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERFRONT 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 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) document did not reflect a signature from the physician that the pharmacist recommendation was reviewed. A review of the CP's Monthly Report dated 09/16/20 revealed a recommendation that Regarding the comment made on 08/17/2020: A duration must be specified for PRN psychoactive medications. First order is limited to only 14 days, but if rationale documented by prescriber to continue order, then next duration may be longer, i.e. 30,60 or 90 days. Please update order for [MEDICATION NAME] per CMS regulations. **The Pharmacy Consult was not addressed. The surveyor noted a handwritten Action Taken on the CP's Monthly Report dated 9/16/20. The handwritten Action Taken revealed reach out to MD spoke with NP (nurse practitioner) stated she'll have MD call, spoke with MD gave d/c (discontinue) date for [MEDICATION NAME] to be extended until 1/8/2021. The documents did not reflect a signature from the physician that the pharmacist recommendation was reviewed. A review of the Nursing Progress Note dated 10/08/20 at 4:33 PM revealed Spoke with MD stated for residents [MEDICATION NAME] prn order to extend for 90 days. MD will write note as to why medication is bring (sic) extended. All orders noted. A review of the Advanced Practice Nurse (APN) History & Physical (H&P) dated 08/11/20 revealed Resident #21 has panic attacks. The 08/11/20 H&P further revealed start [MEDICATION NAME] 0.5 mg every four hours prn for anxiety for a trial for 10 days to assess anxiety . A review of the APN PCP (Primary Care Physician) Progress Note - Clinical dated 08/18/20 and 09/22/20 did not address the recommendations of the PC. A review of the Physician's PCP Progress Note - Clinical dated 08/28/20 and 09/10/20 did not address the recommendations of the PC. A review of the Psychiatrist Consultation dated 07/29/20 revealed to Continue current medications. The Psychiatrist Consultation revealed Resident #21 was on the following medications for the [DIAGNOSES REDACTED]. The 07/29/20 Psychiatrist Consultation report did not address the as needed [MEDICATION NAME]. During an interview with the surveyor on 10/08/20 at 12:05 PM, the Licensed Practical Nurse (LPN #1) Unit Manager stated that a new PRN [MEDICATION NAME] order should have a stop date of 14 days and then be reevaluated by the physician. If the physician wants to continue the PRN order, we have to make sure there is a stop date and the physician documents an explanation for the medication's continued use. LPN #1 Unit Manager stated that she usually received an email with the Pharmacy Consultant's recommendations. She stated that she reviewed the recommendations; and if there was a need to call the physician, she would do so. LPN #1 Unit Manager further stated there are some some recommendations I can do myself. LPN #1 Unit Manager stated that she was not instructed when to complete the pharmacy recommendations. During an interview with the surveyor on 10/08/20 at 2:30 PM, the Infection Control Regional Nurse (IC RN) stated that the nurse will address the nurse concerns. For a physician concern, the nurse will call the physician or put the recommendation in the physician's mailbox. Once it is addressed by the physician, the completed forms will be returned to the Director of Nursing (DON). The forms addressed by the physician are put in the chart. The process should be completed in one week. During an interview with the surveyor on 10/08/20 at 2:35 PM, the DON stated that he expects that PRN [MEDICATION NAME] is initially ordered for 14 days with an end date. During a follow-up interview with the surveyor on 10/08/20 at 2:36 PM, the IC RN stated that with the initial PRN [MEDICATION NAME] 14-day order, the nurses will document the behaviors. After 14 days, the physician will reevaluate the resident and may reorder the PRN medication with a rationale as to why to continue the medication and include a duration date in the order. During an interview with the surveyor on 10/09/20 at 11:32 PM, the LPN #2 stated that she works night shift and reviews the physician orders. She will check to make sure that a PRN [MEDICATION NAME] order had a 14-day stop date; and if not, she will call the physician and clarify. LPN #2 further stated that if a PRN [MEDICATION NAME] is reevaluated by the physician and is reordered, she ensured that the order had a stop date and that the physician wrote a rationale to continue the medication. The facility policy dated December 2016 and titled, Antipsychotic Medication Use indicated that antipsychotic medications will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. The policy also reflected that: -Residents will not receive prn doses of [MEDICAL CONDITION] medications unless that medication is necessary to treat a specific condition that is documented in the clinical record. -The need to continue prn for [MEDICAL CONDITION] medications beyond 14 days requires that the practitioner document the rational for the extended order. The duration of the prn order will be indicated in the order. -PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication. NJAC 8:39 - 29.3(a)(4)
F 0825 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide or get specialized rehabilitative services as required for a resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined that the facility failed to effectively document Restorative Nursing Program orders in the Electronic Medical Record (EMR) for 4 of 15 residents reviewed (Residents #36, #62, #109 and #135) for therapy recommendations utilizing assistive devices. This deficient practice was evidenced by: 1. The surveyor observed Resident #109 laying supine in bed with the head of the bed elevated on 10/05/20 at 9:46 AM, 10/06/20 at 08:46 AM, 10/06/20 at 10:44 AM, 10/06/20 at 12:20 PM and 10/07/20 at 8:37 AM. With each observation, the surveyor did not observe a hand splint to the resident's left hand. According to the Admission Record, Resident #109 was admitted to the facility with [DIAGNOSES REDACTED]. Review of the October 2020 Orders in the EMR, the Occupational Therapist wrote an order Respectfully recommending L (left) resting hand splint use for 6-7 hours during AM shift to promote optimal position, decrease risk for further contracture and to decrease c/g (caregiver) assistance during performance of ADL tasks dated 10/01/20. The surveyor noted the EMR October 2020 Treatment administration Record (TAR) did not reveal a corresponding order for the nurse to sign that the resting hand splint had been applied and removed as recommended by the Occupational Therapist. The Significant Change Minimum Data Set ((MDS) dated [DATE] revealed that Resident #109 was cognitively impaired, required total assistance with Activities of Daily Living (ADL) and had upper extremity impairment on one side of the shoulder, elbow, wrist or hand. The ongoing Care Plan revealed a Focus that Resident #109 had an alteration in musculoskeletal status r/t (related to) hand contractions with an intervention of Encourage/supervise/assist The resident with the use of supportive devices L (left) resting hand splint as recommended dated 10/05/20. During an interview with the surveyor on 10/07/20 at 8:53 AM, CNA #1 stated that she is the primary CNA for Resident #109. CNA #1 stated that she was not aware that there was an order for [REDACTED].#1 searched the resident's room and could not locate the hand splint in the resident's room. On 10/07/20 at 9:14 AM, CNA #1 showed Resident #109's left hand splint in a mesh laundry bag. CNA #1 stated that she found the splint in the laundry. 2. During tour on 10/02/20 at 12:31 PM, the surveyor observed Resident #36 lying in bed with both arms flexed inward towards the shoulders. The surveyor observed a blue colored hand splint lying directly on the overbed table. On 10/05/20 at 9:43 AM, the surveyor observed Resident # 36 lying in bed with both hands covered by the sheet and a blue colored hand splint lying directly on the overbed table. On 10/05/20 at 12:10 PM, the surveyor observed a blue colored hand splint lying directly on the bedside table. On 10/06/20 at 8:20 AM and at 12:34 AM, the surveyor observed a blue colored hand splint lying directly on the bedside table. On 10/07/20 at 9:30 AM and at 1:24 PM, the surveyor observed a blue colored hand splint lying directly on the bedside table. According to the Admission Record, Resident #36 was admitted to the facility with [DIAGNOSES REDACTED]. Review of the September 2020 orders in the EMR, the Occupational therapist wrote an order Recommending use of left-hand splint for 6-7 hour or as tolerated during AM shift without s/s (signs and symptoms) of redness of skin tear, dated 09/08/20 and signed by the attending physician on 09/08/20 at 3:58 PM. The surveyor noted the EMR September and October 2020 TAR did not reveal a corresponding order for the nurse to sign/document that the left hand splint had been applied and removed. The Quarterly MDS dated [DATE] revealed the resident was severely cognitively impaired and required total assistance for ADLs, had impairment on mobility and had upper extremity impairment on one side. The ongoing care plan, dated 09/28/20, revealed a Focus that Resident #36 had a need for Restorative Nursing Program (RNP) due to decrease in ROM, presence of contractures with an intervention to apply splint on (L)(Left)) as ordered. During an interview with the surveyor on 10/05/20 at 12:48 PM, CNA #2 stated that Resident #36 left arm was contracted and had a splint that therapy puts on the resident. During an interview with the surveyor on 10/07/20 at 9:30 AM, CNA #3 stated that Resident #36 does not use any splints or braces on his/her arms. During an interview with the surveyor on 10/07/20 at 10:51 AM, LPN #2 stated that Resident # 36 had a splint for the left hand that the aides put on the resident after the resident gets washed. During an interview with the surveyor on 10/07/20 at 10:51 AM, the Occupational Therapist (OT) stated that after a resident has been evaluated and treated in therapy, they may go on restorative care. Myself and the other OTs were taught by our supervisor to write a restorative order for the resident in the EMR. We cannot take a telephone order from the physician; we put the order in the EMR, and the nurses call the physician to get the order approved. Before we put the orders in the EMR, we used to complete a written order in the paper chart and flag it for the nurse to address with the physician. During an interview with the surveyor on 10/07/20 at 11:12 AM, the Director of Rehabilitation stated that the OTs document the orders in the EMR. The Director of Rehabilitation stated that it is job of the Restorative Aid, CNA or nurse to continue the plan of care. Once the order is documented in the EMR, it will be reviewed for the nurses/physician to sign off. During an interview with the surveyor on 10/07/20 at 1:05 PM, the LPN Unit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING _____ B. WING _____	10/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERFRONT 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 0825 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) Manager stated that she believes the 11-7 shift does the chart checks. The 11-7 nurse will run an Order Listing Report which shows all orders for the last 24 hours. The nurse would print the report daily and compare the orders with the Medication Administration Record (MARS) and the TARS so that it is an exact match. During a follow-up interview with the surveyor on 10/07/20 at 1:10 PM, the Director of Rehabilitation stated that when a resident is on case load, therapy monitored the resident. When a resident is discharged from therapy, residents are then screened quarterly and it is up to the nursing staff to report if there is a problem with a device, i.e. skin breakdown, a lost device or the resident cannot tolerate the device. During an interview with the surveyor on 10/07/20 at 1:23 PM, LPN #1 reviewed the order for the left hand splint. LPN #1 stated that the order was a recommendation, so she thought it was something that therapy was doing. She did not know about the order because it was not reflected on the TAR. LPN #1 stated that if she saw the order, she would have asked therapy about it. LPN #1 stated that she did not know that Resident #109 had a splint. During an interview with the surveyor on 10/07/20 at 12:29 PM, LPN #2 stated that there was an order for [REDACTED]. LPN #2 further stated that she did not apply the hand splint on Resident #36 and that the nurse on night shift should have checked the orders on the 24-hour chart check. During a follow up interview with the surveyor on 10/07/20 at 2:13 PM, LPN #2 further stated that if an order in the computer does not seem correct, she would call the doctor to clarify the order. LPN #2 stated she did not call the doctor to clarify the order but did notify her unit manager. During an interview with the surveyor on 10/07/20 at 02:38 PM, the Infection Control Regional Nurse (IC RN) stated that she expected the nurses to clarify the OT order. A completed order included the start date, application time and removal time for a restorative device. The IC RN further stated that the night nurse pulled the Order Listing Report daily and reviewed each order to confirm that it was documented on the MAR/TAR, the frequency of use and the start time. There was a large notebook on each unit that contained the Order Listing Reports that were reviewed daily and signed by the nurse who completed the review. The surveyor reviewed the Order Listing Report notebook for Pavilion I. The surveyor observed the Order Listing Report for the order date range of 09/30/20 - 10/31/20 did not reveal the OT order for Resident #109 dated 10/01/20. The surveyor reviewed the Order Listing Report notebook for Pavilion III. The surveyor observed the order Listing report for the order date range of 09/07/20 - 09/10/20 did not reveal the OT order for Resident #36. During a follow up interview with the surveyor on 10/08/20 at 11:18 AM, the IC RN stated that chart checks should be completed daily by night shift. The IC RN stated that the facility called the EMR company and found out that when therapy wrote an order, it was not flagged for the nurses to check. The IC RN further stated that the OT orders did not need to be verified by nursing or confirmed by the physician. The IC RN confirmed that the OT orders did not populate on the Order Listing Report. The IC RN stated that the 11-7 nurse will pull the report to complete the chart check. The IC RN stated that currently the OTs will not be writing any orders in the EMR until this has been resolved. The OTs will handwrite the order in the paper chart and flag the order for the nurse to follow up. During an interview with the surveyor on 10/09/20 at 10:58 AM, LPN #3 stated that she worked the 11-7 shift and had completed chart checks. LPN #3 stated that she ran the Order Listing Report each night. She would print the report but did not compare the orders to the MARs and TARs. LPN #3 stated that she did not do that because once the order is confirmed, it usually goes onto the MAR/TAR. The surveyor and LPN #3 reviewed Resident #109's OT order dated 10/01/20. LPN #3 stated that she would have called the physician for a clarification because the order stated that it is a recommendation. The LPN went on to say that she usually did not see orders that had been written by the OTs. On 10/08/20 at 2:15 PM, the facility provided the surveyor with copies of the OT orders written for an additional 13 residents (Residents #47, #50, #52, #54, #62, #63, #77, #93, #107, #123, #124, #130 and #135). The survey team reviewed the orders to confirm that the OT orders matched the TARs for each resident. Two of the 13 residents (Resident #62 and #135) were added to the sample for surveyor review. 3. During an interview with the surveyor on 10/09/20 at 7:50 AM, Resident #62 told the surveyor that he/she wore a splint to the right hand and that he/she had been in and out of the hospital several times with several room changes. The resident stated that the splint was usually kept in the drawer and that he/she had not seen the staff member who puts the splint on. According to the Admission Record, Resident #62 was admitted to the facility with [DIAGNOSES REDACTED]. Review of the October 2020 Orders in the EMR, the Occupational Therapist wrote an order for [REDACTED]. (approximately) 7 hours during day hours, 3-5 x/wk. skin check pre/post orthotic application for signs of skin breakdown dated 10/05/20. The surveyor noted the EMR October 2020 Treatment Administration Record (TAR) did not reveal a corresponding order for the nurse to sign that the hand orthotic was applied and removed. The Order Listing Report with an Order Date Range of 10/05/20 - 10/06/20 did not reveal the OT order dated 10/05/20. The Admission MDS dated [DATE] revealed the resident is cognitively intact. The ongoing Care Plan revealed a Focus that Resident #62 required extensive assist x2 staff with bed mobility transfer, dressing, toileting, personal hygiene, bathing and required extensive assist x1 staff with eating and locomotion with an intervention to apply right hand splint in (sic) at start of shift, remove prior to end of shift dated 10/08/20. During an interview with the surveyor on 10/09/20 at 8:05 AM, the LPN #4 stated that Resident #62 does not wear a splint to the right hand. During an interview with the surveyor on 10/09/20 at 8:10 AM, the CNA #4 stated that Resident #62 does not wear a splint to either hand. 4. On 10/09/20 at 7:55 AM, the surveyor observed Resident #135 lying in bed asleep with the head of the bed elevated. The surveyor observed that both resident's hands were under the covers. According to the Admission Record, Resident #135 was admitted to the facility with [DIAGNOSES REDACTED]. Review of the October 2020 Orders in the EMR, the Occupation Therapist wrote an order R (right) grip hand orthotic approx. 7 hours during daytime hours, 3-5X/wk. skin check pre/post orthotic application for signs of skin breakdown dated 10/07/20. The surveyor noted the EMR October 2020 TAR did not reveal a corresponding order for the nurse to sign that the right grip hand orthotic was applied and removed. The Order Listing Report with an Order Date Range of 10/07/20 - 10/08/20 did not reveal the OT order dated 10/07/20. The Significant MDS dated [DATE] revealed the resident was cognitively impaired, required total assistance with Activities of Daily Living and had upper extremity impairment on both sides of the shoulder, elbow, wrist or hand. The ongoing Care Plan revealed a Focus that Resident #135 was at risk for further contractures and requires right grip hand (sic) with a Goal to Apply right hand palm guard daily in AM and remove palm guard each evening at bedtime through next review revised on 10/07/20. During an interview with the surveyor on 10/09/20 at 8:05 AM, LPN #4 stated that Resident #135 does not wear hand splints. During an interview with the surveyor on 10/09/20 at 8:10 AM, the CNA #4 stated that Resident #135 does not wear hand splints. A review of the facility's policy titled, Splinting, dated 02/2020, revealed that a physician's orders [REDACTED]. An attending physicians order for splint services must be in the chart indicating: A. reason why splint is needed and B. frequency and wearing schedule of the splint. The policy further reveals that the nursing department is responsible for splint application and will document placement in the electronic medical record. The facility was unable to provide a policy for 24-hour chart checks by nursing staff. NJAC 8:39-37.1
F 0842 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to maintain complete and accurate medical records. This deficient practice was identified for 1 of 1 residents who expired in the facility (Resident #152) and was evidenced by the following: According to the Admission Record, Resident #152 was admitted to the facility with [DIAGNOSES REDACTED]. The Admission Minimum (MDS) data set [DATE] revealed resident was cognitively impaired and required extensive to total assistance with Activities of Daily Living. A review of the Nursing Progress Note dated [DATE] at 8:00 AM in the Electronic Medical Record (EMR) revealed that the resident expired at 7:45 AM and that the physician and family were notified. The progress note further revealed that a funeral home had not been prearranged and that the family was asked to choose a funeral home and notify the facility. The surveyor observed the EMR Progress Notes did not reveal further entries after the Nursing Progress Note dated [DATE] at 8:00 AM. The surveyor reviewed the closed paper chart for Resident #152. The paper chart did not reveal the name of the funeral home and that the resident's remains were removed from the facility. During an interview with the surveyor on [DATE] at 9:08 AM, the Director of Nursing (DON) reviewed the EMR progress note dated [DATE] at 8:00 am and the closed paper file. When asked where the body was, the DON could not say. He indicated that he would like to research this matter and get information from the funeral home that the body was picked up. The DON stated that his expectations were that the nurse document the funeral home and the time the body was removed from the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315225	A. BUILDING _____ B. WING _____	10/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERFRONT 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 0842 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	(continued... from page 4) During an interview with the surveyor on [DATE] at 9:29 AM, the Registered Nurse, who wrote the progress note on [DATE], stated that she probably worked overnight and the resident's remains were picked up during the day after she left. She stated that when the funeral home picked up the body, they leave a form which we have to sign. The RN further stated that when the remains were picked up, the nurse should have written a progress note and there should have been a form from the funeral home that the body was removed from the facility. Review of the facility's policy, Death of a Resident, adopted ,[DATE], revealed that The name of the mortician and person removing the deceased resident must be entered in the resident's medical record. Review of the facility's policy, Charting and Documentation, adopted ,[DATE], revealed that Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. NJAC 8:,[DATE].2
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observation, interview and review of other pertinent facility documentation, it was determined that the facility failed to follow appropriate infection control practices for a.) washing hands between residents and b.) disinfecting durable medical equipment in between resident use. This deficient practice was identified for 1 of 2 nurses on 1 of 2 units (Pavilion II) during medication administration observation and was evidenced by the following: On 10/06/20 at 08:47 AM, the surveyor conducted a medication administration observation with a Licensed Practical Nurse (LPN) on Pavilion II (second floor). The surveyor observed the following: The surveyor observed the LPN prepare and administer medications to Resident #202. The LPN did not perform hand hygiene (washing hands or using an alcohol-based hand rub) prior to the medication preparation. The LPN took the resident's blood pressure (BP), pulse, temperature and pulse Ox (used to measure the concentration of oxygen in the blood) with an all-in-one vital sign (VS) machine. After the LPN took the resident's VS, she was observed touching the resident's breakfast tray, cup and other resident items on the resident's bedside table. The LPN then administered the medication to Resident #202. The LPN then cleaned the blood pressure cuff and the inside of the pulse Ox with a small alcohol pad. She did not clean the thermometer part of the VS machine. The LPN then exited the room and did not perform hand hygiene. The LPN went to the next resident's room and prepared to take the vital signs of Resident #203. Prior to the LPN taking the resident's vital signs, the surveyor asked the LPN what product should she clean the VS machine with. The LPN replied, I guess I should have cleaned it with the purple top disinfectant. The surveyor then inquired why she did not clean the thermometer with the disinfectant, and the LPN replied that she forgot. The LPN then cleaned the VS machine with the appropriate disinfectant and went into Resident #203's room to take the resident's VS. The surveyor stopped the LPN and asked her what should she do next before touching the resident. The LPN did not respond to the surveyor. The LPN was then reminded by the surveyor that she should wash her hands or perform hand hygiene before resident to resident contact. The LPN then washed her hands, took the resident's vital signs and administered the medications to Resident #203. After the LPN was finished with this resident's VS and medications she washed her hands, came out of the resident's room and signed out the medications in the Medication Administration Record [REDACTED]. The LPN did not respond to the surveyor. The surveyor then reminded the LPN that she now had to sanitize the VS machine. The LPN responded with O yea, I forgot. During an interview with the surveyor on 10/6/20 at 11:28 AM, the Regional Infection Control Registered Nurse (IC RN) stated that the LPN was a relatively new nurse in the facility and that she would require some education on infection control during medication pass. The IC RN confirmed that the LPN should have washed her hands after resident-to-resident contact and should have cleaned the VS machine with disinfectant wipes after resident contact. During an interview with the surveyor on 10/13/2020 at 11:30 AM, the Director of Nursing (DON) had no additional information to provide to the surveyor. The facility policy dated April 2019 and titled, Administering Medications reflected that staff should follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. The facility policy dated October 2018 and titled, Cleaning and Disinfection of Resident-Care Items and Equipment indicated that resident-care equipment, including reusable and durable medical equipment (DME) will be cleaned and disinfected according to current Center for Disease Control (CDC) recommendations for disinfection and OSHA Bloodborne Pathogens Standard. The policy indicated that reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment.) The policy also indicated that reusable care equipment and DME must be cleaned and disinfected before reuse by another resident and according to manufactures instructions. The facility policy dated August 2019 and titled, Handwashing/Hand Hygiene indicated that the facility considers hand hygiene the primary means to prevent the spread of infection and that all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents and visitors. The facility hand hygiene policy reflected that use of an alcohol-based hand rub containing 62% alcohol: or alternatively, soap and water for the following situations: -Before and after direct contact with residents -Before preparing or handling medications -Before and after eating or handling food. -After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident. NJAC 8:39 - 19.4(a)