

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/18/2025
NAME OF PROVIDER OR SUPPLIER  River View Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1555 East End Boulevard Plains Twp Wilkes Barre, PA 18711	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on a review of clinical records and staff interviews, it was determined the facility failed to provide nursing services consistent with professional standards of quality to ensure that licensed nurses administered medications as prescribed to three residents out of 14 sampled (Resident 1, 2, and CR1).</p> <p>Findings included:</p> <p>According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the Registered Nurse (RN) was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals.</p> <p>The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health care team by exercising sound judgment based on preparation, knowledge, skills, understandings, and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) document and maintain accurate records.</p> <p>A review of a facility policy titled Administering Medications, last reviewed on January 22, 2025, revealed that medications are administered in accordance with prescriber orders, including any required time frame, and are administered within one hour of their prescribed time unless otherwise specified. As required or indicated for a medication, the individual administering the medication records in the resident's medical record the date and time the medication was administered.</p> <p>A clinical records review revealed Resident 1 was admitted to the facility on [DATE], with diagnoses of dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and bipolar disorder (a mental health disorder that causes unusual shifts in a person's mood, energy, activity levels, and concentration).</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 19, 2025, revealed Resident 1 had moderately impaired cognition with a BIMS score of 10 (Brief Interview for Mental Status-a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 8-12 indicates cognition is moderately impaired).</p> <p>A review of Resident 1's clinical record revealed a physician's order dated March 21, 2025, for Oxycodone 10 mg (an opioid pain medication used to treat moderate to severe pain), with instructions to administer one tablet three times a day for back pain.</p> <p>A review of Resident 1's May 2025 Medication Administration Record (MAR) revealed the resident did not receive their scheduled oxycodone 10 mg administration on May 8, 2025, at 2:00 P.M.</p> <p>An interview with Resident 1 on June 18, 2025, at 1:00 P.M. revealed he did not receive his medication on May 8, 2025, at 2:00 P.M., and stated they did not give a reason why it wasn't administered.</p> <p>A clinical records review revealed that Resident 2 was admitted to the facility on [DATE], with diagnoses to include neuropathy (a nerve problem that can cause pain, numbness, tingling, swelling, or muscle weakness in different parts of the body) and depression (a mental health condition characterized by low mood or loss of pleasure or interest in activities for long periods of time).</p> <p>A review of a quarterly MDS dated [DATE], revealed Resident 2 had moderately impaired cognition with a BIMS score of 11 (a score of 8-12 indicates cognition is moderately impaired).</p> <p>A review of Resident 2's clinical record revealed a physician's order dated January 2, 2025, for Gabapentin 100 mg (a medication used to treat neuropathic pain), with instructions to give two capsules three times a day for neuropathy.</p> <p>A review of Resident 2's May 2025 MAR revealed the resident did not receive their scheduled gabapentin 100 mg administration on May 8, 2025, at 2:00 P.M.</p> <p>A clinical records review revealed that Resident CR1 was admitted to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and fracture (a bone break) of the acetabulum (part of the pelvis that forms the socket of the hip joint, where the head of the thigh bone fits in).</p> <p>A review of a quarterly MDS dated [DATE], revealed that Resident CR1 was cognitively intact with a BIMS score of 15 (a score of 13-15 indicates cognition is intact).</p> <p>A review of Resident CR1's clinical record revealed a physician's order dated April 9, 2025, for Gabapentin 600 mg, with instructions to give one capsule three times a day for neuropathy.</p> <p>A review of Resident CR1's May 2025 MAR revealed the resident did not receive the scheduled gabapentin 100 mg administration on May 8, 2025, at 2:00 P.M.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a medication error report, dated May 9, 2025, for Resident 1 revealed he did not receive his medication at 2:00 P.M. Further review revealed the nurse assigned to his unit left early, and she did not give Resident 1 his scheduled oxycodone for 2:00 P.M.</p> <p>A review of a facility investigative report/employee corrective action form, dated May 13, 2025, revealed Employee 1, LPN, had accepted the assignment from Employee 2, LPN, without ensuring that all care and medications ordered were provided before the end of the shift. Further review revealed that Employee 2 left the assigned unit for an extended period of time without ensuring alternative coverage of the assignment was available.</p> <p>An interview with Employee 1 on June 18, 2025, at approximately 1:30 P.M. revealed she did take over Employee 2's assignment on May 8, 2025, around 1:00 P.M., due to Employee 2 having to leave early. Employee 1 stated prior to her taking over the assignment, she had been an extra staff member in the facility throughout the day and was assisting other employees who needed help. Employee 1 stated after she received the report, she had left the unit she was then assigned to help assist employees on another floor. Employee 1 stated she was not sure how long exactly she left the floor but stated it was not a long time, around five minutes. Employee 1 did acknowledge she did not check to make sure resident medications and treatments were provided before she left her shift at 3:00 P.M. When asked if she knew what treatments or medications were not provided before the end of the shift, she stated that three residents had missed their 2:00 P.M. medication administration, which had consisted of an oxycodone and two gabapentin doses.</p> <p>An interview with Employee 2 on June 18, 2025, at approximately 1:00 P.M., revealed she was assigned to Resident 1 on May 8, 2025, for the 7:00 A.M. to 3:00 P.M. shift and left early due to a family emergency and gave report to Employee 1, who took over the assignment until the end of the shift. Employee 2 stated after she gave report, she saw Employee 1 go in the elevator and leave the unit.</p> <p>There were no medication error reports for Resident 2 and Resident CR1 available for review.</p> <p>An interview with the Nursing Home Administrator on June 18, 2025, at approximately 2:30 P.M., confirmed the nurse failed to administer medications as prescribed,</p> <p>The facility failed to provide nursing services consistent with professional standards of quality to ensure that licensed nurses administered medications as prescribed to Resident 1, Resident 2, and CR1.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing Services</p> <p>28 Pa. Code 211.5 (f) (xi) Medical Records</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on a review of clinical records, controlled drug records, and staff interviews, it was determined the facility failed to implement procedures to promote accurate accounting and the administration of controlled medications for one of 14 residents sampled (Resident 1).</p> <p>Findings include:</p> <p>A review of a facility policy titled Administering Medications, last reviewed on January 22, 2025, revealed that medications are administered in accordance with prescriber orders, including any required time frame, and are administered within one hour of their prescribed time unless otherwise specified. As required or indicated for a medication, the individual administering the medication records in the resident's medical record the date and time the medication was administered.</p> <p>A review of Resident 1's clinical record revealed a physician's order dated March 21, 2025, for Oxycodone 10 mg (an opioid pain medication used to treat moderate to severe pain), with instructions to administer one tablet three times a day for back pain.</p> <p>A review of the controlled substance record for Resident 1's Oxycodone 10 mg tablet (schedule II opiate narcotic medication; schedule II drugs have a high potential for abuse) showed that nursing staff signed out doses of the medication on the following dates and times:</p> <p>May 3, 2025, at 6:00 AM</p> <p>May 24, 2025, at 6:00 AM.</p> <p>However, a review of Resident 1's May 2025 Medication Administration Record (MAR) revealed there was no documentation indicating that the medication was administered to the resident on these dates and times.</p> <p>During an interview on June 18, 2025, at 2:30 PM, the Nursing Home Administrator confirmed the discrepancies in the accounting and administration of opioid pain medications for Resident 1.</p> <p>28 Pa Code 211.5 (f)(xi) Medical records</p> <p>28 Pa Code 211.12 (d)(1)(3)(5) Nursing services</p> <p>28 Pa Code 211.9(a)(1)(k) Pharmacy services</p>		