

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 09/23/2025
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)
F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide special eating equipment and utensils for residents who need them and appropriate assistance. (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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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interviews, it was determined the facility failed to provide adaptive dining equipment as required and prescribed for three residents out of 12 sampled (Residents 1, 2, and 3). Findings include: A review of the clinical record revealed Resident 1 was admitted to the facility on [DATE], with diagnosis to include dysphagia (difficulty swallowing food or liquid), mild protein-calorie malnutrition (a condition caused by not getting enough calories or the right amount of protein and nutrients needed for health), and lack of coordination. A review of the physician's orders, dated January 16, 2025, revealed the resident was to utilize a Kennedy cup (lightweight, spill-proof drinking cup designed to be easy to hold and grip) with meals. Review of Resident 1's plan of care, dated June 7, 2024, indicated the resident had a nutritional problem or potential nutritional problem due to variable appetite, history of protein-calorie malnutrition and dysphagia. Interventions included the use of adaptive equipment. More specifically, the resident was to utilize a Kennedy cup with all hot beverages. Observation of Resident 1's lunch meal ticket (a menu-based document that provides essential information about a resident's meal such as diet order, preferences, food allergies, dislikes, dining location, supplements, and adaptive equipment if required, and helps staff accurately prepare and serve meals to residents based on their individual needs and preferences) indicated the resident was to be provided with a Kennedy cup. However, an observation of the lunch meal tray on September 23, 2025, at 11:43 AM, revealed that the dietary staff failed to provide the physician-ordered Kennedy cup to the resident. A review of the clinical record revealed Resident 2 was admitted to the facility on [DATE], with diagnosis to include muscle wasting and atrophy (a condition that causes a progressive loss of muscle mass, strength, function, and power), and major depressive disorder. A review of the physician's orders dated April 27, 2023, revealed the resident was to utilize a Kennedy cup with all meals. Review of Resident 2's plan of care, dated January 21, 2025, indicated the resident had a nutritional problem or potential nutritional problem due to muscle wasting and atrophy, COPD (chronic obstructive pulmonary disease- type of obstructive lung disease which causes difficulty breathing), type 2 diabetes (a chronic disease where the body does not use insulin properly, leading to high blood sugar levels), metabolic encephalopathy(temporary brain dysfunction caused by chemical imbalances in the body, such as infection, organ failure, or electrolyte problems), dysphagia, sepsis (a life-threatening condition where the body's response to an infection spreads through the bloodstream and can cause organ failure), hypokalemia (low levels of potassium, a mineral important for heart and muscle function, in the blood), iron deficiency anemia (a condition where a lack of iron leads to too few healthy red blood cells, causing fatigue and weakness), osteoarthritis (a common joint disease where the cartilage wears down, leading to pain, stiffness, and limited movement), hypertension (high blood pressure), GERD (Gastroesophageal Reflux Disease- a condition where stomach acid flows back into the esophagus, causing heartburn and irritation.), depression, altered skin integrity, and significant weight gain. Interventions included the use of adaptive equipment. More specifically, the resident was to utilize a Kennedy cup. Observation of Resident 2's lunch meal ticket indicated the resident was to be provided with a Kennedy cup. However, an observation of the lunch meal tray on September 23, 2025, at 11:45AM, revealed the dietary staff failed to provide the physician-ordered Kennedy cup to the resident. A review of the clinical record revealed Resident 3 was admitted to the facility on [DATE], with diagnosis to include dysphagia, severe protein-calorie malnutrition, legal blindness, and lack of coordination. A review of the physician's orders dated July 30, 2025, revealed the resident was to utilize a Kennedy cup for all liquids. Review of Resident 3's plan of care dated July 17, 2026, indicated the resident had a nutritional problem or potential nutrition problem due to malnutrition. Interventions failed to include the use of the physician ordered Kennedy cup for all meals. Observation of the lunch meal tray on September 23, 2025, at 11:47 AM, revealed the dietary staff failed to provide the physician-ordered Kennedy cup to the resident. An interview with Employee 1 (nurse aide) on September 23, 2025, at 11:50 AM, stated the dietary staff frequently fail to provide Kennedy cups on the resident trays. She further stated that nursing staff must then stop meal service to contact the kitchen to obtain the adaptive equipment, causing interruptions in resident care and meal service. Interview with the Dietary Manager on September 23, 2025, at approximately 2:50 PM, confirmed the facility failed to consistently provide the required adaptive dining equipment as ordered by the physician. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.</p>		