

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 04/25/2025
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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on clinical record review and staff interview it was determined the facility failed to accurately identify a resident's request for future health care and advance directives (a written instruction such as a living will or durable power of attorney for health care for when the individual is incapacitated) as evidenced by one resident (Resident 173) out of 27 residents sampled.</p> <p>Findings include:</p> <p>A review of the clinical record of Resident 173, revealed the resident was admitted to the facility on [DATE], with diagnoses that included osteoarthritis (type of arthritis that causes joints to become painful and stiff) and atrial fibrillation (an irregular heart rate that commonly causes poor blood flow).</p> <p>Review of Resident 173's clinical record revealed a completed and signed POLST (Physician Orders for Life-Sustaining Treatment a medical order form used to communicate a resident's preferences for life-sustaining measures across care settings) dated [DATE]. The POLST indicated that the resident elected DNR status (Do Not Resuscitate a medical order directing that cardiopulmonary resuscitation [CPR], a life-saving procedure performed when the heart or breathing stops, should not be attempted), with a goal of allowing a natural death.</p> <p>Further review of the resident's current physician orders, initially entered on [DATE], in the electronic health record, identified the resident's code status as Full Code, indicating CPR was to be performed in the event of cardiopulmonary arrest.</p> <p>There was no documentation to indicate that Resident 173 had revised the advance directive or changed the preference documented on the POLST. No clinical notes or care conference records reflected a discussion or update to the resident's wishes regarding life-sustaining treatment.</p> <p>An interview with the Director of Nursing (DON) on [DATE], at 9:10 AM confirmed that physician orders are required to align with the most current, signed POLST. The DON acknowledged that Resident 173 had elected DNR status on the POLST form and the current physician orders incorrectly reflected Full Code, which did not honor the resident's documented treatment preferences.</p> <p>28 Pa. Code 201.29(a) Resident rights.</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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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.5 (f)(i) Medical records. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on a review of clinical records, select facility policies, documentation provided by the facility, and staff interviews, it was determined the facility failed to ensure that four residents out of 27 sampled (Residents 18, 104, 108, and 224) were free from abuse perpetrated by another resident (Residents 37 and 49) and failed to ensure one resident out of 27 sampled was free from neglect (Resident 57).</p> <p>Findings include:</p> <p>A review of the facility policy titled Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, last reviewed by the facility on January 22, 2025, revealed it is the facility's policy that residents have the right to be free from abuse and neglect. The policy indicated the facility's resident abuse and neglect prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: (1) protect residents from abuse and neglect by anyone, including, but not necessarily limited to, facility staff and other residents.</p> <p>A clinical record review revealed Resident 49 was admitted to the facility on [DATE], with diagnoses that include dementia (a condition characterized by the loss of cognitive functioning, such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities).</p> <p>A review of a five-day Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 31, 2025, Section C1000. Cognitive Skills for Daily Decision Making revealed that Resident 49 is severely impaired in her ability to make decisions regarding tasks of daily life. The assessment indicated the resident's BIMS score was 99 (Brief Interview for Mental Status- a tool to assess cognitive function; a score of 99 indicates that the resident was unable to provide or did not provide answers to complete this section).</p> <p>A care plan revealed Resident 49 is at risk for harm related to homicidal ideation, grabbing other residents, and resident-to-resident altercations initiated on April 15, 2024. Interventions in place to assist Resident 49 with her goal of other residents remaining without injury include a one-staff-to-one-resident level of observation, one-staff-to-one-resident re-education including maintaining distance from other residents, keeping the resident at least an arm's length away from other residents, encouraging the resident to verbalize the cause for aggression, placing staff between the resident and other residents to prevent altercation, maintaining a consistent schedule with a daily routine, and minimizing environmental stimuli.</p> <p>A care plan revealed Resident 49 has a problem with impaired thought processes related to dementia initiated on April 15, 2024. Interventions implemented to assist Resident 49 to communicate her basic needs include asking yes/no questions, cueing, reorienting, supervising as needed, and presenting one thought, idea, question, or command at a time.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of clinical records and documentation provided by the facility revealed Resident 49 physically abused three residents from November 26, 2024, through February 24, 2025, including slapping Resident 224 in the face, punching Resident 108 in the back of the head, and pushing Resident 104.</p> <p>A clinical record review revealed Resident 224 was admitted to the facility on [DATE], with diagnoses that included dementia.</p> <p>A review of an annual MDS assessment dated [DATE], revealed that Resident 224 is severely cognitively impaired with a BIMS score of 03 (a score of 01-07 indicates severe cognitive impairment).</p> <p>A progress note dated November 26, 2025, at 5:50 PM indicated Resident 224 was slapped in the face by Resident 49 in the dining room. Resident 224 was upset, stating, She just came up to me. Emotional support provided and skin assessment completed; no bruising, bleeding, swelling, or reports of pain assessed.</p> <p>A progress note dated November 26, 2025, at 5:50 PM indicated Resident 49 was seen slapping Resident 224 in the dining room. No provocation witnessed. Resident 49 slapped Resident 224 behind the back of the one-to-one safety sitter who was between the residents.</p> <p>A statement form dated November 26, 2024, revealed Employee 8, Nurse Aide (NA), turned around as she heard Resident 49 get upset, standing by Resident 224 at the table in the dining room. Employee 8, NA, indicated Resident 49 backhand slapped Resident 224 in the face.</p> <p>A statement form dated November 27, 2024, revealed Employee 9, Activities Aide (AA), indicated she was in between Resident 49 and Resident 224 when Resident 49 reached around Employee 9, AA, and hit Resident 224.</p> <p>A clinical record review revealed Resident 108 was admitted to the facility on [DATE], with diagnoses that include dementia. A review of a quarterly MDS assessment dated [DATE], revealed that Resident 224 is severely cognitively impaired with a BIMS score of 06 (a score of 01-07 indicates severe cognitive impairment).</p> <p>A progress note dated January 17, 2025, at 9:05 AM revealed Resident 49 spat, punched, and scratched a nurse aide during morning care. Supervision and administration were notified. The note indicated a physician order not to send the resident to the emergency department, and the administration was in agreement.</p> <p>A progress note dated January 17, 2025, at 1:30 PM revealed Resident 108 was walking in the hallway. Staff witnessed Resident 49, unprovoked, hit Resident 108 on the left side of her head with a closed fist. The residents were separated. Resident 108 was assessed with no open area, scratches, or bruising noted. Resident 108 denied pain.</p> <p>A progress note dated January 17, 2025, at 1:51 PM revealed that while on a one-to-one (level of observation of one staff member to one resident continuous observation), Resident 49 hit Resident 108 with the back of her hand, with a closed fist. Resident 49 was assessed without injury.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A clinical record review revealed Resident 104 was admitted to the facility on [DATE], with diagnoses that include dementia. A review of a quarterly MDS assessment dated [DATE], revealed that Resident 104 is severely cognitively impaired with a BIMS score of 04 (a score of 01-07 indicates severe cognitive impairment).</p> <p>A progress note dated February 24, 2025, at 5:34 AM revealed Resident 104's roommate was agitated and trying to spit and hit the nurse aide. Resident 104 asked Resident 49 to stop. Resident 49 shoved Resident 104 on to her bed. Resident 104 was assessed, and no injuries were noted.</p> <p>A progress note dated February 24, 2025, at 6:42 AM revealed Resident 49 is on a one-to-one. The note indicated Resident 49 slept without incident until 2:00 AM, when she began walking the hallways and became aggressive towards the nurse aide and the roommate, Resident 104. The roommate tried to intervene, Resident 49 pushed her back on the bed, and scratched, punched, and spat at the nurse aide.</p> <p>A statement form, dated February 24, 2025, revealed Employee 13, Licensed Practical Nurse (LPN), was with Resident 104, beginning on February 23, 2025, at 10:00 PM. Employee 13, LPN, indicated at 2:00 PM Resident 49 began walking the hall, punching, pushing, scratching, and spitting. Redirection was attempted. Employee 13, LPN, indicated Resident 49 pushed Resident 104 because Resident 104 told her to stop.</p> <p>A clinical record review revealed Resident 37 was admitted to the facility on [DATE], with diagnoses that included hemiplegia (paralysis on one side of the body). A review of a quarterly MDS assessment dated [DATE], revealed that Resident 37 was cognitively intact with a BIMS score of 15 (a score of 13-15 indicates cognition is intact).</p> <p>A review of the care plan for Resident 37, initiated May 1, 2024, revealed the resident had a very low tolerance for confused and behavioral residents. Documented behaviors included yelling at other residents, calling residents names, making obscene gestures, and swinging at other residents. Interventions to address these behaviors included intervening as necessary to protect the rights and safety of others, praising progress and improvement in behavior, and educating the resident on successful coping and interaction strategies.</p> <p>A clinical record review revealed Resident 18 was admitted to the facility on [DATE], with diagnoses to include dementia. A review of a quarterly MDS assessment dated [DATE], revealed that Resident 18 was severely cognitively impaired with a BIMS score of 02 (a score of 01-07 indicates severe cognitive impairment).</p> <p>A progress note dated March 7, 2025, at 7:30 PM, documented that a nurse aide reported Resident 18 had been struck multiple times with the laundry room door by Resident 37. The physician was notified and ordered a STAT X-ray.</p> <p>A progress note dated March 7, 2025, at 8:45 PM revealed Resident 37 struck Resident 18's left arm multiple times with the laundry room door. Residents were separated, and both residents were assessed for injuries. No injuries were documented in the note.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A witness statement, dated March 7, 2025, completed by Employee 11, Nurse Aide (NA), revealed the employee heard yelling while at the nurses' station. Upon investigation, Employee 11 witnessed Resident 37 slamming the laundry room door against Resident 18's left arm repeatedly. Employee 11 reported running toward the residents, verbally directing Resident 37 to stop. Resident 37 stated, She's going to lock me in the laundry room. Tell her to get out of the way. Employee 11 separated the residents and reported that Resident 37 continued yelling at staff.</p> <p>A witness statement dated March 7, 2025, completed by Employee 12, Nurse Aide (NA), revealed the employee observed Resident 37 taking the laundry room door and striking Resident 18's left forearm multiple times with the door handle. Employee 12 documented that Resident 37 continued hitting Resident 18 even after staff directed Resident 37 to stop. Staff intervened and separated the residents.</p> <p>A progress note dated March 10, 2025, at 3:22 PM, documented that Resident 18 sustained an injury to the left arm as a result of the altercation with Resident 37, with Resident 18 reporting pain but no bruising observed. The X-ray results were negative for fracture.</p> <p>During an interview conducted on April 25, 2025, at approximately 10:00 AM, the Nursing Home Administrator (NHA) confirmed that it is the facility's responsibility to ensure that residents are free from abuse, including abuse between residents. The NHA confirmed that it is the facility's responsibility to ensure that Resident 37 and other residents do not physically abuse other residents.</p> <p>The facility was aware of the physically aggressive behaviors of Resident 49 but failed to implement effective interventions to prevent the physical abuse of other residents. Also, the facility was aware of Resident 37's low tolerance for confused residents, but failed to implement effective interventions including supervision to prevent the physical abuse of another resident.</p> <p>A review of Resident 57's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include end-stage renal disease (the final stage of kidney decline where the kidneys are no longer able to function to meet the body's needs) dependent on dialysis (the process of removing waste products and excess fluid from the body when the kidneys are unable to adequately filter the blood) and bilateral below-the-knee amputation of his lower extremities.</p> <p>A review of a quarterly MDS dated [DATE], revealed that Resident 57 had moderately impaired cognition with a BIMS score of 12 (a score of 8-12 indicates cognition is moderately impaired).</p> <p>Additionally, the MDS was coded that the resident had functional limitations in range of motion with impairments to both sides of the lower extremities, and the resident was identified as dependent with bed-to-chair transfer (the ability to transfer to and from a bed to a chair or wheelchair).</p> <p>The most current review of a quarterly MDS, dated [DATE], revealed that Resident 57 is cognitively intact with a BIMS score of 14 (a score of 13-15 indicates cognition is intact).</p> <p>Resident 57's comprehensive person-centered plan of care was initiated on November 23, 2024, and indicated the resident required the assistance of two staff members with transfers and was revised on December 16, 2024, to include the use of a mechanical lift (a mechanical device designed to lift/transfer individuals that have limited mobility in a safe manner and reduce injuries) with transfers.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 57's clinical record revealed physician orders dated December 6, 2024, directed the use of a mechanical lift for all transfers and bed mobility, with the assistance of two staff members.</p> <p>A review of Resident 57's task report (an electronic record that summarized planned resident-centered tasks completed by nursing) revealed that Resident 57 was an assist of two staff members via the mechanical lift for transferring initiated on December 8, 2024.</p> <p>A review of a facility investigative report dated December 13, 2024, at approximately 2:30 PM, revealed that Employee 14, an agency nurse aide was transferring Resident 57 and experienced a fall during the transfer.</p> <p>A review of a witness statement from Employee 14, dated 2:30 PM, indicated he was transferring the resident to his wheelchair and grabbed the resident under both arms, and that Resident 57 was holding onto him with both arms and while during the transfer his left below-the-knee amputation stump became stuck in the wheelchair arm. Employee 14 then called out for help and received assistance from Employee 15, the maintenance director, to help dislodge his stump from the wheelchair arm. Employee 14 then attempted to reposition the resident into the wheelchair but stumbled over clutter on the floor and placed the resident on the floor to prevent harm. The statement did not acknowledge that the mechanical lift, as required by physician order and care plan, had not been used.</p> <p>A review of a witness statement from Employee 15, dated 2:30 PM, indicated that he heard someone yelling for help and witnessed Employee 14 holding Resident 57 under both arms while Resident 57 had both of his arms wrapped around Employee 14, and Employee 14 asked Employee 15 to help dislodge his left stump from the wheelchair arm. Employee 15 assisted in freeing the resident's stump from the wheelchair arm. After the stump was freed, Employee 14 lost balance and the resident was found lying on the floor. Employee 15 also observed clutter on the floor and water from a bottle that spilled during the incident.</p> <p>A review of a nurse's incident/accident statement dated December 13, 2024, at 4:21 PM, revealed that they found Resident 57 on the floor lying next to Employee 14 and noted debris of a cup, paper, and water on the floor.</p> <p>The facility's investigation report lacked documentation of an interview with Resident 57 regarding the incident. The Nursing Home Administrator (NHA) was unable to provide a reason why no statement was obtained from the resident.</p> <p>A nurse's progress note dated December 14, 2024, at 10:37 AM, indicated that Resident 57 complained of right-sided rib pain following the fall on December 13, 2024. A physician's order was obtained for an x-ray of the right ribs.</p> <p>An x-ray report dated December 17, 2024, showed no acute or chronic fracture. A physician's progress note dated December 19, 2024, documented a clinical impression of a right rib contusion (bruise) based on the negative x-ray and the resident's continued pain.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 57's Medication Administration Record from December 2024 revealed that he received Tylenol as needed for right rib pain on December 14, 2024, at 8:24 AM for a pain of 8; (pain scale rating of 1 equals no pain 10 equals the worst pain) on December 15, 2024, at 4:22 AM for a pain of 7; and on December 20, 2024, at 9:26 PM for a pain of 3.</p> <p>An interview with Resident 57 on April 24, 2025, at 8:40 AM, revealed that prior to the transfer, he mentioned to Employee 14 that he required the use of a mechanical lift for transfer with two staff members and that Employee 14 ignored his request. Resident 57 stated that he felt Employee 14 moved him without the lift because he was in a hurry to get it done faster.</p> <p>An attempt was made to contact Employee 14 via telephone on April 24, 2025, during the on-site survey. The employee could not be reached, and no additional clarification regarding the incident was obtained. Employee 14 was no longer employed by the facility. The NHA could not provide a reason for his departure.</p> <p>An interview on April 24, 2025, at 11:00 AM with Employee 15 revealed he was unsure why Employee 14 was transferring the resident alone.</p> <p>A review of Employee 14 personnel file acknowledged that he completed training and was deemed proficient to perform all assigned tasks, including proper transfer techniques, and received training on abuse and neglect of a resident.</p> <p>Despite this documented competency, the resident's clinical record confirmed that Employee 14 did not follow established care plan and physician-ordered protocols requiring the use of a mechanical lift and two-person assistance when transferring Resident 57 on December 13, 2024.</p> <p>Despite this documented training and acknowledgment of competency, review of Resident 57's clinical record confirmed that Employee 14 failed to adhere to established care plan and physician-ordered protocols requiring the use of a mechanical lift and two-person assistance when transferring the resident on December 13, 2024.</p> <p>An interview with the NHA on April 24, 2025, at 1:30 PM, confirmed that the facility failed to ensure staff followed the resident's care plan and physician orders for the use of a mechanical lift with two-person assistance for transfers. The NHA acknowledged that failure to follow these directives resulted in increased pain and discomfort to the resident.</p> <p>Refer to F610</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 201.29(a) Resident Rights</p> <p>28 Pa. Code 211.12 (d)(5) Nursing Services</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52053</p> <p>Based on observation, clinical record review, review of facility policy, investigative documentation, and staff and resident interviews, it was determined the facility failed to thoroughly investigate an incident involving a fall with minor injury to determine whether neglect occurred and failed to identify that planned fall interventions were not in place for one of 27 sampled residents (Resident 57).</p> <p>The findings include:</p> <p>A review of the facility policy titled Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, last reviewed by the facility on January 22, 2025, revealed it is the facility's policy that residents have the right to be free from abuse and neglect. The policy indicated the facility's resident abuse and neglect prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: (1) protect residents from abuse and neglect by anyone, including, but not necessarily limited to, facility staff and other residents.</p> <p>Further review of the facility policy revealed the facility will identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property, and will investigate and report any allegations within time frames required by federal requirements.</p> <p>A review of Resident 57's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include end-stage renal disease (the final stage of kidney decline where the kidneys are no longer able to function to meet the body's needs) dependent on dialysis (the process of removing waste products and excess fluid from the body when the kidneys are unable to adequately filter the blood) and bilateral below-the-knee amputation of the lower extremities.</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 December 12, 2024, revealed that Resident 57 had moderately impaired cognition with a BIMS score of 12 (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>Additionally, the MDS indicated the resident had functional limitations in range of motion with impairments to both sides of the lower extremities, and the resident was indicated to be dependent with bed-to-chair transfer (the ability to transfer to and from a bed to a chair or wheelchair).</p> <p>The most current review of a quarterly MDS, dated [DATE], revealed that Resident 57 is cognitively intact with a BIMS score of 14 (a score of 13-15 indicates cognition is intact).</p> <p>Resident 57's comprehensive person-centered plan of care initiated on November 23, 2024, indicated the resident required the assistance of two staff members with transfers. The care plan was revised on December 16, 2024, to include the use of a mechanical lift (a mechanical device designed to lift/transfer individuals that have limited mobility in a safe manner and reduce injuries) with transfers.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 57's clinical record revealed physician's orders dated December 6, 2024, to utilize a mechanical lift for all transfers and bed mobility with the assistance of two staff members.</p> <p>A review of Resident 57's task report (an electronic record that summarized planned resident-centered tasks completed by nursing) initiated on December 8, 2024, revealed that Resident 57 was an assist of two staff members via the mechanical lift for transferring.</p> <p>A review of a facility investigative report dated December 13, 2024, at approximately 2:30 PM, revealed that Employee 14, an agency nurse aide, was transferring Resident 57 and experienced a fall during the transfer.</p> <p>A review of a facility investigative report dated December 13, 2024, at approximately 2:30 PM, revealed that Employee 14, an agency nurse aide was transferring Resident 57 and experienced a fall during the transfer.</p> <p>A review of a witness statement from Employee 14, dated 2:30 PM, indicated he was transferring the resident to his wheelchair and grabbed the resident under both arms, and that Resident 57 was holding onto him with both arms and while during the transfer his left below-the-knee amputation stump became stuck in the wheelchair arm. Employee 14 then called out for help and received assistance from Employee 15, the maintenance director, to help dislodge his stump from the wheelchair arm. Employee 14 then attempted to reposition the resident into the wheelchair but stumbled over clutter on the floor and placed the resident on the floor to prevent harm. The statement did not acknowledge that the mechanical lift, as required by physician order and care plan, had not been used.</p> <p>A review of a witness statement from Employee 15, dated 2:30 PM, indicated that he heard someone yelling for help and witnessed Employee 14 holding Resident 57 under both arms while Resident 57 had both of his arms wrapped around Employee 14, and Employee 14 asked Employee 15 to help dislodge his left stump from the wheelchair arm. Employee 15 assisted in freeing the resident's stump from the wheelchair arm. After the stump was freed, Employee 14 lost balance and the resident was found lying on the floor. Employee 15 also observed clutter on the floor and water from a bottle that spilled during the incident.</p> <p>A review of a nurse's incident/accident statement dated December 13, 2024, at 4:21 PM, revealed that they found Resident 57 on the floor lying next to Employee 14 and noted debris of a cup, paper, and water on the floor.</p> <p>The facility investigation failed to obtain a resident statement from Resident 57 at the time of the incident. During the survey, the Nursing Home Administrator (NHA) was unable to explain the omission of the resident's statement. When interviewed on April 24, 2025, at 8:40 AM, Resident 57 stated that he had informed Employee 14 he required a mechanical lift with two-person assistance, but the aide proceeded to transfer him manually. The resident believed the aide</p> <p>in a hurry to get the transfer done faster.</p> <p>(continued on next page)</p>		

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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	
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nurse's progress note dated December 14, 2024, at 10:37 AM documented complaints of rib pain, and a subsequent x-ray was ordered. Although the December 17, 2024, radiology report showed no fracture, a physician's note dated December 19, 2024, noted that Resident 57 was likely to have a right rib contusion (bruise), as x-ray findings were negative, and the resident was experiencing pain.</p> <p>The resident required Tylenol for rib pain on multiple occasions between December 14-20, 2024, with reported pain scores ranging from 3 to 8 (pain scale of 1 to 10 1 being no pain and 10 being the worst pain).</p> <p>The facility investigation lacked evidence the facility evaluated whether the plan of care for Resident 57 was implemented as directed. There was no documentation identifying the resident was transferred by only one staff member or that the mechanical lift was not used. The facility failed to identify or document the deviation from the care plan.</p> <p>Furthermore, attempts to re-contact Employee 14 during the on-site survey were unsuccessful. The NHA was unable to provide documentation or rationale for the staff member's departure from the facility. Employee 15, interviewed on April 24, 2025, stated he did not know why the aide was transferring the resident alone.</p> <p>A review of Employee 14 personnel file acknowledged that he completed training and was deemed proficient to perform all assigned tasks, including proper transfer techniques, and received training on abuse and neglect of a resident.</p> <p>Despite this documented training and acknowledgment of competency, review of Resident 57's clinical record confirmed that Employee 14 failed to adhere to established protocols by not using the required mechanical lift to transfer Resident 57 along with another staff member on December 13, 2024.</p> <p>The facility failed to implement its established procedures in response to a fall with minor injury by failing to conduct a thorough investigation to rule out potential abuse, neglect, or mistreatment of the resident as a potential cause of the fall with minor injury. There was no indication the facility identified at the time of the incident that there was only one nurse aide, Employee 14, and no use of a mechanical lift for transfers.</p> <p>During an interview conducted on April 24, 2025, at 1:30 PM, the NHA confirmed that the facility could not provide documented evidence the facility fully investigated to rule out potential neglect following Resident 10's fall with minor injury. The facility failed to identify that planned interventions were not in place and/or implemented in a manner to ensure the resident's safety to prevent the fall and prevent future reoccurrence to the extent possible and implement appropriate corrective actions to prevent recurrence.</p> <p>Refer F600</p> <p>28 Pa. Code 201.14 (a)(c) Responsibility of licensee</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 201.29 (a)(c) Resident Rights</p> <p>(continued on next page)</p>		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12 (c)Nursing Services

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on a review of clinical records and the Resident Assessment Instrument (RAI) and staff interviews, it was determined the facility failed to ensure the Minimum Data Set Assessments (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of three residents out of 27 sampled (Residents 2, 40, and 47).</p> <p>Findings included:</p> <p>A review of Resident 2's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) and atrial fibrillation (an irregular heart rate that commonly causes poor blood flow).</p> <p>A current physician order initially dated January 28, 2025, noted an order for Warfarin Sodium (an anticoagulant medication also known as a blood thinner) 4 mg via PEG-tube (percutaneous endoscopic gastrostomy- feeding tube placed directly into the stomach through the abdominal wall to provide liquid nutrition, medications, and fluids into the stomach) at bedtime for diagnosis of atrial fibrillation.</p> <p>A review of Resident 2's February 2025 Medication Administration Record revealed Apixaban 5 mg (anticoagulant) was administered daily as ordered by the physician.</p> <p>A review of Resident 2's quarterly MDS assessment dated [DATE], indicated the resident did not receive an anticoagulant (blood thinner) medication during the 7-day look-back period.</p> <p>An interview with the RNAC (registered nurse assessment coordinator) on April 23, 2025, at approximately 1:30 PM confirmed Resident 2's MDS assessment was not accurate.</p> <p>A review of Resident 40's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included dementia (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 peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs).</p> <p>A review of Resident 40's annual MDS assessment dated [DATE], Section I active diagnoses, infection in the past seven days, indicated infections of MDRO (multi-drug resistant organism is a germ that is resistant to many antibiotics) and pneumonia (infection that affects one or both lungs, which makes it difficult to breathe and can cause a fever and cough). However, review of the clinical record revealed no documented evidence the resident had an MDRO infection or pneumonia.</p> <p>An interview with the RNAC on April 23, 2025, at approximately 1:45 PM confirmed that Resident 40 did not have an MDRO infection or pneumonia during the seven-day look-back period of the MDS assessment. The RNAC confirmed that Resident 40's MDS assessment was not accurate.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A clinical record review revealed Resident 47 was admitted to the facility on [DATE], with diagnoses to include diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces).</p> <p>A review of a 5-day MDS assessment dated [DATE], Section N0350. Insulin: Resident 47 did not receive any insulin injections during the seven-day look-back period. However, a review of Resident 47's Medication Administration Record dated February 2025 revealed Resident 47 received a Lantus 100 unit/ml solution pen injector (insulin) on five occasions from February 7, 2025, through February 11, 2025.</p> <p>During an interview on April 24, 2025, at approximately 1:30 PM, the RNAC confirmed Resident 47's February 11, 2025, MDS, Section N0350. Insulin was not accurate.</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738</p> <p>Based on clinical record review, facility policy review, and staff interview, it was determined the facility failed to ensure that nursing services met professional standards of quality according to the Pennsylvania Code Title 49, Professional and Vocational Standards, by failing to implement nursing practices for the administration of intravenous medication via a peripheral IV (thin, flexible plastic tube inserted into a peripheral vein to allow for the administration of fluids, medications, and other therapies into the bloodstream and used for short-term intravenous therapy) for one of 27 residents reviewed (Resident 101).</p> <p>Findings include:</p> <p>According to the Pennsylvania Code Title 49, Professional and Vocational Standards Department of State, Chapter 21 State Board of Nursing, Chapter 21.145 Functions of the LPN (Licensed Practical Nurse) requires the following:</p> <p>The LPN is prepared to function as a member of the health care team by exercising sound nursing judgement based on preparations, 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. (b) The LPN administers medication and carries out the therapeutic treatment ordered for the patient in accordance with the following: (d) The Board recognizes codes of behavior as developed by appropriate practical nursing associations as the criteria for assuring safe and effective practice.</p> <p>Chapter 21.145b. IV therapy curriculum requirements;</p> <p>(f) An LPN may perform only the IV therapy functions for which the LPN possesses the knowledge, skill and ability to perform in a safe manner, except as limited under S 21.145a (relating to prohibited acts), and only under supervision as required under paragraph (1).</p> <p>(1) An LPN may initiate and maintain IV therapy only under the direction and supervision of a licensed professional nurse or health care provider authorized to issue orders for medical therapeutic or corrective measures (such as a CRNP, physician, physician assistant, podiatrist or dentist).</p> <p>(g) An LPN who has met the education and training requirements of S 21.145b (relating to IV therapy curriculum requirements) may perform the following IV therapy functions, except as limited under S 21.145a and only under supervision as required under subsection (f):</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>(1) Adjustment of the flow rate on IV infusions.</p> <p>(2) Observation and reporting of subjective and objective signs of adverse reactions to any IV administration and initiation of appropriate interventions.</p> <p>(3) Administration of IV fluids and medications.</p> <p>(4) Observation of the IV insertion site and performance of insertion site care.</p> <p>(5) Performance of maintenance. Maintenance includes dressing changes, IV tubing changes, and saline or heparin flushes.</p> <p>(6) Discontinuance of a medication or fluid infusion, including infusion devices.</p> <p>(7) Conversion of a continuous infusion to an intermittent infusion.</p> <p>(8) Insertion or removal of a peripheral short catheter.</p> <p>(9) Maintenance, monitoring and discontinuance of blood, blood components and plasma volume expanders.</p> <p>(10) Administration of solutions to maintain patency of an IV access device via direct push or bolus route.</p> <p>(11) Maintenance and discontinuance of IV medications and fluids given via a patient-controlled administration system.</p> <p>(12) Administration, maintenance and discontinuance of parenteral nutrition and fat emulsion solutions.</p> <p>(13) Collection of blood specimens from an IV access device.</p> <p>A review of the facility Continuous Administration of IV Fluids by Pump Policy dated January 22, 2025, indicated that continuous infusions of IV fluids or medications in volumes greater than 250 ml may be controlled via electronic pump. Further review of the policy failed to include which licensed nursing staff (RN or LPN) would be responsible for the infusion of physician ordered IV fluids or medications.</p> <p>Interview with the administrator (NHA) and director of nursing (DON) on April 24, 2025, at approximately 10:00 AM confirmed the facility did not have a written policy or protocols to allow LPNs to administer IV fluids or medications. The NHA and DON failed to provide written evidence that LPNs employed at the facility had completed a Board approved educational program to start and discontinue an intravenous infusion and administer and withdraw intravenous fluids and medications with a physician's order. The NHA and DON also failed to provide documented evidence that a yearly in-service on administration of IV fluids and medications was provided to LPNs who have completed the Board certified educational program.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Clinical record review revealed that Resident 101 was admitted to the facility on [DATE], with diagnoses which included dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning).</p> <p>A physician order dated April 16, 2025, noted an order for Meropenem-Sodium Chloride Intravenous Solution (an antibiotic) reconstituted 500 MG/50ML use 500MG intravenously every 8 hours for urinary tract infection for seven days.</p> <p>An IV therapy note dated April 16, 2025, noted that a peripheral IV was placed in the right forearm.</p> <p>Review of the Resident 101's April 2025 Medication Administration Record (MAR) revealed that between April 16 through April 22, 2025, Employee 1 (LPN), Employee 2 (LPN), Employee 3 (LPN), Employee 4 (LPN), and Employee 5 (LPN) signed the MAR as administering the IV antibiotic medication to the resident through the peripheral IV.</p> <p>Interview on April 24, 2025, at approximately 11:00 AM with Employee 1 (LPN), stated she never administered medications through residents' intravenous lines at the facility based on facility policy. She confirmed that she did sign out on April 16, 2025, at 2:00 PM that she had administered the medication even though the RN was the one who had administered the IV medication through the resident's peripheral IV. Employee 1 (LPN) indicated she was never educated at the facility on the administration of intravenous medications.</p> <p>There was no documented evidence of any education or supervision regarding IV administration for any LPNs working at the facility.</p> <p>During an interview on April 25, 2025, at approximately 9:00 AM the DON failed to provide documented evidence that LPNs in the facility received education regarding the administration of intravenous medications. The DON further confirmed that facility policy indicated the nurse administering the medications are to sign the MAR indicating it was administered.</p> <p>28 Pa. Code 201.20(a) Staff Development.</p> <p>28 Pa Code 211.12 (d)(5) Nursing services.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>21738</p> <p>Based on observation, clinical record review, and staff interview it was determined the facility failed to ensure respiratory care including tracheostomy (surgical procedure where a hole is created in the neck and a tube is inserted into the trachea or windpipe to help a person breathe) care was provided in accordance with physician orders for one of three sampled residents (Resident 2).</p> <p>Findings include:</p> <p>Review of the clinical record revealed Resident 2 had diagnoses which included chronic respiratory failure (condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) with tracheostomy and cerebral palsy (brain disorder that appears in infancy or early childhood and permanently affects body movement and muscle coordination).</p> <p>A physician order dated February 3, 2025, was noted for a Pulmonary Consult on February 17, 2025.</p> <p>Review of the Pulmonary Consult dated February 17, 2025, revealed that Resident 2 was weaned to room air (normal air without supplemental oxygen) during the appointment. The plan/medical decision making/recommendations included to use oxygen as needed to maintain O2 level (oxygen saturation- the amount of oxygen carried by red blood cells in blood) was greater than 89%. Maintain humidification (process of adding moisture to the air a person with a tracheostomy breathes, without humidification the air can dry out secretions, making them thick and difficult to clear) via trach even if on room air. Start vest (SmartVest- provides high frequency chest wall oscillation to simulate repetitive mini-coughs to shear mucus away from the walls of the lung's airways and reduce the viscosity [thickness] of secretions) twice daily as tolerated for airway clearance. Use Albuterol (bronchodilator which works by relaxing and opening the air passages to the lungs to make breathing easier) twice daily with vest. Follow-up with pulmonary medicine in three months for evaluation.</p> <p>A physician order following the Pulmonary Consult dated February 17, 2025, noted to use oxygen as need to keep O2 level greater than 89%. Use humidification for trach. Start vest therapy twice daily to assist with mucous clearance if the resident tolerates. Use Albuterol nebulizer twice daily with vest therapy.</p> <p>Observation of Resident 2 on April 24, 2025, at 1:25 PM revealed the resident was in bed. Further observation revealed the resident was not receiving oxygen or humidification via the resident's tracheostomy. There was no evidence of a SmartVest in the resident's room.</p> <p>Interview with Employee 8 (RN) on April 24, 2025, at approximately 1:40 PM confirmed that humidification was not being used for the resident when the resident is on room air. Employee 8 (RN) confirmed the resident had not yet received a SmartVest.</p> <p>Further review of the clinical record revealed no documented evidence that arrangements had been made to obtain a SmartVest for the resident based on the physician order dated February 17, 2025, for vest therapy twice daily.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Upon surveyor inquiry on April 24, 2025, the facility clarified recommendations from the resident's pulmonary consult on February 17, 2025.</p> <p>A telephone encounter note dated April 25, 2025, confirmed the resident should be receiving humidification when on room air to keep secretions moist and easier for the resident to cough the secretions out or be suctioned. A phone number to obtain a SmartVest was also provided.</p> <p>Interview with the director of nursing on April 25, 2025, at 12:23 PM failed to provide documented evidence that physician orders related to respiratory and tracheostomy care for Resident 2 were timely implemented.</p> <p>28 Pa. Code 211.5 (f)(i) Medical records.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51726</p> <p>Based on a review of clinical records, select facility policy, and resident and staff interviews, it was determined the facility failed to ensure that pain management was provided to residents consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for one resident out of 27 sampled (Resident 55).</p> <p>Findings include:</p> <p>A review of the facility procedure titled Pain Assessment and Management, last reviewed by the facility on January 22, 2025, revealed that under the section titled Monitoring and Modifying Approaches, the facility was to monitor residents' pain and its consequences at least each shift for acute pain or significant changes in chronic pain, using standardized assessment tools.</p> <p>A clinical record review revealed Resident 55 was admitted to the facility on [DATE], with diagnoses that included sciatica (pain radiating along the sciatic nerve which runs down one or both legs from the lower back) and unspecified abnormalities of gait and mobility.</p> <p>Physician orders dated June 18, 2024, directed staff to observe and document verbal and nonverbal signs and symptoms of pain every shift. Additionally, a physician's order dated March 21, 2025, directed the administration of oxycodone 10 mg (an opioid analgesic) by mouth three times daily for back pain.</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 that Resident 55 moderately cognitively impaired 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 moderate cognitive impairment).</p> <p>During an interview with Resident 55 conducted on April 23, 2025, at 12:45 PM, Resident 55 stated he experiences a lot of pain, especially at night.</p> <p>Despite the physician's order and facility policy requiring consistent monitoring of pain, a review of the clinical record revealed no documented pain assessments or monitoring entries beyond March 21, 2025.</p> <p>During an interview conducted on April 25, 2025, at approximately 8:45 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) were unable to provide documented evidence of pain monitoring for Resident 55.</p> <p>28 Pa. Code 211.10 (c) Resident care policies.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51726</p> <p>Based on a review of clinical records, resident, and staff interviews, it was determined the facility failed to develop and implement an individualized person-centered plan to render trauma informed care to a resident with a diagnosis of Post-Traumatic Stress Disorder for one out of 27 residents reviewed (Resident 55).</p> <p>Findings include:</p> <p>A review of Resident 55's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included Post Traumatic Stress Disorder (PTSD a mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event).</p> <p>A review of the clinical record also revealed a physician's order dated March 12, 2025, for Prazosin HCL (a medication that decreases levels of norepinephrine in the central nervous system thereby reducing nightmares related to PTSD), with instructions to administer 1 mg tablet by mouth at bedtime for nightmares.</p> <p>During an interview conducted on April 23, 2025, at approximately 12:45 PM, Resident 55 indicated he served two tours in Vietnam and had nightmares every night prior to the initiation of the Prazosin.</p> <p>The resident's current care plan, in effect at the time of review on April 25, 2025, did not identify the resident's PTSD symptoms or triggers related to this diagnosis and resident specific interventions to meet the resident's needs for minimizing triggers and/or re-traumatization.</p> <p>The facility failed to develop and implement an individualized person-centered plan to address, this resident's diagnosis of PTSD according to standards of practice to promote the resident's emotional well-being and safety.</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on April 25, 2025, at 8:50 AM, confirmed the facility was unable to demonstrate the facility provided culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for resident's experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident.</p> <p>28 Pa Code 211.12 (d)(3)(5) Nursing services.</p>		

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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	

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on a review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to ensure that a resident's drug regimen was free of unnecessary antibiotics for one out of 27 residents sampled (Resident 47).</p> <p>Findings included:</p> <p>A review of the facility policy titled Antibiotic Stewardship, last reviewed by the facility on January 22, 2025, revealed it is the facility's policy that antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The policy indicates when a resident is admitted from an emergency department, the admitting nurse will review discharge and transfer paperwork for current antibiotic and anti-infective orders. When a culture and sensitivity (C&S) is ordered, lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued.</p> <p>A clinical record review revealed Resident 47 was admitted to the facility on [DATE], with diagnoses that include epilepsy (a chronic brain disorder in which groups of nerve cells, or neurons, in the brain sometimes send the wrong signals and cause seizures).</p> <p>A progress note dated March 24, 2025, at 2:06 PM revealed Resident 47 was sent to the community emergency department related to lethargy and a change in mental status.</p> <p>A progress note dated March 24, 2025, at 10:49 PM, indicated that Resident 47 returned to the facility from a community emergency department visit. The note documented the physician to verify new medications from the hospital, including Cephalexin 500 mg (an antibiotic medication), and instructed that all hospital-prescribed medications be continued. The note further indicated that the physician planned to evaluate the resident in person the following day. Resident 47's vital signs at the time were assessed to be within normal limits.</p> <p>A physician's order initiated on March 25, 2025, at 10:30 PM directed administration of Cephalexin oral capsule 500 mg by mouth four times daily for a urinary tract infection (UTI), with a stop date of April 1, 2025.</p> <p>Laboratory review revealed a urine culture (method to grow and identify bacteria that may be in the urine) and quantitative report dated March 26, 2025, at 7:35 AM. The results showed no significant growth, indicating the absence of detectable bacteria or other microorganisms in the urine. A concurrent urinalysis noted an elevated white blood cell (WBC) count at 30-49 per high-powered field (normal range: 0-2/HPF), but no clinical documentation correlated this laboratory result with active symptoms of a urinary tract infection.</p> <p>A review of the Medication Administration Record (MAR) for March 2025 revealed that Resident 47 was administered a total of 25 doses of Cephalexin 500 mg from March 24, 2025, through April 1, 2025.</p> <p>(continued on next page)</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A comprehensive review of the clinical record failed to reveal documentation of any clinical signs or symptoms of a UTI from March 24, 2025, through April 1, 2025, including but not limited to, acute dysuria (painful urination), elevated temperature, increased urinary urgency, suprapubic pain, increased urinary incontinence, or gross hematuria.</p> <p>During an interview on April 24, 2025, at approximately 1:30 PM, the facility's Infection Preventionist (IP) confirmed that the clinical record did not contain documentation of a clinical rationale supporting the continued use of Cephalexin for Resident 47 during the noted period.</p> <p>In an interview conducted on April 25, 2025, at approximately 10:00 AM, the Nursing Home Administrator (NHA) was unable to provide documentation of a clinical rationale for the administration of Cephalexin oral capsule 500 mg. The NHA acknowledged it is the facility's responsibility to ensure that each resident's drug regimen remains free from unnecessary antibiotics.</p> <p>28 Pa. Code 211.2(d)(3)(5) Medical Director</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on observations, a review of select facility policies, the facility's infection control log, and staff interviews, it was determined the facility failed to maintain and implement a comprehensive infection prevention and control program and failed to implement transmission-based precautions to mitigate the spread of infectious disease for one out of the 27 residents sampled (Resident 56).</p> <p>Findings included:</p> <p>A review of a facility policy titled Respiratory Syncytial Virus (RSV) Prevention, last reviewed by the facility on January 22, 2025, revealed it is the facility policy to ensure that residents diagnosed with RSV are placed on contact precautions for the duration of the illness.</p> <p>A review of a facility policy titled Isolation-Categories of Transmission-Based Precautions, last reviewed by the facility on January 22, 2025, revealed that contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Staff and visitors are to wear gloves (clean-nonsterile) and a disposable gown when entering the room and remove before leaving the room and to avoid touching potentially contaminated surfaces with clothing after gown is removed.</p> <p>A clinical record review revealed Resident 56 was admitted to the facility on [DATE], with diagnoses that included 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 schizophrenia (a chronic and severe mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions).</p> <p>A quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) of Resident 56 dated February 03, 2025, revealed the resident was severely cognitively impaired with a BIMS score of 03 (brief interview for mental status, a tool to assess the residents' attention, orientation, and ability to register and recall new information, a score of 0-7 indicates severe cognitive impairment).</p> <p>A review of Resident 56's clinical record for the laboratory of a respiratory panel, which resulted on April 22, 2025, at 11:11 AM, revealed abnormal results of positive RSV.</p> <p>A review of Resident 56's clinical record revealed a laboratory result from a respiratory panel collected April 22, 2025, at 11:11 AM, indicated the resident tested positive for Respiratory Syncytial Virus (RSV), an infectious viral illness that requires implementation of transmission-based precautions.</p> <p>A physician's order dated April 22, 2025, at 12:17 PM, directed that contact precautions (prevent the spread of bacteria or viruses by the use of gowns, gloves and masks) be initiated for Resident 56 due to the positive RSV result, to remain in place through May 2, 2025.</p> <p>However, an observation conducted on April 22, 2025, at 1:30 PM revealed:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>No signage was posted outside Resident 56's room indicating that contact precautions were in effect.</p> <p>No personal protective equipment (PPE), such as gloves or gowns, were available outside the resident's room for staff use.</p> <p>An interview conducted at the time of observation with Employee 6, Licensed Practical Nurse (LPN), confirmed that Resident 56 required contact precautions due to the RSV diagnosis.</p> <p>A second observation conducted at 2:20 PM on April 22, 2025, again revealed the continued absence of contact precaution signage and PPE outside the resident's room.</p> <p>A third observation conducted on April 23, 2025, at 8:10 AM continued to show no signage or PPE readily available for use.</p> <p>An interview with Employee 7, LPN, conducted during the April 23, 2025, observation, revealed that the nurse was unaware that Resident 56 required contact precautions.</p> <p>An interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on April 23, 2025, at 9:40 AM confirmed the contact precautions ordered for Resident 56 were not implemented as directed by the physician. The NHA further confirmed that the contact precautions were not initiated until approximately 11:00 AM on April 23, 2025, one day after the observation after the order was issued, and only following surveyor inquiry. The NHA confirmed the facility is responsible for ensuring full implementation of infection control procedures, including contact precautions, in accordance with facility policy and nationally recognized infection control guidelines.</p> <p>A review of a select facility policy titled Infection Prevention and Control Program, last reviewed by the facility on January 22, 2025, revealed it is the facility's policy to establish an infection prevention and control program (IPCP) to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The IPCP provides a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement.</p> <p>The policy indicates surveillance data and reporting information are used to inform the infection prevention and control committee of potential issues and trends. Data gathered during surveillance is used to oversee infections and spot trends. The policy indicates the infection Preventionist collects data from the nursing units, categorizes each infection by body site (these can also be categorized by organism or according to whether they are facility- or community-acquired), and records the absolute numbers of infections.</p> <p>A review of the facility's infection control data revealed the facility's infection control program failed to implement an operational system to monitor and investigate causes of infection and manner of spread from November 2024 through April 2025. The facility's surveillance and data analysis system of infectious disease data failed to identify clusters of infection, track changes in prevalent organisms, or identify increases in infection rates in a timely manner.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on April 25, 2025, at approximately 9:00 AM, the infection Preventionist indicated that she has not been able to keep up with infection control data analysis. She provided handwritten infection surveillance logs from November 1, 2024, through March 18, 2025, that indicated the resident's name, prescribed medication, date range of administered medications, and an incomplete listing of infectious disease category (e.g., urinary tract infection, rash, wound).</p> <p>The Infection Preventionist, explained that she was behind on her data analysis and surveillance of facility infectious disease. She indicated the last time she was able to fully analyze infectious disease was October 2024.</p> <p>Additionally, review of the logs from November 2024 through April 2025 indicated the facility failed to consistently document critical infection-related details such as:</p> <ul style="list-style-type: none"> Resident room numbers or location in the facility Identification of organisms as applicable Indication of whether infections were facility- or community-acquired Symptoms experienced by residents Date of infection onset <p>During an interview on April 25, 2025, at approximately 10:00 AM, the NHA confirmed the facility is responsible for implementing a comprehensive infection control program that includes effective surveillance and timely analysis of infectious disease trends. The NHA was unable to provide documentation demonstrating that the facility had a functional surveillance system capable of tracking infection clusters or analyzing changes in prevalent organisms from November 2024 through April 2025.</p> <p>28 Pa. Code 211.10(d) Resident care policies.</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.</p>