

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/27/2026
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, select facility policy, and staff interview it was determined the facility failed to accurately identify a resident's request for future health care and advance directives as evidenced by one resident (Resident 73) out of 25 residents sampled. Findings include: Review of the facility Advance Directives Policy last reviewed [DATE], indicated the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, family members, and, or legal representative, about the existence of any written advance directives. The resident or resident representative is provided with written information concerning the right to refuse or accept medical or surgical treatment, and the right to formulate an advance directive is provided in a manner that is easily understood by the resident or resident representative. The resident has the right to refuse medical or surgical treatment, whether or not he or she has an advance directive. A clinical record review revealed Resident 73 was admitted to the facility on [DATE], with diagnoses that included COPD (chronic obstructive pulmonary disease, lung disease which causes restricted airflow and breathing problems), congestive heart failure (heart cannot pump enough blood) and atrial fibrillation (an irregular heart rate that commonly causes poor blood flow). Review of Resident 73'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 February 17, 2026. The POLST indicated that the resident elected DNR status (Do Not Resuscitate a medical order directing that CPR, cardiopulmonary resuscitation, a lifesaving procedure performed when the heart or breathing stops, should not be attempted, with a goal of allowing a natural death). Further review of the resident's current physician orders, initially entered on February 12, 2026, 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. There was no documentation to indicate that Resident 73 had revised an 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. An interview with the Director of Nursing (DON) on February 27, 2026, at 9:00 AM confirmed that physician orders are required to align with the most current, signed POLST. The DON acknowledged that Resident 73 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. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.5 (f)(i) Medical records. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.		

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and clinical records, and staff interviews, it was determined the facility failed to develop comprehensive care plans that included specific and individualized interventions to address the residents' needs for communication for one of 25 residents reviewed (Resident 15).Findings include: A review of the policy titled Care Plans, Comprehensive Person Centered last reviewed by the facility on January 21, 2026, revealed that a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical psychosocial and functional needs is developed and implemented for each resident. Review of Resident 15's clinical record revealed the resident was admitted to the facility on [DATE], with a diagnosis of Disease of the Pharynx (a disease of the muscular tube connecting the mouth and nose to the esophagus and larynx /voice box) and dysphagia (difficulty swallowing). An attempt at an interview on February 24,2026 at 11:45 AM in Resident 15's room revealed the resident was unable to verbalize his needs. A review of Resident15's annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 20, 2026, revealed Resident 15 was cognitively intact with a BIMS score of 15 (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 13 through 16 indicates intact cognition). The assessment indicated Resident 15 had unclear speech. An interview with the Nursing Home Administrator on February 25, 2026, at 9:15 AM revealed she communicated with Resident 15 by the resident writing things down so she can understand his needs. An interview with Employee 1(LPN) on February 26, 2026, at 8:39 AM revealed if the resident needs something he writes it down so staff can understand his needs. A review of the resident's care plan initiated on March 19, 2024 and updated January 28, 2026, revealed there was no communication care plan to address Resident 15's inability to verbally communicate with staff. An interview was conducted with the Director of Nursing (DON) on February27,2026, at 11:30 AM to review the above findings related to the facility's failure to develop a comprehensive person-centered care plan to meet the resident's physical, psychosocial, and functional needs. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, resident and staff interviews, and facility provided documentation, it was determined the facility failed to ensure that residents who were dependent on staff for assistance with activities of daily living (ADLs) consistently received necessary care and services to maintain personal hygiene and dignity for one resident out of 25 sampled residents (Residents 119). Findings include: A review of Resident 119's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include respiratory failure (occurs when the lungs cannot properly move oxygen into the blood or remove carbon dioxide) and muscle wasting (the loss of muscle tissue causing reduced size, strength, and movement capability). Review of Resident 119's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 4, 2025, revealed that Resident 119 was cognitively intact with a BIMS score of 15 (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 13-15 indicates cognition is intact). A review of Resident 119's Kardex (a quick-reference summary for staff to guide delivery of care) documented that Resident 119 was scheduled to receive showers on Mondays and Fridays during the evening shift. A review of the Documentation Survey Report v2 for December 2025 and January 2026 revealed that on multiple scheduled shower dates (December 5, December 8, December 12, December 15, December 19, December 22, and January 9), showers were either not documented as provided or the resident was provided a bed bath with no documented reason for a bed bath and not a shower as preferred. There was no supporting documentation indicating a change in condition that would have precluded showering. During an interview with the Director of Nursing (DON) on February 26, 2026, at 11:00 AM, the DON acknowledged that Resident 119 was scheduled to receive showers on Mondays and Fridays and confirmed that showers should have been provided as scheduled. The DON could not explain why showers were not consistently provided or documented. The above findings were reviewed with the DON on February 27, 2026, at 11:00AM. The facility could not provide documented evidence that Resident 119's showers were provided as ordered and preferred by the resident. 28 Pa. Code 211.12 (c)(d)(5) Nursing services.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interview, it was determined the facility failed to provide nursing services consistent with professional standards of quality to ensure that licensed nurses accurately administered prescribed medication for one resident out of 25 sampled residents (Resident 73). Findings include: 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. 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 judgement 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. Review of the facility policy titled Administering Medications last reviewed by the facility on January 15, 2026, revealed that medications are administered as prescribed and in a safe and timely manner. Medications are administered in accordance with prescriber orders, including any required time frame. A clinical record review revealed Resident 73 was admitted to the facility on [DATE], with diagnoses to include COPD (chronic obstructive pulmonary disease, lung disease which causes restricted airflow and breathing problems) and hypotension (low blood pressure). Review of a physician's order dated February 12, 2026, revealed an order for Midodrine hydrochloride 10 mg, to be given by mouth twice daily for hypotension, with instructions to hold the medication for systolic blood pressure greater than 110 mmHg (systolic blood pressure is the top number in the blood pressure reading representing the pressure in the arteries when the heart beats and pumps blood). Review of Resident 73's Medication Administration Record (MAR) for February 12, through February 26, 2026, revealed that Midodrine was administered four times outside of the physician ordered parameters, as evidenced by the following documented blood pressure readings at the time of administration: February 21, 2026, at 9:00 AM BP 133/68 mmHg February 22, 2026, at 9:00 PM BP 120/62 mmHg February 23, 2026, at 9:00 PM BP 112/74 mmHg February 26, 2026, at 9:00 AM BP 125/67 mmHg These administrations occurred despite the physician's explicit hold parameters. During an interview on February 27, 2026, at 11:00 AM the Director of Nursing acknowledged that nursing staff did not follow acceptable standards of nursing practice related to medication administration. 28 Pa. Code 211.5(f)(ii)(ix) Medical records. 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of select facility policy and clinical records, and staff interview, it was determined the facility failed to develop and implement an individualized plan to meet the toileting needs of one of 25 sampled residents (Resident 119), including the timely provision of staff assistance with toileting and management of urinary and bowel incontinence. Findings include: A review of facility policy titled Urinary Continence and Incontinence Assessment and Management reviewed by the facility on January 21, 2026, revealed that, as appropriate, and based on assessment of the category and causes of incontinence (inability to control the release of urine or stool) staff will provide scheduled toileting (a planned program in which staff assist the resident to use the toilet at routine, predetermined time intervals to reduce episodes of incontinence), prompted voiding (a toileting program in which staff regularly remind or ask the resident if they need to urinate and provide assistance to the toilet based on the resident's response), or other interventions to try to improve the individual's continence status. The staff and physician will review the progress of individuals with impaired continence until continence is restored or improved as much as possible, or it is identified that further improvement is unlikely. A review of Resident 119's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include respiratory failure (occurs when the lungs cannot properly move oxygen into the blood or remove carbon dioxide) and muscle wasting (the loss of muscle tissue causing reduced size, strength, and movement capability). Review of Resident 119's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 4, 2025, revealed that Resident 119 was cognitively intact with a BIMS score of 15 (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 13-15 indicates cognition is intact). A review of the resident's person-centered plan of care, dated December 1, 2025, included a focus area related to bladder incontinence related to impaired mobility. Resident goals included remaining free from skin breakdown due to incontinence and brief use. Interventions included providing cleaning peri-area after each incontinence episode, monitor for signs and symptoms of a urinary tract infection, monitor, document, and report any possible causes of incontinence. However, the care plan failed to identify or implement a structured toileting schedule or individualized incontinence program (e.g., check-and-change protocols, scheduled toileting, or prompted voiding) to manage the resident's known incontinence and promote timely care to prevent the potential of skin breakdown. A review of the resident's Kardex (a nursing information system used to obtain specific care information for each resident) in effect at the time of the survey ending February 27, 2026, failed to include the incontinence management needs of the resident. There was no documented evidence on the Kardex that staff were instructed to provide the resident with timely toileting or incontinence care. A review of a 3 day voiding diary (a record kept over a continuous 72 hour period that documents the times a resident urinates, amount, episodes of incontinence and related toileting patterns to evaluate bladder function to plan care) dated November 29, 2025, through December 3, 2025, revealed Resident 119 was incontinent majority of the time. A review of a Functional Abilities Assessment and Goals assessment documented on December 1, 2025, at 3:22PM revealed Resident 119 was completely dependent on staff for toileting hygiene. A review of Documentation Survey Report v2 (general care nursing tasks completed for the resident) for December 2025 revealed Resident 119 was incontinent of urine, resident was incontinent of urine 82% of the time, of the documented shifts. 13% of the documentation was left blank on multiple different shifts. A review of the Documentation Survey Report v2 for January 2026 revealed Resident 119 was incontinent of urine 67% of the documented shifts. There was no evidence the facility had developed and implemented a plan to address the (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's toileting needs based on an evaluation of the resident's habits and voiding patterns and assure timely care was provided to meet the resident's toileting needs and manage the resident's urinary incontinence to prevent extended periods of time without toileting, checking for incontinence and changing the resident. An interview with the Director of Nursing on February 27, 2026, at 11:15 AM, revealed the facility was unable to provide documented evidence the facility developed and implemented planned incontinence management for Resident 119. 28 Pa. Code 211.10(a)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policy, and staff interview it was determined the facility failed to ensure that physician ordered intravenous (giving fluids or medication directly into a vein using a needle or tube) antibiotics were administered as prescribed for one resident out of 25 sampled (Resident 73). Findings include: Review of the facility policy titled Administering Medications last reviewed by the facility on January 15, 2026, revealed that medications are administered as prescribed and in a safe and timely manner. Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meals). The individual administering the medication initials the resident's medication administration record (MAR) on the appropriate line after giving each medication and before administering the next ones. A clinical record review revealed Resident 73 was admitted to the facility on [DATE], with diagnoses that included COPD (chronic obstructive pulmonary disease, lung disease which causes restricted airflow and breathing problems), congestive heart failure (heart cannot pump enough blood) and atrial fibrillation (an irregular heart rate that commonly causes poor blood flow). Review of a hospital procedure note dated January 30, 2026, revealed that Resident 73 had a tunneled central venous catheter (a thin, flexible tube that is inserted into a large vein to the heart to deliver medications and other therapies into the bloodstream) inserted into the right chest on January 30, 2026. A physician order dated February 13, 2026, noted an order for Cefazolin Sodium (an antibiotic medication) Intravenous (IV) Solution reconstituted 2 gram intravenously every 8 hours for bacteremia (bacteria in the blood) until March 6, 2026. Review of Resident 73's Medication Administration Record (MAR) for February 2026, indicated that he was scheduled to receive Cefazolin Sodium at 6:00 AM, 2:00 PM, and 10:00 PM. The MAR was not signed by licensed staff to confirm the medication was administered as scheduled on the following dates: February 16, 2026, the 6:00 AM dose was coded 9 (per the MAR means other, see progress note). However, review of progress notes revealed no documented explanation for the indicated code of 9. February 17, 2026, the 10:00 PM dose was left blank. February 18, 2026, the 10:00 PM dose was left blank. February 23, 2026, the 2:00 PM dose was left blank. February 24, 2026, the 2:00 PM dose was left blank. Interview with the Director of Nursing (DON) on February 26, 2026, at 10:00 AM failed to provide documented evidence the facility timely administered 5 doses of the IV antibiotic therapy prescribed for Resident 73. The DON confirmed that licensed staff failed to document medication administration on the MAR for the 5 doses of IV antibiotic as required per facility policy to ensure that physician ordered IV antibiotics were administered as prescribed by the physician. 28 Pa. Code 211.9(a)(1)(k) Pharmacy services. 28 Pa. Code 211.10 (a)(c)(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services.		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and staff interview, it was determined the facility failed to develop and implement an individualized person-centered plan to address dementia and dementia related behaviors displayed by one out of 25 residents reviewed. (Resident 47) Findings include: A review of Resident 47's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included 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). A review of Resident 47's Annual Minimum Data Set Assessment (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated September 19, 2025, revealed the resident was severely cognitively impaired. A review of Resident 47's nursing progress notes during February 2026, revealed the resident had an increase in exit seeking behaviors, culminating in the resident being transferred to the facility's locked dementia unit on February 23, 2026. A review of the Resident 47's current care plan initially dated May 28, 2025, last revised May 28, 2025, revealed there were no new interventions to address these concerns. Further review revealed no documented evidence the facility had developed an individualized person-centered plan for the resident's dementia care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety and using individualized, non-pharmacological approaches to care, including purposeful and meaningful activities that address the resident's customary routines, interests, preferences, and choices to enhance the resident's well-being. The facility failed to develop and implement an individualized person-centered plan to address, modify and manage this resident's dementia-related behaviors. The resident's care plan for dementia failed to include individualized interventions based on an assessment of the resident's preferences, social/past life history, customary routines, and interests in an effort to manage, modify or decrease the resident's dementia-related behavioral symptoms. Interview with Nursing Home Administrator on February 27, 2026, at 10:00 AM, confirmed the facility was unable to provide evidence of the development and implementation of an individualized person-centered plan to address the resident's dementia care. 28 Pa Code 211.12 (d)(3)(5) Nursing services		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policy, and staff interview, it was determined the facility failed to implement procedures to maintain records of controlled drugs and ensure accurate drug administration for one out of the 30 residents sampled (Resident 3). Findings include: A facility policy titled Controlled Substances last reviewed by the facility on January 21, 2026, revealed that the facility will comply with all laws, regulations, and other requirements related to handling, storage, disposal and documentation of controlled medications (medications regulated by federal law due to the potential for abuse, dependence, or misuse requiring strict storage, prescribing and record keeping control). The policy indicated the facility's system for reconciling the receipt, dispensing, and disposition of controlled medications includes documentation of personal access and usage, medication administration records, declining inventory records, and records for destruction, waste, or return of medication to the pharmacy. A clinical record review revealed Resident 3 was admitted to the facility on [DATE], with diagnoses that include wedge compression fracture of the T11-T12 vertebrae (a spinal injury in which the front portion of a vertebra collapses, often related to trauma or osteoporosis, a disease that causes bones to become weak and fragile) and fibromyalgia (a chronic medical condition characterized by widespread musculoskeletal pain, fatigue, and sleep disturbance). Review of Resident 3's clinical record revealed a physician's order dated December 6, 2025, directing staff to administer OxyContin Oral Tablet HCL ER 12-hour abuse-deterrent formulation 15 milligrams every 12 hours for moderate to severe pain. OxyContin is an extended-release (ER) opioid pain medication designed to slowly release medication over a 12-hour period. The abuse-deterrent formulation contains properties intended to make the medication difficult to crush, dissolve, or inject in order to discourage misuse. OxyContin contains oxycodone, which is classified as a Schedule II narcotic medication, meaning it has a high potential for abuse and therefore requires strict control and documentation. Continued review revealed a physician's order dated December 4, 2025, directing staff to administer Oxycodone HCL oral tablet 15 milligrams by mouth every six hours as needed for moderate to severe pain rated 7 through 10 on the pain scale (standardized tool to measure intensity of pain where 0 means no pain and 10 represents the worst pain) for fourteen days. A review of facility records revealed the facility utilizes a Controlled Drug Receipt/Record/Disposition Form, which is a controlled medication inventory log used to track the receipt, dispensing, and remaining quantity of each controlled medication. The facility also utilizes a Medication Administration Record (MAR) to document each medication administered to a resident. The MAR records the medication administered, the date and time of administration, the staff member administering the medication, the resident's pain level before administration, and the clinical reason for administering the medication. A comparison of Resident 3's Controlled Drug Receipt/Record/Disposition Form with Resident 3's Medication Administration Record (MAR) for the period of December 1, 2025, through February 2026, revealed seven entries indicating Oxycodone HCL was removed or utilized according to the Controlled Drug Receipt/Record/Disposition Form; however, there was no corresponding documentation in Resident 3's MAR indicating the medication was administered. The discrepancies occurred on the following dates and times: December 6, 2025, at 9:00 PM December 9, 2025, at 8:10 PM December 11, 2025, at 8:08 PM December 14, 2025, at 5:34 PM December 20, 2025, at 9:00 PM December 24, 2025, at 11:30 AM January 28, 2026, at 2:00 AM Continued comparison of Resident 3's Controlled Drug Receipt/Record/Disposition Form with Resident 3's Medication Administration Record for the same period revealed two additional entries in which Oxycodone HCL 15 milligrams was documented on the MAR as administered; however, there was no corresponding entry on the Controlled Drug Receipt/Record/Disposition Form documenting removal of the medication from the controlled medication inventory. These discrepancies occurred on the following dates and times: December 11, (continued on next page)		

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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	
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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2025, at 9:00 AMFebruary 2, 2026, at 6:32 PMOn February 27, 2026, at 11:35 AM, an interview was conducted with the Director of Nursing (DON) regarding the discrepancies identified between Resident 3's controlled medication inventory record and the Medication Administration Record. The DON reviewed the findings related to the facility's failure to consistently reconcile Resident 3's controlled substance medications, including OxyContin and Oxycodone. 28 Pa Code 211.5(f)(xi) Medical records 28 Pa Code 211.9(a)(1)(k) Pharmacy services. 28 Pa Code 211.10 Resident care policies. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing services.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of facility documents and staff interview, it was determined the facility failed to ensure the Medical Director or designee participated in the facility's Quality Assurance and Performance Improvement (QAPI) Committee meetings on a quarterly basis for two of four quarters reviewed. (Quarter 2 and Quarter 3 of 2025). Findings include: A review of the facility policy titled Quality Assurance Performance Improvement (QAPI, a facility wide program that uses ongoing review of data and care practices to identify problems, correct them, and improve the quality and safety of services provided to residents) last reviewed by the facility on January 21, 2026, revealed the facility would develop and maintain an effective, comprehensive, data-driven QAPI program. However, the policy did not clearly identify the required QAPI committee membership, did not specify the required participation of the Medical Director or a physician designated by the Medical Director, and did not outline attendance expectations or accountability for participation in quarterly QAPI meetings. A review of QAPI committee meeting sign-in sheets for the period of April 2025 through January 2026 revealed the facility conducted QAPI meetings on a quarterly basis. However, documentation showed that the Medical Director or a designated physician representative was not present at the QAPI meetings held on April 30, 2025, August 8, 2025, and December 31, 2025, representing three of the four quarterly meetings reviewed for 2025. Without participation of the Medical Director or the Medical Director's designated physician representative, the QAPI committee lacked required physician involvement in the facility's process for reviewing clinical care practices, identifying potential quality or safety concerns, and implementing improvements. During an interview on February 27, 2026, at 9:35 AM, the Director of Nursing and the Nursing Home Administrator reviewed the findings related to the absence of the Medical Director or designee from the identified QAPI committee meetings and acknowledged the physician representative had not attended those meetings. 28 Pa. Code 201.18 (e)(1)(3) Management. 28 Pa. Code 211.2 (d)(3)(4)(5)(6) Medical director. 28 Pa. Code 211.10(c)(d) Resident care policies.		