STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395691	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverstreet Manor	440 North River Street Wilkes-Barre, PA 18702

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 39235 Based on review clinical records and resident and staff interviews it was determined that the facility failed to provide care in a manner and environment, which promotes each resident's quality of life by failing to respond timely to residents' requests for assistance, as evidenced by experiences reported by six residents out of 15 interviewed (Residents 2, 40, 54, 69, 89, and 92). Findings include: A review of resident clinical records, and a facility provided BIMS (brief interview mental status - to assess cognitive status) report, and random interviews conducted on April 24, 2024, with 15 alert and oriented residents, to include six residents residing on nursing station 1, and nine residents residing on the nursing station 2, revealed that 6 residents' interviewed expressed complaints regarding staff's failure to respond to their requests for assistance and provide requested and needed care and services in a timely manner. During the random interviews, the residents stated that they feel the facility is not adequately staffed because they wait extended periods of time for staff to respond to their requests for assistance, including untimely responses to their requests via the nurse call bell system. Of those residents interviewed, 4 of 6 residents residing on nursing station 1, and 2 of 9 residents residing on nursing station 2, expressed concerns with untimely staff response to their requests and needs as described above. Interview with Resident 2 on April 24, 2024, at approximately 11:06 AM, revealed that she waits 30 minutes, or more for staff assistance when requested. The resident stated that the extended waits occur daily, and happen at any time of day, including all three shifts, day, evening, or night shift, and that there have been times she has soiled herself while waiting for staff to answer her call bell. Interview with Resident 54 on April 24, 2024, at approximately 11:10 AM, revealed she waits 30 minutes for staff to answer her call bell, and these waits occur weekly, often two or three times each week. The resident stated that these waits occur on 2nd shift (evening shift) of nursing duty. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident 89 on April 24, 2024, at approximately 11:15 AM, revealed that she waits up to an hour for someone to answer her call bell, and these waits that long have occurred two or three times in the last month. The resident stated that there have been times she has soiled herself while waiting for staff to answer her call bell for assistance with toileting needs Interview with Resident 40 on April 24, 2024, at approximately 11:26 AM, revealed that she waits 30 minutes for staff to answer her call bell, and these waits occur daily. The resident stated that these waits occur mostly on 3rd (night shift) of nursing duty. The resident revealed that there have been times she has soiled herself while waiting for staff to answer her call bell when she needs toileting assistance. Interview with Resident 69 on April 24, 2024, at approximately 11:48 AM, revealed that she has waited greater than 1 hour, at least once a week, for staff to answer her call bell. The resident stated that these waits occur mostly on 2nd shift (evening shift) of nursing duty, and that there have been times she has soiled herself while waiting for the call bell to be answered to provide assistance with toileting. Interview with Resident 92 on April 24, 2024, at approximately 11:54 AM, revealed that she can wait 1 hour, weekly, for staff to answer her call bell. The resident stated that these waits occur mostly on 2nd shift (evening shift) of nursing duty. Interview on April 24, 2024, at approximately 2:10 PM with the Nursing Home Administrator (NHA) verified that it is her expectation that all residents be treated with dignity and respect. The NHA was unable to explain why multiple residents are reporting untimely staff response times to their requests for care and assistance, resulting in the residents' feelings that the facility is not adequately staffed, which was negatively affecting the residents' quality of life in the facility. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa Code 211.12 (c)(d)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on observations, a review of clinical records and select grievances/complaints lodged with the facility, resident, and staff interviews it was determined that the facility failed to consistently administer oxygen as ordered and maintain sanitary oxygen delivery systems for two out of five sampled residents (Residents 59, and 72). Findings included: According to the American Thoracic Society, oxygen is a medication that requires a prescription from a healthcare provider. The provider will prescribe your oxygen at a specific flow rate and a specific number of hours per day. It is very important that oxygen is used as prescribed. Using too little oxygen may put a strain on the heart and brain, causing heart failure, fatigue, or memory loss. Using too much oxygen can also be a problem. For some patients, using too much oxygen can cause them to slow their breathing to dangerously low levels. It is important to wear oxygen as your provider ordered it. If the patient starts to experience headaches, confusion, or increased sleepiness after using supplemental oxygen, the patient may be getting too much. A review of a grievance lodged with the facility dated March 21, 2024, revealed that Resident 83's son called the facility reporting that on Wednesday, the resident's brother at the facility visiting with the resident in the resident's room and observed that the resident's portable oxygen tank was empty. The facility immediately monitored the resident's oxygen saturation and updated the order to check the resident's oxygen tank and provide in-service education of staff on placing resident back on concentrator when back in room. A review grievance lodged with the facility dated April 12, 2024, indicated that Resident 83's son called the facility to report that his uncle was in the facility visiting the resident last evening around 6:00 PM and observed the resident's oxygen concentrator was off and her nasal canula was upside down. He said her pulse Ox was in the 80's when obtained. The facility called the resident's brother and confirmed that the resident's oxygen was off and he obtained her pulse ox with the one he brought in and she was 85%. The resident's brother stated that he got the supervisor, she went right down to check the resident. The grievance resolution was that the resident's oxygen was being checked hourly. A review of clinical record revealed Resident 59 was admitted to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disease ([COPD] chronic obstructive pulmonary disease- chronic inflammatory lung disease that causes obstructed airflow from the lungs), dependence on supplemental oxygen, and a solitary pulmonary nodule (small, round, or oval growth in the lung). A review of a current physician order dated April 12, 2024, for continuous oxygen 2 L/min via nasal canula (NC). A review of an admission MDS (minimum data set- a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated April 17, 2024, indicated the resident was severely cognitively impaired and required assistance with activities of daily living (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 59's plan of care dated April 17, 2024, and revised April 22, 2024, revealed that the resident was resistive/noncompliant with treatment/care. It was noted that the resident was refusing oxygen (O2) and disconnecting wound vac, refusing breathing treatments. The interventions included to a allow for flexibility in ADL routine to accommodate mood, preferences and customary routine, elicit family input for best approaches, provide non-care related conversation proactively before attempting ADLs. An observation on April 24, 2024, at approximately 9:15 AM, and at 9:55 AM, revealed Resident 59 sitting in bed, with his oxygen tubing, including the nasal canula lying observed on the floor next to the bed. Another observation in the presence of Employee 1, Licensed Practical Nurse (LPN), on April 24, 2024, at approximately 10:05 AM, revealed Resident 59 sitting in bed at which time, Employee 1 confirmed the observation of the resident's oxygen tubing, including the nasal canula laying on the floor next to the bed, and that the resident was not receiving the oxygen as ordered. Resident 59 stated he can reach it (the nasal cannula). Employee 1 (LPN), picked up the oxygen tubing and nasal canula from the floor and placed it on the resident's lap without cleaning, or replacing the set up. Resident 59 was then observed to place the nasal cannula that had been on the floor, in his nose. Interview with Employee 1, LPN on April 24, 2024, at approximately 10:22 AM, confirmed that the resident was not receiving the oxygen as physician ordered, and that he had not adhered to infection control procedures, by picking up the oxygen tubing, including the nasal canula that was lying on the floor, and placing it on the resident's lap without cleaning, or replacing it. Following surveyor observations and interviews with staff, the facility obtained a physician order dated April 24, 2024, for staff to monitor Resident 59's oxygen (02) and wound vac on properly, every hour, and document compliance. A review of clinical record revealed Resident 72 was most recently admitted to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disease (COPD), obstructive sleep apnea, acute and chronic respiratory failure with hypoxia, hypertensive heart and chronic kidney disease with heart failure, congestive heart failure (CHF), and morbid (severe) obesity due to excess calories. A review of a quarterly MDS assessment dated [DATE], indicated that the resident was cognitively intact. A review of Resident 72's plan of care, dated January 17, 2024, revealed that the resident requires use of Oxygen to maintain oxygenation with interventions to check the filter and clean weekly, check oxygen tubing length and placement to avoid tripping hazard, humidifier as indicated, monitor for skin breakdown related to oxygen tubing contact with skin, oxygen therapy per physician's order and weekly change of oxygen tubing date. The resident's care plan, dated December 4, 2023, revealed that the resident was resistive/noncompliant with treatment/care interventions to allow for flexibility in ADL routine to accommodate mood, preferences and customary routine, if resisting care, leave (if safe to do so) and return later, physician to explain/reinforce need for treatment as necessary, provide education about risks of not complying with therapeutic regimen, provide non-care related conversation proactively before attempting ADLs, and psych consult as ordered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident had a current physician order dated January 17, 2024, for continuous oxygen 2 L/min via nasal canula (NC), and to check the oxygen saturation every (Q) shift and as needed. (Oxygen [02] saturation is the percentage of 02 in a person's blood, normal 02 saturation levels are between 95 % and 100 %, and levels below 90% are considered low and may indicate hypoxemia, which is an abnormally low level of oxygen in the blood that could be a life - threatening condition). Observations on April 24, 2024, at approximately 9:21 AM, and at 9:58 AM, revealed Resident 72 sitting in bed, without the nasal cannula on delivering continuous oxygen as ordered. The oxygen concentrator was turned on, but the nasal cannula was observed on the resident's lap, under her bedding (sheets/blanket). A third observation in the presence of Employee 2, Licensed Practical Nurse (LPN), on April 24, 2024, at approximately 10:13 AM, revealed Resident 72 sitting in bed. Employee 2, LPN, confirmed that the resident's nasal cannula located was her lap, under her sheets and blankets and the resident was not not receiving the oxygen as ordered by the physician. In response, the resident stated, I was told I can remove it (the oxygen). On April 24, 2024, at approximately 10:25 AM, Resident 72's oxygen saturation was measured by Employee 1, LPN and read 85 %, while wearing the oxygen nasal canula. Interview with Resident 72 on April 24, 2024, at approximately 12:10 PM, revealed this was not the first time she had removed the nasal canula. The resident stated that she removes her oxygen daily, and that facility staff are aware. The resident stated that staff had told her she could remove it, but the resident was unable to identify which staff member had told her that. The facility failed to consistently monitor Resident 72's compliance with oxygen use and oxygen saturation levels to timely identify the resident's oxygenation status and potential need for intervention. Interview with the Nursing Home Administrator (NHA) on April 24, 2024, at approximately 2:10 PM, confirmed that the physician's order for supplemental oxygen was not consistently followed for Resident 59, and 72, and oxygen equipment is to be kept clean, and maintained in a sanitary manner. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on observations, a review of the the minutes from Residents' Council meetings and grievances lodged with the facility, resident and staff interviews it was determined that the facility failed to provide food that accommodates resident preferences for 26 residents of 26 resident meal trays observed and as reported by nine residents out of 15 interviewed (Residents 1, 72, 73, 87, 88, 89, 91, 92, and 94). Findings include: A review of the minutes from the Resident Council meeting dated March 4, 2024, revealed that Resident 93 voiced concern that there has not been a good variety of food being offered at meals. A review of the minutes from the Resident Council meeting dated April 1, 2024, revealed that Resident 27 complained that the rice is always hard. Resident 93 voiced concern that the meat served during the St. Patrick's Day meal was tough and food is often hard or under cooked. A review of facility grievance dated February 23, 2024, indicated that Resident 44 complained that the scrambled eggs were burnt. The facility's response to that grievance was that the employee that was cooking had resigned and other cooks will be educated regarding proper cooking procedures. A review of facility provided BIMS (brief interview mental status - to assess cognitive status) report, and random interviews conducted on April 24, 2024, with 15 alert and oriented residents, to include six residents residing on nursing station 1, and nine residents residing on the nursing station 2, revealed that 9 residents interviewed expressed complaints/concerns regarding the preparation of the food, selection of food, and taste of food served at the facility Of those residents interviewed, 3 of 6 residents residing on nursing station 1, and 6 of 9 residents residing on nursing station 2, expressed concerns as described above. Interview with Resident 89 on April 24, 2024, at approximately 11:15 AM, revealed that it is her experience that the food is over cooked a lot. According to the resident, she has made this known to the kitchen/dietary staff. Interview with Resident 88 on April 24, 2024, at approximately 11:18 AM, revealed that the food tastes lousy, and is over cooked quite a bit. Interview with Resident 94 on April 24, 2024, at approximately 11:24 AM, revealed that it is his experience that the food served does not taste good, and that additional items like condiments and butter, are missing from his meal tray. The resident stated you never get it (butter and condiments). (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident 87 on April 24, 2024, at approximately 11:51 AM, the resident stated that she is not happy with some of the meals served and that her preferences are not accommodated. She stated that dietary staff documented her dislikes and preferences, but then she is not offered the food she likes, such as tacos and spaghetti. The resident stated that she has expressed this complaint to the facility's dietary staff in the recent past, without any changes in food service. Interview with Resident 92 on April 24, 2024, at approximately 11:54 AM, revealed that it is her experience that sometimes the food is good, but mostly not. Interview with Resident 73 on April 24, 2024, at approximately 11:57 AM, revealed that the food is not edible. Interview with Resident 1 on April 24, 2024, at approximately 12:07 PM, revealed that the food served is bland, and that additional items, like condiments and butter, are missing from her meal tray. The resident stated that butter is very scarce. Interview with Resident 72 on April 24, 2024, at approximately 12:10 PM, revealed that the food served is often salty, and that the vegetables are frequently overcooked. Interview with Resident 91 on April 24, 2024, at approximately 12:15 PM, revealed that it is her experience that the food is not too good. An observation of the lunch meal in the presence of Employee 3, Registered Nurse (RN) Unit Manager, on April 24, 2024, at approximately 12:31 PM, on nursing station 2, revealed 17 of 17 food trays observed had no butter on the resident meal trays (resident room [ROOM NUMBER] A/B, 58 B, 42 B, 43 A, 56 A/B, 44 A, 54 B, 53 B, 46 A, 47 A, 52 A, 48 B, 49 A/B, and 50 A), as confirmed by Employee 3 RN, Unit Manager. An observation of the lunch meal trays in the presence of Employee 1, Licensed Practical Nurse (LPN), on April 24, 2024, at approximately 12:40 PM, nursing station 1, revealed 13 of 13 food trays observed had no butter (resident room P 3, 17 A/B, 4, 5 A, 6 A, 7 B, 10 A, 15 A, 29 B, 28 A, 27 B, and 24 B), as confirmed by Employee 1 LPN. During an observation of the kitchen, on April 24, 2024, at approximately 12:50 PM, in the presence of the Employee 4, Dietary Manager, revealed 1 box of whipped spread, 900 count of individual packets, located in the walk-in cooler. A further observation of the box revealed it open and half empty. Employee 4, Dietary Manager stated there was approximately 500 individual packets left. The facility census on April 24, 2024, was 101. Employee 4, Dietary Manager acknowledged there were no butter packets on the resident food trays at today's lunch meal, and stated that butter (whipped spread) are only provided with certain food items such as dinner rolls, baked potatoes. Employee 4 stated that should a resident request butter, the staff would need to contact the kitchen and one packet would be provided because the butter packets (whipped spread) stay in the cooler at all times. Interview with the Nursing Home Administrator (NHA) on April 24, 2024, at approximately 2:05 PM, indicated the reason for the lack of butter observed was because today's meal did not call for butter, but when asked who decides whether a meal or food items calls for butter, the NHA responded the resident. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the NHA on April 24, 2024, at approximately 2:10 PM, confirmed the facility failed to consider individual food preferences, to increase resident satisfaction with meals, and failed to accommodate individual food preferences, to the extent possible, to increase resident satisfaction with meals. 28 Pa. Code 211.6 (a) Dietary services 28 Pa. Code 201.18 (a) Resident rights