

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395691	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/11/2024
NAME OF PROVIDER OR SUPPLIER  Riverstreet Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  440 North River Street Wilkes-Barre, PA 18702	

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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41460</b></p> <p>Based on a review of clinical records and select facility policy and staff interviews it was determined that the facility failed to provide emergency care consistent with a resident's advanced directives for one resident out of 14 residents reviewed (Resident CR1).</p> <p>Findings include:</p> <p>According to the national library of medicine, irreversible death is classified as a person having the following: rigor mortis (stiffening of the joints and muscles of a body a few hours after death), dependent lividity (pooling of blood to dependent areas resulting in a red/purple coloration), decapitation (total separation of the head from the body), transection (cut in half), and decomposition (the state or process of rotting)</p> <p>A review of Resident CR1's clinical record revealed admission to the facility on [DATE], with multiple diagnoses including cancer of the right lung, type 2 diabetes, heart disease, and anxiety.</p> <p>A review of Resident CR1's clinical record revealed a physician order dated [DATE], identifying the resident was to receive CPR (cardio pulmonary resuscitation-emergency lifesaving procedure performed when the heart stops beating or if the resident stops breathing. Immediate CPR can double or triple chances of survival after cardiac arrest) in the event of cardiac or pulmonary arrest.</p> <p>A nurse's note dated [DATE], at 11:15 AM, completed by Employee 3 (LPN), indicated that Resident CR1 was declining while in wheelchair, transferred to bed. Physician Assistant (PA) notified and at bed side. Resident expired. Resident pronounced by Physician assistant.</p> <p>A review of the PA's progress note dated [DATE], it revealed she was called to the room to see Resident CR1. The resident had been in the dayroom asking to go back to his room. He was wheeled back to his room and according to the PA's documentation he took his last breath while being placed back in bed. The progress note indicated the resident was found lying in bed, and unresponsive to verbal or noxious (painful) stimuli. The resident's pupils were fixed and dilated (when the pupil, round black part of the eye does not respond to light or fixed, indicating the brain is not responding to send a signal back to the eye to constrict, the pupil- fixed and dilated pupils are a sign if brain death) and his heart sounds could not be heard. The resident was without a pulse or respirations.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Although the resident's physician's orders indicated that if the resident were to suffer a cardiac or respiratory event the facility was to perform CPR in order to attempt to save the resident during a cardiac arrest, the facility failed to implement CPR as ordered.</p> <p>The facility failed to provide cardio-pulmonary resuscitation (CPR) to a resident who had requested this emergency care and was identified as a full code status (designation that means to intercede if a patient's heart stops beating or if the patient stops breathing).</p> <p>Interview with the Director of Nursing and Nursing Home Administrator on [DATE], at approximately 4:00 PM, confirmed that nursing staff failed to provide CPR according to the resident's wishes according to his advanced directive ( legal document that provide instructions for medical care and only go into effect if the resident's wishes could not be communicated) and physician order.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>41460</p> <p>Based on observation and staff interview, it was determined the facility failed to maintain an environment free of potential accident hazards and obstacles for safe mobility and use of mobility assistance devices on one of two resident units (Station 2).</p> <p>Findings include:</p> <p>An observation on August 11, 2024, at 8:50 AM of the hallway leading to the therapy department from the main entrance of the facility revealed 4 large reclining/wheelchairs lined up against the right-hand side of the wall.</p> <p>The hallway leading down the resident care area revealed multiple high back chairs setting outside of resident rooms, causing congestion in the hallways.</p> <p>These items obstructed continued access to the handrails which are to be used for resident ambulation or mobility assistance and did not create a homelike environment.</p> <p>During an interview August 11, 2024, the Nursing Home Administrator stated that resident care areas should be maintained in a clean and orderly manner.</p> <p>28 Pa. Code 201.18 (e)(2.1) Management</p> <p>28 Pa. Code 205.9 (c) Corridors</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>41460</p> <p>Post nurse staffing information every day.</p> <p>Based on observation and staff interview, it was determined that the facility failed to post nurse staffing information.</p> <p>Findings include:</p> <p>During an observation on August 11, 2024, at approximately 8:15 AM the facility's current posted nursing hours were not observed.</p> <p>Interview with Employee 1, a registered nurse supervisor, on August 11, 2024, at 8:46 AM, indicated she did not know what posted nursing time was.</p> <p>Interview with the facility's Assistant Director of Nursing on August 11, 2024, at approximately 9:45 AM confirmed the facility failed to post the daily nurse staffing data as required</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services</p> <p>28 Pa. Code 201.18 (b)(1)(3) Management</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41460</p> <p>Based on observation, review of select facility policy and staff interview, it was determined the facility failed to implement procedures to ensure acceptable storage for medications on one of two nursing units observed (Station 1).</p> <p>Findings include:</p> <p>A review of facility policy titled Discontinued Medications, provided by the facility on August 11, 2024, revealed that discontinued medications are destroyed or returned to the issuing pharmacy in accordance with facility policy and state regulations. This policy refers to the policy entitled Discarding and Destroying Medications.</p> <p>A review of facility policy titled Discarding and Destroying Medications provided by the facility on August 11, 2024, revealed that individual resident medications supplied in sealed unopened containers may be returned to the issuing pharmacy for disposition provided that all such medications are identified as to lot or control number and the receiving pharmacist and a registered nurse employed by the facility sign a separate log that lists the resident's name; the name, strength, prescription number, and amount of the medication returned; and the date the medication was returned. The medication disposition record contains, at a minimum, the following information: resident's name, name and strength of the medication, the prescription number, the name of the dispensing pharmacy, date medications destroyed, the quantity destroyed, method of destruction, reason for destruction, and signature of witnesses.</p> <p>Observation of the Station One medication room on August 11, 2024, at 8:53 AM, in the presence of Employee 2, a licensed practical nurse (LPN), revealed a mauve wash basin on the counter labeled Return to Rx [pharmacy]. The basin contained 16 medication cards that needed to be returned to the pharmacy.</p> <p>Interview with Employee 2 indicated that it is the responsibility of the registered nurse supervisor to inventory the medications, complete disposition paperwork, and return the medications to pharmacy. Employee 2 stated the medication nurse removes any medications from their cart that are no longer in use due to a resident's discharge, death, or discontinuation. The medications are removed from the cart and placed in the bin in the medication room. The medication nurse does not complete disposition of medication paperwork when the medication is removed from the cart.</p> <p>Observation of the basin revealed that medications prescribed for Resident CR4 who was discharged on [DATE], remained in the medication room, awaiting return to the pharmacy. There was no evidence that a medication disposition form had been completed at time of survey ending August 11, 2024.</p> <p>Observation of an unlocked drawer located at the nurse's station on August 11, 2024, at 9:00 AM, in the presence of Employee 2, LPN, revealed a blue zipper pouch filled with numerous single use vials of medications.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The zipper pouch contained;</p> <p>(17) 2ml vials of Methylprednisolone 20mg,</p> <p>(7) 2ml vials of Lidocaine 1%,</p> <p>(3) vials of Methylprednisolone 40mg,</p> <p>(1) vial of Vancomycin 1 gm labeled for intravenous use only, and</p> <p>(2) vials of Piperacillin &amp; Tazobactam 4.5 gm labeled for intravenous use only.</p> <p>None of the medications within the zipper pouch were labeled as prescribed for any resident residing in the facility.</p> <p>Further review of the drawer revealed;</p> <p>(1) bottle of SPS (Sodium polystyrene sulfonate) 15 gm/60 mL suspension (medication to treat high potassium in blood stream). The medication label indicated it was prescribed for Resident 19,</p> <p>(5) single pill packets of Fluconazole 150mg prescribed for Resident 11,</p> <p>(3) full tubes of Santyl ointment prescribed for Resident 10,</p> <p>a box containing a full tube of Triamcinolone 0.5% cream prescribed for Resident 13,</p> <p>(3) boxes of Narcan nasal spray 4mg, and</p> <p>(1) box of Scopolamine transdermal patches.</p> <p>Employee 2 confirmed at time of observation the medications were not stored properly. Employee 2 stated the Station 1 registered nurse unit manager keeps the medications on hand in the event pharmacy can't deliver timely and that some medications the unit manager keeps due to theft. According to Employee 2, the drawer at the nurse's station is usually locked.</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on August 11, 2024, at approximately 10:00 AM confirmed the medications at the nurse's station were not stored accordingly, labeled accordingly, and/or returned to pharmacy according to policy.</p> <p>28 Pa. Code 211.9 (a)(1)(j.1)(1)(2)(3)(4)(5)(k) Pharmacy Services</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>41460</p> <p>Based on review of clinical records, observation and staff interview it was determined the facility failed to maintain accurate and complete clinical records for three out of 14 residents reviewed. (Residents 7, 11, and 14)</p> <p>Findings included:</p> <p>The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound 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.</p> <p>According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care:</p> <p>Assessments</p> <p>Clinical problems</p> <p>Communications with other health care professionals regarding the patient</p> <p>Communication with and education of the patient, family, and the patient ' s designated support person and other third parties.</p> <p>A review of Resident 7's clinical record revealed that on July 18, 2024, treatments scheduled for the 3:00 PM to 11:00 PM shift were signed out as completed by Employee 4, the facility's licensed practical nurse who functioned as a unit secretary. According to the treatment record, Employee 4 documented that she completed the following scheduled treatments for Resident 7 at 2:50 PM:</p> <p>Tabs alarm (resident safety alarm to notify staff of a resident fall) checked on the resident's chair and ensure placement and function on every shift,</p> <p>Tabs alarm on the resident's bed, ensure placement and function every shift,</p> <p>check placement of dressing to left buttock every shift, and , check inflation and settings every shift of the mattress.</p> <p>A review of Resident 11's clinical record revealed that on July 18, 2024, the following treatments scheduled for the 3:00 PM to 11:00 PM shift were signed out as completed by Employee 4 at 3:01 PM:</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>apply zinc oxide to scabbed MASD (moisture associated skin damage) of the left buttock and cover with foam dressing every evening shift,</p> <p>check placement of dressing to left buttock every shift,</p> <p>apply skin prep to bilateral heels and ensure that heels are off loaded,</p> <p>monitor skin for any changes every shift,</p> <p>check dialysis access site dressing every shift and reinforce as needed, notify physician as needed, and dialysis on hold until further notice.</p> <p>A review of Resident 14's clinical record revealed that on July 18, 2024, the following treatments scheduled for the 3:00 PM to 11:00 PM shift were signed out as completed by Employee 4 at 2:47 PM:</p> <p>apply skin prep to bilateral heels and ensure that heels are off loaded every shift,</p> <p>apply skin prep to Stage 1 pressure ulcers and bilateral heels every shift,</p> <p>apply zinc oxide barrier cream for MASD to bilateral groins/scrotum cleanse with soap and water and pat dry,</p> <p>check placement of dressing to right medial malleolus (inner ankle) every shift,</p> <p>keep heels off of bed with heels up device every shift,</p> <p>apply skin prep to stage 1 pressure ulcer right lateral foot beneath 5th toe every shift,</p> <p>apply zinc oxide to MASD on sacrum every shift,</p> <p>apply zinc oxide to MASD left buttock every shift,</p> <p>Tab alarm to bed, check placement and function every shift, and Tab alarm to wheelchair, check placement and function every shift.</p> <p>Review of nurse staffing schedule for July 18, 2024, failed to provide evidence that Employee 4 was scheduled to work as an assigned nurse in the facility on that date.</p> <p>Interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on August 11, 2024, at approximately 12:00 PM revealed that Employee 4 is hired as an LPN Unit Secretary and will at times assist on the floor with duties of the LPN in addition to secretarial duties. The NHA and DON confirmed there was no evidence that Employee 4 was scheduled to work as an LPN on July 18, 2024 therefore there was no reason as to why Employee 4 documented that she completed the aforementioned treatments for the residents .</p> <p>The NHA and DON further confirmed the treatments signed out as completed by Employee 4 were signed out prior to the start of the 3:00 PM to 11:00 PM shift.</p> <p>(continued on next page)</p>		

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