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	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverstreet Manor	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and staff interview, it was determined that the facility failed to maintain a clean and sanitary environment for 2 of 2 resident shower areas in the facility and maintain a clean and safe outdoor smoking area Findings include: On October 21, 2025, at 1:00 P.M., observations of the Area 145 shower/bathroom revealed multiple items stored inappropriately within resident bathing areas, including two shower chair buckets, a mechanical lift sling, a pair of sneakers, and an open plastic bag of briefs placed inside the bathtub. The bathtub's waterspout was coated with a thick layer of dried white residue. In the first shower stall, the perimeter of the floor was coated with a black, sticky substance. The floor surface showed visible soil and buildup. A stainless-steel soap dispenser on the wall exhibited visible streaks and brown discoloration, and the ceiling vent was layered with lint. The air conditioning/heating ceiling unit also had visible accumulations of dust and debris. The shower bed in the second shower stall was observed with a white powdery film and areas of dried residue. In the Area 158 shower room, the perimeter of the flooring contained a similar black, sticky buildup. A large rust stain was visible on the wall beneath the handrails. Two ceiling cuts were noted, and the ceiling vent displayed significant lint accumulation. A shower chair within this area was stained with brown discoloration. The wheelchair scale had visible buildup and liquid residue, and the stand-up mechanical lift showed dried deposits and surface staining. The bathtub in the same area contained a pair of wheelchair leg rests. The floors throughout the shower room exhibited visible debris, including plastic and paper materials, and the edges contained black adhesive-like residue. An observation of the outdoor smoking area near the laundry entrance revealed extensive cigarette litter across the concrete surface, including ashes and cigarette butts. Three white plastic patio chairs were coated with black residue consistent with cigarette ash. The patio table contained ashes and cigarette debris. Four surrounding fabric chairs appeared worn and soiled, with several burn holes noted on the seat fabric. During an interview on October 21, 2025, at 3:00 P.M., the Nursing Home Administrator acknowledged that all facility areas are expected to be always maintained in a clean and sanitary condition.28 Pa. Code 201.18 (e)(1) (2.1) Management

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

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	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverstreet Manor	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverstreet Manor	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, the facility's abuse prohibition policy, facility investigative documentation, and staff interviews, it was determined the facility failed to ensure that a resident was free from neglect by not providing care with the required assistance of two staff members as planned to ensure safety and prevent major injuries. As a result, one resident (Resident 1) sustained multiple subdural hematomas and closed nasal fracture requiring hospital evaluation, representing actual harm for one resident out of one sampled for abuse prohibition.Findings include: A review of the facility's policy entitled Abuse and Neglect Clinical Protocol, last reviewed by the facility on May 2, 2025, defined neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. It is the policy of the facility, as part of the strategy to prevent abuse, neglect, mistreatment, and exploitation of residents, that volunteers, employees, and contractors hired by the facility are expected to be able to identify neglect as it may occur against residents and prevent resident neglect as a priority throughout all levels of the organization. A review of the facility's policy entitled Managing Falls and Fall Risks, last reviewed by the facility on May 2, 2025, revealed it is the policy of the facility that based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. A clinical record review revealed Resident 1 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis (severe weakness or paralysis on one side of the body) due to cerebral infarction (brain tissue damage caused by interruption of blood flow). A Minimum Data Set Assessment (MDS, a federally mandated standardized assessment process conducted at specific intervals to plan resident care) of Resident 1, dated September 18, 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) and indicated the resident was dependent (relying on someone for physical support) for rolling side to side in bed. Review of Resident 1's care plan for risk of falls, initiated December 28, 2021, indicated the resident was at risk for falls due to impaired balance, poor coordination, and a history of falls. Interventions included the use of a bariatric bed (type of bed used to accommodate overweight or larger individuals) and mattress and encouragement to change positions slowly. Continued review of Resident 1's current comprehensive person-centered care plan indicated the resident had an ADL (activities of daily living) self-care performance deficit related to physical limitations. Planned resident-centered interventions revealed the resident required two-staff assistance with bed mobility initiated on May 6, 2024, with revision on September 29, 2025. A clinical record review for Resident 1 revealed a form titled Lift, Transfer, and Reposition, dated September 12, 2025, that revealed Resident 1 required two staff members for repositioning in bed. A nurse's progress note written by Employee 1 (Registered Nurse Supervisor) dated October 10, 2025, at 2:25 AM, documented that on October 9, 2025, at 10:20 PM, Employee 1 received notification from the nurse assigned to Resident 1 that Resident 1 had been found lying on the floor on their back after a fall from bed. Upon assessment, Resident 1 was noted to have a superficial laceration (wound) on the bridge of the nose measuring 1.2 centimeters (cm) in length and two additional superficial cuts on the forehead measuring 0.5 cm and 0.8 cm, accompanied by mild swelling. Resident 1 complained of right shoulder pain. The bleeding was controlled, the physician was notified of the incident, and orders were received to transfer Resident 1 to the emergency department for further evaluation. Resident 1 was subsequently transported to the hospital for medical assessment and treatment. A nurse's progress note written by Employee 1 (RN Supervisor) dated October 10, 2025, at 2:53 AM revealed that an in-service was conducted with the assigned aide for Resident 1 regarding proper two-person assist for dependent residents, and emphasizing stabilization during turning and hygiene care A review of outside hospital records provided by the facility, dated October 10, 2025, revealed that Resident 1 presented to the emergency department after a fall at the facility that occurred while an aide was rolling Resident 1 during routine care. The documentation indicated that Resident 1 fell onto his right shoulder and forehead, resulting in an abrasion (a scrape or rubbing away of the skin) and a hematoma (a localized collection of clotted blood outside the blood vessels) extending from the nasal bridge into the forehead. A CT scan (computed tomography imaging test that uses X-rays and a computer to create detailed cross-sectional images of the body) of the head revealed

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	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverstreet Manor	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined the facility failed to maintain food delivery equipment in a clean and sanitary condition to prevent potential food contamination for four of four food delivery carts observed (Pine, Oak, Willow, and Spruce hallways).Findings include: Safe food handling and sanitation standards established by the United States Department of Agriculture (USDA) and Food and Drug Administration (FDA) require all equipment and utensils used in the storage, preparation, and delivery of food to be kept clean and in good repair. Equipment must undergo a two-step process consisting of cleaning (removal of visible soil and debris) and sanitizing (application of heat or chemical solution to reduce microorganisms that may cause illness). Harmful bacteria that cause foodborne illness cannot be seen, smelled, or tasted; therefore, strict adherence to cleaning and sanitizing procedures is required to prevent contamination. On October 21, 2025, the following observations were made during meal service: At 11:45 AM, the stainless-steel food delivery cart on the Pine hallway had a large amount of dried food and liquid residue on the top, sides, and doors. The interior floor of the cart contained accumulated food particles, paper debris, and visible dirt. At 11:55 AM, the stainless-steel food delivery cart on the Oak hallway had dried food residue, liquid stains, and visible dirt on the exterior and interior surfaces. At 12:10 PM, the stainless-steel food delivery cart on the [NAME] hallway had dried food and liquid residue on the top, sides, and doors, with paper debris and dirt on the floor of the cart. At 12:30 PM, the stainless-steel food delivery cart on the Spruce hallway had dried food and liquid residue on the top and doors, with accumulated food debris and dirt on the floor of the cart. The metal shelving unit on the left side of the cart was broken, and the detached metal brackets were resting inside the cart. During an interview on October 21, 2025, at 3:15 PM, the Nursing Home Administrator, the above observations were reviewed. 28 Pa code 201.18(b)(1) Management

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	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverstreet Manor	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)
F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. (continued on next page)

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	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverstreet Manor	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)
F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical records, facility policy, and resident and staff interviews, it was determined the facility failed to implement its established smoking policy to ensure resident safety. The facility failed to post the smoking policy in a conspicuous and legible manner, failed to ensure that required smoking safety equipment was available in the designated smoking area, and failed to ensure smoking materials were properly secured for nine residents who smoke (Residents 2, 3, 4, 5, 6, 7, 8, 9, and 10).Findings include: A review of the facility's policy titled Facility Smoking Policy, last reviewed May 2, 2025, revealed that smoking be permitted only in designated areas that are separate from resident care areas, well ventilated, and equipped with portable fire extinguishers. The policy identified the designated smoking location as the courtyard accessible through the door near the laundry and outside the Station 1 dayroom, prohibited oxygen use in smoking areas, and required that residents be evaluated for smoking safety upon admission and re-evaluated quarterly and with a change in condition. The policy required that residents be supervised until evaluated as safe to smoke independently, that smoking times be scheduled at 10:30 AM, 1:30 PM, 4:00 PM, and 7:00 PM, and that each resident's smoking status be reflected in the care plan. In addition, the policy required smoking supplies, including cigarettes, matches, and lighters, to be labeled with the resident's name and room number, maintained by staff, and stored at the reception desk. Residents were not permitted to keep their own lighters, lighter fluid, or matches. During the entrance conference on October 21, 2025, at approximately 10:00 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed that the facility permits smoking in designated areas. A list of smoking residents provided by the facility included Residents 2, 3, 4, 5, 6, 7, 8, and 9. Resident 10 was observed smoking during the survey but was not included on the list provided to the survey team. An observation conducted on October 21, 2025, at approximately 10:15 AM, revealed Residents 3 and 4 smoking on the patio outside the laundry room without staff supervision. Each resident possessed their own cigarettes and lighter and independently lit their cigarettes. Resident 2 was observed entering a door code into the keypad outside the smoking entrance door. Resident 2 was interviewed at that time and stated that she knew the door code and went to the smoking area independently in her wheelchair whenever she wished. She stated she did not wear a smoking apron and kept her cigarettes and lighter at her bedside. Further observation of resident areas and lobby spaces on October 21, 2025, revealed that the facility's smoking policy was not posted in any resident area or common space. At approximately 10:20 AM the same day, Residents 3 and 4 were interviewed and stated that they knew the door code to the smoking area and went out to smoke without notifying staff. They reported they kept their smoking materials and smoked independently. An observation on October 21, 2025, at 10:53 AM revealed Resident 10 in her wheelchair in the first-floor A hallway with a pack of cigarettes and a lighter in her lap. She wheeled herself to the smoking area door, entered the key code, went outside to the patio, lit her cigarette, and began smoking without staff supervision. Resident 2 was admitted [DATE], with a diagnosis of emphysema (a chronic, progressive lung disease that causes shortness of breath). A smoking assessment dated [DATE], identified her as an independent smoker. A care plan initiated April 18, 2024, directed staff to check her room for smoking materials, secure smoking materials at the front-lobby reception desk, and educate family and visitors not to leave smoking items in her room. Resident 3 was admitted to the facility on [DATE], with diagnosis to include Chronic Obstructive Pulmonary Disease (COPD). A quarterly MDS (Minimum Data Set, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated September 8, 2025, revealed a BIMS score of 15 (Brief Interview for Mental Status) is a mandatory tool used to screen and identify the cognitive condition of residents a score of 13 to 15 indicates intact cognition). A smoking assessment dated [DATE], identified him as an independent smoker. His care plan, dated August 19, 2025, directed staff to educate family and visitors not to leave smoking materials in his room and to store such materials at the front-lobby desk. Resident 4 was admitted [DATE], with a diagnosis of COPD. A quarterly MDS dated [DATE], revealed a BIMS score of 15 (cognitively intact). A smoking assessment dated [DATE], identified him as an independent smoker. A care plan initiated May 21, 2025, and revised June 24, 2025, instructed staff to check his room for smoking materials, secure them at the reception desk, educate family and visitors about smoking policies, and ensure oxygen was removed before smoking and replaced after. Resident 5 was admitted [DATE], with COPD. A quarterly MDS dated [DATE], revealed a BIMS score of 15 (cognitively intact). A smoking assessment dated [DATE], identified her