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	12/30/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policies, clinical records, grievances filed with the facility, and staff interviews, it was determined that the facility failed to make prompt and adequate efforts to resolve a resident grievance in accordance with facility policy, for one of ten residents sampled (Resident 1).Findings Include: A review of facility policy entitled Grievance Process Procedure last reviewed by the facility on May 2, 2025, revealed it is the policy of the facility to make prompt efforts to resolve resident grievances to the satisfaction of the resident and or resident representative. The policy indicated a resolution of the concern is desired within five (5) working days from the date the concern was filed. The policy indicated routine follow up on concerns that are outstanding will be completed through the morning process meeting. The policy further identified the grievance official as the Nursing Home administrator (NHA). A grievance is defined as a formal or informal complaint or concern expressed by a resident or resident representative regarding care, services, or conditions at the facility. A review of Resident 1's clinical record revealed the resident was admitted to the facility on [DATE], at 5:20 PM, with diagnoses to include frequent falls and chronic pain syndrome (a condition characterized by persistent pain lasting longer than three months) and was discharged from the facility on November 15, 2025. A review of a Grievance/Concern Form filed by Resident 1 on November 7, 2025, revealed the resident reported that he did not receive his prescribed oxycodone 10 mg (a narcotic analgesic medication prescribed for the treatment of moderate to severe pain and requires timely administration as ordered to manage pain) upon admission to the facility. Further review of the grievance form indicated the grievance was assigned to the Director of Nursing and Unit Manager for follow up. A review of Resident 1's Medication Administration Record and progress notes revealed the resident's ordered narcotic pain medication was not administered until November 8, 2025, at 4:56 PM, following admission to the facility. Further review of the grievance documentation revealed social services met with Resident 1 to discuss the concern on November 10, 2025. Review of the grievance resolution section indicated the grievance was closed with the notation that the resident was discharged prior to resolution. The grievance form was signed by the Nursing Home Administrator, identified by policy as the grievance official. Review of the timeline revealed the resident remained in the facility for eight days following the filing of the grievance, exceeding the facility's stated five working day timeframe for grievance resolution. There was no documented evidence that the facility timely evaluated the resident's grievance regarding the failure to receive prescribed narcotic pain medication upon admission. There was no documented evidence of attempts to resolve the grievance within five working days, as required by facility policy, nor was there documentation of corrective action, findings, or communication of a resolution to the resident prior to discharge. An interview with the Nursing Home Administrator on December 30, 2025, at 1:00 PM, revealed that the Director of Nursing printed the resident's Medication Administration Record in response to the grievance; however, the Nursing Home Administrator confirmed no further action was taken to resolve the grievance. An interview with the Nursing Home Administrator on December 30, 2025, at 1:40 PM, reviewed the above findings and confirmed the facility did not resolve Resident 1's grievance regarding the receipt of prescribed oxycodone prior to discharge. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa Code 211.10 (c) Resident care policies.28 Pa. Code 211.12 (c)(d)(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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident clinical records, select facility policy, and staff interview it was revealed that the facility failed to assure that one of 10 residents reviewed were free of significant medication errors. (Resident 1)Findings include: A review of a facility policy, entitled Reconciliation of Medications on Admission last reviewed by the facility on May 2, 2025, defined the medication reconciliation process as the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescriptions. The policy further detailed the steps in completing a medication reconciliation which included gathering the information needed to reconcile the medication list by using the approved medication reconciliation form, the discharge summary from the referring facility, the admission order sheet, and all prescription and supplement information obtained from the resident/family during the medication history. The policy further explained that the medication reconciliation process is used to ensure that all medications, routes, and dosages on the list are appropriate for the resident and his/her condition. The policy explained that medication reconciliation helps to ensure the medications, routes and dosages have been accurately communicated to the Attending Physician and care team. The steps portion of the policy directed staff to ask the resident or responsible party to list all physician and pharmacies from which he or she obtained medications. The policy revealed that if there was a discrepancy between documentation, the staff member was to contact the nurse from the referring facility, contact the physician from the referring facility, discuss the findings with the resident/family, contact the residents outside provider and pharmacies for an accurate list of current medications. The policy then directed staff to document any discrepancy on the medication reconciliation form, what actions were taken by the nurse to resolve the discrepancy, and document whether the discrepancy was resolved or not. A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnosis to include hypertension (a condition blood pushes too forcefully against artery walls) and hypothyroidism (a condition when the thyroid gland doesn't make enough thyroid hormone). A review of Resident 1's clinical record revealed that upon admission, records were obtained from the referring facility which included a current medication list dated November 3, 2025. The list included the following medications:Sennoside 8.6mg-1 tablet by mouth twice a day for constipation.Pantoprazole 40mg- 1 tablet by mouth daily for acid reflux.Tiotropium 2.5mcg- 2 inhalations by mouth daily for breathing.Bacitracin 500units/gm ointment- apply moderate amount topically twice a day for skin infection.Aspirin 81mg- take one tablet by mouth daily every day for heart health.Oxybutynin 5mg- take one tablet by moth twice a day for overactive bladder.Levothyroxine 175mg- take one tablet by mouth every day at 6am for thyroid hormone replacement.Fluticasone/Salmeterol- inhale 1 puff by mouth twice a day for breathing. Semaglutide 0.25mg/0.375ml- Inject 0.5mg subcutaneously once weekly for diabetes.Hydrophilic cream- apply small amount topically every day for dry skin.Oxycodone 10mg- Take one tablet every 4 hours for pain.Losartan 50mg- Take one half tablet by mouth daily for blood pressure.Gabapentin 300mg- take one capsule by mouth three times a day for pain.Magnesium oxide 400mg- take one tablet by mouth daily for low magnesium.Famotidine 20mg- take one tablet by mouth twice daily.Finasteride 5mg- take one tablet by mouth daily for prostate. Apixaban 5mg- take 1 tablet every 12 hours for atrial fibrillation (an irregular heartbeat).Acetaminophen 325mg- take one tablet every 4 hours as needed for pain.Allopurinol 300mg- take one tablet by mouth daily for gout (an inflammatory disease). Ferrous Gluconate 324mg- take one tablet every other day for iron replacement.Furosemide 40mg- take one tablet by mouth daily for swelling and blood pressure.Tamsulosin 0.4mg- take one capsule by mouth twice a day for enlarged prostate (male reproductive gland).Further review of Resident 1's clinical record revealed the facility failed to ensure an accurate and complete medication reconciliation was completed upon admission, resulting in the resident being placed on medications that had been previously discontinued.A review of Resident 1's clinical record revealed that upon admission, the resident was placed on the following medications that were not included on the current medication list provided by the referring facility:Methimazole 10 mg, administer one half tablet by mouth every Saturday and Sunday for hyperthyroidism (a condition in which the thyroid gland produces excessive thyroid hormone), despite referring facility documentation indicating the resident was being treated with levothyroxine 175 mcg for hypothyroidism (a condition in which the thyroid gland does not produce enough thyroid hormone), representing conflicting thyroid therapies.Simvastatin 40 mg, one tablet by mouth in the evening for high cholesterol, despite the medication not being included on the current medication list from the referring facility