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	05/28/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **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 that the facility failed to ensure a timely and comprehensive skin assessment was completed upon readmission to identify and evaluate an existing pressure injury and guide treatment interventions for one of seven sampled residents reviewed for skin integrity concerns (Resident A1).Findings include:According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, Standardized pressure ulcer risk assessment and care planning and implementation to address the areas of risk. The American College of Physicians (ACP) is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States) Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e. support surfaces, repositioning and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement and wound cleansing; using adjunctive therapies; and considering possible surgical repair. A review of a facility policy entitled Pressure Ulcers/Skin Breakdown -Clinical Protocol last reviewed May 1, 2026, indicated the nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers. In addition, the nurse shall describe and document/report the following: a full assessment of pressure sore including location, stage, length, width, depth, and presence of exudates or necrotic tissue; pain assessment; resident's mobility status; current treatments including support surfaces; and all active diagnoses. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions. The physician will assist the staff to identify the type (for example, arterial or stasis) and characteristics (presence of necrotic tissue, status of wound bed, etc.) of an ulcer. Clinical record review revealed Resident A1 was originally admitted to the facility on [DATE], with diagnoses that included a history of transient ischemic attack (TIA, commonly referred to as a mini-stroke, which occurs when blood flow to part of the brain is temporarily blocked), cerebral infarction (an ischemic stroke caused by loss of blood flow to brain tissue), heart failure (a condition in which the heart cannot pump blood effectively enough to meet the body's needs), and occlusion and stenosis of the carotid arteries (narrowing or blockage of the major arteries that supply blood and oxygen to the brain). A review of the resident's care plan, initiated May 14, 2026, identified Resident A1 was at risk for altered skin integrity related to impaired mobility. The goal was to minimize skin breakdown and maintain skin integrity. Planned interventions included use of a pressure-relieving wheelchair cushion, consultation with wound care specialists, assistance with repositioning, use of a pressure-reducing mattress, administration of preventive skin treatments as ordered, and observation and reporting of changes in skin condition. Clinical record review revealed Resident A1 experienced a change in condition and transferred to the hospital on May 19, 2026. The resident was readmitted to the facility on [DATE]. A review of the hospital Discharge summary dated [DATE], at 2:09 PM (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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented the presence of a sacral wound (a type of pressure injury or ulcer that develops over the sacrum, the triangular bone at the base of the spine, due to prolonged pressure that impedes blood flow and damages tissue). A review of a nursing progress note dated May 24, 2026, at 4:46 PM documented the resident's return to the facility and indicated hospital discharge orders were reviewed with the attending physician. Review of physician orders revealed an order dated May 24, 2026, to cleanse a Stage 2 pressure ulcer (a partial-thickness skin loss involving the outer layers of skin and typically presents as a shallow open wound or blister) of the sacrum with normal saline solution, pat dry, apply hydrogel, a moisture-retaining wound treatment used to promote healing, and cover the wound with bordered gauze. Despite documentation from the hospital identifying the presence of a sacral pressure ulcer and physician orders directing wound treatment upon readmission, review of the clinical record failed to reveal documented evidence that licensed nursing staff completed a comprehensive skin assessment upon the resident's return to the facility on May 24, 2026. A review of the clinical record failed to reveal documentation identifying the wound's measurements, wound bed characteristics, presence or absence of drainage, condition of the surrounding tissue, pain assessment, or a comprehensive staging assessment upon readmission. Additionally, the clinical record failed to reveal documentation that nursing staff completed and recorded the assessment components required by facility policy to evaluate and monitor an existing pressure injury. A review of nursing documentation revealed a skin and wound evaluation completed by the contracted wound care specialist on May 27, 2026, at 2:36 PM. The wound care note documented that the coccyx/sacral wound contained 100 percent slough (a yellow or white nonviable tissue that can delay wound healing and increase the risk of infection). The wound was reclassified as an unstageable pressure injury, meaning the true depth of the wound could not be determined because the wound bed was completely covered with dead tissue. The wound measured 1.0 centimeters in length, 2.0 centimeters in width, and 0.5 centimeters in depth and contained exposed dermal tissue with a light amount of serous exudate a clear, thin, watery fluid produced by the body in response to tissue injury or inflammation). The wound care specialist recommended new treatment interventions including cleansing the wound with normal saline solution, applying Santyl (an enzymatic debridement medication used to remove dead tissue from chronic wounds) covering the wound with a bordered dressing, and changing the dressing daily. The wound characteristics documented by the contracted wound care specialist on May 27, 2026, had not been identified or documented by facility nursing staff upon the resident's readmission on [DATE]. During an interview with the Director of Nursing (DON) on May 28, 2026, at 2:15 PM, the above findings were reviewed. The Director of Nursing stated that skin assessments were expected to be completed and documented by licensed nursing staff upon readmission to identify existing skin impairments and facilitate timely treatment. The facility was unable to provide documentation demonstrating that licensed nursing staff completed the comprehensive skin assessment required by facility policy upon the resident's readmission on [DATE]. The facility failed to ensure a timely and comprehensive skin assessment was completed and documented upon readmission to identify existing skin impairment, evaluate wound characteristics, and guide appropriate interventions to promote healing in accordance with facility policy and accepted standards of practice. 8 Pa. Code 211.10(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 a review of select facility policies, clinical records, resident assessments, grievance documentation, and staff interview, it was determined that the facility failed to develop and implement an individualized bowel and bladder incontinence management program for one of seven residents reviewed for the timely provision of staff assistance with toileting and management of urinary and bowel incontinence (Resident B2).Findings include: A review of facility policy titled Urinary Continence and Incontinence Assessment and Management reviewed by the facility on May 1, 2026, revealed the staff and practitioner will appropriately screen form, and manage individuals with urinary incontinence. As part of the initial and ongoing assessments, the nursing staff and physician will screen for information related to urinary incontinence. Periodically, as required and when there is a change in voiding, staff will define each individual's level of continence, referring to criteria in the Minimum Data Set (MDS). If the residents are incontinent, staff will initiate a toileting plan. Staff will provide scheduled toileting, prompted voiding, or other interventions to try to manage incontinence. Toileting programs will start with a three-to-five-day toileting assistance trial. The staff will document the results of the toileting trial in the resident's medical record. If the resident does not respond or does not try to toilet, or for those with such severe cognitive impairment, staff will use a check and change strategy. A check and change strategy involves checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort and skin integrity. A clinical record review revealed that Resident B2 was admitted to the facility on [DATE], with diagnoses that included dementia (a progressive brain disorder that impairs memory, thinking, reasoning, and the ability to perform daily activities) with behavioral disturbances (patterns of disruptive or inappropriate behaviors that interfere with daily functioning and emotional regulation). A review of the resident's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 29, 2026, revealed that Resident B2 had severe cognitive impairment with a BIMS score of 3 (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 0-7 indicates severe cognitive impairment) The assessment identified that Resident B2 was always incontinent of both bladder and bowel and was not receiving a toileting program to manage incontinence. A review of the resident's care plan revealed a urinary incontinence (involuntary loss of urine or inability to control bladder function resulting in loss of urine) care plan initiated on July 4, 2025, and last revised on May 19, 2026. The care plan identified urinary incontinence related to disease process, impaired mobility, physical limitations, severe cognitive impairment without perception to void (urinate), and recurrent UTIs (urinary tract infections, infections involving the urinary system, including the bladder and urethra). The care plan established goals for the residents to remain as clean, dry, and comfortable as possible, remain free from complications associated with incontinence, and remain free from skin breakdown. Planned interventions included providing toileting assistance or incontinent care as needed, providing incontinence care and comfort measures, using absorbent briefs as needed, and applying barrier cream after perineal care and as needed. A clinical record review revealed an Annual Resident Observation assessment dated [DATE], at 11:14 AM, documenting that Resident B2 utilized pads and briefs and was incontinent of bowel and bladder without awareness or perception of the need to urinate or defecate (bowel movement). A review of nursing documentation dated March 17, 2026, documenting an evaluation following reports of projectile vomiting on March 16, 2026, accompanied by increased abdominal discomfort and pressure. Diagnostic testing was ordered. A KUB (an abdominal x-ray used to evaluate the kidneys, ureters, and bladder) revealed no acute findings. However, a UA (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C&S (urinalysis with culture and sensitivity testing, used to identify urinary tract infections and determine effective antibiotic treatment) revealed a bacterial count of 50,000 to 100,000 colony-forming units per milliliter (CFU/mL) of Pseudomonas (a bacteria commonly associated with urinary tract infections commonly found in water, soil, and moist healthcare environments). The physician ordered Cipro (ciprofloxacin, an antibiotic used to treat bacterial infections) 500 milligrams twice daily for seven days to treat the UTI. A review of Resident B2's Medication Administration Record, (MAR legal record documenting medications administered to a resident), dated March 2026 revealed the resident received all 14 doses of Cipro 500 mg as prescribed by the attending MD for UTI. A review of the Documentation Survey Report v2 for March 2026 revealed nursing staff documented only that incontinence checks and care were completed during each shift, approximately every eight hours. The documentation identified Resident B2 as incontinent of both urine and bowel movements; however, the report contained 15 separate shifts with blank documentation regarding incontinence care. A review of the Documentation Survey Report v2 for April 2026 similarly revealed staff documented incontinence checks and care only once per shift. The report identified Resident B2 as always incontinent of urine and bowel movements and contained 18 separate shifts with blank documentation regarding incontinence care. Documentation Survey Reports for March and April 2026 reflected incontinence care documentation only once per shift, approximately every eight hours. A review of a grievance filed on behalf of Resident B2 dated April 22, 2026, documented concerns that staff were not consistently completing incontinence checks, resulting in the resident remaining wet for extended periods of time. Despite the resident's documented severe cognitive impairment, continuous bowel and bladder incontinence, inability to perceive the need to toilet, recurrent urinary tract infections, and the facility policy directing implementation of a check-and-change program for such residents, the clinical record failed to reveal evidence that staff developed, implemented, monitored, or documented an individualized incontinence management program. Specifically, the record lacked evidence of a check-and-change protocol, scheduled toileting program, prompted voiding program, toileting trial, established toileting intervals, monitoring records, or evaluation of the effectiveness of any incontinence management intervention. Specifically, despite facility policy requiring implementation of a toileting plan for incontinent residents and a check-and-change program for residents with severe cognitive impairment, Resident B2's clinical record failed to contain evidence of a toileting assistance trial, scheduled toileting program, prompted voiding program, check-and-change protocol, established toileting intervals, monitoring records, documentation of program effectiveness, or individualized interventions directing staff regarding the frequency of incontinence care. The care plan failed to include specific individualized interventions directing staff regarding the frequency and method of toileting assistance or incontinence management necessary to address the resident's known continence needs. During an interview on May 28, 2026, at 2:00 p.m., the Director of Nursing reviewed the above findings and stated that Resident B2 was always incontinent of urine and bowel movements and should have been checked and changed every two hours. The Director of Nursing was unable to provide documented evidence demonstrating that two-hour check-and-change interventions were consistently implemented or documented for Resident B2. 28 Pa. Code 211.10(a)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.