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	06/24/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy, documentation provided by the facility, and resident and staff interviews, it was determined the facility failed to implement abuse prevention procedures to protect one resident out of ten residents reviewed (Resident 7) following allegations of sexual abuse perpetrated by a facility employee (Employee 2, nurse aide). Findings include: A review of the facility policy titled Abuse, Neglect, Exploitation, or Misappropriation Prevention Program, last reviewed by the facility on May 1, 2026, revealed it is the facility policy that residents have the right to be free from abuse. The policy indicated the resident abuse prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: protect residents from any further harm during investigations. A review of the facility policy titled Abuse, Neglect, Exploitation, or Misappropriation Reporting and Investigation, last reviewed by the facility on May 1, 2026, revealed it is the facility policy that all reports of resident abuse are thoroughly investigated by facility management. The policy indicated that upon receiving any allegation of abuse, the administrator is responsible for determining what actions (if any) are needed for the protection of residents. The policy stated, Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. A clinical record review revealed Resident 7 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and chronic kidney disease (gradual loss of kidney function). A review of Resident 7's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 7, 2026, revealed that Resident 7 was cognitively intact with a BIMS score of 15 (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 13 through 15 indicates cognition is intact). Employee 1, Nurse Aide (NA), documented that Resident 7 reported being involved in a sexual relationship with Employee 2, NA. Employee 1 documented that she immediately reported the allegation to Employee 3, Registered Nurse Supervisor (RNS). Employee 1 further documented that after Employee 2 was instructed to leave the facility, she observed Employee 2 enter Resident 7's room. A witness statement completed by Employee 3, Registered Nurse Supervisor (RNS), dated June 13, 2026, at 4:05 PM documented that Resident 7 reported she had been involved in a consensual intimate relationship with Employee 2, NA, for approximately two years and stated the encounters occurred during shower care. Employee 3 documented notifying the Assistant Director of Nursing (ADON). During an interview on June 24, 2026, at 2:10 PM the Assistant Director of Nursing (ADON) stated that on June 13, 2026, at approximately 4:19 PM, she was notified of Resident 7's allegation involving Employee 2, NA. The ADON stated she instructed Employee 3, Registered Nurse Supervisor (RNS), to call Employee 2 into a meeting. The ADON stated she participated in the meeting by telephone while Employee 3 informed Employee 2 that he was suspended immediately because of allegations of resident abuse. The ADON stated Employee 2 was instructed that he was not permitted to return to the facility until the investigation was completed. The ADON stated Employee 3 was (continued on next page)

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	06/24/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for implementing the abuse policy that day. The ADON further stated she was not physically present after the telephone call and did not observe events that occurred afterward. Employee 3, Registered Nurse Supervisor (RNS), was no longer employed by the facility and could not be reached for interview. During a telephone interview on June 25, 2026, at 9:25 a.m., Employee 1, Nurse Aide (NA), confirmed that after Resident 7 reported the allegation, Employee 2 entered Resident 7's room while carrying a black backpack. Employee 1 stated she observed Employee 2 enter the room while she was providing care to another resident across the hall. Employee 1 stated she could not determine how long Employee 2 remained inside the room. During an interview on June 24, 2026, at 1:50 PM Resident 7 stated that after reporting the allegation to staff, she was alone in her room crying when Employee 2 entered carrying a black backpack. Resident 7 stated Employee 2 told her he was going home to see his children, took hold of her hands, attempted to kiss her, and told her everything would be alright. Resident 7 stated she pulled her hands away, told him, No everything was not going to be alright, and Employee 2 then left the room. A nursing progress note dated June 13, 2026, at 7:38 PM documented that Resident 7 reported involvement in a consensual sexual relationship with Employee 2, NA. The note documented that the resident representative and on-call medical provider were notified. New physician's orders included laboratory testing for sexually transmitted infections (infections spread through sexual contact) and referral to a gynecologist (a physician specializing in women's reproductive health) if Resident 7 wished to proceed with further evaluation. The progress note documented that Resident 7 requested both the laboratory testing and gynecological referral and denied pain or discomfort. A psychiatry progress note dated June 15, 2026, at 1:00 AM, completed at the facility's request following Resident 7's allegation involving Employee 2, Nurse Aide (NA), documented that Resident 7 was interviewed in her room with privacy maintained. The psychiatric practitioner documented that upon entering the room, Resident 7 stated, Did they send you to talk about what happened? According to the psychiatry note, Resident 7 reported an ongoing sexual relationship with Employee 2 for approximately two years. The psychiatric practitioner documented that Resident 7 reported Employee 2 allegedly entered her room approximately 30 minutes before scheduled shifts to engage in sexual activity. The psychiatric practitioner documented that Resident 7 believed she would eventually marry Employee 2 and became emotionally distressed after learning Employee 2 reportedly had a relationship with another individual. The psychiatric practitioner documented mild symptoms of depression and anxiety and recommended continued non-pharmacological interventions (care approaches that do not involve medication, such as emotional support and reassurance) and supportive counseling. During an interview on June 24, 2026, at 8:50 AM Resident 7 stated that she had been involved in what she described as an ongoing consensual intimate relationship with Employee 2, Nurse Aide (NA), for approximately two years. Resident 7 reported that the relationship began while Employee 2 was providing her care and later became intimate. Resident 7 stated Employee 2 regularly spent time with her in her room before or during work shifts. Resident 7 further stated that Employee 2 asked her to keep the relationship a secret and that she disclosed the relationship to Employee 1, Nurse Aide (NA), after learning Employee 2 was reportedly involved in another relationship.During the interview on June 24, 2026, Resident 7 voluntarily presented social media communications that she identified as occurring between herself and Employee 2, Nurse Aide (NA). Resident 7 stated the social media account displayed a name and profile photograph that she believed belonged to Employee 2. The surveyor observed written messages initiated by Resident 7 expressing affection toward the account holder and audio call records reflecting multiple calls between Resident 7 and that account. The survey team did not independently verify ownership of the social media account or the content of the audio calls. During a telephone interview on June 24, 2026, at 10:04 AM, Employee 2, Nurse Aide (NA), denied engaging in any sexual relationship with Resident 7. Employee 2 acknowledged that after being notified on June 13, 2026, that he was suspended pending investigation of abuse allegations, he entered Resident 7's room to retrieve a documentation tablet that he stated had been left there earlier (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	06/24/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the shift. Employee 2 stated no staff member accompanied him into the room. Employee 2 denied attempting to kiss or otherwise touch Resident 7 during that encounter. During a telephone interview on June 24, 2026, at 1:20 p.m., the investigating law enforcement officer reported that Resident 7 described the relationship as consensual and declined to pursue criminal charges. During an interview on June 24, 2026, at 2:20 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) reviewed the above information. Both confirmed that, under the facility's abuse policy, Employee 2, Nurse Aide (NA), should not have had any resident contact after being suspended pending investigation of the abuse allegation. The NHA and DON acknowledged that Employee 2 entered Resident 7's room after the suspension had been communicated and confirmed that this action was inconsistent with facility policy requiring an employee accused of resident abuse to remain on leave with no resident contact until completion of the investigation. The NHA and DON stated Employee 2's employment was subsequently terminated for failing to comply with facility policy. The facility failed to implement its abuse prevention procedures by allowing the alleged perpetrator access to Resident 7 after the allegation had been reported and the employee had been suspended pending investigation. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management.28 Pa. Code 201.29 (a) Resident rights.28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.