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	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverstreet Manor	440 North River Street Wilkes-Barre, PA 18702

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on a review of clinical records, resident council meeting minutes, and resident and staff interviews, it was determined the facility failed to provide care in a manner that promotes each resident's quality of life by failing to respond timely to residents' requests for assistance, including experiences reported by two out of the 27 residents sampled (Residents 97 and 159) and experiences reported by five out of the seven residents during a resident group interview (Residents 38, 49, 53, 91, and 94). Findings include: A review of the clinical record revealed that Resident 97 was admitted to the facility on [DATE], with diagnoses to include hypertension and lymphedema (swelling caused by a build-up of lymph fluid in the body, usually in an arm or leg). An admission Minimum Data Set assessment (MDS- standardized assessment completed at specific intervals to plan care) dated, August 21, 2024, indicated the resident had a BIMS score of 11 (Brief Interview for Mental Status-a tool to assess the resident's attention, orientation, and the ability to register and recall new information, a score of 8-12 equates to moderate cognitive impairment). During interview with Resident 97, on September 4, 2024, at 1:00 PM the resident noted that at times he waits a long time for the call bell to be answered. Resident 97 noted that when he rings the call bell it is often for ice water which he enjoys drinking with his meals. Resident 97 noted that at breakfast today he was in need of ice water and waited for 20 minutes for the call bell to be answered and staff to provide him with ice water to have during his breakfast. A review of the clinical record revealed that Resident 159 was admitted to the facility on [DATE], for short-term rehabilitation with diagnoses to include diabetes. During interview with Resident 159, a cognitively intact resident, on September 4, 2024, at 11:00 AM the resident revealed that on September 3, 2024, around 7:00 PM he waited for approximately 20 minutes for the call bell to be answered. Resident 159 stated that when staff finally answered the call bell the response to why it took so long was that staff were busy. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident Council meeting minutes dated June 3, 2024, revealed that residents in attendance had concerns regarding nurse staffing. Residents in attendance indicated that a reasonable amount of time to wait for care is 15 minutes. Staff at the meeting explained that efforts were being made to hire additional facility employees, including licensed nurses and nurse aides. A review of Resident Council meeting minutes dated July 1, 2024, revealed that residents in attendance had concerns regarding call bell wait times for care. A review of Resident Council meeting minutes dated August 5, 2024, revealed that residents in attendance had concerns with staff assisting residents to bed and nurse staffing related to staff calling off from work. During a group interview with alert and oriented residents on September 5, 2024, at 10:00 AM, five out of the seven residents interviewed indicated that they rely on staff for care (Residents 38, 49, 53, 91, and 94). Residents 38, 49, 53, 91, and 94 explained they experience long wait times for staff assistance. The residents in attendance indicated that concerns with staffing have been brought up during Resident Council meetings over the past few months, but the long wait times for care remain a problem at the facility. Resident 38 indicated that she sometimes waits 30 minutes for care when the facility is short on staffing. She explained that the evening shift (3:00 PM to 11:00 PM) is often short on nurse aides. Resident 38 indicated that when one or two nurse aides are assigned to her area, there is not enough to take care of all the residents that need assistance. She explained that when this happens, the residents end up waiting a long time for care. Resident 49 indicated that he sometimes waits 30 minutes for care when the facility is short staffed. He explained that his nursing unit was short staffed earlier this week. Resident 49 indicated it took staff about 30 minutes to provide him care after he rang his call bell for assistance. Resident 49 indicated that when the staff are short, they are stressed and not in a good mood. He explained that when they are stressed, they rush, and it affects me and the other residents. Resident 94 indicated that she experiences long wait times for care, but was unsure how long it takes for staff to respond after she rings her call bell for assistance. Resident 94 expressed that she is frustrated because there is not enough staff to take care of the residents at the facility. She explained that short staffing and long wait times for care have been an ongoing problem at the facility. Resident 91 indicated that she often waits one to three hours for staff to respond to her call bell rings for assistance on the evening shift and night shift. She explained that she is independent for most of her care but is unable to perform personal hygiene after she goes to the bathroom. Resident 91 indicated that night shift nursing staff will tell her she is independent and respond very slowly to her rings for assistance. She explained that she often waits until someone from the dayshift arrives to help her get cleaned up. Resident 91 expressed that she is angry and frustrated about her care. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 53 indicated that he experiences long wait times for care. He explained that staff sometimes ask him if he could wait five minutes so they could take care of another resident. He indicated that he is afraid to tell them yes anymore because he would end up waiting 30 minutes to an hour before they would come back to check on him. Resident 53 explained that he waits 30 minutes or longer when he needs staff assistance for care. He expressed that he feels bad the residents need help with care, but there does not seem to be enough staff to provide it. During an interview on September 6, 2024, at approximately 9:30 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) verified all residents at the facility should be treated with dignity and respect. The NHA and DON were unable to explain why residents are reporting untimely staff responses to residents' requests for assistance and care which is negatively affecting their quality of life in the facility. 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a) Resident Rights 28 Pa. Code 211.12 (c)(d)(4)(5) Nursing Services.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on clinical record review and resident interview and staff interview, it was determined the facility failed to ensure that in preparation for room change, a resident and resident representative received written notice, including the reason for the change, before the resident's room was changed for one of 27 residents reviewed (Resident 62). Findings Include: Federal regulatory guidelines note that moving to a new room or changing roommates is challenging for residents. A resident's preferences should be taken into account when considering such changes. When a resident is being moved at the request of facility staff, the resident, family, and/or resident representative must receive an explanation in writing of why the move is required. The resident should be provided the opportunity to see the new location, meet the new roommate, and ask questions about the move. Review of the clinical record of Resident 62 revealed the resident was admitted to the facility on [DATE], with diagnoses to include cerebral infarction (stroke- damage to tissues in the brain due to loss of oxygen to the area) with right side hemiparesis (partial paralysis on one side of the body). Resident 62 had been residing in room [ROOM NUMBER]-A (window bed) and was moved to room [ROOM NUMBER]-A (window bed) on August 28, 2024. A social services note dated August 28, 2024, at 1:19 PM noted the resident was asked if she would move to room [ROOM NUMBER]-A and the resident agreed. A nurses note dated August 28, 2024, at 4:18 PM noted the resident was moved into room [ROOM NUMBER]-A and oriented to new room. Resident with no concerns at this time. Resident representative aware. Further review of Resident 62's clinical record revealed no evidence that written notice, including reason for the room change had been provided to Resident 62 and Resident 62's resident representative. Interview with Resident 62, a cognitively intact resident, on September 4, 2024, at 12:45 PM revealed the resident's room was recently changed. Resident 62 noted that she was okay with the new room but noted that she was only given a few hour notice before her room was changed. Resident 62 noted she did not receive a written notice of the reason for the room change. Interview with the social services director on September 4, 2024, at 1:30 PM confirmed there was no documented evidence the facility provided written notice with an explanation for the reason for the room change, to the resident and/or the resident's responsible party. 28 Pa Code 201.29 (a) Resident Rights

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on clinical record review, resident interview, and staff interview it was determined the facility failed to accurately identify a resident's wishes for future health care and advance directives (a written instruction such as a living will or durable power of attorney for health care for when the individual is incapacitated) as evidenced by one resident (Resident 62) out of 27 residents sampled. Findings include: A review of the clinical record of Resident 62, revealed the resident was cognitively intact and admitted to the facility on [DATE], with diagnoses that included cerebral infarction (stroke- damage to tissues in the brain due to loss of oxygen to the area) with right side hemiparesis (partial paralysis on one side of the body). A POLST a medical order signed by a doctor (Pennsylvania Orders for Life-Sustaining Treatment- is not intended to replace an advance health care directive document or other medical orders. The POLST process and health care decision-making works best when the person has appointed a health care agent to speak for them when they become unable to speak for themselves. A health care agent can only be appointed through an advance health care directive or a health care power of attorney), form signed by the physician extender on [DATE], indicated the resident desired to have CPR (cardiopulmonary resuscitation) if found to have no pulse and is not breathing. However, further review of the POLST form revealed no documented evidence the POLST form was signed by the resident or surrogate as required to indicate the resident wished to have CPR if the resident's heart were to stop beating or the resident stopped breathing. Review of the resident's Social History form dated [DATE], indicated that the resident had a Living Will in place and was offered to formulate an Advance Directives; and that information on Advance Directives was provided. Further review revealed no documented evidence of an Advance Directive in the resident's clinical record. During interview with Resident 62 on [DATE], at 11:45 AM the resident revealed she did not want to receive chest compressions (CPR) to attempt to restart her heart if her heart stopped. Resident 62 denied the facility ever having this discussion with her since she has been at the facility to ensure her wishes are honored. Resident 62 stated that she did not have a Living Will but was sure that she did not want CPR. The facility failed to provide documented evidence related to the periodic review of the resident's Advanced Directive to ensure the resident's wishes are honored. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the director of nursing on [DATE], at approximately 12:30 PM confirmed the resident's POLST form was not signed by the resident as required and did not accurately reflect the resident's wishes if she were to become incapacitated 28 Pa. Code 211.5 (f) Clinical records. 28 Pa. Code 201.29(a) Resident rights

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 21738 Based on a review of clinical records, the facility's abuse prohibition policy, select facility incident reports, and resident and staff interviews, it was determined the facility failed to timely and thoroughly investigate an incident to rule out neglect and identify planned fall interventions not in place which resulted in a resident who requires the assistance of two staff for bed mobility and transfers to sustain a fall with a minor injury for one of 27 residents sampled (Resident 10). The findings include: A review of the facility's Abuse Prohibition Policy last revised May 1, 2021, and last reviewed August 2024, indicated the facility will do all that is within their control to prevent occurrences of abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in the definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Mistreatment is defined as inappropriate treatment or exploitation of a resident. Neglect is defined 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, mental anguish, or emotional distress. The facility will initiate an investigation within 24 hours of an allegation of abuse/neglect that focuses on whether abuse or neglect occurred and to what extent; clinical examination for signs of injuries, if indicated; causative factors; and interventions to prevent further injury. The investigation will be thoroughly documented. Ensure that documentation of witnessed interviews is included. A review of Resident 10's clinical record revealed the resident was admitted to the facility March 10, 2017, with diagnoses to include anxiety and spinal stenosis (narrowing of the spine which puts pressure on the spinal cord and nerves and can cause pain), and polyarthritis (at least five joints are affected with arthritis). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 10's quarterly Minimum Data Set (MDS - federally mandated standardized assessment process completed periodically to plan resident care), dated February 23, 2024, indicated the resident was cognitively intact with a BIMS (Brief Interview for Mental Status) score of 14 (a score of 13-15 indicates cognitively intact), and required two plus person physical assistance for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed) and transfers (how resident moves between surfaces including to or from bed, chair, wheelchair, standing position). Review of a physician order initially dated October 31, 2023,for Resident 10, noted an order for assistance requires with two staff for all transfers, with sit to stand lift with standard sized sling. During interview with Resident 10 on September 5, 2024, at 1:00 PM the resident noted she recalled an incident (could not remember the date) when a nurse aide was putting her in bed with the sit to stand lift (mechanical device designed to assist residents from moving from a sitting to standing position) and only remembers one staff being there. When she got to bed she started to fall and went forward before aide could stop her from falling and she bumped her head on the dresser. Nursing documentation dated April 13, 2024, at 8:58 PM revealed the nurse was called to resident's room by the nurse aide, the resident was found on the floor lying on her left side in no acute distress. The resident had a witnessed fall. The nurse aide stated the resident slid while taking off her heel Medix boots (help to relieve pressure off heels). Body audit completed and small circular skin tear noted to resident's upper left forehead. Nurse aide and resident stated she did not hit her head during the fall, but resident was lying on her left side on the floor while waiting for assistance to get off the floor. No decrease range of motion, shortening, rotation, pain, or other skin alterations noted. Resident assisted back into bed. Physician and resident representative notified. Review of the resident's care plan initially dated August 21, 2021, indicated the resident had a self-care deficit related to physical limitations. Planned interventions included the assist of two staff for bed mobility and assist times two staff via sit to stand lift for all transfers. Review of Resident 10's Documentation Survey Report for April 2024 revealed that on April 13, 2024, on the 3:00 PM shift to 11:00 PM shift the resident required the assistance of two staff for bed mobility and transfers. Review of the facility incident report dated April 13, 2024, indicated the resident was observed on the floor on her left side. At the time of the incident the resident stated that she slid off the mattress while the nurse aide was helping her get ready for bed. A skin integrity report dated April 13, 2024, noted a skin tear to the resident's left forehead which measured 0. 7 cm by 1.0 cm. Neurochecks were initiated and completed following the incident. Review of an Incident/Accident statement by employee 5 (nurse aide) who witnessed the fall noted that the resident was sitting on the side of the bed and as employee 5 (nurse aide) was taking her boots off the resident started sliding and employee 5 (nurse aide) tried to guide the resident slowly to the floor and then notified the nurse. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a statement by Employee 7 (registered nurse) indicated she did not witness the incident. Employee 7 (registered nurse) noted she observed the resident lying on the floor in between the bed and the nightstand on her left side. The resident had a small skin tear to her left forehead that was visible when assessing the resident; other than that no visible injuries were noted. Employee 7 (registered nurse) noted the resident stated the mattress started sliding. Employee 7 (registered nurse) noted she last saw the resident in her wheelchair ten minutes prior to this fall. Further review of the investigation at the time of the incident revealed no indication the facility determined if the resident was assisted with the assistance of two staff members as careplanned for transfer with the mechanical and with assistance for bed mobility. There were no other witness statements at the time of the incident. The notes section of the Incident Report dated April 15, 2024, noted the interdisciplinary team reviewed the incident. The resident was sitting at the edge of her bed and slid. Physical therapy is being completed to assess transfers and cognitive status/awareness/safety. The facility failed to implement its established procedures in response to a fall with minor injury by failing to conduct a thorough investigation to rule out potential abuse, neglect, or mistreatment of the resident as a potential cause of the fall with minor injury. There was no indication that the facility identified at the time of the incident there was only one nurse aide,employee 5 (nurse aide), present during the incident despite employee 5 (nurse aide) signing off on the Resident's Documentation Survey Report that two staff were present. After surveyor inquiry about the incident on September 6, 2024, at approximately 11:00 AM the director of nursing stated to surveyor that additional witness statements were obtained regarding the incident on April 13, 2024. The facility provided the surveyor a statement written by employee 6 (nurse aide) dated September 6, 2024, noted that she was also present during the incident with Resident 10 and that Resident 10 slid off the bed to the floor while providing care. This statement was not obtained at the time of the incident in April. During interview with employee 6 (nurse aide) on September 6, 2024, at approximately 11:15 AM employee 6 (nurse aide) was unable to provide a detailed description of the incident and was unable to explain why the resident's heel boots would be removed while the resident was sitting on the side of the bed. Employee 6 (nurse aide) noted that it was difficult to remember an incident which had happened months before. An interview with the director of nursing on September 6, 2024, at approximately 1:00 PM confirmed the facility could not provide documented evidence the facility fully investigated to rule out potential neglect following Resident 10's fall with minor injury. The facility failed to identify planned interventions were not in place and/or implemented in a manner to ensure the resident's safety to prevent the fall and prevent future reoccurrence to the extent possible. 28 Pa. Code 201.14 (a)(c) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.29 (a)(c) Resident Rights 28 Pa. Code 211.12 (c)Nursing Services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on clinical record review, select facility policy, and resident and staff interviews, it was determined the facility failed to ensure comprehensive care plans were developed and revised with the participation of the resident and the resident's representative for two residents out of 27 residents sampled (Residents 62 and 79) and five out of seven residents during a resident council interview (38, 49, 94, 91, and 53). Findings include: A review of facility policy titled Care Plans, Comprehensive Person-Centered, last reviewed by the facility on August 1, 2024, revealed that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The policy indicates that residents are informed of their right to participate in his or her treatment and provided advance notice of care planning conferences. Also, the policy indicates if the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process. A clinical record review revealed Resident 62 was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (stroke- damage to tissues in the brain due to loss of oxygen to the area) with right side hemiparesis (partial paralysis on one side of the body). A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 21, 2024, revealed that Resident 62 is 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 13-15 indicates cognition is intact). During an interview on September 4, 2024, at 12:45 PM, Resident 62 indicated that she has not participated in any care plan meetings. She was not able to recall being invited to participate in the development or revision of her care plan. Resident 62 indicated that she was staying long-term at the facility. A clinical record review revealed Resident 38 was admitted to the facility on [DATE]. A review of Resident 38's clinical record revealed no evidence Resident 38 or her representative were invited to participate or participated in the development of her person-centered care plan. A clinical record review revealed Resident 94 was admitted to the facility on [DATE]. A review of Resident 94's clinical record revealed no evidence Resident 94 or her representative were invited to participate or participated in the development of her person-centered care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A clinical record review revealed Resident 53 was admitted to the facility on [DATE]. A review of Resident 53's clinical record revealed no evidence Resident 53 or his representative were invited to participate or participated in the development of his person-centered care plan. A clinical record review revealed Resident 49 was admitted to the facility on [DATE]. A review of Resident 49's clinical record revealed no evidence Resident 49 or his representative were invited to participate or participated in the development of his person-centered care plan. A clinical record review revealed Resident 91 was admitted to the facility on [DATE]. A review of Resident 91's clinical record revealed no evidence Resident 91 or her representative were invited to participate or participated in the development of her person-centered care plan. A clinical record review revealed Resident 79 was admitted to the facility on [DATE]. A review of Resident 79's clinical record revealed no evidence Resident 79 or her representative were invited to participate or participated in the development of her person-centered care plan. During a group interview with alert and oriented residents on September 5, 2024, at 10:00 AM, Residents 38, 49, 94, 91, and 53 indicated that they had not been invited to participate in care conference meetings. The residents indicated that they have not been invited to participate in the development of their person-centered care plan. During a resident interview on September 5, 2024, at 12:45 PM, Resident 79 indicated that she has not been invited to participate in the development of her person-centered care plan. During an interview on September 5, 2024, at approximately 1:30 PM, Employee 2, Social Services Director, indicated that care planning conferences were not occurring quarterly for each resident. Employee 2 was not able to provide evidence that residents and resident representatives were being provided the opportunity to participate in the development and revision of comprehensive resident-centered care plans. During an interview on September 6, 2024, at approximately 11:00 AM, the Nursing Home Administrator (NHA) confirmed it is the facility's responsibility to ensure comprehensive care plans are developed and revised with the participation of the resident and the resident's representative. The NHA was unable to provide documented evidence that residents were being provided an opportunity to participate in the development and revision of comprehensive resident-centered care plans. During an interview on September 6, 2024, at approximately 9:30 AM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) confirmed that it is the facility's responsibility to ensure that residents are provided an opportunity to participate in development and revisions of their comprehensive care plans. The NHA and DON confirmed the interdisciplinary team meets quarterly to discuss, revise, and develop each resident's plan of care. The DON and NHA were unable to provide documented evidence that Residents 38, 49, 53, 62, 79, 91, or 9, were offered the opportunity to participate in care conference meetings or the development and revision of their comprehensive resident-centered care plans. The DON and NHA confirmed the facility must include residents in the development and revision of their care plans to the greatest extent possible. 28 Pa. Code 201.29(a) Resident rights. (continued on next page)

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	395691	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverstreet Manor	440 North River Street Wilkes-Barre, PA 18702

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa Code 211.12(d)(3) Nursing services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on observations, a review of clinical records and staff interviews it was determined the facility failed to provide nursing services consistent with professional standards of practice by failing to follow physician orders for the consistent application of prescribed therapeutic devices and or preventative measures, neck positioning pillow, when in bed and chair, for one resident out of 27 sampled (Resident 69) to assure the provision of person-centered care. Findings include: A review of the clinical record revealed that Resident 69 was admitted to the facility on [DATE], with diagnoses to include traumatic subdural hemorrhage (blood collects between the layers of tissue that surround the brain) with loss of consciousness, lack of coordination, abnormal posture, muscle disorder, and fracture of the base of the skull and occiput (flat bone that forms the back of the skull). A quarterly Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated August 7, 2024, revealed the resident has functional limitations on both sides (left and right) in range of motion in his upper and lower extremities, and was dependent on staff for eating, oral hygiene, toileting, upper and lower body dressing, personal hygiene, rolling to the left and to the right, and and transfers from a chair to the bed. The resident's care plan initiated August 5, 2020. indicated he is at risk for decreased ability to perform activities of daily living (ADLS) related to limited mobility, and that he is at risk for skin breakdown related to decreased activity, due to frail and fragile skin. Interventions included to use a neck positioning pillow when in bed and chair to position his neck in neutral position date, initiated on August 13, 2022, and assistance of 2 staff members for bed mobility,initiated May 17, 2024. A review of current physician orders dated August 10, 2022, indicated, use neck positioning pillow when in bed and chair to position the neck in a neutral position (positioned directly between the shoulders). An observation on September 4, 2024, at approximately 10:55 AM, found the resident lying on his back in bed, with his neck laterally flexed (bending the neck sideways) towards his left shoulder without a neck positioning pillow, as ordered by the physician. A second observation on September 4, 2024, at approximately 2:30 PM, found the resident lying on his back in bed, with his neck laterally flexed towards his left shoulder without a neck positioning pillow, as ordered by the physician. A third observation on September 5, 2024, at approximately 8:05 AM, found the resident lying on his back in bed, with his neck laterally flexed towards his left shoulder without a neck positioning pillow, as ordered by the physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A fourth observation on September 5, 2024, at approximately 8:20 AM, in the presence of Employee 1, Licensed Practical Nurse (LPN), found the resident lying on his back in bed, with his neck laterally flexed towards his left shoulder without a neck positioning pillow, as ordered by the physician. During an interview on September 5, 2024, at approximately 8:22 AM, with Employee 1, (LPN), confirmed the observation that resident 69 was lying in bed with his neck laterally flexed towards his left shoulder without a neck positioning pillow as ordered by the physician. During an interview with the Director of Nursing (DON) on September 5, 2024, at approximately 10:10 AM, the DON was made aware of the observations on September 4, and September 5, 2024 regarding the resident's neck pillow. At this time, documentation was requested from the facility to provide evidence the resident's prescribed therapeutic devices were in place as ordered. During an interview with the DON on September 5, 2024, at approximately 1:35 PM, the DON could not provide documented evidence the resident was provided the neck pillow as ordered. The faiclity failed to follow physician orders for this resident's therapeutic device. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services 28 Pa. Code 211.5(f) Medical records

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on observations, review of clinical records and staff interviews it was determined the facility failed to provide person-centered care as prescribed to meet the current clinical needs, failed to ensure the ready availability of prescribed emergency supplies, and failed to follow physician orders for management of a midline catheter (long, thin, flexible tube that is inserted into a large vein in the upper arm. It is used to deliver medications or fluid into the bloodstream) for one resident out of 27 sampled (Resident 100). Findings include: A review of clinical records revealed Resident 100 was admitted to the facility on [DATE], with diagnoses to include urinary tract infection, and Extended Spectrum Beta Lactamase Resistance (ESBL- a bacteria resistant to most antibiotics) in the urine. Review of Resident 100's hospital record Peripherally Inserted Central Catheter (PICC) Midline Insertion Documentation dated August 1, 2024, revealed the resident underwent a procedure for a single lumen midline catheter (thin, soft tube that is placed into a vein, usually in the arm. The catheter is then moved through the vein until the tip sits at the level of the armpit and away from the shoulder, used to administer medications) in his left arm. The catheter (tubing) total length was 15 cm with an external catheter length of 0 cm. A review of physician's order dated August 1, 2024, revealed an order to change the catheter site with Transparent dressing, indicate the external catheter length and upper arm circumference (10 cm above the antecubital area which is the bend of the elbow) and notify the practitioner if the external length of the catheter has changed since the last measurement indicating a potential problem with the midline. Review of Resident 100's Medication Administration Record (MAR) for August 7, 2024, revealed that nursing staff documented an upper arm circumference of 28.5 cm and an external catheter length of 10 cm. There was no documented evidence the physician was notified of the significant change in the measurement of the external catheter length from 0 cm on August 1, 2024, to 10 cm on August 7, 2024. After completion of the ordered antibiotic,a physician's order dated August 13, 2024 at 3:15 PM revealed an order for the RN (registered nurse) to remove the midline catheter. A nurses note dated August 13, 2024, at 7:29 PM indicated that the left upper arm midline catheter was removed. Midline catheter was completely intact, and 15 cm was removed. A nurses noted dated August 14, 2024 at 1:16 PM revealed Resident 100 was being transferred to the hospital due to the resident dislodging his nephrostomy tube (a tube that drains urine from the kidney). (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of nursing documentation dated August 17, 2024, indicated Resident 100 was readmitted to the facility and the resident required an IV antibiotic. The resident is known to be a hard stick (someone whose veins are difficult to locate) and normally pulls out his IVs due to not being situationally aware. Order received for midline catheter placement. A review of the Procedure Note: New Midline dated August 18, 2024, revealed the resident underwent a procedure for a single lumen midline catheter in his right upper arm. Catheter length was 15 cm with external catheter length 0 cm. A review of a physician's order dated August 21, 2024, revealed an order to change the catheter site with transparent dressing, indicate the external catheter length and upper arm circumference (10 cm above the antecubital). Notify practitioner if the external length has changed since last measurement. Review of Resident 100's MAR for August 21, 2024, revealed that nursing staff documented an upper arm circumference of 17 cm and an external catheter length of 10 cm. Review of the MAR for September 4, 2024, revealed nursing staff documented an upper arm circumference of 30.5 cm and an external catheter length of 10 cm. There was no documented evidence that the physician was notified of the significant change in the measurement of the external catheter length from 0 cm on August 18, 2024, to 10 cm on August 21, 2024 and September 4, 2024. Interview with Employee 4 (registered nurse) on September 5, 2024, at 12:15 PM, verified that external measurements of a midline catheter are obtained as per the physician's order. During an observation of Resident 100 on September 5, 2024, at 12:20 PM, Employee 4 measured the external catheter length of the resident's midline catheter and indicated it was 0 cm. Interview with the Director of Nursing on September 6, 2024, at approximately 9:30 AM confirmed there was no documented evidence the physician was notified of the change in the external catheter length documented on August 7, 2024, August 21, 2024, and September 4, 2024, and that the nurse documentation of the external catheter length in the MAR was inaccurate. A review of physician orders dated August 21, 2024, revealed an order to maintain an emergency kit at bedside to include a clamp, gauze, occlusive dressing, and tape for Resident 100's midline catheter. Observation conducted on September 5, 2024, at 10:20 AM revealed no emergency kit available in the resident's room. Interview with Employee 3 (licensed practical nurse) on September 5, 2024, at the time of the observation, verified that Resident 100 had a physician's order for an emergency kit at bedside and confirmed that there was no emergency kit available in Resident 100's room. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on observations, review of clinical records, select facility policy, staff, and resident interviews, it was determined that facility failed to implement pain management interventions when a resident suffered pain without relief for one resident out of 27 sampled (Resident 92). Findings include: A review of the policy title Pain-Clinical Protocol, last reviewed by the facility on August 1, 2024, revealed the physician and staff will identify individuals who have pain or who are at risk for having pain. This includes reviewing known diagnoses and conditions that commonly cause pain. It also includes a review of any treatments that the resident is currently receiving for pain, including pharmacological and non-pharmacological treatments. The policy also indicates staff will identify any situations or interventions where an increase in the resident's pain may be anticipated. With input from the resident to the extent possible, the physician and staff will establish goals for pain treatment. A clinical record review revealed that Resident 92 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities) and aftercare following a fractured femur. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 18, 2024 revealed that Resident 92 is moderately cognitively impaired with a BIMS score of 12 (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 8-12 indicates moderate impairment). A care plan, initiated on September 2, 2024, indicated that Resident 92 has pain related to osteoporosis (a medical condition in which the bones become brittle and fragile from loss of tissue). Interventions include administering pain medication per physician's orders and reporting nonverbal expressions of pain such as moaning or grimacing. A community hospital discharge summary revealed Resident 92 was admitted to the community hospital on August 26, 2024, with an acute closed intertrochanteric fracture of her right femur (broken hip) and underwent surgical repair. She was readmitted to the facility on [DATE], with instructions to follow-up with an orthopedic consult in two weeks and Acetaminophen 325 mg for pain management. A physician's order for Resident 92 to be administered Acetaminophen oral tablet 325 mg with instructions to give 650 mg by mouth every 6 hours as need for pain 1-3 (mild pain) and instructions for non-pharmacological interventions for pain management initiated on August 29, 2024. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Resident Observation Admission Form dated September 2, 2024, indicated Resident 92 is able to identify the location of her pain. She describes the characteristic of her pain as aching, hurting all over, and tingling, and numerically evaluated her pain as 0 out of 10. The assessment indicated the resident is not able to identify factors that aggravate her pain. The assessment indicated she is not able to determine the effectiveness of different interventions on pain management. There was no response indicated if Resident 92 is able to identify factors that alleviate her pain. A Brief Interview for Mental Status Evaluation (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) dated September 4, 2024, revealed Resident 92 has moderate cognitive impairment with a score of 8 (a score of 8-12 indicates moderate impairment). A physical therapy evaluation and plan of treatment evaluation, dated September 3, 2024, indicated that Resident 92 had complaints of minimal pain in her right thigh and knee at rest, which increases with activity. She was unable to provide a specific rating. The document indicated the caregiver goals are to improve mobility and transfers, improve ambulation, and decrease pain. A physical therapy treatment encounter note dated September 3, 2024, at 12:09 PM revealed Resident 92 had complaints of increased pain in her right lower extremity following treatment. There was no documented evidence that Resident 92 was provided pharmacological or non-pharmacological interventions for her pain in anticipation of her pain prior to her therapy session or following her therapy session on September 3, 2024. During an interview on September 4, 2024, at 10:45 AM, Resident 92 indicated she fell last week. She was observed rubbing her right thigh and knee. She indicated it was sore. Resident 92 was unable to indicate what interventions helped her pain or what the facility was implementing to help alleviate her pain. An occupational therapy treatment encounter note dated September 4, 2024, at 2:26 PM revealed that Resident 92 had complaints of right knee pain and was not willing to stand with a mobility device. A physical therapy treatment encounter note dated September 4, 2024, at 2:54 PM revealed Resident 92 screamed with pain in her knee when attempting to stand. There was no documented evidence that Resident 92 was provided pharmacological or non-pharmacological interventions for her pain in anticipation of her pain prior to her therapy session or following her therapy sessions on this date. During an interview on September 5, 2024, at 12:45 PM, Resident 92 indicated her leg was very sore. She was not able to explain what interventions alleviated the soreness and did not respond when asked what her pain level was on a scale of 1 to 10 (numeric pain scale indicating 0-no pain, 1-3 mild pain, 4-6 moderate pain and 7-10 severe pain). Resident 92 was observed rubbing her right leg near her knee. A review of the medication administration record for September 2024 revealed that Resident 92 experienced mild pain on the following dates: On September 2, 2024, Resident 92 experienced 1 out of 10 level of pain during the night shift. On September 3, 2024, Resident 92 experienced 1 out of 10 level of pain during the day shift. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On September 3, 2024, Resident 92 experienced 2 out of 10 level of pain during the night shift. On September 4, 2024, Resident 92 experienced 1 out of 10 level of pain during the day shift. On September 4, 2024, Resident 92 experienced 1 out of 10 level of pain during the evening shift. A clinical record review revealed no documented evidence that Resident 92 was offered any pharmacological or non-pharmacological interventions for her pain on the above shifts with recorded experiences of her mild pain. Furthermore, there was no documented evidence from her re-admission to the facility on [DATE], through September 5, 2024, that Resident 92 was provided interventions for her experienced pain. During an interview on September 6, 2024, at approximately 9:30 AM, the Director of Nursing (DON) was unable to provide documented evidence that Resident 92 received or was offered any interventions for pain management from September 2, 2024, through September 5, 2024, despite indicators and evaluations that the resident was experiencing mild pain. The DON confirmed it is the facility's responsibility to ensure pain management is provided to residents who require such services. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39235 Based on review of clinical records and staff interview, it was determined the facility failed to provide therapeutic social services to promote the mental and psychosocial well-being of one resident out of 27 sampled (Resident 69) Findings include: A review of the clinical record revealed that Resident 69 was admitted to the facility on [DATE], with diagnoses to include major depressive disorder, and intermittent explosive disorder. The resident's care plan, initiated August 5, 2020, indicated he is at risk for distressed/fluctuating mood symptoms related to anxiety. A review of a nursing note dated April 9, 2024, at 1445 at 2:45 PM indicated the nurse entered the residents' room to give Prednisone (a medication that reduces inflammation and suppresses the immune system) and to start his J tube feeding (a soft, plastic tube placed through the skin of the abdomen into the midsection of the small intestine used to administer liquid nutrition). Resident 69 refused, and an attempt was made by a different nurse without success. In questioning why the refusal of medication and nutrition (feedings), Resident 69 relayed he no longer wanted to live and began to cry. The nurse provided emotional support to the resident and notified the physician. A review of the resident's care plan failed to identify and include interventions after the residents expressed he no longer wanted to live. There was no documentation in Resident 69's clinical record that therapeutic Social Services were provided to the resident in response to the residents statement expressed on April 9, 2024. Interview with Employee 2, Social Service Director, on September 4, 2024, at approximately 2:00 PM revealed she had not followed up, or conversed with Resident 69 in response to the April 9, 2024, resident's comments that he no longer wanted to live. The resident's care plan was not updated to address the resident's statement that he no longer wanted to live. Interview with the Nursing Home Administrator (NHA) on September 5, 2024, at approximately 10:10 AM, confirmed that there was no documented evidence of the provision of therapeutic social services provided to Resident 69 following his statement of desire to die. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.16 (a) Social Services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48277 Based on review of facility policy, clinical records and controlled medication records, and staff interview, it was determined the facility failed to implement procedures to promote accurate accounting and administration of controlled medications and maintenance of accurate controlled substance records as evidenced by one resident of 27 sampled (Resident 99). Finding include: A review of the clinical record revealed that Resident 99 had a physician order initially dated June 24, 2024, at 4:15 PM for Oxycodone HCl oral tablet 5 MG (an opioid pain medication used to treat moderate to severe pain), give 5 mg by mouth every 6 hours as needed for pain 4-10 (numeric pain scale 1-10, 1 least pain, 10 most pain). A review of the Controlled Drug Administration Record accounting for the above narcotic medication revealed that on the following dates nursing staff signed for the removal of a dose from the resident's supply of Oxycodone 5 mg: August 21, 2024, at 6:00 PM, August 25, 2024, (time illegible), August (date illegible) at 11:45 PM, and August 28, 2024, at 8:00 PM, However, the administration of the controlled drug to the resident was not recorded on the resident's Medication Administration Record (MAR) on those dates and times. A physician order dated August 28, 2024, at 8:20 PM was noted for Oxycodone HCl tablet 10 MG, give one tablet by mouth every 6 hours as needed for moderate to severe pain (4-10). A review of the Controlled Drug Administration Recordaccounting for the above narcotic medication revealed that on nursing staff signed out a dose of the resident's supply of Oxycodone 5 MG the following dates; August 31, 2024, at 5:00 AM, September 2, 2024 at 5:00 AM, September 3, 2024, at 5:00 AM and September 4, 2024, at 4:30 PM (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medication administration record revealed no evidence of the administration of the controlled drug to the resident on those dates and times. During an interview on September 6, 2024, at 11:24 AM, the Director of Nursing confirmed the inconsistencies in the accounting and administration of the opioid pain medication for Resident 99. A review of facility policy titled Administering Medications last reviewed August 2024, indicated that medications are administered in accordance with the prescriber orders. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication, A physician order dated June 24, 2024 and revised August 5, 2024, August 6, 2024, and August 12, 2024, was noted for Oxycodone HCl oral tablet 5 MG, give 5 mg by mouth every 6 hours as needed for pain 4-10. This medication was discontinued on August 26, 2024. On August 28, 2024, the physician reordered Oxycodone HCl but increased the dose to 10 MG. The order was revised on August 29, 2024, and remained current for Oxycodone HCl 10 MG, give one tablet by mouth every 6 hours as needed for moderate to severe pain (4-10) at the time of the survey ending September 6, 2024. A review of Resident 99's Controlled Drug Administration Record revealed on July 25, 2024, the facility received 30 doses of Oxycodone HCl 5 MG for Resident 99. Further review of the Controlled Drug Administration Record revealed that from August 29, 2024, through September 4, 2024, Resident 99 received fifteen (15) doses of Oxycodone HCl 5 MG instead of the physician ordered Oxycodone HCl 10 MG dose. Interview with the Nursing Home Administrator on September 9, 2024, at approximately 2:00 PM confirmed that nursing staff failed to follow the facility's policy by not checking the medication label to verify the right dose and confirmed the facility failed to follow physician's orders for administration of pain medication. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services. 28 Pa Code 211.9(a)(1)(k)Pharmacy services. 28 Pa Code 211.5 (f) Medical records

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	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverstreet Manor	440 North River Street Wilkes-Barre, PA 18702

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276 Based on clinical record review and staff interviews, it was determined the facility failed to ensure the presence of current documented clinical necessity for use of an antipsychotic medication for one of five residents reviewed for unnecessary medications (Resident 68). Findings include: A clinical record review revealed Resident 68 was admitted to the facility on [DATE], with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities). A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 8, 2024, revealed that Resident 68 is moderately cognitively impaired with a BIMS score of 8 (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 8-12 indicates moderate cognitive impairment). Physician's order dated June 24, 2024 revealed, discontinue Buspar (an anti-anxiety medication) and start Seroquel 12.5 oral tablet mg (Quetiapine Fumarate- an antipsychotic medication) at bedtime for agitation. Resident 68 must eat at the same time as roommate and be in bed at 8:00 PM. There was no corresponding physicians documentation indicating the clinical need for the initiation of the antipsychotic medication. A medication administration record for June 2024 revealed staff indicated Resident 68 did not display anxiety or anxious behaviors (feeling nervous, continuous worrying, difficulty relaxing, restlessness, easily annoyed, irritable, or fearful) from June 1, 2024, through June 26, 2024. The monitoring for these behaviors was discontinued on June 26, 2024. Resident 68's medication administration record review revealed staff indicated Resident 68 did not display insomnia or sleepless behaviors (sleeplessness, difficulty falling asleep, difficulty staying asleep, restlessness, disruption in sleep pattern) from June 1, 2024, through September 5, 2024. Resident 68's medication administration record revealed a monitor was initiated on June 26, 2024, for staff to indicate Resident 68's socially inappropriate or disruptive behavior (self-injury, scratching, hitting, pacing, wandering, screaming, yelling, agitation). No behaviors were indicated from June 26, 2024, through September 5, 2024. A review of the medication administration record indicated Resident 68 has been receiving Seroquel oral tablet 12.5 mg (Quetiapine Fumarate- an antipsychotic medication) since prescribed on June 24, 2024. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on September 6, 2024, at approximately 9:00 AM, the Director of Nursing (DON) could not provide documented evidence of the clinical rationale for the initiation of the physician order for Seroquel, an antipsychotic medication. The DON confirmed it is the facility's responsibility to ensure that antipsychotic drugs are not administered to residents who have not previously used them unless the medication is necessary to treat a diagnosed condition, as documented in the clinical record. 28 Pa Code 211.2(d)(3) Medical director. 28 Pa. Code 211.5 (ix) Clinical records 28 Pa. Code 211.9(a)(1)(k) Pharmacy services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 21738 Based on observation and staff interview, it was determined the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in two of two resident pantries (Station 1 and Station 2). Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean, and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness, according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). Observation of the Station One resident pantry on September 4, 2024, at 12:00 PM and September 5, 2024, at 1:45 PM revealed the interior of the microwave was soiled with dried on food ,splatters and the back interior of the microwave was pitted and rust colored. Observation revealed the interior surface of an upright, long-handled dustpan stored next to the counter in the pantry was heavily soiled with a buildup of dirt and debris. Observation of the ice machine revealed the surface and end of the condensation hose (the hose is connected to the back of the ice machine and collects water that empties from the ice machine) were covered with a thick layer of a black mold-like substance. The end of the condensation hose leading from the ice machine to the floor drain had a heavy buildup of a black-colored substance on the end of the hose. The condensation hose was not placed above the floor sewer drain to allow for an air gap (space that separates the ice machine's condensation hose from the sewer drain to prevent contamination of the ice machine in the case of a sewer drain back-up). Observation of Station 2 resident pantry on September 5, 2024, at 10:40 AM revealed a freezer with food substance stains, discolorations, and tan food debris scattered across the base. A cabinet containing resident snacks had food debris on the shelving. Additionally, the microwave was observed with stains and discolorations on the exterior surfaces, while the interior was marked by food debris and stains on the walls, door base, and ceiling. Observation of Station 2 resident pantry ice machine on September 5, 2024, at 1:30 PM revealed the surface and end of the condensation hose were covered with a thick layer of a black mold-like substance. Interview with the nursing home administrator on September 5, 2024, at 2:00 PM confirmed that sanitary practices for food and ice storage should be maintained in the resident pantries. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 201.18 (e)(2.1) Management