

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395148	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/08/2025
NAME OF PROVIDER OR SUPPLIER: RIVER VIEW NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1555 EAST END BLVD PLAINS TWP WILKES BARRE, PA 18711		
STATE LICENSE NUMBER: 220102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT	E 0000		
E 0032	Based on an Emergency Preparedness Survey completed on April 8, 2025, it was determined that Riverview Nursing and Rehabilitation Center was not in compliance with the requirements of 42 CFR 483.73.	E 0032		
SS=E				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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E 0032 SS=E	Continued from page 1 483.73(c)(3) Primary/Alternate Means for Communication §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.542(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by:	E 0032	1. Facility has updated the Delegation of Authority succession Plan. 2. The facility Delegation of Authority will be reviewed and updated as needed. 3. NHA will educate the Receptionist to ensure the Delegation of Authority is completed as needed. 4. Facility Delegation of Authority will be audited weekly x4 then monthly x3 by NHA/Designee to ensure the plan is up to date. Audits will be reviewed at QAPI for further recommendations.	Completion Date: 05/28/2025 Status: APPROVED Date: 04/23/2025

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E 0032 SS=E	Continued from page 2 Based on documentation review and interview, it was determined the facility failed to maintain the emergency preparedness plan in one instance, affecting three of three floors. Findings include: 1. Observation on April 8, 2025, at 12:50 pm, revealed the facility lacked an updated Delegation of Authority succession plan, last dated 8/2020. Many of the names on the contact list did not match the current staff roster when provided by the Administrator. Exit interview on April 8, 2025, at 1:15 pm, with the Facility Administrator and Facilities Manager, confirmed the emergency preparedness deficiency.	E 0032		



Certified End Page

RIVER VIEW NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 220102

SURVEY EXIT DATE: 04/08/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

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K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 220102 Component 01 Main Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on April 8, 2025, it was determined that River View Nursing and Rehabilitation Center was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a three story, Type II (111), protected, noncombustible building, with unused attic spaces, that is fully sprinklered</p>	K 0000		

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K 0211 SS=E	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K 0211	1.The wheelchair on the 3rd floor Pine Ridge C- Tower exit was removed upon discovery. 2.Education will be provided to all staff by the Maintenance Director/Designee on ensuring wheelchairs are not stored blocking access to the exit doors. 3.The Maintenance director or designee will audit weeklyx4 then monthly x3 to ensure wheelchairs are not stored blocking access to the exit doors. 4.Monthly audits will be reviewed at QAPI for further recommendations.	Completion Date: 05/28/2025 Status: APPROVED Date: 04/23/2025

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K 0211 SS=E	Continued from page 2 Based on observation and interview, it was determined the facility failed to ensure that exit access was being maintained readily accessible in one location, on one of three floors. Findings include: 1. Observation on April 8, 2025, at 12:11 pm, 3rd floor Pine Ridge, C-Tower exit had a wheelchair being stored in the corridor blocking access to the exit door. Exit interview with the Facility Administrator and Facilities Manager on April 8, 2025, at 1:15 pm, confirmed the wheelchair blocking the exit door.	K 0211		
K 0321 SS=E		K 0321		

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K 0321 SS=E	Continued from page 4 This REQUIREMENT is not met as evidenced by:	K 0321		

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K 0321 SS=E	Continued from page 5 Based on observation and interview, it was determined the facility failed to maintain three hazardous area enclosures, affecting two of three floors. Findings include: 1. Observation on April 8, 2025, between 11:15 am, and 12:06 pm, revealed the following: a. At 11:15 am, 1st floor, Holding Room door failed to latch into frame when tested. b. At 11:29 am, 1st floor, Elevator machine room had 6 plastic folding tables being stored within the room. c. At 12:06 pm, 3rd floor Sycamore, Soiled Linen, had unsealed penetrations of the wall due to the wall being damaged. Exit interview with the Facility Administrator and Facilities Manager on April 8, 2025, at 1:15 pm, confirmed the hazardous area enclosure deficiencies.	K 0321		

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K 0352 SS=F	<p>NFPA 101 Sprinkler System - Supervisory Signals</p> <p>Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0352	<p>1. The facility has contracted with Beach Lake Sprinkler to replace the fire pump panel on the week of May 5, 2025.</p> <p>2. The facility fire pump controller will be reviewed and updated as needed.</p> <p>3. NHA will educate the Maintenance Director, to assure the fire pump is updated as needed.</p> <p>4. Fire pump will be audited weekly x4 then monthly x3 by Maintenance Director/Designee to ensure fire alarm pump is up to date. Audits will be reviewed at QAPI for further recommendations.</p>	<p>Completion Date: 05/28/2025 Status: APPROVED Date: 04/23/2025</p>

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K 0352 SS=F	Continued from page 7 Based on documentation review and interview, it was determined the facility failed to maintain the automatic sprinkler in one instance, affecting three of three floors. Findings include: 1. Observation on April 8, 2025, at 11:37 am, revealed a supervisory signal on the fire alarm panel for fire pump loss of power. Facility stated they have a new fire pump on site but it has not been installed. Fire alarm testing on 4/1/2025 found no deficiencies. Exit interview with the Facility Administrator and Facilities Manager on April 8, 2025, at 1:15 pm, confirmed the sprinkler supervisory signal.	K 0352		
K 0353 SS=F		K 0353		

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K 0353 SS=F	Continued from page 8 NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	1. The facilities fire pump panel will be replaced the week of May 5th 2025 with Beach Lake Sprinkler company. Maintenance has sealed the penetrations located in the laundry area. The five Dietary Sprinkler heads have been replaced. The second floor Birch penetration near the nurses' station has been sealed. 2. Maintenance Director /Designee will check the ceiling in the laundry from any additional penetrations, and seal if needed. Maintenance Director/Designee will check all sprinkler heads in the dietary for dust, and replace if needed. Maintenance/designee will inspect the Birch unit for penetrations, and seal if needed. 3. Maintenance Director /designee will complete audit x4 weeks, then monthlyx3. 4. Maintenance Director will report to QAPI audits and findings.	Completion Date: 05/28/2025 Status: APPROVED Date: 04/23/2025

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K 0353 SS=F	Continued from page 9 Based on documentation review and interview, it was determined the facility failed to maintain the automatic sprinkler in two instances, affecting three of three floors. Findings include: 1. Observation on April 8, 2025, at 10:55 am, revealed a quarterly sprinkler inspection report from 2/4/2025, stated the fire pump still works as it should, control panel nonresponsive, Emergency stop used to shut down pump. At the time of the survey, this condition remains. Exit interview on April 8, 2025, at 1:15 pm., with the Facility Administrator and the Facilities Manager, confirmed the fire pump deficiency. 2. Observation on April 8, 2025, between 11:10 am, and 12:28 pm, revealed the following: a. At 11:19 am, Laundry, had an unsealed penetration of a ceiling tile, washer side. b. At 11:25 am, Dietary, had (5) sprinkler heads	K 0353		

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K 0353 SS=F	Continued from page 10 loaded with dust. c. At 12:28 pm, 2nd floor Birch, unsealed penetration in a corridor ceiling tile near the nurse's station. Exit interview on April 8, 2025, at 1:15 pm., with the Facility Administrator and the Facilities Manager, confirmed the sprinkler system defciencies.	K 0353		
K 0363 SS=E		K 0363		

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K 0363 SS=E	Continued from page 11 NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 0363	1. The food service door latch has been adjusted to ensure latching; the Personal Laundry Room door latch has been replaced, Aspen Resident Room 202 latch has been adjusted to ensure latching. 2. Dietary doors will be checked to ensure they latch into their frame . Resident room doors in Aspen will be checked to ensure they latch into their frames. 3. NHA/Designee will in-service Maintenance Director on assuring self-closure doors latch correctly. 4. Maintenance/Designee will audit weeklyx4, then monthly x3. Audits will be reported to QAPI, for further recommendations.	Completion Date: 05/28/2025 Status: APPROVED Date: 04/23/2025

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K 0363 SS=E	Continued from page 12 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	K 0363		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0363 SS=E	Continued from page 13 Based on observation and interview, it was determined the facility failed to maintain three corridor openings, affecting two of three floors. Findings include: 1. Observation on April 8, 2025, between 11:27 am, and 12:32 pm, revealed the following: a. At 11:27 am, Dietary, Food Service Room door required adjustment to fully latch into frame. b. At 12:24 pm, 2nd floor, Personal Laundry Room door failed to latch into frame due to the strike plate being taped over. c. At 12:32 pm, 2nd floor Aspen, Resident Room 202 door failed to latch into frame. Exit interview with the Facility Administrator and Facilities Manager on April 8, 2025, at 1:15 pm, confirmed the corridor opening deficiencies.	K 0363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395148	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u> 10 </u> B. WING: <u> </u>	(X3) DATE SURVEY COMPLETED: 04/08/2025
NAME OF PROVIDER OR SUPPLIER: RIVER VIEW NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1555 EAST END BLVD PLAINS TWP WILKES BARRE, PA 18711		
STATE LICENSE NUMBER: 220102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0741 SS=E	<p>NFPA 101 Smoking Regulations</p> <p>Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions:</p> <p>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.</p> <p>(2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.</p> <p>(3) Smoking by patients classified as not responsible shall be prohibited.</p> <p>(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision.</p> <p>(5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</p> <p>18.7.4, 19.7.4</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0741	<p>1. Cigarette butts have been removed from the exterior mulch bed, outside the main entrance.</p> <p>2. Cigarette butts have been removed from all exterior mulch beds.</p> <p>3. Maintenance/Designee will provide education to all staff on the facility non- smoking policy.</p> <p>4. Maintenance will complete audits x4 weeks and then monthly x3. Audits will be reviewed at QAPI .</p>	<p>Completion Date: 05/28/2025 Status: APPROVED Date: 04/23/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395148	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u> 10 </u> B. WING: <u> </u>	(X3) DATE SURVEY COMPLETED: 04/08/2025
NAME OF PROVIDER OR SUPPLIER: RIVER VIEW NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1555 EAST END BLVD PLAINS TWP WILKES BARRE, PA 18711		
STATE LICENSE NUMBER: 220102				
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K 0741 SS=E	Continued from page 15 Based on observation and interview, it was determined the facility failed to maintain smoking regulations, affecting one of three floors. Findings include: 1. Observation on April 8, 2025, at 11:50 am, revealed discarded cigarette butts within the exterior mulch bed, outside the main entrance. Exit interview with the Facility Administrator and Facilities Manager on April 8, 2025, at 1:15 pm, confirmed the smoking regulations deficiency.	K 0741		
K 0919 SS=E		K 0919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395148	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u> 10 </u> B. WING: <u> </u>	(X3) DATE SURVEY COMPLETED: 04/08/2025
NAME OF PROVIDER OR SUPPLIER: RIVER VIEW NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 1555 EAST END BLVD PLAINS TWP WILKES BARRE, PA 18711		
STATE LICENSE NUMBER: 220102				
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K 0919 SS=E	Continued from page 16 NFPA 101 Electrical Equipment - Other Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0919	1. Storage items have been moved away from all electrical panel's components in third floor storage room near the nurses' station. 2. Items have been moved to at least 36 inches of electrical components in facility storage rooms. 3. Maintenance/Designee will educate all staff about maintaining a 3 foot clearance from all electrical panels. 4. Maintenance/Designee will complete audits weekly x4, then monthly x3. Audits will be reported to QAPI.	Completion Date: 05/28/2025 Status: APPROVED Date: 04/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395148	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u> 10 </u> B. WING: <u> </u>	(X3) DATE SURVEY COMPLETED: 04/08/2025
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NAME OF PROVIDER OR SUPPLIER: RIVER VIEW NURSING AND REHABILITATION CENTER STATE LICENSE NUMBER: 220102	STREET ADDRESS, CITY, STATE, ZIP CODE: 1555 EAST END BLVD PLAINS TWP WILKES BARRE, PA 18711
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K 0919 SS=E	Continued from page 17 Based on observation and interview, it was determined the facility failed to maintain the electrical system in one location, affecting one of three floors. Findings include: 1. Observation on April 8, 2025, at 12:02 pm, 3rd floor Storage room near the nurse's station, revealed the storage of items with 36 inches of electrical components, within the room. Exit interview with the Facility Administrator and Facilities Manager on April 8, 2025, at 1:15 pm, confirmed the electrical systems deficiency.	K 0919		



Certified End Page

RIVER VIEW NURSING AND REHABILITATION CENTER

STATE LICENSE NUMBER: 220102

SURVEY EXIT DATE: 04/08/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY