

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER Ridgeview Health Services, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 907 11th Street, NE Jasper, AL 35504	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, review of a Facility Reported Incident (FRI), review of the facility investigative file and a facility policy titled Abuse, Neglect and Exploitation the facility failed to protect Resident Identifier (RI) #152's right to be free from physical abuse perpetrated by another resident, RI #151. On 03/31/2023, Certified Nursing Assistant (CNA) #12 witnessed RI #151 physically abuse RI #152, a cognitively impaired resident, when RI #151 was found in RI #152's room placing a pillow over RI #152's head while RI #152 was in bed. The facility failed to provide adequate supervision and interventions for RI #151, a resident with a history of wandering and aggressive behaviors, to prevent other residents from being abused by RI #151. The witness, CNA #12 said, someone who had a pillow placed over their head may feel smothered or that someone was trying to harm them. This affected one of nine residents sampled for abuse. Findings include: Cross-reference F740. On 03/31/2023 at 8:32 PM the State Agency received a FRI alleging physical abuse occurred when staff witnessed RI #151 in RI #152's room with a pillow placed over RI #152's head. A facility policy titled Abuse Prevention Policy, last revised 10/12/2022 documented: . The residents of Ridgeview Health Services, (Incorporated) have the right to be free from . physical . abuse, . ABUSE is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, . This presumes that instances of abuse of all residents, even those in a coma, cause physical harm, or mental anguish. PHYSICAL ABUSE includes hitting, slapping, pinching and kicking. It also includes controlling behavior . IDENTIFICATION INTERPRETATION: . The admission process should strive to determine the identification of residents whose personal histories render them at risk for abusing other residents or for aggressive behavior with the staff. Development of appropriate intervention strategies to prevent occurrences. Monitoring of the resident for any changes that would trigger abusive behavior and assessment of strategies on a regular basis. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER Ridgeview Health Services, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 907 11th Street, NE Jasper, AL 35504	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assessment should strive to determine the identification of residents who are at risk for being abused . RI #152 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include Alzheimer's Disease. RI #152's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 03/15/2023 documented a Brief Interview for Mental Status (BIMS) score of three which indicated severe cognitive impairment. RI #151 was admitted to the facility on [DATE] and had diagnosis to include Alzheimer's Disease. RI #151's admission MDS assessment with an ARD of 03/28/2023 documented RI #151 had long and short term memory problems and was severely impaired with cognitive skills. RI #151's Behavioral Care Plan for initiated on 03/17/2023, indicated RI #151 exhibited a potential for mood and behavior problems due to diagnoses of Alzheimer's/Dementia, along with behaviors such as aggression. The interventions directed staff to encourage activities of interest, provide materials as needed for independent activities, have activity staff to visit and provide assistance as necessary and communicate with resident in a calming voice during instances of disruptive behaviors. The facility investigative file contained a typed summary, dated 04/05/2023 signed by the DON that documented the facility substantiated the incident occurred between RI #151 and RI #152, however did not substantiate abuse as both residents had severe cognitive impairment. The facility investigative file contained a handwritten witness statement signed by CNA #12 dated 03/31/2023 that documented: "I came in the room I saw (RI #151) over (RI #152) with a pillow over (his/her) face with (his/her) arm over the pillow. I removed (RI #151) taking (him/her) to (his/her) room and notified my charge nurse (immediately). On 08/07/2025 at 7:10 AM CNA #12 was asked about the incident involving RI #151 and RI #152. CNA #12 said that on 03/31/2023, during the 3PM - 11PM shift, she passed RI #152's room and observed RI #151 with a pillow placed over RI #152's face. She stated that she asked RI #151 what he/she was doing and he/she did not respond. CNA #12 removed RI #151 from the room and reported the incident to the nurse. CNA #12 said, prior to the incident RI #151 had been wandering and wandered all the time. CNA #12 said, it could have been prevented if someone was with RI #151 24/7 (24 hours a day/seven days a week). CNA #12 reported RI #151's behaviors included wandering, entering other resident's rooms, getting into other resident's beds and hitting at staff. When asked about interventions to address these behaviors CNA #12 said staff would offer activities or food but RI #151 was difficult to manage. CNA #12 was asked how a reasonable person may feel to have a pillow placed over their head and she said they would think someone was trying to smother or harm them. On 08/08/2025 at 10:54 AM the Administrator (ADM) was asked about the incident involving RI #151 and RI #152. The ADM said the facility unsubstantiated the incident as abuse. The ADM said, RI #151 was admitted to the facility with wandering behaviors. When asked about the level of supervision RI #151 required due to wandering behaviors, the ADM said, RI #151 was on a locked dementia unit. The ADM said, they were following the care plan when this happened, RI #151 was on the dementia unit and had the right to wander freely. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 11/20/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER Ridgeview Health Services, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 907 11th Street, NE Jasper, AL 35504	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/08/2025 at 2:41 PM the Director of Nursing (DON) was asked about the incident involving RI #151 and RI #152. The DON stated RI #151 had a behavior care plan in place on 03/31/2023, which was initiated on 03/17/2023 upon admission. The DON said RI #151 exhibited behaviors including wandering and refusing care and medications. When asked about RI #151's wandering the DON said that RI #151 wandered constantly and would enter other residents rooms. The interventions for RI #151's behaviors included folding towels, redirection and offering snacks or drinks. The DON was asked what were the possible negative consequences of a resident entering another resident's room, she said the resident could become upset if someone was in their personal space. The DON said, she felt like they had done all they could to for prevention and they could not keep RI #151 from wandering freely. The DON also said, she did not feel like RI #151 knew what he/she was doing because RI #151 had dementia. The DON was asked if she felt this incident was abuse, she said she did not believe RI #151 had any intent to harm RI #152. When asked how a reasonable person would feel to have pillow over their head she said it would depend but may shock them.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 11/20/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER Ridgeview Health Services, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 907 11th Street, NE Jasper, AL 35504	
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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER Ridgeview Health Services, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 907 11th Street, NE Jasper, AL 35504	
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 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, review of a facility policy titled, Negative Pressure Wound Therapy, review of Resident Identifier (RI) #150's hospital records and review of a complaint received by the State Agency, the facility failed to provide, in a timely manner, a wound vacuum (vac) as prescribed by RI #150's hospital physician. On 11/10/2022 RI #150 was admitted to the facility with hospital physician orders for a wet-to-dry packing and a wound vac was to be placed to RI #150's right abdominal surgical wound once RI #150 was admitted to the facility. According to facility staff the wound vac was not placed until 11/14/2022, four days after RI #150 was admitted to the facility. RI #150 was discharged from the facility back to the hospital on [DATE] due to an elevated Creatinine laboratory result. When evaluated in the emergency room (ER), RI #150 was found to have dehiscence (a surgical complication where a closed incision reopens) of the right abdominal surgical wound site and a greenish purulent drainage was noted. RI #150 had to have two surgical debridement's to his/her right abdominal surgical wound site. This affected RI #150, one of one resident sampled for wound vac placement. This deficient practice was cited as a result of the investigation of complaint/report number AL00042527. Findings include: On 12/05/2022 at 6:10 PM, the State Agency received an intake alleging RI #150 was neglected and was not provided a wound vac as ordered for the five days RI #150 was at the facility. The complaint further alleged when RI #150 was transferred back to the hospital RI #150 required two surgical debridement's due to his/her wound worsening. Review of a facility policy titled, Negative Pressure Wound Therapy, with an implemented date of 01/15/2021, revealed the following: Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. This policy addresses the use of negative wound therapy (NPWT) for the treatment and management of wounds. Definitions: Negative pressure wound therapy is an active wound care treatment that uses controlled sub-atmospheric (negative) pressure to assist and accelerate wound healing. The therapy may be gauze based, foam based, or peel and stick, and includes evacuation tube and computerized pump that applies negative pressure. Policy Explanation and Compliance Guidelines: 1. Negative pressure wound therapy will be provided in accordance with physician orders. A review of RI #150's Discharge Summaries, with an electronic signed date of 11/10/2022 at 12:27 PM, documented the following: . Hospital Course . (He/She) will discharge with wet-to-dry packing, however will need wound VAC placed once in subacute rehab . Wound VAC will need to be changed 3 times per week . RI #150 was admitted to the facility on [DATE] at 3:39 PM with diagnoses to include Infection Following a Procedure, Organ and Space Surgical Site Subsequent Encounter and Kidney Transplant Status. RI #150's Skin Assessment, dated 11/11/2022, documented: . Narrative . Wound vac to be placed and changed x (times) 3 weekly . RI #150's Progress Notes, dated 11/13/2022 at 11:45 AM, documented: . Wound Vac not in place at this time . RI #150's November 2022 Treatment Administration Record revealed treatment to include wound vac to be changed three times a week on Monday, Wednesday, and Friday, with an order date of 11/11/2022 was not initialed as provided on Friday, 11/11/2022 and was not initiated until 11/14/2022. RI #150's Progress Notes, dated 11/14/2022 at 11:25 AM, documented: . CRNP (Certified Registered Nurse Practitioner) reviewed recent labs and Creatinine resulted 5.5 and GFR (Glomerular Filtration Rate) resulted 10. CRNP gave new order to send to (name of hospital) due to abnormal lab values at this time . RI #150's Emergency Department (ED) Provider Documentation, dated 11/14/2022 at 1:12 PM, documented: . History of Present Illness The onset was chronic. The course/duration of symptoms is worsening. Location is Abdomen. The character of symptoms is wound abscess/infection. The degree at present is moderate . recent . donor kidney transplant representing to the emergency department for evaluation of elevated creatinine. (He/She) is coming from (his/her) rehab facility today. (He/She) was just discharged 4 days ago on 11/10. (His/Her) postoperative course was completed . was also readmitted for surgical site infection with abdominal wall abscess. Today there is a packing present inside of the abscess site on the right lower abdominal wall. Patient (him/herself) does not appear to have any immediate complaints but rather was sent here out of concern for (his/her) elevated creatinine in the setting of (his/her) recent kidney transplant . Physical Examination . Gastrointestinal: Large abdominal wall incision in the right lower quadrant with purulent exudate and packing present. . Tenderness: Mild, generalized . Medical Decision Making . Patient was sent from a rehab facility. (His/Her) abdominal wall surgical site abscess has significant purulent drainage as well and (his/her) abdomen is mildly tender		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER Ridgeview Health Services, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 907 11th Street, NE Jasper, AL 35504	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews and review of a facility policy titled, ACCIDENT/INCIDENT STAFF RESPONSIBILITY, the facility failed to ensure Resident Identifier (RI) #16's fall interventions to have mats on the floor on both sides of the bed; and for the bed to be lowered for safety was being implemented on three of four days of the survey. This affected RI #16, one of four residents sampled for accidents. Findings Include: Review of a facility policy titled, ACCIDENT/INCIDENT STAFF RESPONSIBILITY, with a revision date of 08/08/2022 revealed the following: . Accident refers to an unexpected or unintentional incident, which may result in injury or illness to a resident . RI #16 was admitted to the facility on [DATE] with diagnoses to include Dementia, Severity, with Agitation and Personal History of Transient Attack. RI #16's Incident Report, dated 12/07/2024, documented the following: . Incident Type . Found on floor (checked) .Note any injury to the head, extremities, or trunk . No injury Noted (checked) .EVALUATIONEvaluation Notes: Staff reported on 12/7/24 (RI #16) was found on floor in (his/her) room . Staff added fall mats to the floor on both sides of (his/her) bed . A review of RI #16's Resident Profile revealed the following: . Problem Category Start Date . Falls 12/07/2024 Fall mats beside bed .Falls 12/11/2024 . low bed for safety . RI #16's Fall care plan documented the following:Approaches . Approach Start Date: 12/11/2024 . low bed for safety .Approach Start Date: 12/07/2024 Fall mats beside bed . During the survey the following observations of RI #16 were made: On 08/05/2025 at 3:58 PM RI #16's bed was observed with a fall mat on the floor on the left side of RI #16's bed. RI #16's bed was not in a lowered position. On 08/06/2025 at 8:27 AM RI #16's bed was observed with a fall mat on the floor on the left side of RI #16's bed and RI #16's bed was again observed not to be in a lowered position. On 08/06/2025 at 3:22 PM RI #16 was observed to have a floor mat only on the floor on the left side of the bed and the bed was not in a lowered position. On 08/07/2025 at 7:52 AM the surveyor again observed a fall mat on the floor only on the left side of RI #16's bed and the bed was not in a lowered position. On 08/07/2025 at 11:43 AM a telephone interview was conducted with Registered Nurse (RN) #14, the nurse assigned to care for RI #16 on 12/07/2024, the evening RI #16 was observed on the floor. When asked what type of fall interventions were put in place after RI #16 was observed on the floor, RN #14 said fall mats were to be on both sides of the bed, and the bed was to be lowered when RI #16 was in the bed. On 08/07/2025 at 2:55 PM a telephone interview was conducted with Certified Nursing Assistant (CNA) #14, the CNA assigned to care for RI #16 on the evening RI #16 was observed on the floor. When asked what type of fall interventions were put in place after RI #16 was observed on the floor on 12/07/2025, CNA #14 said the bed was to be kept in the lowest position. On 08/08/2025 at 11:36 AM the surveyor conducted an interview with CNA #9, RI #16's assigned CNA for the morning of 08/08/2024. The surveyor shared with CNA #9 that the surveyor had observed on 08/05/2025, 08/06/2025 and on 08/07/2025 that RI #16 only had a mat on the left side of the bed and RI #16's bed was not lowered to the floor. CNA #9 said it would be important to ensure a resident's fall interventions were being implemented so the resident would not fall and hurt themselves. On 08/08/2025 at 2:17 PM the surveyor conducted an interview with RN #10, one of the Unit Managers for the hall RI #16 resided on. When asked how staff would know the type of fall interventions a resident had in place, RN #10 said it would be on the resident's profile. RN #10 said according to RI #16's plan of care, fall interventions were put in place after RI #16 had a fall on 12/07/2024. RN #10 said fall mats were to be at the bedside, and the bed was to be let down as far as it would go. RN #10 said the CNAs would be made aware of the fall interventions by looking at the resident's profile. RN #10 said whatever order was on RI #16's profile should have been in place on 08/05/2025, 08/06/2025 and on 08/07/2025. When asked why it would be important to ensure a resident's fall interventions were being implemented, RN #10 said to avoid injury.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 11/20/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER Ridgeview Health Services, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 907 11th Street, NE Jasper, AL 35504	
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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER Ridgeview Health Services, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 907 11th Street, NE Jasper, AL 35504	
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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, resident record review, and review of a facility's policy titled Behavioral Health Services, the facility failed to ensure Resident Identifier (RI) #151, a resident with behaviors that were difficult to manage, had interventions and supervision to prevent abuse of other residents and to protect other residents and ensure safety and privacy from RI #151's aggressive wandering behaviors. This deficient practice affected RI #151 and RI #152 two of four residents sampled for behaviors. This deficiency was cited as a result of the investigation of complaint/report number AL00043781/459160. Findings include: Cross-reference F600 On 03/31/2023 at 8:32 PM, the State Agency received a Facility Incident Report (FRI) reporting that Resident Identifier (RI) #151 was found in RI #152's room and RI #151 had a pillow over RI #152's head. A facility policy titled Behavioral Health & (and) Management with a revised date of 10/13/2022 documented: . It is the policy Ridgeview Health Services to adhere to a behavioral health/management program. Procedures Resident will be placed on observation to closely monitor frequency of resident behavior. After observation period resident will be assessed to determine if the facility will proceed to behavior management program, or a Behavior maintenance program, for the severely, cognitively impaired. Assessment Considerations: The assessment should first identify, what causes the behavior, can the behavior be changed, and is there a history of behavioral problems. Consider the following: Behaviors, which pose a physical and/or emotional threat to another resident or staff member. New admissions. 4. Environmental changes. 5. illness, . 9. Disease processes. On 03/17/2023, RI #151 was admitted the facility with a diagnoses of Dementia, moderate with Agitation, Insomnia due to other Mental Disorders, and Depression. RI #151 was admitted to the facility with a documented history of behaviors that required constant supervision. On 03/17/2023, a behavior care plan was developed to address RI #151's behaviors such as aggression, wandering into other resident's room, sitting/climbing on other residents' beds. The interventions guiding staff responses included: Observe residents (RI #151) interactions with others for unacceptable behavior . 1:1 visits as needed . A review of RI #151's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/28/2023 revealed RI #151 had severely impaired cognition, exhibited wandering behaviors, rejection of care, physical and verbal symptoms towards others. RI #152 was admitted to the facility on [DATE] and readmitted to the facility 03/09/2023 with a diagnosis of Alzheimer's Disease. RI #152's admission MDS with an ARD of 03/17/2023 documented RI #152 scored three out of 15 on the Brief Interview of Mental Status (BIMS) assessment which indicated severe cognitive deficits. An untitled facility record documented progress notes for RI #151 as follows: . 03/23/2023 09:42 AM (9:42 AM) . resident had taken breakfast tray from another resident. Minutes later . resident was sitting on roommate's bed. tried to redirect resident away . started trying to stand up on roommate's bed while roommate was in the bed. order received to give Ativan. RI #151's Departmental Notes dated 03/26/2023 at 4:39 AM documented the following: . Resident was sitting on another residents bed trying to take covers. Not easily redirected grabbed covers . grabbed hold (of) residents pajamas and (would not) turn loose. Aggressive behavior toward residents and staff . On 03/31/2023, a handwritten statement signed by Certified Nursing Assistant (CNA) #12 documented the following: I came in the room I saw (RI #151) over (RI #152) with a pillow over (his/her) face with (his/her) arm over the pillow. I removed (RI #151) taking (him/her) to (his/her) room and notified my charge nurse (immediately). On 08/07/2025 at 7:10 AM an interview was conducted with CNA #12 regarding the incident between RI #151 and RI #152 on 03/31/2023. CNA #12 said she was working that evening and recalled the incident. CNA #12 said RI #151 had been wandering prior to the incident which was his/her usual behavior pattern. CNA #12 said she was walking past the room of RI #152, looked in and saw RI #151 had the pillow over the face of RI #152. CNA #12 said RI #151 had both his/her hands on the pillow and was staring down; she immediately went into the room, intervened and removed RI #151 from the room and notified the supervisor. CNA #12 said, it could have been prevented if someone was with RI #151 24/7 (24 hours a day/seven days a week). When asked about RI #151's usual daily behavior pattern, CNA #12 said RI #151 would wander into other rooms constantly, get into other beds, and would fight back when staff attempted to provide redirection. CNA #12 said RI #151 required redirection out of others rooms frequently, and RI #151's behaviors were difficult to manage. On 08/08/2025 at 2:41 PM an interview was conducted with the Director of Nursing (DON) regarding RI #151's behaviors as identified on RI #151's behavioral care plan. DON said that RI #151 had behaviors such as wandering constantly, refusing care, snitting out meds		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2025
NAME OF PROVIDER OR SUPPLIER Ridgeview Health Services, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 907 11th Street, NE Jasper, AL 35504	
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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, the facility's 2025 Spring/Summer Menu for Wednesday - Day 11, the facility's Portioning Utensils document, and the facility's policies for Menu Planning and Menu Substitution Lists, the facility failed to ensure the correct portions of pureed food were served at Dinner/Supper on 08/06/2025. This had the potential to affect three of eleven residents receiving a Pureed Diet. Findings Include: The facility's policy for Menu Planning, dated 2023, included the following: . Policy: Nutritional needs of individuals will be provided in accordance with the established national standards . Procedure: 1. a. Regular and therapeutic menus will be written to provide a variety of foods served on different days of the week, adjusted for seasonal changes, and in adequate amounts at each meal to satisfy recommended daily allowances. The facility's policy for Menu Substitution Lists, dated 2023, included the following: . Vegetables . Amount Equivalent to 1/2 cup . The facility's 2025 Spring/Summer Menu for Week 2, Day 11, Wednesday, Dinner for 08/06/2025, included the following on the Diet Spreadsheet for Pureed Diets: . Pureed Cheeseburger Soup 2 x (times) # (number) 8 dip (scoop) Pureed Creamy Tomato & Onion Salad #8 dip . The facility's document titled Portioning Utensils, undated, included the following: . 1/4 cup #16 [scoop size] / 2 oz. [ounces] (Blue) 1/2 cup #8 / 4 oz. (Grey) . During a kitchen observation on 08/06/2025 at 4:45 PM, the Dinner trayline included the following: Cheeseburger Soup Creamy Onion and Tomato Salad Pureed Cheeseburger Soup Pureed Carrots (substituted for the Creamy Onion and Tomato Salad) Fortified Mashed Potatoes (with butter and sour cream added to increase calories) At 5:30 PM on 08/06/2025, the use of blue-handled scoops for the Pureed Cheeseburger Soup, Pureed Carrots, and Fortified Mashed Potatoes was questioned. The Nutrition Department Director checked the menu and the scoops being used. The three blue-handled scoops being used were verified to be size #16 scoops. The Nutrition Department Director instructed staff to get size #8 scoops and these were put in place for use. Three of eleven Puree diets had been served, because the Nutrition Aide counted eight Pureed Diet menu slips remaining to be served. On 08/06/2025 at 6:26 PM, the Relief [NAME] In-Training was interviewed. The Relief [NAME] In-Training said the scoops (blue-handled, #16 scoops) were already in the food pans on the trayline and he did not know who placed them there. On 08/06/2025 at 6:30 PM, the Nutrition Manager was interviewed. The Nutrition Manager said she did not know who placed the blue-handled, #16 scoops in the food pans. The Nutrition Manager further said the regular PM [NAME] had been helping the Relief [NAME] In-Training, but she had left before the trayline started. On 08/07/2025 at 11:45 AM, a follow-up interview was conducted with the Nutrition Manager. The Nutrition Manager said the Wednesday Dinner menu for S/S (Spring/Summer) Week 2, Day 11 specified a number eight (#8) dip, which is also called a number 8 scoop, be used twice for each serving of Pureed Cheeseburger Soup. The Nutrition Manager further said a number 8 dip (scoop) should have been used for the Pureed Carrots, which were substituted for the Pureed Creamy Tomato & Onion Salad. The Nutrition Manager additionally said a number 8 dip (scoop) was to be used for the Fortified Mashed Potatoes. The Nutrition Manager said there was a problem with using a #16 scoop (1/4 cup) instead of a #8 scoop (1/2 cup); as the nutrition value would be affected due to the residents not getting enough food. The Nutrition Manager further said it could result in weight loss. On 08/07/2025 at 11:45 AM, immediately following the interview with the Nutrition Manager, the Nutrition Department Director was interviewed. The Nutrition Department Director was asked the problem with using a size #16 scoop instead of a size #8 scoop to serve the Pureed Cheeseburger Soup (#8 scoop times two), the Pureed Carrots, and the Fortified Mashed Potatoes. The Nutrition Department Director said it was not enough food, it was an inadequate serving, and if continued over time the residents could lose weight.		