

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395929	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/22/2025
NAME OF PROVIDER OR SUPPLIER  Ridgeview Healthcare & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  200 Pennsylvania Avenue Shenandoah, PA 17976	

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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</b></p> <p>Based on review of clinical records, the facility's abuse prohibition policy, and select investigative reports, and interviews with staff and residents it was determined the facility failed to ensure that one resident (resident 2) out of 7 residents sampled was free from sexual abuse and resultant psychosocial harm.</p> <p>Findings include:</p> <p>A review of a facility policy entitled Abuse Prevention last reviewed October 2024, revealed abuse, neglect, and/or mistreatment of residents will not be tolerated in any manner. All necessary steps shall be taken to ensure the provision of a safe and secure environment. Residents must not be subjected to abuse by anyone including but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies, family members, friends, or other individuals.</p> <p>A review of Resident 2's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included Huntington's Disease (an inherited disorder that causes nerve cells in parts of the brain to gradually break down and die. The disease attacks areas of the brain that help to control intentional movement, as well as other areas) and Dementia (illnesses that affect your thinking, memory, reasoning, personality, mood, and behavior).</p> <p>A review of the resident's Significant Change Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated December 15, 2024, revealed the resident was rarely understood, was severely cognitively impaired, was totally dependent on staff for eating showering, toileting, and dressing, and required maximal assistance with mobility.</p> <p>A review of Resident 3's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included bipolar disorder (a mental illness that causes extreme mood swings, which can impact a person's energy, thinking, and behavior) and generalized anxiety disorder (a condition that causes excessive and persistent worry that interferes with daily life).</p> <p>A review of Resident 3's admission MDS assessment dated [DATE], revealed that the resident was cognitively intact with a BIMS (Brief Interview for Mental Status, a tool to assess the resident's attention, orientation, and ability to register and recall new information) score of 15 (scores of 13-15 equate to intact cognition).</p> <p>(continued on next page)</p>

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:  395929	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/22/2025
NAME OF PROVIDER OR SUPPLIER  Ridgeview Healthcare & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  200 Pennsylvania Avenue Shenandoah, PA 17976	
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)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 3's clinical record revealed no documented evidence the resident had ever displayed signs of sexually inappropriate behaviors while residing at the facility. Additionally, there was no care plan in place indicating the presence of such behaviors.</p> <p>A review of a facility investigative report dated January 19, 2025, at 1:15 PM revealed Resident 3, a cognitively intact resident was observed by staff performing oral sex on Resident 2, a cognitively impaired resident. A review of the investigative reports and witness statements confirmed that Employee 2 nurse aide (NA) and Employee 3, nurse aide (NA) both witnessed the event and immediately reported to the nurse, Employee 1 registered nurse (RN). When questioned Resident 3 admitted to engaging in the act, stating that Resident 2 had initiated the interaction, although Resident 2, due to her severe cognitive impairment, could not have consented to or initiated sexual behavior.</p> <p>A review of a statement from Resident 3, which did not indicate the date or time it was obtained, revealed that Resident 3 went into Resident 2's room to offer her roommate, some yogurt. Resident 3 stated that Resident 2 was moaning as if she needed a drink. He indicated that he went into the bathroom to get her some water, and upon returning, Resident 2 grabbed his hand and pulled him toward her and started to touch the front of his pants. Resident 3 indicated they began to kiss. Resident 3 stated that Resident 2 had her brief off, so he placed his head between her legs for a few seconds. He stated the staff came in, saw what was happening and he confirmed he immediately got up and left the room.</p> <p>A review of nursing documentation written by Employee 1, RN dated January 19, 2025, at 1:15 PM indicated she was notified by Employee 2 NA that Resident 3 was engaged in inappropriate behavior with Resident 2. When Resident 3 was asked what he was doing, he got up and walked out of the room.</p> <p>Resident 2 was observed lying on her mattress with her incontinence brief removed. When asked if someone hurt her, Resident 2 moaned yes. A body audit was conducted revealing no signs of bruising, marks or bleeding.</p> <p>State police were notified, and an investigation was initiated. Resident 2 was sent to the hospital for a rape kit examination.</p> <p>Resident 3 was separated from this resident and placed on one-to-one observation to ensure residents' safety and provide continuous supervision of this resident.</p> <p>A telephone interview with Employee 2, NA on January 22, 2025, at 1:00 PM revealed she was assigned to Resident 2 on January 19, 2025. Employee 2 stated that she asked Employee 3, NA for assistance with Resident 2's care. When they entered Resident 2's room, the privacy curtain was drawn, and they noticed sneakers sticking out from underneath the curtain. Employee 2 indicated she and Employee 3 then moved around the curtain and observed Resident 3 face positioned between Resident 2's legs. She also noted that Resident 2's brief had been removed and was placed to the side.</p> <p>When asked if Resident 2 would have been capable of removing the brief on her own, Employee 2 responded that she could not. She explained that while Resident 2 had a history of attempting to rip off her brief, the brief tabs were not torn. Instead, the tabs had been carefully undone, and the brief had been intentionally placed to the side. Employee 2 further stated when asked Resident 3 what he was doing, he got up and left the room. She observed that Resident 2 appeared distraught. Employee 2 stated she then helped resident to get dressed and escorted her to the dining room for monitoring.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395929	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/22/2025
NAME OF PROVIDER OR SUPPLIER  Ridgeview Healthcare & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  200 Pennsylvania Avenue Shenandoah, PA 17976	
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)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with Employee 3 on January 22, 2025, at 12:12 PM revealed that on January 19, 2025, she had returned from her break when Employee 2 approached her and asked her for assistance with the care. The Resident 2 Employee 3 stated it was approximately 1:00 when they entered the residence room and noticed a pair of sneakers sticking out from under the privacy curtain. She indicated she then walked around the curtain and observed Resident 2 lying on the bed with her brief removed and saw Resident 3's face positioned between Resident 2's legs. Employee 3 stated that she and Employee 2 immediately yelled What are you doing! At that point, Resident 3 got up and walked out of the room. Employee 3 followed Resident 3 out of the room while Employee 2 stayed with Resident 2. Employee 3 immediately reported the incident to Employee 1 RN on duty. Employee 3 further stated she later returned to Resident 2's room and helped her get dressed and assisted her to the dining room. When asked whether Resident 2 would have been able to reach up to pull Resident 3 toward her or grab him, Employee 3 responded no. She explained that Resident 2 requires assistance with. Activities of daily living and would not have the strength to perform such activities.</p> <p>Multiple attempts were made to interview Resident 3 throughout the day on January 22, 2025, however, the resident was asleep during each attempt.</p> <p>A review of legal records indicated, Resident 3 is facing charges of Indecent Assault on a Person with Mental Disabilities, with a preliminary hearing scheduled for February 6, 2025.</p> <p>Resident 2 is cognitively impaired and did not possess the ability to consent to sexual acts with Resident 3. Applying the reasonable person concept, in the case of Resident 2, who is unable to cognizant speak for herself due to severe cognitive impairment, and the assessment of how most people would react to the situation of being sexually abused by Resident 3, Resident 2 would have been negatively affected by Resident 3's actions.</p> <p>An interview with the Nursing Home Administrator on January 22, 2025, at approximately 3:00 PM confirmed that the facility failed to ensure that Resident 2 was free from sexual abuse perpetrated by Resident 3.</p> <p>28 Pa. Code 201.14 (a) Responsibility of licensee</p> <p>28 Pa. Code 201.18 (e)(1) Management</p> <p>28 Pa. Code 201.29 (a)(c) Resident Rights</p> <p>28 Pa. Code 211.12(c)(d)(5) Nursing Services</p>		