

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 03/13/2025
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>48276</p> <p>Based on observation, a review of clinical records, and select facility policy and staff interview, it was determined the facility failed to ensure the self-administration of medications was clinically appropriate for one of the 20 residents sampled (Resident 63).</p> <p>Findings include:</p> <p>A review of facility policy titled Self-Administration of Medications, last reviewed by the facility in October 2024, revealed residents have the right to self-administer medications if the interdisciplinary team has determined it is clinically appropriate and safe for the resident. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and care plan.</p> <p>A clinical record review revealed Resident 63 was admitted to the hospital on October 17, 2024, with diagnoses that included chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and 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).</p> <p>A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 10, 2024, revealed that Resident 63 is cognitively intact with a BIMS score of 13 (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).</p> <p>A clinical record review revealed a physician's order for Resident 63 to receive Docusil oral capsule 100 mg (docusate sodium- a laxative medication) with directions to give 100 mg by mouth two times a day for stool softener initiated on December 5, 2024.</p> <p>During an observation on March 13, 2025, at 8:57 AM, Resident 63 was observed lying on his bed. On his bedside table were three red gelcap pills in a small, clear plastic cup.</p> <p>A clinical record review failed to reveal documented evidence indicating Resident 63 was assessed and deemed clinically appropriate and safe to self-administer his own medications.</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
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on March 13, 2025, at approximately 1:30 PM, the Director of Nursing (DON) indicated that the red gel capsules on Resident 63's bedside table were Docusil oral capsules 100 mg. The DON confirmed that there was no documented evidence deeming Resident 63 safe or clinically appropriate to self-administer his medication. The DON confirmed that the Docusil oral capsules 100 mg should not have been left at Resident 63's bedside table. The DON confirmed it is the facility's responsibility to ensure the self-administration of medications is safe and clinically appropriate.</p> <p>28 Pa Code: 211.9 (a)(1) Pharmacy services.</p> <p>28 Pa Code 211.10 (c) Resident care policies.</p> <p>28 Pa Code 211.12 (d)(1)(5) Nursing services.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on observations and staff interviews, it was determined the facility failed to provide adequate housekeeping services to maintain a clean, sanitary, and homelike environment in one of the two nursing halls (second-floor nursing unit).</p> <p>Findings Include:</p> <p>An observation conducted on March 13, 2025, at approximately 9:00 AM, in room [ROOM NUMBER] revealed Resident 34 sitting in urine and feces-soaked linens that had leaked onto the floor. The floor beneath the bed and surrounding area was visibly soiled with brown and yellow liquid, emitting a foul, overpowering odor. The unsanitary conditions were immediately apparent from the hallway, creating an environment that was both demeaning and hazardous to the resident's dignity and well-being.</p> <p>A second observation on March 13, 2025, at approximately 1:30 PM, conducted with Employee 4, Registered Nurse, confirmed the yellow liquid remained present beneath the bed and in the surrounding area, still emitting a strong foul odor, indicating that no corrective action had been taken for over four hours.</p> <p>During an interview on March 13, 2025, at approximately 3:00 PM, the Nursing Home Administrator acknowledged the facility had failed to maintain a clean and sanitary environment. This failure to provide fundamental housekeeping services compromised resident dignity, exposed residents to infection risks, and created an unfit living environment.</p> <p>Cross refer F 880</p> <p>28 Pa. Code 201.18 (e)(1) (2.1) Management</p> <p>28 Pa. Code 201.29 (a) Resident Rights</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on a review of clinical records, observation, and resident and staff interviews, it was determined the facility failed to provide nursing services consistent with professional standards of practice by failing to thoroughly assess, obtain physician orders, and develop and implement a person-centered comprehensive care plan in accordance with standards of practice for one resident out of 20 sampled residents. (Resident 34)</p> <p>Findings include:</p> <p>According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care:</p> <ul style="list-style-type: none"> -Assessments -Clinical problems -Communications with other health care professionals regarding the patient -Communication with and education of the patient, family, and the patient's designated support person. <p>A review of the clinical record revealed that Resident 34 was admitted to the facility on [DATE], with diagnoses that included congestive heart failure (CHF occurs when the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs) and morbid obesity (a chronic disease that's characterized by a body mass index of 40 or higher, or a body mass index of 35 or higher with obesity-related health issues).</p> <p>A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 19, 2025, revealed that Resident 34 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).</p> <p>A progress note dated March 6, 2025, documented that Resident 34 was receiving wound care services for a pressure wound on the left buttock and incontinence-associated dermatitis (IAD) to bilateral buttocks.</p> <p>A review of a progress note dated March 6, 2025, revealed that Resident 34 is currently being followed by Integrated Wound Care for wound management for a pressure wound to the left buttock and incontinence-associated dermatitis (IAD a condition caused by prolonged exposure to moisture, friction, and irritants from urine and or stool. Leading to skin maceration, inflammation and potential breakdown) to bilateral buttocks.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of weekly skin assessments dated March 8, 2025, confirmed the presence of a pressure wound to the left buttocks and IAD to the bilateral buttocks, but did not document any other skin issues.</p> <p>An observation during an interview on March 13, 2025, at approximately 9:00 AM with Resident 34 revealed she had redness under the area of her left axilla (armpit) that appeared to be a fungal rash.</p> <p>During an interview on March 13, 2025, at 1:30 PM, Employee 4, Registered Nurse (RN), stated that she believed Resident 34 had multiple fungal areas but noted that the resident frequently refused skin assessments. An attempt was made to assess the rash with the RN present; however, Resident 34 refused further examination at that time.</p> <p>A review of Resident 34's physician orders revealed no documented orders for assessment or treatment of a fungal rash.</p> <p>A review of Resident 34's plan of care, in effect at the time of the abbreviated survey ending March 13, 2025, indicated that the resident had a potential for infection and impaired skin integrity related to refusal of incontinence care and showers. However, the care plan failed to identify or address the fungal rash.</p> <p>The facility was unable to provide documented evidence that Resident 34's fungal rash was assessed, treated, or incorporated into her care plan.</p> <p>An interview with the Director of Nursing (DON) on March 13, 2025, at 2:00 PM, confirmed the facility failed to assess and document the presence of Resident 34's fungal rash, obtain appropriate physician orders, and update the resident's care plan accordingly.</p> <p>This failure placed Resident 34 at risk for undetected complications, inadequate treatment, and worsening of skin integrity.</p> <p>28 Pa. Code 211.5(f)(ii)(iv)(ix) Medical records</p> <p>28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48276</p> <p>Based on observations, a review of clinical records, select facility investigative reports, and resident and staff interviews, it was determined the facility failed to implement effective safety measures and sufficient staff supervision to prevent falls for one out of 20 sampled residents (Resident 35) and maintain a safe environment for three out of 20 sampled residents (Residents 52, 55, and 56).</p> <p>Findings include:</p> <p>A clinical record review revealed Resident 35 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 chronic kidney disease (gradual loss of kidney function).</p> <p>A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 3, 2025, revealed that Resident 35 was severely cognitively impaired with a BIMS score of 3 (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 1-7 indicates severe cognitive impairment).</p> <p>A clinical record review revealed Resident 35 is at risk for falls related to a history of falls initiated on March 1, 2024. Interventions in place included placement of antiskid strips from the bedside to the bathroom, anticipating the resident's needs and ensuring the call light was within reach, keeping the bed in a low position and posting signage to remind the resident to ring the call bell for assistance.</p> <p>A progress note dated March 8, 2025, at 3:28 AM, indicated that Resident 35 fell from the bed and was unable to recall details of the fall. The resident complained of pain but could not specify the location. The resident was provided incontinence care and neurological checks were initiated and performed. There were no injuries identified at the time.</p> <p>The assessment at that time noted:</p> <p>Blood glucose: 164 mg/dL</p> <p>Blood pressure: 108/52 mmHg</p> <p>Body temperature: 102.0 F</p> <p>Oxygen saturation: 92% on room air</p> <p>Despite the fall and the resident's confusion, a review of the clinical record failed to reveal any additional safety measures implemented to prevent further falls.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A fall risk assessment completed at 3:34 AM on March 8, 2025, confirmed that Resident 35 remained at high risk for falls.</p> <p>A progress note dated March 8, 2025, at 1:30 PM, indicated Resident 35 was observed to be diaphoretic, shaking, and covered in sweat. The resident reported not feeling well and stated that she was cold, tired, and wanted to be left alone. The resident is only alert to self and very confused.</p> <p>The assessment at that time noted:</p> <p>Blood pressure: 160/100 mmHg</p> <p>Heart rate: 55 beats per minute</p> <p>Respiratory rate: 24 breaths per minute</p> <p>Oxygen saturation: 89%-90% on room air</p> <p>Body temperature: 102.7 F</p> <p>Resident 35 was placed on 2.0 liters per minute of oxygen via nasal cannula, administered Tylenol per physician's order for fever, and new physician's orders were received for laboratory tests (complete blood count and basic metabolic panel), blood cultures, a chest X-ray, respiratory infection panel, and intravenous fluids of.</p> <p>normal saline solution at 100 ml/hr., and vital signs to be obtained each shift.</p> <p>A progress note dated March 8, 2025, at 4:00 PM, indicated another resident called nursing staff because Resident 35 experienced another fall and was found on the floor. The note indicated Resident 35 was assisted back to bed, at that time, her vital signs were:</p> <p>Blood pressure: 140/90 mmHg</p> <p>Heart rate: 68 beats per minute</p> <p>Respiratory rate: 30 breaths per minute</p> <p>Oxygen saturation: 92% on 2 liters per minute oxygen</p> <p>Body temperature: 103.0 F</p> <p>The resident reported pain in her legs and sacrum. Resident. Was in bed with the bed and the lowest position and her call bell was in reach. The physician was notified who indicated to send the resident to the emergency department for evaluation.</p> <p>Despite this second fall within 24 hours, the clinical record failed to reveal any additional safety interventions implemented to prevent further falls.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 4:10 PM, Resident 35 fell for a third time within a 10-minute period, prompting the facility to initiate one-to-one (1:1) supervision until emergency services arrived at 4:15 PM to transport the resident to the emergency department.</p> <p>A community emergency department discharge summary dated March 12, 2025, revealed Resident 35 was admitted on [DATE], with altered mental status and multiple falls. She was diagnosed and treated for sepsis due to urinary tract infection, acute kidney injury, and electrolyte disturbances.</p> <p>During an interview on March 13, 2025, at approximately 1:30 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed there was no evidence that the facility implemented additional or effective safety measures to mitigate Resident 35's risk for falling on March 8, 2025. The DON and NHA confirmed it is the facility's responsibility to ensure effective safety measures are implemented and residents receive sufficient staff supervision to prevent falls.</p> <p>A clinical record review revealed Resident 52 was admitted to the facility on [DATE], with diagnoses that included epilepsy (a chronic brain disorder characterized by recurrent seizures).</p> <p>A review of a quarterly MDS assessment dated [DATE], revealed that Resident 52 has a problem with short-term and long-term memory, has severely impaired cognitive skills for daily decision-making, and has a BIMS score of 99 (a score of 99 indicates that the resident was unable to provide or did not provide answers to complete this section).</p> <p>A clinical record review revealed Resident 55 was admitted to the facility on [DATE], with diagnoses that included Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination).</p> <p>A review of an annual MDS assessment dated [DATE], revealed that Resident 55 is severely cognitively impaired with a BIMS score of 04 (a score of 01-07 indicates severe cognitive impairment).</p> <p>A clinical record review revealed Resident 56 was admitted to the facility on [DATE], with diagnoses that included epilepsy.</p> <p>A review of a quarterly MDS assessment dated [DATE], revealed that Resident 56 is cognitively intact with a BIMS score of 15 (a score of 13-15 indicates cognition is intact).</p> <p>A clinical record review revealed physician's orders for Resident 52 to receive Atenolol tablet 25 mg (a beta blocker medicine, used to treat high blood pressure) with directions to give by mouth two times a day for hypertension initiated on October 5, 2021.</p> <p>A physician's order for Resident 52 to receive a folic acid tablet (a vitamin supplement that may be used to prevent and treat folate deficiency) was initiated on October 6, 2021.</p> <p>A physician's order for Resident 52 to receive a 500 mg Levetiracetam tablet (an anticonvulsant seizure medication) with directions to give twice daily related to seizures initiated on October 5, 2021.</p> <p>A physician's order for Resident 52 to receive Aspirin 81 mg with directions to give 1 tablet by mouth in the morning for coronary artery disease was initiated on October 27, 2023.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility census dated March 13, 2025, revealed Residents 55 and 56 share a resident room.</p> <p>During an observation on March 13, 2025, at 9:23 AM, five pills in a clear plastic cup were observed on Resident 56's bedside table in the resident's room.</p> <p>During an interview at the same time as the observation, Resident 56 indicated the medications were given to him a few days ago but were not his medications, and he had refused to take them. The resident further explained that the facility frequently gave him his roommate's and neighbor's medications (Resident 55 and his neighbor Resident 52) by mistake. Resident 56 explained the medication has been at his bedside since he refused to take it last week. The resident was unable to recall the exact date the medications were placed on his bedside table</p> <p>Resident 52 and Resident 55 were not able to provide answers when asked about their medications.</p> <p>During an interview on March 13, 2025, at 9:25 AM, Employee 3, Licensed Practical Nurse (LPN), confirmed that Resident 56 should not have had medications at his bedside and immediately collected the medications.</p> <p>During an interview on March 13, 2025, at 1:30 PM, the DON confirmed the medications found at Resident 56's bedside belonged to Resident 52. The DON identified the medications as:</p> <p>Atenolol 25 mg tablet (for hypertension)</p> <p>Folic acid 2.0 mg tablets (two)</p> <p>Levetiracetam 500 mg tablet (an anticonvulsant for seizures)</p> <p>Aspirin 81 mg tablet (for coronary artery disease)</p> <p>The DON was unable to explain how Resident 56 came into possession of Resident 52's medications. The DON confirmed that it is the facility's responsibility to ensure a safe environment free of accident hazards, including preventing medication errors and ensuring proper medication security.</p> <p>28 Pa. Code 201.18 (b)(1)(e)(1) Management.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(4)(5) Nursing services.</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>26142</p> <p>Based on staff interview and a review of employee credentials, it was determined the facility failed to employ a full-time qualified director of food and nutrition services and failed to ensure the registered dietitian (RD) provided the required on-site oversight of the food and nutrition services department.</p> <p>Findings include:</p> <p>An interview with the facility's Nursing Home Administrator (NHA) on March 13, 2025, at approximately 3:00 PM, revealed Employee 1 was appointed as the dietary supervisor on October 28, 2024. However, Employee 1 did not possess the regulatory qualifications for the role, as she was not a Certified Dietary Manager (CDM) and had not yet completed the required CDM program. Additionally, the NHA was unable to provide a definitive timeline for Employee 1's program completion or when she would obtain certification.</p> <p>The NHA further confirmed the full-time registered dietitian (RD) resigned on January 23, 2025. The NHA stated that since that time, the facility had not employed an in-house RD and instead relied on a corporate dietitian who provided services exclusively on a remote basis. She stated that all the dietary documentation/assessments from January 23, 2025, to the date of the survey was completed remotely by the corporate dietitian.</p> <p>The NHA confirmed the corporate RD did not conduct on-site supervisory oversight of the food and nutrition services department, including staff training, direct observation of residents for comprehensive nutritional assessments, or monitoring of meal service.</p> <p>28 Pa Code 201.18 (b)(1)(3) Management.</p>		

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on the facility's accounts payable ledger and staff interviews, it was determined the facility failed to comply with Federal, State, and Local laws and professional standards by not ensuring timely payment for goods and services necessary for daily operations.</p> <p>Findings include:</p> <p>The 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations, subsection 201.14(g), dated July 1, 2023, revealed a facility owner shall pay in a timely manner bills incurred in the operation of a facility that are not in dispute and that are for services without which the resident's health and safety are jeopardized.</p> <p>A review of the current outstanding accounts payable ledger revealed outstanding balances as of January 1, 2025, exceeding 121 days past due, including but not limited to:</p> <p>Allstate Pest Management: \$3,438.64</p> <p>American Express Shenandoah: \$359,551.27</p> <p>Aplus Staffing LLC (nurse staffing agency): \$558,269.78</p> <p>[NAME] foods: \$63,349.93</p> <p>[NAME] of Shenandoah-Sewer: \$2577.32</p> <p>CMS: \$157,209.00</p> <p>Eshyft (nurse staffing agency): \$772,572.57</p> <p>Intelycare (nurse staffing agency): \$182,485.12</p> <p>Milestone staffing (nurse staffing agency): \$322,911.51</p> <p>Nutra Co: 50,940.50</p> <p>Pennsylvania Nursing Facility Assessment-CHC: \$3,556,756.93</p> <p>[NAME] J. Thurick D.O. (facility medical director: \$11,000</p> <p>SEIU Healthcare PA Health and Welfare Plan: \$1,463.25</p> <p>SEIU Union Dues: \$1,835.55</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 03/13/2025
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.

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<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>SEIU Training Fund: \$24,935.69</p> <p>Select Ambulance: \$42,980.40</p> <p>Total Plan Concepts: \$258,058.70</p> <p>Twin Med, LLC: \$95,740.28</p> <p>Xtreme Towing and Recovery, Snow Plowing and Removal: \$1790.00</p> <p>During an interview on March 13, 2025, at 11:00 AM, the facility's Nursing Home Administrator (NHA) confirmed the facility's owners had not provided evidence of payments or formal payment agreements for the outstanding vendor invoices. Additionally, she stated that facility administration did not have direct access to billing or payment records and could not verify whether any past-due bills had been settled.</p> <p>Additionally, the facility's Nursing Home Administrator (NHA) confirmed that 27 facility staff members received payroll checks in January 2025 that were returned due to insufficient funds. The NHA stated that the corporate office later reissued the checks and covered any associated fees.</p> <p>This failure to ensure the timely payment of essential goods, services, and payroll obligations represents noncompliance with Federal, State, and Local laws requiring facilities to maintain financial solvency to prevent operational disruptions that could jeopardize resident health and safety. The facility's failure to pay for critical staffing, food services, medical supplies, and essential utilities created a potential risk of adverse outcomes, including staffing shortages, disruptions in medical care, and food supply issues.</p> <p>28 Pa. Code 201.14(g) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18 (b)(3)(e)(1) Management.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142</p> <p>Based on clinical record review, observation, and interview it was determined, the facility failed to implement effective infection prevention and control practices regarding activities of daily living (ADLs), including toileting, bathing, and bed maintenance, for one of 20 sampled residents (Resident 34).</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 34 was admitted to the facility on [DATE] with diagnosis to include, morbid obesity, acute and chronic respiratory failure, Chronic obstructive pulmonary disease (COPD type of obstructive lung disease characterized by long-term poor airflow. The main symptoms include shortness of breath and cough with sputum production.), diabetes, heart disease and anxiety.</p> <p>A quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated February 19, 2025, revealed a BIMS score of 15 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 13-15 equates to being cognitively intact of 15) and required assistance with activities of daily living.</p> <p>A care plan initiated on November 18, 2022, documented that Resident 34 exhibited alterations in behavior, including frequent refusals of care and refusal to allow housekeeping to clean the mattress or room at times. Interventions included encouraging the resident to demonstrate appropriate behaviors and directing staff to re-offer care and housekeeping services as needed.</p> <p>A care plan dated March 13, 2023, revealed the resident frequently refused incontinent care and showers, threw soiled briefs and linens on the floor, and generated a strong odor in the room. Staff were directed to offer care every two hours and as needed.</p> <p>A care plan update initiated on April 4th, 2024, identified that Resident, 34, continued to lie in her own feces and urine despite staff interventions and refused all hygiene care. Staff documented persistent refusals of assistance with toileting, bathing and perineal care. The goal is to maintain improved hygiene and skin integrity by accepting staff assistance.</p> <p>A care plan goal-initiated June 27, 2022, and last updated October 14, 2024, for bowel and bladder incontinence directed staff to check and change the resident every two hours and as needed, including perineal care and changing soiled clothing after each incontinence episode.</p> <p>A care plan initiated February 27, 2024, identified the resident's refusal of care as a potential infection risk and skin integrity concern related to refusal of showers, refusal of getting out of bed's, refusal to allow housekeeping services, refusal of wound care. And refusal of accepting a new mattress. Interventions included monitoring for signs of infection, educating the resident on risks, and encouraging hygiene care.</p> <p>A review of shower records revealed that Resident 34 had refused a shower twice weekly on:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>February 18, 2025</p> <p>February 21, 2025</p> <p>February 25, 2025</p> <p>February 28, 2025</p> <p>March 4, 2025</p> <p>March 7, 2025</p> <p>March 11, 2025</p> <p>Corresponding (with the residents scheduled showers) nursing weekly skin assessments from January 7, 2025, through March 13, 2025, documented the resident refused all skin assessments.</p> <p>A review of toileting records showed Resident 34 refused two-hour toileting and perineal care from February 18, 2025, through March 13, 2025.</p> <p>On March 13, 2025, at approximately 9:00 AM, Resident 34 was observed in her room sitting in urine- and feces-soaked linens, which had leaked onto the floor. [NAME] and yellow liquid was visible under and around the bed, with a strong foul odor emanating from the room.</p> <p>March 13, 2025, at approximately 1:30 PM, a second observation with Employee 4 (Registered Nurse) confirmed the presence of a yellow liquid under the bed and surrounding area, with a persistent foul odor.</p> <p>On March 13, 2025, at 2:00 PM, the Facility Maintenance Director stated that the resident's urination and defecation had soaked through the mattress and into the floor, creating an odor that could not be removed. He reported the resident's mattress was changed approximately every three months.</p> <p>On March 13, 2025, at 3:00 PM, the Nursing Home Administrator (NHA) confirmed that the resident consistently defecates and urinates in bed, refuses hygiene care, showers/bed baths, change of clothing, and remains in soiled linens for prolonged periods. The NHA stated this had resulted in continuous pressure and moisture-related skin issues. The resident refused weekly wound consultant assessments and nursing assessments for at least the past 7 months. The NHA acknowledged the unsanitary conditions but indicated staff do not know what to do. She confirmed that staff replaced the mattress and linens only when the resident permitted, approximately every three months.</p> <p>At the time of the survey, there was no evidence that the facility maintained a sanitary environment or implemented effective infection prevention and control measures for Resident 34, who required staff assistance for ADLs.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Despite the resident's persistent refusal of toileting, bathing, and incontinence care, the facility failed to develop and implement alternative infection control strategies, such as individualized behavioral interventions, increased staff training, or modifications to care approaches. This failure resulted in prolonged exposure to urine and feces, an unsanitary living environment, increased infection risk, and potential for skin breakdown.</p> <p>Cross refer F584</p> <p>28 Pa. Code 201.18 (b)(3)(e)(1)(2) Management.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(4)(5) Nursing services.</p>		