STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395929	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeview Healthcare & Rehab Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, review of clinical records, select facility policies, and staff and resident interviews, it was determined the facility failed to ensure the resident environment was free from potential accident hazards related to unsecured medications on two out of two nursing units reviewed (Units 2 and 3) and for three out of eight residents sampled (Residents 1, 5, and 13). Findings include: A review of the facility policy titled Administering Medications, last reviewed July 28, 2025, revealed it is the facility's policy that medications are administered in a safe and timely manner and only as prescribed.A review of the facility policy titled Self-Administration of Medications, last reviewed July 28, 2025, revealed it is the facility's policy that medications permitted for self-administration are stored in a safe and secure manner and are not accessible to other residents. The policy further states that if safe storage is not possible in the resident's room, medications are to be stored on a central medication cart or in the medication room. A clinical record review revealed Resident 13 was admitted to the facility on [DATE]. Review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 23, 2025, revealed that Resident 13 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 to 15 indicates cognition is intact). A clinical record review revealed a Medication Self-Administration Screen dated April 16, 2025, which indicated Resident 13 was appropriate for self-administration of medications. An observation conducted on February 5, 2026, at 9:15 AM revealed an orange oblong pill partially obscured by papers on the bedside table in Resident 13's room. During an interview conducted on February 5, 2026, at 9:15 AM, Resident 13 stated the pill must have fallen out of her medication cup. During an interview conducted on February 5, 2026, at 9:20 AM, Employee 1, Licensed Practical Nurse (LPN), collected and secured the medication and identified it as methocarbamol 750 mg (a muscle relaxant medication used to relieve muscle spasms). Employee 1 confirmed Resident 13 had a current physician's order for methocarbamol 750 mg. An additional observation on February 5, 2026, at 9:24 AM in Resident room [ROOM NUMBER] revealed two pills and a clear medication cup on the floor near the window-side bed. One pill was oval shaped and salmon-colored with an 894 imprint. The second pill was yellow and oblong with a dividing line and an imprint of 1 and 8. During an interview on February 5, 2026, at 9:26 AM, Employee 2, LPN, confirmed the medications should not have been on the floor and secured the pills. During an interview on February 5, 2026, at 11:15 AM, the Nursing Home Administrator (NHA) identified the salmon-colored pill as Eliquis 5 mg (an anticoagulant medication used to prevent blood clots) and the yellow pill as sertraline 100 mg (a selective serotonin reuptake inhibitor, a class of medication commonly used to treat depression and anxiety). The aforementioned information was reviewed with the NHA. The facility failed to ensure the resident (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(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 - Some	environment was safe from accident hazards, specifically residents having access or ingestion to unsecured medications A clinical record review revealed Resident 1 was admitted to the facility on [DATE], with diagnoses to include muscle weakness and osteoporosis (disease where bones become weak, porous, and brittle, significantly increasing fracture risk). A review of an admission MDS dated [DATE], revealed that Resident 1 was cognitively intact with a BIMS score of 15. The clinical record review revealed no documentation indicating Resident 1 had been assessed or approved to self-administer medications.An observation conducted on February 5, 2026, at 9:30 AM revealed a tube of hydrocortisone 1 percent cream (a medicated topical corticosteroid used to reduce skin inflammation and irritation) at Resident 1's bedside. The tube lacked instructions for use, dosage information, and labeling. A review of the clinical record revealed no physician order for hydrocortisone cream. During an interview on February 5, 2026, at 9:34 AM, Employee 3, Registered Nurse Supervisor, confirmed Resident 1 should not have had the hydrocortisone cream at her bedside. A clinical record review revealed Resident 5 was admitted to the facility on [DATE], with diagnosis to include diabetes (a chronic condition characterized by high blood sugar levels) and muscle weakness. Review of an admission MDS dated [DATE], revealed Resident 5 was cognitively intact with a BIMS score of 15. An observation conducted on February 5, 2026, at 10:00 AM revealed a tube of zinc oxide 20 percent ointment (a topical skin protectant used to prevent and treat minor skin irritation) at Resident 5's bedside. The tube was labeled with the resident's name and room number written in marker. During an interview at the time of observation, Resident 5 stated staff routinely left the ointment at her bedside for application. The resident further stated she did not apply the medication herself but could if she chose to, and that staff routinely left medications at her bedside, the resident stated the cream is always left at her bedside. During an interview on February 5, 2026, at 11:00 AM, the Nursing Home Administrator was informed of and reviewed the above findings related to nursing staff leaving medicated creams and ointments at residents' bedsides, accessible for use, despite residents not having documentation of assessment or approval to self-administer medications. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(5) Nursing services