

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/03/2025
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)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records and resident and staff interviews, it was determined the facility failed to provide care in a manner that promotes each resident's quality of life by failing to respond timely to residents' requests for assistance, including experiences reported by three residents out of 19 residents sampled (Residents 5, 68, and 80) and one resident representative (Resident 11). Findings include: A clinical record review revealed Resident 68 was admitted to the facility on [DATE], with diagnoses that include peripheral vascular disease (a condition in which narrowed arteries reduce blood flow to the arms or legs). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated September 11, 2025, revealed that Resident 68 was 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). A clinical record review revealed Resident 11 was admitted to the facility on [DATE], with diagnoses that included cerebral infarction (brain damage that results from a lack of blood) and end-stage renal failure (the final stage of kidney decline where the kidneys are no longer able to function to meet the body's needs). A review of a quarterly Minimum Data Set assessment dated [DATE], revealed that Resident 11 was severely cognitively impaired with a BIMS score of 03; a score of 0-07 indicates cognition is severely impaired). A clinical record review revealed Resident 5 was admitted to the facility on [DATE], with diagnoses that include 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). A review of a quarterly MDS dated [DATE], revealed that Resident 5 is cognitively intact with a BIMS score of 15; score of 13-15 indicates cognition is intact. A clinical record review revealed Resident 80 was admitted to the facility on [DATE], with diagnoses that include cerebral palsy (a condition characterized by brain damage or abnormal development shortly after birth that affects movement, muscle tone, and coordination). A review of an admission MDS dated [DATE], revealed that Resident 80 is cognitively intact with a BIMS score of 14; a score of 13-15 indicates cognition is intact. During an interview on September 30, 2025, at 10:05 AM, Resident 80 explained that he was dependent on staff for care and was frustrated and upset about the long wait times he experiences for care. Resident 80 indicated that he has only been at the facility for a few weeks but usually waits about 40 minutes before staff are able to assist him with care. He explained that the longest he waited was one and a half hours for staff to respond to him for assistance. He indicated that he was frustrated because he brought this issue up to social services and the Director of Nursing, but nothing had been done to fix the problem. Resident 80 became tearful, stating that it is not right that there are no staff available to assist him when he needs help. During an interview on September 30, 2025, at 11:15 AM, Resident 11's resident representative explained that she is angry and frustrated by the long wait times Resident 11 experiences for care. She explained that Resident 11 receives hours of dialysis treatment (a procedure where a machine filters the blood through an artificial kidney). After his dialysis treatment, (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 11 is left weak, disoriented, and uncomfortable and then waits 45 minutes to an hour before staff respond to his call bell to be assisted back into bed. Resident 11's representative indicated she has brought this issue up to nursing staff and the Director of Nursing (DON) but was told there is nothing that can be done to improve the situation. During an interview on September 30, 2025, at 11:30 AM, Resident 68 explained that he was happy with the facility but upset that he sometimes waits 30 minutes or 45 minutes for staff to respond to his call bell for assistance. He indicated he needs staff to help him get cleaned up and to transfer to the bathroom, but the wait times for staff can be long. During an interview on October 1, 2025, at 10:00 AM, Resident 5 indicated that she was frustrated and upset that she waits from 45 minutes to two hours for staff to provide her care after she rings her call bell for assistance. She explained the wait times are like this on all shifts. Resident 5 indicated she has brought this issue up to nursing staff and during resident group meetings, but nothing has been done to address her concerns. During an interview on October 1, 2025, at 1:30 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) acknowledged that all residents should be treated with dignity and respect and provided care in a manner that promotes each resident ' s quality of life. The concerns related to residents ' reports of untimely staff responses to requests for assistance and care were reviewed with the NHA and DON; however, no explanation was provided at the time of the interview. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (d)(4) Nursing services.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy, and resident representative and staff interviews, it was determined that the facility failed to timely notify the resident's representative of a hospitalization after a fall for one resident out of 19 sampled (Resident 11). Findings include: A review of the facility policy titled Change in a Resident's Condition or Status, last reviewed by the facility on July 28, 2025, revealed the facility shall promptly notify the resident, his or her attending physician, and representative of changes in the resident's medical or mental condition or status. The policy indicates the nurse will notify the resident's representative when the resident is involved in any accident or incident that results in an injury or when it is necessary to transfer the resident to a hospital or treatment center. A clinical record review revealed Resident 11 was admitted to the facility on [DATE], with diagnoses that include cerebral infarction (brain damage that results from a lack of blood) and end-stage renal failure (the final stage of kidney decline where the kidneys are no longer able to function to meet the body's needs). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated September 19, 2025, revealed that Resident 11 was severely cognitively impaired with a BIMS score of 03 (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 0-07 indicates cognition is severely impaired). A progress note dated June 20, 2025, at 8:35 PM revealed Resident 11 was found on the floor in his room. Resident 11 was found on his back in a supine position with his head resting against the closet door. The resident stated he fell out of his wheelchair while trying to stand up. The resident was alert with periods of confusion. The resident was assessed with two new superficial abrasions noted to the mid-occipital region of the head (back middle of the head). The areas were cleansed with wound cleanser and dried. The nursing supervisor was notified and assessed the resident. After assessment, the physician was notified, and a new order was placed to send the resident to the community emergency department by way of emergency medical services for further evaluation. A progress note dated June 20, 2025, at 11:31 PM indicated an order to send Resident 11 to the emergency department for treatment and evaluation and the physician and resident representative were made aware (this progress note was documented as written two and a half hours after Resident 11 was sent to the emergency department). During an interview on September 30, 2025, at 11:15 AM, Resident 11's resident representative explained she was angry and upset that Resident 11 was sent to the emergency department after his fall on June 20, 2025, and the facility never notified her that he was there until the following day. She explained she felt it was awful that Resident 11 was in the emergency department by himself overnight and she was never informed. She explained that two weeks prior to Resident 11's fall and hospitalization, she provided the facility an updated phone number, but the facility failed to record the information. She also explained there was a secondary emergency contact that was not called when Resident 11 was hospitalized on [DATE]. Resident 11's representative indicated that she was made aware of the hospitalization when the facility contacted the second emergency contact to let them know he returned from the hospital. She expressed that she was frustrated when she found out that Resident 11 was hospitalized without her knowledge. A review of Resident 11's facility admission record revealed two emergency contacts were listed with corresponding phone numbers. During an interview on October 1, 2025, at 1:30 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) were unable to provide evidence the facility provided timely notification to the resident representative that Resident 11 was transferred to the emergency room on June 20, 2025. The facility failed to ensure Resident 11's representative was provided timely notification of his transfer from the facility to the emergency department. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policy review, and staff interview it was determined that the facility failed to ensure that one resident (Resident 53) of an 18 resident sample was free of chemical restraints that were not necessary to treat the resident's medical symptoms, were without justification, and did not demonstrate individualized, nonpharmacological approaches to care. Findings include: A review of the facility policy, Identifying Involuntary Seclusion and Unauthorized Restraint, last reviewed on April 15, 2025, defines a chemical restraint as any drug used for discipline or staff convenience, and not required to treat medical symptoms. The policy further indicated residents must be free from chemical restraints not used to address medical conditions. According to the facility policy, psychotropic medications (drugs that affect one's mental state) will not be administered without documented indication for use and without evaluating for potential underlying causes for distressed behavior. Resident 53 was admitted to the facility on [DATE], with a diagnosis of an encounter for surgical aftercare following surgery on the skin and subcutaneous tissue (care received after surgical procedure) and non-pressure chronic ulcer of other part of unspecified foot (a wound that is not related to pressure that will not heal). A Quarterly Minimum Data Set assessment (MDS- a federally mandated standardized assessment conducted at specific intervals) dated September 22, 2025, indicated Resident 53 was moderately cognitively impaired with a BIMS score of 12 (brief interview for mental status, a tool to assess the resident's attention, orientation and ability to register and recall new information). A score of 12 indicates moderate cognitive impairment. A review of the Resident 53's physician orders revealed the following: September 16, 2025: Alprazolam (a medication used primarily for anxiety and panic disorders) 0.5 mg one tablet by mouth every 24 hours as needed (PRN) for anxiety, discontinue September 17, 2025. September 17, 2025: Alprazolam 0.5 mg one tablet by mouth every 24 hours as needed for anxiety for 14 days, discontinue October 2, 2025. A review of the electronic medication administration record (eMAR) revealed that Resident 53 received PRN (as needed) Alprazolam 0.5 mg on seven occasions between September 17 and September 30, 2025. The administration occurred on September 17 at 3:03 PM; September 19 at 9:57 AM; September 23 at 12:31 AM; September 26 at 12:24 AM; September 27 at 8:59 PM; September 28 at 9:00 PM; and September 30 at 12:16 AM. For all seven administrations, the clinical record did not contain documentation indicating that staff attempted any non-pharmacological interventions (interventions that do not involve medication, such as redirection, conversation, or environmental modification) before the medication was given. In addition, on three of these dates, September 17 at 3:03 PM, September 19 at 9:57 AM, and September 28 at 9:00 PM, the record also lacked documentation of any behavioral symptoms or clinical justification supporting the need for Alprazolam administration. Further review of the MDS Section E (section documenting resident behavioral symptoms) completed by Employee 4 (Registered Nurse Assessment Coordinator) documented that Resident 53 did not exhibit any behavioral, verbal, or physical symptoms during the assessment period of September 16, 2025, through September 22, 2025. During this time, Alprazolam was administered twice on September 17 and 19, 2025. The administration of Alprazolam 0.5 mg in the absence of documented behavioral symptoms or medical justification indicated the drug was not used to treat a specific medical condition and therefore constituted a chemical restraint. A review of Resident 53's plan of care initiated September 17, 2025, documented psychosocial well-being problems related to depression and bipolar disorder. Interventions included administering medications as ordered, introducing Resident 53 to other residents with similar interests, providing familiar items from home, and allowing the resident to express concerns when upset. However, there was no documentation showing that these interventions were implemented prior to the administration of Alprazolam. The Activities Evaluation dated September 17, 2025, indicated that Resident 53 spoke (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	three languages. Greek, German, and Russian, had interests in cars, specifically [NAME], and enjoyed photography. Despite these documented interests, the clinical record contained no evidence that staff used individualized, non-pharmacological interventions related to these preferences to address distress or anxiety before administering the PRN medication. Interviews with the Director of Nursing (DON) on October 1, 2025, could not provide documentation showing medical justification for the administration of Alprazolam or evidence that non-pharmacologic interventions were attempted prior to its use. 28 Pa. Code 211.2(3) Medical director. 28 Pa. Code 211.5(i)(ii)(viii)(xi) Clinical records 28 Pa. Code 211.8 (e) Use of restraints. 28 Pa. Code 211.9(b)(2) Pharmacy services. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(5) Nursing Services.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, the Resident Assessment Instrument (RAI), and staff interview, it was determined the facility failed to ensure the Minimum Data Set Assessments accurately reflected the status of one resident out of 19 sampled (Resident 5). Findings include: According to the Resident Assessment Instrument (RAI) User's Manual (an assessment tool utilized to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan, and the RAI also assists staff to evaluate goal achievement and revise care plans accordingly by enabling the facility to track changes in the resident's status) dated October 2024, Section N Medications Subsection N0350A: Insulin, indicate the number of days during the 7-day look-back period that the resident received insulin (a hormone medication used to treat diabetes) injections. A clinical record review revealed Resident 5 was admitted to the facility on [DATE]. A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated September 8, 2025, Section N Medication Subsection N0350. Insulin revealed that Resident 5 received seven injections of insulin during the 7-day look-back period. A review of Resident 5's medication administration record dated August 2025, and September 2025 revealed no documented evidence Resident 5 received any insulin injections during the seven-day look-back period. During an interview on October 1, 2025, at 1:50 PM, the Nursing Home Administrator confirmed Resident 5 did not receive insulin injections during the seven-day look-back period, as indicated in the resident MDS assessment dated [DATE]. After inquiries made during the survey, the facility corrected the error and submitted a modification to September 8, 2025, MDS assessment for Resident 5. 28 Pa. Code 211.12(d)(3) Nursing services.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, observation, and staff and resident interviews, it was determined the facility failed to incorporate and address an identified resident preference and behavior into the care planning process for one of 19 sampled residents (Resident 1). Findings include: The clinical record review indicated Resident 1 was admitted to the facility on [DATE], with a diagnosis of Anoxic Brain Damage (a condition that occurs when oxygen flow to the brain is cut off or severely reduced, causing brain cell injury and impaired neurological function). The clinical record also revealed Brief Interview for Mental Status assessment (BIMS, a tool to assess the residents attention, orientation and ability to register and recall new information) dated August 13, 2025, with a score of 12, indicating moderate cognitive impairment (moderate impairment means the resident has some loss of memory, reasoning, or judgment but retains partial decision-making ability and may need staff assistance to make safe choices). On September 30, 2025, at 10:15 AM, an interview was conducted with Resident 77, who resided on the same unit. Resident 77 stated that on September 27, 2025 (Saturday), Resident 1 was observed smoking in the third-floor dining room. On September 30, 2025, at 1:00 PM, interviews were conducted with Employee 3 (Registered Nurse) and the Nursing Home Administrator (NHA). Both employees acknowledged that Resident 1 had previously possessed vaping materials (defined as the act of inhaling vapor produced by an electronic cigarette or similar device that heats a liquid containing nicotine or other substances) but denied knowledge of the reported September 27 incident. The NHA explained that a visitor was known to supply Resident 1 with vaping materials and stated that Resident 1 's room was consistently checked for vaping supplies; however, the NHA could not verify when the most recent check had been conducted, how often such checks occurred, or provide documentation of those checks. A review of a social-service progress note dated September 8, 2025, at 10:50 AM documented that while being transported to a medical appointment, Resident 1 attempted to vape in the facility vehicle. The social service worker documented that Resident 1 was educated on facility policy and agreed to give up the vaping device, which was found hidden in her underwear. A review of the facility policy titled Comprehensive Care Planning, last reviewed April 15, 2025, indicated the facility will develop a comprehensive, person-centered plan for each resident that includes measurable objectives to meet the resident 's physical, psychosocial, and functional needs. A review of the facility policy titled Smoking Policy-Residents, last reviewed April 15, 2025, documented that electronic cigarettes (e-cigarettes or vapes) are not considered smoking devices with respect to ignition risk but are considered potential hazards due to health effects for the user, second-hand aerosol exposure, nicotine toxicity (overdose of nicotine which can cause nausea, dizziness, and rapid heart rate), and the risk of battery explosion or fire. The policy further stated that residents who wish to use e-cigarettes are to be assessed for their ability to use the device safely and, if appropriate, may do so only with supervision and in designated smoking areas. A review of Resident 1 's comprehensive care plan, current as of September 30, 2025, revealed no evidence that the resident 's known desire and repeated attempts to vape had been assessed or addressed. The care plan lacked interventions to ensure supervision, safety precautions, or psychosocial supports related to vaping behavior, and did not include measurable goals or objectives consistent with the resident 's expressed preferences and facility policy. The facility failed to ensure that the resident 's expressed preference and behavior concerning vaping were assessed and incorporated into the person-centered care plan. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12(d)(3) Nursing services.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, observation, and staff and resident interviews, it was determined the facility failed to ensure oxygen therapy was administered per physician's orders for one resident out of 19 sampled (Resident 70). Findings include: A review of the facility ' s policy titled Oxygen Administration, last reviewed on July 28, 2025, revealed that the purpose of the policy was to provide guidelines for safe oxygen administration. The policy directed staff to check the oxygen delivery system, including the mask, oxygen tank, and humidifier bottle (also known as humidifier reservoir, the container that holds sterile or distilled water through which oxygen passes to add moisture before being delivered to the resident) to ensure they were in good working order and securely fastened. The policy further required staff to verify that there was an adequate water level in the humidifier bottle so that the water bubbled as oxygen flowed through, and to periodically re-check the water level to ensure proper humidification. A clinical record review revealed that Resident 70 was admitted to the facility on [DATE], with a diagnosis to include respiratory failure (a serious condition that makes it difficult to breathe). A review of an annual Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 6, 2025, revealed that Resident 70 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). A physician ' s order dated September 3, 2025, directed that Resident 70 receive oxygen with humidified water at 4.0 liters per minute by nasal cannula. A nasal cannula is a flexible medical tube with two prongs that fit into the nostrils, used to deliver supplemental oxygen to the resident. The order was initiated for the treatment of chronic obstructive pulmonary disease (COPD), a progressive lung disease that causes airflow blockage and makes breathing difficult. During an interview on September 30, 2025, at 10:50 AM, Resident 70 stated that her nose had been very dry because there was no water humidification attached to her oxygen delivery system. The resident reported that she had notified nursing staff about this concern more than a week earlier. Observation of Resident 70 at that time revealed she was in bed receiving oxygen at 4.0 liters per minute via nasal cannula, with no humidifier bottle attached to the oxygen flowmeter. During a follow-up observation on September 30, 2025, at 1:06 PM, Employee 1 (Licensed Practical Nurse) confirmed that Resident 70 had a physician ' s order for oxygen with humidified water at 4.0 liters per minute by nasal cannula. Employee 1 acknowledged that the resident was not receiving humidified oxygen, as the humidifier bottle was not attached to the oxygen delivery system. During an interview on October 1, 2025, at 1:30 PM, the Nursing Home Administrator (NHA) confirmed it is the facility's responsibility to ensure oxygen therapy is administered in accordance with the physician ' s order. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(1)(3)(5) Nursing services.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility policy, and staff interviews, it was determined that the facility failed to ensure biologicals were stored within their manufacturer ' s expiration date in one of two medication storage areas (third-floor nursing unit).Findings include:A review of the facility ' s policy titled Storage of Medications, last reviewed on [DATE], revealed that drugs and biologicals (defined as substances derived from living organisms and used in medical treatment, such as vaccines, nutritional formulas, and immunotherapies) are to be stored safely, securely, and in an orderly manner. The policy further indicated that discontinued, outdated, or deteriorated drugs or biologicals are to be returned to the dispensing pharmacy or destroyed.An observation conducted on [DATE], at 1:10 PM, in the presence of Employee 2 (Licensed Practical Nurse), revealed fourteen individual cartons of Glucerna CarbSteady 1.2 Cal (medically prescribed therapeutic nutritional biological formula designed for individuals requiring controlled carbohydrate intake) available for resident use. Each carton had an expiration date of [DATE]. Five of the cartons were observed in the refrigerator of the third-floor medication room, and nine cartons were observed on the countertop in the same room. The expired Glucerna CarbSteady cartons were removed from the medication storage area at that time. Employee 2 confirmed that the expired products would be removed from the clinical area and discarded.Further observation of the Central Supply Room (the facility area where biological items are stored prior to being distributed to the clinical units) was conducted with the Nursing Home Administrator (NHA) on [DATE], at 1:30 PM. The following expired biological products were observed on the supply shelves:Four cases (24 cartons per case) of Glucerna CarbSteady 1.2 Cal -Expiration Date: [DATE] One case (24 cartons per case) of Two Cal HN (a high-nitrogen therapeutic nutrition formula) Expiration Date: [DATE] One case (24 cartons per case) of Vanilla Ensure (a nutritional supplement used to provide additional calories and protein) Expiration Date: February 2025 The expired cases were removed from the shelf by the NHA during the observation. The NHA was made aware of the expired biological items on the third-floor nursing medication storage room and confirmed that current, unexpired biologicals were available and being delivered to nursing units.28 Pa. Code 211.9 (k) Pharmacy services.28 Pa. Code 211.10(d) Resident care policies.28 Pa Code 211.12(d)(1) Nursing services.		

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

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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 12/03/2025
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)		
F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, a review of clinical records, and resident and staff interviews, it was determined the facility failed to post a list of names, addresses, and telephone numbers of all pertinent state agencies and advocacy groups and a statement that residents may file a complaint with the state survey agency concerning any suspected violation of state or federal nursing facility regulation in a form and manner accessible and understandable to residents and resident representatives in one of two nursing units sampled (Nursing 2nd Floor). Findings include: A clinical record review revealed Resident 5 was admitted to the facility on [DATE], with diagnoses that include 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). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated September 8, 2025, revealed that Resident 5 was 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). During an interview on October 1, 2025, at 10:00 AM, Resident 5 indicated that she is unable to access the resident grievance information across from the second-floor nursing station. She explained that the posted information and the grievances are too high for her to read and see from her wheelchair. She indicated that she could not read the names, addresses, and telephone numbers of the pertinent state agency and advocacy groups posted. An observation on October 1, 2025, at 12:12 PM of the Second Floor Nursing Unit revealed an area adjacent to the nursing station posted with grievance information and pertinent state agency and advocacy group contact information. The posted information was in a small print and above 48 inches in height, making it difficult for a person in a wheelchair to read or access the information and grievance forms. The information was further obstructed by a shredding box, preventing a person in a wheelchair from moving closer to the information. The Nursing Home Administrator (NHA) acknowledged on October 1, 2025, the Second Floor Nursing Unit's posted grievance forms, grievance information, and pertinent state agency and advocacy group contact information were posted in a manner that created obstructed access to the information for residents who used wheelchairs. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights.		