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	03/20/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, a review of clinical records, and resident, resident representative, and staff interviews, it was determined the facility failed to provide person-centered care by failing to follow physician's orders for the consistent application of prescribed therapeutic measures, compression stockings, for two residents out of 26 sampled (Residents 25 and 66).Findings include: A review of Resident 25's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses of dementia (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 diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces). A review of Resident 25's Annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 20, 2025, revealed that Resident 25 had moderately impaired cognition with a BIMS score of 9 (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 8 through 12 indicates moderate cognitive impairment). A physician order for Resident 25 dated February 12, 2026, noted an order for TED compression stockings (thrombo-embolus deterrent compression stockings, or anti-embolism stockings, which are specially designed to promote circulation and help reduce the risk of developing deep vein thrombosis or blood clots) in the morning and removed in the evening for venous insufficiency (long-term condition where leg veins struggle to send blood back to the heart, causing blood to pool in the legs and ankles, leading to swelling, pain, and aching). A review of Resident 25's March 2026 Treatment Administration Record (TAR) revealed that on March 17, 2026, staff did not document the application of the TED stockings nor was the reason for the TED stockings not being applied documented. Observation on March 17, 2026, at 12:00 PM, confirmed that Resident 25 was not wearing TED stockings. Observation on March 18, 2026, at 1:05 PM revealed that Resident 25 was not wearing TED stockings as ordered and no TED stockings were observed in the resident's room. This observation was confirmed by Employee 5, licensed practical nurse (LPN). A review of the March 2026 TAR revealed staff documented TED stockings were applied at 6:00 AM on March 18, 2026. This documentation was inconsistent with observation findings that the resident was not wearing the ordered TED stockings. A review of Resident 66's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses of dementia and depression. A review of Resident 66's admission MDS dated [DATE], revealed that Resident 66 was severely cognitively impaired with a BIMS score of 5 (a score of 0 through 7 indicates severe cognitive impairment). A physician order dated February 12, 2026, directed staff to apply TED compression stockings in the morning and remove them in the evening for venous insufficiency. During an interview on March 17, 2026, at 11:30 AM, Resident 66's Resident Representative reported that staff did not consistently apply the resident's TED stockings. Observation on March 17, 2026, confirmed Resident 66 was not wearing TED stockings. A review of the March 2026 TAR revealed staff did not document application of TED stockings on March 17, 2026, and did not document a reason the stockings were not applied. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on March 18, 2026, at 1:10 PM confirmed Resident 66 was not wearing TED stockings as ordered. This observation was confirmed by Employee 1, Registered Nurse (RN). A review of the March 2026 TAR revealed staff documented TED stockings were applied at 6:00 AM on March 18, 2026. This documentation was inconsistent with observation findings that the resident was not wearing the ordered TED stockings. During an interview on March 19, 2026, at 9:30 AM, the Director of Nursing (DON) confirmed the facility did not consistently ensure implementation of physician orders related to the application and removal of TED compression stockings for Residents 25 and 66. 28 Pa. Code 211.5(f)(ix) Medical Records. 28 Pa. Code 211.12(c)(d)(3)(5) Nursing Services.

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, observations, and resident and staff interviews, it was determined the facility failed to provide care in a manner that promotes and enhances each resident's dignity and quality of life by failing to respond in a timely manner to residents' requests for assistance for 1 resident out of 26 residents reviewed. (Resident 1).Findings include: A review of Resident 1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses of morbid obesity (excess amount of body fat that significantly increases the risk of serious health problems) and irritable bowel syndrome (IBS, a chronic disorder of the digestive system causing recurrent abdominal pain, bloating, gas, diarrhea, and constipation). A review of Resident 1's Quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 6, 2026, revealed that Resident 1 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 through 15 indicates cognition is intact). A review of Resident 1's comprehensive care plan, last revised on February 6, 2026, revealed a focus on bowel and bladder incontinence (inability to control urine or stool) with a history of chronic urinary tract infections and IBS, with interventions to include staff checking the resident for incontinence and changing the resident every two hours and as needed. Further review of the care plan revealed the resident required extensive assistance from two staff members for bed mobility. During an interview with Resident 1 on March 17, 2026, she rang her call bell at 11:30 AM and then stated, I better ring before they start passing meal trays, otherwise, I'll be stuck waiting until after lunch. When Resident 1 was questioned about what she meant by that, she stated that the Nurse Aides will make her wait until after meal trays are distributed and lunch is finished before getting changed if she rings during meal tray pass or mealtimes. She explained that staff will not provide any incontinent care during a meal, so if she needs assistance at that time, she is forced to wait longer. It was observed that Employee 5, a licensed practical nurse (LPN), answered Resident 1's call bell at 11:43 AM, and when she answered, Resident 1 mentioned she needed to be changed. Employee 5 stated to Resident 1, I'll tell the girls. Employee 5 exited the resident's room without providing care, and proceeded to the hallway where four additional staff members were present waiting for the meal cart delivery for tray pass on the second floor. Employee 5 informed the Nurse Aides (NAs) present that Resident 1 needed to be changed. One staff member was heard stating, We just changed her not even a half hour ago. Staff, including Employee 5, remained in the hallway waiting for the meal cart for approximately five additional minutes. When the tray cart arrived, staff proceeded with tray pass, including delivery of a meal tray to Resident 1, and no staff were observed providing incontinence care at that time. During interview on March 17, 2026, at 12:10 PM, Employee 5 confirmed she informed the Nurse Aides present in the hallway that Resident 1 needed to be changed, however, she was unable to identify which staff member stated the resident had recently been changed or who the staff were present at the time. Employee 5 stated that when residents activate the call bell requesting bathroom assistance or incontinence care during tray pass, staff typically complete tray pass first and assist the resident afterward. Interview with Resident 1 on March 17, 2026, at 12:15 PM revealed the resident was completing her lunch tray and stated she had not yet been changed and would wait until she finished eating. Follow-up interview with Resident 1 on March 17, 2026, at 1:00 PM revealed the resident activated the call bell again at approximately 12:30 PM after finishing lunch to request assistance with incontinence care. At approximately 12:35 PM, one hour and five minutes after the initial call bell activation, a nurse aide provided incontinence care. Review of the facility-provided staffing assignment for March 17, 2026, revealed seven nurse aides were scheduled to work on the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	second-floor day shift at the time of the observation, with three nurse aides assigned to provide care for Resident 1. During interview on March 17, 2026, at 2:00 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) reviewed the above information and indicated residents should not experience extended wait times for call bell response. The DON stated that when residents request assistance during tray pass or mealtimes, staff should be reassigned as needed to ensure resident care needs are addressed. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of resident council meeting minutes, review of resident activities fundraising account information, and resident and staff interviews, it was determined the facility failed to ensure the views and recommendations of residents regarding life in the facility were considered, including decisions related to the use of resident activity fundraising funds, for five of five residents interviewed (Residents 53, 54, 61, 75, and 76).Findings include:A review of a Resident Activities Fundraising Account ledger from January 2026 through March 2026 revealed resident fundraising activities occurred on January 9, 2026, February 5, 2026, March 4, 2026, and March 18, 2026. Debits from the Resident Activities Fundraising Account included the purchase of bingo prizes on January 26, 2026, dye bottles on February 28, 2026, and fundraising supplies on February 28, 2026, and March 15, 2026. A review of Resident Council meeting minutes from December 2025 through February 2026 revealed no documented evidence that the facility considered the views and recommendations of residents determining how resident activity fundraising funds were used. In addition, there was no documented evidence the facility reviewed the resident activities fundraising account information, including debits (money spent), credits (money added), or account balances, with the resident council. During a resident group interview conducted on March 18, 2026, at 10:00 AM, five of five residents in attendance (Residents 53, 54, 61, 75, and 76) indicated they were not afforded the opportunity to express their views or make recommendations regarding how resident activity fundraising funds were spent. The residents stated they were not informed of the balance of the resident activities fundraising account and indicated the facility did not review resident fundraising account information during resident group meetings. During the resident group interview on March 18, 2026, Resident 61 indicated dissatisfaction that residents were not asked for input regarding fundraising activities and expressed a desire for the opportunity to discuss how resident fundraising funds are used. Resident 61 indicated that review of resident fundraising account information had occurred during resident council meetings in the past but had not occurred in recent months. During an interview on March 20, 2026, at 10:30 AM, the above information was reviewed with the nursing home administrator (NHA). The NHA was unable to provide documented evidence that residents were afforded the opportunity to express their views or recommendations regarding the use of resident activities fundraising funds. 28 Pa. Code 201.18 (e)(1)(4) Management. 28 Pa. Code 201.29(a) Resident rights.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policy, and staff interview, it was determined the facility failed to include sufficient minimum healthcare information in the resident's baseline care plan to address the resident's immediate safety needs upon admission for 1 of 26 residents sampled (Resident 74).Findings: A review of the facility policy titled Care Plans-Baseline, last reviewed by the facility April 15, 2025, indicated that it is the policy of the facility to ensure a baseline care plan to meet the resident's immediate needs, which should be developed for each resident within forty-eight (48) hours of admission. The Interdisciplinary Team (IDT) will review the healthcare plan to meet the resident's immediate care needs, including but not limited to initial goals based on admission orders, physician's orders, dietary orders, therapy services, social services, and PASRR (Preadmission Screening and Resident Review, a federally required evaluation completed prior to nursing facility admission to determine whether a person with serious mental illness or intellectual disability requires specialized services) recommendations, if applicable. Clinical record review revealed Resident 74 was admitted to the facility on [DATE], with diagnoses which included adjustment disorder with mixed anxiety and depressed mood (an unhealthy emotional reaction to a specific stressor of a defined identifiable life change) and Alzheimer's disease (a progressive brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). A review of Resident 74's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 9, 2026, revealed Resident 74 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 through 15 indicates cognition is intact). A review of Resident 74's PASRR dated March 1, 2026, revealed the resident reported passive death wishes in December 2025 and stated she had a plan but did not want to share with anyone and reported she wanted to harm herself. Due to the resident's Alzheimer's diagnosis, she was not a candidate for specialized services. A review of a nurse progress note dated March 3, 2026, at 4:01 PM, documented the resident was admitted to the facility following a seventy (70) day hospitalization related to suicidal ideation (thoughts of harming oneself or ending one's life) and a spontaneous hip fracture after admission to the hospital. Review of the baseline care plan initiated March 3, 2026, did not include individualized interventions, monitoring considerations, or care approaches to address the resident's immediate safety needs related to the resident's history of suicidal ideation. During interviews on March 18, 2026, at 12:30 PM, and on March 20, 2026, at 10:30 AM, the above information was reviewed with the nursing home administrator (NHA) and the director of nursing (DON). The NHA and DON were unable to provide documented evidence that the facility developed and implemented a baseline care plan for Resident 74's care plan had been developed to address the resident's history of suicidal ideation. The facility was unable to provide documented evidence the baseline care plan included sufficient information to guide staff in addressing the resident's immediate safety needs upon admission. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa Code 211.12 (d)(1)(2)(3)(5) 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 a review of clinical records, select facility policy, and resident representative and staff interviews, it was determined the facility failed to develop and implement a comprehensive person-centered care plan that included specific and individualized interventions to address dental needs for one out of 26 residents sampled (Resident 66). Findings include: Review of the facility policy titled Comprehensive Person-Centered Care Plans, last reviewed April 15, 2025, indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. A review of Resident 66's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses of dementia (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 depression. A review of Resident 66's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 21, 2025, revealed that Resident 66 was severely cognitively impaired with a BIMS score of 5 (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 through 7 indicates severe cognitive impairment). The assessment did not identify dental concerns at that time. Review of a nurse's note dated February 5, 2026, revealed the resident's diet was downgraded from regular texture to mechanical soft (foods that are chopped, ground, or mashed to make chewing and swallowing easier) due to the loss of the resident's upper denture. The note indicated a speech therapy consult (referral to a specialist to evaluate swallowing and chewing safety) was ordered. During interview on March 17, 2026, at 11:30 AM, the secondary Resident Representative reported the resident's upper denture had been missing for approximately one month and the loss had been reported to nursing staff when first identified. Review of correspondence from the dentist dated February 16, 2026, indicated services to replace the denture required completion of consent forms and prepayment prior to scheduling. Interview with the Nursing Home Administrator on March 18, 2026, at 9:00 AM confirmed the facility was responsible for replacing the lost denture; however, the required prepayment had not yet been provided by the corporate office at that time. The Administrator confirmed payment was subsequently made and a dental appointment was scheduled. Review of the clinical record revealed no documented evidence the facility revised the comprehensive person-centered care plan to reflect the resident's change in condition, specifically the loss of the upper denture, altered diet texture, need for dental evaluation, or interventions to address chewing ability, nutrition needs, or oral health. During interview on March 18, 2026, at 10:00 AM, the Nursing Home Administrator confirmed the facility is responsible for ensuring each resident's comprehensive person-centered care plan reflects identified problems and services necessary to assist the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The Nursing Home Administrator confirmed Resident 66's comprehensive person-centered care plan did not reflect the resident's current dental needs, including replacement of the missing upper denture. Refer F791 28 Pa Code 211.10 (c) Resident care policies. 28 Pa Code 211.12 (d)(1)(3) Nursing services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to implement procedures to maintain accurate records of controlled medications and ensure accurate administration of controlled drugs for 1 of 26 residents sampled (Resident 56).Findings include: A review of the facility policy titled Controlled Substances, last reviewed by the facility on April 15, 2025, revealed the facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. The controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss or diversion and detection. The system of reconciling the receipt, dispensing, and disposition of controlled substances includes a record of personnel access and usage, medication administration records, declining inventory records, and destruction, waste, and return to pharmacy records. The consultant pharmacist, or designee, routinely monitor controlled substance storage records. Clinical record review revealed Resident 56 was admitted to the facility on [DATE], with diagnoses that included chronic pain syndrome (a long-term condition where pain persists or recurs for more than three to six months, often lasting beyond the expected healing time of an initial injury).A physician's order for Resident 56 to receive Tramadol 50 mg (a schedule IV controlled substance, classified as a narcotic and opioid pain medication with a low-to-moderate potential for abuse and dependency) with instructions to give one tablet by mouth every eight hours as needed for pain level on a pain scale (standardized pain rating scale ranging from 0 through 10, where 0 indicates no pain and 10 is the worst pain), of 7 through 10 was initiated on February 9, 2026.A physician's order for Resident 56 to receive Tramadol 25 mg with instructions to give one tablet by mouth two times a day for chronic pain initiated on February 9, 2026, and discontinued on March 4, 2026.A review of Resident 56's clinical record revealed a controlled substance record (a required medication log used to track the receipt, storage, administration, wasting and remaining count of controlled medications to ensure accurate accountability and prevent loss or diversion) for Tramadol 25 mg and a controlled substance record for Tramadol 50 mg. The controlled substance log for Tramadol 25 mg indicated that the last dose of Tramadol 25 mg was administered on February 14, 2026.However, a review of the Medication Administration Record (MAR a legal record used to document medications administered to a resident) for February 2026 revealed Resident 56 was administered Tramadol 25 mg on the following dates and times:February 15, 2026, at 9:00 AM with a pain level 6.February 15, 2026, at 9:00 PM with a pain level 5.February 16, 2026, at 9:00 AM with a pain level 7.February 16, 2026, at 9:00 PM with a pain level 5.February 17, 2026, at 9:00 AM with a pain level 0.February 19, 2026, at 9:00 PM with a pain level 0.February 20, 2026, at 9:00 AM with a pain level 0.February 20, 2026, at 9:00 PM with a pain level 0.February 21, 2026, at 9:00 AM with a pain level 0.February 21, 2026, at 9:00 PM with a pain level 0.February 22, 2026, at 9:00 AM with a pain level 0.February 22, 2026, at 9:00 PM with a pain level 0.February 23, 2026, at 9:00 AM with a pain level 0.February 23, 2026, at 9:00 PM with a pain level 0.February 24, 2026, at 9:00 AM with a pain level 0.February 24, 2026, at 9:00 PM with a pain level 0.February 25, 2026, at 9:00 AM with a pain level 6.February 25, 2026, at 9:00 PM with a pain level 0.February 26, 2026, at 9:00 AM with a pain level 0.February 26, 2026, at 9:00 PM with a pain level 0.February 27, 2026, at 9:00 AM with a pain level 6.February 27, 2026, at 9:00 PM with a pain level 0.February 28, 2026, at 9:00 AM with a pain level 5.February 28, 2026, at 9:00 PM with a pain level 0. The controlled substance log did not reflect removal or reconciliation of Tramadol 25 mg corresponding with these documented administrations after February 14, 2026. The controlled substance log indicated Tramadol 50 mg was removed from the medication supply on the following dates and times:February 15, 2026, at 9:00 AM.February 15, 2026, at 9:00 PM.February 16, 2026, at 9:00 AM.February 16, 2026, at 9:00 PM. February 17, 2026, at 9:00 AM.February 18, 2026, at (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9:00 AM.February 19, 2026, at 9:00 PM.However, review of the February 2026 MAR did not indicate administration of Tramadol 50 mg on these dates and times. During an interview on March 20, 2026, at 10:30 AM, the above findings were reviewed with the Nursing Home Administrator and Director of Nursing. The facility was unable to provide a controlled substance log accounting for 24 doses of Tramadol 25 mg after February 14, 2026, and was unable to reconcile discrepancies between the controlled substance inventory records and the Medication Administration Record for Tramadol 25 mg and Tramadol 50 mg. During an interview on March 20, 2026, at 10:30 AM, the above findings were reviewed with the Nursing Home Administrator (NHA) and Director of Nursing (DON). At the time of the interview, the facility was unable to provide a controlled substance record (required log used to track the receipt, administration, and remaining quantity of regulated medications with potential for abuse) accounting for the quantity of Resident 56's Tramadol 25 mg after February 14, 2026, despite the Medication Administration Record (MAR, legal record documenting medications administered to a resident) indicating the medication was administered 24 times between February 15, 2026, and February 28, 2026. Additionally, the controlled substance record for Tramadol 50 mg reflected seven removals of medication between February 15, 2026, and February 19, 2026, while the MAR did not indicate administration of Tramadol 50 mg on those dates. The facility was unable to reconcile the discrepancies between the controlled substance records and the MAR. The facility failed to implement procedures to maintain accurate controlled substance records and ensure documentation of administration of controlled medications corresponded with inventory records. 28 Pa Code 211.5(f)(xi) Medical records. 28 Pa Code 211.9(a)(1)(k) Pharmacy services. 28 Pa Code 211.10(c) Resident care policies. 28 Pa Code 211.12 (d)(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. Based on observation, review of select facility policy, and staff interviews, it was determined the facility failed to adhere to acceptable storage and labeling for multi-dose medication vials in two of two medication storage rooms (second and third floor medication rooms).Findings include: A review of the facility policy titled Medication Labeling and Storage, last reviewed by the facility April 15, 2025, indicated that it is the policy of the facility to ensure that multi-dose vials (medication that can be punctured by a needle more than once to withdraw multiple doses) that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. An observation of the second-floor medication room on March 19, 2026, at 8:10 AM, in the presence of Employee 3, licensed practical nurse (LPN), of medication stored in the medication refrigerator, revealed two multi-dose vials of Aplisol (solution used for screening tuberculosis) that had been opened and available for use but not dated when initially opened. A review of the manufacturer's dosage and administration recommendation for Aplisol revealed that vials in use for more than 30 days should be discarded. An interview with Employee 3. LPN at the time of the observation on March 19, 2026, at 8:10 AM, confirmed the Aplisol had been opened and not dated to determine how long the vial was available for use, and the medications should have been removed from the medication refrigerator and discarded. An observation of the third-floor medication room on March 19, 2026, at 8:45 AM, in the presence of Employee 4, Registered Nurse (RN), of medication stored in the medication refrigerator, revealed two multi-dose vials of Aplisol (solution used for screening tuberculosis) that had been opened and available for use but not dated when initially opened. An interview with Employee 4 RN, at the time of the observation on March 19, 2026, at 8:45 AM, confirmed the Aplisol had been opened and not dated, and the medications should have been removed from the medication refrigerator and discarded. An interview with the Director of Nursing on March 19, 2026, at 8:50 AM, confirmed the facility failed to adhere to acceptable storage and labeling practices for multi-dose medications.28 Pa. Code 211.9(a)(1)(k) Pharmacy services. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services

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	395929	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeview Healthcare & Rehab Center	200 Pennsylvania Avenue Shenandoah, PA 17976

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policy, payor source data, and resident representative and staff interview, it was determined the facility failed to ensure timely and necessary dental services for one resident who is a Medicaid recipient (Resident 66) out of 26 residents reviewed.Findings include: Review of the facility Availability of Services, Dental policy last reviewed April 15, 2025, indicated that oral and dental services will be provided for each resident. Residents with lost or damaged dentures will be promptly referred to a dentist. A review of Resident 66's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses of dementia (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 depression. A review of Resident 66's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 21, 2025, revealed that Resident 66 was severely cognitively impaired with a BIMS score of 5 (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 through 7 indicates severe cognitive impairment) The assessment identified no dental concerns. During an interview on March 17, 2026, at 11:30 AM the secondary Resident Representative for Resident 66 noted that the resident's upper denture had gone missing about a month ago. The secondary Resident Representative noted that she reported the missing upper denture to nursing at the time she had noticed the upper denture was missing. A Resident Grievance Form which was filed on February 5, 2026, by nursing on behalf of the secondary Resident Representative for Resident 66 noted that the resident's dentures were missing. The resolution dated February 10, 2026, which was signed by the Social Services Director and Nursing Home Administrator noted a referral was made for the dentist to replace the resident's dentures. The resident's primary Resident Representative was made aware of the resolution and was in agreement. Review of a correspondence from the dentist dated February 16, 2026, noted that a consent form for services and a prepayment would first need to be completed before services could be provided. Interview with the Administrator on March 18, 2026, at 9:00 AM confirmed that the facility was responsible for replacing the resident's lost upper denture, but the corporate office had not yet provided the prepayment to the dentist for the services to be completed. Upon surveyor inquiry the Nursing Home Administrator confirmed the required payment was made and the resident was subsequently scheduled for a dental appointment to replace the missing upper denture. The administrator affirmed that it is the facility's responsibility to ensure residents promptly receive the required dental services. Refer F65628 Pa Code 211.12 (c)(d)(3)(5) Nursing services. 28 Pa Code 211.10 (c) Resident care policies

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to ensure clinical records were accurate and complete and reflective of the resident's current status for two of 26 sampled residents (Residents 7 and 85).Findings include: Clinical record review revealed that Resident 85 had a diagnosis of dementia (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). A review of a significant change Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated January 9, 2026, revealed that Resident 85 had 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 through 15 indicates cognition is intact). A review of Resident 85's clinical record revealed documentation dated January 18, 2026, at 8:30 AM, of a body audit (a head-to-toe skin assessment performed to identify skin conditions such as bruising, wounds, or other abnormalities) indicated no skin alterations were observed. A nurse's note dated January 18, 2026, at 11:35 AM documented Resident 85 returned to the facility following a brief hospital visit and had bruising to the bilateral upper extremities (both arms). The nurse's note did not include measurements, color, characteristics, or further description of the bruise. A subsequent nurse's note dated January 20, 2026, at 7:53 AM documented Resident 85 had bruising to the left shoulder; however, the documentation did not include the size, appearance, progression, or resolution of the bruising. The clinical record did not contain documentation identifying when bruising to the right upper extremity resolved. An interview conducted with the Director of Nursing on March 20, 2026, at 11:30 AM confirmed the facility was unable to provide additional documentation regarding Resident 85 clarifying the discrepancy between the January 18, 2026, 8:30 AM body audit indicating no skin alterations and the January 18, 2026, 11:35 AM nurse's note documenting bilateral upper extremity bruising, including when the bruising occurred, the extent of the bruising, or when bruising to the right upper extremity resolved. A clinical record review revealed Resident 7 was admitted to the facility on [DATE], with diagnoses that included heart failure (a condition that develops when the heart doesn't pump enough blood to meet the body's needs).Resident 7's clinical record review revealed a physician's order dated February 26, 2026, for ampicillin-sulbactam sodium intravenous solution reconstituted 3 grams (a combination antibiotic medication administered through a vein) with directions to administer 3 grams intravenously over 30 minutes every six hours for cholecystitis (inflammation of the gallbladder). Review of Resident 7's Medication Administration Record (MAR, a clinical record used to document medications administered to a resident) for March 2026 revealed no documented evidence the resident received ampicillin-sulbactam sodium intravenous solution 3 grams as ordered on March 7, 2026, at 6:00 AM and March 14, 2026, at 6:00 AM. During an interview conducted on March 20, 2026, at 10:30 AM, the above information was reviewed with the Nursing Home Administrator and Director of Nursing. The facility indicated that the medication was administered as ordered, however, the clinical record did not contain documentation confirming administration of the medication on March 7, 2026, at 6:00 AM and March 14, 2026, at 6:00 AM failing to ensure the clinical record was complete and accurate regarding administration of physician-ordered medication for Resident 7. 28 Pa Code 211.5(f)(xi) Medical records. 28 PA. Code 211.12 (c)(d)(1)(3) (5) Nursing services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on clinical record review, select facility policy review, observation, and staff interview, it was determined the facility failed to implement physician-ordered infection control precautions for one of 26 sampled residents (Resident 10) Findings include:Clinical record review revealed Resident 10 had a current diagnosis of rectal cancer. An admission Minimum Data Set assessment, (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care), dated December 18, 2025, 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 12 through 15 indicates the resident is cognitively intact). Current physician orders indicated Resident 10 was prescribed capecitabine (an oral chemotherapy medication used to treat cancer). Capecitabine has known potential side effects including neutropenia (a decreased number of white blood cells, which help the body fight infection). Due to increased risk for infection, current physician orders directed staff to implement neutropenic precautions (protective infection control measures intended to protect individuals with weakened immune systems from exposure to bacteria, viruses, and other infectious organisms that may be carried into the environment by others such as staff, family members and visitors). Observation of Resident 10's room on March 17, 2026, at 10:30 AM revealed signage posted indicating Enhanced Barrier Precautions (infection control interventions intended to prevent transmission of certain organisms from the resident to others through use of protective gowns and gloves during high-contact care activities). The posted Enhanced Barrier Precautions signage did not reflect physician-ordered neutropenic precautions, which focus on protecting the resident from potential exposure to infectious organisms brought into the room by staff or visitors. Review of the facility's Neutropenic Precautions policy, reviewed April 15, 2025, indicated residents identified as requiring neutropenic precautions would follow precautions as ordered by the physician. Observation on March 19, 2026, at 11:50 AM revealed Employee 2, Nurse Aide, obtained a meal tray from the nourishment cart and entered Resident 10's room without performing hand hygiene (cleaning hands using soap and water or alcohol-based sanitizer to reduce spread of germs) and without wearing a face mask or protective garments intended to reduce the potential exposure of the resident to infectious organisms. Employee 2 did not perform hand hygiene when exiting the resident's room. Interview with Employee 2 on March 19, 2026, at 11:52 AM revealed the employee was unaware any resident on the nursing unit required special precautions, including neutropenic precautions requiring use of personal protective equipment (items worn to reduce spread of germs such as masks, gloves, or gowns) and hand hygiene before entering and after leaving the resident's room. Review of Resident 10's care plan dated December 18, 2025, failed to include resident-specific interventions related to implementation of neutropenic precautions necessary to guide staff in protecting the resident from potential exposure to infection. Interview with the Assistant Director of Nursing on March 19, 2026, at 2:00 PM confirmed neutropenic precautions are intended to protect the residents from exposure to infectious organisms from the environment, staff, and visitors. The Assistant Director of Nursing was unable to provide evidence that staff received training or education regarding implementation of neutropenic precautions. Signage reflecting neutropenic precautions with resident-specific interventions was not posted until after surveyor inquiry. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policies and procedures, and staff interviews it was determined the facility failed to develop, implement, and maintain an effective training program to ensure licensed nursing staff demonstrated the knowledge, skills, and documented competencies necessary to safely care for a resident with a central tunneled line catheter for one out of 26 residents reviewed (Resident 7). Findings include: Federal regulation requires that a facility develop, implement, and maintain an effective training program for all new and existing staff. The facility must use the facility assessment to determine the amount and types of training necessary to ensure staff competencies meet the needs of the residents as identified in their care plans and the facility assessment. A clinical record review revealed Resident 7 was admitted to the facility on [DATE], with diagnoses that included heart failure (a condition that develops when the heart doesn't pump enough blood to meet the body's needs). A review of the comprehensive care plan initiated February 26, 2026, revealed Resident 7 was identified as having potential for complications related to a central tunneled line (a thin flexible tube placed into a large vein under the skin to allow long-term delivery of medications or fluids directly into the bloodstream) to the right subclavian vein (a large vein located under the collarbone). A physician's order dated February 26, 2026, directed administration of ampicillin-sulbactam (a combination antibiotic medication used to treat bacterial infections) 3 grams (2 gm - 1 gm) intravenously (administered directly into a vein) over 30 minutes every six hours for cholecystitis (inflammation of the gallbladder). A review of the March 2026 Medication Administration Record (MAR, a clinical record used to document medications administered to a resident) revealed Employee 6, Licensed Practical Nurse (LPN), administered ampicillin-sulbactam intravenously through the subclavian central line on March 2, 2026, March 4, 2026, March 5, 2026, March 7, 2026, March 9, 2026, and March 12, 2026, at 6:00 PM. The MAR further revealed Employee 7, LPN, administered ampicillin-sulbactam intravenously through the subclavian central line on March 6, 2026, at 12:00 AM.During an interview on March 19, 2026, at 9:30 AM, the Regional Nurse Consultant (RNC) was unable to provide documented evidence Employee 6 LPN or Employee 7 LPN demonstrated competency in central line management prior to administering intravenous medications through the central line. The RNC confirmed the facility's annual licensed nursing competency and skills review did not include training related to central line care. The RNC was unable to provide documentation of initial or annual competency validation for central line management through the conclusion of the survey on March 20, 2026. During a follow-up interview on March 20, 2026, at 10:00 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) were unable to provide documented evidence the facility developed or implemented central line management in the annual licensed nursing competency/skills reviews. The facility failed to develop, implement, and maintain an effective training program, including topics such as central line management, based on the resident population and the facility assessment, prior to licensed nursing staff providing care for residents with central lines. Pennsylvania State Board of Nursing regulations Title 49, Chapter 21. 21.148(a)(1), 21.12(3) require that Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) 21.148(a)(1) performing intravenous therapy, including central line care, complete a board-approved education program, receive supervised clinical instruction, and undergo ongoing competency assessments. LPNs may perform only those intravenous therapy functions for which they have documented knowledge, skills, and abilities under appropriate supervision. The facility failed to demonstrate it used the facility assessment to identify the need for central line care training based on the resident population. The facility failed to develop, implement, and maintain an effective training program, including initial and annual competency validation for central line management, prior to licensed nursing staff providing intravenous medication administration through a central tunneled line catheter.28 Pa. Code 201.20(a) Staff Development. 28 Pa Code 211.12(c)(d)(1)(2)(3)(5) Nursing services.

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F 0570 Level of Harm - Potential for minimal harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. Based on a review of the facility's surety bond, resident fund accounts, and staff interviews, it was determined the facility failed to ensure the amount of the surety bond was sufficient to cover the total amount of resident funds held by the facility on two of three months reviewed (February 2026 and March 2026).Findings include: A review of the resident fund checking account statement from January 2026 through March 2026 revealed that the aggregate resident account fund managed by the facility was $216,243.06 on February 3, 2026, and $208,438.08 on March 3, 2026. A review of the facility's surety bond (a legal agreement protecting personal money that facility providers manage for residents) in place since November 1, 2020, revealed the coverage amount was $200,000.00, which was not sufficient to cover the resident fund balances on February 3, 2026, and March 3, 2026. During an interview on March 18, 2026, at 1:30 PM, the above information was reviewed with the regional nurse consultant (RNC). The RNC was not able to provide documented evidence that a surety bond was in place in February 2026 or March 2026 to sufficiently cover facility-managed resident funds. 28 Pa. Code: 201.14 (a) Responsibility of licensee.28 Pa. Code: 201.18(b)(2) Management.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on a review of facility staffing information, Payroll-Based Journal (PBJ) system and staff interviews, it was determined the facility failed to ensure accurate submission of staffing information to the PBJ system for one of two quarters reviewed (Quarter 4 2025).Findings include:A review of the Payroll-Based Journal (PBJ) Staffing Data Report (a federal electronic system nursing homes must use to report staffing hours) and Certification and Survey Provider Enhanced Reports (CASPER) Report 1705D (a federal report that identifies potential staffing compliance concerns based on PBJ data), for fiscal year quarter 4 2025 (July 1-September 30) revealed that the facility's data triggered for no registered nurse (RN) hours on September 24, 2025, September 25, 2025, September 26, 2025, September 27, 2025, September 28, 2025, September 29, 2025, and September 30, 2025. A review of the Payroll-Based Journal (PBJ) Staffing Data Report Certification and Survey Provider Enhanced Reports (CASPER) Report 1705D for fiscal year quarter 4, 2025 (July 1 - September 30) revealed that the facility's data triggered for failing to have licensed nursing coverage 24 hours a day on September 24, 2025, September 25, 2025, September 26, 2025, September 27, 2025, September 28, 2025, September 29, 2025, and September 30, 2025.A review of staffing time sheets and daily nurse assignment sheets revealed that the facility had RN staffing working on each date that triggered no RN hours on the PBJ Staffing Data Reports in September 2025. A review of staffing time sheets and daily nurse assignment sheets revealed that the facility had licensed nursing coverage 24 hours a day on each date that triggered no licensed nursing coverage 24 hours a day on the PBJ Staffing Data Reports in September 2025. During an interview on March 20, 2026, at 10:30 AM, the above information was reviewed with the Nursing Home Administrator (NHA). The NHA stated the facility transitioned to a different reporting system in September 2025 and indicated a lapse in data transmission occurred during the transition process. The NHA confirmed the facility had Registered Nurses and licensed nurses working on the identified dates but indicated the staffing information was not accurately transmitted to the PBJ system. 28 Pa. Code 201.18 (e)(2) Management