

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395929	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/11/2024
NAME OF PROVIDER OR SUPPLIER: RIDGEVIEW HEALTHCARE & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 200 PENNSYLVANIA AVENUE SHENANDOAH, PA 17976		
STATE LICENSE NUMBER: 152502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on December 11, 2024, at Ridgeview Healthcare and Rehab Center, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.



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RIDGEVIEW HEALTHCARE & REHAB CENTER

STATE LICENSE NUMBER: 152502

SURVEY EXIT DATE: 12/11/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

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K 0000	INITIAL COMMENT Facility ID# 152502 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on December 11, 2024, it was determined that Ridgeview Healthcare and Rehab Center, was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.70(a). This is a three story, Type II (222), fire resistive building, with a basement, that is fully sprinklered.	K 0000		
K 0291 SS=E		K 0291		

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TITLE:

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K 0291 SS=E	Continued from page 1 NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:	K 0291	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Law. 1. Batteries in Emergency Lights #10 & #21 were replaced. 2. Whole house test of Emergency Lights completed and addressed accordingly. 3. Education to the Maintenance Director and Maintenance staff on ensuring testing and maintenance of the Emergency Lights in the facility. 4. Weekly testing of Emergency Lights for 4 weeks; monthly testing of Emergency Lights for 2 months. Results of audit(s) to be submitted to the QA Committee Meeting monthly.	Completion Date: 01/14/2025 Status: APPROVED Date: 01/02/2025

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K 0291 SS=E	Continued from page 2 Based on observation and interview, the facility failed to maintain battery-powered emergency lighting in two locations, affecting two of four floors. Findings include: Observation on December 11, 2024, between 10:28 a.m., and 10:43 a.m., revealed that the following battery back-up emergency lights, failed to illuminate when tested. a. At 10:28 a.m., 3rd floor, Emergency Light #10, near Resident room 308. b. At 10:43 a.m., 2nd floor, Emergency Light #21, at the Nurse's station. Exit interview with the Facility Administrator and the Facilities Manager on December 11, 2024, at 11:15 a.m., confirmed the lights did not function when tested.	K 0291		

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K 0353 SS=E	<p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0353	<ol style="list-style-type: none"> 1. The missing ceiling tile in the therapy gym was replaced. The ceiling tiles around the escutcheon(s) located in the 3rd floor shower room and 3rd floor corridor outside the bathing room were corrected to eliminate the gap identified. 2. A one-time facility audit conducted to ensure no gaps were identified around other escutcheons in the facility. 3. Education to the Maintenance Director and Maintenance staff to ensure no gaps are present around any escutcheons in the facility. 4. A monthly audit will be completed for three months to ensure no gaps are present around the escutcheons in the facility. Results of audit(s) to be submitted to the QA Committee Meeting monthly. 	<p>Completion Date: 01/14/2025</p> <p>Status: APPROVED</p> <p>Date: 01/02/2025</p>

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K 0353 SS=E	Continued from page 4 Based observation and interview, it was determined the facility failed to maintain the sprinkler system that provides fire sprinkler protection in two instances, affecting two of four floors. Findings include: 1. Observation on December 11, 2024, at 10:19 a.m., 1st floor, Therapy Room, was missing a ceiling tile, near the windows. Exit interview with the Facility Administrator and the Facilities Manager on December 11, 2024, at 11:15 a.m., confirmed the missing ceiling tile. 2. Observation on December 11, 2024, between 10:27 a.m. and 10:32 a.m., revealed the following: a. At 10:27 a.m., 3rd floor, Shower Room, had a sprinkler head that was not sealed into the escutcheon, creating a gap b. At 10:32 a.m., 3rd floor, Corridor near Bathing Room, had a gap around the sprinkler escutcheon in	K 0353		

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K 0353 SS=E	Continued from page 5 the ceiling. Exit interview with the Facility Administrator and the Facilities Manager on December 11, 2024, at 11:15 a.m., confirmed the sprinkler deficiencies.	K 0353		
K 0511 SS=E	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by:	K 0511	1. The electric panel on the 1st floor, outside the movie room, was locked. 2. A one-time audit performed to ensure that the electric panels are appropriately locked. 3. Education to the Maintenance Director and Maintenance staff to ensure that the electrical panels are appropriately locked unless the panel is being accessed by appropriate personnel. 4. Audits will be completed monthly for three months to ensure that electrical panels are locked when not being accessed. Results of the audit(s) will be submitted to the QA Committee Meeting monthly.	Completion Date: 01/14/2025 Status: APPROVED Date: 01/02/2025

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K 0511 SS=E	Continued from page 6 Based on observation and interview, it was determined the facility failed to maintain electrical panels, in one location, on one of four floors. Findings include: 1. Observation on December 11, 2024, at 10:15 a.m., 1st floor, revealed a corridor wall-mounted recessed electrical panels, near the Game Room, was unlocked and accessible to any unauthorized persons. Exit interview on December 11, 2024, at 11:15 a.m., with the Facilities Manager and the Facility Administrator, confirmed the unlocked electrical panel.	K 0511		



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