STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395929	A. BLDG: 00 B. WING:	12/20/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIDGEVIEW HEALTHCARE & REHAB CENTER STATE LICENSE NUMBER: **152502**	**200 PENNSYLVANIA AVENUE** **SHENANDOAH, PA 17976**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure, Civil Rights Compliance and Abbreviated Complaint Survey, completed on December 20, 2024, it was determined Ridgeview Healthcare & Rehab Center was not in compliance with the following requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0609 SS=D		F 0609		

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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F 0609 SS=D	Continued from page 1 483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0609	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. Facility conducted an immediate investigation upon learning about the allegation. Local police were notified, and the facility replaced the alleged stolen phone, which the resident did not accept. Facility subsequently did report this event to the DOH on 12/20/2024. 2. Facility will audit last 30 days of grievances to ensure facility has made appropriate reports of any alleged misappropriation of resident property. 3. IDT team will be educated on reporting requirements of alleged misappropriation of resident	Completion Date: **02/04/2025** Status: **APPROVED** Date: **01/10/2025**

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F 0609 SS=D	Continued from page 2	F 0609	property. 4. NHA/Designee will conduct audits of grievances to ensure any allegation of misappropriation of resident property has been timely reported to the DOH. Audits will be conducted three times per week x 2 weeks, then weekly x 2 weeks, then monthly x3 months. All result will be reported to the QAPI Committee.	

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F 0609 SS=D	Continued from page 3 Based on review of the facility's abuse policy, clinical records, facility investigations, information submitted by the facility and resident and staff interview it was determined the facility failed to timely report an alleged misappropriation of resident property for one resident out of 18 reviewed (Resident 56). Findings include: Review of the facility's Abuse Policy reviewed by the facility October 2024, indicated abuse, neglect, and/or mistreatment of residents, families, and co-workers will not be tolerated in any manner. All allegations of abuse, neglect, and misappropriation of property/money will be reported to all local and state agencies in the required timeframes as mandated by the department of health (DOH) and ACT 13. For allegations of physical, verbal, mental abuse, neglect, or mistreatment including misappropriation of property or funds: notify the State Regional Licensing Agency (DOH) of any allegations of abuse utilizing the Electronic Event	F 0609		

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F 0609 SS=D	Continued from page 4 Reporting System via the internet within 24 hours. Notify Area Agency on Aging immediately and follow up with a written report within 48 hours. Local law enforcement will be notified immediately of any allegations of misappropriation of property or funds. Law enforcement will conduct an independent investigation in conjunction with the facility. If an alleged perpetrator is identified, a PB-22 will be submitted via the Electronic Event Reporting System via the internet within 5 working days of the reported allegation. Appropriate actions will be taken regarding continuing employment. Review of the clinical record revealed Resident 56 had diagnoses which include anxiety and depression. A quarterly Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted periodically to plan resident care) dated September 27, 2024, indicated that Resident 56 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status - a tool to assess cognitive function; a score of 13-15	F 0609		

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F 0609 SS=D	Continued from page 5 indicates cognitively intact). During interview on December 17, 2024, at 11:30 AM Resident 56 revealed that his cellphone had been stolen in November. Resident 56 confirmed that he promptly notified staff when he discovered the cellphone was missing. Review of a Social Services Referral, dated November 10, 2024, revealed Resident 56 reported his cell phone was missing and alleged two agency nurse aides (Employees 1 and 2) as alleged perpetrators. Both Employee 1 (agency nurse aide) and Employee 2 (agency nurse aide) were terminated from employment with the facility on November 12, 2024. The resident contacted local law enforcement directly on November 14, 2024, initiating a police investigation. A replacement phone was provided to the resident on November 16, 2024. Review of the facility investigation failed to provide documented evidence that local law enforcement	F 0609		

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F 0609 SS=D	Continued from page 6 was timely notified by the facility (within 24 hours) after the allegation of misappropriation of the resident's property. Review of the facility investigation failed to provide documented evidence that the misappropriation of the resident's cellphone was reported to the State Licensing Agency (DOH) utilizing the Electronic Event Reporting System within 24 hours nor the Local Area Agency on Aging immediately and follow up with a written report within 48 hours. There was no evidence that a PB-22 was completed for the alleged perpetrator within five working days. An interview with the administrator on December 20, 2024, at approximately 9:00 AM, failed to provide documented evidence the facility implemented the facility Abuse Policy for reporting to appropriate agencies including the state agency, the local area agency on aging, and law enforcement in response to the resident's allegation of potential misappropriation of resident property on November 10, 2024. The administrator conformed that although there were two identified perpetrators, the	F 0609		

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F 0609 SS=D	Continued from page 7 facility failed to complete a PB-22 via the Electronic Event Reporting within 5 working days of the reported allegation. The administrator confirmed that it was the resident who contacted law enforcement, not the facility. This failure to follow established reporting procedures delayed appropriate investigation and response to the resident's allegation, compromising the facility's obligation to protect residents and ensure accountability. 28 Pa. Code 201.14(a)(c) Responsibility of Licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)(c) Resident rights 28 Pa. Code 211.10 (c) Resident care policies	F 0609		

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F 0609 SS=D	Continued from page 8	F 0609		
F 0679 SS=E	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:	F 0679	1. R-18, R-16 & R-19 will be interviewed by Activity Director to identify their interest in activity programs and bingo prizes. 2. Activity department will discuss activity planning during resident council meetings to engage feedback from residents on the activities they do or do not like. 3. Activity Director has been reeducated on planning activities to meet the needs, interests, preferences and functional abilities of the current resident population. 4. NHA/designee will meet monthly with residents to ensure their activity preferences are being addressed and planned as able into the activity calendars. A summary of each meeting will be submitted to the QA Committee monthly.	Completion Date: **02/04/2025** Status: **APPROVED** Date: **01/10/2025**

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F 0679 SS=E	Continued from page 9 Based on clinical record review and resident and staff interviews, it was determined the facility failed to provide an ongoing program of activities designed to meet the needs, interests, preferences,and functional abilities of four residents out of 18 sampled residents (Residents 18, 16, 19, and 13). Findings include: A review of the facility census at the time of survey ending December 20, 2024, revealed a census of 90 residents. Review of the average age of residents indicated that 18 residents were under the age of 60. Review of the facility assessment revealed that 80-85 of 90 residents had some mental health diagnoses. A review of Resident council meeting minutes revealed during the November 2024 meeting, residents had voiced a concern with the Activities program. Specifically, residents stated the facility plays bingo but that instead of prizes they are given "bingo bucks" which then can be redeemed for	F 0679		

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F 0679 SS=E	Continued from page 10 prizes. Residents stated the prizes were used items and not what they would like. Further residents were told during this meeting the facility does not have an activity budget. During an interview with the Activity Director on December 18, 2024, at approximately 10:00 a.m., revealed she started in August 2024. She stated she does not have a budget, but when she needs anything she purchases items and is reimbursed for these items. The bingo prizes have been items donated to the facility. During a group meeting on December 18, 2024, at 10:30 a.m., with four alert and oriented residents, three of the 4 residents (Residents 18, 16, and 19) confirmed concerns with the activities program. Stating the Bingo prizes are used items but more importantly activities in general do not meet their interests or preferences, are boring and not engaging. A review of the clinical record revealed that	F 0679		

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F 0679 SS=E	Continued from page 11 Resident 18 was admitted to the facility on June 30, 2020, with diagnoses that included morbid obesity. A quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated October 3, 2024, indicated the resident was cognitively intact with a BIMS (Brief Interview of Mental Status-a tool to assess cognitive function) score of 15 (a score of 13-15 indicates intact cognition). Further review conducted during the survey ending December 20, 2024, revealed the resident's activity preferences had not been reviewed since July of 2023. A review of the clinical record revealed Resident 16 was admitted to the facility on July 23, 2018, with diagnoses to include bipolar disorder (a mental health condition that causes extreme mood swings. These include emotional highs, also known as mania or hypomania, and lows, also known as	F 0679		

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F 0679 SS=E	Continued from page 12 depression). Review of Resident 16's annual MDS assessment dated September 30, 2024, indicated the resident was cognitively intact with a BIMS score of 14. A review of the clinical record revealed Resident 19 was admitted to the facility on May 27, 2020, and has diagnoses to include depression. Review of Resident 19's quarterly MDS assessment dated November 26, 2024, indicated the resident was cognitively intact with a BIMS score of 15. A review of the clinical record revealed that Resident 13 was admitted to the facility on October 12, 2022, and has diagnoses to include alcohol dependence and dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities). Review of Resident 13's quarterly MDS assessment	F 0679		

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F 0679 SS=E	Continued from page 13 dated October 17, 2024, indicated the resident was mildly cognitively impaired with a BIMS score of 12. Further review conducted during the survey ending December 20, 2024, revealed the resident's activity preferences had not been reviewed since June of 2023. Review of the facility's Activity Calendars for October 2024, November 2024 and December 2024, and through survey ending December 20, 2024, indicated the scheduled activities provided did not offer variety and include programming designed for the younger residents. Interview with the activity director on December 18, 2024, at 10:00 a.m., revealed there are no specific activities for the younger population and no activities directed towards the mental health needs of residents. The facility failed to develop and implement a	F 0679		

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F 0679 SS=E	Continued from page 14 program of activities to meet the varied preferences, interests and cognitive and functional abilities and needs of the resident population, including offering activities designed for higher functioning younger residents. Refer F838 28 Pa. Code 201.29 (a) Resident rights	F 0679		
F 0689 SS=E		F 0689		

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F 0689 SS=E	Continued from page 15 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	1. R-52, R-49, R-78 & R-48 still reside in the facility. R-41 discharged to another SNF. 2. IDT Team met for R-52 and her individual care plan has been updated for safety interventions. R-49 is able to unlock his breaks independently; Fall(s) attributed to the acute onset and surgical intervention of Acute Appendicitis, Anti-rollback mechanism added to wheelchair; R-78 & R-48 are not independent in the shower room for showers. After residents were assessed by therapy, no resident was deemed to be an independent shower. 3. Fall prevention & safety education provided to staff. Facility will audit the last two weeks of residents falls to ensure appropriate interventions are in place. Outside plumber identified an issue with the main mixing valve on the water heater and replaced. Staff educated on taking water temperatures prior to showering of residents. 4. CNA/Nursing staff will complete purposeful rounding and complete	Completion Date: **02/04/2025** Status: **APPROVED** Date: **01/15/2025**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F 0689 SS=E	Continued from page 16	F 0689	tool five days/week for four weeks, then weekly for two months. Audit of shower temps to be completed three times per week for four weeks and weekly for two months. DON/designee will round three times per week for four weeks with Audits will be submitted to the QA Committee for three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395929	A. BLDG: __00_____ B. WING: _____	12/20/2024

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F 0689 SS=E	Continued from page 17 Based on a review of clinical records, select facility investigative reports, and staff interview, it was determined the facility failed to implement effective interventions, including staff supervision, to promote resident safety and prevent repeated falls for one resident (Resident 52) and further failed to implement effective interventions to prevent a fall for one resident (Resident 49) of four sampled residents and failed to maintain a safe environment in one of 3 resident shower rooms on the third floor. Findings include: A review of the clinical record revealed that Resident 52 was admitted to the facility on July 22, 2021, with diagnoses to include Huntington's disease (an inherited condition that affects brain cells and causes physical and emotional changes that get worse over time). A quarterly Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted periodically to plan resident	F 0689		

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F 0689 SS=E	Continued from page 18 care) dated August 9, 2024, indicated the resident exhibited a severe cognitive impairment with a BIMS score of 7 (Brief Interview for Mental Status - a tool to assess cognitive function; a score of 0-7 indicates severe cognitive impairment) and required extensive staff assistance for mobility, transfers, and toileting. Review of the Resident's Fall Risk Evaluation dated September 20, 2024, revealed the resident was at risk for falls related to a history of three or more falls, decreased muscular coordination, and being chair bound. Review of the resident's care plan initially dated July 22, 2021, indicated the resident was at risk for falls due to gait/balance problems, Huntington's disease, and impulsive behavior. Planned interventions to keep the resident free of injury were to anticipate and meet the resident's needs, be sure call light is within reach, ensure wearing appropriate footwear, and every 15-minute safety checks.	F 0689		

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F 0689 SS=E	Continued from page 19 Review of an investigative report provided by the facility, dated October 9, 2024, at 10:04 PM revealed the resident's alarm sounded, and the resident was found in between the Broda chair (reclining padded wheelchair) and the roommate's wheelchair. A quarter sized area of redness was noted on the resident's left forehead. As a result of the fall the resident was placed in front of the nurses' station for close observation. Review of an investigative report provided by the facility dated October 28, 2024, at 6:30 PM revealed staff heard a "bang" in the resident's bathroom, entered the room, and observed the resident on her right side on the floor in the bathroom. No injuries were noted at this time. Planned new interventions included to monitor the resident frequently for safety purposes, monitor at nurses' station, and check and change/toilet frequently. Review of an investigative report provided by the facility dated December 1, 2024, at 11:15 AM	F 0689		

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F 0689 SS=E	Continued from page 20 revealed staff found the resident on the floor close to the bathroom door sitting upright. No injuries were noted at this time. The resident was placed in her recliner chair at the nurses' station. Review of an investigative report provided by the facility dated December 4, 2024, at 8:30 PM revealed another resident who was visiting the resident's roommate alerted staff that Resident 52 had fallen backwards on to the floor and hit her head on the bedside table. No visible injuries were noted at the time. The immediate intervention was to remove the bedside table out of the resident's room due to safety hazard. Despite the resident's severe cognitive impairment and poor safety awareness, the facility failed to demonstrate the provision of sufficient staff supervision and appropriate interventions, at the level and frequency required to prevent repeated falls. The facility planned approaches, such as using a call light, relied on the resident's cognitive abilities, which were not consistent with the resident's	F 0689		

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F 0689 SS=E	Continued from page 21 documented impairment level. The facility could not provide documented evidence of adequate supervision or effective interventions to prevent the resident's repeated falls. Interview with the Nursing Home Administrator (NHA) on December 20, 2024, at 9:00 AM failed to provide documented evidence that the facility provided sufficient supervision and effective safety measures for Resident 52 to prevent repeated falls. A review of the clinical record revealed that Resident 49 was admitted to the facility on July 21, 2022, with diagnoses to include dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change) and CVA (cardiovascular accident -stroke). A quarterly MDS dated November 13, 2024, indicated the resident exhibited moderate cognitive impairment with a BIMS score of 9 (a score of	F 0689		

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F 0689 SS=E	Continued from page 22 8-12 indicates moderate cognitive impairment) and was dependent on staff for wheelchair mobility. Review of a facility investigative report dated December 4, 2024, at 6:15 PM revealed the resident was in the dining room, stood up from wheelchair, and when attempting to sit back down the wheelchair rolled away from the resident. The resident landed on his back, striking his head against the base of the fish tank. The resident was assessed and found to have no immediate injuries. An anti-roll back device was applied to wheelchair as an intervention. Further review of the investigation revealed staff failed to ensure the wheelchair locks were engaged when positioning the resident at the dining room table. This oversight directly contributed to the resident's fall. Interview with the director of rehab on December 20, 2024, at approximately 10:30 AM confirmed	F 0689		

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F 0689 SS=E	Continued from page 23 the resident's wheelchair locks should have been engaged by staff when staff positioned the resident at the dining room table prior to the fall to prevent the wheelchair from rolling. Interview with the Nursing Home Administrator on December 20, 2024, at approximately 11:00 AM failed to provide documented evidence that measures were taken to ensure the locks were engaged prior to the incident. The facility failed to ensure the safety of Residents 52 and 49 by not implementing and maintaining effective fall prevention measures, including proper supervision and equipment use which increased the risk of injury and compromised resident safety. Clinical record review revealed that Resident 41 was admitted to the facility on September 16, 2021 with diagnosis to include Bipolar disorder (formerly called manic depression, is a mental health condition that causes extreme mood swings) A review of a care plan dated March 25, 2024	F 0689		

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F 0689 SS=E	Continued from page 24 revealed the resident sometimes refuses showers on the scheduled days of the week and scheduled times. Also the care plan noted she may shower independently and shower on other days and times not scheduled. There were no noted interventions regarding "showering independently". On December 18, 2024, at 2:36 A.M., a nurse's note indicated Resident 41 requested assistance in setting up the shower room so she could shower independently. Nursing staff honored the request. After the shower, Resident 41 emerged yelling that she had been burned by the water. She reported letting the water run for two minutes before entering, initially finding it at an appropriate temperature. However, during the shower, the water temperature fluctuated unexpectedly between hot and cold. She stated that at one point, the water became "boiling," causing burns on the right lateral lower leg and the top of her right foot. Nursing staff assessed the resident but observed no redness, warmth, or blistering. Ice was provided, and Tylenol was administered for reported pain. No water	F 0689		

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F 0689 SS=E	Continued from page 25 temperatures were recorded at the time of the incident. At 8:10 A.M. on December 18, 2024, facility maintenance tested the water temperature on the third floor at 5:50 A.M. and found it to be within normal limits. Nursing staff completed an every two-hour skin assessment protocol for 24 hours, and no evidence of burns, blisters, or increased redness was noted to Resident 41. The survey team was informed of the incident December 18, 2024, at 9 A.M. An investigation was initiated, and water temperatures were measured in all facility shower rooms. On the second floor, three showers and sinks were within acceptable ranges. On the third floor, two out of three showers and sinks also had temperatures within normal limits, but the shower room near room 305 showed elevated water temperatures. Resident room sink temperatures on second and third floors were within normal ranges.	F 0689		

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F 0689 SS=E	Continued from page 26 During an interview at approximately 11:00 A.M., the maintenance director acknowledged an issue with one of the facility's boilers, which according to the plumber, could not be repaired for several days. The shower room in question was closed until repairs were completed. On December 19, 2024, at 10:00 A.M., Residents 78 and 48, who are cognitively intact, reported that they shower independently. They described staff assistance as limited to providing supplies, such as towels and clothing, and stated that staff did not remain in the shower room or check water temperatures before they began. Both residents noted that water temperatures would initially be comfortable but could become "hot" during the shower. Interviews revealed no evidence that staff checked water temperatures before resident showers. The Nursing Home Administrator confirmed at 10:30 A.M. on December 18, 2024, that the third-floor	F 0689		

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F 0689 SS=E	Continued from page 27 shower room's water temperature was inconsistent. She also confirmed that water temperatures were not measured at the time of the incident. During an interview December 18, 2024 at 10:15 A.M., Employee 2 (agency NA) stated that prior to a resident shower, she will put her hand under the running shower water to feel if it is comfortable. She confirmed that she does not take a water temperature prior to a resident shower. She further confirmed that if a resident is independent for showering, her assistance was limited to providing their belongings and leaving the shower room. On December 20, 2024, at 10:00 A.M., the Director of Nursing could not confirm how many residents were classified as independent shiverers. He acknowledged that no assessments had been conducted to evaluate whether these residents could safely shower independently and could not define the criteria for "independent showering."	F 0689		

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F 0689 SS=E	Continued from page 28 28 Pa. Code 201.18 (b)(1)(e)(1) Management. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services	F 0689		
F 0698 SS=D	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0698	1. R-60's Dialysis care plan was updated. 2. Care plans for other residents with Dialysis have been reviewed and addressed accordingly. 3. Quarterly review of care plans for Dialysis residents will occur to ensure individualized care plans. 4. Monthly audit of Dialysis resident's care plans to ensure accuracy for three months. Audits will be submitted to the QA Committee for three months.	Completion Date: **02/04/2025** Status: **APPROVED** Date: **01/10/2025**

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F 0698 SS=D	Continued from page 29 Based on review of clinical records, observations, and family and staff interviews, it was determined the facility failed to provide person-centered care for one resident out of 3 residents receiving hemodialysis. (Resident 60). Findings include: A review of the clinical record revealed that Resident 60 was admitted to the facility on November 27, 2022, with diagnoses to include end-stage kidney disease with dependence on kidney dialysis (process of removing waste products and excess fluid from the body when the kidneys are not able to adequately filter the blood). According to the clinical record, the resident had a right arm arteriovenous	F 0698		

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F 0698 SS=D	Continued from page 30 fistula (an AV fistula is a connection that's made between an artery and a vein for dialysis access. A surgical procedure, done in the operating room, is required to stitch together two vessels to create an AV fistula). Current physician orders dated January 26, 2024, indicated dialysis days and times (Tuesday, Thursday, Saturday at 10:30 AM), specific instructions for the right arm fistula (e.g., no blood pressure, blood draws, or injections on the right arm), and to check for bruit and thrill daily. (Bruit is an abnormal swishing sound heard with a stethoscope over a blood vessel. Thrill is the vibration felt over the chest wall by using one's hand. The presence indicates proper function of the AV fistula) The orders also directed the use of an	F 0698		

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F 0698 SS=D	Continued from page 31 emergency kit at the bedside and outlined steps to call vascular surgery if any issues arose with the fistula. However, the orders did not detail the specific care to be provided for the AV fistula. The resident's care plan dated November 27, 2022, included general interventions related to dialysis access, such as monitoring, documenting, and reporting signs or symptoms of infection, and restrictions on blood pressure measurements and blood draws from the right upper extremity. However, the care plan did not include individualized interventions addressing the monitoring, care, maintenance, or emergency management of the AV fistula site, despite this being the resident's current dialysis access site.	F 0698		

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F 0698 SS=D	Continued from page 32 During an interview conducted on December 20, 2024, at 10:00 AM, the Director of Nursing confirmed the absence of a care plan that included emergency measures or planned care specific to the AV fistula for this resident. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.	F 0698		
F 0836 SS=E		F 0836		

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F 0836 SS=E	Continued from page 33 483.70(a)-(c) License/Comply w/ Fed/State/Locl Law/Prof Std §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph.	F 0836	1. January 1, 2025 the company obtained a new accounts payable company. The facility administrator will work with the new company designee to research accuracy of the listed vendors. There are no goods or services that are being withheld from the residents due to the status of the AP liabilities of Ridgeview Healthcare and Rehabilitation Center. 2. The Administrator will receive an AP/Aging report monthly and review the report that bills are paid in a timely manner and continued vital services are rendered for resident care. 3. The Regional Administrator will educate the Administrator on reviewing the monthly vendor AP/Aging report to ensure vital resident services are not interrupted. 4. Administrator/designee will maintain documentation of the monthly review of the AP/Aging reports and implement a monthly accounts payable call to ensure current services for vital goods and vendors are not interrupted and	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/21/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395929	A. BLDG: __00_____ B. WING: _____	12/20/2024

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F 0836 SS=E	Continued from page 34 This REQUIREMENT is not met as evidenced by:	F 0836	being provided. Results of the monthly accounts payable call will be submitted to the QA Committee for three months for any changes or recommendations.	

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F 0836 SS=E	Continued from page 35 Based on the facility's accounts payable ledger and staff interviews, it was determined the facility failed to comply with Federal, State, and Local laws and professional standards by not ensuring timely payment for goods and services necessary for daily operations. Findings include: The 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations, subsection 201.14(g), dated July 1, 2023, revealed a facility owner shall pay in a timely manner bills incurred in the operation of a facility that are not in dispute and that are for services without which the resident's health and safety are jeopardized. A review of the current outstanding	F 0836		

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F 0836 SS=E	Continued from page 36 accounts payable ledger revealed outstanding balances as of December 20, 2024, for greater than 121 days beyond terms of payment which include: Allstate Pest Management: $1,969.48 Commonwealth of Pennsylvania: $16,000.00 Concept Medical: $2,681.31 E. Copier Solutions: $1,372.66 Geisinger Medical Center: $2,576.65 General Healthcare Resources: $19,771.26 Geri Medix: $7,539.46 HD Supply Facilities Maintenance: $1,337.37 Integrated Medical Group LLC: $1,850.00 Lehigh Valley Hospital: $3,395.75 National Care Systems LLC: $2,520.00 Nutro Co: $24,324.00 Otis Elevator: $4,243.42 Respiratory Care Practices Inc.:	F 0836		

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F 0836 SS=E	Continued from page 37 $6,060.90 Robert J. Thurick, DO: $1,850.00 Schuylkill Plus!: $2,435.00 SEIU Healthcare PA Health and Welfare Plan: $172.35 SEIU Union Dues: $1,835.55 SEIU Training Fund: $19,525.02 Select Ambulance: $25,393.95 Smith RX: $1,197.86 Total Plan Concepts: $226,751.24 West Mahanoy Township Tax Collector: $71,758.10 Bertram Foods: $11,779.43 Selective Insurance: $6,472.00 Advanced Audiology: $3,800.00 During an interview on December 19, 2024, at 12 PM, the Nursing Home Administrator confirmed that the facility owners had not provided evidence of payments or payment agreements for the	F 0836		

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F 0836 SS=E	Continued from page 38 outstanding invoices. She also stated that facility administration did not have access to billing or payment records and could not verify whether the listed bills had been paid. This failure to ensure timely payment of essential goods and services demonstrates non-compliance with Federal, State and Local Laws), which requires facilities to pay bills in a timely manner to prevent jeopardizing the health and safety of residents. 28 Pa. Code 201.14(g) Responsibility of Licensee. 28 Pa. Code 201.18 (b)(3)(e)(1)(2) Management.	F 0836		

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F 0838 SS=F	483.71(a)(1)(3)(b)(1)(c)(1)-(5) Facility Assessment §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and	F 0838	1. Ridgeview Healthcare and Rehabilitation Center's Facility Assessment was updated to include the identified areas as outlined in the statement of deficiencies from the annual survey ending December 20, 2024. 2. Regional Administrator educated NHA & IDT team on importance of maintaining the Facility Assessment accurately to reflect current environment of the facility. 3. Updates to Ridgeview Healthcare and Rehabilitation Center's Facility Assessment will be completed upon changes within the organization or at least annually. 4. Ridgeview Healthcare and Rehabilitation Center's Facility Assessment will be reviewed monthly at the QA Committee meeting for three months and at least annually thereafter.	Completion Date: **02/04/2025** Status: **APPROVED** Date: **01/10/2025**

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F 0838 SS=F	Continued from page 40 (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the	F 0838		

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F 0838 SS=F	Continued from page 41 facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff.	F 0838		

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F 0838 SS=F	Continued from page 42 §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by:	F 0838		

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F 0838 SS=F	Continued from page 43 Based on staff interviews and a review of the facility's assessment and resident census and condition it was determined the facility failed to conduct and document a facility wide assessment, which identified the specific resources necessary to care for its specific resident population. Findings include: On December 20, 2024, the facility provided a "facility assessment" in response to surveyor inquiry. However, this document was not specific to the individual needs of the residents. It lacked detailed information on nurse staffing requirements, including staffing levels, use of agency staff, recruitment and retention plans, and emergency contingency plans for nurse staffing. The facility assessment did not address the specific activity needs of the resident population, including the younger residents and those with mental health diagnoses.	F 0838		

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F 0838 SS=F	Continued from page 44 As of the survey ending December 20, 2024, the facility had a census of 90 residents. Of these, 18 residents were under the age of 60, and 80-85 residents had mental health diagnoses. A review of Resident council meeting minutes revealed during the November 2024. meeting, residents expressed dissatisfaction with the activities program, specifically. regarding Bingo prizes, which consisted of used items. Residents were also informed that. the facility did not have a designated activity budget. During an interview with the Activity Director on December 18, 2024, at approximately 10:00 a.m., confirmed the absence of a budget and stated that Bingo prizes were donated items. The director also reported the facility had no specific programming for younger residents or residents with mental health needs. During a group meeting on December 18, 2024, at 10:30 a.m., with four alert and oriented residents,	F 0838		

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F 0838 SS=F	Continued from page 45 three of the 4 residents (Residents 18, 16, and 19) expressed that activities were boring, unengaging, and failed to meet their preferences or interests. Review of the facility's Activity Calendars for October 2024, November 2024, and December 2024, and through survey ending December 20, 2024, revealed a lack of variety and activities tailored to the younger resident population or those with mental health needs. Review of staffing records for the 30 days prior to the survey revealed that the facility relied on agency staff for over 60% of its nursing needs. The facility employed less than half of its required nursing staff during this period. During an interview December 20. 2024 at 10 a.m., the Nursing Home Administrator confirmed the use of agency staff and additional staffing challenges were not addressed in the facility assessment. The facility failed to develop and implement an	F 0838		

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F 0838 SS=F	Continued from page 46 activities program to meet the cognitive, functional, and recreational needs of its resident population, particularly younger residents, and those with mental health diagnoses. The facility failed to assess and plan for appropriate nurse staffing levels and resources, including contingency planning for emergency situations. The facility failed to conduct and document a comprehensive facility-wide assessment, which is required to identify the specific resources necessary to meet the unique needs of its resident population. This deficient practice has the potential to negatively affect the quality of care and quality of life for all residents. Refer F679 28 Pa. Code 201.18 (b)(3)(e)(2) Management.	F 0838		
F 0880 SS=D		F 0880		

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F 0880 SS=D	Continued from page 47 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	1. R-57 & R-34 had no ill effects from incorrect handling of the OTC/vitamins during the medication pass on December 19, 2024. 2. Employee 1 received 1:1 education on proper medication handling and administration of any OTC/vitamin. Education to remaining LPN/RN's on proper medication handling and administration of any OTC/vitamin. 3. Audit(s) will be conducted on correct medication administration of OTC/vitamins three times per week for 4 weeks; weekly times 4 weeks and randomly for 4 weeks. 4. Results of the medication audits will be submitted to the QA Committee for three months.	Completion Date: **02/04/2025** Status: **APPROVED** Date: **01/10/2025**

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F 0880 SS=D	Continued from page 48 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880		

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	395929	A. BLDG: __00_____ B. WING: _____	12/20/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
RIDGEVIEW HEALTHCARE & REHAB CENTER STATE LICENSE NUMBER: **152502**	**200 PENNSYLVANIA AVENUE SHENANDOAH, PA 17976**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F 0880 SS=D	Continued from page 49	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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F 0880 SS=D	Continued from page 50 Based on observation and staff interview, it was determined that the facility failed to adhere to infection prevention and control practices during medication administration for 2 of 2 sampled residents (Residents 57 and Resident 34). Findings include: An observation December 19, 2024, at 9 A.M., Employee 1 (LPN) administered over-the-counter medications to Resident #57 by pouring pills into her ungloved hand, transferring them into a plastic medication cup, and handing the cup to the resident. The medications included: Vitamin B1 Vitamin B12 Multi-vitamin. An observation December 19, 2024, at 9:05 A.M., Employee 1 (LPN) repeated the same practice while administering over-the-counter medications to Resident #34 by pouring the pills into her ungloved	F 0880		

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F 0880 SS=D	Continued from page 51 hand then placing in a plastic medication cup and administering to the resident. The medications included: Multi-vitamin Vitamin B1. Additionally, Employee 1 dropped a capsule on the top of the medication cart, picked it up with her ungloved hand, placed it into a plastic medication cup, and provided it to the resident. During an interview December 20, 2024, at 10:30 A.M. the Director of Nursing confirmed that the observed practices constituted a breach of infection control standards during medication administration. The facility's failure to follow proper infection control practices placed residents at increased risk of infection and compromised their safety. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing	F 0880		

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F 0880 SS=D	Continued from page 52 services	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 1020	Responsibility of licensee. (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other Federal, State and local agencies responsible for the health and welfare of residents. This includes complying with all applicable Federal and State laws, and rules, regulations and orders issued by the Department and other Federal, State or local agencies. This REGULATION is not met as evidenced by:	P 1020	1. The Infection Preventionist is now reporting any HAI (Healthcare Associated Infections) to the PA-PSRS system within 24 hours of confirmation. 2. Education provided to the Infection Preventionist on reporting requirements on HAI's to the PA-PSRS system. 3. The DON/designee will audit the HAI's submission timeframe weekly for four weeks and monthly for two months. 4. Results of the audits will be submitted to the QA Committee for three months.	Completion Date: **02/04/2025** Status: **APPROVED** Date: **01/10/2025**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 1020	Continued from page 1 Based on staff interview and select facility policy review, it was determined the facility did not comply with the requirements of the Act 52 Infection control plan. Findings include: A review of the current facility policy for Infection prevention and control, last reviewed October 2024 revealed, the facility will maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The infection prevention and control plan is comprehensive in that it addresses detection, prevention, and control of infections among residents and	P 1020		

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P 1020	Continued from page 2 employees. Act 52 mandates that healthcare facilities develop and implement an internal infection control plan that improves the health and safety of residents and staff through the establishment of a multidisciplinary committee. This committee should include representatives from the following groups: The multidisciplinary committee to include: (i) Medical staff that could include the chief medical officer or the nursing home medical director (ii) Administration representatives that could include the chief executive officer, the chief financial officer, or the nursing home administrator (iii) Laboratory personnel	P 1020		

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P 1020	Continued from page 3 (iv) Nursing staff that could include a director of nursing or a nursing supervisor (v) Pharmacy staff that could include the chief of pharmacy (vi) Physical plant personnel (vii) A plant safety officer (viii) Members of the infection control team, which could include an epidemiologist (ix) The community, except that those representatives may not be an agent, employee or contractor of the health care facility. In addition, the Act requires effective measures for the detection, control and prevention of health care-associated infections, culture surveillance processes and policies, procedures and protocols for staff who may have potential exposure to a resident known to be colonized or	P 1020		

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P 1020	Continued from page 4 infected with MRSA (methicillin resistant staph aureus, a bacteria resistant to many antibiotics) or MDRO (multi-drug resistant organisms, which are common bacteria (germs) that have developed resistance to multiple types of antibiotics), an outreach process for notifying a receiving health care facility of any resident known to be colonized prior to transfer to another facility, a required infection-control intervention protocol, the procedure for distribution of advisories issued under section 405(b)(4) to staff in the facility, notification to facility staff of the infection control plan, documentation of the facility infection control reporting to PA-PSRS (Patient Safety Reporting System) and written reports, documentation of notification of the serious event(infection) to the resident or responsible party.	P 1020		

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P 1020	Continued from page 5 Per Act 52, nursing homes are required to report confirmed HAIs to the Authority within 24 hours of confirmation (or by 5:00 PM on the next business day if confirmation occurs over a weekend or state holiday). During an interview on December 19, 2024, at 1:00 PM, the Infection Preventionist confirmed the facility's infection control policy and procedures did not include all requirements of Act 52. Specifically, she acknowledged that infections were reported to the state agency at the end of each month rather than within the required 24-hour timeframe. She further stated that this reporting method mirrored her practice in a previous role at another facility.	P 1020		

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P 1020	Continued from page 6 No evidence was provided during the survey to confirm the facility's compliance with the requirements of ACT 52.	P 1020		
P 1080		P 1080		

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P 1080	Continued from page 7 Responsibility of licensee. (g) A facility owner shall pay in a timely manner bills incurred in the operation of a facility that are not in dispute and that are for services without which the resident ' s health and safety are jeopardized. This REGULATION is not met as evidenced by:	P 1080	1. January 1, 2025 the company obtained a new accounts payable company. The facility administrator will work with the new company designee to research accuracy of the listed vendors. There are no goods or services that are being withheld from the residents due to the status of the AP liabilities of Ridgeview Healthcare and Rehabilitation Center. 2. The Administrator will receive an AP/Aging report monthly and review the report that bills are paid in a timely manner and continued vital services are rendered for resident care. 3. The Regional Administrator will educate the Administrator on reviewing the monthly vendor AP/Aging report to ensure vital resident services are not interrupted. 4. Administrator/designee will maintain documentation of the monthly review of the AP/Aging reports and implement a monthly accounts payable call to ensure current services for vital goods and vendors are not interrupted and	Completion Date: **02/11/2025** Status: **APPROVED** Date: **01/21/2025**

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P 1080	Continued from page 8	P 1080	being provided. Results of the monthly accounts payable call will be submitted to the QA Committee for three months for any changes or recommendations.	

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P 1080	Continued from page 9 Based on the facility's accounts payable ledger and staff interviews, it was determined the facility failed to comply with Federal, State, and Local laws and professional standards by not ensuring timely payment for goods and services necessary for daily operations. Findings include: A review of the current outstanding accounts payable ledger revealed outstanding balances as of December 20, 2024, for greater than 121 days beyond terms of payment which include: Allstate Pest Management: $1,969.48 Commonwealth of Pennsylvania: $16,000.00 Concept Medical: $2,681.31 E. Copier Solutions: $1,372.66 Geisinger Medical Center: $2,576.65 General Healthcare Resources: $19,771.26 Geri Medix: $7,539.46 HD Supply Facilities Maintenance: $1,337.37 Integrated Medical Group LLC: $1,850.00	P 1080		

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P 1080	Continued from page 10 Lehigh Valley Hospital: $3,395.75 National Care Systems LLC: $2,520.00 Nutro Co: $24,324.00 Otis Elevator: $4,243.42 Respiratory Care Practices Inc.: $6,060.90 Robert J. Thurick, DO: $1,850.00 Schuylkill Plus!: $2,435.00 SEIU Healthcare PA Health and Welfare Plan: $172.35 SEIU Union Dues: $1,835.55 SEIU Training Fund: $19,525.02 Select Ambulance: $25,393.95 Smith RX: $1,197.86 Total Plan Concepts: $226,751.24 West Mahanoy Township Tax Collector: $71,758.10 Bertram Foods: $11,779.43 Selective Insurance: $6,472.00 Advanced Audiology: $3,800.00 During an interview on December 19, 2024, at 12 PM, the Nursing Home Administrator confirmed that the facility owners had not provided evidence of	P 1080		

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P 1080	Continued from page 11 payments or payment agreements for the outstanding invoices. She also stated that facility administration did not have access to billing or payment records and could not verify whether the listed bills had been paid. This failure to ensure timely payment of essential goods and services demonstrates non-compliance with Federal, State and Local Laws), which requires facilities to pay bills in a timely manner to prevent jeopardizing the health and safety of residents.	P 1080		

Certified End Page

RIDGEVIEW HEALTHCARE & REHAB CENTER

STATE LICENSE NUMBER: 152502

SURVEY EXIT DATE: 12/20/2024

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
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