

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395929	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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
F 0000	INITIAL COMMENT	F 0000		
F 0600 SS=G	Based on an abbreviated complaint survey completed on January 22, 2025, it was determined Ridgeview Healthcare & Rehab Center was not in compliance with the following requirements of 42 Part 483 Subpart B Requirements for Long Term Care Facilities and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0600		

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 0600 SS=G	Continued from page 1 483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 0600	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. The facility will complete an assessment of current residents to identify residents that are at risk for engaging in or being victimized by sexual aggression. Residents that are identified as being at risk will have their individual care plans reviewed and updated with appropriate interventions. This assessment will be conducted upon admission, quarterly, after any significant change and post resident to resident aggression. 2. The facility will review and revise the current facility Abuse Prevention Policy to ensure compliance with	Completion Date: 03/04/2025 Status: APPROVED Date: 03/12/2025

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F 0600 SS=G	Continued from page 2	F 0600	<p>federal and state regulations.</p> <p>3. Facility will conduct re-education for staff across all departments and disciplines on: the facility abuse and prevention policy, recognizing, preventing and reporting sexual abuse. This re-education will include competency testing of staff.</p> <p>4. Facility will conduct audits of residents to ensure a sexual aggression assessment has been conducted and appropriate interventions have been care planed. Audits will be conducted weekly x4, then monthly x 4. The facility will also conduct an audit of incidents. The purpose of this audit will be to identify any trends in recurring issues that need to be addressed through additional education and/or policy revisions. This audit will be conducted weekly x 4, then monthly x 4. All results will be reported to the QAPI Committee.</p>	

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F 0600 SS=G	Continued from page 3 Based on review of clinical records, the facility's abuse prohibition policy, and select investigative reports, and interviews with staff and residents it was determined the facility failed to ensure that one resident (resident 2) out of 7 residents sampled was free from sexual abuse and resultant psychosocial harm. Findings include: A review of a facility policy entitled "Abuse Prevention" last reviewed October 2024, revealed abuse, neglect, and/or mistreatment of residents will not be tolerated in any manner. All necessary steps shall be taken to ensure the provision of a safe and secure environment. Residents must not be subjected to abuse by anyone including but not limited to, facility staff, other residents, consultants, volunteers, staff of other agencies, family members, friends, or other individuals. A review of Resident 2's clinical record revealed the resident was admitted to the facility on July 22,	F 0600		

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F 0600 SS=G	Continued from page 4 2021, with diagnoses which included Huntington's Disease (an inherited disorder that causes nerve cells in parts of the brain to gradually break down and die. The disease attacks areas of the brain that help to control intentional movement, as well as other areas) and Dementia (illnesses that affect your thinking, memory, reasoning, personality, mood, and behavior). A review of the resident's Significant Change Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated December 15, 2024, revealed the resident was rarely understood, was severely cognitively impaired, was totally dependent on staff for eating showering, toileting, and dressing, and required maximal assistance with mobility. A review of Resident 3's clinical record revealed the resident was admitted to the facility on July 23, 2018, with diagnoses which included bipolar disorder (a mental illness that causes extreme mood	F 0600		

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F 0600 SS=G	Continued from page 5 swings, which can impact a person's energy, thinking, and behavior) and generalized anxiety disorder (a condition that causes excessive and persistent worry that interferes with daily life). A review of Resident 3's admission MDS assessment dated December 31, 2024, revealed that the resident was cognitively intact with a BIMS (Brief Interview for Mental Status, a tool to assess the resident's attention, orientation, and ability to register and recall new information) score of 15 (scores of 13-15 equate to intact cognition). A review of Resident 3's clinical record revealed no documented evidence the resident had ever displayed signs of sexually inappropriate behaviors while residing at the facility. Additionally, there was no care plan in place indicating the presence of such behaviors. A review of a facility investigative report dated	F 0600		

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F 0600 SS=G	Continued from page 6 January 19, 2025, at 1:15 PM revealed Resident 3, a cognitively intact resident was observed by staff performing oral sex on Resident 2, a cognitively impaired resident. A review of the investigative reports and witness statements confirmed that Employee 2 nurse aide (NA) and Employee 3, nurse aide (NA) both witnessed the event and immediately reported to the nurse, Employee 1 registered nurse (RN). When questioned Resident 3 admitted to engaging in the act, stating that Resident 2 had initiated the interaction, although Resident 2, due to her severe cognitive impairment, could not have consented to or initiated sexual behavior. A review of a statement from Resident 3, which did not indicate the date or time it was obtained, revealed that Resident 3 went into Resident 2's room to offer her roommate, some yogurt. Resident 3 stated that Resident 2 was moaning as if she needed a drink. He indicated that he went into the bathroom to get her some water, and upon returning, Resident 2 grabbed his hand and pulled him toward her and started to touch the front of his	F 0600		

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F 0600 SS=G	<p>Continued from page 7</p> <p>pants. Resident 3 indicated they began to kiss. Resident 3 stated that Resident 2 had her brief off, so he placed his head between her legs for a few seconds. He stated the staff came in, saw what was happening and he confirmed he immediately got up and left the room.</p> <p>A review of nursing documentation written by Employee 1, RN dated January 19, 2025, at 1:15 PM indicated she was notified by Employee 2 NA that Resident 3 was engaged in inappropriate behavior with Resident 2. When Resident 3 was asked what he was doing, he got up and walked out of the room.</p> <p>Resident 2 was observed lying on her mattress with her incontinence brief removed. When asked if someone hurt her, Resident 2 moaned "yes". A body audit was conducted revealing no signs of bruising, marks or bleeding.</p> <p>State police were notified, and an investigation was initiated. Resident 2 was sent to the hospital for a</p>	F 0600		

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F 0600 SS=G	Continued from page 8 rape kit examination. Resident 3 was separated from this resident and placed on one-to-one observation to ensure residents' safety and provide continuous supervision of this resident. A telephone interview with Employee 2, NA on January 22, 2025, at 1:00 PM revealed she was assigned to Resident 2 on January 19, 2025. Employee 2 stated that she asked Employee 3, NA for assistance with Resident 2's care. When they entered Resident 2's room, the privacy curtain was drawn, and they noticed sneakers sticking out from underneath the curtain. Employee 2 indicated she and Employee 3 then moved around the curtain and observed Resident 3 face positioned between Resident 2's legs. She also noted that Resident 2's brief had been removed and was placed to the side. When asked if Resident 2 would have been capable of removing the brief on her own, Employee 2	F 0600		

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F 0600 SS=G	Continued from page 9 responded that she could not. She explained that while Resident 2 had a history of attempting to rip off her brief, the brief tabs were not torn. Instead, the tabs had been carefully undone, and the brief had been intentionally placed to the side. Employee 2 further stated when asked Resident 3 what he was doing, he got up and left the room. She observed that Resident 2 appeared distraught. Employee 2 stated she then helped resident to get dressed and escorted her to the dining room for monitoring. An interview with Employee 3 on January 22, 2025, at 12:12 PM revealed that on January 19, 2025, she had returned from her break when Employee 2 approached her and asked her for assistance with the care. The Resident 2 Employee 3 stated it was approximately 1:00 when they entered the residence room and noticed a pair of sneakers sticking out from under the privacy curtain. She indicated she then walked around the curtain and observed Resident 2 lying on the bed with her brief removed and saw Resident 3's face positioned between Resident 2's legs. Employee 3 stated that she and	F 0600		

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F 0600 SS=G	<p>Continued from page 10</p> <p>Employee 2 immediately yelled "What are you doing!" At that point, Resident 3 got up and walked out of the room. Employee 3 followed Resident 3 out of the room while Employee 2 stayed with Resident 2. Employee 3 immediately reported the incident to Employee 1 RN on duty. Employee 3 further stated she later returned to Resident 2's room and helped her get dressed and assisted her to the dining room. When asked whether Resident 2 would have been able to reach up to pull Resident 3 toward her or grab him, Employee 3 responded "no". She explained that Resident 2 requires assistance with. Activities of daily living and would not have the strength to perform such activities.</p> <p>Multiple attempts were made to interview Resident 3 throughout the day on January 22, 2025, however, the resident was asleep during each attempt.</p> <p>A review of legal records indicated, Resident 3 is facing charges of Indecent Assault on a Person with</p>	F 0600		

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F 0600 SS=G	Continued from page 11 Mental Disabilities, with a preliminary hearing scheduled for February 6, 2025. Resident 2 is cognitively impaired and did not possess the ability to consent to sexual acts with Resident 3. Applying the reasonable person concept, in the case of Resident 2, who is unable to cognizant speak for herself due to severe cognitive impairment, and the assessment of how most people would react to the situation of being sexually abused by Resident 3, Resident 2 would have been negatively affected by Resident 3's actions. An interview with the Nursing Home Administrator on January 22, 2025, at approximately 3:00 PM confirmed that the facility failed to ensure that Resident 2 was free from sexual abuse perpetrated by Resident 3. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18 (e)(1) Management	F 0600		

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F 0600 SS=G	Continued from page 12 28 Pa. Code 201.29 (a)(c) Resident Rights 28 Pa. Code 211.12(c)(d)(5) Nursing Services	F 0600			

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P 5520	<p>Nursing services.</p> <p>(3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5520	<ol style="list-style-type: none"> 1. Facility cannot retroactively correct the failure to meet the ratio requirements of the Certified Nursing Aides as identified in the outlined PA-2567. 2. Education given to the Nurse Scheduler and Director of Nursing on the Certified Nursing Aides ratio requirements. 3. Facility is actively recruiting Certified Nurses Aides through outside marketing sources; utilizing outside Nurse Agency to supplement Certified Nursing Aides; and daily staffing meetings being conducted in attempts to maintain State Mandated ratios for Certified Nursing Aides. 4. The Administrator will audit the staffing schedules to ensure the appropriate number of Certified Nursing Aides are scheduled to achieve compliance. Audits will occur three times per week for one week; weekly for four weeks and monthly for four weeks. The results of the audits will be submitted to the QA Committee. 	<p>Completion Date: 03/04/2025</p> <p>Status: APPROVED</p> <p>Date: 03/12/2025</p>
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P 5520	Continued from page 1 Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum nurse aide staff to resident ratio was provided on each shift for two shifts out of 21 reviewed. Findings include: A review of the facility's weekly staffing records revealed that on the following dates the facility failed to provide minimum nurse aide staff of 1:11 on the evening shift, and 1:15 on the night shift based on the facility's census. January 19, 2025 - 6.10 nurse aides on the evening shift, versus the required 8 for a census of 88. January 19, 2025 - 5.10 nurse aides on the night shift, versus the required 5.87 for a census of 88. On the above dates mentioned no additional excess higher-level staff were available to compensate this deficiency.	P 5520		

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P 5520	Continued from page 2 An interview with the Nursing Home Administrator on January 22, 2025, at approximately 3:00 PM, confirmed the facility had not met the required nurse aide to resident ratios on the above dates.	P 5520		
P 5530		P 5530		

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P 5530	Continued from page 3 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	1. Facility cannot retroactively correct the failure to meet the ratio requirements of the LPN's as identified in the outlined PA-2567. 2. Education given to the Nurse Scheduler and Director of Nursing on the LPN's ratio requirements. 3. Facility is actively recruiting LPN's through outside marketing sources; utilizing outside Nurse Agency to supplement LPN's; and daily staffing meetings being conducted in attempts to maintain State Mandated ratios for LPN's. 4. The Administrator will audit the staffing schedules to ensure the appropriate number of LPN's are scheduled to achieve compliance. Audits will occur three times per week for one week; weekly for four weeks and monthly for four weeks. The results of the audits will be submitted to the QA Committee.	Completion Date: 03/04/2025 Status: APPROVED Date: 03/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395929	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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
P 5530	Continued from page 4 Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum licensed practical nurse staff to resident ratio was provided on each shift for three shifts out of 21 reviewed. Findings include: A review of the facility's weekly staffing records revealed that on the following dates the facility failed to provide minimum licensed practical nurse (LPN) staff of 1:40 on the night shift based on the facility's census. January 15, 2025 - 2.20 LPNs on the night shift, versus the required 2.28 for a census of 91. January 19, 2025 - 1.33 LPNs on the night shift, versus the required 2.20 for a census of 88. January 21, 2025 - 2.03 LPNs on the night shift, versus the required 2.25 for a census of 90. On the above dates mentioned no additional excess higher-level staff were available to compensate this	P 5530		

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395929	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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
P 5530	Continued from page 5 deficiency. An interview with the Nursing Home Administrator on January 22, 2025, approximately 3:00 PM, confirmed the facility had not met the required LPN to resident ratios on the above dates.	P 5530		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395929	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025
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
P 5640	Continued from page 6 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	1. Facility cannot retroactively correct the failure to meet the overall PPD requirements of the nursing staff as identified in the outlined PA-2567. 2. Education given to the Nurse Scheduler and Director of Nursing on the overall PPD requirements for nursing staff. 3. Facility is actively recruiting Certified Nurses Aides and Licensed Practical Nurses through outside marketing sources; utilizing outside Nurse Agency to supplement Certified Nursing Aides and Licensed Practical Nurses; and daily staffing meetings being conducted in attempts to maintain State Mandated PPD requirements. 4. The Administrator will audit the staffing schedules to ensure the facility is staffed appropriately to reach the mandated State PPD. Audits will occur three times per week for four weeks and weekly for four weeks. The results of the audits will be submitted to the QA Committee.	Completion Date: 03/04/2025 Status: APPROVED Date: 03/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395929	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/22/2025	
NAME OF PROVIDER OR SUPPLIER: RIDGEVIEW HEALTHCARE & REHAB CENTER STATE LICENSE NUMBER: 152502		STREET ADDRESS, CITY, STATE, ZIP CODE: 200 PENNSYLVANIA AVENUE SHENANDOAH, PA 17976		
(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
P 5640	<p>Continued from page 7</p> <p>Based on a review of nurse staffing and resident census and staff interview, it was determined the facility failed to consistently provide minimum general nursing care hours to each resident daily.</p> <p>Findings include:</p> <p>A review of the facility's staffing levels revealed that on the following dates the facility failed to provide minimum nurse staffing of 3.2 hours of general nursing care to each resident:</p> <p>January 19, 2025 - 2.92 direct care nursing hours per resident.</p> <p>The facility's general nursing hours were below minimum required levels on the dates noted above.</p> <p>An interview with the Nursing Home Administrator on January 22, 2025, at approximately 3:00 PM confirmed the facility failed to consistently provide minimum general nursing care hours to each resident daily.</p>	P 5640		

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395929	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 01/22/2025
NAME OF PROVIDER OR SUPPLIER: RIDGEVIEW HEALTHCARE & REHAB CENTER STATE LICENSE NUMBER: 152502			STREET ADDRESS, CITY, STATE, ZIP CODE: 200 PENNSYLVANIA AVENUE SHENANDOAH, PA 17976		
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P 5640	Continued from page 8	P 5640			



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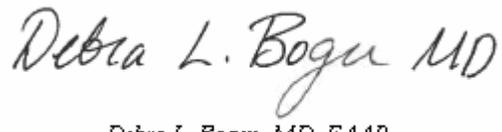
RIDGEVIEW HEALTHCARE & REHAB CENTER

STATE LICENSE NUMBER: 152502

SURVEY EXIT DATE: 01/22/2025

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