STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395929	A. Building B. Wing	11/04/2022

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 26142 Based on a review grievances lodged with the facility and clinical records and resident and staff interviews, it was determined that the facility failed to provide care in an environment, which promotes each resident's quality of life by failing to provide timely assistance to meet resident care needs as evidenced by one resident out of 20 sampled (Resident 49) Findings included: A review of Resident Grievance/Complaint Forms dated from August 1, 2022 through November 4, 2022, revealed that during that time frame Resident 49 voiced complaints regarding delayed staff response to requests for assistance made via the nurse call bell system. The resident stated that these waits occur both during the week and on the weekends, more frequently on 3 PM-11 PM and 11 PM -7 AM shifts of duty. During an interview with Resident 49 on November 1, 2022, at 12 PM, the resident stated that he activates his call bell and when staff responds, they turn it off, and tell him they'll be right back, but then do not return to provide the requested care. He further stated that the wait times are 30 minutes or more on the 3 PM to 11 PM and the 11 PM shift to 7 AM. shift due to lower nurse staffing on those shifts. He stated that he needs assistance with using the urinal and has to wait so long that he becomes incontinent. He also stated that he regularly fills out grievance forms and reports the issue to administrative staff with no resolution. During an interview on November 4, 2022, at approximately 1:30 PM the Director of Nursing and the Nursing Home Administrator acknowledged that Residents 49 continued to have unresolved complaints regarding long waits for staff to respond to his call bells and meet the resident's needs for assistance in a timely manner to promote the resident's quality of life in the facility. 28 Pa. Code 211.12 (a)(c)(d)(4)(5) Nursing Services 28 Pa. Code 201.29 (j) Resident Rights 28 Pa. Code 201.18 (e)(1)(2)(3)(6) Management

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of select facility policy and clinical records, and staff interview, it was determined that the facility failed to timely consult with the physician or notify the resident's interested representative of a significant change in condition, a significant weight loss, for one residents out of one sampled residents (Resident 62). Findings include: A review of the clinical record revealed that Resident 62 was admitted to the facility on [DATE], with diagnoses to include diabetes. A quarterly Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated August 3, 2022, revealed that the resident was moderately cognitively impaired with a Brief Interview for Mental Status (BIMS section of the MDS which assesses cognition, a tool to assess the resident's attention, orientation, and ability to register and recall new information, a score of 8-12 equates to being Moderately Cognitively Impaired) score of a 9. A review of the resident's weight record revealed the following recorded weights: July 21, 2022 - 185 Lbs August 2, 2022 - 168 Lbs weight loss (9.2%) in 2 weeks Resident 62 lost a total of 17 lbs. or 9.2 % of body weight in approximately 12 days (July 21, 2022 to August 2, 2022). There was no documented evidence that the facility had notified the resident's physician or resident representative of the significant unplanned weight loss. Interview with the Director of Nursing (DON) on November 3 2022, at approximately 10:40 AM, confirmed the resident's unplanned weight loss and that the facility failed to notify Resident 62's physician and resident representative of the significant, unplanned weight loss. 28 Pa Code 211.12 (a)(c)(d)(3)(5) Nursing services 28 Pa Code 201.29(a)(l)(2) Resident rights

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on observations and staff interview, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a clean and sanitary environment in the facility. Findings include: Observations of resident room [ROOM NUMBER] during an environmental tour of the facility on November 1, 2022, at 10:30 AM revealed several holes in the wall behind 215 A bed. The floor around and under the bed was littered with dirt, paper debris and a brown sticky substance. The same brown sticky substance was observed on the baseboards. Across from 215 A bed, there was a black substance observed on an area of the wall next to the resident's dresser and the baseboard. During an interview at the time of the observation, Resident 49 (residing in room [ROOM NUMBER] B) stated that that the black substance on the floor and wall has been there for at least a month. Observation on November 3, 2022 at 8:15 AM of the Third-Floor Nursing Unit revealed a thick layer of dust on both the blades of a rotating ceiling fan and the ceiling light next to the ceiling fan located in the hall outside the elevator. Interview with the Administrator on November 3, 2022, at approximately 2 PM confirmed that the resident environment was to be maintained in a clean and sanitary manner. 28 Pa. Code 207.2(a) Administrator's Responsibility.

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	395929	A. Building B. Wing	11/04/2022

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on a review of clinical records, information submitted by the facility, select resident incident/accident and investigative reports, and staff and resident interviews it was revealed that the facility failed to ensure that one resident was free from physical abuse, which resulted in significant physical harm, broken ribs, and emotional distress for this resident (Resident 74) and failed to implement measures necessary to prevent physical abuse for one resident (Resident 67) out of 20 sampled. Findings include: A review of the facility policy entitled Abuse Protection reviewed by the facility August 2022, revealed it is the policy of the facility for residents to have the right to be free from physical abuse, sexual abuse, misuse of restraints, involuntary seclusion, verbal abuse, mental abuse, neglect, abandonment, misappropriation of property, and self-abuse. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical pain or anguish. A review of the clinical record revealed that Resident 74 was admitted to the facility on [DATE]. The resident's diagnoses included schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as depression or mania). A review of Resident 74's Quarterly Minimum Data Set assessment dated [DATE], indicated that the resident was cognitively intact. A review of a resident incident and accident report and a Pennsylvania Department of Health PB-22 report form for investigation of alleged abuse, neglect and misappropriation of property report form, for investigation of alleged abuse, neglect and misappropriation dated October 17, 2022, at 10:00 AM revealed that on October 16, 2022, Employees 1 and 2 (nurse aides reported to Employee 3 (Registered Nurse) that they found Resident 74 on the floor of the resident's room at approximately 7:30 a.m. Upon Employee 3's observation she noted that the resident was tearful and anxious. Resident 74 stated to Employee 3 she was crawling back to bed and complained of pain to her left arm. Employee 3 observed that the resident's left thigh was reddened. When Employee 3 asked Resident 74 what happened she stated, that Employee 4 (RN) she hit me, I fell on the floor, and she left. It was noted that there was water on the floor by the resident's bed. The physician was notified and on October 16, 2022, at 10:10 a.m. the physician ordered an x-ray of the resident's left shoulder, left elbow, left hand, left rib series and left pelvic area. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An employee witness statement written by Employee 1 (nurse aide) October 16, 2022, indicated that on October 16, 2022, at approximately 7:30 a.m. We walked in room to get roommate up for breakfast we found resident {74} on the floor next to her bed. She said to us that the little nurse with short hair from night shift came in tried giving me my meds in the dark and she got mad because she did not turn the light on to see my meds, so she threw the water cup at nurse and nurse hit her causing her to fall and hit her wheelchair and left her on the floor in the dark. Employee 2 (NA) was present, and her witness statement dated October 16, 2022, revealed the exact same statement as Employee 1. A review of a witness statement written by Employee 4 (RN), dated October 18, 2022, revealed that the resident was upset because she was awakened for medication administration. She confirmed that Resident 74 threw water on her, but denied hitting the resident. A review of a witness statement given by Resident 74 on October 17, 2022, revealed that Resident 74 stated when the nurse came in my room it was dark. I could not see to get up and I threw my water on the nurse. When I stood up she pushed me to the floor. When I fell to the floor I was screaming. The resident was unable to recall what time exactly this occurred, only that it was overnight. When asked to further explain what happened when she fell , she stated I fell and hit the back of my head. I hit my roommate's wheelchair. I hope my ribs aren't broken. She laid on the floor and yelled, she further stated that when staff came in they looked her over and had x-rays completed in the facility. A review of an x-ray of the left rib series report dated October 16, 2022, at 2:45 p.m. revealed acute fractures (break in a bone that occurs quickly, rapidly and usually traumatically) involving the left 10th and 11th ribs anterolaterally (situated in front and to one side) in the midaxillary plane (a specific coronal plane that passes through the midline of the body). Upon physician review, it was noted to continue her routine Tramadol (pain medication) and add prn Tylenol for breakthrough pain. Upon further review of the facility report, it was noted that a police investigation into the abuse of Resident 74 was ongoing and was not available for review at the time of survey ending November 4, 2022. The facility's report indicated that Employee 4 was suspended immediately and then terminated from facility employment on October 18, 2022, for abusing Resident 74. A review of the facility's annual abuse training revealed that Employee 4 received this training in September of 2022. The facility failed to ensure that Resident 74 was free from physical abuse resulting in fractured ribs. Interview with the Director of Nursing on November 3, 2022, at approximately 11:00 AM confirmed that Resident 74 had been physically assaulted by a registered nurse during care. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with Resident 78 on November 4, 2022 at 11:30 AM revealed that he reported an allegation of staff physical abuse of Resident 67 back in September 2022. Resident 78 stated he reported that he, along with Resident 92 and Resident 46, were in the dining room and witnessed Employee 4 (RN) put Resident 67 in a choke hold. Resident 78 stated that Resident 67 kept trying to stand and Employee 4 became frustrated and got rough with the resident. Resident 78 explained that he reported the incident to nursing staff, but that no one from the facility ever followed up with him about the incident he observed. Interview with Resident 46 on November 4, 2022 at 12:15 PM revealed that she could not clearly recall the incident. Interview with Resident 92 on November 4, 2022 at 12:30 PM confirmed that she did recall the incident and recalled reporting the incident to the facility. Resident 92 stated that she recalls Employee 4 (RN) clothes-lining Resident 67 in the dining room. Resident 92 stated that the employee who was rough with the resident no longer works at the facility. Interview with an Employee 3 (RN) confirmed that Residents 67, 92, and 46 reported the incident on September 26, 2022 and that Resident Concern/Complaint Forms were completed for all three residents. Review of a facility incident report dated September 26, 2022 at 3:00 PM indicated that Resident 67 was forcefully placed in her chair. The location of the incident was the Third-Floor Nursing Unit dining room. Further review of the incident report noted that the incident which occurred on September 24, 2022 at 3:00 PM was reported by Resident 46 on September 26, 2022. Review of the Resident Concern/Complaint Form, which was attached to the incident report indicated that Resident 46 witnessed Employee 4 (RN) pulling Resident 67's head back by the hair and putting the resident in a choke hold. The nursing follow-up (no date) noted the concern was resolved. According to nursing staff's follow-up they conducted interviews with Resident 46 and Resident 67. Resident 67 stated no she didn't choke her, I'm pissed off, I want to go home. Resident 67 has no visible injuries and denied harm. Date discussed was September 26, 2022. No further action was noted to be taken. Resident 67 to continue to follow with psychiatry and provide a safe environment for the resident. Further review of the incident report revealed no documented evidence that Resident 78's Resident Concern/Complaint Form or Resident 92's Resident Concern/Complaint Form was attached to the incident. A written statement by the director of nursing dated September 26, 2022, indicated tha she spoke to Employee 4 on September 26, 2022 upon hearing of the accusations. Employee 4 was reported that she was assisting with Resident 67's increased behaviors and providing one to one intervention with the resident. Employee 4 stated she did guide Resident 67 to sit, but at no time physically or forcefully made the resident sit. Employee 4 was having conversation with Resident 67 the entire time to keep the resident calm and provide as much support as possible. (continued on next page)

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	395929	A. Building B. Wing	11/04/2022

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Immediate investigation of accident/incident taken by the director of nursing noted that staff interviews and resident interviews were completed, the Area Agency on Aging was notified. Resident 67 was interviewed and denied the incident. No visible injury was noted. A report was submitted to the State Agency and a PB-22 Form was completed. The police were notified on September 26, 2022 at 4:00 PM. Review of the PB-22 Form concluded no harm was noted and the incident was unfounded. There was no documented evidence that the follow-up interview with Resident 46 included a documented statement by the resident as part of the investigation after the initial allegation was reported by the resident. There was no documented evidence that the facility had thoroughly investigated if there were any other resident witnesses to the incident, which occurred in the dining room which is a resident common area. During interview with the director of nursing (DON) on November 4, 2022 at 1:00 PM, the DON noted that she only recalled a Resident Concern/Complaint Form being submitted for Resident 46. The DON confirmed she was unaware that Resident 78 and Resident 92 had also reported the incident along with Resident 46. The DON confirmed that all allegations of abuse were to be thoroughly investigated by the facility. 483.13 - Resident Behavior and Facility Practices, 10-1-1998 edition 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.18 (e)(3) Management 28 Pa. Code 201.29 (a) Resident rights 28 Pa. Code 201.29 (c) Resident rights 28 Pa. Code 211.12 (a) Nursing services 28 Pa. Code 211.12 (c)(d)(5) Nursing services 28 Pa. Code 211.12 (d)(3) Nursing services

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 39929 Based on a review of the facility's abuse policy and employee personnel files and staff interviews, it was determined that the facility failed to implement their established procedures for screening five of five employees for employment (Employees 5, 6, 7, 8, 9) Findings include: A review of the facility's Resident Abuse policy last revised by the facility August 2022, revealed procedures for screening potential employees that included to screen all potential employees for any previous history of abuse, neglect, or mistreating of residents as defined by applicable requirements. All employees undergo a criminal background check and pre-employment drug testing. The facility will contact former employers for information of past employment history and personal references for feedback regarding affirmation for employment. Review of employee personnel files revealed that Employee 5 (NA) was hired July 19, 2022, and there was no documented evidence that reference checks from previous employers were obtained prior to the staff's start of employment. Review of employee personnel files revealed that Employee 6 (PT) was hired September 29, 2022, and there was no documented evidence that reference checks from previous employers were obtained prior to the staff's start date. Review of employee personnel files revealed that Employee 7 (RN) was hired September 19, 2022, and there was no documented evidence that reference checks from previous employers were obtained prior to the staff's start date. Review of employee personnel files revealed that Employee 8 (dietary) was hired October 21, 2022, and there was no documented evidence that reference checks from previous employers were obtained prior to the staff's start date. Review of employee personnel files revealed that Employee 9 (Social Worker) was hired January 14, 2021, and there was no documented evidence that reference checks from previous employers were obtained prior to the staff's start date. Interview with the Director of Human Resources on November 4, 2022, at 11:15 a.m. verified that the facility was unable to provide evidence that a previous employer was contacted according to the facility's screening procedures outlined in the Resident Abuse policy for Employees 5, 6, 7, 8, 9. 28 Pa Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a)(c)(d) Resident rights 28 Pa. Code 205.19 Personnel policies and procedures

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of information submitted by the facility and clinical records and staff and resident interviews was determined that the facility failed to develop and implement an individualized discharge plan for two of 20 residents reviewed (Residents 100 and 78) to meet the resident's post-discharge needs. Findings Include: Clinical record review revealed that Resident 100 was admitted to the facility on [DATE] with diagnose to include traumatic brain injury, multiple fractures, status post motorcycle accident and rehab hospitalization . A review of the resident's care plan, initially dated August 1, 2022, revealed that the resident's goal of I need assistance with discharge planning. The planned interventions were to Inform me, legal guardian of progress made in achieving rehabilitation goal and schedule a team meeting with the me and my legal representative to discuss care needs and discharge planning, if indicated. At the time of the survey ending November 4, 2022, there was no documentation of the resident's discharge plan and returning home. There was no documented evidence that the resident and/or the resident's caregiver/support person were educated on the resident's post discharge needs. The facility failed to identify the resident's discharge and post-discharge needs, including medical equipment and ADL (activities of daily living) assistance required. During an interview with the Nursing Home Administrator and Director of Nursing on November 3, 2022, at 12:00 PM, these staff members acknowledged that there was no documented evidence of discharge instruction/education provided to the resident and/or the resident's representation discharge planning. Clinical record review revealed that Resident 78 was admitted to the facility on [DATE], with diagnoses to include cerebral infarction (stroke) and depression. Interview with Resident 78 on November 4, 2022 at 11:30 AM revealed that the resident had a desire to return to live in the community. The resident stated that the facility was not helping help him with his desired discharge to the community. Review of a quarterly Minimum Data Set Assessment (MDS- a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated September 27, 2022, indicated the resident had a BIMS (brief interview mental screener that aids in detecting cognitive impairment) score of 15 (a score of 13 to 15 indicated that the resident was cognitively intact) and active discharge planning was already occurring for the resident to return to the community. (continued on next page)

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	395929	A. Building B. Wing	11/04/2022

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 78's current care plan initially dated November 9, 2021, revealed no documented evidence that an individualized discharge plan was developed and revised as needed to reflect the resident's desire for discharge and individualized approaches to prepare for a safe discharge from the facility. Interview with the social services director on November 4, 2022 at 12:30 PM confirmed there was no documented evidence the facility developed, reviewed and revised an individualized discharge plan for the resident who desires to return to the community. 28 Pa. Code 201.25 Discharge policy 28 Pa. Code 211.11 (d)(e) Resident care plan 28 Pa. Code 211.16 (a) Social Services

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on observation, review of clinical records, and staff and resident interview, it was determined the facility failed to consistently provide timely and necessary foot care for one of 20 residents sampled (Resident 49). Findings include: Review of Resident 49's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses, which included diabetes and morbid obesity. Observation on November 1, 2022 at 12:00 PM revealed that Resident 49's toenails, on both feet, were thickened, yellowed, and extended past the tips of his toes. Resident 49 stated during interview at that time, that he was not seen by a podiatrist at the facility. Further review of the clinical record revealed that this resident had not been seen by podiatry in the facility Interview with the Director of Nursing (DON) on November 2, 2022, at approximately 1 PM, confirmed that Resident 49 had not been provided routine podiatry care as a resident in the facility. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing Services

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of clinical records and select facility policies and staff interviews, it was determined the facility failed to provide adequate staff supervision of a resident identified at risk for elopement to prevent the resident's elopement from the facility and monitor the activities and whereabouts of a resident with known exit seeking behaviors to timely identify the resident's absence from the facility, for one resident out of 8 residents identified at risk for elopement (Resident 100) and failed to maintain a safe environment free of potential accidents hazards. Findings include: A review of the Med Pass clinical guideline for Elopement overview, last reviewed by the facility August 16, 2022 revealed that The facility elopement definition is as follows: Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e. an order for discharge or leave of absence) and/or any necessary supervision to do so. The guidelines were to Initiate the Missing Resident/Patient Action Plan, if unable to locate a resident /patient. At the time of the survey ending November 4, 2022, the facility was unable to provide the details of the referenced Missing Resident/Patient Action Plan and the corresponding procedures. Obseravtion during the survey ending October 4, 2022, revealed that the exit door magnetic locking system is offline during a fire emergency and the facility had not developed an alternative safety plan to maintain resident safety and prevent elopements when the facility's magnetic locking system is not functional. Clinical record review revealed that Resident 100 was admitted to the facility on [DATE] with diagnoses to include traumatic brain injury and multiple fractures after a motorcycle accident. A review of Resident 100's quarterly Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 3, 2022, revealed that the resident's cognition was severly impaired with a BIMS score (brief interview for mental status -section of MDS that assesses cognition) of 0 (a score of 0-7 indicates severly impaired cognition) and required extensive assistance of one for ambulation. A review of an elopement assessment dated [DATE] indicated that Resident 100 was cognitively impaired, had not exhibited wandering behavior and was not at risk for elopement at that time. A review of nursing documentation dated September 14, 2022 at 8:44 P.M. revealed that nursing noted Staff including this writer (Employee 19, RN) heard door alarm sounded along 3rd floor long hallway. Nursing staff responded, found {Resident 100} at at the bottom of the stairs. He had self opened the long hallway door and went down the stairs. {Resident 100} was re-directed back to the unit without incident. Resident 100 did not get out of the facility. Management (Director of Nursing DON) updated. Resident placed on 15 minutes checks. Ongoing observations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395929	A. Building B. Wing	11/04/2022

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At the time of the survey ending September 14, 2022, revealed that the facility had not determined the circumstances of the resident's exit to determine how Resident 100 was able to leave the third floor without staff knowledge and travel down three flights of stair to the exit door. The resident's room was located next to the third floor, long hall exit door, which is where the resident continued to reside until he eloped from the facility on October 5, 2022. A review of an elopement assessment dated [DATE], indicated that Resident 100 with impaired cognitive status, irritable and restless with exit seeking behavior. Wandering behavior had occurred in the past 1 to 3 days. The facility determined that the resident was At Risk for Elopement. Unsafe Wandering, and Exit Seeking. Nursing documentation and a facility investigation report dated October 5, 2022, 04:57 A.M. revealed At approx 00:45 A.M., Employee 13 (LPN) reportedly was heating up her food and burnt it, which set off fire alarms. 911 called and Maintenance head called-message left. management (DON) also notified. Dining room windows were opened for smoke to get out and all residents were in there rooms with doors closed-fire protocol followed. When fire dept came most of the smoke was gone due to dining room windows that were opened. Fire dept silenced the alarm. Staff went around to make sure all residents were accounted for. Reportedly {Resident 100} was seen walking in the hallway by the dining room prior to maintenance staff re setting the alarm. At approximately 0300 A.M., {Resident 100} was noted to be missing. Staff looked everywhere inside facility. A male staff drove around (the facility building). {Resident 100} was not located. The DON. as notified and 911 called, At approx 0330 A.M.,local city police brought resident back to facility. The police stated that {Resident 100} reported that he got a ride to Mahanoy City and walked into police station. Resident 100 placed on 1 to 1 supervision, a room change closer to the nurses station and the doors to the stairway alarmed with a tab alarm. The immediate action by the facility was noted as RN assessment of {Resident 100}, the resident placed on 1 to 1 supervision, a room change closer to the nurses station and the doors to the stairway alarmed with a tab alarm. A review of a witness statement dated October 5, 2022, (no time indicated) from Employee 11 (nurse aide) noted The fire alarm was going off due to smoke on the third floor because someone burned their lunch (in the microwave). Resident 100 was walking in the hall. After all the commotion, me and Employee 14 (nurse aide) checked the fire doors to make sure they were locked. Then we started a set of rounds and noticed that {Resident 100} was not in his bed. We searched the common areas where the resident gathers and then notified the RN supervisor. A review of a witness statement dated October 5, 2022, (no time indicated) from Employee 14 revealed that myself and a coworker were doing cups (passing water) when the fire alarm went off. We went on the floor to see what was going on. Smoke was coming out into the hallway. A resident alarm was going off, so I was in her room (this resident was not identified in the employee's statement) from 12:30 A.M. to 3:15 A.M. (continued on next page)

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	395929	A. Building B. Wing	11/04/2022

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a witness statement dated October 5, 2022, (no time indicated) from Employee 12 (nurse aide) indicated that food was burned in the microwave causing smoke. The fire alarm went off. The resident was accounted for. After the alarms were turned off and cleared, myself and the other na (Employee 11) began doing rounds. {Resident 100} was not in his room, but he is independent and walks on the unit. While we made our way up the hall we realized that he was not in any common areas on the unit and could not find {Resident 100}. I last saw Resident walking by the dining room at 12:30 A.M. We then alerted the RN supervisor. A review of a witness statement, no date or time indicated from Maintenance Staff revealed that Maintenance Staff received a phone call from Employee 10 (RN supervisor) stating that the fire alarm was going off and there was smoke coming from the microwave where the nurse had burned her Velveeta mac n cheese. I arrived at the facility at 12:42 A.M. and proceeded to the third floor where I checked the microwave and removed the burnt food. I then reset the fire panel. I opened a few windows to air out the burnt food smell and took the glass microwave plate to the basement and then returned to the third floor. I then proceeded down the stairs to the main entrance to leave. All door alarm (mag locks) were reset at that point because I had to enter the codes to get into and out of the stairwell and the main entrance. I exited the building at 1:25 A.M. It could not be determined how {Resident 100} got 3 miles from the facility to the local police station. During an interview November 2, 2022 at 1 P.M., the maintenance supervisor provided the survey team with a facility floor plan identifying the fire exit doors on all three floors in the building. There were three alarmed, locked exit doors on the third floor. He stated that on the night of the fire/smoke event, Resident 100 exited through the door at the end of the third floor long hall. Resident 100's room was next to this door. The maintenance supervisor stated that these doors were locked and staff could disengage the lock by entering the noted code into the keypad located on the wall next to the door. He also stated that the magnetic lock had a delay mechanism for disengaging the lock by pushing on the door bar for 15 seconds which will unlock the door in an emergency. This process causes a very loud alarm to sound. However, in the event of a fire or smoke event, the fire panel will automatically unlock the doors, allowing for evacuation of residents and staff. When the fire panel is reset by either the fire department of the maintenance supervisor, the locking mechanism is reset and the doors are locked. The maintenance supervisor stated that the doors were open and not alarmed from the initial fire alarm at 12:45 A.M to 1:25 A. M. during which time Resident 100 eloped from the facility A review of facility staffing on the third floor, October 5, 2022, 11 P.M. to 7 A.M shift revealed 1 LPN and 2 nurse aides. The facility did not initiate a watch to monitor the exit doors while they remained unlocked during a fire emergency. The facility reportedly conducted a documented head count of residents on the third floor at 1 A.M However, the fire doors remained unlocked for at least 25 minutes until the facility maintenance director reset the fire panel and re engaged the exit door locking system. There was no conclusion to the facility's investigation regarding how this resident exited the building without staff knowledge. The facility had not determined the exact path this resident took to finally arrive at the local police station. Observations revealed a steep hill that leads to the main road with car and truck traffic. (continued on next page)

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	395929	A. Building B. Wing	11/04/2022

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview November 3, 2022 at approimately 12 P.M. the Director of Nursing and the Nursing Home Administrator confirmed that there wa no investigation into the September 14, 2022, incident of Resident 100's exiting seeking behavior and the exit doors were not monitored when the locking mechanism on the exit doors was off on October 5, 2022, allowing Resident 100 to exit the floor and building without staff knowledge. The resident was absent from the facility for greater than 3 hours according to the documentation that was provided at the time of the survey ending November 4, 2022. Interviews with staff during the survey of November 4, 2022, revealed that staff were unaware of the resident's whereabouts' until notified by the police. Staff failed to monitor the resident's whereabouts although the resident was at risk for elopement with a prior attempt to leave the building. There was no determination as to how Resident 100 was able to get off the third floor and exit through an alarmed, locked exit door down three flights of stairs to a basement exit door during the prior elopement attempt. As a result of these failures to adequately supervise and monitor a resident at risk for elopement, which allowed Resident 100 to successfully exit from the facility without staff knowledge, the resident's individualized needs for supervision of exit seeking behaviors were not met. An observation in room [ROOM NUMBER] revealed a power strip plugged into the wall electrical outlet had 4 medical devices plugged into a power strip plugged into the wall outlet. A tube feeding pump, oxygen air compressor, suction machine and a nebulizer respiratory treatment machine were plugged into the power strip. (Power strips may not be used as a substitute for adequate electrical outlets in a facility. Power strips are not designed to be used with medical devices in patient care areas) The observation of the accident hazard, a power strip in a resident care area and used with medical devices, was confirmed November 4, 2022 at 10:15 A.M by the Nursing Home Administrator. 28 Pa Code 201.18(e)(1)(3) Management 28 Pa Code 207.2(a) Administrators Responsibility 28 Pa Code 211.12(a)(c)(d)(3)(5) Nursing Services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on review of clinical records, observations, interviews with staff and residents it was determined that the facility failed to ensure the ready availability of necessary emergency supplies for one resident out of two sampled receiving hemodialysis (Resident 31). Findings include: A review of the clinical record revealed that Resident 31 was admitted to the facility on [DATE], with a diagnoses of end stage renal disease. The resident required hemodialysis for acute renal failure. The resident had a Right chest Permacath catheter (a double lumen tunneled catheter (Permacath) used as an access in End Stage Renal Disease patients requiring hemodialysis). A physician order and a current plan of care dated May 27, 2022 was noted for staff to Ensure that ABD, large, thick gauze pads, hemostat and tape are bagged and taped to backside of the resident's headboard at all times, for emergency care of the dialysis site (bleeding). An observation and interview with the resident on November 3, 2022, at 1 PM revealed there was no emergency equipment located in the resident room or on the resident's headboard. This absence of emergency supplies was confirmed by the resident and also confirmed by the DON (director of nursing) on November 3, 2022 at 2 PM. 28 Pa. Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services. 28 Pa. Code 211.11 (d) Resident care plan

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on review of clinical records and staff interview it was determined that the facility failed to develop a comprehensive plan to address the behavioral health needs of one of 20 sampled residents (Resident 67). Findings include: Review of the clinical record revealed that Resident 67 was admitted to the facility on [DATE], and had diagnoses, which included huntington's disease (a rare, inherited disease that causes the progressive breakdown (degeneration) of nerve cells in the brain. Huntington's disease has a wide impact on a person's functional abilities and usually results in movement, thinking (cognitive) and psychiatric disorders). An annual Minimum Data Set assessment (MDS- a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated September 1, 2022, indicated that Resident 67 had a BIMS (brief screener that aids in detecting cognitive impairment) score of 06 indicating severe cognitive impairment. Review of Resident 67's nursing progress notes for September 2022 and October 2022 revealed consistent behaviors of restlessness, unquenchable thirst, and urinating in the dining room. Review of the resident's behavior tracking for the months of September 2022 through October 2022 revealed that the resident's behavior of frequent restlessness was not consistently monitored in September 2022 or October 2022. There were multiple occasions during the months of September and October 2022, on which no entries were made indicating that the resident's behavior was monitored on the date. Further review of the behavior tracking revealed that the behavior tracking did not include tracking of the interventions attempted to reduce any noted behavioral symptoms, such as the resident's anxiety, and their effectiveness. The resident's current care plan, in effect at the time of the survey of November 4, 2022, did not identify the specific behaviors the resident exhibits and individualized person-centered interventions to address each of these behaviors. A review of Resident 67's physician notes, completed by the CRNP dated April 15, 2022, revealed the resident's behavior of aggressiveness and agitation continued and the resident was being followed by Psych services. Further review of Resident 67's clinical record revealed the resident had only been seen by psych services once since October of 2021, on September 26, 2022. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Nursing Home Administrator (NHA), on November 3, 2022, at approximately 11:00 a.m., the NHA confirmed that the facility was unable to provide evidence of the development and implementation of an individualized person-centered plan to address resident behaviors and consistent and accurate monitoring of the resident's behaviors and any approaches used to manage or modify those behaviors and confirmed that Resident 67 had not received psychological services consistently during the period of October 2021 through October 2022. 28 Pa. Code 201.21 Use of outside resources 28 Pa. Code 201.18 (e)(6) Management

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 21738 Based on observation, resident and staff interviews, and test tray results it was determined that the facility failed to serve food and beverages at palatable, appetizing and safe temperatures for one of two nursing units. Findings include: According to the federal regulation 483.60(i)-(2) Food safety requirements - the definition of Danger Zone, found under the Definitions section, is food temperatures above 41 degrees Fahrenheit and below 135 degrees Fahrenheit that allow rapid growth of pathogenic microorganisms that can cause foodborne illness. Interview with the food service director (FSD) on November 1, 2022 at 9:45 AM revealed that the facility was currently using disposable Styrofoam plates, cups, and bowls and plastic silverware for residents' meals due to a Covid-19 outbreak. The FSD revealed that initially the use of disposable dinnerware began on October 18, 2022 for those residents who tested positive for COVID-19. On October 24, 2022 the facility began to use disposable dinnerware for all residents for every meal. Observation of the lunch trayline on November 3, 2022 at 11:15 AM revealed the planned main entree for the lunch meal was kielbasa with pierogies, mixed vegetable, milk, cookie, lemonade, and coffee. All meals were being served on disposable Styrofoam plates. A test tray was requested for the Second-Floor Nursing Unit. The meal trays for the residents along with the test tray arrived in an enclosed delivery cart on the Second-Floor Nursing Unit at 11:25 AM. The last tray was passed at 12:00 PM (thirty-five minutes after the trays arrived on the unit). A test tray was conducted, on November 3, 2022, on Second Floor Nursing Unit at 12:30 PM, at the time the last resident began eating, revealed the following temperature results: kielbasa was at 101.4 degrees Fahrenheit, pierogies 93 degrees Fahrenheit, mixed vegetables 108 degrees Fahrenheit; milk was at 56 degrees Fahrenheit, and lemonade was at 57 degrees Fahrenheit. The food and beverages were not palatable at the temperatures served. During interview with Resident 3 on November 4, 2022 at 9:10 AM the resident expressed that foods that are to be served warm have not been hot enough since the facility started using disposable Styrofoam plates. Resident 3 noted that breakfast items such as eggs and toast have been especially cold and not acceptable. Interview with the FSD on November 4, 2022, at 11:00 AM, confirmed that the facility failed to consistently serve food items at acceptable and palatable temperatures. 28 Pa. Code 201.29(j) Resident rights. 28 Pa. Code 211.6(c) Dietary services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 21738 Based on observation and staff interview it was determined that the facility failed to maintain sanitary food services practices to prevent the potential spread of food borne illness in the facility's main kitchen and one of two resident pantry areas to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). Observation of the main kitchen on November 1, 2022 at 9:30 AM and November 3, 2022 at 11:00 AM revealed the following sanitation concerns: There was a thick layer of dust on the fins of the portable air conditioner which located next to the ice machine. The ceiling tile above the portable air conditioner appeared wet. There was a build-up of a black substance on the ice machine's condensation hose (drains excess water which forms in the ice machine) which was draining from the ice machine and positioned above the floor drain. Observation of the second-floor nursing unit resident pantry area on November 3, 2022 at 11:45 AM revealed a cloth therapeutic ice pack on top of a frozen burrito in the freezer section of the refrigerator/freezer. There were two 46-ounce opened bottles of honey-thickened juice which were not dated when opened. The manufacturer label on the bottles noted to use within 10 days of opening. The wall area behind the wall-mounted hand soap was patched and visibly soiled. Interview with the food service director on November 3, 2022 at 12:30 PM confirmed the kitchen and resident pantry areas were to maintained in a sanitary manner to prevent the potential spread of food borne illness. 28 Pa Code 207.2 (a) Administrator's responsibility 28 Pa. Code 211.6(c) Dietary services