STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075257	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health Care Center, Inc.	745 Main St East Hartford, CT 06108

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, and facility policy, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to reassess a resident's elopement/wander risk timely when resident had a change in condition and mobility status, resulting in an elopement from the facility. The findings include: Resident #1's diagnoses included dementia, psychotic disturbance, mood disturbance, anxiety, and a history of a fall with a laceration to the head.Review of hospital Discharge summary dated [DATE] identified admission after a witnessed fall at home with head strike and head laceration. History of dementia, family reported often sleeps in a recliner and gets in and out of the recliner throughout the night. Nursing admission assessment dated [DATE] identified Resident #1 was alert and oriented to person, place, time and situation, required maximum assistance of two (2) staff for transfers, and unable to determine gait at the time of assessment, and ambulation was not identified. Wander assessment dated [DATE] identified Resident #1 did not have the physical ability to leave the facility. Further, question A. 3. asked is the resident cognitively impaired AND have the physical ability to leave the building: was answered No. The Resident Care Plan (RCP) dated 9/15/2025 identified self-care deficit related to weakness, and ADL deficit. Interventions directed assist with ADLs, and Resident #1 was non-ambulatory. Physical Therapy assessment dated [DATE] identified Resident #1 had poor standing balance with a rolling walker, required extensive assistance of two (2) staff for transfers, ambulation was not attempted due to safety concerns, and previously ambulated independently. Physical Therapy assessment dated [DATE] identified Resident #1 was able to ambulate 10 to 15 feet with extensive staff assistance. Physical Therapy assessment dated [DATE] identified Resident #1 was able to ambulate 30 feet with minimal assistance. The admission Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #1's preferred language was Spanish, had a Brief Interview for Mental Status (BIMS) score of three out of fifteen, indicative of severe cognitive impairment, required extensive assistance of two (2) with bed mobility and transfers, used a wheelchair and did not ambulate. Nurses note dated 9/21/2025 at 2:13 AM identified Resident #1 was ambulating in room, not able to sleep, agitated at times, and difficult to redirect. Nurses note dated 9/21/2025 at 8 PM identified Resident #1 was found wandering in other resident rooms multiple times during the evening, redirected to room, and request for APRN psychiatry evaluation. APRN note dated 9/22/2025 at 10:15 AM identified Resident #1 was seen for an alleged verbal threat made to roommate (Resident #6). Resident #6 reported that Resident #1 was wandering around the room and opened his/her bedside table drawer and began going through it, and shortly after Resident #1 said I will kill you. Resident #1 has a history of dementia and has been known to get in and out of bed throughout the night. Plan transfer to hospital for evaluation. APRN note dated 9/23/2025 at 9 AM identified Resident #1 returned from the hospital on an antibiotic for a urinary tract infection. History of dementia and Resident #1 has been known to wander around her room and the facility which contributed to recent incident with roommate, an no current concerns of threatening ideations. Physical Therapy assessment dated [DATE] identified Resident #1 was able to ambulate 100 feet with supervisor or touch assist. Nurses note dated 9/27/2025 at 7:07 AM identified agitated with care, refused meds and blood sugar monitoring. Record review failed to identify reassessment of elopement risk when Resident #1 exhibiting agitation and wandering behaviors. Review of facility reportable event dated 9/27/2025 at 2:30 PM identified LPN #1 reported he was going to provide care and told Resident #1 he would be right back, and left the room to obtain supplies. LPN #1 returned to the room approximately two (2) minutes later and did not find Resident #1. LPN #1 alerted staff on the unit and a facility code (code yellow for missing resident) was paged to search for Resident #1. Resident #1 was located outside the facility building walking on the side walk and was returned to his/her room with no injuries identified. A new elopement evaluation was completed, a wander guard bracelet was applied, and placed on one-to-one (1:1) observation until transfer to secure unit. Nursing note dated 9/29/2025 at 2:16 PM identified a BIMS assessment was repeated with assistance of an interpreter due to a suspected language barrier. Resident #1 was alert and cooperative throughout the assessment, and score was 14 out of 15, indicating alert and oriented. Following completion of interview, the resident became distracted by television and subsequently developed anxiety related to its content, cognition appeared to vacillate once anxiety set in. Review of facility summary report dated 10/1/2025 identified follow-up BIMS indicated Resident #1 was alert and oriented. Further, Resident #1 stated that he/she reported wanting to visit his/her child who lived nearby