STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395142	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amoroso Healthcare and Rehabilitation Woodridge	3625 North Progress Ave Harrisburg, PA 17110

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on observations, facility policy review, clinical record review, review of facility investigation documentation, and staff interviews, it was determined that the facility failed to implement interventions, supervision, and effective safety measures to prevent elopement of a resident identified as being at risk for elopement (Resident 1). Resident 1 exited the building through an unlocked door and was found in the facility's parking lot. This failure placed eight additional residents in an Immediate Jeopardy situation who were identified as an elopement risk (Residents 2, 3, 4, 5, 6, 7, 8 and 9). Findings Include: Review of facility policy, titled Wandering and Elopements, revised March 2019, revealed, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. Review of Resident 1's clinical record revealed she was admitted to the facility on [DATE], with diagnoses that included aphasia (a language disorder caused by brain damage, typically from a stroke or head injury, that impairs a person's ability to communicate), 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 depression), and hemiplegia (paralysis) and hemiparesis (weakness) affecting the right dominant side. Review of Resident 1's facility assessment form, titled Elopement/Wander Risk Evaluation, dated February 18, 2026, revealed the Resident scored a 13, indicating she was a high wander risk. Review of Resident 1's facility assessment form, titled Elopement/Wander Risk Evaluation, dated February 19, 2026, revealed the Resident scored a 14, indicating she was a high wander risk. Review of Resident 1's care plan revealed a care plan initiated on February 19, 2026, stating that Resident 1 was an elopement risk/wanderer. Intervention, dated February 19, 2026, is that all staff should be aware of the Resident's tendency to wander, including receptionist. Observation of the elopement book at the receptionist desk on May 11, 2026, at approximately 1:30 PM, revealed Resident 1 was not listed in the book as being an elopement risk. Review of Resident 1's nursing progress note, dated February 19, 2026, revealed Staff observed resident ambulating independently in the hallways aimlessly. Resident put on elopement watch. During an interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on May 11, 2026, at 11:49 AM, they were asked what an elopement watch entails. The DON stated that it means staff should be monitoring and making sure that the resident is not exit-seeking. She further stated that she does not believe that the elopement watch is documented anywhere in the clinical record. Review of Resident 1's nursing progress note dated April 30, 2026, revealed that Resident 1 was observed all dressed up with shoes, going to another resident's room. The nurse went to check on the Resident and Resident 1 stated she was finding her way to go home. The note further stated that Resident 1 was redirected back to her room. Review of Resident 1's skilled nursing note, dated May 2, 2026, revealed the Resident was alert with no behaviors noted and Elopement issues was listed under Other Information. The note provided no additional details regarding the elopement issues. Review of Resident 1's (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	nursing progress note on May 3, 2026, revealed Resident was found by LPN [licensed practical nurse], walking in the parking lot of the facility, with a pack of cigarettes in her hand at approximately 2:50 PM. Resident stated she was trying to get to her car and she needs her keys, she said she want[s] to get a lighter for her cigarette [and] that she got the cigarette from the shop. Resident was redirected back to the facility. The note further stated that an assessment was performed and vital signs obtained. New order was received for hourly elopement checks. Provider and Resident's Responsible Party were notified. Review of Resident 1's incident report dated May 3, 2026, at 2:55 PM, revealed that Resident 1 was found by the LPN walking along the side of the building from the back door to the dumpsters, which was approximately 45 feet. Review of Employee 1's (Nurse Aide) witness statement, dated May 3, 2026, revealed Employee 1 did not know Resident 1 was outside. Employee 1 last saw Resident 1 at approximately 1:00 PM and Resident 1 was in her room. Review of Employee 2's (LPN) witness statement, dated May 3, 2026, revealed that Resident 1 was last observed in her room at 2:10 PM. Review of an additional statement from Employee 2, dated May 4, 2026, revealed Employee 2 was working a double shift and took a break in between shifts. Employee 2 stated she left to get a drink and when she left, she did not notice any issues and did not see Resident 1 in the hall or near any doors. Employee 2 stated she was parked in the side lot and did not see Resident 1 or anyone else outside when she left. Further review of Employee 2's statement revealed she was gone for approximately 10 minutes and upon her arrival back is when she noticed Resident 2 near the dumpsters, with a bag and a pack of cigarettes. Employee 2 then brought Resident 1 back into the facility and alerted the supervisor and nurse aides of what happened. Review of Employee 3's (Nurse Aide) witness statement, dated May 4, 2026, revealed that on May 3, 2026, at approximately 2:20 PM, Employee 3 took a lunch break and was sitting in her car on her phone. Employee 3 stated she looked straight ahead and noticed a female walking in the back parking lot where the dumpster is. Employee 3 stated she thought it was a visitor, so she continued playing on her phone. The statement further stated that Employee 3 looked up again and noticed a worker approach the female and the nurse walked the female back into the building. Review of facility reported incident, dated May 3, 2026, revealed that it was determined Resident 1 had exited through a side door that is used to take trash outside. It further stated that the door is locked with a code, but it was noted that the locking mechanism was not fully engaged. Further review of the facility reported incident revealed that staff immediately performed a head count on all residents in the facility. All exit doors were monitored every 15 minutes throughout the rest of the day and into the night and morning. Review of the door check documentation that the facility provided, revealed the door checks were started on May 3, 2026, at 5:45 PM, and only completed hourly until 10:45 PM. At 10:45 PM, the door checks were then completed every 15 minutes, through May 4, 2026, at 6:30 AM. The facility reported incident also stated that staff education on door locks, monitoring surroundings, checking doors to ensure they are closed as well as monitoring residents during change of shift to ensure residents safety prior to leaving was initiated immediately. It further states that maintenance checked the door and it was properly engaging. Review of Resident 1's nursing progress notes revealed a note on May 3, 2026, at 7:13 PM, stating that during nursing rounds, the Resident was sitting in the common area, fully dressed with sneakers on. She had a bag full of clothing, a hand bag and sunglasses. Resident 1 informed the nurse I am waiting for my ride. They are coming to get me. LPN and Nurse Aide were made aware to continue visually monitoring the Resident hourly while she is in the common area. RN (Registered Nurse) Supervisor will continue to monitor all exit doors to the facility hourly. The RN confirmed that all exit doors were locked at 6:45 PM. Review of a late entry progress note, dated May 6, 2026, revealed that on May 3, 2026, the speech therapist noted the Resident with increased confusion in the morning. She was observed in the hallway on that day with her front wheeled walker and multiple shirts on hangers draped over the walker. Resident had her purse over her shoulder and said she was going to the VA to get the baby. The speech therapist was able to redirect the Resident to her room. Review of an additional speech therapy progress note, dated May 6, 2026, at 1:03 PM, (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	revealed that Resident 1 had confusion at lunch time. She had two garbage bags packed with her clothing and had another bag. Resident wanted to put the items in her car and stated that her husband will be picking her up. Resident was then found ambulating down the hallway pushing her wheelchair with her coat and one garbage bag. Resident was redirected. Review of nursing progress note on May 6, 2026, at 1:49 PM, revealed that the Resident was fully clothed with her shoes and jacket on. She had bags of clothes packed and her purse. The note stated that Resident 1 was actively exit seeking confused stating she is going home to take care of her dogs. She is stating her kids are going to pick her up and they are already outside waiting for her. When redirected she does not understand and keeps saying she is leaving and she knows how to get out. Review of a nursing progress note on May 6, 2026, at 2:27 PM, revealed that the nurse aide reported that Resident 1 was in the back hall attempting to get out of the door. She was redirected back to her room. Review of a nursing progress note on May 6, 2026, at 2:28 PM, revealed that the provider recommended to send Resident 1 to the hospital for evaluation and to seek safe placement following multiple attempts to elope. Resident 1 had been actively seeking exit from the facility. On May 6, 2026, Resident 1 was transferred to the hospital. Despite reported interventions from the facility reported incident regarding the door's locking mechanism, observation during an onsite survey on May 11, 2026, at 11:49 AM, revealed the door that Resident 1 eloped from on May 3, 2026, was not locked. The surveyor was able to push open the door without entering the door code. When the door was closed, the locking mechanism did not engage and the door remained unlocked. Further observation revealed there were seven concrete steps outside of the door that need to be descended in order to reach the parking lot. During an interview with the NHA and DON on May 11, 2026, at 11:50 AM, the DON confirmed which door the Resident eloped from. She confirmed that Resident 1 exited the side door and was found by the dumpsters. She stated that staff take the trash out that door but signs have been put on the door stating that they can no longer take trash out that way. She stated there is a code on the door to go out and to come back in. The DON further stated that, as far as she is aware, the door does not alarm if it is left open and not locked. On May 11, 2026, at 12:02 PM, surveyors and the DON approached the side door that Resident 1 eloped from. The surveyor was again able to push on the door and open the door without putting the code in. When the door slammed shut, the lock did not engage and the door was able to be pushed open again. The door needed to be physically pulled closed in order to latch and lock. At that time, the DON confirmed that the door was not locked and was able to be opened without the code. Clinical record review for Residents 2, 3, and 4 revealed they all scored a high risk on their most recent Elopement/Wander Risk Evaluation. On May 11, 2026, at approximately 1:30 PM, the receptionist provided the surveyor with the elopement book. Residents 5, 6, 7, 8 and 9 were all listed in the book as being a risk for elopement. Residents 1, 2, 3, and 4 were not in the elopement book, even though they all scored high on their most recent elopement/wandering assessments. During an interview with the DON on May 11, 2026, at 2:41 PM, she stated that staff place resident information in the elopement book at the receptionist desk when they feel that a resident is at risk for elopement based on circumstances. She stated that if a resident was exit-seeking or wandering near exits and was not cognitively intact, that resident would be added to the book. She also stated that they do not just go by a resident's elopement assessment because score of the assessment may not be an accurate reflection of the resident's status. She said that on occasion a resident may trigger as an elopement risk based on orientation, mood, medications, or diagnoses, but the resident may be unable to independently ambulate or propel their chair which would eliminate the risk. The facility failed to implement interventions, supervision, and effective safety measures to prevent elopement of Resident 1. In addition, the facility failed to ensure the locking mechanism on the door was fully functioning. This placed all residents with a high risk for elopement score, and those listed in the elopement book, in an Immediate Jeopardy situation. The NHA was provided the immediate jeopardy template on May 11, 2026, at 3:17 PM, and an immediate action plan was requested. On May 11, 2026, at 5:59 PM, the facility's immediate action plan was accepted, which included:Head count completed (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and all residents accounted for.Door vendor contacted to evaluate door. Awaiting response for a date/time a tech will report onsite.Staff will observe the door 24 hours/day until the door vendor evaluates and reports consistent functioning. A staff member will be sitting in a chair at the door to ensure the door is secure.All exterior doors checked by maintenance and determined to be properly secured. All staff currently on shift will receive education on door safety. Staff not working will receive the education prior to their next shift or at the beginning of their next shift. Nursing staff currently on shift will receive education on elopement prevention. Staff not working will receive the education prior to their next shift or at the beginning of their next shift. All current residents' most recent Elopement evaluation scores will be reviewed to identify anyone at moderate or high risk for elopement. Removal plan and event will be reviewed by QAA Committee. Compliance date: May 12, 2026 Observations, interviews, review of education, review of audits, and clinical record reviews conducted on May 12, 2026, between 9:50 AM and 1:20 PM, revealed the facility had completed all immediate actions as stated in their plan. The door repair vendor was noted to be at the facility at 9:45 AM. Interviews were conducted with one Registered Nurse, two Licensed Practical Nurses, two Nurse Aides, one laundry aide, one dietary aide, one housekeeping supervisor, one Physical Therapy Assistant, and one transportation aide/acting receptionist; all who were able to verbalize education they had received regarding elopement risk and door closures. All stated that they completed the training either on May 11, 2026, or prior to their shift starting today, May 12, 2026. During a staff interview with the NHA on May 12, 2026, at 9:50 AM, she stated that she and the DON had decided to expand elopement education to all staff instead of just nursing staff. She further stated that the facility had completed a Quality Assurance Performance Improvement Meeting this morning and reviewed Resident 1's elopement and the facility's immediate action plan. On May 12, 2026, at 1:24 PM, the Immediate Jeopardy was lifted. During a final staff interview with the NHA on May 12, 2026, at 1:27 PM, she confirmed that the door failed to secure properly and that she would have expected staff to make sure the door was fully closed/locked when using the door. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1)(3) Management28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services