STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395277	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Rehabilitation Care Center at Doylestow	432 Maple Avenue Doylestown, PA 18901

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36935 Based on clinical record review and staff interview, it was determined that the facility failed to develop a comprehensive care plan that addressed individual resident needs as identified in the comprehensive assessment for three of seven sampled residents. (Residents 1, 2, and 3) Findings include: Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses that included a traumatic brain injury and psychosis. According to an elopement risk evaluation completed on May 9, 2024, the resident was at risk for elopement (leaving the facility unsupervised) and needed interventions. According to the comprehensive care plan, the risk for elopement had not been added to the care plan until June 21, 2024. Clinical record review revealed that Resident 2 was admitted to the facility on [DATE], with diagnoses that included cerebral palsy and deafness. A Minimum Data Set (MDS) assessment completed on May 16, 2024, indicated that the resident was highly impaired with hearing. According to the Care Area Assessment (CAA) summary from that assessment, the facility identified that communication was a problem for the resident and should have been included on the care plan. Review of the care plan revealed that the facility did not develop interventions to address this care area. Clinical record review revealed that Resident 3 had an MDS assessment completed on December 6, 2023. According to the assessment, the resident needed assistance from staff for activites of daily living. According to the CAA summary from that assessment, the facility identified that falling was a problem for the resident and should have been included on the care plan. Review of the nurses' notes revealed that on May 21, 2024, Resident 3 fell in the facility. Review of the care plan revealed that the facility did not develop interventions to address this care area. In an interview on July 1, 2024, at 1:40 p.m., the Director of Nursing confirmed that the care plans did not include the areas of potential concern identified in the comprehensive assessments. 28 Pa. Code 211.12(d)(5) Nursing services.

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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(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 - Few	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** 14599 Based on clinical record review, policy review, observations, review of facility documentation, and staff interviews it was determined that the facility failed to provide necessary supervision to monitor a resident's whereabouts and prevent an elopement (unauthorized departure from the facility) by one of seven sampled residents. This failure resulted in an Immediate Jeopardy situation. (Resident 1) Additionally, the facility failed to keep the environment free of accident hazards on one of three nursing units. (First Floor) Findings include: Review of the facility policy entitled, Elopement - Overview, last reviewed on March 13, 2024, revealed that each resident was to be assessed for elopement risk when admitted and develop individualized interventions and communicate to staff. Staff was to review and revise the Interdisciplinary Plan of Care as needed. Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], after a stay in a psychiatric facility and had diagnoses that included a traumatic brain injury, difficulty walking, history of seizures (sudden uncontrolled body movements), psychosis (an abnormal condition of the mind with loss of contact with reality), and depressed mood. According to the Minimum Data Set (MDS) assessment (a periodic evaluation of resident care needs), dated May 15, 2024, the resident was cognitively impaired and required substantial assistance to walk. On May 9, 2024, a social worker noted that due to the resident's brain injury, he has a high risk for impulsive and unsafe behaviors and does not understand consequences. That same day, the facility assessed the resident's risk for elopement and determined that he was at risk. Despite the risk for elopement no additional safety measures were implemented. On June 9, 2024, a nurse noted that on the previous evening at 6:00 p.m., the resident left the facility and walked away at a fast pace. According to the facility investigation into the elopement, he was in front of the facility on the patio when he walked away. His whereabouts were unknown until a staff member on their break outside saw the resident. When found, the resident stated that he wanted to hurt himself and he was sent to the hospital for evaluation. On June 9, 2024, at 1:07 p.m., a nurse noted that he returned to the facility. No additional interventions were implemented to increase supervision at that time. On June 10, 2024, the care plan was updated to indicate that the resident enjoys sitting outside, however there was no documented intervention to indicate how staff would ensure that he did so safely. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On June 20, 2024, at 7:00 p.m., a nurse noted that Resident 1 eloped from the facility and walked into town, later found at a coffee shop. Review of the facility investigation revealed that he was again on the front patio when he walked away from the facility unsupervised. His whereabouts were unknown from 6:42 p.m. until 7:15 p.m., when he was found approximately one mile away on the other side of a busy [NAME] street (North Main Street). While away from the facility unsupervised, the resident fell and sustained bruising to his right hip and was bleeding on his right hand. On July 1, 2024, at 4:20 p.m., the Administrator was notified that the failure to provide adequate supervision to prevent elopement constituted an Immediate Jeopardy situation at F689-J, and the Immediate Jeopardy template was provided. The facility was informed that a corrective action plan was required. The facility presented an acceptable action plan for removal of the Immediate Jeopardy on July 1, 2024, at 7:30 p.m. The facility's action plan contained the following: 1. The facility immediately audited all residents identified as an elopement risk to ensure proper interventions were in place. Audits were completed on July 1, 2024. 2. The facility audited residents' most recent elopement assessments to ensure residents identified as at risk for elopement had interventions included on their care plans. Audits were completed on July 1, 2024. 3. The facility educated licensed nursing staff on the elopement assessment scoring system and care planning interventions. Licensed nursing staff that were working on July 1, 2024, were immediately educated on the elopement assessment and scoring system. Other staff, including agency staff, will be re-educated prior to the start of their next shift. 80% of facility licensed nursing staff were re-educated on July 1, 2024. The remaining 20% of staff will be educated by July 5, 2024. 4. Staff in all other departments will be re-educated on the elopement policy and providing supervision to those residents identified as at risk for elopement. Facility staff that were working on July 1, 2024, were immediately educated on the elopement policy and providing supervision to those residents identified as at risk for elopement. Other staff, including agency staff, will be re-educated prior to the start of their next shift. 80% of facility non-licensed nursing staff will be re-educated on July 2, 2024. The remaining 20% of non-licensed staff will be educated by July 5, 2024. 5. Staff providing resident supervision will not be tasked with other responsibilities. 6. Activities department staff along with members of the interdisciplinary team will create a schedule for supervised Fresh Air Breaks for those residents requiring supervision. 7. Facility will audit newly admitted residents' and current residents' assessments (based on the MDS schedule) weekly for three weeks and then monthly for three months. All results will be reviewed and discussed during facility Quality Assurance Performance Improvement (QAPI) meetings. 8. After the elopement on June 20, 2024, Resident 1 supervision was immediately increased to constant supervision by staff (1:1). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. Resident 1 requested to be sent to the hospital for psychiatric evaluation on June 20, 2024, and was subsequently returned to the facility on [DATE], and remained on 1:1 supervision. 10. Resident 1 was evaluated by facility psychiatric practitioner on June 24, 2024, and his medications were adjusted. Resident 1 requested to be sent to hospital again for a psychiatric evaluation and signed voluntary commitment documents (Act 201). Resident was again transported to a psychiatric hospital. The survey team validated that the Immediate Jeopardy was removed on July 1, 2024, at 7:30 p.m., through observation, reviewing the facility training, and review of facility policies and procedures following the facility's implementation of the plan of removal of the Immediate Jeopardy. The deficient practice remained at a D (isolated with potential for more than minimal harm) scope and severity following the removal of the Immediate Jeopardy. Clinical record review revealed that Resident 3 was admitted to the facility with diagnoses that included depression and anxiety. Review of the nurses' notes revealed that on May 21, 2024, Resident 3 fell in the hallway outside his room while transferring into a wheelchair. Review of the facility invetigation revealed that when the resident fell he grabbed the handrail and it broke off the wall. The immediate intervention was to have maintenance audit and replace or repair any loose or faulty handrails. Observations on July 1, 2024, from 10:30 a.m., through 2:00 p.m. revealed nine areas on the first floor nursing unit that did not contain handrail returns (the individual segments connecting the end of a railing to the wall). These areas included: right side of the elevator near the lobby, right side outside of the nursing office doorway, left and right sides of the admissions office doorway, right side of room [ROOM NUMBER]'s doorway, right side of room [ROOM NUMBER]'s doorway, left and right sides of room [ROOM NUMBER]'s doorway, and left side of room [ROOM NUMBER]'s doorway). In an interview at 2:45 p.m. the Director of Nursing confirmed that the hand rail returns were missing. CFR 483.12(d)(1)(2) Free of Accident Hazards/Supervision/Devices Previously cited 10/4/23 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 205.9(a) Corridors. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 212.12(c) Nursing services. 28 Pa. Code 212.12(d)(1)(3)(5) Nursing services.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 14599 Based on observation it was determined that the facility failed to post current nurse staffing information. Findings include: On July 1, 2024, at 9:15 a.m., nurse staffing information was observed posted in the lobby dated June 27, 2024. CFR 483.35(g) Nurse Staffing Information. Previously cited 10/4/23 28 Pa Code 201.18(b)(3) Management.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14599 Based on facility documentation review and staff interview, it was determined that the Nursing Home Administrator and the Director of Nursing failed to effectively manage the facility regarding the elopement of a resident (Resident 1). This was identified as an Immediate Jeopardy situation for one of seven residents reviewed. Findings include: Review of the job description for the Administrator revealed that the Administrator is responsible for maintaining appropriate guidelines and and regulations to assure (sic) the highest degree of attention and care is provided to all residents. Essential job functions included: Ensures that the most current resident care policies .necessary to remain in compliance with required laws regulations and guidelines are available and followed, and Ensures that an adequate number of personnel are employed to met the needs of the residents and State requirements. Review of the job description for the Director of Nursing (DON) revealed that the DON is responsible for developing, organizing, evaluating and administering patient care programs and services of the Center. Resident 1 was admitted to the facility on [DATE], and was identified by the facility at high risk for elopement (leaving the facility unsupervised by staff). He eloped from the facility on June 8 and 20, 2024. The facility had not implemented interventions to prevent elopement until after he did so twice. Based on the deficiencies identified in this report, the Administrator and DON failed to fulfill essential job functions and responsibilities of their positions, contributing to the Immediate Jeopardy situation. Refer to F689. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36935 Based on observation it was determined that the facility failed to provide a safe, sanitary, and comfortable environment on three of three nursing units. (First, Second, and Third Floor) Findings include: Observation on the First floor nursing unit on July 1, 2024, from 10:30 a.m. through 2:00 p.m. revealed the following: In the bathroom in room [ROOM NUMBER] there was brown spots on the ceiling tile frames, black marks on the wall behind the toilet, and white splash marks on the walls. In the bathroom in room [ROOM NUMBER] there was a ceiling tile with brown stains above the toilet. In room [ROOM NUMBER] there were towels on the floor under the air conditioning unit. There was dirt, debris, and two drink containers on the floor. In the bathroom the soap dispenser was broken off the wall, the ceiling tile above the toilet was stained brown, and the molding was missing from the wall on the left side of the toilet. In room [ROOM NUMBER] there were towels on floor under the air conditioning unit and holes in the wall to the right of the unit. In room [ROOM NUMBER] there were holes in the wall to the right of bed 1's headboard and there were brown stains on the privacy curtain. There was a spackled area on the wall the was not painted near the door. In the hallway there were brown stained ceiling tiles near rooms [ROOM NUMBERS] and peeling paint on the wall by the hand sanitizer near room [ROOM NUMBER]. There were multiple brown stained ceiling tiles over the nurses' station. There was a hole in the wall above the electrical panel near room [ROOM NUMBER]. The light fixture outside the shower room and supply room was hanging from the ceiling and the doorways to the shower room and supply room had multiple areas where the wall was crumbling and chipping. The door to the shower room was heavily marred and scratched. In the shower room the flooring near the shower was ripped and peeling. There was one light that did not contain a cover and another with a broken cover. There were brown stains on the walls near the toilet and the soap dispenser near the sink was broken from the wall. There was soiled paper towels, a walker, and a reusable grocery bag on one of the shower gurneys. Observation on the Second floor nursing unit on July 1, 2024, from 10:30 a.m. through 2:00 p.m. revealed the following: In room [ROOM NUMBER] the sink was leaking and the hot water was not functioning. There were yellow stains on the ceiling above beds one and two. The privacy curtains were stained. Moulding around the air conditioner was missing. There was peeling pain above the window. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In room [ROOM NUMBER] there was a hole in the wall near the sink. The window in room [ROOM NUMBER] had no privacy curtains or blinds. In the bathroom of room [ROOM NUMBER] there are missing ceiling tiles and water was leaking through the hole. In the bathroom of room [ROOM NUMBER] there are missing ceiling tiles. In the bathroom [ROOM NUMBER] there was a hole in the wall. The soap dispenser had fallen off the wall and was on the floor. The wall in the dining room near the door was heavily soiled. A piece of baseboard near the entrance in the corridor was peeling and protruding into the hall. The cover to the battery pack for the mechanical list was missing the cover. Observation on the Third floor nursing unit on July 1, 2024, from 10:30 a.m. through 2:00 p.m. revealed the following: In room [ROOM NUMBER] the floor was dirty and sticky in the room and the bathroom. In room [ROOM NUMBER] there were broken tiles on the floor. In room [ROOM NUMBER] the floor was dirty and sticky in the room and the bathroom. In the bathroom of room [ROOM NUMBER] the floor was dirty and sticky. Soiled laundry was in the tub. In room [ROOM NUMBER] the floor was dirty. Throughout the corridor there were portions of the wall that has been spackled but never sanded or painted. Near the stairs there trash on a bed in the hallway throughout the day. Overhead lighting was not working in numerous areas. Throughout the unit lighting fixtures and name plates on the walls were missing. A medicine cup with green liquid was on the floor near room [ROOM NUMBER]. In the shower room there was trash and dirt on the floor. The privacy curtains were heavily stained and partially detached from the ceiling. One of the sinks was missing and dirty, rusty hardware was protruding from the wall. The wall in the dining room near the door was heavily soiled. CFR 482.90(i) Other Environmental Conditions. Previously cited 10/4/23 28 Pa. Code 201.14(a) Responsibility of licensee. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	28 Pa. Code 201.18(b)(1) Management.