STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395277	A. Building B. Wing	08/12/2025

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 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** Based on clinical record review, policy review, review of facility documentation, observation, 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 four sampled residents at risk for elopement. (Resident 1) This failure resulted in an Immediate Jeopardy situation. The incident has been identified as past non-compliance. Findings include:Review of the facility policy entitled, Elopement, last reviewed on July 1, 2025, revealed that staff was to monitor residents' whereabouts who were at risk for unsafe wandering and elopement. The policy further indicated that facility staff was to initiate the missing resident action plan if unable to locate a resident.Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], and had diagnoses that included bipolar disorder, depression, and anxiety disorder. According to the Minimum Data Set assessment (a periodic evaluation of resident care needs), dated April 28, 2025, the resident had memory impairments, could walk without physical assistance, and required supervision when walking. According to the comprehensive care plan, the facility identified that the resident had impaired decision making and required supervision. On July 22 and 24, 2025, nurses noted that the resident was seen walking a lot and pacing. On August 2, 2025, a nurse noted that he was anxious and confused. On August 6, 2025, a nurse noted that local police called the facility at 4:15 p.m. to inform the facility that they located Resident 1 walking and were taking him to the hospital for evaluation. According to the officer's statement, the resident was located approximately two miles away from the facility. The resident was assessed at the hospital where he was found to have no injuries related to the elopement after an evaluation by a specialist. Review of the facility investigation revealed that he was last seen by staff at approximately 2:30 p.m. near the entrance and likely walked out the front door when it was opened for visitors. The investigation further revealed that the receptionist, who was responsible for controlling who enters and leaves through the front door, did not see the resident leave despite opening the door. The investigation indicated that both a nurse and an aide noticed that the resident was not on the unit at approximately 3:15 p.m., however neither staff member initiated the missing resident action plan. The facility was not aware that Resident 1 had left the facility until approximately 90 minutes after he left when the police notified the facility. He returned to the facility on August 7, 2025, at 7:00 p.m. with no related injuries.In an interview on August 11, 2025, at 2:00 p.m., the Administrator stated that the receptionist is responsible for ensuring only authorized people enter and leave the building, and that nursing staff was to ensure all residents were present at the start of their shifts. On August 12, 2025, at 4:30 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 identified the jeopardy at the time of the incident, August 6, 2025, at 4:15 p.m., and implemented the following corrective action plan: 1. The facility conducted an immediate count of all residents to ensure all were accounted for.2. All doors were checked by maintenance and were found to be in good working (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 - Few	order.3. All safety devices were checked to ensure they were in place, including electronic devices applied to residents to prevent doors from opening (Wanderguard). 4. Resident 1's room was changed from the first floor to the third, and a Wanderguard was placed on the resident. The resident's care plan was updated to include risk for elopement.5. Elopement drills were conducted immediately to ensure that all staff are proficient in the facility's procedure if a resident was missing. Additional future drills were scheduled bi-monthly.6. All residents were audited to ensure they were assessed for risk of elopement, and that care plans were in place for those at risk.7. The facility educated all staff in the facility on the facility's procedure for finding a missing resident. Receptionist staff were educated on their responsibilities to ensure only authorized people leave the building.8. The Director of Nursing or designee was to initiate weekly audits and report results to the QAPI (Quality assurance, performance improvement) committee. The first audit was done on August 7, 2025.9. All staff members were required to be trained on this plan before being permitted back to work.On August 12, 2025, a review was conducted to verify the complete implementation of the facility corrective action plan. Licensed employees RN 1 and LPN 1, non-licensed employees NA 1, NA 2, NA 3, and NA 4, and receptionist E 1, were all interviewed regarding education provided. All staff interviewed confirmed that they received the training described in the facility action plan. All nursing staff were aware of the requirements for supervising residents who were at risk for elopement. The receptionist stated that she was aware of her responsibility to monitor the front door for residents. All facility doors and safety devices (Wanderguards) were checked and were functioning properly. Resident 1 was observed on the third floor with safety devices in place. All sampled residents were being supervised by staff when needed. All training was completed by August 7, 2025, with the exception of staff who were not on the schedule. Those staff were not permitted to return to work until they received the training. The Immediate Jeopardy existed on August 6, 2025, from 2:45 p.m. until August 7, 2025, at 4:15 p.m. Verification of all elements of the action plan was completed on August 12, 2025, at 5:00 p.m., and the Immediate Jeopardy was officially lifted as of August 7, 2025. The Nursing Home Administrator and the Director of Nursing were informed the residents were no longer considered to be in immediate jeopardy.28 Pa. Code 201.18(b)(1)(3) Management.28 Pa. Code 211.10(d) Resident care policies.28 Pa. Code 212.12(d)(1)(3)(5) Nursing services.