STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395395	A. Building B. Wing	07/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River's Bend Health & Rehab Center	800 King Russ Road Harrisburg, PA 17109

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. Based on clinical record review, observations, facility document review, staff interviews, and facility policy review, it was determined that the facility displayed past non-compliance by failing to implement interventions, supervision, and effective safety measures to prevent elopement of a resident identified as being at risk for elopement and exhibiting exit seeking behaviors (Resident 1). Resident 1 was found by EMS staff laying on the ground near the public road, which runs in front of the facility, with abrasions to his hand and foot. This failure placed an additional three residents, who were identified as being at risk on their elopement risk evaluations, in an immediate jeopardy situation (Residents 2, 3, and 4). Findings include: Review of facility policy, titled Elopement/Unauthorized Absence Policy, revised August 2, 2024, read, in part; The facility will identify residents with potential and/or actual risk factors for elopement and protect the resident through development and implementation of safety interventions. In the event of a resident elopement the facility will implement its policies and procedures promptly to locate the resident in a timely manner. Review of Resident 1's clinical record revealed diagnoses that included alcohol abuse, encephalopathy (a group of disorders that affect the brain and cause altered mental state), congestive heart failure (chronic condition where the heart is unable to pump blood effectively, leading to fluid buildup in the lungs and other body parts), lack of coordination, and muscle weakness. Further review of Resident 1's clinical record revealed that he was admitted to the facility from the hospital on June 3, 2025. Review of Resident 1's elopement evaluation completed on June 6, 2025, revealed a score of 16 (high risk) with interventions to closely monitor doors and elevators. Review of Resident 1's census information revealed he had been residing in his current room on the second floor at the facility since June 6, 2025. Observation of Resident 1's room on July 8, 2025, at 11:30 AM, revealed it is located next to the second floor ambulance entrance door. Review of Resident 1's nursing progress notes revealed the following: (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	June 3, 2025 - Resident alert to self with some confusion .Tried getting up several times unassisted and stated that he was leaving. Unsteady gait noted. June 6, 2025 - He is oriented to self only .Doesn't always have complete thoughts. He is exit seeking and states he wants to go home. He attempted to bang on the back door to get it open .Resident constantly has to be redirected from doors or going into other residents rooms. His gait is very unsteady. June 7, 2025 - Resident alert with confusion attempting to ambulate independently, gait unsteady agitated and difficult to redirect. Multiple times walking towards ambulance entrance door was redirected but increasing agitation. June 9, 2025 - IDT [Interdisciplinary Team] review completed to discuss behaviors, risks, interventions, and care plan updates for resident. Resident is reviewed as risk of elopement due to diagnoses, history of TBI [Traumatic Brain Injury], and exit seeking/wandering - has Elopement risk observation from admission. Presents with active aggression, exit seeking behaviors, and wandering. June 9, 2025 - Writer was in the room with [a] resident when alarm rang. Upon exiting the room, a staff member informed the writer that [Resident 1] was outside the door open the door himself. Writer placed him on 15 minute checks and notified the RN [Registered Nurse]. June 10, 2025 - Resident frequently hits exit door, then is quickly redirected back into the unit. Recommendation done to move resident from the exit area to another room. June 10, 2025 - IDT review post increased wandering episode completed. Last evening resident was observed to be increasingly confused and exit seeking attempting to go and 'find his car in the parking lot'. Resident is alert and oriented to self only and has poor safety awareness. He is often combative. He was seen pushing on the exit door, successfully opening the door, and staff intervened .New intervention to place resident on 1:1 monitoring on the evening shift. June 19, 2025 - Resident at 7pm was exit seeking redirected by staff to around unit. June 21, 2025 - Non-compliant with transfer and ambulation, exit seeking. June 21, 2025 - noted resident exit seeking, close supervision provided. June 24, 2025 - Resident is up the whole night, refused to go to bed, stating he wants to go home. June 27, 2025 - Resident was found missing from his room. At 0706am, he was found at the ED [Emergency Department] after being transferred by EMS [Emergency Medical Services] who saw him on the road .Today the resident was last seen at 0645am when incontinence care was provided. The exit door alarmed at 0650am with a timely response noted. Head count was performed and resident was identified to be missing. At 0706am, Facility received a call from [the neighboring hospital] about resident. He was found about 500 ft from the facility by an ambulance. Resident verbalized that he was drunk at the time and he was taken to the ED. He was properly dressed for the weather, he was in a tee shirt and a basketball short, but no footwear was noted. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility incident report revealed that on June 27, 2025, Resident 1 was found missing from his room. At 7:06 AM, he was found at the emergency room after being transferred by EMS who saw him on the road. Resident 1 was assessed in the emergency room where he was determined to be medically stable and ready to return to the facility. Resident 1 returned to the facility at noon. A Registered Nurse assessment was completed upon his return and he was found to have minor scrapes on his bilateral hands, knees and feet. Review of Employee 1's (Licensed Practical Nurse) witness statement dated June 27, 2025, revealed, I assisted the CNA [Certified Nurse Aide] to change a resident and at 5:30 to 5:35 after we changed him he was left in his room. About 10 or 15 minutes later I heard an alarm ring out. I went to the nearest exit and saw resident leaving, myself and CNA was at the door. We brought him back from the door. I left the resident with the CNA so I could call the supervisor for her help with the alarm that was ringing out. She came to the floor, turned off the alarm, educated us on how to fix door if this happened again and she left. I left the resident with the CNA. Review of Employee 2's (Nurse Aide) witness statement dated June 27, 2025, revealed about 7 AM I was making my rounds. I went into resident room he wasn't in there. I looked in bathroom. I came out and let the nurse know that he wasn't in the room and started looking on the unit and outside. Review of Employee 3's (Licensed Practical Nurse) witness statement dated June 27, 2025, revealed, [Employee 2] notified me that she had done rounds and could not find [Resident 1]. I checked the dining room & H hall rooms while making my way to the desk to call the RN. I received a call from [the hospital] @ 0730. I didn't catch the name, but the nurse asked if [Resident 1] was a pt [patient] here & if we were aware that he was in the ER. I confirmed yes he was a pt & asked her to hold for RN. Review of emergency department treatment notes dated June 27, 2025, revealed Resident 1 presented after being found outside that morning. Resident 1 reported having drinks with his friends that morning. EMS reported to the emergency department that Resident 1 was laying on the ground. Resident 1 was noted with abrasions to the left fingers, thumb and pointer finger, right foot, multiple abrasions. During an interview with the Director of Nursing (DON) on July 8, 2025, at approximately 11:30 AM, he revealed that on June 27, 2025, when the door alarmed for the second time around 6:50 AM, Employee 1 turned off the alarm again, but did not do a head count or attempt to visualize Resident 1, assuming he was with the nurse aide. The DON revealed that as a result, Employee 1 was disciplined following the incident and chose to resign. The DON confirmed that Employee 1 should have put Resident 1 on 1:1 monitoring after his first attempt to leave on June 27, 2025, and that the 15 second emergency egress function has since been disabled on the ambulance entrance door. The DON also confirmed that Resident 1 was found to have no evidence of alcohol or drugs in his system despite his claims of being intoxicated. During an interview with the Nursing Home Administrator (NHA) on July 8, 2025, at 12:30 PM, she confirmed that Employee 1 did not follow facility policy and procedure, was suspended, and ultimately decided to resign. The facility is located near a main road. There are parking lots in front of the facility, as well as housing complexes on each side of drive to the main road. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Clinical record review for Residents 2, 3, and 4 revealed that they resided on the second floor unit and were determined to be at risk for elopement based on their elopement risk evaluations. The facility failed to implement interventions, supervision, and effective safety measures to prevent elopement. The NHA was provided the immediate jeopardy template on July 8, 2025, at 12:30 PM, and an immediate action plan was requested. On July 8, 2025, at 2:25 PM, the facility's immediate action plan was reviewed and accepted, which included: 1) A headcount was performed on all units. 2) A code was paged. 3) All door alarms were checked for proper function and windows were secured. Ambulance entrance/lock mechanism was found to be functioning properly. 4) A head to toe assessment was completed on Resident 1 in the emergency room by the DON. Current diagnostic studies and treatment plan were discussed. 5) The doctor and resident representative were made aware of the occurrence. 6) A timeline of investigation into the event was completed and witness statements were obtained from staff. 7) The facility was informed that Resident 1's diagnostic studies were complete and negative for any injuries and that Resident 1 would return to the facility that day. 8) Upon Resident 1's return to the facility, a head to toe assessment was completed, elopement assessment and BIMS (Brief Interview for Mental Status) were updated. 9) (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The doctor and resident representative were notified of Resident 1's return to the facility. 10) Resident 1 was placed on 1:1 observation for elopement risk at all times, and his care plan was updated to reflect this. 11) The Social Service Director completed a psychosocial visit to assess impact and provide support following elopement. 12) The psychiatric Nurse Practitioner completed a consult, evaluated Resident 1's medication regimen, and new orders were provided. 13) To identify others with the likelihood to be affected, the DON/designee completed new elopement assessments on all residents to ensure all residents that are at risk for elopement are identified, care plans with personalized interventions were implemented, and that the elopement binder was updated. 14) To prevent a future occurrence, all facility staff were educated on the elopement policy and how to respond to door alarms appropriately. 15) All licensed staff were educated that upon completion of Admission/Readmission/Quarterly assessments, residents identified at risk for elopement will have care plans with personalized interventions implemented and elopement binders updated. 16) The Maintenance Director/designee completed elopement drills across all three shifts. 17) The DON/designee educated all staff that the 15 second egress on the ambulance entrance will be replaced with a keypad for entrance/exit to the facility. 18) To monitor and maintain ongoing compliance, the DON/designee will complete elopement drills across all three shifts to ensure accurate response by staff to an elopement situation. Any inaccurate response will be immediately corrected/remediated weekly x 4 and then monthly x 2. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	19) To monitor and maintain ongoing compliance, the DON/designee will audit elopement assessment scores on 5 random Admission/Readmission/Quarterly assessments to ensure those identified at risk for elopement have a care plan with personalized interventions implemented and elopement binder updated; any missing area identified will be corrected weekly x 4, then monthly x 2. 20) An Ad Hoc QAPI (Quality Assessment and Performance Improvement) meeting was held on June 27, 2025 with the interdisciplinary team. 21) The results of the audits will be forwarded to the QAPI committee for further review and recommendations. The Immediate Jeopardy was lifted on July 8, 2025, at 2:25 PM, after ensuring that the immediate action plan had been implemented. The facility demonstrated past non-compliance by initiating immediate interventions starting June 27, 2025, following the incident. Documents and actions provided by the facility to address the Immediate Jeopardy were reviewed on July 8, 2025, during the onsite survey and included: - An in-house resident head count was completed on June 27, 2025. - The Housekeeping/Laundry director tested the lock and alarm on the ambulance entrance door. He confirmed the door and alarm were in proper working order at 8:15 AM on June 27, 2025. He also checked all the doors and confirmed all were working as they should. - Review of service report dated June 27, 2025, revealed that the egress delay was disabled on the second floor ambulance entrance, labels were applied to the keypads stating to ensure door is closed when walking through, and signs were removed stating that pushing on the door for 15 seconds would open the door. - A new elopement assessment was completed for Resident 1 on June 27, 2025. Resident 1 was again identified as at risk for elopement and immediate interventions were added for 1:1 at all times, psychiatric referral, social services follow-up, redirection, and to encourage 1:1 activities. - A Brief Interview for Mental Status assessment was completed for Resident 1 on June 27, 2025, indicating severe cognitive impairment. - Resident 1's care plan was updated on June 27, 2025, to reflect 1:1 at all times due to elopement risk. - The Social Service Director followed up with Resident 1 on June 27, 2025, and no distress was noted at that time. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- An order was initiated for 1:1 monitoring at all times for Resident 1 effective June 27, 2025. - Elopement drills were conducted on June 27, 2025, on the evening and overnight shifts. - Resident 1 was evaluated by the psychiatric nurse practitioner on June 27, 2025. - Resident 1 was evaluated by his attending practitioner on June 28, 2025. - Elopement assessments were updated for all residents on June 27, 2025. Care plans and the elopement binder were updated for each resident identified at risk for elopement. - Education was provided to all staff on June 27, 2025, regarding the elopement policy and the ambulance door egress. - Education was provided to nursing staff on June 27, 2025, regarding elopement care plan and binder updates. - The first ongoing elopement risk audit of care plans and the elopement binder was completed for the week of June 29, 2025. - The first ongoing audit of the ambulance entrance keypad function was conducted for the week of June 29, 2025. During the onsite survey on July 8, 2025, no additional concerns related to elopement were identified based on observations, clinical record review, interviews with staff, review of audits, and review of education provided to staff. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services