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	07/01/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on facility policy review, clinical record review, facility documentation review, and staff interviews, it was determined that the facility displayed past non-compliance by failing to implement interventions, supervision, and effective safety measures to protect the resident's right to be free from physical abuse by a resident (Resident 1) who displayed aggressive behavior and physically pushed another resident (Resident 2), causing a fall with a hip fracture. This failure resulted in an Immediate Jeopardy situation.Findings include: Review of the facility policy, titled Resident Observation Policy, with a last revised date of May 28, 2021, and a last review date of January 28, 2026, revealed, in part, Procedure: A. The charge nurse will contact the DON (Director of Nursing) who, if necessary, will consult with administrative staff and/or the Director of Mental Health, if applicable, to determine the appropriate observation/interventions if the resident meets on of the following criteria: 2. Resident is a danger to others, to include but not limited to, homicidal comments/threats/actions; 4. Resident is acting out behaviorally, to include but not limited to, throwing items, continuous screaming/disruptive behavior; B.) DON will assign a staff member to complete the appropriate observation/interventions which may include but are not limited to, every 15 or 30 minute checks or 1:1 monitoring. Review of Resident 1's clinical record revealed diagnoses that included chronic obstructive pulmonary disease (an ongoing, progressive lung condition that restricts airflow and makes breathing difficult) and hyperlipidemia (high amounts of fats in the blood). Review of Resident 1's care plan revealed a problem focus area for behavioral symptoms, which included the following behaviors: Resident experiences wandering in hallways and into other rooms, Resident has behaviors of taking roommate's clothing and wearing them despite name tag on clothing, aggressor in resident-to-resident altercation, perception of missing money; makes accusatory statements towards staff and peers; Resident has behaviors of yelling out; Resident refuses care and medications; with a start date of January 27, 2026, and an edited date of June 30, 2026. Interventions included 1:1 Nursing Supervision. Review of Resident 1's clinical record revealed a progress note on May 7, 2026, at 7:16 PM, where the Resident had to be re-directed from hitting another resident in the evening, calling the other resident names using profane language. Resident 1 followed an employee to the medication cart and started pushing the employee and stated, I'm going to punch you in the face. Review of Resident 1's clinical record revealed a progress note on May 10, 2026, at 8:11 PM, that stated Resident 1 was aggressive towards staff and residents, in which a 1:1 was initiated for safety measures. Resident was stating that other residents stole his money, and went to another resident who was standing by the door to her room and stated, where is my money you b***h and walked to where she was standing and kicked her on her left thigh, leaving a red mark. Review of Resident 1's clinical record revealed a progress note on May 23, 2026, at 11:46 PM, that revealed he was noted with some episodes of anxiety, several exit seeking behaviors and being verbally aggressive towards other residents. Review of a nursing progress note on June 3, 2026, at 2:20 PM, revealed Resident 1 was being monitored for close supervision and 15-minute checks. Resident 1 was noted to have increased aggression towards staff and residents, and was also noted to have increased exit seeking behaviors with attempts made to exit the facility. Resident 1 has since been placed on a 1:1 supervision. IDT (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(interdisciplinary team) in agreement that the Resident to be removed from 1:1 monitoring to close observation with 15-minute checks. Review of the facility provided incident report revealed a resident-to-resident altercation between Resident 1 and Resident 2 on June 15, 2026, at approximately 8:00 PM. Further review of the incident report revealed Resident 1 became agitated perceiving he was missing money. Resident 1 approached Resident 2 and became verbally aggressive and subsequently pushed Resident 2 prior to staff being able to intervene. Resident 2 sustained a fall and complained of leg pain and was transferred to the hospital for evaluation and treatment. Hospital imaging revealed that Resident 2 sustained a right hip fracture that required surgical intervention. Review of a nursing progress note on June 15, 2026, at 11:32 PM, revealed Resident 1 had entered into Resident 2's room and pushed her into the wall, causing her to fall to the floor. Staff reported Resident 1 had become agitated, exit-seeking, and was swearing at staff and other residents for some time prior to this event. Staff were monitoring Resident 1 as he walked toward his room. Resident 1 saw Resident 2 in the next room looking out the door to see who was causing the commotion, Resident 1 entered the room and pushed Resident 2. Resident 2 fell and needed to be transported to the emergency department. Review of Resident 2's clinical record revealed a nursing progress note on June 17, 2026, at 8:56 PM, that Resident 2 returned from the hospital after surgical repair of her hip with a dressing and a bruise on her right hip. In a written statement dated June 15, 2026, by Employee 1 (Nurse), revealed that they were at the nursing station around 5:00 PM when Resident 1 was being uneasy and started exit seeking behavior, stating that he was waiting for a bus. Resident 1 started escalating without any provocations and was noted at one point cursing out a nursing aid who was doing her charting on the computer. Resident 1 attempted to grab a gown from another aid who was passing by the station. Resident 1 started accusing staff of stealing his money at this point. Around 6:00 PM he escalated, walking to other resident rooms when staff re-directed him. Attempts to redirect Resident 1 were not effective. In a written statement dated June 15, 2026, by Employee 2 (Nurse Aide [NA]), revealed around dinner time Resident 1 was very wandering and aggressive with other residents and workers. In a written statement dated June 15, 2026, by Employee 3 (NA), revealed they witnessed Resident 1's behavior around 5:30 PM when he started cursing at the residents and staff, walking around grabbing anything in his way, and when stopped he would abuse and curse and got so aggressive he was trying to fight. In a written statement dated June 15, 2026, by Employee 4 (Nurse), revealed around 7:00 PM Resident 1 was agitated and walking up and down the hallways. Resident 1 attempted to enter other resident rooms and was cursing using inappropriate language. Resident 1 had a 1:1 Nursing Supervision order from May 26, 2026 and it was discontinued on June 2, 2026. Review of Resident 1's June 2026 Medication Administration Record (MAR) revealed 15 minute checks with a start date of June 3, 2026, and discontinued on June 11, 2026. Additional review revealed an order for a 1:1 Nursing observation, with a start date of June 19, 2026, after the resident-to-resident abuse. There were no orders for the Resident to be on 15 minute checks or on a 1:1 on June 15, 2026. On June 30, 2026, at 12:36 PM, the Nursing Home Administrator (NHA) and the DON were notified that the facility failed to put effective interventions in place for Resident 1 to ensure the safety of other residents and prevent physical abuse, which resulted in an Immediate Jeopardy situation. The Immediate Jeopardy template was provided. The facility was informed that a correction action plan was required. The facility initiated immediate interventions on June 15 and 16, 2026, after the incident. Documents and actions provided by the facility to address the Immediate Jeopardy included the following: On June 15, 2026, both parties were immediately separated, and initial psycho-social support was provided by nursing staff. On June 15, 2026, head-to-toe assessment on Resident 2 revealed right leg pain with limited range of motion (ROM), new orders were provided to transfer Resident 2 to the emergency room to evaluate and treat status post-fall. On June 15, 2026, an investigation was initiated and witness statements were obtained. On June 15, 2026, the Medical Director and Responsible Parties for both residents were notified of the event. On June 15, 2026, Resident 1 was placed on a 1:1 at all times until further notice. On June 16, 2026, a (continued on next page)

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