STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395469	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing and Rehabilitation	320 South Market Street Elizabethtown, PA 17022

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and documentation, clinical record reviews, and interviews with staff, it was determined the facility failed to provide adequate supervision to one of twelve residents reviewed (Resident R1) who was inaccurately assessed as a low risk for elopement. This failure resulted in Resident R1 exiting nursing unit via the elevator and walking out the front entrance doors. The facility was not aware Resident R1 was missing until the resident's daughter called and informed the facility Resident R1 had walked to her house crossing multiple busy streets. This failure placed the resident at high risk for injury and was identified as an Immediate Jeopardy of past non-compliance. (Resident R1)Findings include: Review of facility policy, titled, wandering and elopements, revealed the facility will identify residents who are at risk of unsafe wandering and strive to prevent while maintaining the least restrictive environment for residents. Review of Resident R1's clinical record revealed Resident R1 was admitted to the facility on [DATE], with the following diagnosis; Parkinson's disease with dyskinesia, without mention of fluctuations (movement disorder of the nervous system that worsens over time); neurocognitive disorder with Lewy bodies (a progressive neurodegenerative disorder characterized by the accumulation of Lewy bodies in the brain, leading to cognitive decline, movement issues, and various other symptoms); muscle weakness (generalized); and difficulty in walking. Review of Resident R1's [NAME]-Elopement Assessment/Evaluation completed on admission dated September 16, 2025, revealed that the facility incorrectly completed the assessment by stating the resident does not have dementia resulting the resident being identified as low risk for wandering instead of moderate risk for elopement. Review of Resident R1's admission MDS (Minimum Data Set-periodic assessment of resident's care needs) completed on September 21, 2025, revealed the resident was assessed with a BIMS (Brief Interview for Mental Status) score of 10. A score of 10 indicates moderate cognitive impairment. Review of facility investigation provided by the facility revealed a timeline dated November 5, 2025. The following is the summary of the timeline: Between 11:00 a.m. and 12:00 p.m. Resident R1 was observed twice by nursing assistant (NA) Employee E1 trying to enter the elevator on the second floor. Employee E1 removed Resident R1 but did not report Resident R1's exit seeking behaviors to her supervisors. Between 12:00 p.m. and 12:30 p.m. registered nurse, Employee (E2) removed Resident R1 from the elevator twice and redirected (him/her) to own room. Employee E2 did not report Resident R1's exit seeking behaviors to her supervisors. At 2:00 p.m. NA Employee E3 observed Resident R1 standing in front of the elevator. Employee E3 redirected Resident R1 back to own room. Employee E3 did not report Resident R1's exit seeking behaviors to the supervisors. Between 2:00 p.m. and 2:15 p.m. licensed Employee E4 was sitting in her car in the facilities parking lot located in a lot across the street from the front entrance and observed Resident R1 walking out of the facility. Employee E4 believed the resident was on leave of absence (LOA) due to observing another individual walking out of the facility at the same time. Employee E4 watched Resident R1 walk up the street by self. Employee E4 did not report her observations to her supervisor. At 2:30 p.m. Resident R1's daughter called the facility to report Resident R1 had left the facility and walked to her house by (himself/herself). Resident R1 was returned to the facility at 6:05 p.m. by (his/her) daughter. Interview conducted with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on December 22, 2025, at 6:15 p.m. revealed Resident R1 followed an unidentified visitor onto the elevator and exited the facility walking alongside the individual; the NHA revealed the resident's proximity to the visitor led a receptionist and Employee E4 to presume the resident was leaving with a family member. Additionally, the NHA and DON confirmed Resident R1's elopement risk assessment was not completed accurately. Based on the above findings, an Immediate Jeopardy to the safety of the resident was identified for failure to accurately complete an elopement assessment and to provide adequate supervision of a resident who was actively exhibiting exit seeking behaviors. The resident went missing on November 5, 2025. The facility was not aware Resident R1 was missing until Resident's daughter called the facility to report Resident R1 was at her house. An Immediate Jeopardy template (document which included information necessary to establish each of the key components of immediate jeopardy) was provided to the Nursing Home Administrator and Immediate Jeopardy was called on December 22, 2025, at 6:49 p.m. The facility provided a Plan of Correction on December 22, 2025, for submission and it was approved at 7:00 p. m. The plan of correction was as follows:a. The Nursing Administration reviewed all resident' electronic health records for accurate elopement/wandering evaluations- completed November 5, 2025 b. Elopement

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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. Based on the review of clinical records, job descriptions, review of facility policy, facility documentation and interviews with staff, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) did not effectively manage the facility to ensure the safety of one of twelve residents reviewed (Resident R1) with a diagnosis of Dementia who eloped from the facility. This failure resulted in an Immediate Jeopardy situation for Resident R1. (Resident R1)Findings Include:Review of the job description for the Nursing Home Administrator (NHA) states, Position Summary-this position is responsible to establish and maintain systems that are efficient and effective to operate the nursing home in a manner to safely meet resident's needs in accordance with federal, state and local regulations. Also, develop and maintain systems that are effective and efficient to operate the facility in a financially sound manner.Further review of the NHA job description revealed, Essential Duties and Responsibilities-. Develop, maintain and implement operational policies and procedures to meet residents need in compliance with federal, state and local requirements. Determine the personnel requirements of the facility in collaboration with Department Managers and hire or arrange for sufficient staff to provide for sound resident care and implement the facility policies and procedures.Review of the job description for the Director of Nursing (DON) states, Position Summary- The Director of Nursing functions as the administrative authority for the Department of Nursing. This Director will be responsible for the organization and oversight of all nursing operations and for the supervision of care for all residents at the facility. Further review of the DON job essential requirements revealed, must possess the ability to plan, organize, develop, implement and interpret the programs, goals, objectives, policies and procedures, etc., that are necessary for providing quality of care.The findings in this report identified the facility failed to maintain the safety of the residents from elopement by ensuring elopement assessments were completed correctly and residents exhibiting behaviors for elopement were prevented from leaving the facility without proper supervision.Refer to F68928 Pa Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management28 Pa. Code 201.18(b)(3) Management