

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395277</b>	(X2) MULTIPLE CONSTRUCTION:  A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>08/12/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>HARBORVIEW REHABILITATION AND CARE CENTER AT DOYLESTOWN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>432 MAPLE AVENUE DOYLESTOWN, PA 18901</b>		
STATE LICENSE NUMBER: <b>040502</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0689  SS=J	<p>Based on the findings of an Abbreviated Survey in response to a complaint and a facility reported incident, completed on August 12, 2025, at Harborview Rehabilitation and Care Center at Doylestown, it was determined that the facility was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.</p> <p>483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p>	F 0689	Past noncompliance: no plan of correction required.	<p>Completion Date: <b>08/26/2025</b> Status: <b>APPROVED</b> Date: <b>09/02/2025</b></p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0689  SS=J	Continued from page 1   This REQUIREMENT is not met as evidenced by:	F 0689			

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F 0689  SS=J	<p>Continued from page 2</p> <p>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.</p> <p>Findings include:</p> <p>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."</p> <p>Clinical record review revealed that Resident 1 was admitted to the facility on October 24, 2024, and</p>	F 0689			

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F 0689  SS=J	Continued from page 4  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	F 0689			

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F 0689  SS=J	<p>Continued from page 5</p> <p>of their shifts.</p> <p>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.</p> <p>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:</p> <ol style="list-style-type: none"> <li>1. The facility conducted an immediate count of all residents to ensure all were accounted for.</li> <li>2. All doors were checked by maintenance and were found to be in good working order.</li> <li>3. All safety devices were checked to ensure they were in place, including electronic devices applied to residents to prevent doors from opening (Wanderguard).</li> <li>4. Resident 1's room was changed from the first</li> </ol>	F 0689			

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F 0689  SS=J	<p>Continued from page 7</p> <p>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.</p> <p>The Immediate Jeopardy existed on August 6,</p>	F 0689			



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F 0689  SS=J	Continued from page 8  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.	F 0689			



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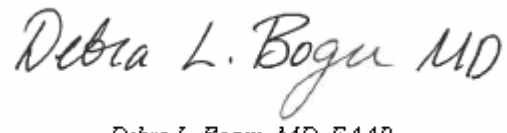
**HARBORVIEW REHABILITATION AND CARE CENTER AT DOYLESTOWN**

**STATE LICENSE NUMBER: 040502**

**SURVEY EXIT DATE: 08/12/2025**

**I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey**

  
Jeanne Parisi  
Deputy Secretary for Quality Assurance

  
Debra L. Bogen, MD, FAAP  
Secretary of Health



**Pennsylvania  
Department of Health**

THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY