

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395395	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/13/2025
NAME OF PROVIDER OR SUPPLIER: RIVER'S BEND HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 800 KING RUSS ROAD LOWER PAXTON, PA 17109		
STATE LICENSE NUMBER: 640202				
(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
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on March 13, 2025, at River's Bend Health & Rehab Center, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

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.



Certified End Page

RIVER'S BEND HEALTH & REHAB CENTER

STATE LICENSE NUMBER: 640202

SURVEY EXIT DATE: 03/13/2025

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

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K 0000	<p>INITIAL COMMENT</p> <p>Facility ID #640202 Component 01 Main Building</p> <p>Based on a Medicare/Medicare Recertification Survey completed on March 13, 2025, it was determined that River's Bend Health & Rehab Center was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a two-story, Type II (000), unprotected noncombustible structure, without a basement, which is fully sprinklered.</p>	K 0000		

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K 0100 SS=D		K 0100		
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K 0100 SS=D	Continued from page 2 NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:	K 0100	Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continually improve the quality of care and to comply with all applicable state and federal regulatory requirements. The portable life safety drawings will be updated with compartment labeling, resident room capacities, fire wall boundaries, smoke wall boundaries and hazardous areas. Annual inspection of installed carbon monoxide detectors will be tested and inspected. A copy of the annual inspection will be kept in the Life Safety Book. Evacuation and alarm protocols will be put in place in accordance with 2016 Act 48 Care Facility Carbon Monoxide Alarms Act. A copy of Protocols will be placed in the Emergency Preparedness Plan of the facility and in the Life Safety Book. A carbon monoxide detector is installed in the Boiler/Generator	Completion Date: 05/12/2025 Status: APPROVED Date: 04/10/2025

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K 0100 SS=D	Continued from page 3	K 0100	<p>Room within 15 feet of the fuel burning Boiler and Generator. Copies of the life safety drawings will be checked for accuracy and updated accordingly.</p> <p>All carbon monoxide detectors will be identified for inspection. Evacuation and alarm protocols will be reviewed by Maintenance Director or designee for any needed adjustments.</p> <p>Placement of carbon monoxide detectors will be reviewed to ensure proper placement within 15 feet of fuel burning equipment</p> <p>The Maintenance Director was re-educated on the need to have accurate portable life safety drawings reflecting compartment labeling, resident room capacities, fire wall boundaries, smoke wall boundaries and hazardous areas; the need for annual inspection and testing of carbon monoxide detectors; the need for evacuation and alarm protocols regarding carbon monoxide alarms and the need for carbon monoxide detectors in boiler and generator rooms.</p>	

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K 0100 SS=D	Continued from page 4	K 0100	<p>The Maintenance Director or designee will review the drawings for any changes monthly for three months.</p> <p>The Maintenance Director or designee will review the documentation of carbon monoxide annual inspection and present at QAPI and ensure annual inspection is available at time of Life Safety survey.</p> <p>The Maintenance Director or designee will review alarm and evacuation protocols at QAPI and at least annually</p> <p>The Maintenance Director of designee will review proper placement of Carbon Monoxide detectors within 15 feet of fuel burning equipment.</p>	

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K 0100 SS=D	Continued from page 5 28 Pa. Code § 201.14(a). RESPONSIBILITY OF THE LICENSEE (a) The licensee is responsible for meeting the minimum standards for the operation of a facility as set forth by the Department and by other State and local agencies responsible for the health and welfare of residents. This REGULATION has not been met. 35 P.S. § 448.808. Issuance of license. (a) STANDARDS - The Department shall issue a license to a health care provider when it is satisfied that the following standards have been met: (2) that the place to be used as a health care facility is adequately constructed, equipped, maintained and operated to safely and efficiently render the services offered. Based on document review, observation and	K 0100		

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K 0100 SS=D	Continued from page 6 interview, it was determined the facility failed to meet the minimum standards for the operation of a facility, as set forth by the Department, and by other State and local agencies responsible for the health and welfare of residents within the component. Findings include: 1. Review of documentation March 13, 2025, between 8:45 AM and 10:45 AM, revealed the facility portable life safety drawings lacked compartment labeling, resident room capacities, fire wall boundaries, smoke wall boundaries and hazardous areas. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed the portable life safety drawings lacked the required information. 2. Review of documentation and interview on March 13, 2025, between 8:45 AM and 10:45	K 0100		

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K 0100 SS=D	Continued from page 7 AM, revealed the facility lacked documentation of annual testing and inspection of installed carbon monoxide detectors, per manufacturer's instructions, in accordance with the 2016 Act 48 Care Facility Carbon Monoxide Alarms Act. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed the annual inspections were not performed, per manufacture's specifications. 3. Review of documentation and interview on March 13, 2025, between 8:45 AM and 10:45 AM, revealed the facility lacked documentation, verifying evacuation and alarm protocols, in accordance with the 2016 Act 48 Care Facility Carbon Monoxide Alarms Act. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed facility lacked	K 0100		

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K 0100 SS=D	Continued from page 8 documentation of evacuation and alarm protocols. 4. Observation and interview on March 13, 2025, at 12:12 PM, revealed the facility lacked a installed carbon monoxide detector, in the Boiler/Generator Room, in accordance with the 2016 Act 48 Care Facility Carbon Monoxide Alarms Act. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed facility lacked an installed carbon monoxide detector, in the Boiler/Generator Room.	K 0100		
K 0211 SS=E		K 0211		

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K 0211 SS=E	Continued from page 9 NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K 0211	The 1st floor exit door, at the Common Area will be repaired or adjusted so that the door opens with a force of less than 30 pounds. A Time Limited Waiver is being requested for this citation due to the construction of the metal framed glass door and metal threshold may require extensive work to make the repair or possibly a new door.	Completion Date: 05/12/2025 Status: APPROVED Date: 04/10/2025

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K 0211 SS=E	Continued from page 10 Based on observation and interview, it was determined the facility failed to maintain the maximum force required to operate exit discharge doors, affecting one of eight smoke compartments within the component. Findings include: 1. Observation on March 13, 2025, at 11:35 AM, revealed the 1st floor exit door, at the Common Area, required a force of more than 30 pounds to set the doors in motion. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed the door did not begin to swing with an applied force of 30 pounds.	K 0211		
K 0291 SS=C		K 0291		

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K 0291 SS=C	Continued from page 11 NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:	K 0291	Battery back-up lighting annual 90 minute test will be performed on 4/2/25. Going forward, the lighting will be tested monthly for 30 seconds and annually for 90 minutes. Record of testing will be maintained in the Life Safety Book All battery back-up lighting has been identified for testing. The Maintenance Director has been re-educated on the need to test the back up lighting monthly for 30 seconds and annually for 90 minutes. The NHA or designee will audit the recording of testing monthly and the documentation is filed in the Life Safety Book.	Completion Date: 04/30/2025 Status: APPROVED Date: 04/10/2025

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K 0291 SS=C	Continued from page 12 Based on document review and interview, it was determined the facility failed to provide documentation, verifying monthly and annual testing of battery back-up emergency lighting, affecting the entire component. Findings include: 1. Review of documentation on March 13, 2025, between 8:45 AM and 10:45 AM, revealed the facility lacked documentation, verifying battery back-up lighting had been tested monthly, for 30-seconds and annually, for a 90-minute test. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed the lack of documentation, verifying battery back-up lighting fixtures had been tested, within the previous twelve months.	K 0291		

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K 0321 SS=E		K 0321		
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K 0321 SS=E	Continued from page 15 This REQUIREMENT is not met as evidenced by:	K 0321	<p>top and latch side, exceeded 1/8 inch will be adjusted or repaired using approved hardware so that gaps do not exceed 1/8 inch.</p> <p>The kitchen scullery door will be repaired to make self-closing.</p> <p>Other doors to hazardous areas throughout the facility will be checked for proper gaps and adjusted or repaired using approved hardware as necessary.</p> <p>The Maintenance Director was re-educated on the need to maintain doors so that gaps are within acceptable range.</p> <p>The NHA of designee will audit door to hazardous areas for proper gaps monthly.</p> <p>A Time Limited Waiver is being requested until July 31, 2025 due to some doors may have to be replaced and the availability of the doors may take up to six months to obtain.</p>	

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K 0321 SS=E	Continued from page 16 Based on observation and interview, it was determined the facility failed to maintain hazardous area doors, to be within the allowed gap margins and failed to self-close, in four of eight smoke zones within the component. Findings include: 1. Observation on March 13, 2025, between 11:00 AM and 12:03 PM, revealed hazardous area doors exceeded minimum gap margins, at the following locations: a. 11:00 AM, 1st floor, Kitchen, Scullery door, top, exceeded 3/16 inch; b. 11:05 AM, 1st floor, Main Kitchen door, top and latch side, exceeded 3/16 inch; c. 11:24 AM, 1st floor, Elevator Machinery Room door, top and latch side, exceeded 1/8 inch; d. 11:30 AM, 1st floor, C Hall Soiled Utility Room door #1, top, exceeded 1/8 inch; e. 11:33 AM, 1st floor, C Hall Soiled Utility Room door #2, top and latch side, exceeded 1/8 inch;	K 0321		

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(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
K 0321 SS=E	Continued from page 17 f. 12:03 PM, 2nd floor, Soiled Utility Room door, by Infectious Control Room, top and latch side, exceeded 1/8 inch. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed hazardous area doors exceeded the allowed gap margins. 2. Observation on March 13, 2025, at 11:02 AM, revealed the 1st floor Kitchen Scullery door failed to self-close. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed Kitchen Scullery door failed to self-close.	K 0321		
K 0324 SS=D		K 0324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395395	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/13/2025
NAME OF PROVIDER OR SUPPLIER: RIVER'S BEND HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 800 KING RUSS ROAD LOWER PAXTON, PA 17109		
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K 0324 SS=D	Continued from page 18 NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by:	K 0324	The maintenance Director performed a quick check on the Kitchen's fixed chemical suppression system on March 28, 2025 and documentation placed in the Life Safety Book The kitchen exhaust and ductwork cleaning was completed on April 8, 2024 and September 20, 2024. The next cleaning of the ductwork is scheduled for May 5, 2025 due to a scheduling conflict. The Maintenance Director was re-educated on the need to perform quick checks on the Kitchen's fixed chemical suppression system monthly. The maintenance Director and Food Service Director were re-educated on the need to schedule kitchen exhaust duct cleaning every 6 months. The NHA or designee will audit that quick checks are being completed, and reports are received and filed in the Life Safety Book. Audits will be conducted quarterly The Maintenance Director or	Completion Date: 04/30/2025 Status: APPROVED Date: 04/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395395	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 03/13/2025
NAME OF PROVIDER OR SUPPLIER: RIVER'S BEND HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE: 800 KING RUSS ROAD LOWER PAXTON, PA 17109		
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K 0324 SS=D	Continued from page 19	K 0324	designee will ensure that the Kitchen exhaust duct cleaning is performed on a semi-annual basis. Inspection reports will be filed in the Life Safety Book NHA or designee will Audit that inspections are timely on a quarterly basis.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395395	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/13/2025	
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K 0324 SS=D	Continued from page 20 Based on document review and interview, it was determined the facility failed to perform owner's quick checks of the fixed chemical extinguishing system, and one full year of semi-annual hood cleanings, affecting one of eight smoke zones within the component. Findings include: 1. Review of documentation and interview on March 13, 2025, between 8:45 AM and 10:45 AM, revealed the facility failed to perform owner's quick checks on the Kitchen's fixed chemical suppression system. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed the facility failed to conduct the owner's quick checks on the Kitchen's fixed chemical fire suppression system. 2. Review of documentation and interview on March 13, 2024, between 8:45 AM and 10:45	K 0324		

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NAME OF PROVIDER OR SUPPLIER: RIVER'S BEND HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 800 KING RUSS ROAD LOWER PAXTON, PA 17109		
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K 0324 SS=D	Continued from page 21 AM, revealed the facility failed to conduct Kitchen exhaust ductwork cleaning, on a semi-annual basis. Documentation verified last cycle was completed on Aril 8, 2024. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed the facility failed to perform semi-annual Kitchen exhaust ductwork, for one full year.	K 0324		
K 0353 SS=F		K 0353		

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NAME OF PROVIDER OR SUPPLIER: RIVER'S BEND HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 800 KING RUSS ROAD LOWER PAXTON, PA 17109		
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K 0353 SS=F	Continued from page 22 NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	The 5-year sprinkler inspection report was located with last inspection performed on June 30, 2021. Results posted in Life Safety Book The failed main drain test performed on August 28, 2024 due to low water pressure will be followed up to make necessary repairs as recommended by a qualified sprinkler company. The sprinkler company will be at the facility on April 1, 2025 to provide the facility with a remedy and work will be scheduled as soon as possible there after. Items laying across sprinkler pipes in the following areas have been removed from the sprinkler pipes: 1st floor, above ceiling by Resident Room D15 1st floor, above ceiling by Resident Room C1 2nd floor, above ceiling by Physical Therapy 2nd floor, above ceiling by Resident Room F18 Maintenance director will spot check other area above ceiling throughout facility on a monthly basis to check	Completion Date: 05/12/2025 Status: APPROVED Date: 04/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395395	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/13/2025
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K 0353 SS=F	Continued from page 23	K 0353	<p>for items laying on sprinkler pipes. After any vendor work above the ceiling, the Maintenance Director or NHA will inspect the area before the vendor leaves the facility. The sprinkler heads in the laundry area have been cleaned and will be inspected monthly by the NHA or designee. Maintenance Director was re-educated on the need to maintain documentation so that it is easily retrievable; to follow up with repairs to any failed inspections and to not have anything laying across sprinkler pipes.</p> <p>The Maintenance Director or designee will audit inspection reports for timeliness and follow up repairs weekly for four weeks and then monthly for 3 months and report the results to the facility's QAPI committee.</p> <p>The NHA or designee will audit inspection reports on a quarterly basis to make sure recommended repairs are completed and that all</p>	

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K 0353 SS=F	Continued from page 24	K 0353	inspection reports are timely and filed in the Life Safety Book.		

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K 0353 SS=F	Continued from page 25 Based on document review, observation and interview, it was determined the facility failed to provide 5-year sprinkler maintenance documentation, annual maintenance, maintain the automatic sprinkler system, to be free of obstructions and sprinkler piping system, to be free of extraneous weight, affecting the entire component. Findings include: 1. Review of documentation on March 13, 2025, between 9:15 AM and 9:18 AM, revealed the facility lacked documentation for the following: a. 9:15 AM, 5-year sprinkler gauge replacement/calibration; b. 9:18 AM, 5-year, internal pipe and valve inspection. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed the lack of	K 0353		

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K 0353 SS=F	Continued from page 26 documentation, verifying the 5-year sprinkler maintenance. 2. Review of documentation and interview on March 13, 2025, between 8:45 AM and 10:45 AM, revealed the facility failed the annual main drain test performed on August 28 2024, due to low water pressure and failed to make repairs. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed the facility failed to address the annual main drain test failure, due to low pressure. 3. Observation and interview on March 13, 2025, between 12:30 PM and 1250 PM, revealed multiple items laying across the sprinkler pipes, at the following locations: a. 12:30 PM, 1st floor, above ceiling, by	K 0353		

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K 0353 SS=F	Continued from page 27 Scheduling Office, various wires; b. 12:35 PM, 1st floor, above ceiling, by Resident Room D15, flex conduit and multiple wires; c. 12:40 PM, 1st floor, above ceiling, by Resident Room C1, multiple wires; d. 12:45 PM, 2nd floor, above ceiling, by Physical Therapy, multiple wires; e. 12:50 PM, 2nd floor, above ceiling, by Resident Room F18, multiple wires. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed various items supported by the sprinkler piping system. 4. Observation and interview on March 13, 2025, between 11:10 AM and 11:15 AM, revealed sprinkler heads were covered with debris, at the following locations: a. 11:10 AM, 1st floor, Laundry Room, Wash Area, 2 sprinkler heads;	K 0353		

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K 0353 SS=F	Continued from page 28 b. 11:12 AM, 1st floor, Laundry Room, Laundry Prep Area, 2 sprinkler heads; c. 11:15 AM, 1st floor, Laundry Room, Dryer Chase, 2 sprinkler heads. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed sprinkler heads were covered with debris.	K 0353		
K 0355 SS=E	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:	K 0355	All portable fire extinguishers have inspected by the Maintenance Director or designee. Our extinguisher vendor will be contacted to perform and annual inspection and Maintenance Director will maintain monthly documentation of quick cheks. The Maintenance Director has been re-educated on the requirement to perform a monthly inspection of all portable fire extinguishers. The NHA or designee will audit the portable fire extinguisher for sign off of inspection monthly on a quarterly basis.	Completion Date: 04/30/2025 Status: APPROVED Date: 04/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395395	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/13/2025
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K 0355 SS=E	Continued from page 29 Based on document review and interview, it was determined the facility failed to provide documentation, verifying monthly inspections of portable fire extinguishers had occurred, affecting six of the previous twelve months affecting the entire component. Findings include: 1. Review of documentation on March 13, 2025, between 8:45 AM and 10:45 AM, revealed the facility failed to inspect portable fire extinguishers during the following months: a. January 2025; b. February 2025; c. July 2024; d. October 2024; e. November 2024; f. December 2024. Interview at the time of the exit conference with the Administrator and Maintenance Director on March	K 0355		

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K 0355 SS=E	Continued from page 30 13, 2025, at 1:45 PM, confirmed the facility failed to perform portable fire extinguishers inspections, monthly.	K 0355		
K 0374 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by:	K 0374	The closer on the left leaf of the cross corridor smoke barrier doors near Resident Room H18 will be repaired or replaced to allow the door to close. All cross corridor doors have been inspected to see if they close. The Maintenance Director has been re-educated on the importance of checking that smoke barrier doors close fully. The Maintenance Director or designee will inspect cross corridor smoke doors for proper closing and smoke resistance each month. The NHA or designee will audit the cross-corridor doors for self-closing and smoke resistance quarterly.	Completion Date: 04/30/2025 Status: APPROVED Date: 04/10/2025

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K 0374 SS=E	Continued from page 31 Based on observation and interview, it was determined the facility failed to maintain cross corridor smoke barrier doors, affecting two of eight smoke compartments within the component. Findings include: 1. Observation on March 13, 2025, at 12:00 PM, revealed the left leaf, of cross corridor smoke barrier doors, failed to close, on the 2nd floor, by Resident Room H18, due to a faulty door closure. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed the cross-corridor door failed to close.	K 0374		
K 0712 SS=E		K 0712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395395	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/13/2025
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K 0712 SS=E	Continued from page 32 NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:	K 0712	The facility will conducted a fire drill on 2nd shift on March 31, 2025. Fire drills will be performed on each shift quarterly. The Maintenance Director was re-educated on the need to have a fire drill on each shift quarterly. The Safety Committee will develop a schedule of monthly fire drills and audit quarterly for completion.	Completion Date: 05/12/2025 Status: APPROVED Date: 04/10/2025

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K 0712 SS=E	Continued from page 33 Based on document review and interview, it was determined the facility failed to conduct and perform 2nd shift fire drills, every quarter, which affects the entire component. Findings include: 1. Review of documentation on March 13, 2025, between 8:45 AM and 10:45 AM, revealed the facility did not perform fire drills for the 2nd shift, during the following quarters: a. 1st quarter, 3rd shift 2024; b. 2nd quarter, 1st, 2nd and 3rd shift 2024; c. 3rd quarter, 1st, 2nd and 3rd shift 2024; d. 4th quarter, 3rd shift 2024. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed the fire drills were not performed.	K 0712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395395	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/13/2025
NAME OF PROVIDER OR SUPPLIER: RIVER'S BEND HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 800 KING RUSS ROAD LOWER PAXTON, PA 17109		
STATE LICENSE NUMBER: 640202				
(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
K 0761 SS=C	NFPA 101 Maintenance, Inspection & Testing - Doors Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by:	K 0761	The fire rated doors in the eight smoke compartments have been inspected by the Maintenance Director. All fire rated doors inspections will be documented and repairs done as needed. Documentation of the inspections will be placed in the Life Safety Book. The Maintenance Director has been re-educated on the need to perform annual inspections on all fire-rated doors. The NHA or designee will audit the door inspections of fire doors to make sure the annual inspection was completed.	Completion Date: 04/30/2025 Status: APPROVED Date: 04/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395395	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/13/2025
NAME OF PROVIDER OR SUPPLIER: RIVER'S BEND HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 800 KING RUSS ROAD LOWER PAXTON, PA 17109		
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K 0761 SS=C	Continued from page 35 Based on document review and interview, it was determined the facility failed to provide documentation of the annual fire door inspection, in eight of eight smoke compartments within the component. Findings include: 1. Review of documentation on March 13, 2025, between 8:45 AM and 10:45 AM, revealed the facility lacked documentation of the annual fire-rated door inspection. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed the facility could not provide documentation of the annual fire door inspection.	K 0761		
K 0912 SS=D		K 0912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395395	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/13/2025
NAME OF PROVIDER OR SUPPLIER: RIVER'S BEND HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 800 KING RUSS ROAD LOWER PAXTON, PA 17109		
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K 0912 SS=D	Continued from page 36 NFPA 101 Electrical Systems - Receptacles Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0912	The outlet on the 2nd floor, behind the ice machine, by Resident Room F5 was replaced with a GFI protected outlet. The 3 outlets in the Boiler/Generator Room, by the boiler lines exterior wall were replaced with GFI protected outlets. The Maintenance Director was re-educated on the need for GFI protected outlets within six feet of a water source. A facility wide inspection for GFI outlets will be conducted and whenever an outlet is replaced to ensure GFI protection within six feet of a water source.	Completion Date: 05/12/2025 Status: APPROVED Date: 04/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395395	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/13/2025
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NAME OF PROVIDER OR SUPPLIER: RIVER'S BEND HEALTH & REHAB CENTER STATE LICENSE NUMBER: 640202	STREET ADDRESS, CITY, STATE, ZIP CODE: 800 KING RUSS ROAD LOWER PAXTON, PA 17109
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K 0912 SS=D	Continued from page 37 Based on observation and interview, it was determined the facility failed to maintain power receptacles to be Ground Fault Interruption (GFI) protected, within six feet of a water source, in one of eight smoke zones within the component. Findings include: 1. Observation on March 13, 2025, between 11:42 AM and 12:10 PM, revealed outlets were not GFI protected, and within six feet of a water source, at the following locations: a. 11:42 AM, 2nd floor, behind ice machine, by Resident Room F5; b. 12:10 PM, Boiler/Generator Room, by boiler lines exterior wall, 3 outlets. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed outlets were not GFI protected.	K 0912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395395	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/13/2025
NAME OF PROVIDER OR SUPPLIER: RIVER'S BEND HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 800 KING RUSS ROAD LOWER PAXTON, PA 17109		
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K 0914 SS=C	<p>NFPA 101 Electrical Systems - Maintenance and Testing</p> <p>Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0914	<p>The electrical receptacles in Patient Care Areas have been inspected. All facility receptacles will be inspected.</p> <p>The Maintenance Director has been re-educated on the requirement to inspect all electrical receptacles in Patient Care Areas.</p> <p>The NHA or designee will audit the inspection results semiannually for proper documentation and placement in the Life Safety Book</p>	<p>Completion Date: 04/30/2025</p> <p>Status: APPROVED</p> <p>Date: 04/10/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395395	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/13/2025
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K 0914 SS=C	Continued from page 39 Based on document review and interview, it was determined the facility failed to provide documentation, verifying electrical receptacles, in Patient Care Areas, had been subjected to inspection, affecting the entire component. Findings include: 1. Review of documentation on March 13, 2025, between 8:45 AM and 10:45 AM, revealed the facility lacked documentation, verifying electrical receptacles, in Patient Care Areas, had been tested and inspected. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed the lack of documentation, verifying electrical receptacles, in Patient Care Areas, had been inspected.	K 0914		
K 0918 SS=F		K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395395	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/13/2025
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K 0918 SS=F	Continued from page 40 NFPA 101 Electrical Systems - Essential Electric System Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10	K 0918	The generator will be run for 30 minute load bank using the transfer switches monthly and will be run for 90 minute load bank annually. An annual fuel quality test will be performed on the generator on April 3, 2025 and the fuel sample will be taken on the same date. The Maintenance Director was re-educated on the need to run the generator 30 minutes monthly under load and annually for 90 minutes under load as well as have a fuel quality test performed annually. The NHA or designee will audit the generator logs monthly 30-minute testing and semi-annually for the 90 minute testing and that all documentation is filed in the Life Safety Book	Completion Date: 05/12/2025 Status: APPROVED Date: 04/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395395	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/13/2025
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K 0918 SS=F	Continued from page 41 (NFPA 70) This REQUIREMENT is not met as evidenced by:	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395395	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 03/13/2025	
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K 0918 SS=F	Continued from page 42 Based on document review and interview, it was determined the facility failed to perform monthly and annual inspections, and testing required, for the Essential Electrical System, which serves the entire component. Findings include: 1. Review of documentation and interview on March 13, 2025, between 10:10 AM and 10:15 AM, revealed the facility failed to perform monthly and annual inspections and testing of the generator, including the following: a. 10:10 AM, monthly, 30-minute load bank, using the transfer switches; b. 10:13 AM, annual, 90-minute load bank; c. 10:15 AM, annual, fuel quality test. Interview at the time of the exit conference with the Administrator and Maintenance Director on March 13, 2025, at 1:45 PM, confirmed the facility failed	K 0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395395	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 03/13/2025
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K 0918 SS=F	Continued from page 43 to perform required maintenance and testing.	K 0918			



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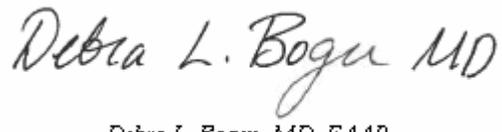
RIVER'S BEND HEALTH & REHAB CENTER

STATE LICENSE NUMBER: 640202

SURVEY EXIT DATE: 03/13/2025

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

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