STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395347	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hill Center for Rehabilitation and Nursing	1020 North Union Street Middletown, PA 17057

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395347	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hill Center for Rehabilitation and Nursing	1020 North Union Street Middletown, PA 17057

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on facility policy reviews, clinical record reviews, and staff interviews, it was determined that the facility failed to ensure that PRN (as needed) psychotropic medication orders were limited to 14 days for one of five residents reviewed (Resident 1); failed to provide side effect monitoring for two of five residents reviewed (Residents 3 and 128); failed to inform resident representatives of initiating psychotropic medication for one of five residents reviewed (Resident 14); and failed to ensure that the resident was free from chemical restraints imposed for the purposes of convenience for one of five residents reviewed (Resident 128). Findings include: Review of facility provided policy, titled Policy for Psychotropic Use in Long-Term Care (LTC), with a last review date of August 18, 2025, revealed its purpose was to ensure the safe and appropriate use of psychotropic medications in residents of Long-Term Care (LTC) facilities, in compliance with regulatory standards and best practice guidelines, while promoting the well-being and rights of residents. Further review revealed that informed consent must be obtained from the resident or their legally authorized representative before initiating or changing any psychotropic medication and residents on psychotropic medications will be regularly monitored for efficacy and adverse effects. This includes periodic reassessment of the need for continued therapy. Review of facility provided policy, titled Antipsychotic Medication Use, with a last review date of August 18, 2025, revealed the following, 14. The need to continue PRN orders for psychotropic medication beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order. Review of Resident 1's clinical record revealed diagnoses that included major depressive disorder (a serious mental health condition marked by persistent sadness, hopelessness, and a loss of interest in activities that significantly impairs daily functioning) and dementia (progressive decline in cognitive function that interferes with daily life). Review of Resident 1's physician's orders revealed an order for ABH Gel (psychotropic medication) every eight hours as needed for agitation, with a start date of October 28, 2025. No end date was documented. Further review of Resident 1's physician's orders revealed an order for Seroquel (antipsychotic medication) every six hours as needed for agitation, with a start date of March 21, 2025. No end date or rational for continued use was documented. An interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON), on December 3, 2025, at 2:19 PM, revealed that the NHA would expect PRN psychotropic medication orders to have a 14 day stop date documented and followed. Review of Resident 3's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) with agitation and depression. Review of Resident 3's physician orders revealed orders for Ativan oral tablet 0.5 milligrams (Lorazepam-medication used to treat anxiety and agitation) give one tablet by mouth once daily as needed for physical and escalated verbal aggression for 120 days, dated August 6, 2025; Seroquel (quetiapine-an antipsychotic medication used to treat psychosis and other mental health diagnoses) 25 milligrams give one tablet three times a day, dated August 11, 2025; Seroquel 25 milligrams give half a tablet (12.5 milligrams) once daily, dated July 25, 2025; Zoloft (sertraline-an antidepressant medication used to treat depression) 100 milligrams give one tablet once daily, dated March 12, 2022; and Zoloft 25 milligrams give one tablet once daily, dated March 17, 2022. Review of Resident 3's clinical record failed to reveal any documentation of monitoring for side effects of his aforementioned psychotropic medications. During a staff interview with the NHA and DON on December 4, 2025, at 9:10 AM, the NHA confirmed that side effect monitoring should have been in place for Resident 3's psychotropic medications. Review of Resident 14's clinical record revealed diagnoses that included anxiety disorder (excessive fear of or apprehension about real or perceived threats) and paranoid schizophrenia (psychiatric disorder characterized by distorted thinking and awareness). Review of Resident 14's physician orders reviewed an order for olanzapine (antipsychotic medication) twice daily. Further review of Resident 14's clinical record revealed a form titled psychoactive medication informed consent.Review of the form failed to reveal a signature from the Resident or Resident Representative consenting to the medication being used. During an interview with the NHA and DON on December 4, 2025, at 11:31 AM, the NHA revealed that it was the expectation of the facility that proper consent be obtained from either the resident or resident representative for psychotropic medication use. Review of Resident 128's medical record revealed diagnoses of major depressive disorder and anxiety disorder. Review of Resident 128's physician orders revealed an order for Lorazepam (anxiety medication) gel 1 mg/ml to be applied to Resident 128's arms or back at bedtime and every 6 hours as needed for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395347	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hill Center for Rehabilitation and Nursing	1020 North Union Street Middletown, PA 17057

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, observations, clinical record reviews, and resident and staff interviews, it was determined that the facility failed to review and revise the resident plan of care for two of 25 residents reviewed (Residents 4 and 80). Findings include: Review of facility policy, titled Care Plans, Comprehensive Person-Centered, with a last review date of August 18, 2025, read, in part, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Review of facility policy, titled Pacemaker, Care of a Resident with, with a last review date of August 18, 2025, revealed, in part, Pacemakers are electronic devices that artificially stimulate the heart muscle with electrical impulses when the heart rhythm is too slow. The following devices or procedures may interfere with pacemaker functioning: a. Cell phones or MP-3 players (for example iPods); b. household appliances, such as microwave ovens; g. Magnetic Resonance Imaging (MRI) machines; and h. Radiation machines for treating cancer. Review of Resident 4's clinical record revealed that she was admitted to the facility on [DATE], with diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning), hypertension (high blood pressure), and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). Observation of Resident 4 on December 1, 2025, at 11:28 AM, revealed she was lying in bed, and she had bilateral enabler bars on her bed. In addition, there was a Pacemaker Monitoring Unit (a bedside home monitor that is provided which performs remote pacemaker checks and then sends the information from the device to the physician). Review of Resident 4's clinical record revealed that the bilateral enabler bars were ordered to be placed on her bed on October 16, 2025. Facility provided documentation confirmed that the enablers were placed on Resident 4's bed on October 17, 2025. Further review of Resident 4's clinical record revealed that she has had a pacemaker since June 2018. Review of Resident 4's current care plan failed to reveal that her use of enablers or her pacemaker and appropriate safety precautions required were care planned. Review of her care plan revision history revealed that her enablers or her pacemaker and safety precautions had never been care planned. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing on December 4, 2025, at 9:06 AM, the NNHA confirmed that Resident 4's pacemaker and appropriate safety precautions and her enablers should have been care planned. Review of Resident 80's clinical record documented diagnoses that included morbid obesity and spondylolisthesis lumbar region (condition where one of the vertebrae in the lower back slips out of its proper position causing lower back pain). Interview with Resident 80 on December 1, 2025, at 10:45 AM, revealed she utilized the bilateral enabler bars and trapeze on her bed for bed mobility and transfers. It was also revealed staff has completed safety checks on both the rails and trapeze. Review of Resident 80's physician orders included assist in bed mobility enabler bar both sides of bed, check every shift for functioning and placement, started September 3, 2025. The consent and risk benefit for use of bed rail was signed December 5, 2024. Review of Resident 80's care plan and Kardex failed to document use of the enabler bars or the trapeze. Per email communication with the NHA on December 2, 2025, at 1:20 PM, it was confirmed that use of the enabler bars and trapeze weren't documented on the care plan or the Kardex and they should have. 28 Pa. Code 201.18 (b)(1) Management28 Pa. Code 211.12(d)(2)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395347	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hill Center for Rehabilitation and Nursing	1020 North Union Street Middletown, PA 17057

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395347	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hill Center for Rehabilitation and Nursing	1020 North Union Street Middletown, PA 17057

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on facility policy review, clinical record reviews, and staff interviews, it was determined that the facility failed to ensure care and services are provided in accordance with professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for four of 25 residents reviewed (Residents 3, 4, 9 and 14).Findings include: Review of the facility policy, titled Wound and Skin Care with a last review date of August 18, 2025, revealed, 3. For new admissions that do not have a pressure area/ulcer, the resident's skin will be monitored weekly through the nurses' skin assessments. Identified issues will be followed through skin program. Review of Resident 3's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) with agitation and depression. Review of Resident 3's clinical record revealed a laboratory order for complete blood count, comprehensive metabolic profile lipid panel, hemoglobin A1C, Phenytoin level, and Levetiracetam level every six months with a start date of April 14, 2025. Review of Resident 3's clinical record failed to reveal any of these laboratory test results for April 14, 2025. Email communication received from the Nursing Home Administrator (NHA) on December 4, 2025, at 9:48 AM, indicated he was unable to locate Resident 3's April 14, 2025, lab results. During a staff interview with the NHA on December 4, 2025, at 11:36 AM, he confirmed that Resident 3's labs were not obtained as ordered and indicated that he would expect physician orders to be followed. Review of Resident 4's clinical record revealed diagnoses that included dementia, hypertension (high blood pressure), and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). Review of Resident 4's clinical record revealed a Consultant Pharmacist MRR (Medication Regimen Review) to Prescriber dated March 26, 2025, which indicated, Please consider adding the following recommended labs: Digoxin: drug level and basic metabolic profile and pulse daily. The document was signed by Resident 4's provider on March 26, 2025. Review of facility provided Nursing Recommendations completed by consultant pharmacist on May 28, 2025, for Resident 4 indicated Pulse should be monitored daily before digoxin is given. Digoxin dose is usually held if a pulse is less than 50. This document was not signed or dated as to when it was reviewed. Review of Resident 4's physician orders revealed an order for Digoxin oral tablet 125 micrograms give one tablet by mouth one time a day, hold for pulse less than 50, dated June 2, 2025; approximately nine weeks after the original recommendation was made by the pharmacist and signed by provider. Further review of Resident 4's clinical orders from March 26, 2025, through current failed to reveal any orders for a digoxin level to be obtained. During a staff interview with the NHA and Director of Nursing (DON) on December 4, 2025, at 11:26 AM, the DON confirmed that Resident 4's pulse monitoring and laboratory testing should have been implemented when the original recommendation was made and signed by provider on March 26, 2025. Review of Resident 9's clinical record revealed diagnoses that included cerebrovascular disease (conditions that impact the blood vessels in your brain) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Review of Resident 9's physicians' orders revealed an order for the Resident to have weekly skin checks every Saturday during the 3-11 shift, and to document weekly skin assessment in point click care (PCC - cloud-based electronic health record solution), with an active date of October 28, 2025. Review of Resident 9's care plan revealed a care plan with a focus area of, the Resident is at risk for skin breakdown due to decreased mobility, initiated on October 17, 2025; with an intervention for the Resident to have skin assessments completed weekly and as needed, initiated on October 17, 2025. Review of Resident 9's clinical record revealed the Resident had a skin assessment completed on October 25, 2025; November 4, 2025; and December 2, 2025. The facility was unable to provide any additional weekly skin assessments that were completed for Resident 9, which included three weeks of missing skin assessments. Interview conducted with the NHA on December 4, 2024, at 11:00 AM, revealed he would have expected Resident 9's weekly skin assessments to have been completed and documented in PCC as ordered by the physician. Review of Resident 14's clinical record revealed diagnoses that included type two diabetes mellitus (the body cannot use insulin properly and sugar builds up in the blood) and anxiety disorder (excessive fear of or apprehension about real or perceived threats).Review of Resident 14's physicians' orders revealed an order for blood glucose checks twice daily and to notify the physician if greater than 400 or less than 60.Review of Resident 14's Medication Administration Record (MAR) from August 2025 - December 2025 revealed Resident 14's blood glucose was documented as greater than 400 on the following dates: August 3 (430); November 3 (432); November 17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395347	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hill Center for Rehabilitation and Nursing	1020 North Union Street Middletown, PA 17057

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on facility policy review, observations, clinical record review, and staff interview, it was determined that the facility failed to provide adequate supervision and assistance devices to prevent accidents for one of five residents reviewed (Resident 4).Findings include: Review of facility policy, titled Falls and Fall Risk, Managing, with a last review date of August 18, 2025, revealed, in part, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Review of Resident 4's clinical record revealed diagnoses that included dementia (a chronic disorder of the mental processes caused by brain disease, and marked by memory disorders, personality changes, and impaired reasoning) and hypertension (high blood pressure). Review of Resident 4's care plan revealed a care plan focus for at risk for falls with a last revision date of January 4, 2024. Interventions included, but were not limited to, bilateral fall mats, with an initiated date of January 15, 2024. Observations of Resident 4 on December 1, 2025, at 11:28 AM; and December 3, 2025, at 12:58 PM, revealed that she was lying in bed and no fall mats were noted at the sides of her bed. In addition, no fall mats were noted to be in Resident 4's room. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing on December 3, 2025, at 2:32 PM, the NHA confirmed that Resident 4's had no bilateral fall mats in her room and that they should have been in place as care planned. 28 Pa. Code 201.14 (a) Responsibility of licensee.28 Pa. Code 201.18 (b)(1) Management.28 Pa. Code 211.12(d)(2)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395347	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hill Center for Rehabilitation and Nursing	1020 North Union Street Middletown, PA 17057

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, observations, and staff interviews, it was determined that the facility failed to ensure residents receive appropriate treatment and services to prevent urinary tract infections in residents with a foley catheter for one of two residents reviewed (Resident 15).Findings include: Review of facility policy, titled Catheter Care, Urinary, with a last review date of August 18, 2025, revealed, in part, Be sure the catheter tubing and bag are kept off the floor. The following information should be recorded in the resident's medical record: the date and time care was given and the name and title of the individual(s) giving the catheter care. Review of Resident 15's clinical record revealed diagnoses that included prostate cancer and Lewy Body dementia (a chronic disorder of mental processes caused by protein build-up in the brain, and marked by visual hallucinations, rigid muscles, slow movement, memory disorders, personality changes, and depression). Observation of Resident 15 on December 1, 2025, at 10:58 AM, revealed that he was lying in bed and his catheter bag was in direct contact with the floor. Observation of Resident 15 on December 3, 2025, at 11:25 AM, revealed that he was up in his chair and his catheter bag was in direct contact with the floor. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on December 3, 2025, at 2:34 PM, the NHA confirmed that Resident 15's catheter bag should not have been in contact with the floor. Further review of Resident 15's clinical record revealed that he was originally admitted to the facility on [DATE], with a foley catheter in place. Resident 15 was transferred to the hospital on November 15, 2025, and returned to the facility on November 21, 2025, with a foley catheter in place. Review of Resident 15's physician orders revealed an order for catheter every shift every day and as needed, dated December 1, 2025. Review of Resident 15's Treatment Administration Records for November 2025 and December 2025 failed to reveal any documentation of catheter care from November 21, 2025, through December 1, 2025. Further review revealed that catheter care was initiated on December 2, 2025, at 6:30 AM, but failed to reveal that catheter care was being administered every shift as ordered. The documentation box was noted to only populate for day shift. During a staff interview with the NHA and DON on December 3, 2025, at 2:34 PM, the NHA indicated that there were progress notes acknowledging that Resident 15 had a foley catheter between November 21, 2025, and December 1, 2025, but that the orders for Resident 15's catheter care were not re-populated until December 1, 2025. The DON confirmed that catheter care should be administered every shift. 28 Pa. Code 211.10(c)(d) Resident care policies28 Pa code 211.12(d)(1)(2)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395347	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hill Center for Rehabilitation and Nursing	1020 North Union Street Middletown, PA 17057

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395347	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hill Center for Rehabilitation and Nursing	1020 North Union Street Middletown, PA 17057

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on facility policy review, clinical record review, and resident and staff interviews, it was determined that the facility failed to manage or prevent pain consistent with professional standards of practice and the resident's goals and preferences for one of one residents reviewed (Resident 69).Findings include: Review of facility policy, titled Pain Assessment and Management, with a last review date of August 18, 2025, revealed, in part, Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. Conduct a comprehensive pain assessment upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. The pain management interventions shall be consistent with the resident's goals for treatment. Such goals will be specifically defined and documented. If pain has not been adequately controlled, the multidisciplinary team, including the physician, shall reconsider approaches and make adjustments as indicated. Review of facility policy, titled Administering Pain Medications, with a last review date of August 18, 2025, revealed, in part, Acute pain should be assessed every 30 to 60 minutes after the onset and reassessed as indicated after analgesic relief is obtained. Document the following in the resident's medical record: 5. Results of the medication (adverse or desired). Review of Resident 69's clinical record revealed diagnoses that included pain, osteoarthritis (degeneration of joint cartilage and the underlying bone, causing pain and stiffness especially in the hip, knee, and thumb joints), and multiple sclerosis (a disease in which the immune system eats away at the protective covering of the nerves which disrupts communication between the brain and the body). During an interview with Resident 69 on December 1, 2025, at 10:19 AM, she indicated that she had ongoing pain management issues. Review of Resident 69's physician orders revealed the following orders: Acetaminophen (Tylenol) tablet 325 milligrams give two tablets by mouth every 4 hours prn (as needed) for pain, dated May 8, 2025; and Oxycodone hydrochloride oral tablet 5 milligrams give one tablet by mouth every 6 hours prn for breakthrough pain, dated May 8, 2025. Review of Resident 69's clinical record revealed that she had no comprehensive pain assessments completed between January 6, 2025, and September 19, 2025. Further review of Resident 69's comprehensive pain assessment completed on September 19, 2025, revealed she indicated that she had almost constant pain, but that it had not made it hard to sleep at night and it did not limit her day-to-day activities. She further identified that her pain goal was a 6. Review of Resident 69's September 2025 Medication Administration Record revealed the following:1) she received 34 doses of prn Tylenol for pain levels ranging from 2-8 (2=1; 5=1; 7=10; 8=22), with 2 doses documented as ineffective and 5 doses documented as effectiveness unknown;2) she received 25 doses of prn oxycodone for pain for pain levels ranging from 7-8 (7=10; 8=15), with 5 doses documented effectiveness unknown; and3) she received her prn Tylenol and her prn oxycodone at the same time on 19 occasions. Review of Resident 69's October 2025 Medication Administration Record revealed the following:1) she received 4 prn doses of Tylenol for a pain level of 0, with one dose documented as effectiveness unknown;2) she received 6 prn doses of Tylenol for fever (no parameter given as to when to administer) and the highest documented temperature was 97.4 and one dose documented as effectiveness unknown;3) she received 19 doses of prn Tylenol for pain levels ranging from 3-8 (3=1; 6=1; 7=9; 8=7), with 6 doses documented as effectiveness unknown;4) she received 1 dose of prn oxycodone for a pain level of 0;4) she received 29 doses of prn oxycodone for pain levels ranging from 4-8 (4=1; 6=4; 7=15; 8=9), with 8 doses documented as effectiveness unknown; and5) she received 19 doses of prn Tylenol and oxycodone at the same time. Review of Resident 69's November 2025 Medication Administration Record revealed the following:1) she received 3 prn doses of Tylenol for a fever and the highest temperature documented was 97.7, with one dose documented as effectiveness unknown;2) she received 6 prn doses of Tylenol for a pain level of 0, with 2 doses documented as effectiveness unknown;3) she received 14 prn doses of Tylenol for pain levels ranging from 7-8 (7=8; 8=6), with 2 doses documented as ineffective and 4 doses documented as effectiveness unknown;4) she received 3 doses of prn oxycodone for a pain level of 0; managemnet1; 7=8; 8=10), with 3 doses documented as ineffective and 6 doses documented as effectiveness unknown; and5) she received 13 prn doses of Tylenol and oxycodone at the same time. During a staff interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on December 4, 2025, at 10:06 AM, the DON confirmed that there should have been parameters for Resident 69's prn pain medications and that the orders were revised after they were made aware of the concern. The DON also acknowledged that the two as needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395347	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hill Center for Rehabilitation and Nursing	1020 North Union Street Middletown, PA 17057

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to ensure that residents who require dialysis receive such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for two of two residents reviewed (Residents 42 and 53).Findings include:Review of facility policy, titled Hemodialysis, without implementation or review date, revealed, The facility will immediately contact and communicate with the attending physician, resident/ representative, and designated dialysis staff (i.e. nephrologist, registered nurse) any significant changes in the resident's status related to clinical complications or emergent situations that may impact the dialysis portion of the care plan.Review of Resident 42's clinical record revealed diagnoses that included heart failure (when your heart muscle doesn't pump blood as well as it should) and end stage renal disease (when the kidneys no longer function normally). Review of Resident 42's physician's orders revealed an order for the Resident to receive dialysis on Tuesday, Thursday, and Saturday, starting on September 16, 2025.Review of Resident 42's care plan revealed a care plan with the focus area of, the Resident needs dialysis related to renal failure, with a revision date of September 5, 2025. Request for Resident 42's dialysis communication sheets (documented communication between the nursing facility and dialysis facility) on December 3, 2025, at 11:00 AM, failed to reveal any communications with the dialysis facility regarding Resident 42's care.Interview with the Nursing Home Administrator (NHA) on December 4, 2025, at 10:36 AM, revealed they were unable to locate Resident 42's dialysis binder with communication sheets and have created a new one. NHA revealed that they typically do not upload dialysis communication sheets to the resident's electronic health records and would expect the dialysis communication sheets be completed and available for review.Review of Resident 53's clinical record revealed diagnoses of chronic kidney disease (a gradual loss of kidney function where the kidneys become damaged and can't filter blood as well as they should) and calculus of kidney (kidney stones, hard objects made of minerals and salts in urine that form inside of the kidney).Review of Resident 53's physician's orders revealed an order for the Resident to receive dialysis on Monday, Wednesday, and Friday, starting on September 6, 2025. Review of Resident 53's care plan revealed a care plan with the focus area of, the Resident needs dialysis related to renal failure, with a revision date of August 5, 2025. Request for Resident 53's dialysis communication sheets (documented communication between the nursing facility and dialysis facility) on December 4, 2025, at 10:00 AM, failed to reveal any communications with the dialysis facility regarding Resident 53's care since November 12, 2025. During that time frame Resident 53 went for dialysis treatments nine times.Interview with the NHA on December 4, 2025, at 12:45 PM, revealed that he would expect the dialysis communication sheets be completed and available for review. 28 Pa Code 211.5(f) Clinical records28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395347	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hill Center for Rehabilitation and Nursing	1020 North Union Street Middletown, PA 17057

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of select facility personnel documentation and staff interview, it was determined that the facility failed to ensure that nurse aide performance evaluations were completed at least annually for five of five nurse aides reviewed (Employees 3, 4, 5, 6, and 7).Findings Include: Review of personnel information revealed that Employee 3's hire date was December 7, 2021; Employee 4's hire date was February 21, 2022; Employee 5's hire date was February 6, 2024; and Employee 6's hire date was October 11, 2022; and Employee 7's hire date was March 7, 2022. Further review of personnel information for Employees 3, 4, 5, 6, and 7, failed to reveal that annual performance reviews were completed. During an interview with the Nursing Home Administrator on December 4, at 12:00 PM, he acknowledged that he had no additional documentation to provide for the selected employees. He confirmed that he would expect annual performance reviews to be completed around an employee's date of hire.28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management28 Pa. Code 201.19(2) Personnel policies and procedures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395347	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hill Center for Rehabilitation and Nursing	1020 North Union Street Middletown, PA 17057

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on review of facility policy, resident and staff interviews, and clinical record review, it was determined that the facility failed to provide routine and emergency dental services for one of one resident reviewed for dental services (Resident 81).Findings: Review of facility policy, titled Dental Services, revised December 2016, read, in part, selected dentists must be available to provide follow-up care. Social services representatives will assist residents with appointments. Review of resident 81's clinical record documented diagnoses that included Alzheimer's disease (progressive brain disorder that slowly damages nerve cells, causing a gradual loss of memory, thinking and language abilities), adjustment disorder with mixed anxiety (a feeling of worry, nervousness, or unease), and depression (feelings of severe despondency and dejection). Interview with Resident 81 on December 1, 2025, at 11:15 AM, revealed she hadn't seen a Dentist for two missing upper right teeth; they were to be replaced. Review of census documentation revealed Resident 81's payor source was Medicaid managed care health plan since June 21, 2024. Review of Resident 81's care plan and Kardex documented to assist with inserting/removing (upper and lower) dentures in AM and at bedtime, initiated February 23, 2023. Review of dental exam dated May 9, 2025, documented denture step 1 visit- impressions were taken of both maxillary (upper jaw) and mandibular (lower jaw) arches for fabrication of upper and lower dentures - continue oral care and remove dentures at night, denture step 3 scheduled May 30, 2025. Dental exam dated June 26, 2025, documented visit for annual exam and step 3 denture visit (a wax or temporary denture try-in appointment to evaluate the look, fit, and bite of future denture) revealed full upper and lower dentures worn with plaque, both ill fitting. Resident in the process of new denture fabrication, a bite registration (impression) was completed, and secondary impressions were obtained of both maxillary and mandibular arches. Recommend annual exam to monitor oral and tissue health, next visit for dentures step 4 (a wax denture try-in to evaluate bite, shape and appearance are correct before dentures are finalized). Dental consult dated July 28, 2025, documented the Resident was scheduled to be treated that day but that the Resident was unavailable; not in her room on 4 attempts during dental visit. Interview with the Nursing Home Administrator (NHA) on December 3, 2025, at 2:39 PM, revealed Resident 81 was scheduled to be seen the coming Friday, December 5th, 2025. It was also revealed that the Dentist comes to the facility about every six weeks, and that Resident 81 should've been see prior to December 5th, 2025, for her step 4 denture fitting. 28 Pa Code 211.15(a) Dental services