

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/27/2024
NAME OF PROVIDER OR SUPPLIER  Oak Glen Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3201 River Road Lewisburg, PA 17837	

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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36798</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to establish clear and consistent resident wishes regarding advance directives for one of five residents reviewed (Resident 66).</p> <p>Findings include:</p> <p>Clinical record review for Resident 66 revealed a current physician's order initiated on [DATE], that indicated her code status (the type of emergency care to be initiated if the resident's heart stops or they stop breathing) to be DNR (Do not resuscitate).</p> <p>Further clinical record review revealed a facility form entitled, Decision of Agent, Guardian, or Health Care Representative Cardiopulmonary Resuscitation (CPR, an emergency procedure that combines chest compressions and rescue breathing when a person's heartbeat or breathing has stopped) Status of Incompetent Resident that indicated the Resident's health care agent did not wish to decide at this time regarding the resident's CPR status. The form was signed and dated [DATE].</p> <p>The Director of Nursing and Nursing Home Administrator were made aware of concerns related to Resident 66's code status form and physician orders on [DATE], at 1:52 PM.</p> <p>Interview with the Nursing Home Administrator on [DATE], at 10:02 AM confirmed the above noted findings related to Resident 66's code status form and physician order not matching.</p> <p>28 Pa. Code 211.5(f) Clinical records</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>19719</p> <p>Based on observations, and staff and family interview, it was determined that the facility failed to provide adequate maintenance services to maintain an orderly environment in a main hallway of the facility (Resident 29).</p> <p>Findings include:</p> <p>Interview with Resident 29's family on September 24, 2024, at 11:20 AM revealed that the facility has had a leaking roof in the hallway for a while now.</p> <p>Observation of a hallway located near the facility's beauty shop on September 26, 2024, at 10:12 AM revealed that the roof was leaking through the ceiling tiles onto the carpeted area. The hallway connects nursing units and provides residents with access to services such as the beauty salon, human resources, therapy, and administration.</p> <p>The facility had two large trash cans placed under the leak attempting to catch the dripping water. There were two large ceiling tiles that were saturated with water with holes in them that were dripping water into the trash cans and surrounding carpet. There was a six-foot area of wet carpet surrounding the trash cans. There was a musty wet odor that was noticeable from around the corner of the leaking roof.</p> <p>Interview with Employee 3, director of maintenance, on September 26, 2024, at 10:14 AM confirmed that the roof has been leaking as long as he has been employed, which has been since January 2024. Employee 3 indicated that the facility obtained a quote to fix the leak, but the facility has stalled on it since. Review of the facility's roofing quote revealed that the facility obtained the quote on May 24, 2024.</p> <p>Interview with the Administrator on September 26, 2024, at 12:30 PM confirmed the above findings and indicated that the facility has been trying to get it fixed.</p> <p>28 Pa. Code 207.2(a) Administrators Responsibility</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>36798</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide care or services to maintain a resident's ambulation status for one of two residents reviewed for ambulation concerns (Resident 17).</p> <p>Findings include:</p> <p>Clinical record review for Resident 17 revealed a Restorative Program Note dated September 5, 2024, at 1:30 PM that indicated she would start a new restorative program for ambulation. The program details include for her to be ambulated with a front wheeled walker in straight paths with the assistance of one staff with one staff to follow with a wheelchair.</p> <p>Review of the task documentation (electronic documentation of care provided) for the dates of September 5-25, 2024, revealed a task for Restorative ambulation to be completed every shift.</p> <p>Interview with Employee 6 (Assistant Director of Nursing) on September 26, 2024, at 2:00 PM revealed that the expectation was for the task to be completed once a day. She said it was scheduled every shift so that if one shift did not get the task done, the next shift could do it.</p> <p>Further clinical record review revealed that the task did not get completed at least one time a day on September 16, 18, 21, 22, 23, 24, and 25, 2024. On those dates the documentation revealed that Resident 17 refused on dayshift and the evening shift documentation revealed that the task was documented as not applicable on all the dates except September 25, 2024, which was left blank.</p> <p>There was no further documentation in the clinical record indicating that Resident 17's plan was reviewed related to her refusals or why the restorative ambulation task was not applicable to Resident 17 on evening shift.</p> <p>The Nursing Home Administrator and Director of Nursing were made aware of the above noted findings related to Resident 17's restorative ambulation program on September 27, 2024, at 9:40 AM.</p> <p>The facility failed to provide care or services to maintain a resident's ambulation status.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>20725</p> <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on review of select facility policies and procedures, clinical record review, observation, and staff and resident interview, it was determined that the facility failed to provide the highest practicable care regarding cardiac pacemakers and central venous catheters for three of 19 residents reviewed (Residents 27, 61, and 82).</p> <p>Findings include:</p> <p>Clinical record review for Resident 27 revealed nursing documentation dated September 9, 2024, at 7:45 PM that Resident 27, returned to facility. Report from hospital staff that line was kinked, and they were able adjust it. It is now patent.</p> <p>Active physician orders for Resident 27 included instructions to change a PICC line (Peripherally Inserted Central Catheter, thin, soft, flexible tube inserted through a vein in the arm and passed through to the larger veins near the heart for the administration of fluids or medication) intravenous dressing every Wednesday. The orders also included instructions to instill heparin (an anticoagulant medication that prevents blood clotting) lock flush solution, five milliliters, intravenously one time a day for line maintenance.</p> <p>Observation of Resident 27 on September 24, 2024, at 2:37 PM revealed a dressing around her right bicep with white netting visible over the dressing. Interview with Resident 27 on the date and time of the observation revealed that she had an intravenous access site in her right arm to receive an antibiotic medication. Resident 27 stated that the facility sent her to the emergency roiaognom on ce since she was admitted to the facility because the staff could not get antibiotic to go through, thought it was clogged, went to the emergency room and was x-rayed, that didn't find anything, all they did was replace the bandage and fix a kink. Observation of Resident 27 and her room revealed no indication of any emergency procedures in place in the event of a central venous catheter line complication (bleeding or breakage) or limb restriction to prevent the inadvertent use of her right arm for venipuncture or blood pressures.</p> <p>Interview with Employee 4 (registered nurse) on September 25, 2024, at 12:49 PM confirmed that there were no instructions on Resident 27's care plan that related to not using her right arm for venipuncture or blood pressure assessments. The care plan also did not include what measures were to be implemented in the event of a potential complication like bleeding or the breakage of the intravenous tubing. The interview also confirmed that there was no information for nurse aide staff on the electronic Kardex (electronic documentation that informs staff providing care to a resident of individualized needs and precautions) that pertained to a PICC line. The interview also confirmed that there were no physician orders or instructions to monitor the tubing length or circumference of the affected arm to ensure that there was no migration of, or complication from, the intravenous tubing. Observation of Resident 27's room with Employee 4 confirmed that there was no signage or indication of restrictions or emergency procedures relating to the PICC line use.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The surveyor requested any facility policy or procedure relating to the planning of care for a resident with a central line intravenous access device during an interview with the Nursing Home Administrator, Director of Nursing, and Employee 6 (assistant director of nursing), on September 25, 2024, at 2:00 PM.</p> <p>Information provided by the facility the morning of September 26, 2024, revealed that the facility did not have a policy or procedure related to the emergency care for PICC lines.</p> <p>Interview with Resident 61 on September 24, 2024, at 1:03 PM revealed that staff removed an intravenous access site from her left arm the day before. She stated that she had antibiotic therapy for approximately six weeks after diagnoses of an infection she sustained after the insertion of a cardiac pacemaker (medical device inserted under the skin of the upper chest to treat abnormalities of the electrical system of the heart) and a new valve in her heart. Observation of Resident 61's room revealed an unused intravenous pump without any medication or tubing attached to the pump. Resident 61 confirmed that she had no pacemaker check device in her room. Resident 61 stated that she had a machine in her apartment at the personal care facility she lived in, but what good is it (machine), when it was in her apartment while she resided at the facility.</p> <p>Clinical record review for Resident 61 revealed a diagnoses list that included the presence of a cardiac pacemaker dated August 1, 2024, and instructions for pacemaker checks as ordered dated September 9, 2024.</p> <p>Interview with Employee 4 on September 25, 2024, at 12:52 PM revealed that the plan of care developed by the facility for Resident 61 did not include the use of a pacemaker check machine. The plan of care indicated that Resident 61 had a dual chamber pacemaker (two wires attached to two chambers of the heart) related to complete heart block (disruption of the electrical signals between the upper portions and lower portion of the heart that are necessary for the heart to beat; can result in a very slow or no heartbeat). The care plan noted that Resident 61 had an appointment with her cardiologist in approximately one year on August 8, 2025.</p> <p>Interview with the Nursing Home Administrator, Director of Nursing, and Employee 6 on September 26, 2024, at 1:30 PM confirmed that the facility did not contact Resident 61's primary care physician or cardiologist to determine if Resident 61 required the use of remote monitoring (pacemaker check machine) while in the facility. The facility staff did not ask Resident 61 if she utilized a pacemaker check machine at home.</p> <p>Interview with Resident 82 and her daughter on September 24, 2024, at 12:41 PM revealed that she had an intravenous access site above her right upper arm for the administration of antibiotics following an infection of surgical hardware that caused her surgical wound to bust open. Resident 82 stated that she broke her left arm in several places. The intravenous access site was not visible under Resident 82's clothing. Observation of Resident 82's room and person revealed no indication that special measures were necessary (e.g., limb restriction or emergency procedures) due to the presence of an intravenous access site.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Nursing documentation dated September 18, 2024, at 5:28 PM revealed that Resident 82 was admitted following hospitalization related to a September 11, 2024, surgical drainage of humerus (arm) incision requiring surgical debridement (cleaning out of unhealthy tissue/material) of the left arm. She then was noted to have MRSA (Methicillin Resistant Staphylococcus Aureus, an infection caused by bacteria that is resistant to commonly used antibiotics) and was started on intravenous Vancomycin (antibiotic). Special care needs indicated that Resident 82 had a right intrajugular central venous line (IJ CVC, intravenous line inserted into a larger central vein, the internal jugular vein, in the neck area).</p> <p>Active physician orders for Resident 82 instructed staff to obtain vital signs (that would include a blood pressure assessment) every shift. The physician orders did not include emergency procedures to use in the event of a complication from Resident 82's IJ CVC (e.g., bleeding or abnormality of tubing patency).</p> <p>Interview with Employee 4 on September 25, 2024, at 12:29 PM confirmed that there was no mention of Resident 82's IJ CVC on her Kardex used by the nurse aides who could complete assessments of her vital signs and perform daily care (like bathing). The interview also confirmed that there were no emergency procedures in place on the plan of care developed by the facility for Resident 82's right IJ CVC.</p> <p>Review of Resident 82's MAR and TAR (Medication Administration Record and Treatment Administration Record, electronic documentation of medications and treatments completed by licensed staff) dated August and September 2024, revealed no evidence of a dressing change to Resident 82's IJ CVC.</p> <p>Interview with Employee 4 on September 27, 2024, at 10:56 AM indicated that she changed the IJ CVC dressing on Resident 82's site on September 20th; however, she had no physician's order to do so. Employee 4 stated that she changed the dressing because Resident 82 was complaining about the patency (that the dressing was beginning to fall off) of the dressing. Employee 4 confirmed that she did not document the dressing change in Resident 82's medical record. Employee 4 stated that all dressing procedures at the facility are the same regardless of PICC insertion site (IJ vs peripheral) and that the procedure is to change the dressing every seven days using a central line dressing kit. Employee 4 stated that she based her care decision for Resident 82 on education received through mandatory in-service education regarding how to care for central lines. The interview confirmed that there was no evidence that staff were measuring exposed tubing from central lines to verify that there was no migration of the access tubing for any resident reviewed for intravenous concerns during this onsite survey.</p> <p>Review of the course content of education provided to staff entitled, Rapid Review: Central Venous Catheter Care, revealed that individuals with a central venous catheter, or CVC, are at risk for infections and complications. Transparent dressings are changed every five to seven days or when soiled. The education did not address emergency measures (e.g., direct pressure or tube clamping) in the event of bleeding or ongoing assessments (e.g., measuring the limb for edema or the tubing length for migration) necessary for residents with a CVC.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 82's medical record revealed that staff obtained new physician orders after the surveyor's questioning, dated September 25, 2024, to obtain blood pressure assessments from Resident 82's lower extremities, that Resident 82 had a restriction to using the upper extremities, and that staff should change the dressing to Resident 82's right chest weekly and as needed for dislodgement.</p> <p>483.25 Quality of Care</p> <p>Previously cited deficiency 10/27/23</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>19719</p> <p>Based on observations, clinical record review, and staff interview, it was determined that the facility failed to appropriately use a positional device related to contractures for one of two residents reviewed (Resident 80).</p> <p>Findings include:</p> <p>Observation of Resident 80 on September 25, 2024, at 9:20 AM revealed she was sitting in the dining room with a travel neck pillow positioned behind her neck. Resident 80's neck naturally is contracted forward and to her left. The bulk of the travel pillow was positioned with the middle directly on the back of her neck, essentially pushing her neck further forward.</p> <p>Review of Resident 80's clinical record revealed an admission Minimum Data Set Assessment (MDS, an assessment completed at specific intervals to determine care needs) dated July 10, 2024, that indicated the facility assessed Resident 80 as having range of motion limitations to one side of both her upper and lower extremities. There was no documented evidence to indicate the use of a travel neck pillow in Resident 80's clinical record until after this surveyor's observations.</p> <p>Observation of Resident 80 on September 26, 2024, at 9:07 AM revealed she was sitting in the lounge area, again with the bulk of a travel pillow positioned directly behind her neck, pushing her neck further forward.</p> <p>Interview with Employee 1, occupational therapist, on September 26, 2024, at 9:10 AM indicated that the travel pillow was being used for comfort and that the bulk of the pillow should be positioned to the left side of her neck for support. There was no documented evidence in Resident 80's clinical record to indicate that's how her neck pillow should be positioned.</p> <p>Interview with Employee 2, nurse aide, on September 26, 2024, at 9:15 AM revealed that she places the bulk of the travel pillow directly behind Resident 80's neck, and that she swivels the bulk of the pillow to the front of her neck when they help Resident 80 eat. There was no documented evidence in Resident 80's clinical record to indicate that nursing staff are to move the travel pillow when feeding her.</p> <p>There was no documented evidence in Resident 80's clinical record to indicate how and when nursing staff are to use the travel neck pillow, or that nursing staff were instructed on its use for Resident 80.</p> <p>Interview with Employee 1, on September 26, 2024, at 9:31 AM confirmed the above findings for Resident 80.</p> <p>S483.25(c) Mobility</p> <p>Previously cited 10/27/23</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 211.12 (d)(1)(5) Nursing services</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738</b></p> <p>Based on observation and staff interview, it was determined that the facility failed to store food items and maintain equipment in a sanitary manner in the facility's main kitchen.</p> <p>Findings included:</p> <p>Initial tour of the facility's main kitchen with Employee 5, General Dietary Manager, on [DATE], between 9:15 AM and 9:40 AM revealed the following:</p> <p>A large circulating fan in the dishwashing area had a significant build-up of dust on the protective guards.</p> <p>The dry storage room contained an open container of peanut butter with no open date on it.</p> <p>A walk-in freezer had a package of croissants that were open and uncovered, exposing several of them to the ambient air.</p> <p>A walk-in cooler had the following findings: a head of celery on a shelf that was not covered exposing it to ambient air; five unused packages of butter in a cardboard box that were partially open and another partially used package of butter that was open and not dated; an open package of mixed vegetables that had a build-up of moisture on the package and no open date on it; two large onions and one partially used onion with an expired facility use by date of [DATE].</p> <p>A second walk-in cooler had the following findings: a container of heavy cream with a facility use by date of [DATE]; a box of cooked chicken with a facility use by date of [DATE]; an opened package of provolone cheese with a facility use by date of [DATE].</p> <p>Two stainless steel shelves on a perimeter wall were noted to have a build-up of debris and dust. One of the shelves had a dead winged insect on it.</p> <p>A knife rack attached to the wall had a build-up of dust on the rack and the section of the wall behind the rack.</p> <p>The Nursing Home Administrator and Director of Nursing were notified of the findings on [DATE], at 2:18 PM.</p> <p>42 CFR 483.60(i) Food Procurement, Store-Sanitary</p> <p>Previously cited [DATE]</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>20725</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure a complete medical record was accessible to the survey team timely for one of six residents reviewed (Residents 10).</p> <p>Findings include:</p> <p>The surveyor reviewed the requirement for resident electronic health records (surveyor access to any information that should be a part of the resident's medical record) during an entrance conference interview with the Nursing Home Administrator and Director of Nursing on September 24, 2024, at 8:53 AM.</p> <p>Clinical record review for Resident 10 on September 24, 2024, at 11:19 AM (first day of the onsite survey) with the Nursing Home Administrator and Employee 6 (assistant director of nursing) revealed that the surveyors' access to the electronic medical record did not permit the review of all physician orders available for Resident 10. The physician orders available did not include any medications or advance care planning decisions for Resident 10.</p> <p>Interview with the Nursing Home Administrator on September 24, 2024, at 12:15 PM indicated that the facility's information technology department updated the surveyor's profile, and the surveyor should have access to all Resident 10's medical record information.</p> <p>The surveyor continued to attempt to access Resident 10's physician orders on September 24 and 25, 2024, without success.</p> <p>The surveyor addressed the issue of inaccessibility to Resident 10's complete electronic medical record again during an interview with the Nursing Home Administrator, Director of Nursing, and Employee 6 on September 25, 2024, at 1:58 PM (near the end of the second day of the onsite survey).</p> <p>The surveyor addressed the issue of inaccessibility to Resident 10's complete electronic medical record again during an interview with the Nursing Home Administrator on September 26, 2024, at 11:11 AM (the third day of the onsite survey). The surveyor reviewed the impediment of the survey process due to the lack of access to the medical record.</p> <p>Interview with the Nursing Home Administrator on September 26, 2024, at 12:36 PM revealed that the facility's information technology department staff changed the surveyor's user profile to now permit access to Resident 10's electronic medical record.</p> <p>The facility failed to ensure that surveyors received access to electronic medical records timely.</p> <p>28 Pa. Code 211.5(f) Medical records</p> <p>28 Pa. Code 211.12(d)(3) Nursing services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/27/2024
NAME OF PROVIDER OR SUPPLIER  Oak Glen Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3201 River Road Lewisburg, PA 17837	
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)		
<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>20725</p> <p>Based on clinical record review and staff interview it was determined that the facility failed to offer the COVID-19 vaccine to one of five residents reviewed for immunizations (Resident 59).</p> <p>Findings include:</p> <p>Current CDC guidelines at <a href="https://www.cdc.gov/covid/vaccines/stay-up-to-date.html">https://www.cdc.gov/covid/vaccines/stay-up-to-date.html</a> recommend that everyone ages six months and older should get a 2024-2025 COVID-19 vaccine. Vaccine protection decreases over time, so it is important to stay up to date with your COVID-19 vaccine. This includes people who have received a COVID-19 vaccine before and people who have had COVID-19.</p> <p>Interview with Employee 7 (registered nurse/infection control prevention coordinator) on September 26, 2024, at 8:47 AM indicated that any information regarding a resident's vaccination history is contained in the electronic medical record under the immunization section. Employee 7 stated, that's what I go by.</p> <p>Clinical record review for Resident 59 revealed that the facility admitted him on August 19, 2022, and his most recent COVID-19 booster was administered on February 14, 2023.</p> <p>Resident 59's medical record contained no evidence that the facility offered any additional doses of the COVID-19 vaccine.</p> <p>Interview with Employee 8 (licensed practical nurse), Employee 4 (registered nurse), and Employee 9 (medical records) on September 27, 2024, from 11:18 to 11:52 AM confirmed that the evidence available in Resident 59's electronic and physical medical records indicated that Resident 59 received his last COVID-19 immunization in February 2023, and that there was no evidence that either Resident 59 or his responsible party refused another COVID-19 booster immunization that would prohibit another vaccine in 2024.</p> <p>The surveyor reviewed the above concerns regarding Resident 59's COVID-19 immunization during an interview with the Nursing Home Administrator on September 27, 2024, at 11:50 AM.</p> <p>28 Pa. Code 211.5(f) Medical records</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		