STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395283	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Glen Healthcare and Rehabilitation Center	15 Ridgecrest Circle Lewisburg, PA 17837

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and staff interview, it was determined that the facility failed to ensure resident dignity during dining on one of three open nursing units (Memory Care, Residents 18 and 36). Findings include:An observation of the lunch meal service in the Memory Care unit on August 19, 2025, at 11:48 AM revealed multiple residents seated in the dining room awaiting the lunch meal. Resident 36 and Resident 18 were observed seated at a table together with beverages in front of them. Employee 15, nurse aide, was observed placing a sandwich on the table in front of Resident 36 and stated, Don't touch that yet because [Resident 18] doesn't have anything, as Employee 15 proceeded to deliver a sandwich to another table. Immediately as Employee 15 was walking to another table, Resident 36 picked up the sandwich, and as Employee 15 was walking back by the resident Employee 15 stated, I told you not to touch that yet. Resident 36 responded, I know, I was just looking to see what kind it was. At 12:00 PM Resident 36 was observed taking the last bite of the sandwich with Resident 18 watching as Employee 15 was completing other tasks in the dining room, the hot lunch meal had not yet arrived on the nursing unit to be served. At 12:10 PM hot food service began on the unit. Resident 36 was served a plate of hot food items at 12:11 PM, and Resident 18 was still waiting for a meal. Resident 18 was not provided a meal until 12:12 PM, although Resident 36 who was sitting with her had already been served and consumed a sandwich, and was served a hot meal first. The above findings were reviewed with the Nursing Home Administrator and Director of Nursing on August 20, 2025, at 2:43 PM. 28 Pa. Code 201.29(a) Resident rights

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident and staff interviews, it was determined that the facility failed to ensure that written notice, including the reason for a room change, was provided to a resident prior to a facility-initiated room change for one of one resident reviewed for concerns related to resident choice (Resident 107). Findings include: Observation of Resident 107 on August 20, 2025, at 11:03 AM revealed he was in a wheelchair in front of the nursing unit's nurses' station. Interview with Resident 107 on August 20, 2025, at 11:03 AM revealed that he believed that he was moving from the [NAME] nursing unit to the Evergreen nursing unit on this date, before lunch. Resident 107 stated that he was not sure why he was moving to a new room or to what room he was moving. Resident 107 stated that he was not shown any rooms on a different nursing unit and that if staff told him a room number it would mean nothing to him without seeing it. Resident 107 stated I hope not, when asked if he was going to have a roommate (Resident 107 did not have a roommate in his current room on the [NAME] nursing unit). Resident 107 stated that he was told he would be moving to a new room a couple days ago. Clinical record review for Resident 107 revealed social services documentation from Employee 7 (social worker) dated August 19, 2025, at 3:40 PM that A 72-hour meeting was held this afternoon with the ID (interdisciplinary) team. His goal is for a short term stay to his home, where he lives with his wife. He is scheduled for surgery in September. (Resident 107) and this writer had a conversation regarding a room change to the long-term care wing until his surgery September and he is agreeable. A call was placed to his wife to discuss planning with her. Interview with Employee 7 on August 21, 2025, at 9:45 AM reviewed the above social services documentation for Resident 107. Employee 7 confirmed that there was no written documentation given to Resident 107 and/or his responsible party of why the room move was required. The facility also could provide no documentation to evidence that Resident 107 was given the opportunity to see the new location or meet his new roommate. Employee 7 confirmed that Resident 107 would now have a roommate, but he had not had a roommate before this room change. The surveyor reviewed the above concerns regarding Resident 107's room and roommate change during an interview with the Nursing Home Administrator, Director of Nursing, and Employee 5 (assistant director of nursing), on August 21, 2025, at 2:00 PM. 28 Pa. Code 201.14(a) Responsibility of licensee 29 Pa. Code 201. 29(a) Resident rights 28 Pa. Code 211.12(d)(3) Nursing services

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policies and procedures, the facility's grievance documentation, observation, and resident and staff interview, it was determined that the facility failed to implement effective corrective action in response to a resident's grievance related to staff call bell response for seven of seven residents reviewed for call bell response concerns (Residents 20, 108, 111, 48, 93, 107, and 3).Findings include: Review of the facility policy entitled, Call Light Policy, effective March 20, 2025, revealed that the call system will be monitored regularly to ensure it is functioning properly. The call light must be kept accessible to the resident at all times. Any malfunctioning call lights must be reported to maintenance or the supervisor immediately. If necessary, staff will use the manual bell as indicated. Review of a Resident Concern Form dated July 17, 2025, revealed that Resident 20 (who resided on the Evergreen unit) voiced concerns related to call bells. Resident 20 reported that staff will respond to a call bell, say they will return, but at times that takes a while. The facility indicated that actions taken included random call bell audits and staff education, Be sure to answer call bells in a timely manner. If you need help closing the request, tell the resident, get assistance, return to do tasks. Documentation provided by the facility indicated that the facility performed call bell audits only on the Evergreen nursing unit. The facility utilizes three nursing units to accommodate the resident census (Evergreen, Memory Care, and [NAME]). Observation of the [NAME] nursing unit on August 19, 2025, at 2:41 PM revealed Resident 108 was in the bathroom in his room, on the toilet, yelling for staff assistance. The light outside Resident 108's room was not lit to indicate the activation of a call bell. Observation of the call bell device in Resident 108's bathroom revealed a light to indicate Resident 108 activated the call bell. Resident 108 stated that staff told him that they would be right back, but he had been waiting too long. Resident 108 was unable to state how long he had been in the bathroom; however, Resident 108 stated that he waited an hour and 10 minutes this morning for someone to respond to his call bell while he was in the bathroom. Interview with Employee 8 (licensed practical nurse) on August 19, 2025, at 2:44 PM revealed that she also could not get the call bell light indicator outside Resident 108's room to work and that she believed it was likely a battery failure. Employee 8 confirmed that staff walking by Resident 108's room would not know that Resident 108 activated a bathroom call bell to obtain staff assistance. Interview with Resident 111 (who resided on the [NAME] nursing unit) on August 19, 2025 (Tuesday), at 1:21 PM revealed that she arrived at the facility on Saturday (August 16, 2025); and had no functioning call bell to summon staff assistance. Resident 111 stated that she had to yell for staff. Resident 111 showed the surveyor a tap bell on her overbed table that the facility provided her on her first night to obtain staff assistance, but Resident 111 stated that she did not believe that any staff would hear the tap bell if she used it. Observation of Resident 111's bed revealed a white push-button, call bell device clipped to her bed. Resident 111 stated that no staff instructed her regarding the use of that device. The cord to the push-button device was not connected to the facility's call bell system. The call bell light outside Resident 111's room did not activate when the push-button device was used. Resident 111 stated that she was told not to go to the bathroom alone; however, she cannot wait as long as it takes for staff to respond if she wants to avoid being incontinent. Resident 111 stated that she can wait 40 minutes for staff to respond to her request for help. Interview with Employee 8 (licensed practical nurse) on August 19, 2025, at 2:24 PM confirmed that Resident 111 did not have a functioning call bell besides the tap bell on her overbed table. Employee 8 confirmed that staff on the other side of the nursing unit or inside the nurses' station (enclosed in glass) would not hear the metal tap bell if Resident 111 used it. Employee 8 confirmed that the facility gave Resident 111 the tap bell because she did not have a device that was connected to the facility's call bell system. Interview with Resident 48 (who resided on the [NAME] nursing unit) on August 20, 2025, at 12:04 PM revealed that her opinion was call bells are a joke. Resident 48 reported that during the previous shift, at 4:00 AM she activated her call bell because she needed to use the bathroom. Resident 48 stated that no staff responded to her call bell, and there was complete silence out there (the hallway); and that she figured out a way to get out of bed and to the toilet herself. Resident 48 stated that when she felt she was done in the bathroom, she activated the bathroom call light and had to wait 35 minutes before staff responded. Observation of the [NAME] nursing unit on August 20, 2025, at 11:29 AM revealed Resident 93's call bell was activated. Resident 93's call bell activation continued through 11:44 AM (15 minutes). Interview with Resident 93 on August 21, 2025, at 1:22 PM revealed that her experience with call bell response times was terrible, pretty

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to provide assistance with activities of daily living (ADL) for dependent residents for two of two residents reviewed for ADL concerns (Residents 107 and 90). Findings include: Clinical record review for Resident 107 revealed that the facility admitted him on August 14, 2025 (Thursday). Observation of Resident 107 on August 20, 2025, at 11:09 AM revealed that his hair appeared uncombed and oily. Resident 107 presented with facial hair indicative of numerous days without shaving. Interview with Resident 107 on the date and time of the observation revealed that he had not received a shower yet at the facility. Resident 107 also confirmed that no staff had assisted him with shaving since his admission to the facility. Resident 107 stated that on this day, nursing staff supplied him with shaving equipment. Interview with Employee 8 (licensed practical nurse) on August 20, 2025, at 11:10 AM confirmed that she provided Resident 107 shaving equipment on this date. Review of a Documentation Survey Report (electronic documentation of resident care needs completed by nurse aide staff) dated August 2025 revealed that Resident 107 was to receive a shower on Wednesday and Saturday evenings. Nurse aide staff did not document the provision of a shower until August 20, 2025, at 11:42 PM (following the surveyor's observation). Resident 107 was totally dependent on the physical assistance of two staff for the shower. There was no evidence that staff offered Resident 107 a shower before August 20, 2025. Resident 107 did not receive a shower on Saturday, August 16, 2025. The surveyor reviewed the above concerns regarding Resident 107's assistance with ADL needs during an interview with the Nursing Home Administrator, Director of Nursing, and Employee 5 (assistant director of nursing) on August 21, 2025, at 2:00 PM. Observation of Resident 90 on August 20, 2025, at 12:33 PM revealed he was sitting at the dining room table for lunch with very scruffy whiskers extending from his lip, cheeks, and down to his neck. The resident stated he needed to shave. Clinical record review for Resident 90 revealed a quarterly MDS (minimum data set, an assessment completed at periodic intervals of time to assess resident care needs), dated July 22, 2025, which indicated facility staff assessed the resident as requiring partial/moderate assistance for personal hygiene and the resident had a BIMS (brief interview of mental status) score of two, indicating severe cognitive impairment. Resident 90's facial hair was reviewed with the Nursing Home Administrator and Director of Nursing on August 20, 2025, at 3:32 PM. In a follow up observation of Resident 90 on August 21, 2025, at 12:18 PM he was seated at a dining room table eating lunch. It appeared the resident's face and neck had been shaved but remained spotty with whiskers in areas of his face and lip. Resident 90 indicated, They shaved me this morning. Resident 90 stated, I like a clean shave, that is how I did it at home, and has a young chap. That is how we had to be on the farm. The above findings for Resident 90 were reviewed with the Nursing Home Administrator and Director of Nursing on August 21, 2025, at 2:20 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of select facility policies and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to implement interventions to prevent resident elopement for one of two residents reviewed for elopement concerns (Resident 15).Findings include: The facility policy entitled, Wandering Residents, implemented March 20, 2025, indicated that the facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering. The facility is equipped with door locks/alarms and all high-risk areas are secured. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for unsafe wandering including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Residents will be monitored for unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. The interdisciplinary team will evaluate the unique factors contributing to risk to develop a person-centered care plan. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff. The facility policy entitled, Elopements, effective March 20, 2025, indicated that it is the facility's policy to ensure the safety and well-being of all residents by implementing proactive measures to prevent elopement and establishing a clear, immediate response protocol in the event a resident is missing or attempts to leave the facility unsafely. Staff will investigate and report all cases of missing residents. A Risk Assessment will be completed on admission to the skilled nursing facility and quarterly. If identified as at risk for hazardous wandering or elopement, the resident's care plan will include strategies and intervention to maintain the resident's safety. When a departing individual returns to the facility, the charge nurse will examine the resident for injuries, notify the attending physician, notify the resident's representative of the incident, complete and file Report of Incident/Accident, and document the event in the resident's medical record. The Elopement policy referred to a Risk Assessment. The Elopement Evaluation assessment in the electronic medical record indicated that any score value of one or higher indicates a risk of elopement. Clinical record review for Resident 15 revealed an Elopement Evaluation dated June 16, 2025, that included a score of zero (no risk for elopement). Behavior note documentation dated July 5, 2025, at 1:24 PM noted that staff were attempting to keep Resident 15 in view as he was, nonstop attempting unattended transfers standing up on his own, breaks not locked, toileted several times unsure why he keeps standing up. Denies pain or discomfort. I gave him his cell phone he called his daughter but that only obscured him for five minutes, will continue to keep busy attempted to sit at table with snack and drink, refused, had him in by TV, he wheeled down to back door several times pushing till alarm sounded. Resident 15's clinical record did not contain evidence that staff repeated an Elopement Evaluation in response to the above noted behavior. Review of plans of care developed by the facility for Resident 15 revealed no person-centered plan of care addressing the unique factors contributing to his wandering. The clinical record did not include additional interventions implemented to reduce the hazard of Resident 15's wandering that risked his safety should he exit the nursing unit or facility building unattended. Interview with the Nursing Home Administrator, Director of Nursing, and Employee 5 (assistant director of Nursing) on August 21, 2025, at 2:00 PM revealed that the main door to the nursing unit on which Resident 15 resided ([NAME]) on July 5, 2025, was not equipped with door locks/alarms at that time. The facility provided a letter dated August 14, 2025, that the Department approved a special locking arrangement for the [NAME] nursing unit that included keypad access. The interview confirmed that the lobby and facility main exit door was and is not continuously monitored by staff or equipped with door locks/alarms during normal business hours. The surveyor also reported that a sign on the door exiting the [NAME] nursing unit included the five-digit code necessary to exit the unit on this date (any person with the cognitive and physical abilities to read and enter a code could exit the unit without staff knowledge or assistance). Nursing documentation dated July 7, 2025, at 3:07 PM revealed that Resident 15 was wandering without purpose on the unit, and he was in and out of other resident rooms. Nursing documentation dated July 7, 2025, at 8:11 PM revealed that

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on review of facility documentation, and staff interview, it was determined that the facility failed to ensure that nursing staff possessed the appropriate competencies and skill sets related to the care and assessment of residents with indwelling catheters and medication administration for three of four employees reviewed (Employees 4, 11, and 14). Findings include: A review of the facility Resident Matrix (CMS-802, form used to identify pertinent care categories for residents who reside in the facility) documentation revealed that the facility had a total of 15 residents with indwelling urinary catheters within the 100 resident census. A review of sampled residents of the current resident population revealed that the facility had multiple residents that received medications. A request by the surveyor for staff competencies that included indwelling catheter care and medication administration was made for Employee 4 (registered nurse), Employee 11 (licensed practical nurse), and Employee 14 (licensed practical nurse). The facility provided multiple trainings for the above individuals; however, there were no competency evaluations or associated documented competency demonstrations that were noted for indwelling catheter care and medication administration. An interview with Employee 6, registered nurse, on August 22, 2025, at 11:23 AM revealed the facility was unable to produce any documentation that the above employees had completed competency evaluations in the areas requested. The facility failed to ensure staff exhibited the appropriate competencies and skill sets to provide nursing and related services necessary for each resident. 28 Pa Code 201. 20(a)(6)(d) Staff development

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on staff interviews it was determined that the facility failed to have sufficient competent dietary staff to perform essential kitchen duties (Employee 2).Findings include:Observation and interview with Employee 2, dietary aide, on August 19, 2025, at 9:30 AM revealed the employee was washing breakfast dishes and flatware in the dish room area of the main kitchen with an industrial dish washing machine. Upon request of the dish machine temperature log (documentation of machine wash and rinse temperatures to ensure proper sanitization), Employee 2 indicated she was not aware of the temperature log. Employee 2 indicated she had worked at the facility as a dietary aide for one month and was working independently as she had served food on one of the nursing units, washed some items in a dishwasher on the unit, and then came to the main kitchen to wash additional items. Employee 2 then stated another employee who works as a dish washer comes in later in the morning, but she was responsible to get the breakfast dishes/utensils washed before the dish washer comes in. Employee 2 indicated she was not aware the dish machine temperatures needing checked when washing dishes and was not aware of how to do it, record them, or what to do if the machine was not meeting the temperature requirements and was never shown this since being hired. In an interview with Employee 1, dining director, on August 19, 2025, at 3:20 PM Employee 1 indicated there was no evidence to indicate Employee 2 was trained and competent to be performing dishwashing or any essential dietary aide duties on her own since her hire date with the facility on July 22, 2025. Employee 2 indicated there was no evidence in writing that any dining/dietary staff were sufficiently trained and competent to be performing dietary duties. The above information was reviewed with the Nursing Home Administrator on August 20, 2025, at 2:45 PM. 28 Pa. Code 201.18(e)(6) Management.28 Pa. Code 201.20(b) Staff Development.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, it was determined that the facility failed to store and serve food and maintain food service equipment in accordance with professional standards for food service safety in the facility's main kitchen, and two of three open nursing units (Memory Care and Evergreen). Findings include: An observation in the facility's main kitchen on August 19, 2025, with Employee 1, dining director, revealed the following: Tile flooring extending through the corridor to enter the kitchen food preparation and food storage areas and extending in front of the dishwashing area was significantly dull, blackened, and contained dried spills, dirt, and debris, which was also observed in the corners of the doorway entrance to the area. Three hot food mobile carts were observed just inside the kitchen. Employee 1 indicated they were used to transport pans of food to the nursing units for meal service. The interior base of all three was soiled with dried spills and dried food debris. Employee 3, cook, was observed preparing food in the kitchen with a full beard and facial hair, which was not covered. Flooring throughout the main kitchen was sticky to walk on. A significant buildup of dirt and debris was observed under the ice machine, the preparation table beside the ice machine, and extended along the wall with the pipes and where the flooring meets the wall to the storage racks on the same wall. Significant debris was also observed on the floor under the cook and hold unit extending to the fryer area. A foot pedal trash can under the handwashing sink located by the ice machine was significantly blackened and contained dried spills and dried food on the exterior of the can. Two large clear plastic storage containers were observed on the preparation table beside the ice machine with both containing white powder like substances. Neither container had a label identifying the contents, when it was placed in the container, or when it needed used by. Employee 1 indicated one container was sugar and one was flour. Two additional clear plastic containers with white powder-like substances in them were observed sitting next to the griddle/cooktop area neither of which contained a label identifying the contents or when they were placed in the containers or needed used by. Employee 1 indicated one of the containers was salt and the other was thickener. Metal wire shelving units with bowls, platters, and inverted plastic food storage containers stored on the bottom shelves six inches from the floor did not contain any solid barrier to prevent potential contamination from floor debris when sweeping or splash from mopping. Lower shelves of preparation tables located in front of the griddle and cook top areas were soiled with dried food debris, dried spills, and grease drippings. Shelving under the griddle area was soiled with pots and pans stored on the shelves. A stand mixer located on a small table between the preparation tables in front of the griddle/cook top area appeared to have a clean mixing bowl and was not in use. The mixer was upright and not covered to protect the mixing bowl from debris and dust particles. The metal mixer guard was coated in a white powdery substance, which stuck to the metal frame. A dried white liquid substance was observed on the sides of the mixer body and base. Four potholders observed on the preparation table were observed stained, blackened, and with dried food on them. A large gray trash bin was observed uncovered by the soak sink and with dried brown and white liquid down the sides of its exterior. A floor storage riser was observed in the dairy cooler with boxes of gallons of milk stored on it. The riser was covered with black debris, and the grooves on the surface of the riser were filled with clear liquid with particles in it. A food storage rack was observed in the dairy cooler with a full-size hotel pan on it. The pan was not labeled or dated and contained pieces of what appeared to be pieces of breaded fish, although Employee 1 later identified the food as a partially used container of lemon bars. A three-tier black cart was also observed in the dairy cooler, with a large plastic tub of iced tea on the top shelf. The top shelf was covered in a liquid spill. A used and empty metal bowl with a whisk in it was on the second shelf of the cart. A storage shelf in the dairy cooler was observed with a large plastic bin labeled as sweet tea. The bin did not have a lid on it. A lid was observed sitting on a tray near the shelf beside two empty plastic pitchers that were stained brown. Shelving units in the dry storage room with boxes of salt, sugar, sweetener, and lemon juice packets on them were soiled with particles from the packets. A large rectangular clear plastic bin was observed on a bottom shelf in the dry storage room containing a crumb like substance. The bin was not labeled or dated. Employee 1 indicated the bin contained breadcrumbs. Cobwebs were observed hanging from several lower shelves in the dry storage area. Three packages of hot dog rolls and one package of hamburger rolls were observed on a rack in the main kitchen. There was no date to indicate when they were placed there or when they needed used by. Employee 1 indicated the bread comes in frozen and he was aware the bread products needed dated as to

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	395283	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Glen Healthcare and Rehabilitation Center	15 Ridgecrest Circle Lewisburg, PA 17837

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on clinical record review and staff interview, it was determined that the facility failed to maintain clinical records that were complete and accurate for three of 20 residents reviewed (Residents 4, 82, and 105). Findings include: Clinical record review for Resident 4 revealed a care plan that noted the resident has a potential alteration in nutritional status related to the medical history. An intervention included to provide and serve diet and supplements as ordered and monitor intake and record every meal. Further review of Resident 4's care plan revealed the resident has a pressure ulcer and an intervention included to monitor nutritional status. The care plan instructed staff to serve the diet as ordered and monitor intake and record. A review of Resident 4's meal intakes for the last 30 days revealed the following days were not recorded as directed in the resident's care plan:July 26, 2025August 5, 2025August 9, 2025August 15, 2025August 18, 2025 Clinical record review for Resident 82 revealed a care plan that noted the resident has a potential alteration in nutritional status related to the medical history. An intervention included to provide and serve diet and supplements as ordered and monitor intake and record every meal. A review of Resident 4's meal intakes for the last 30 days revealed the following days were not recorded as directed in the resident's care plan: July 26, 2025August 5, 2025August 9, 2025August 15, 2025August 18, 2025 The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on August 21, 2025, at 2:15 PM. A follow-up interview with the Director of Nursing on August 22, 2025, at 12:34 PM confirmed the meals were not documented on the above dates for Resident 4 and 82. Review of the policy titled, Disposal of Medications and Medication-Related Supplies, last reviewed on January 16, 2025, noted that medication destruction occurs only in the presence of at least two licensed healthcare professionals or according to regulations and applicable law. Closed clinical record review revealed nursing documentation for Resident 105 dated August 8, 2025, at 5:02 PM that noted the resident had ceased breathing and heart tones were absent with a time of death of 3:30 PM. Review of the medication disposition for Resident 105 revealed the resident had the following controlled substances prescribed: Lorazepam (a medication used to treat various concerns such as anxiety and agitation) 0.5 milligrams (mg), give half a tablet (0.25 mg) sublingually every four hours as needed for terminal restlessness for 14 days; and morphine (a medication used to treat pain and shortness of breath) 20 milligrams per milliliter (ml), give 0.25 ml (5 mg) sublingually every hour as needed for pain / shortness of breath. Further review of Resident 105's disposition of medication log revealed that 30.5 tablets of lorazepam were marked as destroyed on August 8, 2025, by Employee 11, licensed practical nurse. However, there was no noted witness that attested to the destruction of the medication. The area marked WITNESS was blank. Further review of Resident 105's disposition of medication log revealed that 13 ml of Morphine was marked as destroyed on August 8, 2025, by Employee 11, licensed practical nurse. However, there was no noted witness that attested to the destruction of the medication. The area marked WITNESS was blank. An interview with Employee 5, Assistant Director of Nursing, on August 21, 2025, at 11:10 AM revealed the facility is unable to find any documentation with dual signatures. The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on August 21, 2025, at 2:15 PM. 28 Pa. Code 211.5(f) Medical records 28 Pa. Code 211. 12(d)(1)(3)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on review of select facility policies and procedures, clinical record review, observation, and resident and staff interview, it was determined that the facility failed to ensure an environment free from the potential spread of infection for two of two residents reviewed for antibiotic use (Residents 107 and 111), for three of three residents reviewed for transmission based precautions (Residents 3, 48, and 51), and for the facility's water management program.Findings include: The facility policy entitled, Contact Precautions, effective March 20, 2025, indicated that the purpose of the policy is to use contact precautions for residents known or suspected of having infectious diseases or epidemiologically significant pathogens transmitted by direct resident contact or by contact with items in the resident's environment. Gloves should be worn when entering the room and while providing care for a resident. Gloves should be removed before leaving the resident's room and hand hygiene should be performed immediately. The Contact Precautions sign utilized by the facility noted that, Everyone is required to gown and gloves. Wear a gown and gloves and dispose of them prior to exit. Clinical record review for Resident 107 revealed that the facility admitted him on August 14, 2025. admission physician orders for Resident 107 included the following: Contact Precautions for ESBL (Extended-spectrum beta-lactamases (ESBL) are a type of enzyme or chemical produced by some bacteria. ESBL enzymes make some antibiotics ineffective in treating bacterial infections) every shift until August 18, 2025. Amoxicillin-Pot Clavulanate (Augmentin, a penicillin-type antibiotic that treats bacterial infections) tablet 875-125 mg (milligrams) give one tablet by mouth two times a day for urinary tract infection for four days. Review of a laboratory report for a urine culture and sensitivity collected August 7, 2025 (during Resident 107's hospitalization) revealed that Resident 107's urine was infected with: Greater than 100,000 colonies of Enterococcus species (Enterococcal infections are caused by a group bacteria called enterococci, which normally reside in the intestines of healthy people but sometimes cause infection)Greater than 10,000 to 100,000 colonies of E. Coli ESBL (E. Coli, Escherichia coli, bacterium commonly found in the lower intestine; ESBL-producing E. coli are bacteria that can resist some antibiotics and cause serious infections) The medication sensitivity list on the laboratory report indicated that the medication Augmentin was only noted as susceptible for E. Coli, not the Enterococcus species. Another commonly used antibacterial medication, Macrobid (Nitrofurantoin) was susceptible for both organisms infecting Resident 107's urine. Interview with Employee 6 (registered nurse/infection preventionist) on August 21, 2025, at 3:35 PM revealed that the facility had no evidence that staff reviewed the urinalysis report from the hospital to determine if the bacterial organisms infecting Resident 107's urine was susceptible to the Augmentin antibiotic prescribed in Resident 107's admission physician orders. Employee 6 confirmed that there was no evidence that facility staff confirmed with Resident 107's primary care physician that the Augmentin medication was the preferred treatment for Resident 107's urinary tract infection based on the culture and sensitivity laboratory report. Interview with Resident 111 on August 19, 2025, at 1:53 PM revealed that she contracted a urinary tract infection so severe that it affected her kidneys and was infecting her bloodstream. Resident 111 stated that she was still taking the antibiotic for the infection. Clinical record review for Resident 111 revealed that the facility admitted her on August 16, 2025. An admission physician order dated August 16, 2025, instructed staff to administer Cephalexin (a cephalosporin antibiotic that fights bacteria in your body) 500 mg oral capsule three times a day for Resident 111's urinary tract infection for 10 Days. Review of Resident 111's MAR (Medication Administration Record, electronic documentation of the administration of medications by licensed nursing staff) dated August 2025, revealed that Resident 111 received the Cephalexin medication starting August 16, 2025, at 8:30 PM until discontinued on August 21, 2025, at 10:04 AM. The surveyor requested all urinalysis testing laboratory reports available for Resident 111 to support the use of her antibiotic therapy during an interview with the Nursing Home Administrator, Director of Nursing, and Employee 5 (assistant director of nursing) on August 20, 2025, at 2:15 PM and repeated the request to the Nursing Home Administrator on August 22, 2025, at 9:31 AM. Interview with the Nursing Home Administrator on August 22, 2025, at 11:12 AM confirmed that the facility had no evidence that facility staff obtained pertinent urinalysis testing reports for Resident 111 to support the use of the Cephalexin medication. Clinical record review for Resident 3 revealed that the facility admitted him on July 28, 2025, with diagnoses that included bacteremia (infection detected in the blood) that required contact isolation precautions starting July 28, 2025, and potentially ending August 30, 2025. A care plan initiated by the facility on August 5, 2025, noted that Resident 3 was receiving intravenous medications for MRSA bacteremia (infection of the blood

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of select facility policies, clinical record review, and staff interview it was determined that the facility failed to administer a pneumococcal vaccine to a resident who consented to and was eligible to receive it for one of five residents selected for vaccination review (Resident 53).Findings include: The facility policy entitled, Infection Control - Vaccination Policy, last reviewed January 16, 2025, revealed that the purpose of the policy is to prevent infection and control the potential spread of COVID-19, influenza, and pneumococcal pneumonia through adherence to Centers for Disease Control and Prevention (CDC) vaccination guidelines and recommendations. Each resident is offered immunization unless it is medically contraindicated, or the resident has already received the vaccine. Refer to the CDC guidelines for vaccine type and timing: CDC Pneumococcal Vaccine Timing. CDC Pneumococcal Vaccine Timing for Adults (https://www-new.cdc.gov/pneumococcal/downloads/Vaccine-Timing-Adults-JobAid.pdf) instructs that a complete series would be a PCV13 (Prevnar 13, pneumococcal conjugate vaccine) at any age, a PPSV23 (Pneumovax 23, pneumococcal polysaccharide vaccine) at greater than or equal to 65 years, and together with the resident, vaccine providers may choose to administer PCV20 (Prevnar 20, 20-valent pneumococcal conjugate vaccine) or PCV21 (CAPVAXIVE, 21-valent conjugate vaccine) to adults greater than or equal to [AGE] years old who have already received the PCV13 (but not PCV15, PCV20, or PCV21) at any age and PPSV23 at or after the age of [AGE] years old. The CDC stipulates that, Based on shared clinical decision-making, decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. Clinical record review for Resident 53 revealed that the facility admitted him on April 19, 2022, at age [AGE] years old. Resident 53's immunization history documentation indicated that he received the pneumococcal polysaccharide PPV23 (Pneumovax 23) vaccine before his admission to the facility on December 6, 2007 (when he was [AGE] years old). Resident 53 received the pneumococcal conjugate PCV 13 (Prevnar 13) vaccine before his admission to the facility on March 4, 2016 (when he was [AGE] years old). Resident 53's clinical record contained no evidence that the interdisciplinary team, in coordination with Resident 53 and/or his responsible party, reviewed his condition to decide whether to administer one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose (March 4, 2016). A Resident Vaccination Consent Form signed by Resident 53's responsible party on November 5, 2024, indicated that he consented to pneumococcal vaccinations for Resident 53. Interview with Employee 6 (infection control prevention coordinator) on August 21, 2025, at 3:40 PM confirmed that Resident 53 was not offered a pneumococcal vaccine despite consent to receive and CDC guidance to offer. The surveyor reviewed the above pneumococcal findings for Resident 53 with the Nursing Home Administrator on August 22, 2025, at 9:31 AM. 28 Pa. Code 211.12(d)(1)(5) Nursing services