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	10/30/2024

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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48484 Based on clinical record and hospital record review, policy review, and staff interviews, it was determined that the facility failed to implement treatment and care in accordance with professional standards of practice, which resulted in actual harm, evidenced by a urinary tract infection and septic shock for one of three residents reviewed (Resident 1), and failed to follow physician orders for one of three residents reviewed (Resident 1). Findings include: Review of the facility policy, titled Collecting a Urine Specimen from a Closed Drainage System, read, in part, The purpose of this procedure is to obtain an uncontaminated urine specimen from a resident with a catheter. The policy included steps in the specimen collection procedure to prevent specimen contamination. These steps included Wash your hands thoroughly before beginning the procedure, cleanse the speci-port with the alcohol swab, do not touch the inside of the specimen container, place the lid on the specimen container, do not touch the inside of the lid. Review of facility policy, titled Catheter Care, Urinary, last revised September 2014, read, in part, The purpose of this procedure is to prevent catheter-associated urinary tract infections. The following information should be recorded in the resident's medical record: The date and time that the catheter care was given. The signature and title of the person recording the data. Review of Resident 1's clinical records revealed diagnoses that included history of urinary tract infections (UTI), pressure ulcer of sacral region, stage 4 (wound that occurs when the skin and tissue are damaged by prolonged pressure), hypertension (high blood pressure) and need for assistance with personal care. Resident 1 had an order for a foley catheter (a tube inserted into the bladder to drain urine). Resident 1 also had an order for foley catheter care every shift, with a start date of September 26, 2024. Review of Resident 1's September 2024 and October 2024 TAR (Treatment Administration Record-documentation for treatments/medication administered or monitored), failed to reveal catheter care was completed on September 28, 2024, in the AM; October 3, 2024, in the AM; and October 17, 2024, in the PM. (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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Further review of the clinical record revealed lab results from October 14, 2024, which noted an elevated white blood cell (WBC - blood cells that fight infection) of 18.1 (normal is 4.5-11) Review of Physician orders revealed an order dated October 14, 2024, for Doxycycline Hyclate Tablet (antibiotic) 100 MG. Give one tablet by mouth two times a day for infection for 7 Days, with a start date of October 14, 2024, and discontinued on October 21, 2024. Resident 1's physician orders revealed an order dated October 14, 2024, for a Urinalysis culture and sensitivity (lab test that checks for bacteria in urine and determines what kind of antibiotic can treat it) ordered stat (immediately) related to fever unspecified. Resident 1's clinical record revealed no evidence of a fever. During an interview with the Director of Nursing (DON) on October 29, 2024, at 1:34 PM, she stated that the urine culture was ordered due to the elevated WBC's. Review of the Urinalysis report revealed that the urine specimen wasn't obtained until the following day, despite being ordered stat. Review of Resident 1's October 2024 MAR (Medication Administration Record) revealed her doxycycline antibiotic medication failed to be administered as ordered on October 14, 2024. Review of Resident 1's clinical record revealed a progress note on October 14, 2024, at 8:35 PM, stating the doxycycline was not given because it was not at the facility and unable to be pulled from their back up supply. Interview with the DON on October 29, 2024, at 1:37 PM, revealed their back up stock was out of the doxycycline so they had to wait until it came from pharmacy, and that it should be documented that the provider was notified of the missed dose of the antibiotic. She further revealed that the lab was likely not obtained that afternoon of the 14th because the provider ordered the urinalysis around 2:30 PM, and the last lab pick up of the day is at 3:00 PM and it was about to be nursing shift change. Review of Resident 1's urinalysis lab report revealed the results were available on October 15, 2024, at 9:57 AM, and were positive for bacterial species (infection) but indicated that the sample was likely contaminated, so it was not cultured. The urinalysis was not signed by the physician until October 17, 2024. Review of the clinical record revealed that no additional directions or orders were noted and no new urine sample was obtained. Interview with the DON on October 29, 2024, at 2:01 PM, revealed she would expect a response from the physician regarding the contaminated urine sample as to any new orders or new plan of care. She further revealed the physicians have access to lab reports as soon as they are resulted, and she would expect a timely physician response the same day. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a nursing progress note written by Employee 1 (Registered Nurse) on October 18, 2024 at 5:57 AM, stated that Employee 1 was called to Resident 1's room by the LPN for a change in condition. Upon assessment at 5:30 AM, Resident 1 would not turn head to look at the nurse and would not follow commands to assess neurological status. When her bilateral upper extremities were lifted, they fell to the bed before 5 seconds. Her lower extremities fell immediately. Her blood pressure was 111/64 (normal is 120/80) and her respiratory rate was 30 (normal 12-20). Per LPN, Resident 1 was responding appropriately at 4:15-4:30 AM. Further review of the clinical record revealed that LPN documented that Resident 1 would not take her medication at 1:34 AM. Further review of the nursing progress note dated October 18, 2024 at 5:47 AM, revealed a call was put in to on call provider, waiting to hear back. Nursing progress note written by Employee 1 on October 18, 2024, at 6:01 AM, revealed resident also has had decreased urine output. A follow up nursing progress note written by Employee 1 at 6:17 AM, stated MD called back will be sending resident out to hospital, family notified. Review of Resident 1's hospital records revealed that when she arrived to the ER her blood pressure was 93/63 (normal is 120/80), and heart rate was 110 (normal is 60-11). She was unable to complete words or follow commands. Upon assessment she was noted to appear unwell and toxic, and she was extremely dry. Her Glasgow Coma Scale (GCS) was a 7, which indicated that a severe brain injury and immediate medical attention is required. For this reason, the Resident was intubated (when a tube is inserted into the airway to allow air to flow into their lungs, the tube is connected to a machine that provides oxygen). The ER note stated that IV (intravenous) placement was unsuccessful because the Resident was very dry and her veins were very collapsible. A central line (a long tube inserted into a large vein near the heart) was placed. She was given IV fluids and IV Cefepime (antibiotic) and Vancomycin (antibiotic). The physician ordered labs and a urine analysis and urine cultures. The Resident 1's bloodwork showed a WBC count of 47.9 (counts above 11 are considered to be high and 50 is critical). The Resident had no urine output while in the ER. Her foley catheter was replaced and she had large volume of cloudy urine. Another ER note described her urine as frothy and concentrated. The Resident was admitted to the intensive care unit for septic shock (a widespread infection causing organ failure and dangerously low blood pressure). Further review of hospital records revealed Resident 1's blood cultures and urine culture were positive for Proteus mirabilis bacteremia from a UTI. The Resident was started on cefazolin (antibiotic used to treat serious infections), and was later switched to Zosyn and then to Bactrim (antibiotics). Review of the facility policy, titled Wound Care, read, in part, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. The following information should be recorded in the resident's medical record: The type of wound care given. The signature and title of the person recording the data. Review of Resident 1's physician orders revealed the orders for wet to dry dressings two times a day. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 1's October 2024 TAR (Treatment Administration Record- documentation for treatments/medication administered or monitored), failed to reveal her wound treatments were completed on October 3, 2024, in AM, and October 17, 2024, in PM. Further review of Resident 1's orders revealed an order for Weight on admission and weekly x 4 weeks, every evening shift every Saturday, with a start date of September 26, 2024, and discontinued on October 21, 2024. Review of Resident 1's clinical record failed to reveal weekly weight measures were obtained during the weeks ending October 5 and 12, 2024. Interview with the Nursing Home Administrator (NHA) on October 29, 2024, at 1:07 PM, revealed the facility has identified an issue with weights being obtained per physician order and they are working on this process as an interdisciplinary team. During an interview with the NHA and DON on October 29, 2024, at 2:49 PM, the surveyor revealed the concern with Resident 1's overall quality of care regarding the missing documentation for wound treatments, catheter care, and weights; missed medication without documentation of physician notification; and delay in the physician's response to the urinalysis report. The NHA revealed he is aware of what processes the facility will need to fix in response to the concern. The facility failed to provide care and services to identify and treat a urinary tract infection for Resident 1. This failure resulted in further decline and hospitalization for septic shock. 28 Pa. Code 201.4(a) Responsibility of Licensee 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(d) Pharmacy services 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services