

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/04/2025
NAME OF PROVIDER OR SUPPLIER  Oak Hill Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0600  Level of Harm - Actual harm  Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on facility policy review, clinical record review, review of facility investigation documentation, and staff interviews, it was determined that the facility failed to ensure that residents were free from neglect, which resulted in actual harm as evidenced by bilateral lobe pneumonia with small left-sided effusion (a collection of fluid around the lungs) for one of 10 residents reviewed (Resident 1).</p> <p>Findings include:</p> <p>Review of the current facility policy, titled Pre-Thickened Liquids Policy, read in part, Pre-thickened liquids will be provided at bedside in individual packaged containers per physician orders. Pre-thickened liquids will be offered between meals per physician orders.</p> <p>Review of facility's Guidelines for Volunteers, revealed instructions that the facility volunteers Do not give a resident food or drink, whether or not they ask for something specific, without asking the resident's nurse first.</p> <p>Review of facility policy, titled Abuse and Neglect-Clinical Protocol, dated July 2017, revealed 'Neglect', as defined at §483.5, means 'the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.'</p> <p>Review of Resident 1's clinical record revealed diagnoses that included dysphagia (difficulty swallowing), dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning), and muscle weakness.</p> <p>Review of Resident 1's physician orders revealed an order for Regular diet, Mechanical Soft texture, Nectar Thickened Fluids consistency, with a start date of February 9, 2024.</p> <p>Review of Resident 1's clinical record revealed a nursing note on May 22, 2025, at 2:35 PM, that read [Resident 1] was in activity room and received thin liquids, began coughing. Diet order for nectar thick [liquids]. Nurse Practitioner notified. Activities aware not to let [Resident 1] have thin liquids now.</p> <p>Further review of Resident 1's clinical record revealed that a chest X-ray (CXR) was done on May 23, 2025.</p> <p>(continued on next page)</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 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 1's CXR results revealed bilateral lobe atypical pneumonia (a type of lung infection caused by bacteria that are not typically associated with typical pneumonia) with small left-sided effusion.</p> <p>Review of Resident 1's physician orders revealed an order dated May 23, 2025, for Amoxicillin (antibiotic) 500 mg (milligrams), give one capsule three times a day for infection, for 10 days.</p> <p>Review of facility incident report revealed that On May 22, 2025, at approximately 2:30 PM, while in activities, a volunteer [Employee 1] was offering drinks and [Resident 1] was given a thin liquid drink. [Resident 1] took a sip and began coughing. It was noted the drink was thin liquids and [Resident 1] is nectar thick. The drink was removed, and Registered Nurse and provider were notified. Chest x-ray was ordered. X-ray performed on May 23, 2025, and results received on May 23, 2025, at 12:08 PM and showed bilateral lobe pneumonia with small left-sided effusion. Provider notified at 12:34 PM, and order given for [antibiotic] three times a day for 10 days. Description of follow-up action: Resident placed on alert charting and activities volunteer program suspended pending review. Volunteer no longer allowed in facility due to substantiated neglect.</p> <p>Review of facility investigation revealed that the Nursing Home Administrator (NHA) spoke with Employee 1 on May 23, 2025.</p> <p>Review of the interview revealed [Employee 1] stated that she holds cook club on a monthly basis- She failed to check with the activities team/staff regarding [Resident 1's] liquid status. States she knows he is on thickened liquids and had forgotten to have staff thicken the liquid that was provided to him. Apologized for the error. NHA reiterating that her as well as the entire volunteer program is currently suspended pending review. [Employee 1] understood.</p> <p>Further review of the facility investigation revealed an email correspondence from Employee 1 to the NHA on May 27, 2025, at 4:37 PM that read, in part, On May 22, 2025, at 2:00 PM, I was hosting a cook club. Sometimes I give drinks, and that day I did. I was asked if I gave a drink to [Resident 1] from nursing staff, or physical therapy without thickening it first, I said I did. I said yes, I did that and apologized 15 times.</p> <p>During an interview with the NHA on June 4, 2025, at 9:11 AM, he revealed Employee 1 should not have been handing out beverages to residents, and that the volunteer program is suspended at this time as a result of the substantiated neglect.</p> <p>During a follow-up interview with the NHA on June 4, 2025, at 1:23 PM, he revealed his expectation that volunteers should not pass drinks to residents, physician orders are followed, and diets and fluids are provided at the proper consistency.</p> <p>The facility failed to ensure that Resident 1 was free from neglect when Employee 1 provided a drink to Resident 1, without first asking Resident 1's nurse. Employee 1 provided Resident 1 with the wrong liquid consistency, resulting in Resident 1 experiencing bilateral lobe pneumonia with small left-sided effusion.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management</p> <p>(continued on next page)</p>		

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F 0600  Level of Harm - Actual harm  Residents Affected - Few	28 Pa. Code 201.29(c) Resident rights

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<p>F 0805</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>Based on facility policy review, clinical record review, review of facility incident report, observations, and staff interviews, it was determined that the facility failed to ensure each resident receives, and the facility provides, drinks prepared in a form designed to meet individual needs for two of 10 residents reviewed (Residents 1 and 2), which resulted in actual harm to Resident 1, experiencing bilateral lobe pneumonia (an infection that inflames the lungs' air sacs) with small left-sided effusion (a collection of fluid around the lungs).</p> <p>Findings include:</p> <p>Review of facility policy, titled Pre-Thickened Liquids Policy, read in part, Pre-thickened liquids will be provided at bedside in individual packaged containers per physician orders. Pre-thickened liquids will be offered between meals per physician orders.</p> <p>Review of facility's Guidelines for Volunteers, revealed instructions that the facility volunteers Do not give a resident food or drink, whether or not they ask for something specific, without asking the resident's nurse first.</p> <p>Review of Resident 1's clinical record revealed diagnoses that included dysphagia (difficulty swallowing), dementia (a chronic disorder of the mental processes caused by brain disease, marked by memory disorders, personality changes, and impaired reasoning), and muscle weakness.</p> <p>Review of Resident 1's current physician orders revealed an order for Regular diet Pureed texture, Nectar Thickened Fluids consistency, pureed diet with added gravy, with a start date of June 3, 2025.</p> <p>Further review of Resident 1's physician orders revealed an order for Regular diet, Mechanical Soft texture, Nectar Thickened Fluids consistency, with a start date of February 9, 2024, and an end date of June 3, 2025.</p> <p>Review of Resident 1's clinical record revealed a nursing note on May 22, 2025, at 2:35 PM, that read [Resident 1] was in activity room and received thin liquids, began coughing. Diet order for nectar thick [liquids]. Nurse Practitioner notified. Activities aware not to let [Resident 1] have thin liquids now.</p> <p>Review of select facility incident report provided revealed an email correspondence from Employee 1 (Volunteer) to the Nursing Home Administrator (NHA) on May 27, 2025, at 4:37 PM that read, in part, On May 22, 2025, at 2:00 PM, I was hosting a cook club. Sometimes I give drinks, and that day I did. I was asked if I gave a drink to [Resident 1] from nursing staff, or physical therapy without thickening it first, I said I did. I said yes, I did that and apologized 15 times.</p> <p>(continued on next page)</p>		

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<p>F 0805</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of select facility incident report provided, revealed Factual Description: On May 22, 2025, at approximately 2:30 PM, while in activities, a volunteer was offering drinks and [Resident 1] was given a thin liquid drink. [Resident 1] took a sip and began coughing. It was noted the drink was thin liquids and [Resident 1] is nectar thick. The drink was removed, and Registered Nurse and provider were notified. Chest x-ray was ordered. X-ray performed on May 23, 2025, and results received on May 23, 2025, at 12:08 PM and showed bilateral lobe pneumonia with small left-sided effusion. Provider notified at 12:34 PM, and order given for [antibiotic] three times a day for 10 days. Description of follow-up action: Resident placed on alert charting and activities volunteer program suspended pending review. Volunteer no longer allowed in facility due to substantiated neglect.</p> <p>During an interview with the NHA on June 4, 2025, at 1:23 PM, he revealed his expectation that volunteers should not pass drinks to residents, physician orders are followed, and diets and fluids are provided at the proper consistency.</p> <p>The facility failed to ensure a proper drink texture was provided, resulting in Resident 1 experiencing bilateral lobe pneumonia with small left-sided effusion.</p> <p>Review of Resident 2's clinical record revealed diagnoses that included dysphagia, dementia, and muscle weakness.</p> <p>Review of Resident 2's physician orders revealed a diet order for Regular diet, Pureed texture, Nectar Thickened Fluids consistency, no straws, with a start date of May 28, 2025.</p> <p>Further review of Resident 2's physician orders revealed the fluid texture of her diet order changed from thin liquids to nectar thickened liquids on May 28, 2025.</p> <p>Review of Resident 2's care plan revealed a focus area at risk for nutrition/hydration problems related to dysphagia with interventions for honor food/fluid preferences within diet regimen, and provide, serve diet as ordered.</p> <p>Review of Resident 2's nurse aide tasks revealed a task for fluids offered and that Resident 2 is dependent on staff for eating and drinking.</p> <p>Observation in Resident 2's room on June 4, 2025, at 11:18 AM, revealed she was sleeping in her bed, and she had a Styrofoam cup at her bedside with a straw in the lid.</p> <p>Observation of the Styrofoam cup from Resident 2's bedside, revealed it contained clear thin liquid consistent with plain water.</p> <p>Interview with Employee 4 (Nurse Aide) on June 4, 2025, at 11:18 AM, revealed she passed the water on Resident 2's bedside earlier that day. She further revealed she was unaware that Resident 2 was ordered thickened liquids, as she normally works at night. It was confirmed that Resident 2 is dependent on staff for drinking.</p> <p>Interview with Employee 6 (Speech Language Pathologist) on June 4, 2025, at 11:32 AM, revealed Resident 2 is currently receiving speech therapy services for dysphagia, and she should be receiving nectar thickened liquids per her physician order.</p> <p>(continued on next page)</p>		

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F 0805  Level of Harm - Actual harm  Residents Affected - Few	Interview with the NHA on June 4, 2025, at 1:19 PM, revealed his expectation that physician orders are followed, and diets and fluids are provided to residents at the proper consistency.  28 Pa. Code 201.14(a) Responsibility of licensee  28 Pa. Code 201.18(b)(1) Management  28 Pa. Code 211.10(c) Resident care policies  28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services