

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 08/04/2025
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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on clinical record review and staff interviews, it was determined that the facility failed to provide pharmaceutical services to meet the needs of each resident for one of three residents reviewed (Resident 1). Findings Include: Review of Resident 1's clinical record revealed diagnoses that included type II diabetes mellitus (condition characterized by high blood sugar levels due to insulin resistance and relative lack of insulin production) and muscle weakness (muscles aren't as strong as they should be). Review of Resident 1's June 2025 MAR (Medication Administration Records - forms used to document physician orders as well as when and how medications are administered to a resident) revealed an order for Ozempic subcutaneous solution (medication that mimics a hormone that lowers blood sugar) every Sunday for diabetes mellitus. Further review of the MAR revealed that nursing staff documented 9 other/see note on Sunday June 22, 2025, and Sunday June 29, 2025. Review of Resident 1's progress notes failed to reveal further documentation for the aforementioned dates. Further review of the clinical record revealed no evidence that the Ozempic was administered. An interview with the Director of Nursing on August 4, 2025, at approximately 2:00 PM, revealed that she had called the pharmacy on August 4, 2025, and the Ozempic had never been dispensed to the facility. The DON was unable to provide any additional information. Further review of Resident 1's clinical record failed to reveal documentation that any follow up regarding the facility not receiving the ordered medication had been done or that the physician had been notified the medication was not available. An interview with the Nursing Home Administrator on August 4, 2025, at approximately 2:15 PM, revealed he would expect staff to follow up with the pharmacy and physician when medications are not available. 28 Pa. Code 211.9(a)(1) Pharmacy services 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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