

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 09/11/2025
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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(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	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, it was determined that the facility failed to provide services consistent with professional standards of practice to ensure the resident's highest level of well-being, which resulted in harm as evidenced by a delay in sending the resident to the hospital following confirmation of a femur fracture, and by failure to provide appropriate pain assessment and management for the fracture, for one of three residents reviewed (Resident 1). Findings include: Review of Resident 1's clinical record revealed diagnoses that included Alzheimer's Disease and Dementia (a progressive cognitive and mental decline that is severe enough to interfere with daily life, affecting memory, thinking, language, and judgment). Resident 1 resided on the locked memory care unit at the facility. Review of the clinical record revealed Resident 1 had a fall on August 26, 2025, at 4:45 PM. Resident 1 complained of pain in her right thigh and had an x-ray (an imaging test that uses a small amount of radiation to create images of internal body structures, such as bones, organs, and soft tissues) completed that same day on Resident 1's right hip, which came back negative for a fracture. Resident 1 was ordered Oxycodone hcl oral tablet (narcotic pain medication) 5 milligrams (mg) by mouth every 4 hours as needed for pain. Review of Resident 1's comprehensive care plan revealed a focus area for falls indicating the Resident is at risk for falls related to confusion, is unaware of safety needs, with an initiation and revision date of September 12, 2024, and an intervention to anticipate and meet the Resident's needs, initiated on September 12, 2024. Review of Resident 1's care plan also revealed a focus area that indicated the Resident has a communication problem related to impaired cognitive status, with an intervention to anticipate and meet needs, initiated and revised on August 21, 2025. Review of Resident 1's August 2025 Medication Administration Record (MAR) revealed an order to monitor for pain from a scale of 0-10, every shift. On August 26, 2025, during the night shift, it was documented that Resident 1 had a pain level of 8. On August 27, 2025, at 6:30 AM, Resident 1 was documented as having a pain level of 5. On August 27, 2025, during the night shift, Resident 1 was documented as having a pain level of 4. On August 28, 2025, at 6:30 AM, Resident 1 was documented as having a pain level of 4. From August 1 to August 25, the resident's pain score was zero. Further review of Resident 1's August 2025 MAR revealed an order for oxycodone hcl oral tablet 5 mg - give 5 mg by mouth every 4 hours as needed for pain. On August 27, 2025, at 2:08 AM, the Resident was documented as having a pain level of 8 and was administered the medication as ordered. On August 27, 2025, at 6:58 AM, the Resident was documented as having a pain level of 5 and was administered the medication as ordered. At 12:35PM, the Resident was documented as having a pain level of 6, and was administered the medication. Further review of Resident 1's August 2025 MAR revealed an order for oxycodone hcl oral tablet 5 mg - give 2.5 mg by mouth every 6 hours as needed for pain. On August 27, 2025, at 4:12 PM, the Resident was documented as having a level 8 pain, and was administered the medication as ordered. Review of Resident 1's clinical record revealed a nursing progress note on August 27, 2025, at 2:08 AM, that Resident 1 was yelling and moaning in pain on right hip area, and was administered 5 milligrams of oxycodone oral tablet. Further review of Resident 1's nursing progress notes revealed a note on August 27, 2025, at 6:58 AM, that the Resident was calling out, can't state her pain level, and was administered 5 milligrams of oxycodone oral tablet for pain. Further review of Resident 1's nursing progress notes revealed a note on August 27, 2025, at 12:35 PM, that the Resident was moaning and unable to walk, and received 5 milligrams of oxycodone oral tablet for pain. Review of Resident 1's clinical record revealed a physician note on August 27, 2025, at 4:06 PM, that read, in part, due to ongoing pain and difficulty ambulating, another x-ray will be ordered to check both right and left hip/femur/knee. On August 27, 2025, at 4:12 PM, there was a nursing progress note that Resident 1 was moaning in pain and was administered 5 milligrams of oxycodone oral tablet. At 7:11 PM, on August 27, 2025, a follow up nursing progress note was documented that the Resident still had a pain level of 4. There was no further documentation in Resident 1's clinical record to indicate any pain intervention or assessment was completed. Review of Resident 1's x-ray patient report dated August 27, 2025, at 11:26 PM, revealed the Resident had an acute fracture of the right sub capital femur. Review of Resident 1's clinical record revealed no documentation of the physician being notified of the Resident's fracture. Review of Resident 1's clinical record revealed no physician or nursing progress note after the notification of the fracture. There was no additional PRN (as needed) Oxycodone administered after the dose on August 27, 2025 at 4:12 PM. An interview conducted with the Director of Nursing (DON) on September 8, 2025 at</p>		