STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395428	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Dauphin Nursing and Rehabilitation Center	990 Medical Road Millersburg, PA 17061

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on facility policy review, clinical record review, review of facility investigation, and resident and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards of practice for six of eight residents reviewed (Residents 1, 2, 3, 4, 5, and 6). Findings Include: Review of facility policy, titled Administering Medications, dated April 2019, revealed Medications are administered in a safe and timely manner, and as prescribed. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. Review of facility policy, titled Controlled Substances, dated November 2022, revealed The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976).Review of Resident 1's clinical record revealed diagnoses that included chronic pain syndrome and osteoarthritis of the left hip (a form of arthritis that occurs when the protective cartilage that cushions the ends of the bones wears down over time). Review of Resident 1's physician orders revealed an order, with a start date of December 18, 2024, for oxycodone (narcotic pain medication), 5 mg (milligrams), five times a day, related to the presence of a left artificial hip joint and oxycodone, 10 mg, every morning at 4:00 AM, related to the presence of a left artificial hip joint. Review of a grievance form completed by Resident 1, dated December 8, 2025, revealed that Resident 1 did not receive his 12:00 AM dose of oxycodone. Resident 1 further stated on the grievance that at 3:00 AM, he was provided two white tabs that were look alikes for 5 mg oxycodone, but he stated they had imprints of G 10 on the pills, which he stated were generic Claritin, which is loratadine (non-drowsy allergy medicine). Review of a statement by the ADON (Assistant Director of Nursing), dated December 8, 2025, revealed that on December 8, 2025, at approximately 7:15 AM, she was made aware that Resident 1 reported that he did not receive his scheduled medication at 12:00 AM and his 4:00 AM medication was given at 3:00 AM, however, it was not the medication he is prescribed. Upon further investigation, it was discovered that he received 2 loratadine tablets instead of his scheduled oxycodone.Review of facility reported incident, dated December 8, 2025, revealed that on December 8, 2025, at 7:30 AM, Resident 1 reported that his 4:00 AM dose of oxycodone that he was provided was not oxycodone. Resident 1 saved the two pills he was provided to show as proof, as he firmly believes the two pills were loratadine. Resident 1 also reported that he did not receive his 12:00 AM dose of oxycodone. The facility reported incident further stated that the nurse was identified as Employee 1 (Licensed Practical Nurse [LPN]) and the medication believed to be provided to Resident 1 was over the counter loratadine. Review of the manufacturer package insert for loratadine 10 mg, revealed it is a round, white, 6 mm (millimeter) pill, with an imprint code of G 10. During an interview with Resident 1 on December 22, 2025, at 12:15 PM, he stated that when he asked Employee 1 about not receiving his 12:00 AM dose of oxycodone, she told him that she shook him and called his name, but he wouldn't wake up to take the medication. Resident 1 stated that he is a light sleeper and a light tap would have woken him up. Resident 1 further stated that he used to be a pharmacy technician, so he knew the 4:00 AM dose of oxycodone he was provided was not oxycodone and knew it was loratadine. He stated that he saved the pills as evidence that he was not provided his oxycodone. Review of facility's controlled substance record form (a form used to maintain accurate records of all controlled substances that are being administered), revealed a signature for the nurse dispensing the medication, the date, time and amount dispensed, and the amount of medication remaining. Review of Resident 1's controlled substance record for the oxycodone, 5 mg, one tablet five times a day, revealed Employee 1 signed that the medication was dispensed on December 7, 2025, at 4:00 PM; December 7, 2025, at 8:00 PM; and December 7, 2025, at 12:00 AM.Review of Employee 1's time card report revealed she was not working on December 7, 2025, at 12:00 AM. Review of Resident 1's controlled substance record for the oxycodone, 10 mg at 4:00 AM, revealed Employee 1 signed that the medication was dispensed on December 7, 2025, at 4:00 AM.Review of Employee 1's time card report revealed she was not working on December 7, 2025, at 4:00 AM.Review of a typed statement by Employee 1, undated, in reference to the shift worked on December 7, 2025, 3:00 PM-7:00 AM, revealed At approximately 3:30 AM, I administered [Resident 1] his ordered medication and directly observed him taking it. The statement mentioned nothing about the 12:00 AM dose, in which Resident 1 stated he did not receive. During an interview with the Director of Nursing (DON) on December 22, 2025, at 11:40 AM, she stated that Employee 1 was an agency nurse and the DON notified the agency of