STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395502	A. Building B. Wing	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Heights Village	10 Vo Tech Drive Oil City, PA 16301

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	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Based on review of facility policy, facility documentation, and clinical records, and staff interviews, it was determined that the facility failed to ensure that one resident was free of neglect during care which resulted in actual harm of a laceration to the right forehead and an intraventricular hemorrhage (brain bleed) for one of 11 residents reviewed (Resident R1).Findings include: The Abuse, Neglect, and Exploitation policy, dated 1/14/25, revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . Neglect means 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. Resident R1's clinical record revealed an admission date of 8/18/19, with diagnoses that included Alzheimer's Disease (a progressive disorder that affects memory, thinking, and behavior), Parkinsonism (movement disorder which includes slowness of movement, muscle stiffness, and tremors), and muscle weakness. Resident R1's task order summary (a program used by nursing staff to verify resident bed mobility assist orders) revealed task order reviews dated 10/25/23, 1/16/24, and 7/30/25, all indicating to utilize an assist of two staff for rolling side to side. Resident R1's ADL (Activities of Daily Living) Self Care Performance Deficit care plan, date initiated 11/12/23, revealed, Bed Mobility: The resident is totally dependent on two staff for repositioning and turning in bed. Resident R1's clinical record revealed a nursing note written by Registered Nurse (RN) Employee E2, dated 8/5/25, at 5:56 a.m. CNA (Certified Nursing Assistant) was performing AM care with resident. When resident was rolled, he/she rolled out of bed and struck his/her head on the roommate's bed frame. Resident was assessed. 3 cm (centimeter) x 0.6 cm laceration to right forehead with bruising observed. Wound was cleansed with normal saline, steri-strips (thin adhesive bandages used to close small shallow wounds by sealing the edges of the wound together) were applied with good approximation of skin. Bleeding was controlled. Neuro-checks (assessments completed to check overall brain function) initiated per facility protocol. PCP (Primary Care Provider) and family updated.Resident R1's clinical record revealed a nursing note written by RN Employee E10, dated 8/5/25, at 10:16 a.m. that identified Resident continues to be in a great deal of pain following his/her fall and the injury to his/her forehead. Resident continues to cry in pain. Tylenol administered per order. After assessment of the open area this resident MD (Medical Doctor) contacted, and order received to transfer to hospital for eval and treatment with possible stitches. Residents HOB (head of bed) placed at 30 degrees. Neuro checks continue and are WNL (within normal limits). Family notified. Will continue to monitor.Resident R1's clinical record revealed a nursing note written by Licensed Practical Nurse (LPN) Employee E3, dated 8/5/25, at 2:38 p.m. that included call received from the local hospital's Emergency Department PA-C (Certified Physicians Assistant) stating that resident had a CT scan (Computed Tomography Scan- an imaging test used to see detailed pictures of organs, bones, and body tissues) done of his/her head and that it showed a small hemorrhage. Physicians Assistant stated that normally they would send resident to larger hospital for observation and consult with neurosurgery, but due to CMO (Comfort Measures Only) status residents family does not want him/her sent and that resident would be sent back to facility for us to monitor and keep comfortable as needed. RN phoned and updated on phone call. Resident R1's clinical record revealed CT scan results dated 8/5/25, at 1:50 p.m. indicating acute (new) very low volume bilateral intraventricular hemorrhage. The facility investigation revealed RN Employee E2 emailed the Director of Nursing (DON) a statement on 8/6/25 at 9:30 a.m. indicating he/she was called to the third floor for a resident who had fallen. Once he/she arrived in the room Resident R1 was laying supine in his/her bed with a significant laceration on his/her right forehead. RN Employee E2 asked agency CNA Employee E1 what had happened. Agency CNA Employee E1 stated that he/she was standing between Resident R1's bed and his/her roommates' bed and when agency Employee E1 went to roll Resident R1 towards him/her he/she did not realize how stiff Resident R1 was and Resident R1's torso rolled out of the bed and struck his/her forehead on the bed frame of the roommates' bed. Agency Employee E1 was asked to wait at the nurse's station at that time, and he/she was relieved of his/her duties and left the building. The facility investigation revealed that agency CNA Employee E1 provided a written statement with an incident date of 8/5/25, which revealed, that as he/she was turning Resident R1 his/her head hit the other bed because it was so close, and nobody told him/her that Resident R1 was so stiff. Resident R1 hit his/her head on the edge of the bed and agency Employee E1 called for help. The facility investigation revealed that CNA

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on review of facility policy, facility documentation, and clinical records, and staff interviews, it was determined that the facility failed to provide the required level of assistance with bed mobility (rolling side to side or turning in bed) as identified in the plan of care, task order summary, and in accordance with facility policy which resulted in actual harm of a laceration to the right forehead and an intraventricular hemorrhage (brain bleed) for one of 11 residents reviewed (Resident R1). This deficiency is cited as past non-compliance. Findings include: The Safe Resident Handling/Transfers policy, dated 1/14/25, revealed, It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the resident . Resident R1's clinical record revealed an admission date of 8/18/19, with diagnoses that included Alzheimer's Disease (a progressive disorder that affects memory, thinking, and behavior), Parkinsonism (movement disorder which includes slowness of movement, muscle stiffness, and tremors), and muscle weakness. Resident R1's task order summary (a program used by nursing staff to verify resident bed mobility assist orders) revealed task order reviews dated 10/25/23, 1/16/24, and 7/30/25, all indicating to utilize an assist of two staff for rolling side to side. Resident R1's ADL (Activities of Daily Living) Self Care Performance Deficit care plan, date initiated 11/12/23, revealed, Bed Mobility: The resident is totally dependent on two staff for repositioning and turning in bed. Resident R1's clinical record revealed a nursing note written by Registered Nurse (RN) Employee E2, dated 8/5/25, at 5:56 a.m. CNA (Certified Nursing Assistant) was performing AM care with resident. When resident was rolled, he/she rolled out of bed and struck his/her head on the roommate's bed frame. Resident was assessed. 3 cm (centimeter) x 0.6 cm laceration to right forehead with bruising observed. Wound was cleansed with normal saline, steri-strips (thin adhesive bandages used to close small shallow wounds by sealing the edges of the wound together) were applied with good approximation of skin. Bleeding was controlled. Neuro-checks (assessments completed to check overall brain function) initiated per facility protocol. PCP (Primary Care Provider) and family updated. Resident R1's clinical record revealed a nursing note written by RN Employee E10, dated 8/5/25, at 10:16 a.m. that identified Resident continues to be in a great deal of pain following his/her fall and the injury to his/her forehead. Resident continues to cry in pain. Tylenol administered per order. 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Physicians Assistant stated that normally they would send resident to larger hospital for observation and consult with neurosurgery, but due to CMO (Comfort Measures Only) status residents family does not want him/her sent and that resident would be sent back to facility for us to monitor and keep comfortable as needed. RN phoned and updated on phone call. Resident R1's clinical record revealed CT scan results dated 8/5/25, at 1:50 p.m. indicating acute (new) very low volume bilateral intraventricular hemorrhage. The facility investigation revealed RN Employee E2 emailed the Director of Nursing (DON) a statement on 8/6/25 at 9:30 a.m. indicating he/she was called to the third floor for a resident who had fallen. Once he/she arrived in the room Resident R1 was laying supine in his/her bed with a significant laceration on his/her right forehead. RN Employee E2 asked agency CNA Employee E1 what had happened. Agency CNA Employee E1 stated that he/she was standing between Resident R1's bed and his/her roommates' bed and when agency Employee E1 went to roll Resident R1 towards him/her he/she did not realize how stiff Resident R1 was and Resident R1's torso rolled out of the bed and struck his/her forehead on the bed frame of the roommates' bed. Agency Employee E1 was asked to wait at the nurse's station at that time, and he/she was relieved of his/her duties and left the building. The facility investigation revealed that agency CNA Employee E1 provided a written statement with an incident date of 8/5/25, which revealed, As he/she was turning Resident R1 his/her head hit the other bed because it was so close, and nobody told him/her that Resident R1 was so stiff. Resident R1 hit his/her head on the edge of the bed and agency CNA Employee E1 called for help. The facility investigation revealed that CNA Employee E4 provided a written