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	12/04/2025

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 0684 Level of Harm - Minimal harm or potential for 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 - Minimal harm or potential for actual harm Residents Affected - Few	Based on review of clinical records and facility policy, and staff interviews, it was determined that the facility failed to accurately transcribe a physician's order to promote comfort during care and/or prevent discomfort for one of three residents reviewed (Resident R1). Findings include: Review of facility policy entitled Medication Orders dated 1/14/25, revealed PRN Medication Orders - When recording PRN medication orders, specify. the reason for administration. Review of facility policy entitled Medication and Treatment Orders dated 1/14/25, revealed Orders for medications must include. symptoms for which the medication is prescribed. Review of Resident R1's clinical record revealed an admission date of 5/28/21, with diagnoses that included diabetes (a health condition that is caused by the body's inability to produce enough insulin), dementia (a disease that affects short term memory and the ability to think logically)and hypertension (high blood pressure). Review of hospice physician's order dated 10/12/25, revealed an order to pre-medicate (premed) prior to care with Ativan (anti-anxiety medication) 0.5 mg (milligrams) every 2 hours as needed (PRN) and morphine 10 milligrams (mg) every two hours PRN. Review of facility transcribed physician orders revealed an order dated 10/12/25, transcribed at 2:30 p.m. for Lorazepam (Ativan) 0.5 mg every two hours PRN for premed prior to care. Another order dated 10/10/25, for Morphine 20 mg/ml (milliliter) give 0.5 ml every hour PRN and lacked instructions to premed prior to care as ordered on 10/12/25. Further review revealed a physician's order dated 10/12/25, to reposition Resident R1 every two hours. Review of Resident R1's Medication Administration Record r(MAR) revealed that on 10/12/25, PRN Ativan and PRN Morphine were administered at 4:38 p.m. and no other administration documented after that administration. On 10/13/25, PRN Morphine was administered at 1:53 a.m., 5:30 a.m., 1:15 p.m., 4:54 p.m., 5:22 p.m., then again on 10/14/25, at 9:15 a.m., 11:21 a.m., 2:00 p.m., 3:58 p.m., and 8:00 p.m., then again on 10/15/25 at 12:07 a.m., 4:18 a.m., 11:31 a.m., 2:07 p.m., 6:16 p.m.; the PRN Lorazepam was not administered with PRN morphine as ordered. Further review of Resident R1's MAR revealed that Resident R1 was repositioned on 10/12/25, at 6:00 p.m., 8:00 p.m., and 10:00 p.m., then again on 10/13/25, at 12:00 a.m., 2:00 a.m., 4:00 a.m. , 6:00 a.m., 8:00 a.m., 10:00 a.m., and 12:00 p.m There was no evidence that Resident R1 was premedicated with his/her PRN Lorazepam and PRN Morphine prior to his/her care as ordered. Review of Resident R1's task (charting area where nursing assistants document in the clinical record) revealed that Resident R1 was repositioned on 10/13/25, at 10:00 p.m., then again on 10/14/25, at 12:00 a.m., 4:00 a.m., 6:00 a.m., 10:00 a.m., and 12:00 p.m., There was no evidence that Resident R1 was premedicated with his/her PRN Lorazepam and PRN Morphine prior to his/her care as ordered. Review of Resident R1's nursing progress notes revealed a note dated 10/12/25, at 11:23 p.m., indicating that Resident R1 appears comfortable other than when care is provided. Another nursing progress noted dated 10/13/25, at 5:02 p.m. indicated that Resident R1 had increased moaning and anxiety while repositioning and incontinence care being provided. During an interview on 12/3/25, at 9:55 a.m. the Director of Nursing confirmed that Resident R1's Morphine order lacked instructions to administer with Lorazepam prior to care as ordered. He/she also confirmed that the Morphine order should have been transcribed as it was written by the physician. 28 Pa. Code 211.5(f) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of clinical records and facility policy, and staff interview, it was determined that the facility failed to have complete and accurate documentation regarding oral hygiene for one of three residents reviewed (Resident R1).Findings include: Review of facility policy entitled Mouth Care dated 1/14/25, revealed Documentation -The following information should be recorded in the residents clinical record: The date and time the mouth care was provided. Review of Resident R1's clinical record revealed an admission date of 5/28/21, with diagnoses that included diabetes (a health condition that is caused by the body's inability to produce enough insulin), dementia (a disease that affects short term memory and the ability to think logically) and hypertension (high blood pressure). Review of Resident R1's task (charting area in the clinical record where nursing assistant's document) under section GG oral hygiene every shift revealed that for day shift on 10/1/25, 10/4/25, 10/14/25, there lacked documentation that oral care was completed. On evening shift 10/2/25, 10/11/25, there lacked documentation that oral care was completed and Not Applicable (NA) was marked on 10/5/25, 10/10/25, 10/13/25. On the overnight shift on 10/11/25, there lacked documentation and NA was marked on 10/2/25, 10/3/25, 10/4/25, 10/5/25, 10/6/25, 10/8/25, 10/10/25, 10/12/25, 10/13/25, and 10/14/25 that oral hygiene was completed. During an interview on 12/3/25, at 9:55 a. m. the Director of Nursing (DON) confirmed that Resident R1's clinical record did not have complete documentation regarding oral hygiene. The DON also confirmed that oral hygiene should be done per the order/task and documented in the clinical record. 28 Pa. Code 211.5(f) Medical Records28 Pa. Code 211. 12(d)(1)(5) Nursing Services