

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395564	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2024
NAME OF PROVIDER OR SUPPLIER Oak Ridge Rehabilitation & Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 500 West Hospital Street Taylor, PA 18517	
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 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The resident has the right to receive notices in a format and a language he or she understands.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on a review of clinical records, guidance issued by the Centers for Medicare and Medicaid Services and facility documentation, and staff interview, it was determined that the facility failed to develop and implement policies and procedures designed to protect residents from unacceptable practices of disenrolling residents from their Medicare health plans by ensuring all risks of disenrolling are explained, both verbally and in writing, and the residents are found to be competent to make informed decisions for four of four reviewed disenrolled from Medicare health plans (Resident 11, 16.17, 21).</p> <p>Finding include:</p> <p>A review of a CMS guidance entitled Memo to Long Term Care (LTC) Facilities on Medicare Health Plan Enrollment dated October 2021 revealed that CMS continues to hear reports of the unacceptable practice of nursing facilities or skilled nursing facilities (collectively, long-term care or LTC facilities) disenrolling beneficiaries from Medicare health plans (Medicare Advantage plans with and without Part D, Medicare-Medicaid plans, or Programs of All-Inclusive Care for the Elderly {PACE}) without the beneficiary's or the beneficiary's representative's request, consent, knowledge, and/or complete understanding.</p> <p>CMS guidance noted that Only a Medicare beneficiary, the beneficiary's authorized or designated representative, or the party authorized to act on behalf of the beneficiary under state law can request enrollment in or voluntary disenrollment from a Medicare health or drug plan. Changes in a beneficiary's health care coverage generally must be initiated by the beneficiary or their representative. If a beneficiary or their legal representative requests assistance from the LTC facility in changing the beneficiary's health care coverage, the LTC facility should take the following steps to help ensure changes to a beneficiary's health care coverage comply with regulations regarding enrollment/disenrollment and resident rights:</p> <p>1) Explain orally and in writing the impact to the beneficiary if they change coverage (e.g., to a stand-alone prescription drug plan (PDP) and Original Medicare, or to a different Medicare health plan).</p> <p>(continued on next page)</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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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2) Develop written policies and procedures regarding the process of assisting beneficiaries with changing their health care coverage. At a minimum, information should include the circumstances under which the facility can assist a beneficiary with a plan change. The need to obtain a document signed by the beneficiary or representative that acknowledges that the specific information regarding the impact of a change in coverage was provided to them orally and in writing, and that that the beneficiary and/or the representative understand the information. The need to obtain an attestation signed by the facility staff member that assisted with the change in enrollment, attesting that the beneficiary or representative requested the change and that the beneficiary or representative (as applicable) received and understood the minimum required information listed above. In cases where beneficiaries request disenrollment from PACE, LTC facilities that are contracted with PACE organizations should work directly with the PACE organization and the participant's interdisciplinary team to ensure the PACE participant receives the information required under the PACE regulations and to coordinate the transition of care, including as specified in their contract requirements.</p> <p>If a LTC facility cannot provide documentation of a beneficiary's request to change enrollment, this may suggest that the enrollment action was not initiated by the beneficiary or their legal representative and therefore was not legally valid.</p> <p>Lastly If the facility has the beneficiary sign documentation regarding their understanding of an enrollment change, CMS will expect to find that the beneficiary's assessed cognitive function also supports an ability to understand this type of information. If CMS becomes aware of enrollment actions that the beneficiary alleges were taken without their request, consent, knowledge, and/or complete understanding, CMS will expect the facility to provide the above noted documentation to support that it appropriately assisted the beneficiary with their choice to change coverage, including that the beneficiary's cognitive function supports such decision-making.</p> <p>A review of Resident 11's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included type 2 diabetes and chronic kidney disease.</p> <p>An admission Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated January 3, 2024, revealed that the resident was cognitively intact with a BIMS score of 13 (Brief Interview for Mental Status - a tool to assess cognitive function - a score of 13-15 indicates cognitively intact).</p> <p>Upon admission the resident's primary insurance payer was noted to be United Health Care Medicare Advantage Plan. On January 1, 2024, the resident's primary insurance payer was changed to traditional Medicare.</p> <p>A review of a facility form entitled Medicare Advantage Disenrollment Form dated December 29, 2023, revealed a request to disenroll the resident from the resident's Medicare Advantage plan so that the resident may be covered under original Medicare benefits.</p> <p>A review of Resident 11's clinical record revealed no documented evidence of the date or time the resident initiated the want or desire to disenroll from her Medicare Advantage Plan. Further there was no documentation that the facility had assessed her cognitive abilities and function before explaining and having the resident sign the disenrollment form to identify the resident's ability to understand this type of health insurance information. The resident's cognitive function was not assessed until January 3, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 16's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses which included schizophrenia and cerebral infarction (stroke).</p> <p>A Significant Change Minimum Data Set assessment dated [DATE], revealed that the resident was moderately cognitively impaired with a BIMS score of 10 (Brief Interview for Mental Status - a tool to assess cognitive function - a score of 8-12 indicates moderately cognitively impaired).</p> <p>A review of the resident's primary insurance payer revealed Blue Cross Blue Shield of PA Medicare Advantage Plan was the resident's insurance plan on October 13, 2023. On January 1, 2024, the resident's Medicare Advantage plan was changed to traditional Medicare.</p> <p>A review of a facility form entitled Medicare Advantage Disenrollment Form dated December 29, 2023, revealed a request to disenroll the resident from the resident's Medicare Advantage plan so that the resident may be covered under original Medicare benefits. The form was sign by the resident despite the resident being assessed as moderately cognitively impaired.</p> <p>A review of Resident 16's clinical record revealed no documented evidence of the date or time the resident, or his health care decision maker listed in his clinical record as his daughter, initiated their wish or desire to disenroll from his Medicare Advantage Plan. The resident was moderately cognitively impaired at the time of the disenrollment and there was no documentation that the resident's health care decision maker, his daughter, was made aware of this disenrollment and been provided, in writing an explanation of the risks of disenrollment and agreed to the change in the resident's Medicare health plan.</p> <p>A review of Resident 17's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses which included a history of traumatic brain injury and hypertension (high blood pressure).</p> <p>A Significant Change Minimum Data Set assessment dated [DATE], revealed that the resident was cognitively intact with a BIMS score of 15.</p> <p>A review of the resident's primary insurance payer revealed [NAME] Quality Options Medicare Advantage Plan was the resident's insurance plan on December 5, 2023. On January 1, 2024, the resident's Medicare Advantage plan was changed to traditional Medicare.</p> <p>A review of a facility form entitled Medicare Advantage Disenrollment Form dated December 29, 2023, revealed a request to disenroll the resident from the resident's Medicare Advantage plan so that the resident may be covered under original Medicare benefits.</p> <p>A review of Resident 17's clinical record revealed no documented evidence of the date or time the resident initiated a request, wish or desire to disenroll from his Medicare Advantage Plan.</p> <p>A review of Resident 21's clinical record was admitted to the facility on [DATE], with diagnoses which included dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain).</p> <p>(continued on next page)</p>		

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<p>F 0574</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A Quarterly Minimum Data Set assessment dated [DATE], revealed that the resident was moderately cognitively impaired with a BIMS score of 11.</p> <p>A review of the resident's insurance payer revealed Humana Medicare Advantage Plan. On February 1, 2024, the resident's Medicare Advantage plan was changed to traditional Medicare.</p> <p>A review of a facility form entitled Medicare Advantage Disenrollment Form dated January 31, 2024, revealed a request to disenroll the resident from the resident's Medicare Advantage plan so that the resident may be covered under original Medicare benefits. The form was sign by the resident despite being moderately cognitively disabled.</p> <p>A review of Resident 21's clinical record revealed no documented evidence of the date or time the resident, or his responsible party listed in his clinical record, as his daughter, initiated the request, wish or desire, to disenroll from his Medicare Advantage Plan.</p> <p>The resident was assessed as moderately cognitively impaired on November 8, 2023, and there was no documented evidence that the facility had assessed his current cognitive function before having the resident sign the disenrollment form to accurately identify the resident's ability to understand this type of information. The resident was moderately cognitively impaired and there was no documentation that the resident's responsible party was made aware of this disenrollment and was explained the risks of disenrollment and agreed to the change in the resident's Medicare plan.</p> <p>An interview with Employee 2, Business Office Manager, on February 27, 2024, at 10:50 AM revealed that she, the Admissions Director, and the Nursing Home Administrator go around to the residents to discuss their Medicare Advantage Plans and tell them that straight Medicare might cover more therapy if they shall need it and ask the residents if they would like to change their Medicare Advantage Plan. When asked why the facility was initiating these changes, and asking residents if they would like to switch, Employee 2 stated that Managed Medicare Plans make the determination on what the resident may receive under their coverage. Employee 2 stated she only deals with switching plans for long term residents and the Admission Director and Nursing Home Administrator (NHA) oversee talking with short term residents about changing their Medicare health plans.</p> <p>An interview with Employee 3, Admission Director, and the Nursing Home Administrator on February 27, 2024, at 10:55 AM revealed Employee 3 stated she has never asked any resident to switch their insurance plan, but the Nursing Home Administrator verified that she does go around to the short term residents to discuss their Medicare Advantage Plans. When asked why she was approaching residents about changing their Medicare Advantage Plans, the NHA stated to keep them informed of their options.</p> <p>A telephone interview was conducted with the Director of Nursing on February 29, 2024, at 3:15 PM, verified that that facility did not have any policies or procedures in place that outline the process of assisting beneficiaries and their representatives with changing their Medicare health plans. She confirmed the facility failed to assure a current assessment of the residents' cognitive abilities prior to asking the residents to sign the document to disenroll to ensure the residents were fully capable of making an informed decision, and possessed the functional abilities to understand the potential implications of disenrolling from their Medicare Advantage plans. The DON also verified that the facility did not contact the representatives of Residents 16 and 21, who were assessed as cognitively impaired.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277</p> <p>Based on a review of facility's abuse policy, clinical records, and select reports and staff interviews it was determined that the facility failed to assure that one resident (Resident 18) out of four sampled was free from sexual abuse perpetrated by another resident (Resident 19).</p> <p>Findings included:</p> <p>A review of the current facility policy titled Abuse Policy, provided by the facility during the survey of February 27, 2024, revealed it is the policy of the facility that the residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. Sexual abuse is defined as non-consensual, sexual harassment, sexual coercion, contact or sexual assault. Residents have the right to engage in consensual sexual activity. However, anytime the facility has reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility must take steps to ensure that the resident is protected from abuse. These steps should include evaluating whether the resident has the capacity to consent to sexual activity. As part of the resident abuse prevention program, the administration will protect the residents from abuse by anyone including, but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual.</p> <p>The current policy titled Identifying Sexual Abuse and Capacity to Consent provided by the facility during the survey of February 27, 2024, revealed that sexual contact is non-consensual if the resident appears to want the contact to occur, but lacks the cognitive ability to consent.</p> <p>A review of Resident 19's clinical record revealed admission to the facility on [DATE], with diagnoses to include Parkinsonism (conditions that cause slowed movements, stiffness and tremors), dementia, adult failure to thrive (a syndrome of decline in older adults that affects their physical, mental, and social well-being), anxiety and depression.</p> <p>An admission Minimum Data Set assessment (a federally mandated standardized assessment completed periodically to plan resident care) dated December 25, 2023, indicated that the resident was severely cognitively impaired with a BIMS (brief interview to assess cognitive status) score of 5 (0-7 represents severe cognitive impairment).</p> <p>A review of a nursing documentation dated January 17, 2024, at 3:48 PM revealed Resident 19 was walking in the hallway holding hands and kissing a cognitively impaired female resident. Resident 19 became verbally aggressive when staff redirected him away from the other resident.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 19's current care plan dated December 18, 2023, and revised January 1, 2024, revealed that the resident had the potential for complications with psychiatric/mood status due to dementia. Interventions planned were to encourage the resident to stay in the dayroom for increased supervision, administer medications as prescribed, encourage resident to ask questions, talk calmly when agitated, offer choices, and provide a calm, safe environment when he is emotional or frustrated. The resident's care plan did not identify any sexual behaviors, or physical affection towards other residents, that the resident exhibited, and the interventions designed to address those behaviors as observed on January 17, 2024.</p> <p>A review of a nursing documentation dated February 14, 2024, at 3:10 PM revealed that a nurse aide alerted the nurse that Resident 19 and a female resident. Resident 18, were sitting side by side on Resident 19's bed, fully clothed, and engaged in a kiss. The nurse aide separated both residents. No signs or symptoms of anxiety or agitation were noted before or after the incident. The residents were pleasant and cooperative with all care. Both residents were placed on 15-minute checks.</p> <p>A review of Resident 18's clinical record revealed that the resident was severely cognitively impaired with a BIMS score of 6. Resident 18 did not possess the mental capacity to consent to sexual contact and activity.</p> <p>Review of a Pennsylvania Dept of Aging/Dept of Human Services Mandatory Abuse Report dated February 14, 2024, at 11:00 (no AM or PM indicated) indicated that the abuse type was sexual abuse, and noted that Employee 4 (nurse aide) was making her rounds on the unit and saw Resident 18 (a female resident with severe cognitive impairment) in Resident 19's room, sitting on the side of the bed next to each other. Resident 19 kissed Resident 18. Both residents were fully clothed, and there no signs or symptoms (s/s) of being unwanted. Neither resident experiencing signs or symptoms of distress at the time when observed or after the incident. No otherwise inappropriate/intimate physical contact or interaction of sexual nature occurring. Employee 4 separated both residents safely and both were cooperative with staff. Physician, Responsible Party, Area Agency on Aging, and Police notified. Intervention was to place both residents on 15-minute checks, Social Services supportive visits to ensure no negative effects, and to interview all capable residents in the facility to rule out unwanted advanced from related peers.</p> <p>The Nursing Home Administrator (NHA) confirmed during an interview on February 27, 2024, at approximately 1:20 PM, that Resident 18 (the victim) was severely cognitively impaired and did not possess the cognitive ability to consent to sexual activity. She confirmed that the facility substantiated the resident abuse of Resident 18 and verified that the facility failed to ensure that Resident 18 was free from sexual harrassment perpetrated by Resident 19.</p> <p>Refer F744</p> <p>28 Pa. Code 201.29 (a)(c) Resident rights</p> <p>28 Pa. Code 201.18 (e)(1) Management</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from medications that restrain them, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277</p> <p>Based on review of clinical records and staff interview it was determined that the facility failed to ensure that one resident out of 21 sampled was free of chemical restraints used to most readily control the resident's behavior and not required to treat the resident's medical symptoms (Resident 19).</p> <p>Findings include:</p> <p>A review of Resident 19's clinical record revealed admission to the facility on [DATE], with diagnoses to include Parkinsonism (brain conditions that cause slowed movements, stiffness and tremors), dementia with behavioral disturbances (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change) and adult failure to thrive (a syndrome of decline in older adults that affects their physical, mental, and social well-being).</p> <p>An admission Minimum Data Set assessment (a federally mandated standardized assessment completed periodically to plan resident care) dated December 25, 2023, indicated that the resident was severely cognitively impaired with a BIMS (brief interview to assess cognitive status) score of 5 (0-7 represents severe cognitive impairment).</p> <p>A review of the resident's clinical record revealed that the resident was prescribed Quetiapine Fumarate 25 mg (Seroquel, an antipsychotic drug used to treat certain mental/mood disorders, such as schizophrenia, bipolar disorder, sudden episodes of mania or depression associated with bipolar disorder) on December 18, 2023.</p> <p>A nursing note dated January 17, 2024, at 3:48 PM revealed that staff observed Resident 19 was walking in the hallway holding hands and kissing a female resident. Resident 19 became verbally aggressive when staff redirected him away from the female resident. The CRNP (certified registered nurse practitioner) from supportive care saw the resident and a new order to increase Resident 19's dose of Seroquel (Quetiapine Fumarate) from 25 mg to 75 mg was discussed.</p> <p>In response to nursing's notification of the physician regarding the above incident, a physician order was received January 18, 2024, at 9:00 PM for Quetiapine Fumarate (Seroquel, a psychotropic medication) 75 mg by mouth daily at bedtime for diagnosis of dementia.</p> <p>At the time of the survey ending February 27, 2024, the facility failed to provide physician documentation of the clinical rationale for increasing the dosage of the antipsychotic drug, Seroquel, from 25 mg to 75 mg following Resident 19's behavior of becoming verbally aggressive when staff redirected him away from the female resident on on January 17, 2024.</p> <p>The facility failed to show evidence that a less restrictive alternative treatment was attempted based on an appropriate assessment, care planning by the interdisciplinary team, and physician documentation of the medical symptoms.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The resident's clinical record failed to contain evidence that the facility staff and/or physician had identified, to the extent possible, and addressed the potential underlying causes of Resident 19's behavior such as environmental factors, such as over stimulation.</p> <p>During an interview with the Director of Nursing (DON) on February 27, 2024, at 1:50 PM, the DON confirmed that the facility failed to provide documented evidence that the antipsychotic drug was not increased to most readily control the resident's behavior following the incident on January 17, 2024, and failed to provide physician documentation that the antipsychotic drug was required to treat the resident's medical symptoms.</p> <p>Refer F600</p> <p>28 Pa. Code 211.8 (c.1)(1)(e) Use of Restraints.</p> <p>28 Pa. Code 211.5 (f) Medical records</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581</p> <p>Based on a review of clinical records and select reports, observations, and staff interview, it was determined that the facility failed to develop and implement individualized plans to manage residents' dementia related behavioral symptoms to promote resident safety and the residents' highest practicable physical and mental well-being for two residents (Resident 14 and 19) out of 21 sampled.</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident 14 was admitted to the facility on [DATE], with a diagnoses of dementia (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability), behavioral disturbance (globally described as agitation, wandering, and hoarding), unsteadiness on feet and lack of coordination (refers to abnormal motor planning and execution, disturbed negotiation with obstacles or the environment), and had a history of falls.</p> <p>A quarterly Minimum Data Set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated January 31, 2024, revealed that the resident was severely cognitively impaired.</p> <p>A review of the resident's current care plan dated November 1, 2023, for the problem of impaired cognition revealed interventions in place to provide the resident with simple activities and provide one-to-one sessions. The resident's plan of care for activities revealed planned interventions to provide the resident with activities such as music and crime television shows, reminisce about memories, offer outside activity weather permitting, offer pet visits especially with dogs and polish her nails. Also, the care plan noted for staff to offer one-to-one activity as needed.</p> <p>A review of progress notes dated January 16, 2024, at 7:30 PM revealed that the resident was witnessed pushing the dayroom doors closed, which caused minor bruising to her finger, which was between the door frame and the door. The facility noted that the resident had poor safety awareness.</p> <p>A review of a facility incident report dated February 5, 2024, at 6:37 AM revealed that staff were called into another resident's room and upon entering, found Resident 14 positioned against the wall in an upward position. The resident hit her head on the wall. The resident was unable to give a description of what occurred. Witness statements revealed that another resident, residing in that room, grabbed Resident 14's wrists to guide her out of her room into which she had wandered. At that time, Resident 14 was guided back and fell. The immediate actions that were implemented was to assess the resident and place a stop sign to the doorway to prevent Resident 14 from entering other residents' rooms.</p> <p>A facility incident report dated February 5, 2024, at 12:00 PM indicated, that the resident had an unwitnessed fall and was found on the floor in front of another resident's Geri chair on her buttocks without any injuries. The immediate action taken was to initiate 15-minute safety checks of Resident 14. The resident immediately started ambulating without difficulty after three staff assisted her from the floor. The possible contributing factor to this fall was noted as dementia.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a facility incident report dated February 13, 2024, at 10:45 AM indicated, that the resident had a witnessed fall in the dayroom. Staff observed the resident attempting to sit on a chair and she missed the seat, landing on her buttocks. A medication review and adjustment would be conducted in response, no injuries were noted and neurological checks were within normal limits. Resident 14 remained on 15-minute safety checks at this time.</p> <p>A review of Resident 14's current care plan dated February 13, 2024, identified that the resident wanders into other residents' rooms and with planned interventions to utilize distractions to help decrease wandering such as watching a crime show, music, and search word puzzles.</p> <p>A review of the resident's current care plan that was dated on February 13, 2024, with revision on February 16, 2024, identified that the resident has wandering/pacing behavior and noted interventions were to attempt to minimize excess stimulation, provide redirection and encourage rest periods by sitting with the patient and encouraging to drink fluids.</p> <p>A review of a facility incident report dated February 16, 2024, at 8:30 AM indicated, that Resident 14 had another unwitnessed fall in the dayroom and was found on the floor (prior unwitnessed fall in the dayroom, was 3 days earlier on 2/13/24). The predisposing factors noted that led to this fall were related to the resident's impaired memory, confusion, and wanderering. The resident remained on 15-minute safety checks at this time, which proved ineffective in preventing the two unwitnessed falls in the dayroom.</p> <p>There was no evidence of the implementation of the diversional activities, noted in the resident's care plan, to distract this resident while the resident was in the dayroom.</p> <p>A review of a facility incident report dated February 17, 2024, at 3:40 AM indicated that the resident had an unwitnessed fall in her bedroom. Staff found the resident on the floor with a laceration measuring 3.0 cm x 0.1 cm x 0.1 cm above her right eyebrow and a bruise to the top of right shoulder measuring 3.0 cm x 3.0 cm. The resident was bleeding and pressure was applied to the site. The resident was wearing non-skid socks and the call bell was not activated. The resident required assistance from a mechanical lift to transfer from the floor. The resident was transported to the hospital for evaluation. Witness statements revealed that the resident was last seen at 3:30 AM in bed. The resident was found on the floor at 3:38 AM after an alarm sounded.</p> <p>The resident received four sutures above her right eyebrow and a computed tomography (CT) scan of the head (diagnostic imaging procedure used to produce images inside the body) revealing no intracranial bleeding or fractures. She returned to the facility at 11:45 AM. 15-minute safety checks continued at this time, despite the ineffectiveness in preventing repeated falls which were attributed to the resident's dementia related behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a facility incident report dated February 19, 2024, at 7:00 AM indicated that staff found the resident lying on the floor in the hall in front of another resident's room without injury. The immediate action taken was to place the resident on one-to-one supervision until an audit of all alarms were performed to ensure function and education would be provided to staff related to the resident's doors be kept open. A predisposing factor related to this fall was noted that the resident was incontinent and ambulating without assistance. A witness statement revealed that staff observed Resident 14 ambulating out of her room going into another room. The staff attempted to reach her before the resident tripped over a blanket and fell . The bed alarm was not sounding. The staff member stated that the bed alarm was checked and is functioning.</p> <p>A review of progress notes dated February 21, 2024, at 1:30 PM revealed that the resident exhibits poor impulse control but is easily redirectable. The resident has the impulse to walk continuously but exhibits periods where she will sit in inappropriate places. The resident is an assist of two staff for transferring and utilizes a wheelchair. Resident was placed on one-to-one safety supervision and provided a stuffed bunny for redirection, distraction, and comfort to remain seated. The resident will be encouraged to remain in the dayroom while awake for engagement and supervision. The facility decreased the resident's level of supervision to 15-minute safety check supervision at this time and while awake will be offered walks during periods of increased anxiety or restlessness.</p> <p>Observations On February 27, 2024, at approximately 1:06 PM revealed Resident 14 was seated in a wheelchair in the dayroom at a table by herself. The resident appeared confused and was unable to communicate with the surveyor. The resident had a stuffed bunny sitting on the table in front of her. The resident was not provided any other diversional activities as outlined in the resident's dementia care plan at the time of the observation.</p> <p>An interview with Employee 1 CNA (certified nurse aide) verified that individualized diversional activities were not provided to Resident 14 as care planned. Employee 1 stated that prior to Resident 14 receiving her stuffed bunny a few days ago there was nothing specific staff would with her. Employee 1 stated that the resident likes to walk around mostly in the dayroom, that she never sat down, she was constantly moving around but that direct care staff did not use specific interventions to redirect the resident or for diversional activities.</p> <p>There was no documented evidence at the time of the survey ending February 27, 2024, to demonstrate that facility staff had implemented the specific interventions planned for diversional activities as outlined in her plan of care to manage the resident's dementia related behavioral symptoms.</p> <p>A review of Resident 19's clinical record revealed admission to the facility on [DATE], with diagnoses to include Parkinsonism (a term that refers to brain conditions that cause slowed movements, stiffness and tremors), dementia with behavioral disturbances and adult failure to thrive (a syndrome of decline in older adults that affects their physical, mental, and social well-being).</p> <p>An admission Minimum Data Set assessment dated [DATE], indicated that the resident was severely cognitively impaired with a BIMS (brief interview to assess cognitive status) score of 5 (0-7 represents severe cognitive impairment).</p> <p>A review of a nursing note dated December 22, 2023, at 6:49 PM revealed that Resident 19 was continuously going in and out of everyone's room, rooting through other residents belongings.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a nursing note dated January 17, 2024, at 3:48 PM revealed Resident 19 was walking in the hallway holding hands and kissing a female resident. Resident 19 became verbally aggressive when redirected away from the other resident.</p> <p>Review of a nursing note dated February 14, 2024, at 3:10 PM revealed that a nurse aide alerted the nurse that Resident 19 and a female resident, Resident 18, were sitting side by side on Resident 19's bed, fully clothed, and engaged in a kiss. Nurse aide separated both residents. No signs or symptoms of anxiety or agitation were noted before or after the incident. Resident pleasant and cooperative with all care. Residents were placed on 15-minute checks.</p> <p>Review of the Pennsylvania Dept of Aging/Dept of Human Services Mandatory Abuse Report dated February 14, 2024, at 11:00 (no AM or PM indicated) indicated that the abuse type was sexual abuse and revealed that Employee 4 (nurse aide) was making her rounds on the unit and saw Resident 18, a female resident with severe cognitive impairment, in Resident 19's room, sitting on the side of the bed next to each other. Resident 19 kissed Resident 18. Both residents were noted to be fully clothed, occurrence noted with no signs or symptoms (s/s) of being unwanted. Neither resident experiencing s/s of distress at the time when observed or after the incident. No otherwise inappropriate/intimate physical contact or interaction of sexual nature occurring. Employee 4 separated both residents safely and both were cooperative with staff. Physician, Responsible Party, Area Agency on Aging, and Police notified. Intervention was to place both residents on 15-minute checks, Social Services supportive visits to ensure no negative effects, and to interview all capable residents in the facility to rule out unwanted advanced from related peers.</p> <p>Resident 19's current care plan, in effect at the time of the survey ending February 27, 2024, included a focus area of the potential for complications with psychiatric/mood status due to dementia. Interventions planned were to encourage the resident to stay in the dayroom for increased supervision, administer medications as prescribed, encourage resident to ask questions, talk calmly when agitated, offer choices, and provide a calm, safe environment when he is emotional or frustrated.</p> <p>The resident's care plan related to dementia did not identify the specific behaviors of intrusive wandering and the sexual behaviors that the resident exhibited, and the interventions designed for staff to employ in response to those behaviors.</p> <p>The facility failed to develop and implement an individualized person-centered interdisciplinary plan to address, modify and manage this resident's dementia-related behaviors.</p> <p>An interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON) on February 27, 2024, at approximately 2:35 PM confirmed that the facility failed to demonstrate timely and consistent implementation of interdisciplinary person-centered individualized dementia care plans to address the residents' ongoing behaviors and multi-disciplinary development and implementation individualized person-centered plans to address dementia-related behaviors.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services</p> <p>28 Pa. Code 201.18 (e)(1) Management</p> <p>28 Pa. Code 201.29 (a) Resident rights</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>41581</p> <p>Based on review of the facility's plan of correction from the survey of January 25, 2024, and the findings of the survey ending February 27, 2024, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies related to abuse and dementia care and to ensure that plans designed to improve the delivery of care and services were consistently implemented to effectively deter future quality deficiencies.</p> <p>Findings include:</p> <p>A review of the facility's plan of correction for the deficiencies cited under abuse and dementia care during the survey ending January 25, 2024, revealed the facility developed a plan of correction that included quality assurance monitoring systems to ensure that solutions were sustained, which were to be functional by December 12, 2024. The results of the current survey ending February 27, 2024, identified repeat quality deficiencies in prevention of resident abuse and dementia care.</p> <p>In response to the deficiency cited related to resident abuse during the survey of January 25, 2024, the facility's plan of correction revealed that the NHA (nursing home administrator) or designee educated all facility staff on caring for individuals with dementia and managing difficult behaviors including preventing escalation in behaviors with managing external stimuli and promoting appropriate environment, as well as early identification of escalation of behaviors and appropriate interventions to prevent resident to resident altercations. Further it was indicated The DON (director of nursing), or designee will audit progress notes 5 days per week for 4 weeks, then monthly for 2 months to residents exhibiting signs and symptoms of escalation of behaviors had appropriate steps taken to ensure appropriate environment and interventions attempted.</p> <p>However, at the time of the revisit survey ending February 27, 2024, review of clinical records revealed on January 17, 2024, at 3:48 PM Resident 19 was walking in the hallway holding hands and kissing a cognitively impaired female resident. Resident 19 became verbally aggressive when redirected. Resident 19 was again found kissing Resident 18, a severely cognitively impaired female resident, on February 14, 2024. The facility failed to revise Resident 19's care plan to address this type of behavior to protect other residents in the facility from sexual abuse and harrassment.</p> <p>In response to the deficiency cited related to dementia care during the survey of January 25, 2024, the facility's plan of correction revealed that the plan indicated that the NHA or designee educated all facility staff on caring for individuals with dementia and managing difficult behaviors including preventing escalation in behaviors with managing external stimuli and promoting appropriate environment, as well as early identification of escalation of behaviors and appropriate, personalized interventions to prevent resident to resident altercations. Further it was indicated The NHA, or designee will audit front line behavior management meeting minutes to ensure it is taking place and residents with challenging dementia related behavioral/mood issues are discussed as well as person centered approaches weekly for 4 weeks, then monthly for 2 months.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>However, at the time of the revisit survey ending February 27, 2024, review of clinical records revealed Resident 14 had six falls in the month of February 2024 related to her dementia related behaviors. The facility failed to implement individualized interdisciplinary plans designed to manage resident's dementia related behavioral symptoms to promote resident safety. Further review of clinical records revealed on January 17, 2024, at 3:48 PM Resident 19 was walking in the hallway holding hands and kissing a cognitively impaired female resident. Resident 19 became verbally aggressive when redirected. Resident 19 was again found kissing a female cognitively impaired resident, Resident 18, on February 14, 2024. The facility failed to identify, develop, and implement an individualized person-centered plan to address the resident's dementia-related behavioral symptoms.</p> <p>The facility's QAPI committee failed to identify these ongoing quality deficiencies and failed to develop plans of actions to sustain correction of these quality deficiencies.</p> <p>Refer F600 and F744</p> <p>28 Pa. Code 211.12(c) Nursing services</p> <p>28 Pa. Code 201.18(e)(1) Management.</p>		