| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395564 | A. Building<br>B. Wing | 09/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Oak Ridge Rehabilitation & Healthcare Center | 500 West Hospital Street<br>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) |
|---|---|
| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>(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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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policy, investigative documentation, and staff interviews, it was determined the facility failed to thoroughly investigate an incident involving a resident being left unattended while at an outside medical appointment to determine whether neglect occurred for one of 22 sampled residents (Resident 1).Findings include: A review of the facility policy titled Abuse Policy last reviewed by the facility on April 8, 2025, revealed it is the facility's policy that residents have the right to be free from abuse and neglect. The policy indicated it is the expectation that any allegation of abuse or neglect is to be reported to the Nursing Home Administrator and other officials. The policy further indicates that an investigation into the allegation will be initiated immediately and include complete statements and interviews from staff and residents involved in the allegation within time frames required by federal regulations. A review of Resident 1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including dementia (conditions that cause a decline in cognitive abilities, such as memory, thinking, reasoning, and problem-solving, severe enough to interfere with daily life, and heart failure (a condition in which the heart does not pump blood effectively, leading to fatigue and difficulty with daily activities). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 22, 2025, revealed that Resident 1 had severely impaired cognition with a BIMS score of 4 (Brief Interview for Mental Status-a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; (a score of 0-7 indicates severe cognitive impairment). A review of the resident's comprehensive person-centered care plan initiated on August 25, 2025, revealed Resident 1 was identified as at risk for elopement (leaving the facility without staff awareness or supervision). The care plan directed that Resident 1 would not leave the facility unattended. An interview with Employee 1NA (Nurse Aide) conducted September 24,2025, at 9:39AM, revealed on September 12, 2025, revealed that on September 12, 2025, she accompanied Resident 1 to an outside cardiology appointment. Employee 1 stated that after the appointment, she wheeled the resident to a lobby area, closed the door, and went to use the restroom, leaving the resident unattended. Employee 1 stated that when she exited the restroom, Resident 1 was no longer in the lobby. She reported she then ran outside and observed Resident 1 with a [NAME] driver, who was questioning the resident about where her caregiver was. The interview further revealed that upon return to the facility, Employee 1 verbally reported the incident to Employee 2, an LPN (licensed practical nurse). Employee 1 stated that Employee 2 provided her education not to leave residents who were identified as elopement risks unattended at any time. An interview with Employee 2, conducted on September 24, 2025, at 9:58 AM, confirmed that Employee 1 NA reported the incident. Employee 2 LPN stated she verbally educated Employee 1NA and wrote a witness statement, which she provided to Employee 3, an RN (registered nurse) Supervisor. Employee 2 LPN stated she followed her chain of command. An interview with Employee 3, RN Supervisor, conducted on September 24, 2025, at 10:35 AM, confirmed she was the RN Supervisor on duty on September 12, 2025. Employee 3 stated she was told about the incident by Employee 4, the transportation driver, later that evening at the end of her working shift around 7:00PM). Employee 3 stated she believed the information was a rumor and did not report it to the Nursing Home Administrator (NHA) or the Director of Nursing (DON). Employee 3 further stated she was not directly informed by Employee 2 about the incident. An interview with Employee 4 (Transportation Driver) conducted September 24, 2025, at 11:16 AM revealed on September 12, 2025, Employee 4 arrived at the outside cardiology facility to transport Resident 1 back to her facility. Employee 4 stated upon arrival at the cardiology office he witnessed Resident 1, Employee 1 NA, and the [NAME] driver outside of the facility. Employee 4 stated the [NAME] driver informed him Resident 1 was witnessed to be propelling herself out of the facility when the [NAME] driver asked her where she was going. While the [NAME] driver was questioning the resident, Employee 1 NA came running out of the building to the resident. The [NAME] driver stated Employee 1 NA was using the restroom when the resident began to wheel herself out of the facility but was stopped. Employee 4, transportation driver further stated upon return to the facility he told Employee 3 RN Supervisor about the incident but did not report the information to the NHA or the DON. An interview with the DON on September 24, 2025, at 11:30 AM, revealed she was not made aware of the incident involving Resident 1 until the survey team's investigation. Despite staff interviews and statements, the facility failed to implement |