STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395564	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Ridge Rehabilitation & Healthcare Center	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)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policies, and staff interviews, it was determined the facility failed to ensure a resident was afforded the right to participate in the planning of care and treatment, including the facility's failure to conduct a required quarterly care plan conference, for one of 10 residents reviewed (Resident 4).Findings include: Review of the facility policy titled Care Plans, Comprehensive Person-Centered last reviewed by the facility on January 14, 2026, indicated the interdisciplinary team (IDT, a group of facility staff from different professional backgrounds to develop, review and revise the residents plan of care) in conjunction with the resident and the resident's family or legal representative, is responsible for developing and implementing a comprehensive, person-centered care plan for each resident. The policy indicated that each resident has the right to participate in the development and implementation of the plan of care, including the right to participate in the planning process requesting care plan meetings or revisions, establishing goals and outcomes, and determining the type, amount, frequency, and duration of care provided. The policy required the IDT to review and update the care plan following a significant change in condition, when outcomes are not met, upon readmission, and at least quarterly in conjunction with the Minimum Data Set (MDS) assessment (a federally mandated standardized assessment process conducted periodically to plan resident care). Review of the clinical record revealed Resident 4 was admitted to the facility on [DATE], with diagnoses to include post-polio syndrome (a neurological disorder causing new, slowly progressive muscle weakness, intense fatigue, and muscle and joint pain in polio survivors, typically occurring 10 to 40 years after the initial infection) and malignant neoplasm of the major salivary gland (a rare, fast growing cancer that develops in the salivary gland. The salivary gland is responsible for producing the majority of saliva to lubricate the mouth, aid digestion and protect teeth). A review of Resident 4's Quarterly Minimum Data Set assessment dated [DATE], revealed that Resident 4 was cognitively intact with a BIMS score of 15 (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 13 through 15 indicates intact cognition). Review of a care plan meeting invitation letter revealed the facility scheduled a care plan conference with the resident and the resident's daughter for December 16, 2025, at 1:00 PM.Review of Social Services documentation dated December 16, 2025, at 1:15 PM revealed the resident's daughter contacted the facility on the day of the scheduled meeting and requested the meeting be rescheduled. Documentation indicated Social Services left a voicemail message for the daughter offering alternative dates and times for the meeting. There was no documented evidence that the facility rescheduled or conducted the quarterly care plan conference after December 16, 2025. There was also no documented evidence that the facility made additional follow-up attempts to contact the daughter or conducted the care plan meeting with Resident 4 independently, despite the resident being cognitively intact and able to participate in the care planning process. During an interview conducted on April 22, 2026, at 11:30 AM, the Social Services Director confirmed the care plan conference scheduled for December 16, 2025, was not conducted due to the daughter's request to reschedule the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395564	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Ridge Rehabilitation & Healthcare Center	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)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meeting. The Social Services Director stated a return telephone call was made and a voicemail message was left; however, no additional follow-up attempts were made after the daughter did not respond. The Social Services Director further confirmed there was no documentation the facility conducted the care plan meeting with Resident 4 independently. During an interview on April 22, 2026, at 2:35 PM, the Nursing Home Administrator and Director of Nursing reviewed the findings and confirmed there was no documentation to support that a quarterly care plan conference had been conducted for Resident 4. The facility failed to ensure Resident 4 was afforded the right to participate in the care planning process by failing to conduct a required quarterly care plan conference and failing to make reasonable efforts to reschedule and complete the meeting. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12(d)(3) Nursing services. 28 Pa. Code 211.10 (c)(d) Resident care policies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395564	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Ridge Rehabilitation & Healthcare Center	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff interviews, it was determined the facility failed to consistently implement person-centered care plan interventions related to fall prevention for three of six residents reviewed for falls (Residents 5, 7, and 9).Findings include: Clinical record review revealed that Resident 5 was admitted to the facility on [DATE], with diagnoses to include nontraumatic intracerebral hemorrhage (bleeding into the brain not caused by trauma) and hemiplegia (paralysis) and hemiparesis (weakness) affecting the resident's left side.Review of Resident 5's current comprehensive care plan dated March 14, 2024, indicated the resident was at risk for falls due to impaired mobility, incontinence and spastic hemiplegia (paralysis characterized by stiff, tight muscles and involuntary spasms). Interventions included placement of bilateral (two) fall mats on the floor next to the bed while the resident was in bed. Observation on April 22, 2026, at 8:40 AM revealed Resident 5 in bed. The left fall mat was observed folded in half and propped between the PTAC unit (Packaged Terminal Air Conditioner, a self-contained, ductless heating and cooling system installed directly through an exterior wall) and the resident's wheelchair. The fall mat was not positioned on the floor as directed in the care plan to reduce the risk of injury in the event of a fall. Interview with Employee 1, Registered Nurse, on April 22, 2026, at 8:42 AM confirmed the fall mats were a fall prevention intervention and should have been positioned on both sides of the bed while the resident was in bed. Employee 1 confirmed the left fall mat was not in place as required. Clinical record review revealed that Resident 7 was admitted to the facility on [DATE], with diagnoses to include dementia (a progressive decline in cognitive functions including memory, thinking, reasoning and behavior what interferes with daily life) and chronic respiratory failure (long-term condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low oxygen in the blood). Review of Resident 7's current comprehensive care plan dated December 29, 2025, indicated the resident was at risk for falls due to weakness, unsteady gait (walking), and urinary incontinence (inability to control the flow of urine). Interventions included use of a bathroom door alarm (a safety device which uses a sensor to alert staff when a resident opens a door, primarily used for fall prevention and wandering detection for residents with dementia) and to maintain the call light within reach of the resident. Observation on April 21, 2026, at 12:26 PM revealed Resident 7 seated alone in a wheelchair next to the bed. The bathroom door was open, and the bathroom door alarm was not sounding. A second observation on April 22, 2026, at 8:49 AM again revealed Resident 7 seated alone in the wheelchair next to the bed with the bathroom door open and the alarm not sounding. Further observation revealed the call light was draped over a bedside chair located behind the resident and was not within reach. Interview with Employee 1, Registered Nurse, on April 22, 2026, at 8:58 AM confirmed the bathroom door alarm was a fall prevention intervention and acknowledged the bathroom door was open and the alarm was turned off. Employee 1 also confirmed the call light was not within the resident's reach as required by the care plan. Clinical record review revealed that Resident 9 was admitted to the facility on [DATE], with diagnosis to include fracture of the right femur (upper leg bone) and muscle weakness. Review of Resident 9's current comprehensive care plan dated March 30, 2026, indicated the resident was at risk for falls related to decreased strength, decreased endurance, and a history of falls. Interventions included maintaining the call light within reach of the resident. Observation on April 21, 2026, at 12:36 PM revealed Resident 9 seated in the wheelchair on the left side of the bed. The call light was attached to the right side of the bed near the pillow and was not within the resident's reach. Interview with Employee 2, Nurse Aide, on April 21, 2026, at 12:40 PM confirmed the call light was not within the resident's reach. During an interview on April 22, 2026, 11:45 PM, the findings were reviewed with the Nursing Home Administrator and Director of Nursing. They acknowledged that staff failed to consistently implement the fall prevention interventions identified in the care plans for Residents 5, 7, and 9. 28 Pa. Code 211.12 (d)(5) Nursing services.