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	05/28/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, observations, and staff interviews, it was determined the facility failed to ensure residents received necessary treatment and services consistent with professional standards of practice to promote healing of existing pressure injuries for two of 10 residents reviewed (Residents 1 and 2).Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, standardized pressure ulcer risk assessment, and care planning and implementation to address the areas of risk. The American College of Physicians (ACP) is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States, Clinical Practice Guidelines, indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e., support surfaces, repositioning, and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement, and wound cleansing; using adjunctive therapies; and considering possible surgical repair. A review of the facility policy titled Wound Care, last reviewed by the facility on January 29, 2026, revealed it is the policy of the facility to provide wound care to new wounds and wounds present on admission to promote healing. The policy revealed it is the expectation of the facility to prepare to change wound care dressings by assembling the equipment and supplies needed to complete the wound care, follow the steps detailed in the policy to complete the procedure including: Use disposable cloth to establish a clean area on the resident's overbed table.Wash and Dry HandsPosition the resident in a position that would allow for a sterile dressing changePut on exam gloves, loosen the tape and remove the old dressing.Pull gloves over dressing and discard into the appropriate receptacle. Wash and dry hands thoroughly.Put on gloves, use a no touch technique, use sterile blades and applicators to remove ointments creams.Mark Tape with initials, time and date and apply the dressing as ordered by the physician.Discard any soiled laundry, linens, towels, and container. Clinical record review revealed Resident 1 was admitted to the facility on [DATE], with diagnoses including pressure ulcer of the buttock (tissue damage or pain caused by sustained pressure restricting blood flow), and disorientation (an altered sense of awareness). A review of Resident 1's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 6, 2026, revealed that Resident 1 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 no cognitive impairment). The MDS revealed at the time of assessment, Resident 1 had 3 Stage 3 pressure ulcers (severe, full-thickness skin injury where all layers of the skin are lost, exposing the fatty subcutaneous tissue beneath) that were present on admission, and one unstageable pressure injury (serious wound where full-thickness skin and tissue loss has occurred, but the true depth of 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
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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	damage cannot be determined because it is obscured by dead tissue) A review of Resident 1's Treatment Administration Record (TAR) revealed a physician order placed May 13, 2026, for staff to cleanse the right buttock with 1/4 strength Dakin's solution (medical grade antiseptic solution used to clean, disinfect, and prevent bacterial infections in open wounds), apply calcium alginate (a wound dressing) topped with Medi-honey (a medical grade honey used for wound care) to the base of the wound. The order directed staff to pack the wound with Dakin's soaked gauze and cover with a dry dressing daily and as needed if soilage or dislodgement was present. An observation conducted on May 28, 2026, at 10:15AM in the presence of Employee 1 Licensed Practical Nurse (LPN) revealed Resident 1 to have no dry dressing in place. The right buttock was observed to be opened to air in Resident 1's brief which appeared to be soiled. The sheets under Resident 1 were observed to have serosanguineous (light pink, thin, and watery fluid containing serum and blood) drainage present, indicating the wound was leaking onto the sheets. The wound was observed to have no gauze packing present inside the area as ordered. Interview with Employee 1, LPN at the time of observation revealed Resident 1 should have had a dry dressing in place. Employee 1 LPN proceeded to provide wound care to Resident 1 as ordered by the physician. A review of Resident 2's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included muscle weakness and multiple wounds. A review of Resident 2's admission Minimum Data Set assessment (MDS) dated [DATE], revealed that Resident 2 was cognitively intact with a BIMS score of 15 (a score of 13 through 15 indicates no cognitive impairment). The MDS revealed Resident 2 had one Stage 4 pressure area (a severe pressure injury with full-thickness tissue loss exposing bone, tendon, cartilage, fascia, or muscle) that was present on admission. The area measured 5.5 cm (centimeters) x 8cm x 1cm A review of Resident 2's clinical record revealed a physician order dated May 12, 2026. The physician order directed staff to cleanse the sacral wound with normal saline (a sterile saltwater solution commonly used for wound cleansing), gently pat the area dry, apply collagen (a wound care product containing proteins that support tissue growth and healing), then apply saline wet-to-dry gauze (gauze moistened with saline that assists with removal of dead tissue as it dries and is removed), followed by a foam dressing (a protective absorbent wound covering designed to maintain a moist healing environment) every day during the day shift. The order further directed staff to change the dressing as needed if it became soiled (contaminated with drainage, urine, stool, or other substances) or dislodged (moved from its proper position or no longer securely covering the wound). An observation conducted on May 28, 2026, at 10:39AM of Resident 2's coccyx (the small, triangular bone at the very base of the human spine) area revealed a dry dressing in place but the dressing was visibly soiled with no date time or initials written as indicated in the policy. It was unable to be determined when the dressing was applied. During an interview on May 28, 2026, at 11:30 AM, the above findings were reviewed with the Nursing Home Administrator. The facility failed to ensure Residents 1 and 2 received necessary treatment and services consistent with professional standards of practice to promote healing of pressure injuries, including ongoing wound monitoring and implementation of wound care as ordered by the physician and facility policy according to resident-specific clinical needs. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.