

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/16/2026
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)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility documentation, facility policy, and staff interviews, it was determined the facility failed to ensure one of 10 sampled residents (Resident 1) remained free from physical abuse when an employee used force while providing incontinence care. Findings include: A clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses that include dementia (a loss of memory, language, problem-solving, and other thinking abilities severe enough to interfere with daily life) and anxiety (a condition characterized by excessive fear, worry, or feelings of unease). A review of Resident 1's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 29, 2026, revealed that Resident 1 had severe cognitive impairment with a BIMS score of 00 (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 00 through 07 indicates cognition severely impaired). A review of Resident 1's comprehensive care plan revealed the resident required maximal assistance with toileting because of impaired ability to perform self-care related to dementia with behavioral disturbances. The care plan indicated Resident 1 frequently demonstrated verbal and physical behaviors, including hitting and grabbing staff. Staff interventions included approaching the resident slowly and from the side, respecting the resident's personal space, gaining the resident's attention before touching or speaking, allowing additional time to provide care, and discontinuing care and reapproaching later if the interventions were ineffective and it was safe to do so. The care plan directed staff to provide toileting assistance at 5:00 AM with two staff members. The care plan directed staff to provide incontinence care while the resident remained in bed and to transfer the resident to the toilet only for bowel movements. The care plan also documented the resident had a history of making false accusations and expressing racist remarks. Interventions included assigning Caucasian staff to provide care whenever possible and having non-Caucasian staff provide care with another nurse aide present. A review of documentation provided by the facility dated June 20, 2026, revealed Employees 1 and 2, both Nurse Aides (NAs), were providing incontinence care to Resident 1 at 5:00 AM when Employee 1 forcefully held the resident's arms across the resident's chest and covered the resident's mouth with a hand. A review of a written statement completed by Employee 1 dated June 20, 2026, revealed the resident scratched and spit during care. Employee 1 documented, I was not forceful in covering her mouth, and denied forcefully grabbing the resident. During a telephone interview conducted on July 16, 2026, at 10:00 AM, Employee 1 acknowledged covering Resident 1's mouth because the resident was spitting toward Employee 2. Employee 1 stated the purpose of covering the resident's mouth was to prevent Employee 2 from being spat upon. Employee 1 further stated he did (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not routinely care for Resident 1 and was unaware the resident's care plan directed staff to provide incontinence care in bed. Employee 1 stated he wanted to complete care quickly and covered the resident's mouth to stop the spitting. Employee 1 stated Resident 1 was not light he held the upright while pulling the resident's pants up and acknowledged continuing to provide care after covering the resident's mouth. Employee 1 reported he continued caring for other residents following the incident until a supervisor removed him from resident care. Employee 1 confirmed the facility suspended him pending investigation. A review of a written witness statement completed by Employee 2 on June 20, 2026, revealed Employee 2 requested Employee 1's assistance with providing incontinence care. Employee 2 documented Resident 1 initially resisted care and that Employee 1 grabbed the resident's arms, pushed them downward forcefully, and placed a hand over the resident's mouth with significant force. Employee 2 further documented Employee 1 continued using force while assisting the resident to stand, causing the resident to be jerked while Employee 2 attempted to pull up the resident's pants. Employee 2 documented immediately notifying the nurse and supervisor after care was completed. During a telephone interview conducted on July 16, 2026, at 11:00 AM, Employee 2, Nurse Aide (NA), stated she asked Employee 1, NA, to assist with providing incontinence care to Resident 1 because she had never cared for the resident before. Employee 2 stated that after entering the bathroom, Resident 1 pushed Employee 2's hands away as Employee 2 attempted to lower the resident's pants. Employee 2 stated Employee 1 then grabbed Resident 1's arms, pushed the resident onto the toilet, and held the resident's arms tightly across the resident's chest. Employee 2 stated she observed Employee 1 forcefully place his hand over Resident 1's mouth. Employee 2 reported Resident 1 immediately began scratching Employee 1's hand in an attempt to remove it from her mouth. Employee 2 further stated Resident 1's eyes appeared to bulge while attempting to remove Employee 1's hand. Employee 2 reported Employee 1 repeatedly stated, Stop it, we need to clean you, while continuing to hold his hand over the resident's mouth. Employee 2 stated Employee 1 then held Resident 1 in a standing position while she attempted to pull up the resident's pants and repeatedly jerked the resident during the process. Employee 2 stated that after Resident 1 was returned to the wheelchair and taken to the nurses' station, Employee 1 attempted to approach the resident and Resident 1 immediately pulled away from him. Employee 2 stated she immediately reported the incident to the nurse and nursing supervisor, after which Employee 1 was removed from resident care. Employee 2 stated she was unaware Resident 1's care plan directed staff to provide incontinence care in bed but knew Resident 1 required the assistance of two staff members for toileting. Employee 2 stated she knew Resident 1 frequently displayed behavioral symptoms associated with dementia and was attempting to calm the resident during the episode. Employee 2 stated Resident 1 was making noises and pushing staff away while care was being provided but was not continuously spitting throughout the encounter. Employee 2 stated Resident 1 did not begin displaying combative behaviors until after Employee 1 became forceful while providing care. Employee 2 further stated she did not physically intervene because she feared Employee 1 might also harm her. Documentation provided by the facility revealed the Director of Nursing (DON) became aware of the allegation at 5:20 AM on June 20, 2026. Employee 1 was removed from resident care and suspended pending investigation at 6:30 AM. Facility documentation further revealed the facility completed assessments of residents who had received care from Employee 1 on June 20, 2026, and re-educated staff regarding abuse prevention, neglect prevention, and dementia care following the incident. A review of a nursing progress note dated June 20, 2026, revealed Resident 1 received a comprehensive physical assessment following the incident. The assessment identified no observable injury. A psychology consultation dated June 24, 2026, documented Resident 1 experienced significant agitation and (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physical aggression on June 20, 2026. The psychologist recommended non-pharmacological (interventions that do not involve medication) approaches, including reducing confusion and fear, providing comfort measures, maintaining the resident's routine, and utilizing the Tolerate, Anticipate, Don't Agitate ([NAME]) approach when responding to behavioral symptoms associated with dementia. During an interview conducted on July 16, 2026, at 1:00 PM, the aforementioned information was discussed with the Director of Nursing and the Nursing Home Administrator. The facility failed to ensure Resident 1 remained free from physical abuse when Employee 1 forcefully restrained the resident by holding the resident's arms across the chest and covering the resident's mouth while providing incontinence care. The facility also failed to ensure care was provided in accordance with the resident's individualized care plan, which directed staff to discontinue care and reapproach later if behavioral interventions were ineffective and to provide incontinence care in bed. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(3)(5) Nursing services.		