STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395646	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Hill Rehabilitation & Healthcare Center	827 Georges Station Road Greensburg, PA 15601

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on review of facility policy, clinical records, and a facility investigation, as well as staff interviews, it was determined that the facility failed to maintain a complete and accurate accounting of controlled medications (medications with the potential to be abused) in an emergency access box and failed to maintain a complete and accurate accounting of controlled medications for two of two residents reviewed (Resident 1 and Resident 2).Findings include:The facility's policy for the process to remove emergency medications from the narcotic E-box dated February 19, 2025, indicated that before removing any medication, the nurse must fully complete the emergency supply sign-out sheet and fax it to the pharmacy for an authorization code. Always remember to include quantity remaining so the pharmacy knows your quantity on hand and ensures that you never run out of a medication. Follow up by calling the pharmacy to notify them that you just faxed the sheet and need the authorization code to write on the sign out sheet and also to write on the emergency narcotics E-box access sheet. The nurse and witness must log the entry with signatures onto the emergency narcotic E-box Access sheet, cut the zip tie tag (way to lock the box), logging the tag numbers as requested. The nurse and the witness to remove the medication need to log the entry on the controlled substance record (tracks each dose of a controlled medication) or controlled patch record. Before locking the narcotic box, the nurse and witness must cycle count every item in the narcotic box, reconciling the quantity on the punch card item against the quantity written on the controlled substance record or controlled patch record. If there is a discrepancy, notify your Director of Nursing/management as soon as possible. Nurse and witness are to lock the narcotic box with zip tie tag numbers on the emergency narcotics E-box access sheet and file the narcotic supply sign-out sheet per the facility's process. The facility's policy for medication administration dated February 19, 2025, indicated that the individual administering the medication initials the resident's medication administration record (MAR) on the appropriate line after giving each medication and before administering the next ones. As required or indicated for a medication, the individual administering the medication records in the resident's medical record the date and time the medication was administered, the dosage, the route of administration, any complaints or symptoms for which the drug was administered, any results achieved and when those results were observed, and the signature and title of the person administering the drug.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1 dated July 24, 2025, indicated that the resident was cognitively impaired, was dependent on staff for daily care needs, had a diagnosis of cancer of the ovary (female reproductive organ), and was receiving hospice (end-of-life care) services. Physician's orders for Resident 1 dated July 26, 2025, included an order for the resident to receive one milliliter (ml) of Ativan Solution by mouth four times a day for seizure activity.Review of the MAR for Resident 1 dated July 2025 indicated that one ml of Ativan solution was administered on July 26 at 6:00 p.m. and July 27 at midnight. There was no documented evidence on any controlled substance record of this medication being administered. Review of an incident investigation provided by the facility dated August 28, 2025, indicated that Licensed Practical Nurse 1 and Licensed Practical Nurse 2 identified that on August 16, 2025, there was no Ativan solution available to be counted in the emergency narcotic E-box. There was no documented evidence that this was reported to the Director of Nursing, management, or pharmacy. The Assistant Director of Nursing reported that she found an empty pharmacy box that should have had Ativan solution in it on August 28, 2025, while cleaning the refrigerator. She reported this to the Director of Nursing and an investigation was initiated. A supervisor emergency medication supply form dated July 23, 2025, indicated that the emergency narcotic box did contain one 30 ml bottle of Ativan Intensol (concentrated liquid medication). Interview with Director of Nursing and Nursing Home Administrator on November 12, 2025, at 1:54 p.m. revealed that the facility completed an investigation regarding the missing Ativan solution and believed that the Ativan solution was removed from the E-box for a hospice resident identified as Resident 1 because two doses of the medication were documented as administered before the medication was received from the pharmacy. Staff were not following proper procedures for counting medications in the narcotic E-box when accessing it, therefore there was no way to identify exactly when it went missing. There was no documented evidence of the Ativan solution being removed from the narcotic E-box or being disposed of, and therefore they were unable to account for the missing Ativan solution. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2 dated August 19, 2025, indicated that the resident was cognitively intact, required assistance from staff for daily