STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395710	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oxford Rehabilitation and Healthcare Center	300 East Winchester Ave Langhorne, PA 19047

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on facility policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to ensure physician's orders were implemented for two of 36 sampled residents. (Residents 12 and 26) Findings include: Review of the facility policy entitled, Administering Medications, last reviewed April 29, 2025, revealed staff were to obtain vital signs if necessary, and document physician indicated medication administration information. Clinical record review revealed that Resident 12 had diagnoses that included hypertension (high blood pressure) and required renal dialysis. On September 9, 2025, the physician ordered staff to administer a blood pressure medicine, metoprolol tartrate, two times a day. Staff were not to administer the medication if the resident's systolic blood pressure (SBP, the first measurement of blood pressure when the heart beats and the pressure is at its highest) was less than 110 millimeters of mercury (mmHg). Review of Resident 12's Medication Administration Record (MAR) for October 2025 and November 2025 revealed that staff administered the medication 85 times with no documented evidence that the blood pressure was assessed prior to medication administration per physician's order. On August 27, 2025, the physician ordered staff to administer a blood pressure medication (hydralazine) every eight hours as needed if the SBP was greater than (>) 170 mmHg. Review of Resident 12's MARs revealed his SBP was > 170 mmHg two times in October 2025 and three times in November 2025. There was no evidence that staff administered the hydralazine per the physician's order. In an interview on November 14, 2025, at 10:21 a.m., the Director of Nursing confirmed that vital signs were to be entered into the MAR and that there was no documented evidence that the blood pressure was taken prior to medication administration of the metoprolol per physician's order. Clinical record review revealed that Resident 26 had diagnoses that included a history of stroke caused by a blood clot in the brain, diabetes, and muscle wasting. On April 23, 2025, the physician ordered staff to apply a compression stocking (thrombo-embolus deterrent, T.E.D., stocking that prevents blood clots) to Resident 26's left lower leg at 6:00 a.m., and to remove the stocking at 6:00 p.m. for swelling in his leg. Observations on November 12, 2025, at 12:30 p.m. and 2:00 p.m., November 13, at 7:58 a.m., 10:22 a.m., and 12:47 p.m., and on November 14, 2025, at 10:22 a.m., revealed that Resident 26 was observed in the hallway in his wheelchair; his ankle was visibly swollen over the top of the sock elastic. The compression stocking was not in place. (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
	395710	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oxford Rehabilitation and Healthcare Center	300 East Winchester Ave Langhorne, PA 19047

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on November 14, 2025, at 12:50 p.m., the Director of Nursing confirmed that the compression stocking should have been applied. CFR 483.25 Quality of Care Previously cited 11/15/24 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on clinical record review, observation, and staff interview, it was determined that the facility failed to maintain a medication error rate of less than five percent (%) during medication administration on two of three nursing units. (1st and 2nd floor)Findings include: Observations of medication administration on November 13, 2025, from 7:30 a.m. to 11:30 a.m., and November 14, 2025, from 9:30 a.m. to 10:00 a.m., revealed 28 medication opportunities with two medication errors that resulted in a medication administration error rate of 7.14%. Clinical record review revealed that Resident 51 had diagnoses that included atrial fibrillation (fast heart rate), hypertension, and heart failure. A physician's order dated November 8, 2025, directed staff to administer Losartan Potassium 25 milligrams (mg) daily. Observation of the medication pass on November 13, 2025, at 11:03 a.m., revealed that Licensed Practical (LPN) 1 administered a half tablet of losartan potassium to the resident, which was only 12.5 mg, half of the dose ordered by the physician. Clinical record review revealed that Resident 191 had diagnoses that included dementia and gastroesophageal reflux disease. A physician's order dated November 6, 2024, directed staff to administer Protonix delayed release tablet (a medication for gastroesophageal reflux disease). A review of the administration instructions for Protonix delayed release tablet revealed that the medication was not to be crushed. Observation of the medication pass on November 13, 2025, at 7:30 a.m., revealed that LPN 2 crushed the Protonix delayed release tablet prior to administration. In an interview on November 14, 2025, at 12:49 p.m., the Director of Nursing confirmed the medications were not administered per the physician's orders. 28 Pa. Code 211.12(d)(1)(5) Nursing services.