

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395347</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED:  <b>01/09/2025</b>
NAME OF PROVIDER OR SUPPLIER: <b>OAK HILL CENTER FOR REHABILITATION AND NURSING</b>			STREET ADDRESS, CITY, STATE, ZIP CODE: <b>1020 NORTH UNION STREET MIDDLETOWN, PA 17057</b>		
STATE LICENSE NUMBER: <b>062102</b>					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE	
F 0000	INITIAL COMMENT  Findings of an abbreviated complaint survey completed on January 9, 2025, at Oak Hill Center for Rehabilitation and Nursing identified that the facility was not in compliance with the following requirements of the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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P 5520	<p>Nursing services.</p> <p>(3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5520	<p>1) Facility cannot retroactively correct.</p> <p>2) NHA/designee will review CNA staffing ratios for the last 4 weeks to ensure compliance and adherence to regulation.</p> <p>3) NHA/Designee will re-educate staff scheduler and DON on regulation of CNA staffing ratios to ensure ongoing compliance. Facility will conduct daily staffing meeting to review CNA ratios to ensure ongoing compliance and systematic change. Facility will educate nursing staff on call off policy and hold weekly meeting to review call offs and enforce disciplinary action per call off policy.</p> <p>4) NHA/Designee will conduct audit of projected CNA ratios 3 x a week x 4 weeks and once a month x 2 months to ensure compliance with regulation. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly until substantial compliance is met</p>	<p>Completion Date: <b>02/03/2025</b></p> <p>Status: <b>APPROVED</b></p> <p>Date: <b>01/23/2025</b></p>
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P 5520	<p>Continued from page 1</p> <p>Based on review of staffing documents and staff interview, it was determined that the facility failed to ensure a required minimum of one nurse aide (NA) per 10 residents on day shift for four of seven days reviewed (December 29, 2024; and January 2, 3, and 4, 2025); one NA per 11 residents on evening shift for two of seven days reviewed (December 31, 2024; and January 3, 2025); and one NA per 15 residents on night shift for one of seven days reviewed (January 1, 2025).</p> <p>Findings Include:</p> <p>Review of facility-provided staffing ratio information for December 29, 2024, on day shift, revealed a census of 123 residents. Further review revealed a NA ratio of 12.0; therefore, the facility did not meet the required ratio of 12.30.</p> <p>Review of facility-provided staffing ratio information for December 31, 2024, on evening shift, revealed a census of 127 residents. Further review revealed a NA ratio of 11.40; therefore, the facility did not</p>	P 5520		

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P 5520	Continued from page 2  meet the required ratio of 11.55.  Review of facility-provided staffing ratio information for January 1, 2025, on night shift, revealed a census of 127 residents. Further review revealed a NA ratio of 7.0; therefore, the facility did not meet the required ratio of 8.47.  Review of facility-provided staffing ratio information for January 2, 2025, on day shift, revealed a census of 127 residents. Further review revealed a NA ratio of 12.0; therefore, the facility did not meet the required ratio of 12.7.  Review of facility-provided staffing ratio information for January 3, 2025, on day shift, revealed a census of 125 residents. Further review revealed a NA ratio of 12.0; therefore, the facility did not meet the required ratio of 12.5.  Review of facility-provided staffing ratio information for January 3, 2025, on evening shift, revealed a census of 125 residents. Further review revealed a	P 5520		

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P 5520	Continued from page 3  NA ratio of 11.0; therefore, the facility did not meet the required ratio of 11.36.  Review of facility-provided staffing ratio information for January 4, 2025, on day shift, revealed a census of 125 residents. Further review revealed a NA ratio of 12.0; therefore, the facility did not meet the required ratio of 12.5.  During an interview with the Nursing Home Administrator on January 9, 2025, at 2:53 PM, he confirmed that the staffing information was correct and the facility did not meet the NA ratios on the aforementioned shifts.	P 5520		
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P 5530	Continued from page 4  Nursing services.  (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight.  This REGULATION is not met as evidenced by:	P 5530	1) Facility cannot retroactively correct  2) NHA/designee will review LPN staffing ratios for the last 4 weeks to ensure compliance and adherence to regulation.  3) NHA/Designee will re-educate staff scheduler and DON on regulation of LPN staffing ratios to ensure ongoing compliance. Facility will conduct daily staffing meeting to review LPN ratios to ensure ongoing compliance and systematic change. Facility will educate nursing staff on call off policy and hold weekly meeting to review call offs and enforce disciplinary action per call off policy.  4) NHA/Designee will conduct audit of projected LPN ratios 3 x a week x 4 weeks and once a month x 2 months to ensure compliance with regulation. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance	Completion Date: <b>02/03/2025</b> Status: <b>APPROVED</b> Date: <b>01/23/2025</b>

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P 5530	Continued from page 5	P 5530	Improvement Committee monthly until substantial compliance is met	

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P 5530	Continued from page 6  Based on review of staffing documents and staff interview, it was determined that the facility failed to ensure a required minimum of one licensed practical nurse (LPN) per 30 residents on evening shift for one of seven days reviewed (December 31, 2024); and one LPN per 40 residents on night shift for two of seven days reviewed (December 31, 2024; and January 1, 2025).  Findings Include:  Review of facility-provided staffing ratio information for December 31, 2024, on evening shift, revealed a census of 127 residents. Further review revealed a LPN ratio of 4.0; therefore, the facility did not meet the required minimum LPN ratio of 4.23.  Review of facility-provided staffing ratio information for December 31, 2024, on night shift, revealed a census of 127 residents. Further review revealed a LPN ratio of 3.0; therefore, the facility did not meet the required minimum LPN ratio of 3.18.	P 5530		

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P 5530	Continued from page 7  Review of facility-provided staffing ratio information for January 1, 2025, on night shift, revealed a census of 127 residents. Further review revealed a LPN ratio of 3.0; therefore, the facility did not meet the required minimum LPN ratio of 3.18.  During an interview with the Nursing Home Administrator on January 9, 2025, at 2:53 PM, he confirmed that the staffing information was correct and the facility did not meet the LPN ratios on the aforementioned shifts.	P 5530		
P 5640		P 5640		

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P 5640	Continued from page 8  Nursing services.  (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident.  This REGULATION is not met as evidenced by:	P 5640	1) Facility cannot retroactively correct  2) NHA/designee will review PPDs for the last 4 weeks to ensure compliance and adherence to regulation.  3) NHA/Designee will re-educate staff scheduler and DON on regulation of PPD to ensure ongoing compliance. Facility will conduct daily staffing meeting to review PPDs to ensure ongoing compliance and systematic change. Facility will educate nursing staff on call off policy and hold weekly meeting to review call offs and enforce disciplinary action per call off policy.  4) NHA/Designee will conduct audit of projected PPDs 3 x a week x 4 weeks and once a month x 2 months to ensure compliance with regulation. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly	Completion Date: <b>02/03/2025</b> Status: <b>APPROVED</b> Date: <b>01/23/2025</b>

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P 5640	Continued from page 9  Based on review of staffing documents and staff interview, it was determined that the facility failed to ensure the total number of nursing care hours provided in each 24-hour period be a required minimum of 3.20 hours of direct care for each resident for three of seven days reviewed (January 1, 2, and 3, 2025).  Findings Include:  Review of facility provided staffing information dated December 29, 2024 through January 4, 2025, revealed that the facility provided only 3.18 hours of direct care for each resident on January 1, 2025; 3.17 hours on January 2, 2025; and 3.18 hours on January 3, 2025.  During an interview with the Nursing Home Administrator on January 9, 2025, at 2:53 PM, he confirmed that the provided staffing information was correct.	P 5640	until substantial compliance is met	



# Certified End Page

**OAK HILL CENTER FOR REHABILITATION AND NURSING**

**STATE LICENSE NUMBER: 062102**

**SURVEY EXIT DATE: 01/09/2025**

**I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey**

  
Jeanne Parisi  
Deputy Secretary for Quality Assurance

  
Debra L. Bogen, MD, FAAP  
Secretary of Health



**Pennsylvania  
Department of Health**

THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY