STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395300	A. Building B. Wing	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perry Health & Rehab Center	9850 Old Perry Highway Wexford, PA 15090

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical records, and staff interviews it was determined that the facility failed to ensure the appropriate assistance for bed mobility was provided for one of seven residents (Residents R1), which resulted in actual harm when Resident R1 fell out of bed and sustained a right hip fracture and head contusion.Review of the facility policy Fall Prevention and Management dated 3/4/25, reviewed 3/14/25, stated it is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. Fall prevention and management is the process of identifying risk factors that can minimize the potential for falls and also a process to manage resident's care if a fall occurs. A fall assessment should be completed upon admission, quarterly, and with any significant changes. The care plan should address how the resident can be transferred up and out of bed as well as how the resident can ambulate and move around the facility. Review of the facility policy Incidents/Accidents dated 5/13/25, stated it is the policy of the facility to provide a safe and healthy environment for residents by minimizing possible exposure to safety hazards. Review of the facility policy Routine Resident Care dated 6/11/25, indicated it is the facility policy to promote resident centered care by attending to the total medical, nursing, physical, emotional, mental, social, and spiritual needs and honor resident's preference while in the care of this facility. Licensed staff will provide care planning and implementation and provide access to resident care policies for any staff providing care. Nurse aides are to provide routine daily care including toileting, and assisting with ambulation, transfers, and repositioning. Review of Residents R1's admission record revealed the resident was admitted on [DATE], with diagnoses of cancer, anxiety, and depression. Review of Residents R1's care plan dated 5/11/23, revealed the resident required assistance of two persons with bed mobility. Review of Resident R1's Fall Risk Observation Tool dated 4/29/25, revealed the resident was bedrest, non-ambulatory, and required a total mechanical lift for all transfers. The resident was identified to be at risk for falls. Review of Residents R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/21/25, indicated the diagnoses were current. Section GG- Functional Abilities revealed the resident was dependent with rolling left to right and required the assistance of two or more helpers. Review of Resident R1's progress note dated 6/29/25, at 9:15 p.m. entered by Registered Nurse (RN), Employee E1 stated around 9:15 p.m. a nurse aide (NA) was changing Resident R1's brief and the resident rolled out to the left side and fell from the bed to the floor. The resident sustained a right temporal injury measuring about 2.5 centimeters (cm), a right upper arm and right knee skin tear. The resident was sent to the emergency room for sutures. Review of Resident R1's post fall evaluation dated 6/29/25, revealed the resident fell on 6/29/25, around 9:20 p.m. The resident sustained head and skin injuries following a witnessed fall while NA, Employee E3 was changing the resident. The height of the bed was in normal position. A left lateral temporal laceration measuring 2.5 cm x 0.25 cm x 0.15 cm. was observed. The resident also had a left upper arm skin tear that measured 6 cm x 1 cm and a left lateral knee skin tear that measured 2 cm x 2cm. It was revealed the resident complained of pain, and the pain was new to the resident. The resident had a temporal injury with pain. The resident's pain was rated 5/10 and described it as hurting. Review of Resident R1's progress note dated 6/29/25, entered by Nurse Practitioner, Employee E2 revealed Resident R1 was assessed via a telehealth visit after a fall. The NA was present at the bedside and reported while changing the resident, the NA went to grab a sheet, and the resident rolled out of bed. The resident had a large 2.5 cm right forehead laceration and a skin tear to the right arm. The resident was ordered to be transferred to the hospital for sutures.Review of Resident R1's hospital records dated 6/29/25, revealed Resident R1 presented to the emergency department secondary to a fall. Resident R1 apparently had fallen out of bed and was found down on the ground. The resident sustained a hematoma/contusion to the right occipital (back of brain) parietal (top and back of brain) portion of the scalp as well as abrasions to the right upper arm and right lower leg. The resident's daughter arrived at the emergency room and was concerned that the facility staff indicated the resident had right leg shortening. On reevaluation, the resident's leg was slightly shorter on the right than the left. An x-ray of the right hip and pelvis was completed and revealed an impacted sub capital fracture (intracapsular neck of femur fracture that typically results from falls or direct trauma to the hip). Surgical options were discussed, and it was decided to not have the resident hospitalized or to undergo surgery. Review of Resident R1's Radiology Report dated 6/29/25, revealed a hip with pelvis x-ray was performed due to a fall. It was revealed the resident sustained a right lateral impacted sub capital fracture