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	12/10/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and staff interview, it was determined that the facility failed to maintain a clean, safe, and homelike environment for three of six residents (Resident R1, R2, and R3) and one of two shower rooms on the second floor (Large Shower Room).Findings Include:Interview with the Nursing Home Administrator on 12/10/25, at 12:51 p.m. indicated the facility does not have a policy regarding homelike environment.Review of the clinical record indicated Resident R1 admitted to the facility on [DATE].Review of the clinical record indicated Resident R2 admitted to the facility on [DATE].Review of the clinical record indicated Resident R3 admitted to the facility on [DATE].Review of the Grievance Log dated December 2025, indicated on 12/8/25, Resident R1's family filed a grievance regarding a pipe in the room.Interview on 12/9/25, at 9:05 a.m. Registered Nurse (RN) Employee E2 indicated Resident R1 and Resident R2's room had a water leak from a pipe in the ceiling. RN indicated working last Friday, 12/5/25, and there was a large bin placed under the leaking pipe where water was dripping into the bin. Indicated the water was turned off to the pipe and the ceiling tile was removed.Interview on 12/9/25, at 9:10 a.m. Nurse Aide (NA) Employee E3 indicated that water was leaking in the room from a pipe in the ceiling since Friday. Indicated the leak was above the entrance to the bathroom door inside the room and that Resident R1 moved to another room on 12/8/25, when the plumber came to fix the pipe and they removed the large bin from the room.Observation of Resident R1 and Resident R2's room on 12/9/25, at 9:04 a.m. indicated Resident R1 was not in the room, and Resident R2 was in bed resting. A ceiling tile was missing from the ceiling, a silver pipe exposed facing downward into the room, directly outside the entrance to the resident room's bathroom.Observation and interview with the Director of Nursing on 12/9/25, at 9:15 a.m. confirmed the appearance of the exposed pipe and missing ceiling tile directly above the bathroom door and confirmed the residents should have been relocated until the pipe could be fixed.Interview with Resident R1 on 12/9/25, at 11:30 a.m. indicated that The ceiling was leaking for several days before they could get it fixed. There was water running down across the floor to my bed. I could hear water in the pipes and toilets flushing and thought to myself where is the water coming from? The staff would sop the water up in front of the bathroom door so that Resident R2 could go in the bathroom with the walker.Review of the timeline provided by Maintenance worker Employee E1 indicated on 12/4/25, during morning rounds a nurse reported a wet tile in Residents R1 and R2's room. The leak's origin could not be identified, and the ceiling tile was replaced. On 12/5/25, during morning rounds the nurse again reported the tile was wet. The leak's origin could be found but unable to be fixed by facility staff. On 12/8/25, the plumber was notified and fixed the issue. The Nursing Home Administrator was made aware and moved Resident R1 but failed to relocate Resident R2.Interview on 12/9/25, at 11:42 a.m. Resident R3 indicated they had been here for a while and they never have cleaned the privacy curtain to the right side of the resident's bed. Resident said, Look under my bed and along the walls, dresser, there's dirt and debris and my windowsill and blinds do not get cleaned.Observation on 12/9/25, at 11:43 a.m. Resident R3's room had a dirty privacy curtain with a white/brown stain on the bottom fold, debris and crumblike substances along the perimeter of the wall, under the bed, along the dressers, the windowsill was dusty along with the blinds covering the windows.Observation on 12/9/25, at 11:50 a.m. the large shower room on the second floor was noted to have the hose/shower head detached from the pipe in the wall and lying on the floor of the shower stall. There was a brown spot on the floor of the shower room stall.Interview on 12/9/25, at 11:51 a.m. Housekeeping Employee E4 confirmed the hose/shower head was detached from the pipe in the wall and the brown debris on the floor of the shower stall.Interview on 12/10/25, at 12:51 p.m. the Nursing Home Administrator confirmed that the facility failed to maintain a clean, safe, and homelike environment for three of six residents (Resident R1, R2, and R3) and one of two shower rooms on the second floor (Large Shower Room).28 Pa. code: 201.14 (b) Responsibility of licensee.28 Pa Code: 201.18 (e)(1)(2) Management. 28 Pa Code: 201.29 (a)(c) Resident Rights.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to implement written policies and procedures to ensure a complete and thorough investigation of an allegation of abuse for one of three residents (Resident R4). This failure was determined to be past noncompliance as of 12/5/25.Findings include:Review of facility policy Pennsylvania Resident Abuse Policy dated 3/14/25, indicated the facility's policy is to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, intimidation, exploitation of residents, misappropriation of resident property and injuries of unknown source. Review of the admission record indicated Resident R4 was admitted to the facility on [DATE].Review of Resident R4's Minimum Data Set (MDS- a periodic assessment of care needs) dated 11/7/25, indicated the diagnoses of cachexia (a complex metabolic syndrome causing severe, unintentional weight loss), dysphagia (difficulty swallowing), and hypothyroidism (thyroid gland doesn't produce enough thyroid hormone). Section C0500 the Brief Interview for Mental Status (BIMS - is a screening test that aids in detecting cognitive impairment) indicated a score of 15, cognitively intact.Review of Resident R4's progress notes indicated the following:-11/15/25, at 1:34 a.m. found resident at approximately 11:30 p.m. on 11/14/25, crying with complaints of lower back pain, which resident verbalized the pain started when resident was turned when getting a brief changed by Nurse Aide (NA) at approximately 10:00 p.m.-11/17/25, at 11:20 a.m. family at nurses' station inquiring about phone call that she received from their mom regarding care from NA on Friday night. This nurse reported information to management for further review. Patient also has increase pain in lower back. -11/17/25, Provider note at 12:19 p.m. resident seen today at the request of the facility for acute onset lower back pain. Resident seen lying in bed. Resident states that pain originated during care. Resident feels that their leg was elevated too much, causing immediate pain that has persisted. X rays obtained without acute injury.-11/20/25, at 10:35 a.m. Physician note resident seen lying in bed in distress after having been changed and repositioned by staff complaining of severe lower back pain.Review of facility provided documentation dated 12/2/25, at 3:30 p.m. indicated the Director of Nursing was speaking with Resident R4's family. During the conversation family verbalized an occurrence involving an aide elevating resident's legs during incontinence care causing pain on the evening of 11/14/25.Interview on 12/10/25, at 12:51 p.m. the Director of Nursing confirmed the allegation of abuse was not reported to administration and the facility failed to implement written policies and procedures to ensure a complete and thorough investigation of an allegation of abuse for Resident R4 and requested past noncompliance status be reviewed for the event and handed over information on immediate interventions and education that had been completed regarding abuse policy and procedures once facility administration became aware.Review of facility's corrective action plan indicated on 12/2/25, the Director of Nursing became aware that facility was out of compliance with F607 Develop/Implement Abuse/Neglect Policies. In lieu of discovery facility immediately initiated the following:-On 12/2/25, the Director of Nursing called residents family to discuss status of patient who is currently admitted to hospital. During conversation, family verbalized an occurrence involving an aide elevating resident's legs during incontinence care causing pain on the evening of 11/14/2025.-Immediate investigation was initiated including the following:-Identified the aide that was assigned to the resident on date of noted incident with notification and statement attained.-Aide was suspended pending investigation and removed from schedule.-All other residents on unit that are able to be interviewed were interviewed with no care concerns noted.-Per investigation look back at the initial x-ray was negative of any acute findings. A CT scan (advanced imaging test that uses X rays and a computer to create detailed, cross-sectional pictures of the inside of the body) was completed on 11/20/25, during a hospital transfer with an indeterminate L4 (fourth vertebrae of the lower spine) compression fracture (break or collapse) that was reviewed by the in house Nurse Practitioner and could not be verified as acute. -Education was completed on abuse and the timeliness of reporting concerns/customer service timely.-Skin sweeps are being completed on all residents in the facility Adult Protective Services is aware at this time. -Audits will be completed twice weekly for one month with random residents for any care/concern issues. -Facility is not substantiating abuse or neglect related to statements attained and results of investigation. -PB22 was completed.-Facility came back into compliance on 12/5/25, when education was completed.On 12/10/25, at 12:51 p.m. it was verified that the facility had implemented its corrective action plan, and education was verified for 121 facility employees on abuse and the timeliness of reporting concerns timely

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident clinical records, facility provided documents, reports submitted to the State, and staff interview it was determined that the facility failed to report an allegation of abuse for one of three residents (Resident R4).Findings include:Review of facility policy Pennsylvania Resident Abuse Policy dated 3/14/25, indicated the facility's policy is to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, intimidation, exploitation of residents, misappropriation of resident property and injuries of unknown source. Facility must immediately report all such allegations to the Administrator who will immediately begin an investigation and notify applicable local and state agencies in accordance with the procedures in this policy.Review of the admission record indicated Resident R4 was admitted to the facility on [DATE].Review of Resident R4's Minimum Data Set (MDS- a periodic assessment of care needs) dated 11/7/25, indicated the diagnoses of cachexia (a complex metabolic syndrome causing severe, unintentional weight loss), dysphagia (difficulty swallowing), and hypothyroidism (thyroid gland doesn't produce enough thyroid hormone). Section C0500 the Brief Interview for Mental Status (BIMS - is a screening test that aids in detecting cognitive impairment) indicated a score of 15, cognitively intact.Review of Resident R4's progress notes indicated the following:-11/15/25, at 1:34 a.m. found resident at approximately 11:30 p.m. on 11/14/25, crying with complaints of lower back pain, which resident verbalized the pain started when resident was turned when getting a brief changed by Nurse Aide (NA) at approximately 10:00 p.m.-11/17/25, at 11:20 a.m. family at nurse's station inquiring about phone call that they received from their mom regarding care from NA on Friday night. This nurse reported information to management for further review. Patient also has increase pain in lower back. -11/17/25, Provider note at 12:19 p.m. resident seen today at the request of the facility for acute onset lower back pain. Resident seen lying in bed. Resident states that pain originated during care. Resident feels that their leg was elevated too much, causing immediate pain that has persisted. X rays obtained without acute injury.-11/20/25, at 10:35 a.m. Physician note resident seen lying in bed in distress after having been changed and repositioned by staff complaining of severe lower back pain.Review of facility provided documentation (State report) dated 12/2/25, at 3:30 p.m. indicated the Director of Nursing was speaking with Resident R4's family. During the conversation family verbalized an occurrence involving an aide elevating resident's legs during incontinence care causing pain on the evening of 11/14/25.Interview on 12/10/25, at 12:51 p.m. the Director of Nursing confirmed the allegation of abuse was not reported to administration and the facility failed to report an allegation of abuse for one of three residents (Resident R4) and requested past noncompliance status be reviewed for the event and handed over information on immediate interventions and education that had been completed regarding abuse policy and procedures once facility administration became aware.Review of facility's corrective action plan indicated on 12/2/25, the Director of Nursing became aware that facility was out of compliance with F609 Reporting of Alleged Violations. In lieu of discovery facility immediately initiated the following:-On 12/2/25, the Director of Nursing called residents family to discuss status of patient who is currently admitted to hospital. During conversation, family verbalized an occurrence involving an aide elevating resident's legs during incontinence care causing pain on the evening of 11/14/2025.-Immediate investigation was initiated including the following:-Identified the aide that was assigned to the resident on date of noted incident with notification and statement attained. -Aide was suspended pending investigation and removed from schedule.-All other residents on unit that are able to be interviewed were interviewed with no care concerns noted.-Per investigation look back at the initial x-ray was negative of any acute findings. A CT scan (advanced imaging test that uses X rays and a computer to create detailed, cross-sectional pictures of the inside of the body) was completed on 11/20/25, during a hospital transfer with an indeterminate L4 (fourth vertebrae of the lower spine) compression fracture (break or collapse) that was reviewed by the in house Nurse Practitioner and could not be verified as acute. -Education was completed on abuse and the timeliness of reporting concerns/customer service timely.-Skin sweeps are being completed on all residents in the facility Adult Protective Services is aware at this time. -Audits will be completed twice weekly for one month with random residents for any care/concern issues. -Facility is not substantiating abuse or neglect related to statements attained and results of investigation. -PB22 was completed.-Facility came back into compliance on 12/5/25, when education was completed.On 12/10/25, at 12:51 p.m. it was verified that the facility had implemented its corrective action plan, and education was verified for 121 facility employees on abuse and the timeliness of reporting concerns Exit

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, facility policy, clinical records, and staff interview, it was determined that the facility failed to conduct a thorough investigation of an allegation of abuse for one of three residents (Resident R4).Findings include:Review of facility policy Pennsylvania Resident Abuse Policy dated 3/14/25, indicated the facility's policy is to investigate all allegations, suspicions and incidents of abuse, neglect, involuntary seclusion, intimidation, exploitation of residents, misappropriation of resident property and injuries of unknown source. 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In lieu of discovery facility immediately initiated the following:-On 12/2/25, the Director of Nursing called residents family to discuss status of patient who is currently admitted to hospital. During conversation, family verbalized an occurrence involving an aide elevating resident's legs during incontinence care causing pain on the evening of 11/14/2025.-Immediate investigation was initiated including the following:-Identified the aide that was assigned to the resident on date of noted incident with notification and statement attained.-Aide was suspended pending investigation and removed from schedule.-All other residents on unit that are able to be interviewed were interviewed with no care concerns noted.-Per investigation look back at the initial x-ray was negative of any acute findings. 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