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	04/08/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of three residents sampled with facility-initiated transfers (Residents R1 and R4) and failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for two of three resident hospital transfers (Residents R1 and R4) .Findings include: Review of the facility Discharge Planning Policy last reviewed 2/8/26, indicated the facility will take steps to ensure that the transfer or discharge is documented in the resident's medical record and necessary information is communicated to the receiving health care institution or provider. Review of the clinical record indicated resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/9/26, indicated diagnoses of high blood pressure, septicemia (infection in blood) and chronic obstructive pulmonary disease (makes it hard to breathe). Review of the clinical record indicated Resident R1 was transferred to the hospital on 3/21/26, and has not returned to the facility. Review of Resident R1's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R1's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 3/21/26. Review of the clinical record indicated resident R4 was admitted to the facility on [DATE]. Review of Resident R4's MDS dated [DATE], indicated diagnoses of cancer, anemia (low iron in the blood) and high blood pressure. Review of the clinical record indicated Resident R4 was transferred to the hospital on 3/17/26, and has not returned to the facility. Review of Resident R4's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of Resident R4's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 3/17/26. During an interview completed on 4/7/26, at 12:15 p.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of three residents sampled with facility-initiated transfers (Residents R1 and R4) and failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for two of three resident hospital transfers (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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Residents R1 and R4) . 28 Pa. Code: 201.14(a)Responsibility of licensee.28 Pa. Code: 201.29 (a)(c.3)(2) 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to properly secure a medication cart for three of four medication carts (Second Floor B, C, G Hall Medication Cart, Third Floor Front Hall Medication Cart and Third Floor Back Hall Medication Cart).Findings include: Review of the facility policy General Dose Preparation and Medication Administration last reviewed 2/8/26, indicated the facility should ensure that medication carts are always locked when out of sight or unattended. Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE]. Review of Resident R7's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/10/26, indicated diagnoses of dementia (loss of cognitive functioning, remembering, and reasoning) asthma (chronic lung disease that makes it hard to breathe) and high blood pressure. Section C0500 Brief Interview for Mental Status (BIMS) score coded as 04 indicating severely impaired cognition. During an observation completed on 4/7/26, at 12:27 a.m. Resident R7 was seated in her wheelchair next to the medication cart near room [ROOM NUMBER]. Resident R7 reached up and removed an item that was sitting on top of the medication cart. The Speech Therapist (ST) Employee E3 observed her removing the item from the top of the cart and was attempting to redirect the resident and retrieve the item. The ST Employee E3 identified the item as someone's personal cell phone. The medication cart was found to be unlocked. During an observation and interview completed on 4/7/26, at 12:30 p.m. Registered Nurse (RN) Employee E4 returned to the medication cart and stated that the cell phone was hers that's mine and retrieved the phone off the resident. RN Employee E4 confirmed that the cell phone was left sitting on top of the medication cart and that the medication cart was left unattended and unlocked. RN Employee E4 identified the Medication Cart as the Second Floor B, C, G Hall Medication Cart. During an observation completed on 4/7/26, at 12:40 p.m. an unlocked medication cart was found sitting in the hallway near room [ROOM NUMBER]. During an interview completed on 4/7/26, at 12:43 p.m. Registered Nurse (RN) Employee E5 confirmed that the medication cart was left unattended and unlocked. RN Employee E5 identified the medication cart as the Third Floor Front Hall Medication Cart. During an observation completed on 4/7/26, at 12:45 p.m. an unlocked medication cart was in the hallway near room [ROOM NUMBER]. During an interview completed on 4/7/26, at 12:47 p.m. RN Employee E6 confirmed the medication cart was left unattended and unlocked. RN Employee E6 identified the medication cart as the Third Floor Back Hallway Medication Cart. During an interview completed on 4/7/26, at 1:15 p.m. the Director of Nursing confirmed that the facility failed to properly secure a medication cart for three of four medication carts (Second Floor B, C, G Hall Medication Cart, Third Floor Front Hall Medication Cart and Third Floor Back Hall Medication Cart). 28 Pa. Code: 201(a) Responsibility of licensee.28 Pa. Code: 211.9(a)(1) Pharmacy services.28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on review of facility provided documents and staff interviews, it was determined that the facility failed to ensure residents' records are readily accessible to the State Survey Agency which caused a delay in the survey process for one of three residents (Resident R3).Findings include: During an interview completed on 4/7/26, at approximately 12:15 p.m. upon asking the Director of Nursing (DON) concerning documentation prior to 12/1/25, informed State Agency that the Matrix (computer program) was just started on 12/1/25, with new ownership and that residents in the facility during the transition period on 12/1/25, have records in the Point Click Care (PCC-computer program). The facility does not have access to PCC, will have to contact corporate (corp) office to gain access. During an interview completed on 4/7/26, at 1:00 p.m. the Regional Registered Nurse (RN) Employee E1 stated they (corp) do not have access to PCC will contact them again to gain access. During an interview completed on 4/7/26, at 2:08 Regional Registered Nurse (RN) Employee E1 stated that corp had to contact legal in an effort to gain access to PCC and the program was still unavailable to State Agency. During an interview completed on 4/7/26, at 3:15 p.m. the PCC program was still not accessible to the State Agency. State Agency to return to facility on 4/8/26. During an interview on 4/8/26, at 8:45 a.m. the State Agency received access to the PCC system for record review. The DON stated, we had to have legal get involved as the prior ownership company took everything and would not give us access and confirmed the facility failed to ensure resident records are readily accessible to the State Survey Agency which caused a delay in the survey process for one of three residents. 28 Pa. Code: 211.5(f)(g)(h) Clinical records.