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	06/09/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility provided documents, clinical record review, and staff interviews, it was determined that the facility failed to develop a comprehensive care plan that included specific and individualized interventions to address the care needs of residents with pressure ulcers for one of four residents (Resident R1).Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set Assessments (MDS - periodic assessment of care needs) dated October 2025, indicated that Section V: Care Area Assessment (CAA) Summary instructions stated, For each triggered care area, Column B Care Planning Decision is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. Review of facility policy Comprehensive Care Planning dated 2/23/26, indicated an interdisciplinary plan of care will be established and updated as indicated for every resident in accordance with state and federal regulatory requirements. The facility will develop a comprehensive person-centered care plan for each resident that includes measurable goals and timetables to meet resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment. The comprehensive care plan will be developed within (7) days after completion of the comprehensive assessment (MDS). Review of the clinical record indicated Resident R1 was originally admitted to the facility 4/30/24, then readmitted [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/4/26, indicated diagnoses of quadriplegia (paralysis that affects all limbs and body from the neck down), osteomyelitis (bone infection) of vertebrae (backbone), sacrum (triangular bone at the base on the spine), and sacrococcygeal (area at base on spine where the sacrum meets the coccyx (tailbone)) region, and protein-calorie malnutrition. Review of Section M: Skin Conditions indicated resident is at risk of developing pressure ulcer/injuries and indicated the presence of a Stage III (full-thickness skin loss) pressure ulcer. Review of Section V: Care Area Assessment Summary indicated that the Pressure Ulcer Care Area was triggered with an X, and Care Planning Decision was triggered with an X, indicting the triggered care area is addressed in the care plan. Review of Resident R1's physician order dated 4/21/26, indicated right gluteal fold Special instructions: Cleanse with normal saline (sterile solution), pat dry, apply medical grade honey (sterile, clinically tested honey used to promote wound healing, fight infection, and support tissue repair), calcium alginate (natural, highly absorbent material), zinc oxide paste (skin protectant) to peri wound, apply border gauze (specialized wound dressing), as needed for soilage, once a day 23:00 (11:00 p.m.) - 07:00 (7:00 a.m.). Review of Resident R1's clinical progress note Skin and Wound note dated 5/5/25, indicated right gluteal fold, stage 3. Patient (R1) would like to resume service with doctor at wound center. Treatment has included medical honey/calcium alginate. Patient (R1) has refused debridement (medical removal of dead, damaged, or infected tissue to promote healing and reduce the risk of infection). Review of the current care plan on 6/9/26, failed to reveal a plan of care developed with goals and interventions for the risk that Resident R1 may develop pressure ulcer/injuries, and failed to reveal a plan of care developed with goals and (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions related to Resident R1 having an actual pressure ulcer. During an interview on 6/9/26, at 2:40 p.m., the Director of Nursing (DON) confirmed that the facility failed to develop a comprehensive care plan that included specific and individualized interventions to address the care needs of residents with pressure ulcers for Resident R1. 28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.