

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395300	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Perry Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review, observation, and staff interviews, it was determined that the facility failed to properly monitor residents in room personal refrigerator temperatures for two of three residents (Residents R33 and R46) which created the potential for food borne illness, failed to implement appropriate transmission-based precautions for nine of 18 residents (Residents R46, R55, R75, R92, R102, R153, R163, R169, and R173), and failed to implement infection control practices to prevent cross contamination during a dressing change for one of three residents (Resident R46). Findings include: Review of the facility policy Storage of Resident Food dated 3/14/25, indicated residents must allow staff to monitor and log the refrigerator temperatures and expiration of food items. Review of the Pennsylvania Department of Health Toolkit for Control of Norovirus Outbreaks in Long-Term Care Facilities dated 10/11/24, and expanded from infection prevention and control guidance from the Centers for Disease Control and Prevention (CDC) for nursing homes and Long-Term Care Facilities revealed the following: GI Illness Outbreak Recommendations Checklist - GI (gastrointestinal) Illness - illnesses that can be caused by a variety of different disease-causing microbes and germs. Common symptoms may include diarrhea, nausea, vomiting, abdominal cramps, and fever. - LTCF (long-term care facilities) GI Illness Outbreak - an occurrence of two or more similar GI illnesses resulting from a common exposure- Place patients with suspected norovirus gastroenteritis on contact precautions until symptom-free for at least 48 hours. Review of the CDC (Centers for Disease Control and Prevention) Guidelines indicated Contact Precautions are measures that are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. Contact Precautions require the use of gown and gloves on every entry into a resident's room, regardless of the level of care being provided to the resident. Review of facility policy Enhanced Barrier Precautions dated 3/14/25, indicated Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs hand hygiene, targeted gown and glove use during high contact resident care activities that include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing. Review of the admission record indicated Resident R33 admitted to the facility on [DATE]. Review of Resident R33's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/30/25, indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), high blood pressure, and depression. Observation on 10/20/25, at 11:26 a.m. of Resident R33's in room personal refrigerator indicated a temperature log dated October 2025. The log indicated to record temperatures once per day. The log was blank on 10/2/25, 10/3/25, 10/4/25, 10/5/25, 10/9/25, 10/10/25, 10/11/25, and 10/12/25. Interview on 10/20/25, at 11:35 a.m. Licensed Practical Nurse (LPN) Employee E3 confirmed Resident R33's temperature log was not consistently monitored and logged as required. Review of the admission record indicated Resident R46 was admitted to the facility on [DATE]. Review of Resident R46's MDS dated [DATE], indicated the diagnoses of anemia, high blood pressure, and heart failure (heart doesn't pump blood as well as it should). Observation on (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/20/25, at 11:30 a.m. of Resident R46's in-room personal refrigerator indicated a temperature log dated October 2025. The log indicated to record temperatures once per day. The log was blank from 10/5/25, through 10/20/25. Interview on 10/20/25, at 11:35 a.m. LPN Employee E3 confirmed Resident R46's temperature log was not consistently monitored and logged as required and that the facility failed to properly monitor residents in room personal refrigerator temperatures for two of three residents (Residents R33, and R46) which created the potential for food borne illness. Review of Resident R46's clinical record revealed a Nurse Practitioner (NP)/PA (Physician Assistant) Progress Note dated 1/15/25, that stated, Patient notes a few days prior she began experiencing diarrhea with acute onset. Patient does not recall eating anything different from her typical diet. This is likely a viral etiology as there has been an outbreak of an acute gastrointestinal illness across the entire building. Review of Resident R46's clinical record failed to reveal documentation to indicate the resident had been placed on Contact Precautions. Review of the clinical record indicated Resident R55 was admitted to the facility on [DATE]. Review of Resident R55's MDS dated [DATE], indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fats in the blood), and anxiety. Review of a nursing progress note dated 1/13/25, stated, Sudden digested food emesis. Denies nausea today at all. CNA (Certified Nurse Aide) reports loose stool also. Afebrile (without fever). Denies chills, cough. Review of Resident R55's clinical record failed to reveal documentation to indicate the resident had been placed on Contact Precautions. Review of the clinical record indicated Resident R75 was admitted to the facility on [DATE]. Review of Resident R75's MDS dated [DATE], indicated diagnoses of anemia, high blood pressure, and hemiplegia (paralysis on one side of the body). Review of a NP/PA Progress Note dated 1/15/25, stated, Patient seen today at the request of staff for refusal of meals and meds on 1/14. Patient had acute vomiting, diarrhea the day prior, likely of viral etiology. Review of Resident R75's clinical record failed to reveal documentation to indicate the resident had been placed on Contact Precautions. Review of the clinical record indicated Resident R92 was admitted to the facility on [DATE]. Review of Resident R92's MDS dated [DATE], indicated diagnoses of high blood pressure, anxiety, and muscle weakness. Review of a progress note dated 1/13/25, stated, Lethargy noted today when trying to communicate. Several loose stools noted during morning shift. Resident refused lunch due to nausea, medicated per as needed orders which has been effective. Review of Resident R92's clinical record failed to reveal documentation to indicate the resident had been placed on Contact Precautions. Review of the clinical record indicated Resident R102 was admitted to the facility on [DATE]. Review of Resident R102's MDS dated [DATE], indicated diagnoses of anemia, high blood pressure, and history of falling. Review of a NP/PA Progress Note dated 1/13/25, stated, Patient seen today for acute GI symptoms on 1/11 - nausea/vomiting/diarrhea, body aches. Review of Resident R102's clinical record failed to reveal documentation to indicate the resident had been placed on Contact Precautions. Review of the clinical record indicated Resident R153 was admitted to the facility on [DATE]. Review of Resident R153's MDS dated [DATE], indicated diagnoses of anemia, high blood pressure, and other lack of coordination. Review of a NP/PA Progress Note dated 1/17/25, stated, Patient seen acutely per staff request for nausea, vomiting, and diarrhea symptoms that began acutely overnight. Other residents with similar secondary to viral illness. Review of Resident R153's clinical record failed to reveal documentation to indicate the resident had been placed on Contact Precautions. Review of the clinical record indicated Resident R163 was admitted to the facility on [DATE]. Review of Resident R163's MDS dated [DATE], indicated diagnoses of high blood pressure, weakness, and unsteadiness on feet. Review of a NP/PA Progress Note dated 1/13/25, stated, Patient seen today for acute GI symptoms over the weekend. Patient noted to have watery stools, roommate with similar, current norovirus suspected. Review of a physician order dated 1/12/25, indicated to send stool specimen for norovirus one time only for diarrhea. Review of Resident R163's clinical record failed to reveal documentation to indicate the resident had been placed on Contact Precautions. Review of the clinical record indicated Resident R169 was admitted to the facility on [DATE]. Review of Resident R169's MDS dated (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, observations and staff interview, it was determined that the facility failed to determine whether it was safe to self-administer medications for two of three residents (Resident R42 and R62). Findings include: Review of the facility policy Resident Self-Administration of Medications dated 3/14/25, indicated residents in the facility who wish to self-administer their medications may do so if the interdisciplinary team has determined that this practice is clinically appropriate. Assessments will include addressing the following and documenting in the care plan: storage of the medication, responsible party for storage of medication, documenting the administration of drugs, and location of where the drugs will be administered. Review of the admission record indicated Resident R42 was admitted to the facility on [DATE]. Review of Resident R42's Minimum Data Set (MDS- a periodic assessment of care needs) dated 10/2/25, indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), high blood pressure, and peripheral vascular disease (a condition in which narrowed blood vessels reduce blood flow to the limbs). Observation on 10/20/25, at 10:45 a.m. of Resident R42's room indicated a bottle of Dakin's solution (a diluted antiseptic wound cleansing solution), a tube of zinc oxide (skin protectant), and a tube of Medi Honey (medical grade honey used for wound care). Review of Resident R42's clinical record failed to have a physician order, assessment, or plan of care addressing self-administration of medications. Interview on 10/20/25, at 10:45 a.m. Licensed Practical Nurse (LPN) Employee E3 confirmed the medications were stored in the resident room inappropriately and that Resident R42 failed to have an assessment, physician order, or plan of care for self-administration of medications. Review of the admission record indicated Resident R62 was admitted to the facility on [DATE]. Review of Resident 62's Minimum Data Set (MDS- a periodic assessment of care needs) dated 9/27/25, indicated the diagnoses of dysphagia (impairment in the production of speech resulting from brain disease or damage), hypertension and constipation. Observation on 10/20/25, at 10:15 a.m. of Resident R62's room indicated a bottle of Tum's (over-the-counter antacid). Review of Resident R62's clinical record failed to have a physician order, assessment, or plan of care addressing self-administration of medications. Interview on 10/20/25, at 10:15 a.m. Registered Nurse (RN) Employee E13 confirmed the medications were stored in the resident room inappropriately and that Resident R62 failed to have an assessment, physician order, or plan of care for self-administration of medications. 28 Pa code: 211.12(d)(1)(5) Nursing services.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to accommodate the call bell needs for one of five residents (Resident R91). Findings include: Review of facility policy Resident Rights dated 3/14/25, indicated call light or bell access will be within reach of the resident as one method to communicate needs to staff. Review of the clinical record indicated Resident R91 was admitted to the facility on [DATE]. Review of Resident R91's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/24/25, indicated diagnoses of high blood pressure, hemiplegia (paralysis on one side of the body), and anemia (too little iron in the blood). Review of Resident R91's care plan, dated 4/24/24, indicated to place touch pad call bell in reach of resident at all times. During an observation on 10/20/25, at 10:57 a.m. Resident R91 was observed laying in their bed. Resident R91's touch pad call bell was observed on the resident's dresser, out of the resident's reach. During an interview on 10/20/25, at 10:59 a.m. Registered Nurse Employee E1 confirmed Resident R91's call bell was not accessible and unavailable for use to the resident and that the facility failed to accommodate Resident R91's call bell needs. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, and staff interviews, it was determined that the facility failed to ensure the physician was appropriately notified of missed medication doses for one of five residents reviewed (Resident R1). Findings include: 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 9/10/25, indicated diagnoses of high blood pressure, left knee pain, and difficulty in walking. Review of a physician order dated 9/8/25, indicated to provide Resident R1 with levothyroxine (medication used to treat an underactive thyroid) 100 micrograms, 1 tablet by mouth in the morning every Tuesday, Wednesday, Thursday, Friday, Saturday, and Sunday. Review of Resident R1's September 2025 Medication Administration Record revealed the scheduled medication was not administered on the following dates:- Tuesday 9/9/25-Wednesday 9/10/25 During an interview on 10/23/25, at 2:27 .m. the Assistant Director of Nursing (ADON) stated that the facility had the medication in the facility, however as resident had a reported allergy to dyes used in the medication, the facility had to wait until the pharmacy was able acquire an appropriate medication without dyes for Resident R1, and had missed doses on 9/9/25, and 9/10/25 as ordered. During an interview on 10/24/25, at 11:40 a.m. the Director of Nursing stated the facility was unable to provide documentation that the physician was made aware of Resident R1's medication being unavailable and that the facility failed to ensure the physician was appropriately notified of missed medication doses for Resident R1. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1) Management.28 Pa. Code: 211.10 (c)(d) Resident Care policies.28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on review of facility documentation and staff interview it was determined that the facility failed to provide in a timely manner, notice of Skilled Nursing Facility Advance Beneficiary Notice (SNF-ABN), Form CMS - 10055 for one of two residents reviewed (Resident R142). Findings include: Review of the clinical documentation indicated Resident R142 was discharged from skilled services on 5/11/25. Review of facility documentation failed to include a SNF-ABN form prior to discharge from skilled services. During an interview on 10/24/25, at 12:32 p.m. Business Office Employee E16 confirmed that the facility failed to provide in a timely manner, SNF-ABN form CMS-10055 for Resident R142. 28 Pa. Code 201.14(a) Responsibility of licensee.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on review of facility policy, observation, and staff interview it was determined that the facility failed to maintain the confidentiality of residents' medical information on one of eight medication carts (second floor cart). Findings include: Review of the facility's Health Insurance Portability and Accountability Act (HIPAA) dated 3/14/25, indicated HIPAA requires providers and others to implement security measures to guard the integrity and confidentiality of medical information. During an observation on 10/21/25, at 11:16 a.m. a medication cart by the nurse's station was left unattended with a paper nursing report sheet with identifiable information any passerby could see resident personal and confidential information. During an interview on 10/22/25, at 8:51 a.m. Registered Nurse Employee E5 confirmed the above observation and that the facility failed to maintain the confidentiality of residents' medical information as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.29(c.3) Resident Rights. 28 Pa. code: 211.5(b) Medical records. 28 Pa. Code: 211.12(d)(1)(3) Nursing services.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, facility documents, observations, and staff interviews, it was determined that the facility failed to identify the use of bolsters (a long, thick cushion) on a bed as a possible restraint, failed to obtain a physicians order, failed to develop a person-centered plan of care for the use of physical restraints, and failed to provide ongoing re-evaluation of the need for physical restraints for one of two residents reviewed (Residents R15). Findings include: Review of facility policy Restraint- Use and Management dated 3/14/25, indicated physical restraint refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Before a resident is restrained, the facility will determine the presence of a specific medical symptoms that would require the use of restraints, and determine: a. How the use of restraints would treat the medical symptom. b. The length of time the restraint is anticipated to be used to treat the medical symptom, who may apply the restraint, and the time and frequency that the restraint will be released. c. The type of direct monitoring and supervision that will be provided during the sue of the restraint. d. How the resident will request staff assistance and how his/her needs will be met while the restraint is in place. e. How to assist the resident in attaining or maintaining his/her highest practicable level of physical and psychosocial well-being. Review of the clinical record indicated Resident R15 was admitted to the facility on [DATE]. Review of Resident R15's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 8/31/25, indicated diagnoses of high blood pressure, right elbow contracture, and decreased white blood cell count. Section P0100 indicated that no restraints were in use. During an observation on 10/21/25, at 8:54 a.m. Resident R15 was observed lying in bed and the mattress had bilateral (on both sides) raised edges on top and bottom portions. Review of Resident R15's active physician orders on 10/22/25, failed to include an order for bolsters or a concave mattress. Review of Resident R15's comprehensive care plan on 10/22/25, failed to reveal goals and interventions related to the usage of bolsters or a concave mattress. Review of Resident R15's clinical record failed to identify any assessments or ongoing evaluations for the usage of bolsters or a concave mattress. During an interview on 10/23/25, at 9:17 a.m. Physical Therapist (PT) Employee E15 stated that therapy was not involved in ordering, evaluating, or placing bolsters on Resident R15's bed. PT Employee E15 stated that air mattress sometimes comes with bolsters zipped into the mattress, and When we have to get them [residents] out of bed, we have to unzip the mattress cover to remove the bolsters, so they can get out of bed. During an interview on 10/23/25, at 11:17 a.m. the Director of Nursing confirmed that the facility failed to identify the use of bolsters (a long, thick cushion) on a bed as a possible restraint, failed to obtain a physicians order, failed to develop a person-centered plan of care for the use of physical restraints, and failed to provide ongoing re-evaluation of the need for physical restraints for one of two residents reviewed (Residents R15). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.8(e) Use of restraints. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.		

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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 one of two residents sampled with facility-initiated transfers (Residents R1).Findings include: 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 9/10/25, indicated diagnoses of high blood pressure, left knee pain, and difficulty in walking. Review of the clinical record indicated Resident R1 was transferred to the hospital on 9/10/25. 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. During an interview on 10/24/25, at 11:40 a.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 one of two residents sampled with facility-initiated transfers (Residents R1). 28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.		

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NAME OF PROVIDER OR SUPPLIER Perry Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9850 Old Perry Highway Wexford, PA 15090	
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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 policies, clinical records, and staff interviews, it was determined that the facility failed to develop comprehensive care plans to meet resident care needs for one of five residents (Resident R119). Findings include: Review of facility policy Plan of Care Overview dated 3/14/25, indicated the Plan of Care, also Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care. Review of the clinical record indicated Resident R119 was admitted to the facility on [DATE]. Review of Resident R119's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/7/25, indicated diagnoses of high blood pressure, unsteadiness on feet, and malnutrition (lack of sufficient nutrients in the body). Question B0300 Hearing Aid was coded 1 for yes, hearing aid or other hearing appliance used. Review of a physician order dated 7/1/25, indicated bilateral (both sides) hearing aids. Remove at HS (night) and place in container. Insert in ears in AM (morning) every day and evening shift. During an observation on 10/20/25, at 10:52 a.m. Resident R119 was observed wearing her bilateral hearing aids. Review of Resident R119's current care plan failed to include the development of goals and interventions related to the resident's bilateral hearing aid usage. During an interview on 10/24/25, at 11:56 a.m. the Director of Nursing confirmed that the facility failed to develop a comprehensive care plan to meet resident care needs for Resident R119. 28 Pa Code: 201.14(a) Responsibility of licensee. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a resident's interview, clinical record review and review of the facility policy, it was determined that the facility failed to provide assistance with application of a stump shrinker resulting in a resident's inability to attend therapy for ambulation for one of three residents (Resident R46). Findings include: Review of the facility policy Routine Resident Care dated 3/14/25, indicated routine daily care by a certified nursing assistant with specialized training in rehabilitation/restorative care including but not limited to assisting with special devices such as prosthesis (denoting an artificial body part) and eating devices. Providing an environment that contributes to a positive self-image preserves dignity and promotes privacy. Review of the admission record indicated Resident R46 was admitted to the facility on [DATE]. Review of Resident R46's Minimum Data Set (MDS- a periodic assessment of care needs) dated 8/21/25, indicated the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), high blood pressure, and heart failure (heart doesn't pump blood as well as it should). Section C0500 a 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 R46's physician order dated 9/29/25, indicated Physical Therapy three times per week for thirty days for therapeutic exercise and gait training. Review of Resident R46's care plan dated 8/21/25 indicated resident has an activities of daily living (ADL) self-care performance deficit and requires assistance with ADLs due to weakness, deconditioning, and right below the knee amputation. Intervention resident to wear gel liner and sock when out of bed at all times. Only wearing prosthetic for transfers. Interview on 10/20/25, at 10:20 a.m. Resident R46 indicated the staff on evening shift did not put on the stump shrinker (a compression garment worn by amputees to reduce swelling, shape the residual limb, and prepare it for a prosthetic) when asked to yesterday and today resident is unable to apply the prosthetic leg due to swelling of the limb. The Resident had to refuse therapy for the day because therapy is working on ambulation, and resident is unable to participate without the prosthetic in place. Interview with Resident R46 and the Director of Nursing confirmed the limb was swollen and the facility failed to provide assistance with application of a stump shrinker resulting in a resident's inability to attend therapy for ambulation for one of three residents (Resident R46). 28 Pa. Code 211.10d) Resident care policies28 Pa. Code 211.12(c)(d)(1) Nursing services		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility documentation, resident and staff interview it was determined that the facility failed to provide an on-going program of activities to meet the interests of and support the physical, mental, and psychosocial and well-being of residents for one of seven residents (Resident R128).Findings include: Review of facility documentation Activities Program dated 3/14/25, indicated: 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. The activity program is: Designed to encourage restoration to self-care and maintenance of normal activity that is geared to the individual resident's needs. Review of Resident R128 Was admitted on [DATE]. Review of facility documentation dated 4/29/25 indicated: Review of the expert report also indicated diagnosis - anxiety disorder. During an interview on 10/20/25, at 9:45 a.m. Resident R128 indicated that they have no relevant activities to do. Per the resident they don't have any peers who are close to in age, and they try to keep themselves busy by reading, doing sudoku, and walking around the facility. Review of the MDS (minimum data set - a periodic assessment of resident needs) Section F indicated these areas were very important to the resident: reading books/newspapers, magazines, listen to music, keeping up with the news, go outside to get fresh air. Review of the clinical documentation 4/22/25: psychiatric note indicated:Pt and the therapist discussed pt's continued disdain for living within facility, feeling the drone of daily activities (or pts report of lack thereof). Pt and therapist discussed pt's plans for future. Review of Resident R128 facility documentation for September/August and July of 2025 indicated that Resident R128 did all activities by themselves. Activities for September: were conversation/social time/family time, relaxation/self- directed activity, with one group activity of men/women party.Activities for August: were conversation/social time/family time, and relaxation/self- directed activityActivities for July: were conversation/social time/family time and relaxation/self - directed activity. During an interview on 10/24/25, at 10:45 a.m. the Nursing Home Administrator was informed that the facility failed to provide an on-going program of activities to meet the interests of and support the physical, mental, and psychosocial and well-being of residents for one of seven residents (Resident R128). 28 Pa. Code201.18 (b)(3) Management.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, observations, and staff interviews, it was determined that the facility failed to ensure a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility for two of four residents (Residents R56 and R57). Findings include: Review of the facility policy Routine Resident Care dated 3/14/25, indicated routine daily care by a certified nursing assistant with specialized training in rehabilitation/restorative care including but not limited to maintaining proper body position and alignment for all residents, encouraging maximum function for each resident, and assisting with special devices such as prosthesis (denoting an artificial body part) and eating devices. Review of the clinical record indicated Resident R56 was admitted to the facility on [DATE]. Review of Resident R56's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/24/25, indicated diagnoses of high blood pressure, stroke (damage to the brain from an interruption of blood supply), and heart failure (heart doesn't pump blood as well as it should). Review of Resident R56's physician order dated 9/18/25, indicated device/adaptive equipment palm guard (prevents the fingers from digging into the palm of the hand) to right hand. On with morning care and off with bedtime care two times daily. Review of Resident R56's care plan dated 9/17/25, indicated splint/brace/orthotic: palm guard to right hand on with morning care and remove with bedtime care. Observation on 10/20/25, at 9:20 a.m. Resident R56 was observed in bed. A hand splint was noted on the bedside stand. Resident R56 failed to have a splint on either hand. The right hand's fingers were closed into the palm of the hand. Interview and observation on 10/20/25, at 12:07 p.m. Licensed Practical Nurse (LPN) Employee E3 confirmed the palm guard was not on the resident as ordered. Review of the admission record indicated Resident R57 was admitted to the facility on [DATE]. Review of Resident R57's MDS dated [DATE], indicated diagnoses of repeated falls, seizure disorder (a person experiences abnormal behaviors, symptoms and sensations, sometimes including loss of consciousness), and muscle weakness. Observation on 10/20/25, at 9:30 a.m. Resident R57 was observed in a Geri-chair (a type of recliner designed for individuals with limited mobility) with the right leg dangling over the right side of the chair's arm. Interview on 10/20/25, at 9:35 a.m. Nurse Aide (NA) Employee E14 indicated staff have a hard time keeping Resident R57 in the chair. Observation on 10/22/25, at 11:20 a.m. Resident R57 was in a Geri-chair sitting with both legs dangling over the right side of the chair's arm. Resident proceeded to turn body in the chair so that the feet were at the head area and the back and head were where the feet should be. Interview and observation on 10/22/25, at 11:25 a.m. Registered Nurse (RN) Employee E6 repositioned Resident R57 in the chair and indicated the resident has brain cancer and has little safety awareness. Review of Resident R57's physician orders and care plan failed to include an order or care plan for use of the Geri-chair. Interview on 10/22/25, at 11:30 a.m. the Director of Nursing confirmed the facility failed to have physician orders or care plan for Resident R57 to be in the Geri-chair and that the facility failed to ensure a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility for two of four residents (Residents R56 and R57). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10(a)(c)(d) Resident care policies. 28 Pa. Code: 211.12(c)(d)(1)(2)(3)(5) Nursing services.		

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to provide colostomy care and services consistent with professional standards of practice for two of two residents reviewed (Resident R13 and R77). Findings include: Review of facility policy Colostomy Appliance Bag Change dated 3/14/25, indicated that staff should position appropriately sized appliance to fit well around stoma (a surgically created opening in the abdomen that allows waste to exit the body) to prevent leakage. Measure the stoma with a stoma measuring guide. [NAME] the paper backing. Check the opening in the new pouch to ensure that it is large enough to fit the diameter of the stoma. Review of the clinical record revealed that Resident R13 was admitted to the facility on [DATE]. Review of Resident R13's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 9/26/25, indicated diagnoses of high blood pressure, muscle wasting, and colostomy (surgery to divert the colon into an artificial opening in the abdominal wall for waste elimination). Review of Resident R13's physician orders dated 8/16/25, indicated to monitor left side colostomy site for discoloration. Change ostomy bag as needed. The order failed to include size and type of colostomy appliance to be used. Review of Resident R13's current care plan dated 8/18/25, failed to include size and type of colostomy appliance being used. Review of the clinical record revealed that Resident R77 was admitted to the facility on [DATE]. Review of Resident R77's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 10/3/25, indicated diagnoses of ulcerative colitis (type of inflammatory bowel disease that causes inflammation in the digestive tract), diverticulitis of large intestine (inflammation of one or more diverticula) and diabetes mellitus. Review of Resident R77's physician orders dated 10/9/25, indicated to monitor colostomy site for discoloration. Change ostomy bag as needed. The order failed to include size and type of colostomy appliance to be used. Review of Resident R77's current care plan dated 10/3/25, failed to include size and type of colostomy appliance being used. During an interview on 10/23/25, at 11:12 a.m. the Director of Nursing (DON) confirmed that colostomy orders for Resident R13 and R77 did not include any size and type of colostomy appliance to be used. DON stated that staff should measure the opening per policy to determine what should be used. However, DON confirmed that the facility failed to document that measuring was being completed, and failed to document what size and type of appliance was being used for two of two residents. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident clinical records, and staff interview it was determined the facility failed to provide consistent and complete communication with the dialysis center for two of two residents reviewed (Residents R17 and R65). Findings include: Review of the facility policy Hemodialysis Care and Monitoring dated 3/14/25 indicated the facility will provide a method for on-going communication and collaboration. Review of the clinical record indicated that Resident R17 was admitted to the facility on [DATE]. Review of Resident R17's Minimum Data Set (MDS- a periodic assessment of care needs) dated 10/14/25, indicated with the diagnoses of end stage kidney disease (a condition where the kidney reaches advanced state of loss of function), dependance on renal dialysis and high blood pressure. Review of R17's physician order dated 10/8/25, indicated the resident has dialysis one time a day every Monday, Wednesday, and Friday. Review of Resident R17's Dialysis Communication Records from 10/10/25-10/20/25, revealed five days of missing completed communication sheets: 10/10/25, 10/13/25, 10/15/25, 10/17/25, and 10/20/25. Review of the clinical record indicated that Resident R65 was admitted to the facility on [DATE]. Review of Resident R65's MDS dated [DATE], indicated with the diagnoses of end stage kidney disease, dependance on renal dialysis and heart failure. Review of R65's physician order dated 10/6/25, indicated the resident has dialysis one time a day every Monday, Wednesday, and Friday. Review of Resident R65's Dialysis Communication Records from 10/1/25-10/21/25, revealed three days of missing communication sheets: 10/3/25, 10/15/25 and 10/17/25. Interview on 10/23/25 at 11:15 a.m. the Director of Nursing confirmed the facility failed to provide consistent and complete communication with the dialysis center for two of two residents reviewed (Residents R17 and R65). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.5(f) Medical records.28 Pa. Code: 211.12(c)(d)(1)(3)(5) Nursing services.		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by two of four residents reviewed (Residents R111 and R119). Findings include: Review of facility policy Dementia Care Resident Rights and Privileges dated 3/14/25, indicated residents with dementia (a group of symptoms that affects memory, thinking and interferes with daily life) and/or dementia-related diagnosis will be treated with the same respect and dignity and afforded the same resident rights regardless of diagnosis, severity of condition or payment source including but not limited to visual privacy for bathing, ADL (activities of daily living) care and toileting. Individual goals will be addressed on the care plan that meet the needs of the resident for quality of life and quality of care including safety and maximize independence and functioning. Review of the Resident Assessment Instrument 3.0 User's Manual, effective October 2025, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of the clinical record indicated Resident R111 was admitted to the facility on [DATE]. Review of Resident R111's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/31/25, indicated diagnoses of high blood pressure, dementia, and Parkinson's Disease (neuromuscular disorder causing tremors and difficulty walking). Question C0500 BIMS Summary Score indicated the resident scored a 4, severe impairment. Review of Resident R111's care plan, failed to indicate the facility had developed and implemented a person-centered care plan to address Resident R111's dementia and cognitive loss. Review of the clinical record indicated Resident R119 was admitted to the facility on [DATE]. Review of Resident R119's MDS dated [DATE], indicated diagnoses of high blood pressure, unsteadiness on feet, and malnutrition (lack of sufficient nutrients in the body). Question C0500 BIMS Summary Score indicated the resident scored a 9, moderately impaired. Review of a Nurse Practitioner/PA (Physician Assistant) Progress Note dated 7/1/25, completed by PA Employee E9 stated, Pt (patient) is a 90 yr (year) old female with a pmh (past medical history) of DMII (diabetes type 2), CKD (chronic kidney disease), MDD (major depressive disorder), migraines, neuropathy, hypothyroidism and dementia who presents to facility for assistance with personal care. Review of a Physician Progress Note, dated 7/7/25, completed by Physician Employee E12 stated, Pt is a [AGE] year female with a pmh of DMII, CKD, MDD, migraines, neuropathy, hypothyroidism and dementia who presents to facility for assistance with personal care. Review of Resident R119's active diagnosis and admission paperwork failed to include a diagnosis for dementia. During an interview on 10/24/25, at 9:46 a.m. the Director of Nursing (DON) stated the facility was unable to locate documentation regarding a dementia diagnosis for Resident R119. The DON stated she spoke with PA Employee E9 who stated, You can just walk in the room and tell she [Resident R119] has it [dementia]. I'll write a diagnosis if you need me to. Review of Resident R119's care plan failed to indicate the facility had developed and implemented a person-centered care plan to address Resident R119's dementia and cognitive loss. During an interview on 10/24/25, at 11:56 a.m. the DON confirmed that the facility failed to develop and implement individualized person-centered care plans to address dementia and cognitive loss displayed by two of four residents reviewed (Residents R111 and R119). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility documentation, clinical record review, resident and staff interview it was determined that the facility failed to provide medically related social services to help a resident reach their highest practicable psych-social needs for addressing the recommendations of a psychologist report for one of two residents (Resident R128). Findings include: Review of facility policy Social Services dated [DATE], indicated: The department, shall as necessary, help and support residents in addressing concrete service needs, including but not limited to: A. Educating residents about state and federal benefits and how to apply. B. Management of trust fund, as necessary. E. Mental Health information and referral services. The social service staff shall document progress pertaining to adjustment, quality of life and general behavioral manifestations. The social service worker shall provide follow up evaluation and intervention as necessary. The social service staff shall be responsible for making referrals to community social service agencies, should a resident require a service that cannot readily be provided by the facility. Review of Social Service Director position description indicates: The position of Social Service Director provides planning, assessing, coordinating and implementation of services to enhance each resident's social and psychosocial well-being and assure that care standards are met and the highest degree of quality resident care is provided at all times. Perform all duties involved in resident advocacy. During an interview on [DATE], at 9:44 a.m. Resident R128 Indicated: When they first came in, they came in due to their history of drinking and needed help. Resident R128 admits they have a history of drinking, and need help- they have not had a drink since 2021, they have been in the facility for years, they have talked with several staff (social workers), physicians, nurses, nurse aides etc. about leaving the facility. Whenever Resident R128 ask he's told they will follow up but nobody ever does. Resident R128 feels anxious, frustrated, and tired of asking about leaving when nobody seems to help. Resident R128 has asked about housing and support services (AA/12 step meetings) but to no avail - he has not been to AA/12 step meeting. He does not feel like he has any peers in the facility - so he keeps to himself, tries to stay busy all day by reading, or trying to take walks around the outside of the facility, or watch tv. Resident R128 understands they have memory issues but feels there is so much more they could be doing if they could get some support and help. Resident R128 misses his children and being able to lead a regular life, working, etc. Resident R128 is open to going to a halfway house (would want to be in a house that focuses on alcoholics), group home, any housing that would allow for a safe placement so he/she can start on recovery and work. Resident R128 is unaware of their income as their family member handles their money. Resident R128 driver's license is expired - has made the facility aware but, has yet to get assistance. Resident R128 feels a current ID and being aware of their income will assist with getting into a facility and getting employment. Resident R128 wants to leave the facility the right way - not go AMA without any place to go or the skill set to maintain sobriety - he just wants help. Review of the Resident Assessment Instrument 3.0 User's Manual, effective [DATE], indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of Resident R128 was admitted on [DATE]. Resident R128 MDS (minimum data set - a brief periodic assessment of resident needs) indicated: BIMS was a 10 on [DATE], 13 on [DATE], 15 on [DATE]. Review of the expert report (for a competency hearing) for Resident R128 dated [DATE], indicated diagnosis: Alcohol dependence with alcohol - induced persisting dementia - DX (diagnosis) by another clinician - I have not seen signs of this, alcohol dependence with other alcohol - induced disorder - DX by another clinician- I have not seen signs of this, anxiety disorder, unspecified - intense worry; pervasive thinking. Recommendations of the expert report: Resident would benefit from a connection (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to AA services and regular AA meetings, as well as a sponsor and individual psychotherapy. Resident would benefit from regular work, and monitoring of alcohol dependency. At this time, memory does not appear to be significantly impaired to impact this. During an interview on [DATE], at 9:06 a.m. with Employee E19 Licensed psychologist indicated: they were licensed psychologist who saw resident regularly monthly since March of 2024 (recently left agency and was unaware of who was currently seeing resident for therapy), they came in person to assess resident on [DATE], for the assessment. They were the professional who completed the expert report. They confirmed the findings from the report - that Resident R128 Is alert and oriented, that they did not give the resident a diagnosis of dementia. Resident R128 should be assisted by the facility (social services) with a transfer to a different facility to meet their needs. They did not find from the testing that was completed a current diagnosis of dementia, and that the expectation was for the facility to address/follow the recommendations given in May of 2025. The findings of the report were reviewed with the facility (social service) as they recommended for the facility to assist with the AA services, regular meetings, individual psychotherapy, work, etc. During an interview on [DATE], at 10:30 a.m. with Business Office Employee E16, Social Service Director Employee E17 and Assistant Employee E18, and NHA (Nursing Home Administrator) indicated: They confirm Resident R128 has been in the facility since 2021, and that the facility was aware that the Resident wanted to leave. That the facility did receive the expert report from the licensed psychologist but failed to act upon the recommendations. The facility was informed that they failed to provide medically related social services to help a resident reach their highest practicable psych-social needs for addressing the recommendations of a psychologist report for one of two residents (Resident R128). 28 Pa. Code 201.14(b) Responsibility of licensee.28 Pa. Code 201.18 (b)(1)(3)(e) (1) Management.28 Pa. Code 201.29 (a)Resident rights.28 Pa. Code 211.16(a)(1) Social services.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395300	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2025
NAME OF PROVIDER OR SUPPLIER Perry Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 policy, observations, and staff interview, it was determined that the facility failed to properly secure medications on one of eight medication carts (Dover Medication Cart), failed to properly label medications upon opening on one of eight medication carts (Royal Pavilion Back Hall Medication Cart), and failed to properly secure a medication cart while not in use for one of eight medication carts ([NAME] Gardens Medication Cart). Findings include: Review of the facility policy Storage of Medications dated 3/14/25, indicated medications and biologicals are stored safely, securely and properly. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. During an observation on 10/21/25, at 11:16 a.m. the Dover Medication Cart indicated a prefilled injection (Lovenox - a medication used to thin the blood), and two clear nebulizer solution ampules on top of the cart and unattended. Interview on 10/21/25, at 11:18 a.m. Registered Nurse (RN) Employee E5 confirmed the medications were not securely stored in the locked medication cart as required. During an inspection of the Royal Pavilion Back Hall Medication Cart on 10/22/25, at 10:25 a.m. the following inhalation medications were revealed opened and not dated as required: a box of albuterol ampules, two boxes of ipratropium bromide (makes breathing easier), and two Trelegy inhalers. Interview on 10/22/25, at 10:25 a.m. RN Employee E8 confirmed the inhalation medications were not dated when opened as required. During an observation on 10/24/25, at 9:42 a.m. the [NAME] Gardens Medication Cart at the nurses' station was left unlocked and unattended. During an interview on 10/24/25, at 9:43 a.m. Licensed Practical Nurse Employee E8 confirmed the above observation and that the facility failed to properly secure a medication cart while not in use. 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 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations and staff interview, it was determined that the facility failed to post contact information for Adult Protective Services, and State Long-Term Care Ombudsman program as required for three out of three nursing floors (First Floor, Second floor, and Third Floor) Findings include: During observations completed on 10/24/25, no contact information including name, address, email address, and phone number were located for Adult Protective Services and State Long-Term Care Ombudsman were posted in a form and a manner that was accessible and understandable to residents or resident representatives. During interview, on 10/24/25, at 12:38 p.m. the Nursing Home Administrator confirmed that the facility failed to post contact information for Adult Protective Services, and State Long-Term Care Ombudsman program as required, on three of three nursing floors. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(e) Management.		