STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395426	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier at Perry Village for Nursing and Rehab, LL	213 East Main Street New Bloomfield, PA 17068

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to provide and document sufficient preparation to residents to ensure a safe and orderly discharge from the facility; and failed to provide a discharge summary that included a post-discharge plan of care, including post-discharge services, for one of five discharged residents reviewed (Resident 1). Findings Include:Review of facility policy, titled Discharging the Resident, dated December 2016, revealed If the resident is being discharged home, ensure that resident and/or responsible party receive teaching and discharge instructions.Review of Resident 1's clinical record revealed diagnoses that included congestive heart failure (CHF-a chronic condition in which the heart doesn't pump blood as well as it should) and gastroesophageal reflux disease (GERD-acid reflux). Further review of Resident 1's clinical record revealed that she was discharged to home on July 18, 2025. Review of Resident 1's physician orders revealed an order, dated July 18, 2025, for Home Health with physical therapy, occupational therapy and skilled nursing. Review of Resident 1's progress notes revealed a note, dated July 16, 2025, that a referral was made to a home health agency, but the agency was unable to accept the Resident. Review of Resident 1's progress note on July 17, 2025, revealed that a second referral was made to a different home health agency, but the agency was unable to accept the Resident. Review of Resident 1's progress note on July 18, 2025, at 9:12 AM, revealed that a third referral was made to a home health agency and the facility is waiting to hear back if they will accept the Resident or not. Review of Resident 1's progress note on July 18, 2025, at 10:47 AM, revealed that the Resident was discharged to home. Review of Resident 1's progress note on July 18, 2025, at 11:11 AM, revealed that the third home health agency notified the facility that they were unable to accept the Resident. Review of Resident 1's clinical record revealed no evidence that the physician was made aware that home health services were not set up prior to Resident 1's discharge from the facility and no evidence that any additional referrals were made. Review of Employee 1's (Social Services) witness statement, dated August 14, 2025, revealed that on July 30, 2025, another referral was sent on behalf of Resident 1 to a fourth home health agency.Review of that referral revealed that since the Resident's discharge was greater than 48 hours, the home health agency would likely need to get a new referral from the Resident's primary care physician in the community. During an interview with the Director of Nursing (DON) on September 4, 2025, at 10:45 AM, she stated that it is a struggle to find home health agencies that will service the rural county where Resident 1 resided. She stated that Resident 1's responsible party was insistent on taking Resident 1 home on July 18, 2025, even though home health services had not yet been set up. During a follow up interview with the DON on September 4, 2025, at 2:24 PM, she stated that the Resident and her family were aware that home care might not be an option in their area, but they were insistent on being discharged . She further stated that the physician would not have postponed the Resident's discharge based on lack of home health services being set up. Review of Resident 1's clinical record revealed she had an indwelling Foley catheter, as of July 18, 2025, and there was no evidence that it was discontinued prior to her discharge from the facility. Further review also revealed Resident 1 was receiving oxygen while at the facility.Review of Resident 1's discharge summary revealed no mention of the Foley catheter and no evidence that Resident 1 received education on the management of the Foley catheter upon discharge. The discharge summary also failed to mention for Resident to follow up with any outside providers for the management of her Foley and no mention of Resident 1 requiring oxygen at discharge. Further review of Resident 1's discharge summary revealed no mention of the home health referrals. During an interview with the DON on September 4, 2025, at 1:48 PM, she stated that an audit was done after Resident 1's discharge and the facility found issues with Resident 1's discharge summary. The DON provided education that was given to Employee 1 and Employee 2 (Registered Nurse). The education included ensuring the discharge summary is completed in its entirety and that copies of any education provided needs to be retained, including but not limited to, education on Foley catheters. 28 Pa. Code 201. 14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management28 Pa. Code 211.12(d)(1)(3)(5) Nursing services