STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395489	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corry Manor	640 Worth Street Corry, PA 16407

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on review of clinical records and Minimum Data Set (MDS - federally mandated standardized assessment conducted at specific intervals to plan resident care), and staff interview, it was determined that the facility failed to ensure that MDS assessments accurately reflected the status of one of 16 residents reviewed (Resident R2).Findings include: MDS instructions for section N Medications, subsection N0415E1 High-Risk Drug Classes: Use and Indication Anticoagulant - check if the resident is taking any medications by pharmacological classifications, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days. Resident R2's clinical record revealed an admission date of 12/27/25, with diagnoses that included Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications), peripheral vascular disease (PVD - a condition when there is restricted blood flow to the limb, usually legs), and pain. Resident R2's admission MDS with an ARD of 12/30/25, revealed section N0415E Anticoagulant - check if the resident is taking any medications by pharmacological classifications, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days. was coded as No. Resident R2's physician orders revealed an order dated 12/28/25, for Rivaroxaban (an anticoagulant medication that decreases the ability of blood to clot) 15 milligrams (mg) once a day. Medication Administration Record for December 2025, revealed Resident R2 received Rivaroxaban once a day from 12/28/25 through 12/31/25. During an interview on 2/5/26, at 12:50 p.m. the Social Worker confirmed that Resident R2 received an anticoagulant medication since admission/entry and his/her 12/30/25 admission MDS, was coded inaccurately regarding use of anticoagulant medication. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.5(f)(ix) Medical records

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 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. Based on review of facility policy and clinical record and staff interview, it was determined that the facility failed to develop a comprehensive plan of care for one of 16 residents reviewed (Resident R2).Findings include: A facility policy entitled, Care Plan Policy dated 12/2/25, indicated the facility will develop a comprehensive person centered care plan for each resident that includes measurable objective and timetables to meet a resident's medical, nursing, and mental and psychosocial needs. Resident R2's clinical record revealed an admission date of 12/27/25, with diagnoses that included Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications), peripheral vascular disease (PVD - a condition when there is restricted blood flow to the limb, usually legs), and pain. Review of Resident R2's physician orders revealed an order dated 12/28/25 for Rivaroxaban (an anticoagulant medication that decreases the ability of blood to clot) 15 milligrams (mg - metric unit of measure) once a day. Review of Resident R2's comprehensive plan of care failed to reveal a care plan for the use of an anticoagulant medication and how to manage anticoagulant therapy. During a telephone interview on 2/05/26, at 12:50 p.m. the Social Worker confirmed that Resident R2's comprehensive plan of care did not include a care plan for the use of an anticoagulant. The Social Worker revealed there should have been a care plan initiated for Resident R2 for the use of an anticoagulant. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of facility policy and clinical records, and staff interviews, it was determined that the facility failed to review and/or revise resident care plans for two of 16 residents reviewed (Residents R2 and R13). Findings include: Review of facility policy dated 12/2/25, entitled Care Plan Policy revealed the facility will develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. And Periodically reviewed and revised by a team of qualified persons after each assessment. Resident R2's clinical record revealed an admission date of 12/27/25, with diagnoses that included Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications), peripheral vascular disease (PVD - a condition when there is restricted blood flow to the limb, usually legs), and pain. Review of Resident R2's comprehensive care plan on 2/5/26, revealed that of the nine care plans present, nine had an outstanding target date (date that the care plan would be reviewed and revised with a new target date determined) of 1/13/26. The care plans included the problem categories of: allergies, self-care deficit, risk for skin breakdown, risk for falls, pain, nutrition/hydration needs, discharge, elopement, and code status. Resident R13's clinical record revealed an admission date of 6/15/25, with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), Bipolar Disorder (a mental health condition where you experience extreme mood swings that include emotional highs and lows. It causes significant shifts in mood, energy, activity levels, and concentration, affecting a person's overall functioning), and Diabetes (a health condition caused by the body's inability to produce enough insulin). Review of Resident R13's comprehensive care plan on 2/5/26, revealed that of the nine care plans present, nine had an outstanding target date of 1/11/26. The care plans included the problem categories of: discharge plan, psychotropic medications, altered nutrition and hydration, risk for skin breakdown, self-care deficit, risk for falls, smoker, code status, and altered respiratory status. During a telephone interview on 2/5/26, at 11:30 a.m. the Social Worker confirmed that Residents R1 and R13's care plans were not reviewed and/or revised within the required timeframes. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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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 policies and clinical records and staff interviews, it was determined that the facility failed to maintain accurate and complete documentation for five of seven residents reviewed (Residents R1, R2, R13, R22, and R23).Findings include: Review of facility policy dated 12/2/25, entitled Medication Administration - General Guidelines revealed the The individual who administers the medication dose records the administration on the resident's MAR (Medication Administration Record) directly after the medication is given. At the end of each medication pass the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medications report off duty without first recording the administration of any medication. Resident R1's clinical record revealed an admission date of 10/23/24, with diagnoses that included dementia (loss of memory, language, problem-solving, and other thinking abilities), Osteoarthritis (degenerative joint disease that results from the breakdown of joint cartilage and bones), and high blood pressure. Resident R1's clinical record revealed a physician's order dated 12/11/25, for Dakins (1/4 strength) External Solution 0.125 % (type of antiseptic used for cleaning wounds) Apply to Coccyx (tail bone) topically (to the skin) every shift for Wound healing; Wound Treatment - Cleanse the pressure injury on the coccyx with 1/4 strength Dakins solution, gently pack the wound bed with 1/4 strength Dakins solution moistened gauze and cover with a silicone border dressing (type of wound dressing). Change twice daily and as needed. Review of Resident R1's Treatment Administration Records (TAR) from 12/11/25 to 2/3/26, lacked documentation indicating wound treatment was completed per physician's orders for 16 out of 109 opportunities. Resident R2's clinical record revealed an admission date of 12/27/25, with diagnoses that included Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications), peripheral vascular disease (PVD - a condition when there is restricted blood flow to the limb, usually legs), and pain. Resident R2's clinical record revealed a physician's order dated 1/2/26, for Triad Hydrophilic Wound Dressing External Paste (type of wound dressing) apply to buttocks topically every shift for wound healing. Review of Resident R2's TAR from 1/2/26 to 2/3/26, lacked documentation indicating wound treatment was completed per physician's orders for seven out of 65 opportunities. During an interview on 2/4/26, at 3:00 p.m. the Director of Nursing (DON) confirmed that Resident R1 and R2's clinical records were incomplete regarding treatment documentation. Resident R13's clinical record revealed an admission date of 6/15/25, with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), Bipolar Disorder (a mental health condition where you experience extreme mood swings that include emotional highs and lows. It causes significant shifts in mood, energy, activity levels, and concentration, affecting a person's overall functioning), and Diabetes (a health condition caused by the body's inability to produce enough insulin). Resident R13's clinical record revealed physician orders dated 6/10/25, for Oxygen at 2 liter per minute via nasal cannula as needed to maintain oxygen saturations at or above 90%; Check pulse oxygen levels every shift; monitor for pain every shift; Novolog (medication used to treat diabetes) 15 units subcutaneous (sq) three times a date; Anoro Ellipta Inhaler (medication used to treat COPD) one puff daily; Atorvastatin Calcium (medication used to treat high cholesterol) 40 mg daily; Nortriptylline HCL (medication used to treat depression); Levetiracetam (medication used to treat seizures) 1500 mg twice a day; oxygen maintenance (changing oxygen tubing, supply bag, wipe down concentrator, clean filter, and change water jug) weekly; gold bond healing lotion to bilateral feet every shift; monitor for bruising / bleeding every shift, and pressure reducing (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cushion to chair when out of bed. Physician orders dated 6/11/25, for Toujeo Solostar (medication used to treat diabetes) 66 units sq daily; Lasix (medication used to treat congestive heart failure) 40 mg twice a day; and Risperdal (medication used to treat bipolar disorder) 2 mg daily. Physician orders dated 7/1/25, for elevating head of bed to reduce shortness of breath. Physician orders dated 7/16/25, for apply compression stockings to bilateral lower legs in the morning and remove at bedtime. Physician orders dated 7/22/25, for Resident to continue chin tuck maneuver with swallowing. Physician order dated 7/23/25, for Baclofen (medication used to treat muscle spasms) 10 mg po (by mouth) three times a day. Physician orders dated 11/16/25, for Metoprolol Succinate ER (medication used to treat high blood pressure) 100 milligram (mg) daily. Physician orders dated 1/14/26, for Gabapentin (medication used to treat muscle spasm) 600 mg every eight hours. Review of Resident R13's MAR from 12/1/25, to 2/3/26, lacked documentation indicating medications and/or physician orders were completed as ordered for the following: Out of 45 opportunities to document Gabapentin, four were blank; Out of 65 opportunities to document Metoprolol Succinate two were blank, Toujeo Max Solostar three were blank, Anoro Ellipta Inhaler one was blank, Atorvastatin Calcium one was blank, Nortriptylline HCL one was blank, and Risperdal one was blank; Out of 130 opportunities to document Lasix three were blank, oxygen use three were blank, Levetiracetam one was blank, and [NAME] Tuck Maneuver one was blank; Out of 195 opportunities to document pulse oxygen levels 11 were blank, monitor resident for pain eight were blank, Novolog six were blank, and Baclofen one was blank. Review of Resident R13's TAR from 12/1/25, to 2/3/26, lacked documentation indicating treatments and/or physician orders were completed as ordered for the following: Out of nine opportunities to document oxygen maintenance two were blank; Out of 130 opportunities to document gold bond lotion 16 were blank, monitoring for bruising / bleeding six were blank, applying and removing compression stockings six were blank, elevating head of bed six were blank, and pressure reducing cushion six were blank. Resident R22's clinical record revealed an admission date of 12/11/24, with diagnoses that included Epilepsy (a chronic brain disorder which a group of nerve cells or neurons will sometimes send wrong signals and cause a seizure which temporarily affects your consciousness, muscle control, and behavior), Down Syndrome (congenital condition caused by defect involving chromosome 21 characterized by a distinctive pattern of physical characteristics including a flattened skull, pronounced folds of skin in the inner corner of the eyes, large tongue, and short stature and by some degree of limitation of intellectual ability and social and practical skills), and Hypothyroidism (a condition resulting from decreased production of thyroid hormones. The symptoms vary between individuals). Resident R22's clinical record revealed physician orders dated 12/11/24, for privacy bag for catheter every shift; Indwelling Catheter care every shift; monitor for signs and symptoms of bruising / bleeding every shift; pressure reducing cushion to wheelchair when out of bed; and maintain foley catheter to gravity drain every shift. Physician orders dated 12/23/24, for secure catheter in place at all times. Physician orders dated 3/20/25, for Phytoplex Protectant Ointment to buttocks every shift. Physician orders dated 4/13/25, to monitor for pain every shift. Physician orders for intake and output every shift. Physician orders dated 6/11/25 for Triad Hydrophilic paste to scrotum every shift. Physician orders dated 7/29/25, for Aricept (medication used to treat dementia) 10 mg daily; Flomax (medication used to treat difficulty urinating) 0.4 mg daily; Trazadone HCL (medication used to treat depression) 50 mg daily; Baclofen (medication used to treat pain) 10 mg twice daily' Lamictal (medication used to treat seizures) 150 mg twice daily; Memantine HCL (medication used to treat dementia) 10 mg twice daily; Zonisamide (medication used to treat seizures) 100 mg twice daily; Tylenol 500mg three times daily; Renacidin Irrigation Solution 30 cubic centimeters (cc) every night; and Nystatin-Triamcinolone Cream to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	groin every shift; Physician orders dated 8/14/25, for Artificial tears (medication used for dry eyes) 1.4% one drop in each eye twice daily. Physician orders dated 11/6/25 for cleansing skin tear to left groin with normal saline, apply collagen powder and triad cream and leave open to air. Physician orders dated 11/19/25, for Levothyroxine (medication used to treat thyroid disorder) 200 micrograms (mcg) daily. Physician orders dated 12/25/25, for Ceftriaxone Injection (medication used to treat infection) 1 gram (gm) intramuscular (IM) x one dose. Physician orders for 1/22/26 for skin prep to blisters on left foot three times a day. Review of Resident R22's MAR from 12/1/25, to 2/3/26, lacked documentation indicating medications and/or physician orders were completed as ordered for the following: Out of one opportunity to document Ceftriaxone one was blank; Out of 65 opportunities to document Levothyroxine three were blank, Aricept two were blank, Flomax two were blank, and Trazadone two were blank; Out of 130 opportunities to document Baclofen two were blank, Lamictal two were blank, Memantine HCL two were blank, Zonisamide two were blank, Artificial tears two were blank, and monitor for pain one was blank; Out of 195 opportunities to document Tylenol three were blank. Review of Resident R22's TAR from 12/1/25, to 2/3/26, lacked documentation indicating treatments and/or physician orders were completed as ordered for the following: Out of two opportunities to document cleansing skin tear to left groin, two were blank; Out of three opportunities to document Triad Hydrophilic Paste two were blank; Out of 19 opportunities to document skin prep to left foot blisters, two were blank; Out of 46 opportunities to document Renacidin Irrigation 12 were blank; Out of 130 opportunities to document Phytoplex Protectant Ointment 12 were blank, Indwelling catheter care eight were blank, Monitor for bleeding seven for blank, Nystatin - Triamcinolone 17 were blank, Pressure reducing cushion to chair when out of bed seven times were blank, secure catheter in place seven times were blank, and privacy bag for catheter two were blank; Out of 195 opportunities to document intake and output 35 were blank and maintain foley catheter to gravity 26 were blank. Resident R23's clinical record revealed an admission date of 2/20/24, with diagnoses that included COPD, Diabetes, and Atrial Fibrillation. Resident R23's clinical record revealed physician orders dated 9/9/25, for changing oxygen tubing, nebulizer tubing, blue tubing, and trach mask weekly; check oxygen saturation every four hours; and Tracheostomy care twice a day. Physician orders dated 9/12/25, for monitor for pain every shift; change enteral feeding syringe every night; Trazadone HCL (medication used to treat depression) 50 mg daily; Apixaban (medication used to prevent blood clots) 5 mg po twice daily; Bactroban to enteral feed insertion side three times a day; flush enteral tube with 20 to 30 cc of water before and after medications; Diabetasource AC formula 1.2 at 50 cc per hour every shift; Clonazepam (medication used to treat anxiety) 0.5 mg twice daily, Docusate Sodium (medication used for constipation) 100 mg twice daily; Sodium Chloride Nasal Spray (medication used for dryness) one spray each nostril twice daily; document total intake of enteral feeding and water flushed three times a day; Baclofen (medication used for pain) 5 mg twice daily; Metoprolol Tartrate (medication used to treat high blood pressure) 25 mg twice daily; indwelling catheter care every shift, monitor for signs and symptoms of bruising / bleeding; maintain foley catheter to gravity drainage every shift; triple antibiotic ointment to tube site every shift; Pressure reducing cushion to chair every shift; pressure reduction mattress to bed every shift; and privacy bag to catheter every shift. Physician orders dated 9/13/25, for Nexium (medication used to treat gastric reflux) 40 mg daily. Physician orders dated 9/15/25, for head of bed elevated thirty degrees at all times in bed; and oxygen at 5 liters per minute to trach with F1O2 of 28% every shift. Physician orders dated 10/5/25, for change enteral feeding bag and tube daily. Physician orders dated 10/8/25, for checking gastric tube residual and placement before formula, medications, flushes or at least every eight hours. Physician orders dated (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/14/25, for Acetylcysteine Solution (medication used to thin mucus and secretions) 20% 3 milliliters (ml) inhaled every eight hours. Physician orders dated 11/24/25, for Zinc Oxide to coccyx and buttocks every shift. Physician orders dated 11/25/25, for Skin prep to bilateral toes and left medial hallux every shift. Physician orders dated 12/23/25, for Diabetasource AC formula 1.2 at 60 cc per hour every shift. Physician orders dated 1/13/26, for Piperacillin (medication used to treat infection) 3.375 grams three times a day; Sodium Chloride 0.9% 5 ml IV flush three times a day; change midline dressing every 7 days; and monitor for signs and symptoms of infection every shift. Review of Resident R23's MAR from 12/1/25, to 2/3/26, lacked documentation indicating medications and/or physician orders were completed as ordered for the following: Out of nine opportunities to document Piperacillin one was blank; Out of 37 opportunities to document Sodium Chloride IV flush two were blank; Out of 65 opportunities to document changing enteral feeding syringe eight were blank, change enteral feeding bag and tubing one was blank, Trazadone two were blank, and Nexium 10 were blank; Out of 67 opportunities to document Diabetasource AC at 50 cc / hr 2 were blank; Out of 70 opportunities to document Bactroban to enteral tube insertion site four were blank; Out of 127 opportunities to document Diabetasource AC at 60 cc / hr 10 were blank; Out of 130 opportunities to document Apixaban two were blank, Clonazepam three were blank, Docusate Sodium three were blank, Sodium Chloride Nasal Spray three were blank, Baclofen two were blank, and Metoprolol Tartrate two were blank; Out of 195 opportunities to document monitor for pain 16 were blank, checking gastric tube residual and placement 21 were blank, 20 - 30 cc of water flush before and after meals 21 were blank, Acetylcysteine 18 were blank, and documenting total intake of enteral feeding and water flushes 29 were blank. Review of Resident R23's TAR from 12/1/25, to 2/3/26, lacked documentation including treatments and/or physician orders were completed as ordered for the following: Out of three opportunities to document change midline dressing one was blank; Out of eight opportunities to document changing oxygen tubing, nebulizer tubing, blue tubing, and tach mask weekly two were blank; Out of 43 opportunities to document monitoring site for infection five were blank; Out of 130 opportunities to document pressure reducing cushion to chair eight were blank, pressure reduction mattress eight were blank, skin prep to bilateral toes and left medical hallux 15 were blank, tracheostomy care 23 were blank, privacy bag to catheter eight were blank, head of bed elevated eight were blank, indwelling catheter care nine were blank, monitor for bruising / bleeding nine were blank, oxygen at 5L 10 were blank, and zinc oxide to coccyx / buttocks 19 were blank; Out of 195 opportunities to document maintain foley drainage to gravity 30 were blank, and triple antibiotic to tube site 58 were blank; Out of 266 opportunities to document oxygen saturations 82 were blank. During an interview on 2/4/26, at 1:49 p.m. the DON confirmed that Resident R13's, R22's, and R23's clinical records were incomplete regarding MARs and TARs documentation. 28 Pa. Code 211.5(f)(ii)(viii) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services