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	09/11/2025

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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to ensure physician orders and residents Physician Order for Life Sustaining Treatment (POLST- a legal document specifying the resident/responsible party choices regarding life-sustaining treatments) were consistent for two of 25 residents reviewed (Residents R12 and R56). Findings include: The facility policy entitled Advance Directives dated [DATE], revealed .We recognize each resident's right to refuse treatment, to live a dignified life, and to self-determination.Documentation, written or oral, of informed consent to withhold or withdraw treatment must be placed in the resident's clinical record together with the attending physician's order regarding the withholding or withdrawal of treatment. The physician's order should also be noted on the resident's plan of care and on the inside of the resident's clinical record . Resident R12's clinical record revealed an admission date of [DATE], with diagnoses that included anxiety, hyperlipidemia (high cholesterol), and hypertension (high blood pressure). Resident R12's physician's orders dated [DATE], indicated for cardiopulmonary resuscitation (CPR-emergency life-saving procedure that is done when breathing or a heartbeat has stopped and when performed immediately can double or triple chances of survival after cardiac arrest). Resident R12's clinical record revealed a POLST dated [DATE], indicated Do Not Resuscitate-Allow Natural Death (DNR). Resident R56's clinical record revealed an admission date of [DATE], with diagnoses that included heart failure, hypertension, and muscle weakness. Resident R56's physician's orders dated [DATE], indicated Do Not Resuscitate-Allow Natural Death (DNR). Resident R56's clinical record revealed a POLST indicated cardiopulmonary resuscitation (CPR-emergency life-saving procedure that is done when breathing or a heartbeat has stopped and when performed immediately can double or triple chances of survival after cardiac arrest). During an interview on [DATE], at approximately 2:30 p.m. the Director of Nursing confirmed Residents R12 and R56's physician's orders and POLST's were not consistent with each other. 28 Pa. Code 201.18 (b)(1)(e)(1) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.5(i)((vii) Medical records 28 Pa. Code 211.10(c) Resident care policies

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide a clinical rationale for the continued use of a PRN (as needed) psychotropic (affecting the mind) medication beyond 14-days for one of five residents reviewed (Resident R8).Findings include: Review of facility policy entitled PRN Order for Anti-Psychotic Medications dated 12/4/24, indicated . limits PRN orders for anti-psychotic medication to 14 days and cannot be renewed unless the attending physician. evaluates the resident for appropriateness of that medication. Review of Resident R8's clinical record revealed an admission date of 6/10/25, with diagnoses that included anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), bipolar disorder (a mental illness that causes extreme mood swings with emotional highs and emotional lows), and hypertension (high blood pressure). Review of Resident R8's physician's orders revealed an order dated 7/9/25, for Ativan (anti-anxiety medication) 0.5mg (milligram) by mouth every eight hours as needed. Review of Resident R8's August 2025 Medication Administration Record (MAR) revealed that Ativan was used on 8/3/25, 8/7/25, 8/17/25, 8/21/25, and 8/31/25. Review of the September 2025 MAR revealed that Ativan was used 9/3/25. During an interview on 9/10/25, at 2:45 p.m. with the Director of Nursing (DON) he/she confirmed that Resident R8's PRN Ativan order lacked the required stop date within 14 days or a clinical rationale for continued use beyond 14 days. 28 Pa. Code 211.12(d)(1)(3)(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. Based on review of facility policy, clinical records, and staff interviews it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider upon transfer to the hospital for three of seven residents reviewed (Residents R1, R4, and R11). Findings include: Review of facility policy entitled Transfer, Discharge and Room Change dated 12/4/24, indicated clinical records describing the residents needs, including list of orders and medications, as directed by the attending physician, shall accompany the resident. Resident R1's clinical record revealed an admission date of 6/12/24, with diagnoses that included congestive heart failure (the inability of the heart to maintain an adequate supply of blood to organs and tissues), chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), and diabetes (a health condition that is caused by the body's inability to produce enough insulin). Resident R1's progress notes revealed a note dated 12/26/24, indicating transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. Resident R4's clinical record revealed an admission date of 3/10/25, with diagnoses that included hypertension (high blood pressure), dementia (a disease that affects short term memory and the ability to think logically), and hypothyroidism (a condition when the thyroid produces low amounts of thyroid hormones). Resident R4's progress notes revealed a note dated 5/28/25, indicating transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. Review of Resident R11's clinical record revealed an admission date of 1/30/25, with diagnoses that included diabetes dependence on renal dialysis (a treatment that helps remove extra fluid and waste products from the blood when the kidneys are not able to), and hypertension. Resident R11's progress notes revealed a note dated 7/31/25, indicating transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. During an interview on 9/10/25, at 1:50 p.m. the Director of Nursing (DON) confirmed that there was no evidence that Residents R1, R4 and R11 necessary clinical information was provided to the receiving healthcare provider upon transfer and also confirmed when the transfers occurred clinical information should be provided to the receiving healthcare provider upon transfer. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3) (2) Resident rights

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on review of clinical records and staff interview, it was determined that the facility failed to provide a written summary of the baseline care plan and order summary to the resident and/or representative for one of 18 residents reviewed (Resident R8).Findings include: Review of Resident R8's clinical record revealed an admission date of 6/10/25, with diagnoses that included anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), bipolar disorder (a mental illness that causes extreme mood swings with emotional highs and emotional lows), and hypertension (high blood pressure). Resident R8's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R8 and/or his/her representative. During an interview on 9/11/25, at 11:53 a.m. the Director of Nursing confirmed that the clinical record of Resident R8 lacked evidence that a written summary of the baseline care plans, and order summaries were provided the Resident and/or their representative upon admission to the facility. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 201.18 (b)(1) Management

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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, clinical records, and staff interviews, it was determined that the facility failed to develop comprehensive person-centered care plans for a resident requiring oxygen therapy that included measurable objectives and timetables to meet a resident's needs for one of 25 residents reviewed (Resident R88). Findings include: A facility policy entitled, Care Plan Policy dated 12/4/24, 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 . Review of Resident R88's clinical record revealed an admission date of 5/7/25, with diagnoses that included respiratory failure (a condition where your lungs don't exchange air properly), chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), and hypertension (high blood pressure). Review of Resident R88's physician's orders revealed an order for oxygen two liters per minute PRN (as needed) via nasal cannula (a thin tube with two prongs that fit into the resident's nostrils to deliver oxygen). Review of Resident R88's oxygen saturation percentages from 8/8/25, through 9/11/25, revealed Resident R88 had used his/her oxygen on 31 of the days. Review of Resident R88's person centered plans of care lacked evidence that a plan of care for respiratory care with use of oxygen was developed. During an interview on 9/11/25, at 1:20 p.m. the Director of Nursing confirmed that a plan of care for respiratory care with use of oxygen was not developed for Resident R88 and also confirmed that a respiratory plan of care with use of oxygen should have been developed. 28 Pa. Code 201.14 (a) Responsibility of Licensee 28 Pa. Code 201. 18 (b)(1)(3) Management 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, clinical records, and staff interviews, it was determined that the facility failed to review and/or revise resident care plans to reflect resident's current condition and failed to ensure that resident care plan meetings were held timely for two of 25 residents reviewed (Residents R22 and R56). Findings include: Review of facility policy entitled “Care Plan Policy” dated 12/4/24, revealed that the care plans are periodically reviewed and revised by a team of qualified persons after each assessment. The policy further indicated that the Resident will have the opportunity to discuss their goals for care including their preferences for advanced care planning with the interdisciplinary team. Resident R22's clinical record revealed an admission date of 6/21/19, with diagnoses that included obstructive and reflex uropathy (urinary tract disorder that occurs when urine flow is obstructed), benign hyperplasia prostatic (an enlarged gland below the bladder that causes difficulty urinating) with lower urinary tract symptoms, weakness and dementia (a condition that causes a decline in cognitive functions, such as memory, thinking, and problem solving). Review of Resident R22’s physician's orders revealed an order dated 6/25/25, for a suprapubic catheter (tube directly into the bladder to drain urine). Resident R22 had a previous order for a foley catheter. Review of Resident R22's care plan revealed a foley catheter care plan created on 1/20/20, with a revision date of 7/7/25. The care plan lacked any evidence that Resident R22 had a suprapubic catheter. During an interview on 9/11/25, at 10:40 a.m. the Director of Nursing confirmed that Resident R22's care plan was not updated to reflect Resident R22’s current status and care needs. Resident R56’s clinical record revealed an admission date of 11/21/24, with diagnoses that included heart failure, hypertension (high blood pressure), and muscle weakness. Resident R56's clinical record lacked evidence that a care plan meeting was scheduled timely. He/she had a care plan meeting on 1/21/25, and the next care plan meeting was held on 8/10/25. During an interview on 9/10/25, at 11:45 a.m. the Social Worker confirmed that Resident R56’s care plan meeting was not scheduled timely after the meeting held on 1/21/25, and that his/her next care plan meeting should have been scheduled and completed in May 2025. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(3)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to provide oxygen according to physician's orders for one of two residents reviewed for respiratory services (Resident R88). Findings include: Review of facility policy entitled Oxygen Concentrators dated 12/4/24, indicated external filters are to be cleaned weekly. Prefilled bubble humidifier bottles. need to be changed weekly and as needed. Review of Resident R88's clinical record revealed an admission date of 5/7/25, with diagnoses that included respiratory failure (a condition where your lungs don't exchange air properly), Chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), and hypertension (high blood pressure). Review of Resident R88's physician's orders revealed orders for oxygen (O2) two liters per minute PRN (as needed) via nasal cannula (a thin tube with two prongs that fit into the resident's nostrils to deliver oxygen) dated 8/7/25, and oxygen maintenance change O2 tubing and supply bag weekly, wipe down concentrator and clean filter weekly, change water jug weekly dated 8/7/25. Review of Resident R88's oxygen saturation percentages between 8/8/25, through 9/11/25, revealed Resident R88 had used his/her oxygen on 31 of the days. Observations on 9/8/25, at 1:15 p.m., and again at 3:30 p.m. revealed Resident R88 sitting in his/her wheelchair with supplemental oxygen in place and the oxygen concentrator liter flow set at one and a half liters/minute. Further observations revealed no water bottle attached to the oxygen concentrator, and no filter on the back of the concentrator. Observations on 9/9/25, at 11:16 a.m. and again at 2:15 p.m. revealed Resident R88's oxygen continued to be set at one and a half liters/minute and continued to have no water bottler or filter attached to the oxygen concentrator. Observations on 9/10/25, at 11:15 a.m. and again at 1:30 p.m. revealed Resident R88's oxygen continued to be set at one and a half liters/minute and continued to have no water bottler or filter attached to the oxygen concentrator. Observations on 9/11/25, at 10:00 a.m. and again at 12:58 p.m. revealed Resident R88's oxygen continued to be set at one and a half liters/minute and continued to have no water bottler or filter attached to the oxygen concentrator. During an interview on 9/11/25, at 12:58 p.m. the Director of Nursing (DON) confirmed that Resident R88's oxygen concentrator was on and set at one and a half liters/minute which was not in accordance with the physician's order dated 8/7/25, for oxygen at two liters/minute and that there was no water bottler or filter attached to the oxygen concentrator. The DON also confirmed that Resident R88's oxygen flow rate should be set per physician order and that there should have been a water bottle and filter attached to the oxygen concentrator. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on review of facility policy and clinical records, and staff interviews, it was determined that the facility failed to ensure that the physician sign and date all orders during each of his/her visits for five of 25 residents reviewed (Residents R1, R2, R29, R98 and R100). Findings include: Review of facility policy entitled Physician Services dated 12/4/24, indicated Physician visits will comply with the following: The resident must be seen every thirty (30) days for the first ninety (90) days after admission, then every sixty (60) days thereafter. The resident's total plan of care (including medication and treatments) must be reviewed with each scheduled visit. and All orders must be recorded in the resident's clinical record and renewed every thirty (30) days. Resident R1's clinical record revealed an admission date of 6/12/24, with diagnoses that included congestive heart failure (the inability of the heart to maintain an adequate supply of blood to organs and tissues), chronic obstructive pulmonary disease (COPD-when your lungs do not have adequate air flow), and diabetes (a health condition that is caused by the body's inability to produce enough insulin). Review of Resident R1's clinical record revealed that the last time his/her physician reviewed, signed, and dated his/her physician orders was on 3/28/25. Resident R2's clinical record revealed an admission date of 7/16/24, with diagnoses that included COPD, heart failure (a condition where the heart cannot supply the body with enough blood), and hypertension (high blood pressure). Review of resident R2's clinical record revealed that the last time his/her physician reviewed, signed, and dated his/her physician orders was on 2/2/25. Resident R29's clinical record revealed an admission date of 6/18/24, with diagnoses that included COPD, hyperlipidemia (high cholesterol), and hypothyroidism (a condition when the thyroid produces low amounts of thyroid hormones). Review of resident R29's clinical record revealed that the last time his/her physician reviewed, signed, and dated his/her physician orders was on 10/31/24. Resident R98's clinical record revealed an admission date of 4/19/24, with diagnoses that included hypotension (low blood pressure), hyperlipidemia, and benign prostatic hyperplasia (a noncancerous condition that causes the prostate gland to become enlarged and cause difficulty urinating). Review of resident R98's clinical record revealed that the last time his/her physician reviewed, signed, and dated his/her physician orders was on 2/2/25. Resident R100's clinical record revealed an admission date of 10/23/24, with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), hypertension, and hypothyroidism. Review of resident R100's clinical record revealed that the last time his/her physician reviewed, signed, and dated his/her physician orders was on 6/3/25. During an interview on 9/10/25, at 10:40 a.m. the Director of Nursing (DON) confirmed that physician orders for Residents R1, R2, R29, R98, and R100 were past due to be reviewed and signed by the physician. The DON also confirmed that physician orders should be reviewed and signed with every physician visit on admission then every 30 days for the first 90 days then every 60 days. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.5(f)(i) Medical records

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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. Based on review of facility policies, observations,and staff interviews it was determined that the facility failed to appropriately discard outdated medications for one of two medication carts reviewed and one of one medication rooms reviewed (facility medication room and A wing medication cart). Findings include: Review of facility policy entitled Medication Storage dated 12/4/24, indicated Medications and biologicals are stored safely, securely and properly, following manufacturer's recommendations. and Outdated, contaminated, or deteriorated medications. are immediately removed from stock. Review of manufacturer's guidelines revealed that an open pen of Lantus Insulin must be used within 28 days after opening or be discarded, even if the pen still contains insulin. Review of manufacturer's guidelines revealed that an open pen of Aspart Insulin must be used within 28 days after opening or be discarded. Review of manufacturer's guidelines revealed that an open vial of Tubersol should be discarded within 30 days after opening. Observation of drug storage on 9/8/25, at 2:35 p.m. of the facility medication room revealed an open vial of Tubersol (a solution used for tuberculosis testing upon admission and employment) with no date indicating when the Tubersol was opened. Further observations of the A wing medication cart, revealed an open Aspart insulin pen with an open date of 7/12/25, another open Aspart insulin pen with an open date of 7/14/25, and an open Lantus insulin pen with no date indicating when the insulin was opened. During an interview on 9/8/25, at the time of observation Licensed Practical Nurse (LPN) Employee E1 confirmed that the open dates on the aspart insulin pens were 7/12/25, and 7/14/25. LPN Employee E1 also confirmed that the open vial of Tubersol, and the open Lantus insulin pen lacked opened dates, and staff were unable to determine the discard dates. He/she also confirmed that the Aspart insulin pens, the Lantus insulin pen and the Tubersol should have been discarded. 28. Pa. Code 201.18(b)(1) Management 28. Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1) Nursing services

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of Hospice contract, facility policy, clinical records, and staff interviews, it was determined that the facility failed to make certain that Hospice documentation was maintained in the clinical record for one of 25 residents reviewed (Resident R74).Findings include: Review of the facility Hospice contract indicated that coordination of care between the nursing facility staff and the Hospice Interdisciplinary Team. It further indicated that Hospice will maintain a medical record of hospice services provided and that the record will be incorporated into the nursing facility medical record. Hospice personnel will chart the services in this record. Review of facility policy Hospice Policy, dated 12/04/24, indicated that the facility shall take direction from the Hospice agency regarding implementation of the coordinated plan of care related to the resident's terminal illness. The policy also indicated that the attending physician will make an order for Hospice services. Review of Resident R74's clinical record revealed an admission date of 7/18/25, with diagnoses that included interstitial pulmonary disease, chronic respiratory failure with hypoxia, pulmonary hypertension, and diabetes, and a physician's order dated 9/08/25, to admit Resident R74 to Hospice services. Further review of Resident R74's clinical record revealed a care plan dated 7/18/25, for Hospice services to coordinate care with the facility. A nurse's note dated 7/18/25, revealed Resident R74 was a new admission on Hospice with lung issues. Resident R74's clinical record revealed a hospice plan of care dated 8/3/25, and a nurse's visit assessment dated [DATE]. The clinical record lacked any other evidence of collaboration/communication of Hospice and documentation of Hospice communication detailing Hospice services and service dates. During an interview on 9/11/25, at111:50 a.m. the Director of Nursing confirmed that there was no evidence of communication sheets provided to the facility from the Hospice provider other than the 8/11/25, nurse's assessment and confirmed that the physician's order was not obtained upon Resident R74's 7/18/25, admission date. 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services