STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395003	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - New Castle	520 Friendship Street New Castle, PA 16101

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 0842 Level of Harm - Potential for minimal 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 clinical records, facility documentation, facility policies, and staff interview, it was determined that the facility failed to maintain complete and accurate records for six of 31 residents (Residents R3, R19, R59, R87, R114 and Closed Record CR150).Findings include: Review of facility policy entitled Admission dated 1/13/26, revealed that staff will complete an inventory of all belongings; document on the inventory form; sign and date the form; have resident/family sign. Review of facility policy entitled, Care of Resident's Belongings dated 1/13/26, revealed that an inventory of personal effects will be completed when the resident is admitted to the care community, transferred or discharged ; be completed by nursing staff with the assistance of the resident or family; and that it must be signed by two people. A facility document located in the inventory binder at the nurse's station and provided by the facility on 5/20/26, indicated that social services will check for completion the next working day after admission. Resident R3's clinical record revealed an admission date of 6/25/21, with diagnoses including morbid obesity [complex chronic condition of a severe amount of body fat that can lead to several serious health issues], heart failure, irregular heartbeat, and pressure ulcer of the lower back. Resident R3's inventory of personal effects sheet dated 11/03/25, lacked evidence of resident and staff signatures. Resident R19's clinical record revealed an admission date of 3/09/23, with diagnoses including kidney disease, heart disease, respiratory failure, and seizures. Resident R19's clinical record lacked evidence that an inventory of personal effects was completed and signed. Resident R59's clinical record revealed an admission date of 3/22/19, with diagnoses including angina [chest pain or discomfort caused by reduced blood flow to the heart], irregular heartbeat, heart failure, and kidney disease. Resident R59's clinical record lacked evidence that an inventory of personal effects was completed and signed. Resident R87's clinical record revealed an admission date of 6/10/24, with diagnoses including chronic obstructive pulmonary disease [COPD- common lung disease causing restricted airflow and breathing problems], heart failure, sleep apnea, and kidney disease. Resident R87's inventory of personal effects sheet dated 6/10/24, lacked evidence of staff signatures. Resident R114's clinical record revealed an admission date of 10/27/16, with diagnoses including lung cancer, COPD, Rheumatoid arthritis [the immune system mistakenly attacks the body's own tissues, causing pain, swelling, and stiffness to the joints], and epilepsy. Resident R114's clinical record lacked evidence that an inventory of personal effects was completed and signed. Resident CR150's clinical record revealed an admission date of 12/27/25, with diagnoses that included Protein Calorie Malnutrition (occurs when the body does not receive enough protein and energy [calories] to maintain normal tissue structure and function. It can result from inadequate dietary intake, increased nutrient requirements, or conditions that impair nutrient absorption such as chronic illness), Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications), and High Blood Pressure. Resident CR150's task for Amount Eaten (an areas in point of care where the nurse aides document the amount the resident ate at each meal) revealed that for the month of December 2025, there was no documentation to indicate the percent of meal he/she consumed for two of 13 opportunities. For the month of January 2026, there was no documentation to indicate the percent of (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	meal he/she consumed for 23 of 93 opportunities. For the month of February 2026, there was no documentation to indicate the percent of meal he/she consumed for 12 of 84 opportunities. For the month of March 2026, there was no documentation to indicate the percent of meal he/she consumed for three of 27 opportunities. During an interview on 5/21/26, at 1:15 p.m. Nursing Home Administrator (NHA) confirmed that Resident CR150's clinical record for amount eaten lacked documentation for each meal as required. NHA further confirmed that staff should document the residents' meal intake after each meal. 28 Pa. Code 211.5(f)(v)(viii) Medical records 28 Pa. Code 211.12(d)(1)(5) Nursing services