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	05/08/2025

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility policy and clinical records, observations, and staff and resident interview, it was determined that the facility failed to ensure the privacy and dignity of residents with an indwelling foley catheter (tubing inserted into the bladder to drain urine) for two of three residents reviewed for catheters (Residents R129 and R383). Findings include: Review of facility policy entitled Indwelling Urinary Catheter dated 1/8/25, revealed If the bed is placed in a low position, the catheter bag can be placed in a basin to prevent it from touching the floor, and The catheter bag should have a privacy cover applied at all times. Resident R129's clinical record revealed an admitted [DATE], with diagnoses that included kidney failure (condition where the kidneys are no longer able to work therefore cannot filter waste and toxins from the blood), cellulitis of right toe (bacterial infection of the skin and underlying tissues), and high blood pressure. Resident R129's clinical record revealed a physician's order dated 4/11/25, for an indwelling foley catheter. Observations on 5/5/25, at 12:39 p.m. and again at 3:37 p.m. revealed Resident R129 sitting in his/her wheelchair with the catheter bag secured under the seat lacking a privacy cover and was visible from the corridor. Interview with Resident R129 on 5/5/25 at 12:39 p.m. revealed that he/she would like to have a privacy cover. Resident R383's clinical record revealed an admitted [DATE], with diagnoses that included amputation of left foot (the surgical removal of a body part due to severe injury, infection, or disease) diabetes (a health condition caused by the body's inability to produce enough insulin), and high blood pressure. Resident R383's admission documentation revealed an indwelling foley catheter was present upon his/her entry into the facility. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 5/5/25, at 12:42 p.m. and again at 3:37 p.m. revealed that Resident R383 was laying in his/her bed with his/her urinary catheter drainage bag on the floor, visible from the corridor and lacked a privacy cover. During an interview on 5/5/25, at 3:37 p.m. the Director of Nursing confirmed that Residents R129 and R383's urinary catheter bags should have a privacy cover in place. 28 Pa. Code 201.29(a) Resident rights 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** 40177 Based on review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual October 2024 (RAI-assessment guide used to plan the provision of care for residents), clinical records and facility policy, and resident and staff interviews, it was determined that the facility failed to notify the resident's representative of a change in condition and/or treatment for one of six residents reviewed (Resident R22). Findings include: Review of the RAI manual instructions for Section C0500 Brief Interview for Mental Status (BIMS-a test to help determine resident cognitive status) revealed that a score of 13-15 identified a resident as cognitively intact and a score of 8-12 identified a resident as moderately impaired, and a score of 0-7 as severely impaired. Facility policy entitled Communication of Health Status / Notification of Family dated 1/8/25, revealed that residents and/or residents' family are to be provided with information regarding the resident's total health status and that residents family and/or responsible party will be notified of a residents change in condition or health status. The policy further revealed that communication will be documented in the resident's clinical record and would include who was informed, what they were informed of and their response. Resident R22's clinical record revealed an admitted [DATE], with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), respiratory failure (a condition where you don't get enough oxygen or you get too much carbon dioxide in your body), and obesity. Resident R22's BIMS revealed a score of 8/15 indicating moderate cognitive impairment. Resident R22's clinical record revealed a progress note dated 3/17/25, at 1:42 p.m. indicating Resident R22 remained shaky in appearance with flushed cheeks and dusky fingers. Pulse ox (SPO2-a medical device that measures the oxygen saturation of blood) is currently 83-84% on oxygen at 3 liters per minute (LPM) via nasal cannula (N/C - a thin tube with two prongs that fit in a person's nostrils to deliver oxygen). His/her heart rate is very irregular and fluctuating anywhere from low 100 to 140. Waiting on Chest X-Ray (CXR) results at this time. Further review of the clinical record progress note dated 3/17/25, at 3:25 p.m. revealed Resident R22 was examined by his/her medical provider. Medical Provider progress notes indicated Resident R22 was seen for an Acute Episodic Visit. It further stated that the facility reported Resident R22 was short of breath and hypoxic (a lack of oxygen). It did appear at first that there was an issue with the oxygen coming unplugged. Nail beds were purple. SPO2 came up and then dropped again. Breathing treatment was given. Resident continued to report shortness of breath. Bumex (a diuretic that treats fluid retention in individuals with heart, liver, or kidney problems) 1 milligram (mg) intramuscular (IM - injection into the muscle) x1 and Solumedrol (steroid used to treat various conditions) 40 mg IM x 1 was given with improvement noted. Provider's note further stated that Resident R22 is high-risk and has had a significant change in condition. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident R22's clinical record revealed physician orders dated 3/17/25, for Levaquin (antibiotic used to treat bacterial infections) 750 mg every evening for pneumonia (lung infection) for 7 days and Prednisone (steroid) 40 mg daily for 3 days, then 30 mg daily for 3 days, then 20 mg daily for 3 days, and then 10 mg daily for 3 days. Further review revealed another physician's order dated 3/18/25, for Acetazolamide (a carbonic anhydrase) 250 mg twice a day for two days for Hypercapnia (too much carbon dioxide in the blood) The clinical record lacked evidence that Resident R22's representative was notified of Resident R22's change in condition/treatments. During an interview on 5/8/25, at 10:20 a.m. Nursing Home Administrator (NHA) and Director of Nursing (DON) revealed that Resident R22 will tell staff that he/she does not want his/her family notified of changes. During an interview on 5/8/25, at 10:26 a.m. Resident R22 stated that he/she wants his/her family to be notified of everything. During an interview on 5/8/25, at 10:35 a.m. NHA and DON confirmed there was no documented evidence that Resident R22 instructed staff not to notify his/her family or that staff attempted to notify Resident R22's family of the above changes in condition and treatments. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12 (d)(1)(5) Nursing services 28 Pa. Code 201.18(b)(1) Management

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual October 2024 (RAI-assessment guide used to plan the provision of care for residents), and clinical record review, and staff interview, it was determined that the facility failed to initiate a baseline care plan and provide a written summary of the baseline care plan and order summary to the resident and/or representative for four of 13 residents reviewed (Resident R119, R28, R129, and R383). Findings include: No policy provided by facility. Review of the RAI manual instructions for Section C0500 Brief Interview for Mental Status (BIMS-a test to help determine a resident's cognitive status) revealed that a score of 13-15 identified a resident as cognitively intact and a score of 8-12 identified a resident as moderately impaired, and a score of 0-7 as severely impaired. Resident R119 's clinical record revealed an admitted [DATE], with diagnoses that included dementia (a disease of the brain that affects behavior, moods and decision making), protein-calorie malnutrition (a condition that involves a deficiency in protein and calories with oral intake), pneumonia (inflammation of the lungs typically caused by infection), and malignant neoplasm of prostate (a cancer in a man's prostrate). Resident R119's BIMS revealed a score of 3/15 indicating severe cognitive impairment. R119's clinical record lacked evidence that a baseline care plan was initiated for Resident R119, and/or a summary of the baseline care plan and order summary were provided to the resident representative. During an interview on 5/08/25, at 1:42 p.m. the Nursing Home Administrator (NHA) confirmed that the clinical record of Resident R119 lacked evidence that a baseline care plan was initiated, and/or a summary of the baseline care plan and order summary were provided to the resident representative. Resident R28's clinical record revealed an admitted [DATE], with diagnoses that included sleep apnea (a disorder that makes you stop breathing repeatedly during sleep), End Stage Renal Disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), and high blood pressure. R28's clinical record lacked evidence that a baseline care plan was initiated for Resident R28, and/or a summary of the baseline care plan and order summary were provided to the resident and/or his/her representative. Resident R129's clinical record revealed an admitted [DATE], with diagnoses that included kidney failure (kidneys are no longer able to work therefore cannot filter waste and toxins from the blood), diabetes (a health condition caused by the body's inability to produce enough insulin), and high blood pressure. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R129's clinical record lacked evidence that a baseline care plan was initiated for Resident R129, and/or a summary of the baseline care plan and order summary were provided to the resident and/or his/her representative. Resident R383's clinical record revealed an admitted [DATE], with diagnoses that included Amputation of left foot (the surgical removal of a body part due to severe injury, infection, or disease, diabetes, and high blood pressure. R383's clinical record lacked evidence that a baseline care plan was initiated for Resident R383, and/or a summary of the baseline care plan and order summary were provided to the resident and/or his/her representative. During an interview on 5/08/25, at 10:15 a.m. the NHA confirmed that the clinical record of Residents R28, R129, and R383 lacked evidence that a baseline care plan was initiated, and/or a summary of the baseline care plan and order summary were provided to the resident and/or his/her representative. 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 211.10(c) Resident Care Plan 28 Pa. Code 211.12(d)(1) Nursing services

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to ensure adequate physician orders were in place for an indwelling urinary catheter (a medical device that helps drain urine from the bladder) and failed to provide appropriate care for one of three residents reviewed for catheters (Resident R383). Findings include: Review of facility policy entitled Indwelling Urinary Catheter dated 1/8/25, revealed If the bed is placed in a low position, the catheter bag can be placed in a basin to prevent it from touching the floor, and The catheter bag should have a privacy cover applied at all times. Review of facility policy entitled Catheter: Care of Indwelling Urinary dated 1/8/25 revealed verify physician order, and secure catheter tubing to keep the drainage bag below the level of the resident's bladder and off the floor. Resident R383's clinical record revealed an admitted [DATE], with diagnoses that included amputation of left foot (the surgical removal of a body part due to severe injury, infection, or disease) diabetes (a health condition caused by the body's inability to produce enough insulin), and high blood pressure. Resident R383's admission documentation revealed an indwelling foley catheter was present upon his/her entry into the facility. Review of R383's order summary lacked evidence that physician orders were in place for a urinary catheter and related care orders. Observations on 5/5/25, at 12:42 p.m. and again at 3:37 p.m. revealed that Resident R383 was laying in his/her bed and the urinary drainage bag was on the floor and was visible from the corridor and lacking a privacy cover. During an interview on 5/5/25, at 3:37 p.m. the Director of Nursing confirmed that Resident R383's urinary catheter bag should not be on the floor and a privacy cover should be in place. During an interview on 5/6/25, at 3:10 p.m. the Director of Nursing confirmed that physician orders were not in place regarding the indwelling foley catheter or related care for Resident R383. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(1)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to promote cleanliness and help prevent the spread of infection regarding respiratory care equipment for three of three residents reviewed (Residents R1, R22, and R28). Findings include: A facility policy entitled, Oxygen Concentrator (device that takes air from your surroundings, extracts oxygen and filters it into purified oxygen to breathe) dated 1/8/25, revealed do not run concentrator without a filter or with a dusty filter, and remove, rinse and pat dry air intake filter weekly or more often if needed to keep clean and free of dust. Resident R1's clinical record revealed an admitted [DATE], with diagnoses that included obstructive sleep apnea (a disorder that makes you stop breathing repeatedly during sleep), End Stage Renal Disease (ESRD-a condition in which the kidneys lose the ability to remove waste and balance fluids), and high blood pressure. Resident R1's clinical record revealed a physician's order dated 2/15/25, for oxygen at 2 liters per min (lpm) via nasal cannula (a thin tube with two prongs that fit in a resident's nostrils to deliver oxygen) every evening and night shift, and a physician's order dated 2/10/25 for oxygen at 2 liters per minute via nasal cannula as needed for difficulty breathing. Observations on 5/5/25, at 3:30 p.m. revealed Resident R1 lying on his/her bed with the oxygen concentrator at the bedside with the oxygen tubing and nasal cannula lying on the floor. Further observation of the filter on the oxygen concentrator revealed a large amount of a gray fluffy substance covering the entire filter. Resident R22's clinical record revealed an admitted [DATE], with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), respiratory failure (a condition where you don't get enough oxygen or you get too much carbon dioxide in your body), and obesity. Resident R22's clinical record revealed a physician's order dated 11/13/23, for oxygen at 3 lpm via nasal cannula continuous every shift. Observation on 5/05/25, at 3:00 p.m. revealed Resident R22 lying on his/her bed with supplemental oxygen in place and the oxygen concentrator liter flow set at 3 lpm. Further observation of the concentrator filter on the oxygen concentrator revealed a large amount of a gray fluffy substance covering the filter. Resident R28's clinical record revealed an admitted [DATE], with diagnoses that included sleep apnea, ESRD, and high blood pressure. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 28's clinical record revealed a physician's order dated 2/18/25, for supplemental oxygen at 3 lpm continuous every evening and night shift. Observations on 5/5/25, at 3:30 p.m. revealed Resident R28 sitting in his/her wheelchair with the oxygen concentrator at the bedside with the oxygen tubing and nasal cannula lying on the floor. Further observation of the filter on the oxygen concentrator revealed a large amount of a gray fluffy substance covering the entire filter. During an interview on 5/5/25, at 3:30 p.m. Resident R28 revealed that every morning when they take off my oxygen, they just throw it on the floor. During an interview on 5/5/25, at 3:39 p.m. the Director of Nursing confirmed that Residents R1, R22, and R28's oxygen concentrator filter contained a large amount of gray fluffy substance and should be cleaned and that Residents R1 and R28's oxygen tubing and nasal cannula should not be touching the floor. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(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** 40177 Based on review of the facility documents and clinical records, and resident and staff interview, it was determined that the facility failed to maintain complete and accurate records relating to dialysis (a medical procedure that filters blood when the kidneys are not functioning properly) communication for one of three residents reviewed for dialysis (Resident R28). Findings include: Review of the Long Term Care Facility Dialysis Services Agreement signed on 7/25/19, revealed that the facility agrees to provide to the Dialysis Center all medical and administrative information relating to the resident's condition. This information includes but is not limited to the resident's history of renal illness, record of laboratory and x-ray findings, and current treatment including medications. The agreement further stated that the Dialysis Center will provide to the facility appropriate information and guidance regarding the renal condition of the resident including but not limited to medications, directions for handling medical and non-medical emergencies, and care of the shunts and fistulas. Resident R28's clinical record revealed an admitted [DATE], with diagnoses that included End Stage Renal Disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), dependence on renal dialysis and high blood pressure. Resident R28's clinical record revealed a physician's order dated 12/31/24, for Dialysis-Every Monday, Wednesday, and Friday. During an interview on 5/7/25, at 2:30 p.m. Resident R28 revealed that the dialysis clinic checks his/her weights at every visit and was told that he/she has had weight loss. Resident R28 stated that he/she has a dialysis communication binder that is usually kept in his/her wheelchair, but did not know where it is currently. During an interview on 5/7/25, at 2:15 p.m. and again 5/8/25, at 10:00 a.m. the Director of Nursing confirmed that Resident R28's dialysis communication binder was not readily available in the facility for review. During an interview on 5/8/25, at 1:30 p.m. the Nursing Home Administrator confirmed that Resident R28's dialysis communication binder was not readily available in the facility for review. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.5(f)(viii) Medical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17260 Based on review of facility policy, observations, and staff interview, it was determined that the facility failed to label a multi-dose insulin (medication to treat elevated blood sugar levels) vials with the date it was opened, in two of three medication carts (Cart 1 and Cart 2). Findings include: A facility policy entitled Vials and Ampules of Injectable Medications last reviewed [DATE], directed staff to place a date opened sticker on a vial or container when opened and to enter the date the container or vial was opened along with the expiration date of the medication. Observations on [DATE], from 10:45 a.m. through 10:55 a.m., revealed three opened undated multi-dose insulin vials in Medication Cart 1 and two opened undated multi-dose insulin vials in Medication Cart 2, therefore staff were not able to determine how long the vials were able to be used. The manufacturer's directions for these multi-dose insulin vials indicated that the insulin expired 28 days after opening and should be thrown away 28 days after opening, even if it still has insulin in it. During interview at the time of the above observations, Registered Nurse Employee E11 confirmed that multi-dose vials/containers of insulin were not dated upon opening as required. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.12(d)(1) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42655 Based on a review of facility records, observations, and staff interview, it was determined the facility failed to maintain safe storage of ice for residents for one of one ice machines located in the kitchen. Findings include: Review of the manufacturer guidelines for the Manitowoc S Model Ice Machine, dated 8/25/03, revealed Do not trap drain line, leave air gap between drain tube and drain. Observations in the kitchen on 5/05/25, at 11:15 a.m., revealed the ice machine hose drain resting on a floor drain and lacked a vertical air gap between the end of the hose drain and floor drain. The floor drain and surrounding floor were observed rusty in color and unclean. An interview with the Maintenance Director on 5/05/25, at 12:15 p.m. confirmed the ice machine's hose drain and floor drain lacked an air gap, allowing the ice machine hose drain to rest on the unclean floor drain creating unsafe storage for ice. 28 Pa. Code 201.14(a) Responsibility of licensee

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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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40177 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to implement enhanced barrier precautions for one of four residents reviewed related to infection control (Resident R383). Findings include: Facility policy entitled Enhanced Barrier Precautions dated 1/8/25, indicated that Enhanced Barrier Precautions (EBP) are utilized to prevent the spread of MDRO's (Multidrug Resistant Organisms - a germ resistant to many antibiotics), and EBP's are used as an infection prevention and control intervention to reduce the spread of MDRO's to residents. The policy further stated examples of high-contact resident care activities requiring the use of EBP 's included the following: Device care or use for urinary catheters and wound care. The Center for Disease Control and Prevention (CDC) defines Enhanced Barrier Precautions as an infection control intervention designed to reduce transmission of MDRO's using an approach of isolation gown and gloves during high-contact resident care activities including catheter care and wound care. CDC further indicated that facilities should post clear signage indicating EBP requirements. Resident R383's clinical record revealed an admitted [DATE], with diagnoses that included amputation of left foot (the surgical removal of a body part due to severe injury, infection, or disease), diabetes (a health condition caused by the body's inability to produce enough insulin), and high blood pressure. Resident R383's admission documentation revealed an indwelling foley catheter was present upon his/her entry into the facility and that Resident R383 was receiving wound care due to amputation of left foot and a coccyx (small bone at the base of the spine) wound. Observations on 5/5/25, at 12:42 p.m. and 3:37 p.m. revealed that Resident R383 was laying in his/her bed with an indwelling catheter present. Further observation of Resident R383's room revealed that there was no signage alerting persons entering the room of EBP for infection control. During an interview on 5/5/25, at 3:37 p.m. the Director of Nursing (DON) confirmed that Resident R383's room lacked signage of EBP. During an interview on 5/6/25, at 3:10 p.m. the DON confirmed that Resident R383 had an indwelling catheter, and wound care to his/her left foot amputation site and coccyx that required EBP. The DON further confirmed that Resident R383's clinical record lacked physician orders for EBP. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services