STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395118	A. Building B. Wing	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Chicora	Donegal Township, Box Q Chicora, PA 16025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to ensure that residents were free from neglect by not providing adequate supervision for one of three residents (Resident R1) resulting in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) from the facility. Findings include: Review of facility policy Resident Protection From Abuse, Neglect, Mistreatment or Exploitation dated 2/9/24, indicated neglect is the failure of the facility, its employees or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident requires but the facility fails to provide the to the resident, that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/29/24, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking, and interferes with daily life), and muscle weakness. A review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS, a screening test that aides in detecting cognitive impairment). The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of Resident R1's MDS assessment dated [DATE], Section C0500-BIMS screening indicated a score of 5 revealing that Resident R1 had severe cognitive impairment. (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: 395118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER Quality Life Services - Chicora		STREET ADDRESS, CITY, STATE, ZIP CODE Donegal Township, Box Q Chicora, PA 16025	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Health Status Note dated 3/11/24, at 3:49 p.m. stated, Patient continues to be confused, keeping patient near nurses station for increased supervision. Patient was found by Personal Care staff this morning after he wheeled through the cafeteria and into Personal Care, he believed he that he saw his wife. Review of a witness statement completed by Registered Nurse (RN) Employee E2 dated 3/11/24, stated, Resident R1 was brought back to Fairgrounds Unit by Personal Care Director. Unsure of how patient go to Personal Care. Patient remains at nurses station on Fairgrounds for increased supervision related to fall risk when patient in room alone. Review of incidents submitted to the State indicated, Resident R1 was found to be in the Personal Care building (attached to Skilled Facility) on the facility campus following lunch. Resident does not have an order for Leave of Absence (LOA) while admitted under his skilled stay. He exited through the Settlers dining room into the Vista Royale Personal Care building. Personal Care staff immediately returned resident back to Skilled Facility. During an interview on 3/20/24, at 11:44 a.m. the Director of Nursing (DON) stated, The RN Supervisor is responsible for completing the post-elopement assessment and completing a risk management form, where the staff can enter statements. The RN Supervisor would be able to complete a new Wandering Risk Assessment as part of the nursing assessment. We were not made aware that Resident R1 eloped from the facility until the following day, 3/12/24. It was a breakdown in communication, the RN Supervisor did not complete an incident report. We are not sure when exactly Resident R1 eloped from the facility and we are not sure how long Resident R1 was gone from the facility. During an interview on 3/20/24, at 11:44 a.m. the DON confirmed that the facility did not complete an incident report and did not obtain witness statements form staff on duty at the time of Resident R1's elopement. During a telephonic interview on 3/20/24, at 12:32 p.m. RN Supervisor Employee E1 stated, I can't recall who was working that day, I was the supervisor until 6 p.m. I overhead someone saying that Resident R1 was found over in Personal Care. I can't recall the exact time of the day that I heard it. I asked if he was hurt and I was told he was fine, so I didn't do anything because he wasn't harmed. I said there should be a security bracelet on him. He didn't make it outside, so I didn't think it was an elopement. After a resident elopes I know to do an assessment, call the physician, complete an incident report, and update the care plan. I did not assess Resident R1 after he was brought back and I did not complete an incident report. During a tour of the facility on 3/20/24, at 12:52 p.m. State Agency was able to exit the Fairgrounds Village Unit through the Settlers Dining Room and enter the Personal Care Home (PCH) without restricted access, walk through the entire PCH, and exit to the parking lot without having any encounter with PCH staff. During an interview on 3/20/24, at 2:45 p.m. the Nursing Home Administrator and DON confirmed that the facility failed to ensure that residents were free from neglect by not providing adequate supervision for one of three residents (Resident R1) resulting in an elopement from the facility. 28. Pa Code 201.14(a) Responsibility of licensee. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Chicora	Donegal Township, Box Q Chicora, PA 16025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28. Pa Code 201.18(b)(1)(e)(1) Management. 28. Pa. Code 211.12(d)(1)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER Quality Life Services - Chicora		STREET ADDRESS, CITY, STATE, ZIP CODE Donegal Township, Box Q Chicora, PA 16025	

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to failed to implement written policies and procedures to ensure a complete and thorough investigation of an incident involving the potential for neglect for one of three residents (Resident R1) resulting in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) from the facility. Findings include: Review of facility policy Resident Protection From Abuse, Neglect, Mistreatment or Exploitation dated 2/9/24, indicated neglect is the failure of the facility, its employees or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident requires but the facility fails to provide the to the resident, that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. All reports of abuse, neglect, exploitation, or mistreatment including injuries of unknown source, and misappropriation or resident property will be investigated and documented. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/29/24, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking, and interferes with daily life), and muscle weakness. A review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS, a screening test that aides in detecting cognitive impairment). The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of Resident R1's MDS assessment dated [DATE], Section C0500-BIMS screening indicated a score of 5 revealing that Resident R1 had severe cognitive impairment. Review of a Health Status Note dated 3/11/24, at 3:49 p.m. stated, Patient continues to be confused, keeping patient near nurses station for increased supervision. Patient was found by Personal Care staff this morning after he wheeled through the cafeteria and into Personal Care, he believed he that he saw his wife. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER Quality Life Services - Chicora		STREET ADDRESS, CITY, STATE, ZIP CODE Donegal Township, Box Q Chicora, PA 16025	

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a witness statement completed by Registered Nurse (RN) Employee E2 dated 3/11/24, stated, Resident R1 was brought back to Fairgrounds Unit by Personal Care Director. Unsure of how patient go to Personal Care. Patient remains at nurses station on Fairgrounds for increased supervision related to fall risk when patient in room alone. During an interview on 3/20/24, at 11:44 a.m. the Director of Nursing (DON) stated, The RN Supervisor is responsible for completing the post-elopement assessment and completing a risk management form, where the staff can enter statements. The RN Supervisor would be able to complete a new Wandering Risk Assessment as part of the nursing assessment. We were not made aware that Resident R1 eloped from the facility until the following day, 3/12/24. It was a breakdown in communication, the RN Supervisor did not complete an incident report. We are not sure when exactly Resident R1 eloped from the facility and we are not sure how long Resident R1 was gone from the facility. During an interview on 3/20/24, at 11:44 a.m. the DON confirmed that the facility did not complete an incident report and did not obtain witness statements form staff on duty at the time of Resident R1's elopement. During a telephonic interview on 3/20/24, at 12:32 p.m. RN Supervisor Employee E1 stated, I can't recall who was working that day, I was the supervisor until 6 p.m. I overhead someone saying that Resident R1 was found over in Personal Care. I can't recall the exact time of the day that I heard it. I asked if he was hurt and I was told he was fine, so I didn't do anything because he wasn't harmed. I said there should be a security bracelet on him. He didn't make it outside, so I didn't think it was an elopement. After a resident elopes I know to do an assessment, call the physician, complete an incident report, and update the care plan. I did not assess Resident R1 after he was brought back and I did not complete an incident report. During an interview on 3/20/24, at 2:45 p.m. the Nursing Home Administrator and DON confirmed that the facility failed to failed to implement written policies and procedures to ensure a complete and thorough investigation of an incident involving the potential for neglect for one of three residents (Resident R1) resulting in an elopement from the facility. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility documents, facility policy, clinical records, and staff interview, it was determined that the facility failed to conduct a thorough investigation of an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) to rule out neglect for one of three residents (Resident R1). Findings include: Review of facility policy Resident Protection From Abuse, Neglect, Mistreatment or Exploitation dated 2/9/24, indicated neglect is the failure of the facility, its employees or services providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident requires but the facility fails to provide the to the resident, that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. All reports of abuse, neglect, exploitation, or mistreatment including injuries of unknown source, and misappropriation or resident property will be investigated and documented. Review of facility policy Elopement Prevention dated 2/9/24, indicated the facility will properly assess residents and plan their care to prevent accidents related to wandering behavior or elopement. Upon admission, readmission, quarterly and as necessary, nurses will complete a Wandering Risk Assessment. Should the resident's behavior warrant elopement prevention measures, a comprehensive elopement prevention plan will be documented as part of the care plan. Staff observations will be noted during the resident's stay and modifications will be made to the care plan and prevention techniques. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/29/24, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking, and interferes with daily life), and muscle weakness. A review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS, a screening test that aides in detecting cognitive impairment). The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of Resident R1's MDS assessment dated [DATE], Section C0500-BIMS screening indicated a score of 5 revealing that Resident R1 had severe cognitive impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024

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Quality Life Services - Chicora	Donegal Township, Box Q Chicora, PA 16025

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Health Status Note dated 3/11/24, at 3:49 p.m. stated, Patient continues to be confused, keeping patient near nurses station for increased supervision. Patient was found by Personal Care staff this morning after he wheeled through the cafeteria and into Personal Care, he believed he that he saw his wife. Review of a witness statement completed by Registered Nurse (RN) Employee E2 dated 3/11/24, stated, Resident R1 was brought back to Fairgrounds Unit by Personal Care Director. Unsure of how patient go to Personal Care. Patient remains at nurses station on Fairgrounds for increased supervision related to fall risk when patient in room alone. Review of the clinical record failed to indicate a physical assessment, vital signs, and a Wandering Risk Assessment were completely after Resident R1 was returned to the facility by Personal Care staff. Review of incidents submitted to the State indicated, Resident R1 was found to be in the Personal Care building (attached to Skilled Facility) on the facility campus following lunch. Resident does not have an order for Leave of Absence (LOA) while admitted under his skilled stay. He exited through the Settlers dining room into the Vista Royale Personal Care building. Personal Care staff immediately returned resident back to Skilled Facility. During an interview on 3/20/24, at 11:44 a.m. the Director of Nursing (DON) stated, The RN Supervisor is responsible for completing the post-elopement assessment and completing a risk management form, where the staff can enter statements. The RN Supervisor would be able to complete a new Wandering Risk Assessment as part of the nursing assessment. We were not made aware that Resident R1 eloped from the facility until the following day, 3/12/24. It was a breakdown in communication, the RN Supervisor did not complete an incident report. We are not sure when exactly Resident R1 eloped from the facility and we are not sure how long Resident R1 was gone from the facility. During an interview on 3/20/24, at 11:44 a.m. the DON confirmed that the facility did not complete an incident report and did not obtain witness statements form staff on duty at the time of Resident R1's elopement. During a telephonic interview on 3/20/24, at 12:32 p.m. RN Supervisor Employee E1 stated, I can't recall who was working that day, I was the supervisor until 6 p.m. I overhead someone saying that Resident R1 was found over in Personal Care. I can't recall the exact time of the day that I heard it. I asked if he was hurt and I was told he was fine, so I didn't do anything because he wasn't harmed. I said there should be a security bracelet on him. He didn't make it outside, so I didn't think it was an elopement. After a resident elopes I know to do an assessment, call the physician, complete an incident report, and update the care plan. I did not assess Resident R1 after he was brought back and I did not complete an incident report. During an interview on 3/20/24, at 2:45 p.m. the Nursing Home Administrator and DON confirmed that the facility failed to conduct a thorough investigation of an elopement to rule out neglect for one of three residents (Resident R1). 28 Pa Code: 201.18 (e)(1)(2) Management 28 Pa Code: 201.29 (a)(c)(d) Resident Rights (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Quality Life Services - Chicora		STREET ADDRESS, CITY, STATE, ZIP CODE Donegal Township, Box Q Chicora, PA 16025	

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code: 211.12 (a)(c)(d)(1)(3)(5) Nursing services

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated and revised to reflect the resident's specific care needs after a resident eloped (resident exits to an unsupervised or unauthorized area without the facility's knowledge) from the facility for one of three residents (Resident R1). Findings include: Review of facility policy Elopement Prevention dated 2/9/24, indicated the facility will properly assess residents and plan their care to prevent accidents related to wandering behavior or elopement. Upon admission, readmission, quarterly and as necessary, nurses will complete a Wandering Risk Assessment. Should the resident's behavior warrant elopement prevention measures, a comprehensive elopement prevention plan will be documented as part of the care plan. Staff observations will be noted during the resident's stay and modifications will be made to the care plan and prevention techniques. Review of facility policy Care Plan and Interdisciplinary Care Conferences dated 2/9/24, indicated the care plan is reviewed and updated at least quarterly, and is based on ongoing assessment and evaluation of resident needs. It may be specifically reviewed up and updated as the resident's condition changes, when there are resident/family concerns, when there are newly identified risk factors, because of a resident's response to current interventions. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/29/24, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking, and interferes with daily life), and muscle weakness. A review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS, a screening test that aides in detecting cognitive impairment). The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of Resident R1's MDS assessment dated [DATE], Section C0500-BIMS screening indicated a score of 5 revealing that Resident R1 had severe cognitive impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Health Status Note dated 3/11/24, at 3:49 p.m. stated, Patient continues to be confused, keeping patient near nurses station for increased supervision. Patient was found by Personal Care staff this morning after he wheeled through the cafeteria and into Personal Care, he believed he that he saw his wife. Review of a witness statement completed by Registered Nurse (RN) Employee E2 dated 3/11/24, stated, Resident R1 was brought back to Fairgrounds Unit by Personal Care Director. Unsure of how patient go to Personal Care. Patient remains at nurses station on Fairgrounds for increased supervision related to fall risk when patient in room alone. A review of Resident R1's care plan on 3/20/24, failed to include goals and interventions related to Resident R1's elopement on 3/11/24. During a telephonic interview on 3/20/24, at 12:32 p.m. RN Supervisor Employee E1 stated, I can't recall who was working that day, I was the supervisor until 6 p.m. I overhead someone saying that Resident R1 was found over in Personal Care. I can't recall the exact time of the day that I heard it. I asked if he was hurt and I was told he was fine, so I didn't do anything because he wasn't harmed. I said there should be a security bracelet on him. He didn't make it outside, so I didn't think it was an elopement. After a resident elopes I know to do an assessment, call the physician, complete an incident report, and update the care plan. I did not assess Resident R1 after he was brought back and I did not complete an incident report. During an interview on 3/20/24, at 1:30 p.m. the Director of Nursing confirmed that the facility failed to ensure that a resident's care plan was updated and revised to reflect the resident's specific care needs after a resident eloped from the facility for one of three residents (Resident R1). 28 Pa. Code 211.11(d) Resident care plan 28 Pa. Code 211.12(d)(3) Nursing services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48546

Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision that resulted in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one of three residents (Resident R1).

Findings include:

Based on facility policy Elopement Prevention dated 2/9/24, indicated the facility will properly assess residents and plan their care to prevent accidents related to wandering behavior or elopement. Upon admission, readmission, quarterly and as necessary, nurses will complete a Wandering Risk Assessment. Should the resident's behavior warrant elopement prevention measures, a comprehensive elopement prevention plan will be documented as part of the care plan. Staff observations will be noted during the resident's stay and modifications will be made to the care plan and prevention techniques.

Review of facility policy Accidents and Incidents dated 2/9/24, indicated an accident/incident is any happening, which is not consistent with routine operations or the routine care of the particular resident. When a resident incident/accident occurs, the resident will be assessed by a Registered Nurse (RN). The Charge Nurse or designee will complete a risk management report noting witnesses, if applicable, and notes of any corrective action, and that the family and physician were notified. The licensed nurse responsible for the resident will update resident's plan of care as necessary related to the incident/accident.

Review of the facility Registered Nurse job description indicated the RN is to ensure accurate documentation of all incidents/accidents occurring during the shift and report problems to the Director of Nursing (DON) and assist in developing and implementing corrective actions.

Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE].

Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/29/24, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking, and interferes with daily life), and muscle weakness.

A review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS, a screening test that aides in detecting cognitive impairment). The BIMS total score suggests the following distributions:

13-15: cognitively intact

8-12: moderately impaired

0-7: severe impairment

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of Resident R1's MDS assessment dated [DATE], Section C0500-BIMS screening indicated a score of 5 revealing that Resident R1 had severe cognitive impairment.

Review of a Health Status Note dated 3/11/24, at 3:49 p.m. stated, Patient continues to be confused, keeping patient near nurses station for increased supervision. Patient was found by Personal Care staff this morning after he wheeled through the cafeteria and into Personal Care, he believed he that he saw his wife.

Review of a witness statement completed by RN Employee E2 dated 3/11/24, stated, Resident R1 was brought back to Fairgrounds Unit by Personal Care Director. Unsure of how patient go to Personal Care. Patient remains at nurses station on Fairgrounds for increased supervision related to fall risk when patient in room alone.

Review of the clinical record failed to indicate a physical assessment, vital signs, and a Wandering Risk Assessment were completed after Resident R1 was returned to the facility by Personal Care staff.

Review of incidents submitted to the State indicated, Resident R1 was found to be in the Personal Care building (attached to Skilled Facility) on the facility campus following lunch. Resident does not have an order for Leave of Absence (LOA) while admitted under his skilled stay. He exited through the Settlers dining room into the Vista Royale Personal Care building. Personal Care staff immediately returned resident back to Skilled Facility.

During an interview on 3/20/24, at 11:44 a.m. the DON stated, The RN Supervisor is responsible for completing the post-elopement assessment and completing a risk management form, where the staff can enter statements. The RN Supervisor would be able to complete a new Wandering Risk Assessment as part of the nursing assessment. We were not made aware that Resident R1 eloped from the facility until the following day, 3/12/24. It was a breakdown in communication, the RN Supervisor did not complete an incident report. We are not sure when exactly Resident R1 eloped from the facility and we are not sure how long Resident R1 was gone from the facility.

During an interview on 3/20/24, at 11:44 a.m. the DON confirmed that the facility did not complete an incident report and did not obtain witness statements form staff on duty at the time of Resident R1's elopement.

During a telephonic interview on 3/20/24, at 12:32 p.m. RN Supervisor Employee E1 stated, I can't recall who was working that day, I was the supervisor until 6 p.m. I overhead someone saying that Resident R1 was found over in Personal Care. I can't recall the exact time of the day that I heard it. I asked if he was hurt and I was told he was fine, so I didn't do anything because he wasn't harmed. I said there should be a security bracelet on him. He didn't make it outside, so I didn't think it was an elopement. After a resident elopes I know to do an assessment, call the physician, complete an incident report, and update the care plan. I did not assess Resident R1 after he was brought back and I did not complete an incident report.

During a tour of the facility on 3/20/24, at 12:52 p.m. State Agency was able to exit the Fairgrounds Village Unit through the Settlers Dining Room and enter the Personal Care Home (PCH) without restricted access, walk through the entire PCH, and exit to the parking lot without having any encounter with PCH staff.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER Quality Life Services - Chicora		STREET ADDRESS, CITY, STATE, ZIP CODE Donegal Township, Box Q Chicora, PA 16025	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/20/24, at 2:45 p.m. the Nursing Home Administrator (NHA) and DON confirmed that the facility failed to make certain each resident receives adequate supervision that resulted in an elopement for one of three residents (Resident R1). 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.