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	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Chicora	160 Medical Center Road 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** 50075 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 using the safest transfer status for one of two residents (Resident R2). Findings include: Review of facility policy Resident Protection From Abuse, Neglect, Mistreatment or Exploitation dated 7/22/24, 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 that 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 R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/13/24, indicated diagnoses of depression, Alzheimer ' s disease (a type of brain disorder that causes problems with memory, thinking and behavior), and anemia (too little iron in the body causing fatigue). Section GG0170 indicated resident is dependent for chair or bed to chair transfers. Review of Resident R2's physician orders dated 2/19/24, at 11:12 a.m. indicated mechanical lift assist times two. Ambulation status: none. Review of Resident R2's care plan dated 2/19/24, at 11:30 a.m. indicated mechanical lift assist times two. Total assist with personal hygiene. (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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(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 Resident R2's clinical record on 8/27/24, at 12:02 p.m. reveal that three Nursing Assistants (NA) were standing resident up from a shower chair after providing care. One NA was holding resident under left arm, another NA was holding resident under right arm, and another NA was pulling incontinent brief up when they heard a pop sound. They then transferred her from standing to her chair without using a mechanical lift, as ordered. They notified Registered Nurse (RN) who assessed resident with no noticeable injuries. Later that same day, swelling was noted to left shoulder. X-ray revealed no acute fracture. Resident is nonverbal but showed facial grimacing (a sign of pain) and was medicated, as ordered, for pain. During an interview on 8/27/24, at 1:20 NA Employee E1 stated, We stood Resident R2 up underneath her arms to finish dressing her after her shower. One under one arm, one under the other, and one pulling her brief up. Then I heard a pop. We sat her in her chair and went and told the supervisor. I knew she was a mechanical lift, but she needed to be out of bed to eat and we couldn ' t find any hoyer pad to use with the lift. NA Employee E1 stated she would find transfer status in residents care plan. During a phone interview on 8/27/24, at 1:33 p.m. with NA Employee E3 stated I showered Resident R2 and I got help to lift her from the shower chair to her chair. We couldn ' t find any of those pads to use to lift people with so we stood her up. We arm pitted her (one aide under each arm) and stood her up while someone was pulling her pants up. When we stood her up, I said did you hear that, what was that? We put her into her chair and told the nurse. NA Employee E3 stated she did not know how to find out someone's transfer status and thought she was an assist times one because she was a small lady. During a phone interview on 8/27/24, at 1:45 p.m. NA Employee E2 stated that while two other NA ' s stood resident up after her shower from the shower chair, I pulled her pants up. We heard a pop noise, they sat her in her chair and told the nurse. I always look up resident ' s transfer status on the computer. I wasn't transferring her; I only pulled her pants up. During an interview on 8/27/24, at 9:38 a.m. Director of Nursing (DON) stated They didn't use the correct transfer method and said Resident R2 should have been transferred by a mechanical lift. During an interview on 8/27/24, at 4:05 p.m. Nursing Home Administrator and DON confirmed that the facility failed to ensure that residents were free from neglect by not using the safest transfer status for one of two residents (Resident R2).

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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** 50075 Based on review of facility documents, facility policy, clinical records, observation, 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 15 residents (Resident R1), failed to accurately complete assessments and monitor safety device for 15 out of 15 residents, and failed to ensure that residents were transfered safely using the safest transfer status for one of two residents (Resident R2) Findings include: Based on facility policy Elopement Prevention dated 7/22/24, 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 Resident Protection From Abuse, Neglect, Mistreatment or Exploitation dated 7/22/24, 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 that 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 5/9/24, indicated diagnoses of Huntington's Disease (a condition that leads to progressive degeneration of nerve cells in the brain), malnutrition (lack of sufficient nutrients in the body), and personality disorder (a type of mental disorder). 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 15 revealing that Resident R1 is cognitively intact. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R1's care plan dated 1/18/23, indicated to monitor my location frequently. Review of Resident R1's clinical record on 8/27/24, at 10:21 a.m. indicated that resident refused to wear a wander guard (a small device worn by the resident that alarms the facility if a resident is close to an exit) in the past and has cut it off and disposed of it before. Review of Resident R1's physician orders dated 8/26/27, indicated check wander guard placement every two hours and wander guard on at all times for safety after resident signed a Behavioral agreement with the facility. During an observation on 8/27/24, at 10:22 a.m. revealed Resident R1 was wearing a wander guard on her left ankle. Review of an Incident Note dated 7/31/24, at 4:00 p.m. stated, Writer was informed that resident was not on unit. Resident was sitting in enclosed courtyard with other residents and staff member. Then one resident came into facility, when returning to get this resident was not found in courtyard. Resident left courtyard and was seen out of facility near exit door. No injuries noted. Resident was fully dressed and had shoes on both feet. Resident then escorted back into facility and taken to room. Resident stated, I was just taking a walk. Assisted back into building without problems. During an interview on 8/27/24, at 2:20 p.m. Nursing Assistant Employee E1stated, Me and another aide were taking turns sitting with a group of residents in the courtyard. We decided to come in but then Resident R1 came up to me when I came in and asked if she could go outside. I said sure. I opened the door into the courtyard and seen her go to the left. I walked back in the facility for a second to get my drink. The other aide asked, as she was walking up the hallway, if everybody came in yet. I said yes but I just left Resident R1 outside in the courtyard. I ' m going to go out and sit with her. The other aide walked out to check on her and she was nowhere in sight. She came back in and told me, and I said no way because I just left her out. I went outside yelling her name. I came back in while checking her room. I called the LPN on break. I was going to tell the supervisor but then the receptionist called and said that Scheduler Employee E4 had resident at front door. NA Employee E1 stated that Resident R1 was unsupervised in the courtyard for approximately two minutes. Review of incidents submitted to the State indicated, Resident R1 was outside in the enclosed courtyard off the memory unit. While staff were bringing in other residents, Resident R1 was able to get through the courtyard door to the main building. She was witnessed exiting the main doors and was brought back into the facility and returned to her unit. Resident R1 was dressed appropriately and was outside for less than one minute. During clinical record review of a facility provided list of residents with wander guards indicated; - 3/15 Wandering, Elopement Risk Evaluations failed to be completed in a timely manner. - 10/15 Wandering, Elopement Risk Evaluations failed to accurately be completed. - 15/15 Wandering, Elopement Risk residents failed to have physician orders to check the function of the wander guard and replace when indicated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of wander guard manufacture guidelines on 8/27/24, at 1:15 p.m. indicated that the wander guards should be tested on a weekly basis, per recommendation. During a tour of the facility and Courtyard on 8/27/24, at 9:32 a.m. State Agency was able to exit through the gate which had a chain and an unlocked lock on it into the Memory Courtyard from the main facility. During an interview on 3/20/24, at 4:05 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 15 residents (Resident R1) and failed to accurately complete assessments and monitor safety device for 15 out of 15 residents. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/13/24, indicated diagnoses of depression, Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior), and anemia (too little iron in the body causing fatigue). Section GG0170 indicated resident is dependent for chair or bed to chair transfers. Review of Resident R2's physician orders dated 2/19/24, at 11:12 a.m. indicated mechanical lift assist times two. Ambulation status: none. Review of Resident R2's care plan dated 2/19/24, at 11:30 a.m. indicated mechanical lift assist times two. Total assist with personal hygiene. Review of Resident R2 ' s clinical record on 8/27/24, at 12:02 p.m. reveal that three Nursing Assistants (NA) were standing resident up from a shower chair after providing care. One NA was holding resident under left arm, another NA was holding resident under right arm, and another NA was pulling incontinent brief up when they heard a pop sound. They then transferred her from standing to her chair without using a mechanical lift, as ordered. They notified Registered Nurse (RN) who assessed resident with no noticeable injuries. Later that same day, swelling was noted to left shoulder. X-ray revealed no acute fracture. Resident is nonverbal but showed facial grimacing and was medicated, as ordered, for pain. During an interview on 8/27/24, at 1:20 NA Employee E1 stated, We stood Resident R2 up underneath her arms to finish dressing her after her shower. One under one arm, one under the other, and one pulling her brief up. Then I heard a pop. We sat her in her chair and went and told the supervisor. I knew she was a mechanical lift, but she needed to be out of bed to eat and we couldn ' t find any hoyer pad to use with the lift. Employee E1 stated she would find transfer status in residents care plan. During a phone interview on 8/27/24, at 1:33 p.m. with NA Employee E3 stated I showered Resident R2 and I got help to lift her from the shower chair to her chair. We couldn ' t find any of those pads to use to lift people with so we stood her up. We arm pitted her (one aide under each arm) and stood her up while someone was pulling her pants up. When we stood her up, I said did you hear that, what was that? We put her into her chair and told the nurse. NA Employee E3 stated she did not know how to find out someone ' s transfer status and thought she was an assist times one because she was a small lady. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 8/27/24, at 1:45 p.m. NA Employee E2 stated that while two other NA ' s stood resident up after her shower from the shower chair, I pulled her pants up. We heard a pop noise, they sat her in her chair and told the nurse. I always look up resident ' s transfer status on the computer. I wasn ' t transferring her; I only pulled her pants up. During an interview on 8/27/24, at 9:38 a.m. Director of Nursing (DON) stated They didn't use the correct transfer method and said Resident R2 should have been transferred by a mechanical lift. During an interview on 8/27/24, at 4:05 p.m. Nursing Home Administrator and DON confirmed that the facility failed to ensure that residents were transfered safely by not using the safest transfer status for one of two residents (Resident R2). 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.