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	11/10/2025

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 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. (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
	395118	A. Building B. Wing	11/10/2025

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record review, and staff interviews, it was determined that the facility failed to ensure the physician was appropriately notified of change in condition for one of four residents reviewed (Resident R4). Findings include: Review of the facility policy Resident Change in Condition or Status dated 5/19/25, revealed it is the policy of the facility promptly addressing all resident changes in condition and managing them in compliance with all applicable standards of care. When a resident exhibits a change in condition from their baseline, the licensed nurse assigned to the resident will do the following: provide any necessary physical assessment to determine underlying cause, review any available diagnoses, request assistance from other staff as necessary, and ensure timely notification to charge nurse, physician, and family. Documentation must be provided in the resident record regarding: any assessment of the resident and findings, all applicable interventions, and all communication. All documentation provided must indicate the time at which it happened. Resident R4 was admitted to the facility on [DATE], with diagnoses of anxiety, muscle weakness, and high blood pressure. Review of the clinical record physician order dated 6/3/25, indicated Resident R4 was ordered assist with toileting and hygiene every two hours and as needed. Review of Resident R4's care plan dated 6/4/25, revealed the resident was a high risk for falls related to confusion, deconditioning, gait/balance, and psychoactive drug use with a history of falls. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/4/25, indicated diagnoses of anxiety, muscles weakness, and high blood pressure. Question C0500 BIMS Summary Score revealed Resident R4's score to be 4, severe impairment. Section GG-Functional Abilities-revealed the resident required substantial/maximal assistance with toileting transfers and hygiene. and with sit to stand. Review of the facility's incident report revealed Registered Nurse (RN), Employee E13 stated This RN was informed by nurse on memory lane unit that a resident had fallen just then, upon entering his room noticed him sitting on the floor between the sink and toilet in his bathroom, he stated he was trying to get up from using the toilet when he lost his balance/fell back hitting his head, he is alert, skin tear about 9millimeter (mm) x 8 mm to right forearm/actively bleeding, xeroform and dressing applied to area. Patient able to move all limbs, complaints of pain to back of head and feeling dizzy, neurological checks started, this RN notified his step daughter/POA and discussed the above, no indication of needing to go to hospital at this time, range of motion is good, no other opening noted to his skin/no redness at this time, no pain to pelvis reported by resident at this time. Will place call to on call for physician, resident encourage to call staff when he needs help. A further review of Resident R4's incident report revealed the resident's family member was notified on 11/2/25 (a total of 20 days later), at 2:14 p.m. and the physician was notified on 10/16/25, at 2:27 p.m. (a total of 3 days later). Review of RN, Employee E14's witness statement dated 10/14/25, stated at approximately 11:30 p.m. This writer was standing in the hallway at the medication cart. This writer heard a loud thud followed by the resident yelling for assistance. This writer and nurse aide immediately went down hall and upon entering, the resident was observed to be sitting on the floor between the commode and the sink. Resident stated, I was trying to get back into by wheelchair. Review of Resident R4's hospital dated 10/14/25, stated per nursing home staff, the resident had an unwitnessed fall last night. They put him back into bed. It was revealed around 4 a.m. the facility notified the Nurse Practitioner who recommended the resident was sent to the Emergency Department because the resident was on Eliquis (blood thinning medication). During an interview on 11/9/25, at 2:48 p.m. RN Supervisor, Employee E15, if an incident occurs the physician and family are notified immediately. RN, Supervisor, Employee E15 confirmed the facility failed to timely notify a physician after a resident had a fall. During an interview on 11/10/25, at 9:52 a.m. Registered Nurse, Employee E14 stated As far as hospital situation, I was unaware he was going. It was revealed the resident fell before midnight on 10/13/25, and then around 5 a.m. all the sudden the ambulance showed up, I had no idea he was going, Supervisor never notified me. RN, Employee E14 stated I am unsure if I documented a progress note. During an interview on 11/10/25, at 12:06 p.m. Nursing Home Administrator confirmed the facility failed to ensure the physician was appropriately notified of change in condition for one of four residents (Resident R4). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10 (c)(d) Resident Care policies. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.

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	11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Chicora	160 Medical Center Road 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy, and staff interview, it was determined that the facility failed to ensure that residents' medication regime was free from unnecessary psychotropic (a mind-altering medication) medication for one of three residents (Resident R8). Findings include: Review of facility Behavior Standard Index policy dated 5/19/25, indicated the purpose is to develop and implement behavioral plans, and medication regimes, in efforts to optimize the functional abilities of residents while monitoring for adverse side effects and improve behaviors. Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE]. Review of Resident R8's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/4/25, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), anxiety, and high blood pressure. Review of Resident R8's physician order dated 7/14/25 through 10/14/25, indicated to administer Ativan (used to treat anxiety) 0.5 milligrams every six hours as needed (PRN) for three months. Review of Resident R8's physician order failed to include a 14 day stop date and there was no documented rationale by the physician for the medication to extend past 14 days for Resident R8's Ativan. Review of Resident R8's Medication Administration Record dated September 2025, indicated that residents received Ativan PRN 27 times. Review of Resident R8's Medication Administration Record dated October 2025, indicated that residents received Ativan PRN 22 times. Review of Resident R8's Progress Notes dated September and October 2025, failed to indicate any non-pharmacological interventions used prior to administering Resident R8's Ativan. During an interview on 11/9/25, at 2:56 p.m. Registered Nurse Employee E11 stated we should order psychotropic medications for 14 days and prior to giving PRN medication we would try non-pharma logical interventions (NPI) such as toileting, offering drinks or food to decrease behaviors. If you give a psychotropic medication the behaviors and NPI should be documented. During an interview on 11/9/25, at 4:15 p.m. the Chief Nursing Officer Employee E7 confirmed that the facility failed to ensure that residents medication regime was free from unnecessary psychotropic medication for one of three residents (Resident R8). 28 Pa. Code 211.2(d)(3) Medical director 28 Pa. Code 211.10(a) Resident care policies

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	11/10/2025

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. (continued on next page)

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	395118	A. Building B. Wing	11/10/2025

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Quality Life Services - Chicora	160 Medical Center Road 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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on policy, employee files, facility documents, staff interviews, it was determined that the facility failed to ensure all nursing staff were educated on abuse/neglect before working in the facility for one of five staff members (LPN, Employee E1) and two of five staff members (LPN, Employee E2 and Registered Nurse, Employee E3) annually. The facility failed to identify incidents of abuse/neglect, and timely report and investigate allegations of abuse/neglect. The facility put other residents at risk for abuse/neglect from Licensed Practical Nurse (LPN), Employee E1 by allowing the staff member to continue to work after abuse/neglect allegations were made. This failure created an immediate jeopardy situation.Findings include: Review of the facility's policy titled Resident Protection from Abuse, Neglect, Mistreatment or Exploitation review date of 5/19/25, indicated it is the policy of the facility that each of its own and operated homes treat all residents with kindness, respect and in a manner that is at all times free from any form of abuse, neglect, misappropriation of property, exploitation, or mistreatment. To protect our residents, each of our homes will implement procedures in the areas of screening, training, prevention, identification, investigation, protection, reporting/response and corrective action. The facility has developed and implemented personnel and other policies to ensure that all staff are qualified and meet all regulatory standards for hire. In addition, we screen our employed contracted prior to employment, Employed staff, upon hire and at least annually through in-service education will receive training on issues related to abuse prohibition and prevention. We provided adequate supervision of our staff to identify inappropriate behaviors and to ensure that care/services are provided safely and as needed. We provide appropriate information to our staff of those residents with potential for aggressive behavior. Abuse and neglect will be identified through various methods such as reports from employed or contracted staff, utilization of resident incident reports, review prior incidents and any patterns of staff behaviors. Allegations involving residents, visitors, employees, or any other person must be reported to the Administrator or Director of Nursing (DON) immediately. The Administrator or DON will notify the Department of Health via electronic reporting system within 24 hours of the incident and complete an on-line PB-22 if directed to do. The County Area Agency on Aging will be contacted and a verbal report of allegation of abuse will be submitted within 24 hours of the event. All written reports shall include, at a minimum, the name and age of the resident, address of resident representative, address of the home, nature of the alleged offense, and any specific comments or observations that are directly related to the alleged incident and individuals involved. All investigation will be conducted thoroughly and will attempt to gather as much factual information as possible. If a specific employee is suspected of abuse of a resident, the home shall immediately implement a plan of supervision or, where appropriate, reassignment, suspension or where appropriate, reassignment, suspension or termination of employment of the employee. The Elder Justice Care Act requires each owner, operator, employee, manager, agency, or contractor of a nursing home facility (a covered individual) to report any responsible suspicion of a crime no later than (2) hours after forming the suspicion. In addition to reporting all obligation described above, covered individuals must report any reasonable suspicion of a crime to the Department of Health and to the local police serving the community where the resident is receiving care. Review of witness statement dated 10/31/25, revealed Housekeeper, Employee E6 has worked at the facility for 13 years and since LPN, Employee E1 started on the memory impaired unit she has never seen so many die at one time. Housekeeper, Employee E6 stated I think they are given something they shouldn't be. It raises flags, and stated residents seem sedated. Review of Nurse Aide (NA), Employee E5's undated witness statement revealed, I have concerns with LPN, Employee E1, keeps people snowed. and gives melatonin and Tylenol even if not ordered. Review of LPN, Employee E4's witness statement dated 10/31/25, revealed about a month ago, LPN, Employee E4 was receiving report from LPN, Employee E1 when it was reported Resident R1 was hypothermic and when asked if the resident's temperature was rechecked or a nurse was notified, LPN, Employee E1 stated a RN wasn't informed. During report LPN, Employee E1 also stated everyone gets melatonin and made references to administering everyone Tylenol. Resident R1 was found to have an abnormally low rectal temperature upon follow up. Residents were also more sedated than usual and lethargic. Residents were not fully awake or unable to eat a meal until supper time. This was the resident's daily for the whole weekend. Also, NA, Employee E5 came to me stating that LPN, Employee E1 gave everyone Tylenol and melatonin. I told aide to do the right thing and report this to the DON and Nursing Home Administrator. Review of facility documentation submitted on 11/3/25, revealed the DON was approached by staff that they had suspicions

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	11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Chicora	160 Medical Center Road Chicora, PA 16025

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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	395118	A. Building B. Wing	11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Chicora	160 Medical Center Road 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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on review of state laws, facility policy and facility documents, and staff interviews, it was determined the facility failed to identify and timely report criminal allegations of abuse/neglect to local law enforcement and required agencies to protect residents for one of five staff members Licensed Practical Nurse (LPN, Employee E1). This failure created an immediate jeopardy situation. Findings include: Review of the Older Adult Protective Services Act of 11/6/87, amended by Act 1997-13, Chapter 7, Section 701, requires any employee or administrator of a facility who suspects abuse is mandated to report the abuse. All reports of abuse should be reported to the local area agency on aging and licensing agencies. If the suspected abuse is sexual abuse, serious bodily injury, or suspicious death, the law requires additional reporting to the Department of Aging and local law enforcement. Review of the State Operations Manual, Appendix PP revised 7/23/25, revealed the facility must develop and implement written policies and procedures that ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.(i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements.(A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility.(B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. Review of the facility policy titled, Resident Protection from Abuse, Neglect, Mistreatment or Exploitation review date 5/19/25, indicated it is the policy of the facility to identify abuse/neglect through various methods such as reports from employed or contracted staff, utilization of resident incident reports, review prior incidents and any patterns of staff behaviors. Allegations involving residents, visitors, employees, or any other person must be reported to the Administrator or Director of Nursing (DON) immediately. The Administrator or DON will notify the Department of Health via electronic reporting system within 24 hours of the incident and complete an on-line PB-22 if directed to do. The County Area Agency on Aging will be contacted and a verbal report of allegation of abuse will be submitted within 24 hours of the event. All written reports shall include, at a minimum, the name and age of the resident, address of resident representative, address of the home, nature of the alleged offense, and any specific comments or observations that are directly related to the alleged incident and individuals involved. All investigation will be conducted thoroughly and will attempt to gather as much factual information as possible. The Elder Justice Care Act requires each owner, operator, employee, manager, agency, or contractor of a nursing home facility (a covered individual) to report any responsible suspicion of a crime no later than (2) hours after forming the suspicion. In addition to reporting all obligations described above, covered individuals must report any reasonable suspicion of a crime to the Department of Health and to the local police serving the community where the resident is receiving care. Review of facility investigation documentation including witness statement dated 10/31/25, revealed Housekeeper, Employee E6 has worked at the facility for 13 years and since LPN, Employee E1 started on the memory impaired unit she has never seen so many die at one time. Housekeeper, Employee E6 stated I think they are given something they shouldn't be. It raises flags, and stated residents seem sedated. Review of Licensed Practical Nurse (LPN), Employee E4's witness statement dated 10/31/25, revealed about a month ago, LPN, Employee E4 was receiving report from LPN, Employee E1 on 9/28/25, when it was reported Resident R1 was hypothermic and when asked if the resident's temperature was rechecked or a nurse was notified, LPN, Employee E1 stated a RN wasn't informed. During report LPN, Employee E1 also stated everyone gets melatonin and made references to administering everyone Tylenol. Resident R1 was found to have an abnormally low rectal temperature upon follow up. Residents also were more sedated than usual and lethargic. Residents were not fully awake or unable to eat a meal until supper time. This was the residents' daily behavior for the whole weekend. Also, NA, Employee E5 came to me stating that LPN, Employee E1 gave everyone Tylenol and melatonin. I told aide to do the right thing and report this to the DON and Nursing Home Administrator. Review of the facility's investigation revealed an undated document titled by Nurse Aide (NA), Employee E5's name revealed, I have concerns with LPN, Employee E1. She keeps people snowed and gives Tylenol/Melatonin even if not ordered. I can tell a difference when LPN, Employee E1 works from

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	11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Chicora	160 Medical Center Road Chicora, PA 16025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, resident record review, and staff interviews, it was determined that the facility failed to follow professional standards of practice when documenting for one of eight residents. (Resident R4). Findings include: Resident R4 was admitted to the facility on [DATE], with diagnoses of anxiety, muscle weakness, and high blood pressure. Review of the clinical record physician order dated 6/3/25, indicated Resident R4 was ordered assist with toileting and hygiene every two hours and as needed. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/4/25, indicated diagnoses of anxiety, muscles weakness, and high blood pressure. Question C0500 BIMS Summary Score revealed Resident R4's score to be 4, severe impairment. Section GG-Functional Abilities-revealed the resident required substantial/maximal assistance with toileting transfers and hygiene. and with sit to stand. Review of Resident R4's late entry progress note effective 10/13/25, entered on 10/22/25, by Nursing Home Administrator, stated at approximately 11:30 p.m. this nurse was standing at the med cart in the hall when a loud bang was heard this writer and CNAs on unit immediately went down the hall resident noted to be found sitting on the floor beside the commode. Resident stated, I was trying to get back into my wheelchair Resident told this writer he got dizzy prior to falling he stated he hit his head on the wall and complained of a headache. Resident assessed immediately. Residents noticed that they had a skin tear on right inner forearm, approximately 8x8 RN cleaned and dressed, no other visible injuries noted. Vital signs stable. Neuro checks started prior to the protocol. No other complaints of pain besides having a slight headache. Resident assisted back to bed with assistance x2. RN supervisor aware. Family made aware. Physician notified. During an interview on 11/9/25, at 2:48 p.m. Registered Nurse Supervisor, Employee E15 stated other staff shouldn't enter a note for someone else. During an interview on 11/9/25, at 3:06 p.m. the Chief Nursing Officer, Employee E10 confirmed the Nursing Home Administrator is not a nurse and the facility failed to follow professional standards of practice when documenting for one of eight residents. (Resident R4). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10 (c)(d) Resident Care policies. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.

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	11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Chicora	160 Medical Center Road Chicora, PA 16025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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	395118	A. Building B. Wing	11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Chicora	160 Medical Center Road Chicora, PA 16025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policy, clinical record, and staff interview, it was determined that the facility failed to ensure a resident is provided non-pharmacological interventions and an assessment prior to administering as needed pain medications for one of seven residents (Resident R1).Findings include: Review of facility policy Pain Assessment and Management dated 5/19/25, indicated all residents are screened for the presence of pain evaluated periodically for the presence of pain. Observe residents who are cognitively impaired/comatose or who have difficulty communicating for physical signs of pain including: grimaces, frowning, crying, change in behavior, loss of function, decreased activity level, resistance to care, agitation, eating or sleeping poorly to evaluate. Balance interventions for pain management with an adequate response to provide comfort while maintaining functional status and quality of life. Document screening for presence of pain, assessment of pain, interventions and resident's response, and physician notification and response, if indicated. Review of the facility policy Resident Change in Condition or Status dated 5/19/25, revealed it is the policy of the facility promptly addressing all resident changes in condition and managing them in compliance with all applicable standards of care. When a resident exhibits a change in condition from their baseline, the licensed nurse assigned to the resident will do the following: provide any necessary physical assessment to determine underlying cause, review any available diagnoses, request assistance from other staff as necessary, and ensure timely notification to charge nurse, physician, and family. Documentation must be provided in the resident record regarding: any assessment of the resident and findings, all applicable interventions, and all communication. All documentation provided must indicate the time at which it happened. 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 9/10/25, indicated diagnoses of anxiety, Alzheimer's disease, and high blood pressure. Review of a physician order dated 4/28/23, indicated to administer 325 mg Acetaminophen, give two tablets by mouth every six hours as needed for pain. Review of Resident R1's September 2025 Medication Administration Record revealed the as needed medication was administered on 9/27/25, at 11:16 p.m. by Licensed Practical Nurse (LPN), Employee E1 for 7/10 pain. A further review revealed the residents did not receive any other PRN Acetaminophen for the month of September. Review of Resident R1's clinical record on 9/27/25, failed to include evidence a physical assessment or vital signs were obtained for the resident's change in condition (increased pain). There was no evidence non-pharmacological interventions were implemented prior to administering the acetaminophen for pain. A review of Resident R1's clinical record revealed LPN, Employee E1 reassessed Resident R1's pain on 9/28/25, at 2:01 a.m. and the resident pain was zero. A review of progress note dated 9/28/25, at 7:40 a.m. revealed nursing notified the Certified Registered Nurse Practitioner (CRNP), that the resident had a change in condition. The resident's rectal temperature was 93.5, heart rate was 48, and blood pressure was 100/50. Nurse reports the resident was unresponsive and did not move or speak when the nurse was assessing the resident or when rectal temperature was taken. Significant concern related to heart rate and temperature. The nurse spoke to family, and they would like the resident sent to the emergency room. Review of Resident R1's clinical record on 9/28/25, revealed Resident R1 was admitted to the hospital for alerted mental status and a urinary tract infection. During an interview on 11/5/25, at 10:47 a.m. LPN, Employee E4 stated There have been a few incidents, I followed [LPN, EmployeeE1], and there were things I had to immediately bring to the RN supervisor's attention. LPN, Employee E5 stated on one occasion, Resident R1 usually never gets Tylenol for pain and is unable to verbalize pain. Prior to administering Tylenol, pain is assessed by looking for any indicators like guarding or grimacing. For a change in a resident's condition, physical assessment, vitals, and notification to physician and family must be completed. It was indicated Resident R1 typically screams out and has behaviors. During report on the morning of 9/28/25, LPN, Employee E1 notified LPN, Employee E4 that Resident R1 temps were low. It was indicated LPN, Employee E1 stated it was around 5:00 a.m. when [he/she] first noticed the resident was diaphoretic, cold, clammy, so LPN, Employee E1 turned the fan off. It was revealed a RN Supervisor was not notified. During an interview on 11/5/25, at 12:40 p.m. LPN, Employee E1 stated prn medications are given anytime resident needs it for pain or anxiety. If unable to determine pain, assess based on non-verbal cues, the way they act. When I give PRN, it has option to put progress note attached to medication depending on what's going on. I will add to progress note more info as to why. LPN, Employee E1 stated If change in condition

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	11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Chicora	160 Medical Center Road 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 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. (continued on next page)

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	395118	A. Building B. Wing	11/10/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, and staff interviews, it was determined that the facility failed to implement fall prevention interventions and conduct post fall monitoring for one of four residents (Resident R4).Findings include: Review of the facility policy Resident Change in Condition or Status dated 5/19/25, revealed it is the policy of the facility promptly address all resident changes in condition and to manage them in compliance with all applicable standards of care. When a resident exhibits a change in condition from their baseline, the licensed nurse assigned to the resident will do the following: provide any necessary physical assessment to determine underlying cause, review any available diagnoses, request assistance from other staff as necessary, and ensure timely notification to charge nurse, physician, and family. Documentation must be provided in the resident record regarding: any assessment of the resident and findings, all applicable interventions, and all communication. All documentation provided must indicate the time at which it happened. Resident R4 was admitted to the facility on [DATE], with diagnoses of anxiety, muscle weakness, and high blood pressure. Review of the clinical record physician order dated 6/3/25, indicated Resident R4 was ordered assist with toileting and hygiene every two hours and as needed. Review of Resident R4's care plan dated 6/4/25, revealed the resident was a high risk for falls related to confusion, deconditioning, gait/balance, and psychoactive drug use with a history of falls. Interventions include always using bed/chair alarm, anticipating and meeting the residents' needs. The care plan also included the following interventions: Assist me with toileting, catheter care or check or incontinence at least every two hours and provided with care as needed. Check me for incontinence at least once every two hours and promptly clean me for any incontinence episodes. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/4/25, indicated diagnoses of anxiety, muscles weakness, and high blood pressure. Question C0500 BIMS Summary Score revealed Resident R4's score to be 4, severe impairment. Section GG-Functional Abilities-revealed the resident required substantial/maximal assistance with toileting transfers and hygiene. and with sit to stand. Review of the facility's incident report revealed Registered Nurse (RN), Employee E13 stated This RN was informed by nurse on memory lane unit that a resident had fallen just then, upon entering his room noticed him sitting on the floor between the sink and toilet in his bathroom, he stated he was trying to get up from using the toilet when he lost his balance/fell back hitting his head, he is alert, skin tear about 9millimeter (mm) x 8 mm to right forearm/actively bleeding, xeroform and dressing applied to area. Patient able to move all limbs, complaints of pain to back of head and feeling dizzy, neurological checks started, this RN notified his step daughter/POA and discussed the above, no indication of needing to go to hospital at this time, range of motion is good, no other opening noted to his skin/no redness at this time, no pain to pelvis reported by resident at this time. Will place call to on call for physician, resident encourage to call staff when he needs help. Not part of the Medical Record was written at the bottom of the incident report. A further review of Resident R4's incident report revealed the resident's family member was notified on 11/2/25 (a total of 20 days later), at 2:14 p.m. and the physician was notified on 10/16/25, at 2:27 p.m. (a total of 3 days later). Review of RN, Employee E14's witness statement dated 10/14/25, stated at approximately 11:30 p.m. this writer was standing in the hallway at the medication cart. This writer heard a loud thud followed by the resident yelling for assistance. This writer and nurse aides immediately went down hall and upon entering, the resident was observed to be sitting on the floor between the commode and the sink. Resident stated, I was trying to get back into by wheelchair. Review of Resident R4's late entry progress note effective 10/13/25, entered on 10/22/25, by Nursing Home Administrator, stated at approximately 11:30 p.m. this nurse was standing at the med cart in the hall when a loud bang was heard this writer and CNAs on unit immediately went down the hall resident noted to be found sitting on the floor beside the commode. Resident stated, I was trying to get back into my wheelchair Resident told this writer he got dizzy prior to falling he stated he hit his head on the wall and complained of a headache. Resident assessed immediately. Resident noted to have a skin tear on right inner forearm approximately 8x8 RN cleaned and dressed, no other visible injuries noted. Vital signs stable. Neuro checks started prior per protocol. No other complaints of pain besides having a slight headache. Resident assisted back to bed with assistance x2. RN supervisor aware. Family made aware. Physician notified. A review of Resident R4's clinical record on 10/13/25, and 10/14/25, failed to include evidence that a physical assessment was completed by a Registered Nurse or documentation Q15 minute checks were initiated. During an interview

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	11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and interviews with staff, it was determined that the facility failed to ensure that residents are free of significant medication errors for one of four residents reviewed (Resident R6).Findings include: Review of facility policy Medication Administration-General Guidelines reviewed 5/19/25, stated medications are administered as prescribed in accordance with good nursing principles and practices and only by person legally authorized to do so. Personnel authorized to administer medication do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling, and administration). Five rights- Right resident, right drug, right route and right time, and applied for each medication being administered. A triple check of these 5 rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication is put away. Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of Resident R6's clinical record reveal an allergy to Tylenol with an unknown severity as of 7/22/25. Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/28/25, indicated diagnoses of dementia, aphasia, and malnutrition. Review of Resident R6's progress note dated 8/22/25, at 5:34 a.m. entered by Registered Nurse, Employee E12 stated resident had a temperature. Floor nurse gave [him/her] Tylenol and then realized the resident was not ordered Tylenol, and it was listed as an allergy. Vitals and assessment completed with no adverse reaction note. The Certified Registered Nurse Practitioner was notified. As needed, Benadryl was ordered but not needed. Ibuprofen was ordered as needed for fever/pain. Vitals obtained every 15 minutes for one hour then every hour for four hours for monitoring. Review of the facility incident report dated 8/22/25, revealed a witness statement entered by LPN, Employee E1 that stated Resident had a fever of 101. Gave Tylenol and realized upon charting that no Tylenol order and was listed as an allergy. Supervisor made aware of error and Nurse Practitioner called. Vital signs were done every 15 minutes for one hour then, every hour for four hours. Resident has no signs and symptoms of reaction at this time. During an interview on 11/5/25, at 12:43 p.m., Licensed Practical Nurse (LPN), Employee E1 confirmed [he/she] gave Resident R6 Tylenol without an order, and the resident had an allergy. LPN, Employee E1 stated I did not look at chart before I gave Tylenol. During an interview on 11/9/25, at 3:12 p.m. the Chief Nursing Officer, Employee E10, confirmed that the facility failed to ensure that residents are free of significant medication errors for one of four residents reviewed (Resident R6).28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 211.10 (c)(d) Resident Care policies. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.

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	11/10/2025

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job descriptions, clinical records and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage and implement the facilities abuse and neglect policy, and failed to report alleged criminal activity of a Licensed Practical Nurse (LPN) Employee E1 to the proper authorities, which created an immediate jeopardy situation for all 95 of 95 residents.Findings include: The job description for the Nursing Home Administrator dated 4/14/24, indicated the NHA is to direct the day-to-day operations of the facility in accordance with current federal, state, and local standards governing long-term care facilities and to ensure that the highest degree of resident care and services are delivered and maintained. The position is responsible for establishing and maintaining systems that are effective and efficient. Oversee all departments and department supervisors to ensure the Nursing Home is operating safely and efficiently. Operate the company in accordance with the established policies and procedures. The job description for the Director of Nursing dated 5/8/25, indicated the DON is to provide nursing management, set resident care standards for all direct care providers and provide complete supervision and management of the nursing department. Assume accountability for the development, organization, and implementation of approved policies and procedures. Ensure compliance with all federal, state, and local regulations. Based on findings identified, the facility failed to implement the facilities Abuse and Neglect policy and failed to report alleged criminal activity to the proper authorities, which placed the residents in Immediate Jeopardy. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 11/9/25, at 4:15 p.m. the Chief Nursing Officer Employee E7 was notified that the NHA and DON failed to implement the facilities abuse and neglect policy and failed to report allegations of criminal activity, which created an immediate jeopardy situation for all residents. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201. 18(b)(1)(3)(e)(1) Management.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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	395118	A. Building B. Wing	11/10/2025

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on review of job description, facility documents and staff interviews, it was determined that the facility failed to provide Quality Assurance and Performance Improvement (QAPI) training to one of five direct care facility staff reviewed (Employee E5).Findings include: Review of the facility Nursing Assistant Job Description indicated the purpose of your job role is to provide direct care to residents, under the supervision of a licensed nurse, in accordance with policies and procedures and report resident needs and concerns to a licensed nurse. Attend all in-service classes as assigned and complete assignments. During an interview on 11/9/2025, at 10:30 a.m. Chief Nursing Officer Employee E7 stated that education is conducted by calendar year running January through December. Review of facility education documents for the year 2024 revealed the following concerns: Review of Nurse Aide (NA) Employee E5's facility provided information did not include training on QAPI. During an interview on 11/9/25, at 10:54 a.m. the Chief Nursing Officer Employee E7 confirmed that the facility failed to provide QAPI training to one of five direct care facility staff reviewed (Employee E5). 28 Pa. Code: 201.14(a) Responsibility of Licensee 28 Pa. Code: 201.20(a) Staff Development

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	395118	A. Building B. Wing	11/10/2025

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of job description, facility documents and staff interviews, it was determined that the facility failed to conduct the minimum 12 hours of nurse aide (NA) training per year for four of four direct care facility staff reviewed (NA Employee E5, E8, E9, and E10). Findings include: Review of the facility Nursing Assistant Job Description indicated the purpose of your job role is to provide direct care to residents, under the supervision of a licensed nurse, in accordance with policies and procedures and report resident needs and concerns to a licensed nurse. Attend all in-service classes as assigned and complete assignments. During an interview on 11/9/2025, at 10:30 a.m. Chief Nursing Officer Employee E7 stated that education is conducted by calendar year running January through December. Review of facility education documents for the year 2024 revealed the following concerns: Review of NA Employee E5's facility provided information failed to include the minimum 12-hour NA annual training. Review of NA Employee E8's facility provided information failed to include the minimum 12-hour NA annual training. Review of NA Employee E9's facility provided information failed to include the minimum 12-hour NA annual training. Review of NA Employee E10's facility provided information failed to include the minimum 12-hour NA annual training. During an interview on 11/9/25, at 10:57 a.m. the Chief Nursing Officer Employee E7 confirmed that the facility failed to provide a minimum of 12 hours of NA training to four of four direct care facility staff reviewed (NA Employee E5, E8, E9, and E10), as required. 28 Pa. Code: 201.14(a) Responsibility of Licensee 28 Pa. Code: 201. 20(a) Staff Development