| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395118 | A. Building<br>B. Wing | 12/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Quality Life Services - Chicora | 160 Medical Center Road<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical and facility record review, facility provided documents, and staff interviews, it was determined that the facility failed to provide adequate supervision for one resident resulting in elopement (resident exits to an unsupervised and unauthorized location without staff's knowledge) for one of three residents (Resident R94) and failed to provide adequate supervision to ensure a safe environment resulting in a burn for one of three resident's (Resident R35).Review of the facility policy Accidents and Incidents dated 10/13/25, indicated a safe environment will be promoted for all residents.<br><br>Review of Resident R35's admission record indicated she was admitted to the facility on [DATE].<br><br>Review of Resident R35's Minimum Data Set (MDS-periodic assessment of a resident's abilities and care needs) dated 10/21/25, indicated diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), depressive disorder and hypertension.<br><br>Review of Resident R35's physician's orders dated 11/3/25, indicated restorative dining.<br><br>Review of a progress note dated 11/7/25, at 1:02 p.m. indicated Nurse was informed by CNA that resident was in the dining area for activities and had coffee spilled in her lap and it was red and blistered. Resident assessed and RN supervisor notified. Daughter was notified of incident.<br><br>Review of facility provided documents indicated Coffee was provided by the Activities department and not dietary. The temperature of the coffee was not taken prior to serving the resident's.<br><br>During an interview on 12/3/25, at 2:30 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to provide adequate supervision for one of three residents, which resulted in a burn.<br><br>Review of the facility policy Elopement Prevention dated 10/13/25, indicated the facility properly assesses residents and plans their care to prevent accidents related to wandering behavior or elopement. The admitting nurse will perform an initial assessment. A care plan will be developed that reflects the potential for elopement and preventative measures.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the admission Record indicated Resident R94 was admitted to the facility on [DATE], with the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), renal insufficiency (a condition in which the kidneys lose the ability to remove waste and balance fluids), and vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain).<br><br>Review of the Nursing Review V-12 form dated 10/3/25, at 1:46 p.m. indicated family brought resident to the facility due to living alone and having severe dementia. Resident is walking independently. Resident is alert to person only and sometimes understands others. Resident has a known history of wandering. Does not understand surroundings. Resident photo will be added to those at risk.<br><br>Review of Resident R94's baseline care plan on 12/1/25, failed to include interventions for supervision and resident centered interventions to prevent elopement.<br><br>Review of Resident R94's progress notes indicated the following:-10/4/25, at 9:42 a.m. indicated Resident R94 was asking Where is the door so I can leave?. Wander guard placed on resident's right wrist. Resident refused to have it placed on the ankle.-10/4/25, at 5:42 p.m. indicated staff took resident dinner tray to the room, on the tray table was the wander guard that was placed that morning on the wrist. Resident removed the wander guard. Staff immediately began searching for the resident. Personal care staff notified the skilled nursing side that resident was in the personal care unit. Resident stated they were looking for their sister. -10/4/25, at 9:50 p.m. indicated safety checks began every 15 minutes.-10/5/25, at 4:42 p.m. indicated Resident was sitting in the lounge, got up quickly and stated I am getting out of here. My sister's blue Subaru just pulled up to pick me up. Writer attempted to show resident that no cars had pulled up outside, when resident pushed past writer stating, She is out there. continues to pace in front of the window looking for the blue Subaru.-10/5/25, at 5:19 p.m. indicated Resident was pacing back and forth in front of the window watching for the sister's car. Writer walked around the corner to the printer and heard the wander guard alarm. Writer immediately returned to where resident was last seen, and they were no longer there. Writer ran to the front door and resident was standing outside the front doors with another resident's family standing with resident and asking resident where they were going. Resident indicated I'm looking for my sister's blue Subaru; there is a Subaru right there (pointing at cars in the parking lot).<br><br>Review of Personal Care Employee E10's undated witness statement indicated on 10/4/25, while working on the personal care unit, they heard the door alarm sound. Staff went to the door to see who it was, and an elderly man was through the door. Staff asked resident if they needed something as they kept walking down the hall. Resident said that they were looking for their sister. When staff reached the personal care unit's lobby, they had the resident sit down to take a break on the couch. Staff then called over to the skilled nursing side and told them Resident R94 was on the personal care unit.<br><br>Interview on 12/3/25, at 11:15 a.m. the Director of Nursing confirmed the facility failed to ensure proper supervision and failed to implement patient centered interventions for a resident identified as an elopement risk, which resulted in an elopement to personal care on 10/4/25, and elopement out the front doors of the facility on 10/5/25.<br><br>28 Pa. Code 201.14 Responsibility of Licensee.28 Pa. Code 201.18(b)(1)(3) Management.28 Pa. Code 201. 29 Responsibility of Licensee.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.28 Pa. Code 211.10(d) Resident care policies. |