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Form Approved OMB
No. 0938-0391

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	01/28/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, facility policy, and staff interview, it was determined that the facility failed to ensure comfortable air temperature levels were provided for one of 34 resident rooms (room [ROOM NUMBER]) and two of three resident areas (Millers Common Room and Dining Room).Findings Include:Review of the facility policy Extreme Weather dated 12/1/25, indicated excessive cold for lengthy periods of time can negatively impact center operations. Excessive cold poses a severe potential harm to confused exit-seeking residents. Geriatric residents have a greater risk of suffering hypothermia because their bodies do no effectively regulate internal temperatures.During an interview on 1/28/26, at 9:30 a.m. the Nursing Home Administrator (NHA) revealed that on 1/25/26, the boiler (form of heat source) needed reset.Observations conducted on 1/28/26, from 12:15 p.m. to 12:45 p.m. with the Maintenance Director, Employee E2 revealed the following air temperatures:[NAME] Lane Nursing Floor-room [ROOM NUMBER]-68 of degrees FahrenheitMiller Common Room-Common Room - 67.3 degrees Fahrenheit-[NAME] Dining Room - 70.5 degrees FahrenheitDuring an interview on 1/28/26, at 3:00 p.m. the Nursing Home Administrator confirmed the facility failed to ensure comfortable air temperature levels were provided for one of 34 resident rooms (room [ROOM NUMBER]) and two of three resident areas (Millers Common Room and Dining Room).28 Pa. Code: 201.18(b)(3) Management

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 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** 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 17 residents (Resident R1). Findings include:Based on facility policy Elopement Prevention dated 12/1/25, 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 residents' 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 11/9/25, indicated diagnoses of depression, dementia (a group of symptoms that affect memory, thinking and interferes with daily life), and anxiety.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 intact8-12: moderately impaired0-7: severe impairmentReview of Resident R1's MDS assessment dated [DATE], Section C0100 screening indicated a score of 0 revealing that Resident R1 is rarely/never understood and the BIMS screening test was not completed. Review of Resident R1's care plan dated 5/22/24, indicated Resident R1 was an elopement risk/wanderer as evidence by a history of attempts to leave home unattended prior to admission. Care plan included identifying any patterns of wandering that I exhibit: purposeful wandering, aimless, or attempting to escape. Monitor my frequent location.Review of documentation provided by facility dated 1/22/26, at 1:40 p.m. revealed, Resident R1 was observed ambulating outside of the locked memory lane unit, on another resident hallway. Resident R1 was observed in the hallway next to memory lane unit and approximately 36 feet away from memory lane unit.Review of an interview conducted by NHA on 1/23/26, at 2:00 p.m. revealed that Resident R1's husband had visited on 1/22/26, and felt that the resident was far enough from locked door when he exited and left the unit. Residents' husband was in a hurry to get to the pharmacy and failed to look behind him upon leaving the unit.Review of witness statement dated 1/23/26, at 4:15 p.m. revealed that Licensed Practical Nurse Employee E1 indicated the Resident R1 followed her husband out of the unit and staff noticed resident in the hallway and returned resident to locked memory unit.During a review of progress notes dated 6/1/2025, through 1/28/26, revealed that Resident R1 had documented behaviors but none were exit seeking.During an interview on 1/28/26, at 2:08 p.m. the Director of Nursing (DON) stated that when she worked in the locked memory unit that Resident R1's husband would come and go since he knew the code to the doors.During an interview on 1/28/26, at 2:45 p.m. the Nursing Home Administrator (NHA) and DON confirmed that the facility failed to make certain each resident received adequate supervision that resulted in an elopement for one of 17 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.