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	03/09/2026

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. Based on review of facility policy, observations and staff interviews it was determined that the facility failed to provide a clean, safe, comfortable, and homelike environment by not securing maintenance equipment behind a secured door as required (Dining room outside of the kitchen).Findings Include: Interview on 3/9/26, at 2:00 p.m. the Director of Nursing indicated the facility did not have a policy specific to safe, clean, and homelike. During a facility tour on 3/9/26, at 11:00 a.m. the Resident Dining Room directly outside of the facility kitchen, revealed the following equipment being stored: maintenance equipment and carts, resident hand railings (not attached to the wall), a nail gun, a drill with bits, a case of metal ratchets and pieces, scraping tools, shop vacuum, fans amongst other repair tools. The doors to the dining area were not secured with a lock at the front or side entrances of the room. A sign on the doors to the dining room indicated the room was closed and to keep doors closed when not in use. Interview on 3/9/26, at 1:19 p.m. Project Manager Employee E3 indicated the facility has an on-going project to renovate and paint certain areas of the facility. The vendor comes on site at night to not disrupt residents and their activities. Indicated this has been going on for approximately three to four weeks to give the facility a makeover. Further interview on 3/9/26, at 1:20 p.m. Project Manager Employee E3 confirmed the facility failed to provide a clean, safe, comfortable, and homelike environment by not securing maintenance equipment behind a secured door as required (Dining room outside of the kitchen). 28 Pa. code: 201.14 (b) Responsibility of licensee.28 Pa Code: 201.18 (e)(1)(2) Management.28 Pa Code: 201.29 (a)(c) Resident Rights.

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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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 policy, clinical record review, facility provided documents, and staff interviews, it was determined that the facility failed to provide adequate supervision to ensure a safe environment resulting in a burn for one of three residents (Resident R1).Findings include:Review of facility policy Accidents and Incidents dated 12/1/25, indicated a safe environment will be provided for all residents. Review of the clinical record revealed 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 1/8/26, indicated diagnoses of high blood pressure, muscle weakness, and need for assistance with personal care.Review of a change in status note dated 2/16/26, stated, Resident served dinner tray and took her tea to drink and dropped it on herself. Burns noted to Right thigh 27x40 cm (centimeters), left inner thigh 4x3 cm, left outer thigh 12x4.5, r/l (right and left) lower quadrant (abdomen) 19x9 cm, upper abdominal quadrant r/l 12.0x3.5 cm, superior (above) to upper quadrant 0.5x1.0 raise flesh color.Review of an Emergency Department Note dated 2/16/26, stated, The patient presents for evaluation of a burn. A staff member at the nursing home accidentally dropped hot water for tea on the patient. She has a superficial (a first-degree burn, involve the top layer of skin. These may present as red and painful to touch, and the skin will show mild swelling) burn to the upper abdomen and the right thigh. The burn area is very minimal. There is no blistering. We applied topical antibiotic ointment to the burn area. Instructions given on discharge papers for nursing home staff to apply this twice daily for the burns. Review of a witness statement dated 2/16/26, completed by Dietary Aide Employee E1 stated, My normal routine, the pitchers of coffee and hot water came down to the dining room at 5:10 p.m. I went around and poured coffee and the hot water for tea and hot cocoa. I was on the other side at the TV end of the dining room with my back towards where Resident R1 was sitting. I heard Resident R1 crying out, I went over and she had spilled her tea water into her lap. This was around 5:25 p.m. I immediately got one of the aides and they took her back to Fairgrounds (nursing unit).Review of a witness statement dated 2/17/26, completed by Dietary Aide Employee E2 stated, I had Dietary Aide Employee E1 pour coffee and teas around 5 - 5:15 p.m. I did not see or hear Resident R1 drop her tea until after service. I was busy getting ready to serve dinner to the residents. We did not check temps of coffee/tea water. Review of an undated and unsigned witness statement indicated, This writer spoke to Resident R1's tablemate concerning incident of Resident R1 getting burned. I asked her if she could tell me what happened. She stated that a kitchen staff member was pouring beverages in dining room. He poured hot water into Resident R1's tea cup and moved on. She said she was eating when she heard Resident R1 screaming and looked up to see her cup tipped over on the table. She said the gentleman ran over to see what happened and then went to get help. I asked her where the staff member was at the time of the incident and she stated he was on the other side of the dining room pouring beverages for other residents.During an interview on 3/4/26, at 10:32 a.m. the Nursing Home Administrator (NHA) stated, The kitchen did not temp the water prior to it being served to residents. Two dietary members were in the dining room at the time of the incident. The assigned Nurse Aide was bringing another resident to the dining room when the incident occurred. During an interview on 3/4/26, at 10:32 a.m. the NHA confirmed that the facility failed to provide adequate supervision to ensure a safe environment resulting in a burn for one of three residents (Resident R1). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(5) Nursing Services.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to follow droplet precautions for one of four residents in isolation precautions (Resident R2).Findings include: Review of facility provided document Covid Positive Steps dated 12/1/25, indicated the positive resident must have:-An appropriate sign on their door,-The door should remain closed-Vitals every shift while in isolation-Remains in isolation for 10 days-Appropriate PPE (personal protective equipment) stationed by their room for staff to utilize. Review of the admission record indicated Resident R2 admitted to the facility on [DATE]. Review of the Minimum Data Base (MDS - a periodic assessment of care needs) dated 12/22/25, indicated the diagnoses of high blood pressure, chronic obstructive pulmonary disease (COPD- a group of diseases that block airflow and make it hard to breathe), and depression. Review of facility provided documentation dated 3/6/26, indicated Resident R2 tested positive for covid-19 (respiratory infection). Review of Resident R2's physician orders dated 3/6/26, indicated droplet precautions every shift. Review of Resident R2's care plan dated 3/6/26, indicated maintain droplet precautions as ordered. Observation on 3/9/26, at 11:59 a.m. Resident R2's door had signage for droplet precautions on the door. The door stood in a wide-open position to the outer hallway. Interview on 3/9/26, at 12:00 p.m. Registered Nurse (RN) Employee E4 indicated that Resident R2 was positive for covid-19, was in droplet precautions and the door should remain closed at all times to prevent cross contamination potential. Observation on 3/9/26, at 1:17 p.m. Resident R2's door had signage for droplet precautions on the door. The door remained in a wide-open position to the outer hallway. Interview on 3/9/26, at 1:20 p.m. the Director of Nursing confirmed the facility failed to follow droplet precautions for one of four residents in isolation precautions (Resident R2). 28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.28 (b)(1)(e)(1) Management.28 Pa Code: 211.10 (d) Resident care policies.