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	06/26/2026

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 - Some	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 for nine of sixteen residents (Resident R1, R2, R3, R4, R5, R6, R7, R8, and R9).Findings Include: Interview on 6/26/26, at approximately 12:00 p.m. the Director of Nursing indicated the facility did not have a policy specific to safe, clean, and homelike. During an observation on 6/26/26, at 10:45 a.m. Resident R1's former room had large patches of paint missing with exposed drywall. The floor around the commode in the in-room restroom was damaged with the subfloor visible in spots, potentially causing a fall risk and infection control risk. During an observation on 6/26/26, at 10:49 a.m., the room assigned to Resident R2, R3, R4, and R5 revealed numerous gouges in the floor. Additionally, a wooden closet door had a hole in it, approximately four inches across, with jagged wood present. During an observation on 6/26/26, at 10:49 a.m., the room assigned to Resident R6 and R7 revealed a large section of peeling paint in the restroom and the wall behind the bed had gouges. During an observation on 6/26/26, at 10:51 a.m., the room assigned to Resident R8 and R9 revealed exposed sheetrock and the radiator cover unattached. During an interview on 6/26/26, at approximately 1:30 p.m. the Nursing Home Administrator confirmed the facility failed to provide a clean, safe, comfortable, and homelike environment for nine of sixteen residents. 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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(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 ten residents identified to be elopement risks not who did not reside on a secured unit (Resident R10). This was identified as past non-compliance.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 R10 was admitted to the facility on [DATE]. Review of Resident R10's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/5/26, included diagnoses of paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease) and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of the Wandering / Elopement Risk Evaluation dated 4/9/26, indicated, Noted increased confusion and does wander throughout the facility and will go outside with electric w/c (wheelchair) propelling self. Review of Resident R10's plan of care for elopement risk / wandering initiated 4/9/26, indicated Resident R10 exhibited aimless wandering and included the intervention (dated 5/4/26) of, Monitor for entering restricted areas unattended or statements about going outside with IDT (interdisciplinary team) review for modifications if need warranted. Review of a facility submitted information dated 5/13/26, indicated that on 5/12/26, PT (Physical Therapy) Manager informed DON (Director of Nursing) on 5/12/2026 that she had been notified resident was reportedly found within enclosed secure courtyard residential area the previous evening by another staff member. Information was immediately escalated to RN (Registered Nurse) Supervisor, CRNP (Certified Registered Nurse Practitioner), and DON. Follow-up staff interviews initiated with all scheduled staff from evening 5/11/2026. CNA (Nurse Aide) from previous shift questioned and confirmed resident had been found present within enclosed secure courtyard residential area. Two witness statements obtained reporting consistent findings. RN Supervisor and licensed nurses on unit reported they had not been notified of resident presence in courtyard area at time of occurrence and were unaware resident had accessed courtyard area. Review of facility investigation information indicated that Resident R10 was not accounted for approximately 15 minutes last seen in common area near nurse's station. Review of an employee statement dated 5/12/26, Nurse Aide Employee E1 stated, On Monday May 11th on 6p-6a (6:00 p.m. to 6:00 a.m.), I found [Resident R10] in the courtyard stuck behind the door and in a chair. I told the aid [NA Employee E2] who I was working with and we notified the nurse on our floor [Registered Nurse Employee E3]. Review of an employee statement dated 5/22/26, Nurse Aide Employee E2 stated, [Employee E4] asked [Employee E1] and I to keep an eye on [Resident R1]. After a few minutes [Employee E1] and I came up to hall and [Resident R1] was outside the doors at the courtyard. His wheelchair was stuck on the cement. [Employee E1] and I assisted him back to his room. On 5/12/26, the facility initiated a plan of correction that included:-Resident placed on one-to-one observation.- Flow Sheet for mentation and wheelchair mobility initiated.-Immediate placement of two door alarms to courtyard access doors to alert staff of entry into eh courtyard area.-Vendor contacted on 5/13/26, regarding implementation of keypad locking mechanisms and additional environmental safety measures needed.-Installation of interior exit buttons-Staff education initiated regarding (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immediate escalation of impaired safety awareness concerns, resident supervision expectations, and chain of command notification requirements.-A resident headcount was conducted, and all residents were accounted for.-Plans of care were updated as appropriate.-Audits of exit doors completed.-Incident reviewed with the Safety Committee. The facility demonstrated compliance by 5/13/26. During an observation on 6/26/26, at approximately 12:00 p.m. the outdoor courtyard was noted to have numeric keypad locks to enter the courtyard. During an interview on 6/26/26, at approximately 1:30 p.m. the Nursing Home Administrator and DON confirmed that the facility failed to make certain each resident received adequate supervision that resulted in an elopement for one of ten residents identified to be elopement risks not who did not reside on a secured unit. This was identified as past non-compliance. 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.