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	11/15/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50075 Based on review of facility policy, observation, and staff interview it was determined that the facility failed to provide a dignified dining experience by failing to provide assistance with meals timely for two of six residents (Resident R35 and R55). Findings include: Review of the facility Dysphagia Protocol policy dated 11/8/24, indicated residents who have swallowing difficulties will receive evaluation and treatment interventions to promote adequate nutrition and hydration. Review of the facility Resident Rights policy dated 11/8/24, indicated residents shall be treated with dignity and respect. Review of Resident R35's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R35's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 9/2/24, indicated diagnoses of depression, malnutrition (lack of sufficient nutrients in the body), and Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior). Section GG Functional Abilities GG0130 Eating was coded as a 2, indicating resident requires substantial maximal assistance and the helper does more than half the effort. During an observation on 11/12/24, at 11:45 a.m. four staff members were assisting other residents in the dining room to eat. During an observation on 11/12/24, at 11:50 a.m. Resident R35 was sitting in the dining room at a table with another resident, with her meal sitting in front of her without being assisted. Review of Resident R55's clinical record indicated the resident was admitted to the facility on [DATE]. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident R55's MDS) dated [DATE], indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and dementia (a group of symptoms that affects memory, thinking and interferes with daily life). Section GG Functional Abilities GG0130 Eating was coded as a 1, indicating resident is dependent and the helper does all the effort. During an observation on 11/12/24, at 11:46 a.m. four staff members were assisting other residents in the dining room to eat. During an observation on 11/12/24, at 11:53 a.m. Resident R55 was sitting in the dining room at a table with another resident, with her meal sitting in front of her without being assisted. During an interview on 11/12/24, at 11:55 a.m. Nursing Assistant (NA) Employee E13 stated, I would usually go tell someone that we need more staff to feed residents, but I have not done that yet. I will go tell them now. During an interview on 11/12/24, at 11:57 a.m. Assistant Director of Nursing Employee E2 confirmed that the facility failed to provide a dignified dining experience by failing to provide assistance with meals timely for two of six residents (Resident R35 and R55). 28 Pa Code: 201.29 (i) Resident rights.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27424 Based on review of clinical records and staff interview it was determined that the facility failed to notify the physician of a change in condition for one of seven residents (Resident R1). Findings include: Resident R1 was admitted to the facility on [DATE]. Review of the MDS (Minimum Data Set a periodic assessment of resident needs) dated 9/30/24, indicated diagnosis of hyperlipidemia (abnormal levels of fat in the blood), and depression (mood disorder that causes persistent feeling of sadness and loss of interest). Review of Resident R1's clinical record, progress notes dated 9/15/24, indicated, Aide notified writer that resident has scratches on right hip area non open, red raised, white heads on bumps, 3 small, raised patches on abdomen and right front side, yeast infection under left breast bright pink in color non open, odor, right breast small light pink rash starting, writer told aides to clean under breast, dry very well apply anti-fungal cream not powder under breast, apply orange tube barrier cream to bottom, anti-fungal cream to scratch area on right hip. RN (Registered Nurse) notified, writer showed RN areas, RN agreed with findings and also stated to apply the creams to the areas writer mentioned. Writer will monitor client skin. Review of Resident R1's clinical record progress notes failed to indicate notification to the physician. During an interview on 11/24/24, at 10:19 a.m. Director of Nursing confirmed that the facility failed to notify the physician of the change in condition and application of a cream for 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.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on a review of facility admission documents and staff interview, it was determined that the facility failed to ensure resident rights to make informed decisions and choices about important aspects of residents' health, safety and welfare by making certain residents understand the Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) form and failed to ensure the agreement is explained to the resident and his or her representative in a form and manner that he or she understands for one of three residents (Resident R84). Findings include: Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019 indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of the clinical record indicated Resident R84 was admitted to the facility on [DATE]. Review of Resident R84's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/11/24, indicated diagnoses of high blood pressure, anemia (too little iron in the body), and muscle weakness. Review of Section C: Cognitive Patterns, Questions C0500 BIMS Summary Score revealed CR Resident R84's score to be 8, moderately impaired. Review of the SNF ABN form dated 10/3/24, revealed that it was signed by Resident R84. During an interview on 11/13/24, at 2:01 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E1 stated that she would not have someone with a BIMS of 8 sign the SNF ABN form. During an interview on 11/13/24, at 2:01 p.m. RNAC Employee E1 confirmed that the facility failed to ensure the SNF ABN was explained to the resident and his or her representative in a form and manner that he or she understands for one of three residents as required. 28 Pa. Code 201.24 (b) Admission Policy. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(2) Management. 28 Pa. Code 201.29(a)(j) Resident Rights.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469 Based on review of facility policy, observation clinical record review and staff interview it was determined that the facility failed to obtain a physician order and develop a resident centered care plan for the placement of a bed against the wall for one of two residents (Resident R42). Review of the facility policy Physical Restraint dated 7/22/24, last reviewed 11/8/24, indicated each resident is to attain and maintain his/her highest practical well-being in an environment that prohibits the use of restraints for discipline or convenience and limits use of restraints use to circumstances in which the resident has medical symptoms that warrant the use of restraint, the use of restraint will be a last resort alternative intervention. Review of the facility Resident Rights dated 7/22/24, last reviewed 11/8/24, indicated a resident shall be free of restraints. Review of Resident R42's clinical record indicated an admitted [DATE]. Review of resident 42's MDS dated [DATE], indicated the diagnosis of coronary artery disease (CAD - affects that arteries that supply the heart with blood), hypertension (high blood pressure) and hyperlipidemia (high level of fat in the blood). During an observation and interview completed on 11/14/24, at 11:06 a.m. Nurse Assistant (NA) Employee E12 confirmed Resident R42's bed was pushed up against the wall. A review of the Physicians orders indicated the facility failed to obtain physician order for Resident R42's bed against the wall. Review of Resident's R42's care plan dated 4/16/24, with revision on 10/1/24, indicated he would be free of falls. The care plan did not include placing Resident R40's bed next to the wall. During an interview completed on 11/14/24, at 11:38 a.m. the Director of Nursing confirmed that the facility failed to obtain a physician order and develop a resident centered care plan for the placement of a bed against the wall for one of two residents (Resident R42). 28. Pa Code 201.14(a) Responsibility of licensee. 28 Pa. Code: 201. 18(e)(1) Management. 28 Pa. Code 211. 12(d)(5) Nursing Services.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for five of six residents sampled with facility-initiated transfers (Residents R2, R13, R82, R83, and R88). Findings include: Review of facility policy Medical Emergency dated 7/22/24, and last reviewed 11/8/24, indicated if transfer is required complete transfer form and send appropriate documentation with the resident. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 11/4/24, indicated diagnoses of high blood pressure, Alzheimer ' s disease (a type of brain disorder that causes problems with memory, thinking and behavior), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of the clinical record indicated Resident R2 was transferred to hospital on 8/11/24 and returned to the facility on [DATE]. Review of Resident R2's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R13 was admitted to the facility on [DATE]. Review of Resident R13's MDS dated [DATE], indicated diagnoses of muscle weakness, depression, and anemia (too little iron in the body causing fatigue). Review of the clinical record indicated Resident R13 was transferred to hospital on 10/11/24 and returned to the facility on [DATE]. Review of Resident R13's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R82 was admitted to the facility on [DATE]. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R82's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and coronary artery disease (damage or disease in the heart's major blood vessels). Review of the clinical record indicated Resident R82 was transferred to hospital on 10/19/24 and returned to the facility on [DATE]. Review of Resident R82's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R83 was admitted to the facility on [DATE]. Review of Resident R83's MDS dated [DATE], indicated diagnoses of high blood pressure, Alzheimer's disease , and muscle weakness. Review of the clinical record indicated Resident R83 was transferred to hospital on 9/7/24 and returned to the facility on [DATE]. Review of Resident R83's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. Review of the clinical record indicated Resident R88 was admitted to the facility on [DATE]. Review of Resident R88's MDS dated [DATE], indicated diagnoses of high blood pressure, hyponatremia (too little sodium in the blood), and muscle weakness. Review of the clinical record indicated Resident R88 was transferred to hospital on 10/28/24 and returned to the facility on [DATE]. Review of Resident R88's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility. During an interview on 11/15/24, at 10:00 a.m. the Director of Nursing confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for five of six residents as required. 28 Pa. Code 201.29 (a) (c.3) (2) Resident rights.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167 Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for four of six resident hospital transfers or therapeutic leave of absence (Resident R2, R69, R82, and R83). Findings Include: Review of the facility policy Notice of Bed Hold Policy at Time of Transfer Due to hospitalization or Therapeutic Leave indicated that the bed hold policy will be provided to residents at the time of transfer of a resident for hospitalization or therapeutic leave. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of Resident R2's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 11/4/24, indicated diagnoses of high blood pressure, Alzheimer ' s disease (a type of brain disorder that causes problems with memory, thinking and behavior), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of the clinical record indicated Resident R2 was transferred to hospital on 8/11/24 and returned to the facility on [DATE]. Review of Resident R2's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 8/11/24. Review of the clinical record revealed that Resident R69 was admitted to the facility on [DATE]. Review of Resident R69's MDS dated [DATE], indicated diagnoses of dementia (neuro-cognitive disorder impacting reasoning, judgment, and memory), high blood pressure, and muscle weakness. Review of Resident R69's clinical record revealed that the resident left the facility for a therapeutic leave of absence on 9/13/24, and returned to the facility on [DATE]. Review of Resident R69's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of her therapeutic leave of absence on 9/13/24. Review of the clinical record indicated Resident R82 was admitted to the facility on [DATE]. Review of Resident R82's MDS dated [DATE], indicated diagnoses of high blood pressure, dementia, and coronary artery disease (damage or disease in the heart's major blood vessels). (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record indicated Resident R82 was transferred to hospital on 10/19/24 and returned to the facility on [DATE]. Review of Resident R82's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 10/19/24. Review of the clinical record indicated Resident R83 was admitted to the facility on [DATE]. Review of Resident R83's MDS dated [DATE], indicated diagnoses of high blood pressure, Alzheimer's disease, and muscle weakness. Review of the clinical record indicated Resident R83 was transferred to hospital on 9/7/24 and returned to the facility on [DATE]. Review of Resident R83's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 9/7/24. During an interview on 11/15/24, at 9:57 a.m. the Director of Nursing confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy for Resident R2, R69, R82, and R83. 28 Pa. Code: 201.29(b)(d)(j) Resident rights.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46167 Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to assess a resident for safe smoking for one of two residents (Resident R42), and failed to make certain each resident received adequate monitoring of elopement (leaving an area without permission) prevention devices for three out of three residents (Residents R67, R69, and R72), Findings include: Review of the facility policy Smoking dated 11/8/24, and previously dated 7/22/24, indicated that a Smoking Assessment will be completed upon move-in, quarterly, and as needed if there is a decline in the residents Activities of Daily Living. Review of the facility policy Elopement Prevention dated 11/8/24, and previously reviewed 7/22/24, indicated that if a resident's behavior warrants elopement prevention measures, a comprehensive elopement prevention plan will be documented as part of the plan of care. Staff observations will be noted during the resident's stay and modifications will be made to the care plan and prevention techniques. Review of the facility policy Physician Orders dated 11/8/24, and previously dated 7/224, indicated that physician orders are followed in accordance with good nursing principles and practices and are transcribed and carried out by persons legally authorized to do so. Review of Resident R42's clinical record indicated an admitted [DATE]. Review of resident 42's MDS (Minimum Data Set- a periodic assessment of resident care needs) dated 9/3/24, indicated the diagnosis of coronary artery disease (CAD - affects that arteries that supply the heart with blood), hypertension (high blood pressure) and hyperlipidemia (high level of fat in the blood). Review of resident R42's care plan dated 5/24/24 indicated I use tobacco/nicotine products: tobacco smoking (history of smoking 3 packs/day). I will have a smoking evaluation completed upon admission, re-admission, annually and as needed for decline in activities of daily living (ADLS). Review of Resident R42's Nursing review dated 6/10/24, section I smoking indicated yes, the resident uses tobacco products or vaping device. No further assessment was found to be completed. During an interview completed on 11/15/24, at 11:07 a.m. the Director of Nursing confirmed the last smoking assessment completed for resident R42 was 6/10/24, no further assessments were completed as required and that the facility failed to assess a resident for safe smoking for one of two residents (Resident R42). Review of the clinical record revealed that Resident R67 was admitted to the facility on [DATE]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R67's MDS dated [DATE], indicated diagnoses of dementia (neuro-cognitive disorder impacting reasoning, judgment, and memory), anxiety, and muscle weakness. Review of Resident R67's clinical record revealed a physician's order dated 9/1/24, to check Wanderguard (a device applied to the resident that alerts staff when they leave a safe area) battery percentage weekly. Replace Wanderguard when battery percentage is below ten percent. Review of Resident R67's clinical record revealed a physician's order dated 8/29/24, for Wanderguard to be on at all times. Check placement, function and skin integrity every shift. Review of Resident R67's treatment record revealed that Wanderguard battery function was not completed as ordered on 9/8/24, 9/29/24, 10/13/24, and 11/10/24. Review of Resident R67's treatment record revealed that Wanderguard placement, function and skin integrity was not completed on 9/5/24, during the day shift, 9/11/24, on the day shift, 9/20/24, on the evening and night shift, 10/10/24, on the night shift, 10/16/24, on the night shift, and 10/18/24, on the night shift. Review of the clinical record revealed that Resident R69 was admitted to the facility on [DATE]. Review of Resident R69's MDS dated [DATE], indicated diagnoses of dementia, high blood pressure, and muscle weakness. Review of Resident R69's clinical record revealed a physician's order dated 8/29/24, to check Wanderguard battery percentage weekly. Replace Wanderguard when battery percentage is below ten percent. Review of Resident R69's clinical record revealed a physician's order dated 8/29/24, for Wanderguard to be on at all times. Check placement, function and skin integrity every shift. Review of Resident R69's treatment record revealed that Wanderguard battery function was not completed as ordered on 9/29/24, and 10/13/24. Review of Resident R69's treatment record revealed that Wanderguard placement, function and skin integrity was not completed on 9/5/24, during the day shift, 9/13/24, during the evening shift and night shift, 9/29/24, during the night shift, 10/10/24, during the day shift, 10/13/24, during the night shift, and 11/4/24, during the evening shift. Review of the clinical record revealed that Resident R72 was admitted to the facility on [DATE]. Review of Resident 72's MDS dated [DATE], indicated diagnoses of Huntington's disease (an inherited condition in which nerve cells in the brain break down over time resulting in progressive movement, thinking and psychiatric symptoms), dementia, and malnutrition (lack of proper nutrition). Review of Resident R72's clinical record revealed a physician's order dated 8/29/24, to check Wanderguard battery percentage weekly. Replace Wanderguard when battery percentage is below ten percent. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R72's clinical record revealed a physician's order dated 8/29/24, and reordered on 9/23/24, for Wanderguard to be on at all times. Check placement, function and skin integrity every shift. Review of Resident R72's treatment record revealed that Wanderguard battery function was not completed as ordered on 9/15/24, and 9/29/24. Review of Resident R72's treatment record revealed that Wanderguard placement, function and skin integrity was not completed on 9/4/24, during the evening shift or the night shift, 9/13/24, during the day shift, 9/15/24, during the night shift, 9/29/24, during the night shift, 10/10/24, during the day shift, and 11/4/24, during the evening shift. During an interview on 11/14/24, at 10:36 a.m. the Director of Nursing confirmed that the facility failed to properly monitor the function of elopement devices as ordered for three of three residents (Resident R67, R69, and R72). 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.

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Quality Life Services - Chicora	160 Medical Center Road Chicora, PA 16025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469 Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure appropriate treatment and services were provided for residents with an indwelling urinary catheter (a tube inserted in the bladder to drain urine) for one of four residents reviewed (Residents R88). Findings include: Review of facility policy Indwelling Urinary Catheter dated 7/22/24, and last reviewed 11/8/24, indicated that an indwelling catheter not medically justifies will be discontinued as soon as clinically warranted. The catheter bag should have a privacy cover applied at all times unless it has one built in by the manufacturer. Review of the clinical record indicated Resident R88 was admitted to the facility on [DATE]. Review of Resident R88's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/28/24, indicated the diagnosis of anemia (low iron in the blood), hypertension (high blood pressure), and neurogenic bladder (a bladder dysfunction caused by neurological damage). Review of R88's physician order dated 11/17/24, indicated the resident has an indwelling foley catheter (flexible tube that drains urine from the bladder through the urethra) size 16 French (standard measurement size for foley catheters) with a 10cc (cubic centimeter) balloon (holds catheter in place in the bladder). Review of Resident R88's care plan dated 10/24/24 indicates indwelling foley catheter 16 French/10cc balloon related to neurogenic bladder. Observation on 11/12/24 at 10:23 a.m. Resident R88's foley catheter bag was hanging on the bed frame and failed to have a privacy cover. During an interview on 11/12/24 at 10:23 a.m. Licensed Practical Nurse (LPN) Employee E3 confirmed that the foley catheter bag did not have a privacy cover and that the facility failed to ensure appropriate treatment and services were provided for residents with an indwelling urinary catheter. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.29(a)(c)(d)(j) Resident rights. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469 Based on review of facility policy, clinical records, and staff interviews, it was determined that facility staff failed to maintain ongoing communication with the dialysis (a machine filters wastes, salts, and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately) center for two of three residents reviewed (Resident R57, and R59). Findings include: Review of CMS guidelines, 483.25(1) states the facility assures that each resident receives care and services for the provision of dialysis (a machine filters wastes, salts, and fluid from your blood when your kidneys are no longer healthy enough to do this work adequately) including the ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments. Review of the clinical record indicated that Resident R57 was admitted to the facility on [DATE]. Review of Resident R57's Minimum Data Set (MDS - periodic assessment of care needs) dated 9/6/24, indicated the diagnoses of anemia (low iron in the blood), hypertension (high blood pressure) and end stage renal disease (ESRD-kidneys permanently fail to work). Review of a physician's order dated 8/31/24, indicated Resident R57 was to receive dialysis three days a week on Monday, Wednesday, and Friday. Review of Resident R57's care plan dated 8/29/23, indicated to assess left upper arm AV fistula auscultate for bruit and palpate for thrill daily. Maintain communication with my dialysis clinic. Review of R57's dialysis communication sheets from 9/6/24 through 11/11/24 indicated two of 21 communication sheets not completed prior to dialysis. (9/6/24, 9/9/24, 9/11/24, 9/14/24, 9/16/24, 9/18/24, 9/20/24, 9/23/24, 9/27/24,10/4/24, 10/7/24, 10/16/24, 10/21/24, 10/23/24, 10/25/24, 10/28/24, 10/30/24, 11/1/24, 11/4/24, 11/8/24. 11/11/24). Review of the clinical record indicated that Resident R59 was admitted to the facility on [DATE]. Review of Resident R59 's Minimum Data Set (MDS - periodic assessment of care needs) dated 8/7/24, indicated the diagnosis of heart failure (heart can ' t pump blood the way it should), hypertension (high blood pressure and end stage renal disease (ESRD-kidneys permanently fail to work). Review of a physician's order dated 6/1/23, indicated Resident R59 was to receive dialysis three days a week on Monday, Wednesday, and Friday. Review of Resident R59's care plan dated 8/29/23, indicated to assess left upper arm AV fistula auscultate for bruit and palpate for thrill daily. Maintain communication with my dialysis clinic. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R59's the dialysis communication sheets from 9/6/24 through 11/11/24, indicated 18 of 20 communication sheets not completed prior to dialysis. (9/6/24, 9/9/24, 9/11/24, 9/16/24, 9/18/24, 9/20/24, 9/23/24, 9/27/24, 10/4/24, 10/7/24, 10/15/24, 10/21/24, 10/23/24, 10/25/24, 10/28/24, 10/30/24, 11/1/24, 11/8/24). During an observation and interview completed on 11/14/24 at 12:59 p.m. Licensed Practical Nurse (LPN) Employee E3 confirmed the dialysis sheets were not completed and stated, we don ' t normally fill the top portion out. During an interview on 11/14/24, at 1:06 p.m. Registered Nurse (RN) Employee E15 stated, the top portion needs to be filled out and we send the book and any order summaries. During an interview completed on 1/14/24 at 1:11 p.m. the Director of Nursing confirmed the dialysis books were incomplete and that the facility failed to maintain ongoing communication with the dialysis center for two of three residents reviewed (Resident R57, and R59). 28 Pa. Code: S211.5(g)(h) Clinical records. 28 Pa. Code: S201.14(a)(b)(e)(1)(3) Management. 28 Pa. Code: S211.10(c) Resident care policies. 28 Pa. Code: S211.12(c)(d)(1)(3)(5) Nursing services.

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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** 48546 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 five residents reviewed (Resident R1). Findings include: Review of facility policy Physician Orders dated 7/22/24, and last reviewed 11/8/24, indicated physician orders are followed in accordance with good nursing principles and practices and are transcribed and carried out by persons legally authorized to do so. Medications and treatments will be administered and signed off per physician orders. If dose is missed, take dose as scheduled; do not double dose. Review of Davis's Drug Guide for Nurses, 19th Edition, dated 2024, indicated Mercaptopurine is a medication used to treat Crohn's disease (a long-time disease that causes inflammation and irritation in the digestive tract) by reducing irritation and inflammation in the intestines. 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 9/30/24, indicated diagnoses of anemia (too little iron in the blood), anxiety (a feeling of worry, nervousness, or unease), and Crohn's disease. Review of a physician order indicated to administer Mercaptopurine 50 milligrams, give two tablets by mouth in the morning. Review of Resident R1's Medication Administration Record (MAR) dated April 2024 indicated the resident did not receive the scheduled Mercaptopurine on 4/19/24, and 4/20/24, due to the medication not being available. Review of Resident R1's clinical record failed to reveal that the physician was notified of Resident R1's missed doses of Mercaptopurine on 4/19/24, and 4/20/24. During an interview on 11/15/24, at 10:00 a.m. the Director of Nursing confirmed that the facility failed to ensure that residents are free of significant medication errors for one of five residents as required. 28 Pa. Code: 211.12(d)(1)(3)(5)Nursing services. 28 Pa. Code: 201.29(b)(d)(j) Resident rights. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.9 (k)(l)(1)(2) Pharmacy services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469 Based on review of facility policy, observation and staff interview, it was determined that the facility failed to make certain a medication room refrigerator containing narcotics was properly locked and that open medications stored in the medication room refrigerator were labeled with a dated upon opening for one of two medication rooms ([NAME] Crossings Medication Room), failed to store medications and treatments for residents properly to prevent cross contamination for two of four medication carts ([NAME] Crossing Medication Cart and Settlers Cart 6), and failed to label medications upon opening and ensure medication was in pharmacy labeled medication bag for two of four medication carts ([NAME] Crossing Medication Cart and Settlers Cart 6). Review of facility Management of Controlled Drugs dated [DATE] last reviewed [DATE], indicated that all controlled substances are stored under double lock separate from other medication. Review of facility Storage of Medications dated [DATE], last reviewed [DATE], indicated that medications and biologicals are stored safely, securely, and properly. Orally administered medications are kept separate from externally used medications and treatments. When the original seal of a manufactures container or vial is initially broken, the container or vial will be dated. During an observation the [NAME] Crossings Mediation Room on [DATE], at 9:29 a.m. the refrigerator was found unlocked and the top shelf contained three opened boxes of Lorazepam (a medication used to treat anxiety). A vial of Tubersol solution (used to diagnose tuberculosis) was also stored in the medication room storage refrigerator, however the vial failed to have a date of which it was opened. During an interview on [DATE], at 9:29 a .m. Licensed Practical Nurse (LPN) Employee E5 confirmed that the medication room refrigerator was found unlocked and contained three boxes of Lorazepam, the vial of Tubersol was opened and undated, and that the facility failed to make certain a medication room refrigerator containing narcotics was properly locked and that open medications stored in the medication room refrigerator were labeled with a dated opened for one of two medication rooms ([NAME] Crossings Medication Room). During a medication cart review on [DATE], at 9:20 a.m. it was observed that there were two opened tubes of Biofreeze gel (for muscle or joint pain) on the medication cart and an Albuterol inhaler (a medication used to help with breathing) that was opened and failed to be labeled with a date. During an interview on [DATE], at 9:24 am LPN Employee E5 confirmed the Biofreeze gel was stored in the medication cart and stated, those should be on the treatment cart. LPN Employee E5 confirmed that an Albuterol inhaler was not labeled with an opened date, and confirmed that the facility failed to store treatments for residents properly to prevent cross contamination and failed to label medications upon opening for one of two medication carts ([NAME] Crossing medication cart). During a medication cart review (Settlers Cart 6) on [DATE], at 9:25 a.m. the following were observed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Humalog (an insulin used to treat high blood sugars) expired on [DATE]. - Admelog (an insulin used to treat high blood sugars) expired [DATE]. - Novolog (an insulin used to treat high blood sugars) expired [DATE]. - Lantus (an insulin used to treat high blood sugars) expired [DATE]. - Enoxaparin (a medication used to prevent blood clots) was not in a pharmacy labeled bag and had no name or date on it. - Breo Ellipta (a medication used to treat a breathing condition) was not in a pharmacy labeled bag and had no open or expiration date. During an interview on [DATE], at 9:27 a.m. LPN Employee E14 stated, I didn't realize these medications were expired, I will get new vials of medications to replace them. During an interview on [DATE], at 9:30 a.m. LPN Employee E14 confirmed that the facility failed to store medications appropriately, and failed to store medications in a pharmacy labeled bag for one of two medication carts (Settlers Cart 6) as required. 28 Pa. Code: 211.9(a)(1)(k) Pharmacy services. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46167 Based on review of facility policies, observations, and staff interviews, it was determined the facility failed to properly date and store food products, and failed to maintain clean equipment in a manner to prevent foodborne illness in the Main Kitchen. Findings include: Review of facility policy Food Storage dated 11/8/24, and previously dated 7/22/24, indicated all foods should be covered, labeled, and dated. Food should be dated as it is placed on the shelves. Review of facility policy Cleaning and Sanitation dated 11/8/24, and previously dated 7/22/24, indicated that food service staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. During an observation in the Baker's Refrigerator on 11/12/24, at 9:55 a.m. three packages of whipped topping were not dated. During an observation in the Stand- Up Freezer on 11/12/24, at 10:00 a.m. three lemon meringue pies were not dated. During an observation in the Walk-in Refrigerator on 11/12/24, at 10:05 a.m. an opened package of sliced turkey was not labeled and dated. During an interview on 11/12/24, at 10:06 a.m. Dietary Supervisor confirmed that the facility failed to properly label and date food to prevent foodborne illness. During an observation and interview on 11/14/24, at 1:36 a.m. Registered Dietitian Employee E7 confirmed that a fan that was pointed towards the clean dishes coming out of the dish machine, was covered in a gray, fuzzy substance, and that the facility failed to maintain clean equipment to prevent foodborne illness. 28 Pa. Code: 201.14(a) Responsibility of licensee 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.6(c) Dietary services.

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 48546 Based on review of facility policy, Quality Assurance attendance records, and staff interview, it was determined that the facility failed to conduct Quality Assessment and Assurance (QAA) meetings at least quarterly with all of the required committee members for one of three quarters (January 2024 through March 2024). Findings include: Review of facility policy Quality Assurance Performance Improvement (QAPI) Structure, Scope and Plan dated 7/22/24, and last reviewed 11/8/24, indicated a QAPI Committee shall be established to administer the QAPI Plan as it pertains to that home. Members of the homes' QAPI Committee will consist of at least the following: Nursing Home Administrator, Director of Nursing, Medical Director, Personal Care Administrator, Consultant Pharmacist, Direct Care Team Member, Medical Records representative, Laundry/Housekeeping Director, Maintenance Director, Activities Director, Social Worker, Culinary Director, Human Resources Director, RNAC, at least one member of the Safety Committee, Laboratory representative, Community Member, and Representatives from any Performance Improvement Process (PIP) Teams. A review of the QAPI Committee meeting sign-in sheets from the period of January 2024 through March 2024, did not reveal that the Medical Director/designee or Infection Preventionist were in attendance. During an interview on 11/15/24, at 10:05 a.m. the Nursing Home Administrator confirmed that the facility failed to conduct QAA meetings at least quarterly with all of the required committee members as required. 28 Pa Code: 201.18(e)(1)(2)(3)(4) Management.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49469 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to properly monitor resident's personal refrigerators to ensure that food is properly stored and maintained for two of four residents (Residents R16 and R68), failed to implement infection control practices to prevent cross contamination during a dressing change for one of three residents (Resident R46), failed to review annual infection control policies for ten out of ten years (2014 through 2024), and failed to notify residents or resident representatives of two out of two outbreaks (COVID and Norovirus (a virus causing nausea, vomiting, and diarrhea)). Review of facility policy Food Brought in from Outside Source dated 7/22/24, last reviewed 11/8/24, indicated the purpose of this policy is to have procedures in place for the safe and sanitary storage, handling and consumption of food including food and fluids purchased through third party vendors and brought in by family members and other visitors. Refrigerators will be maintained at or below 41 degrees freezers will be kept at 0 degrees and below, facility staff will monitor and document the temperature daily. Review of the facility policy Wound Dressing Change dated 7/22/24, last reviewed 11/8/24, indicated all wound care will be performed under medical aseptic technique. The procedure includes but not inclusive to: - Gather equipment. - Individual resident supplies may be placed on the over bed table after it has been disinfected and a protective barrier has been placed. - Open dressings to be used without touching the dressing. Keep the dressing in the open packet and place it directly on top of the barrier. - Expose area to be treated and protect privacy. - Cleanse your hands apply clean gloves. - Cleanse wounds remove the soiled gloves, cleanse hands apply clean gloves. - Apply treatment as ordered. - Apply clean dressing, secure the dressing with tape, press edges into place. During an interview and observation on 11/12/24, at 9:54 a.m. Resident R16 had a small personal refrigerator in his room there was no thermometer inside, and no temperature log that included daily monitoring for Resident R16's personal refrigerator. During an interview completed on 11/12/24 at 9:54 a.m. Licensed Practical Nurse (LPN) Employee E3 confirmed Resident R16's refrigerator did not contain a thermometer or temperature log. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation completed on 11/12/24 at 9:56 a.m. Resident R68 had a small personal refrigerator in his room there was no thermometer inside, and no temperature log that included daily monitoring for Resident R68's personal refrigerator. During an interview completed on 11/12/24 at 10:04 a.m. LPN Employee E3 confirmed Resident R68's refrigerator did not contain a thermometer or temperature log and that the facility failed to properly monitor resident's personal refrigerators to ensure that food is properly stored and maintained for two of four residents (Residents R16 and R68). Review of the clinical record indicated Resident R46 was admitted to the facility on [DATE], with the diagnosis of paraplegia (impairment in motor or sensory function of the lower extremities), diabetes (high sugar in the blood) and depression. Review of physician order dated 11/6/24, indicated wound treatment: right ischium, left ischium and coccyx wounds: cleanse with dakins, pat dry apply silver alginate cover with optilock super absorbent dressing and then cover with abdominal pad change daily and as needed. During an observation on 11/13/24, at 10:25 a.m. LPN Employee E4, had dressing supplies in a pink basin, she placed the basin on the bedside stand, opened dressings and placed on stand, she continued to place a barrier under Resident R46 without using gloves, applied gloves removed dressings, applied new gloves cleansed the wounds and continued to apply the ordered treatment. She removed one glove to retrieve more tape and applied more tape to secure the dressing using one hand. During an interview completed on 11/13/24, at 10:42 a.m. LPN Employee E4 confirmed she did not clean the bedside stand or place a barrier prior to placing dressings. Using ungloved hands placed a barrier under the resident, did not completing hand hygiene after cleansing the wound and placing new dressings, removing one glove to retrieve more tape with ungloved hand holding the tape and using the gloved hand to apply tape to secure dressing and that the facility failed to implement infection control practices to prevent cross contamination during a dressing change for one of three residents (Resident R46). During a review of the Infection Control manual on 11/14/24, at 10:30 a.m. revealed a policy last review date of 1/12/14. During an interview on 11/14/24, at 10:39 a.m. the Infection Preventionist (IP) Employee E2 confirmed that the facility failed to review the Infection Control policies annually. During a resident group on 11/13/24, at 10:40 a.m. the resident group stated that they were unaware of the facility having a norovirus outbreak. The group said they were not notified of a norovirus outbreak, recently or in the past. During a review of facility provided documents on 11/14/24, at 1:30 p.m. revealed that the facility failed to notify residents or the resident representative for a COVID-19 (a respiratory infection) outbreak from 8/21/24 and a Norovirus outbreak from 10/10/24. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/14/24, at 1:45 p.m. Director of Nursing confirmed that the facility failed to notify residents or the resident representative of two out of two infectious outbreaks. 28 Pa. code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b) (1) (e) (1) Management. 28 Pa. Code: 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.

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	395118	A. Building B. Wing	11/15/2024

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 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 48546 Based on review of facility policy and documents, and staff interview, it was determined that the facility failed to provide training on effective communication for one of five staff members (Nurse Aide (NA) Employee E9). Findings include: Review of the facility's Employee Handbook indicated as required by the Commonwealth of Pennsylvania and in order to maintain the high degree of skill and ability necessary to ensure superior resident care, all employees are required to participate in mandatory or approved meetings, in-service training programs and online courses. Review of NA Employee E9's personnel file indicated a hire date of 3/12/18, and failed to include effective communication training between 11/14/23, and 11/14/24. During an interview on 11/14/24, at 2:00 p.m. the Director of Nursing confirmed that the facility failed to provide training on effective communication for one of five staff members as required. 28 Pa. Code: 201.14(a) Responsibility of Licensee. 28 Pa. Code: 201.20(c) Staff Development.