

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Quality Life Services - Chicora		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. Based on observations and staff interview, it was determined that the facility failed to properly maintain sanitary conditions in the walk-in cooler which created the potential for cross contamination in the designated main kitchen. Findings include: During an observation of the main designated kitchen on 12/1/25, at 10:30 a.m. the following was observed: -(2) fans in walk-in cooler- brown debris -ceiling in walk-in cooler-brown debris During an interview on 12/1/25 at 1:30 p.m. Dietary Director Employee E11 confirmed the brown debris in the walk-in cooler. During an interview on 12/2/25 at 10:00 a.m., Dietary Manager Employee E11 confirmed that the facility failed to maintain sanitary conditions which created the potential for cross contamination. 28 Pa. Code: 201.18(b)(1) Management.28 Pa. Code: 211.6(c) Dietary services.28 Pa. Code: 201.14(a) Responsibility of licensee.		

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 - 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** 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. Review of Resident R35's admission record indicated she was admitted to the facility on [DATE]. 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. Review of Resident R35's physician's orders dated 11/3/25, indicated restorative dining. 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. 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. 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. 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. 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). 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. 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. (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 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). 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. 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. 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.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident record review, and staff interviews, it was determined that the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for three of three residents (Residents R24, R41, and R81). Findings include: Review of facility job description Social Worker, indicated that the Social Worker will carry out social evaluations and plan interventions based on evaluation findings, and counsel residents/family/caregivers as needed in relationship to stress and other identified coping difficulties. Ensure compliance with all Federal, State, and local regulations. Review of the admission record indicated Resident R24 admitted to the facility on [DATE]. Review of Resident R24's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/28/25, indicated the diagnoses of post-traumatic stress disorder (PTSD - a psychiatric disorder that may occur in persons that have witnessed a traumatic event causing intense, disturbing thoughts and feelings related to the experience), anemia (the blood doesn't have enough healthy red blood cells), and paranoid schizophrenia (delusions and hallucinations that blur the line between what is real and what isn't). Review of Resident R24's current care plan indicated the resident has delirium (a sudden severe state of confusion and altered awareness, not a disease but symptom of an underlying medical problem). Resident will be free of the signs and symptoms of delirium such as the following: exhibiting a change in behavior, mood, cognitive function, communication, level of consciousness, or restlessness through the next review date. During an interview on 12/4/25, at 11:34 a.m. Social Worker Employee E4 confirmed that Resident R24 did not have a traumatic informed care plan addressing the PTSD or identifying potential triggers and prevention for re-traumatization. Review of the clinical record revealed Resident R41 was admitted to the facility on [DATE] with diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), PTSD, and muscle weakness. Review of the resident's Social Services assessment dated [DATE], revealed the facility documented the resident does not have a history of trauma/Post-Traumatic Stress Disorder. Review of the resident's Social Services assessment dated [DATE], revealed the facility documented the resident does not have a history of trauma/Post-Traumatic Stress Disorder. Review of the resident's Social Services assessment dated [DATE], revealed the facility documented the resident does not have a history of trauma/Post-Traumatic Stress Disorder. Review of the resident's Social Services assessment dated [DATE]/25, revealed the facility documented the resident does not have a history of trauma/Post-Traumatic Stress Disorder. Review of Resident R41's care plan on 12/1/25, failed to address PTSD by identifying any triggers or (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	how to avoid them. During an interview on 12/4/24, at 11:34 a.m. Social Worker Employee E4 stated Resident R41's Social Service assessments should be documented to reflect the resident does have a history of trauma/Post-Traumatic Stress Disorder and confirmed Resident R41's care plan failed to address PTSD by identifying any triggers or how to avoid them. Review of the admission record indicated Resident R81 admitted to the facility on [DATE]. Review of Resident R81's MDS dated [DATE], indicated the diagnoses of anemia, PTSD, and renal insufficiency (a condition in which the kidneys lose the ability to remove waste and balance fluids). Review of Resident R81's current care plan indicated trauma informed care: resident has a history of actual trauma : PTSD related to Vietnam War. Resident will feel safe and comfortable in the home environment and will express any concerns or fears to the staff. During an interview on 12/4/25, at 11:34 a.m. Social Worker Employee E4 confirmed that Resident R81 did not have a traumatic informed care plan addressing the PTSD in identifying potential triggers and prevention for re-traumatization. Interview on 12/5/25, at 12:30 p.m. the Director of Nursing confirmed the facility failed to provide a trauma survivor with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for three of three residents (Resident R24, R41, and R81). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1) Management.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to maintain accurate resident care plans and conduct ongoing accurate assessments to ensure that bedrails were used to meet residents' needs and the risks associated with bedrail usage for three of three residents (Residents R1, R63, and R92). Findings include: 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 11/10/25, indicated diagnoses of high blood pressure, muscle weakness, and need for assistance with personal care. During an observation on 12/1/25, at 9:58 a.m. bilateral (both sides) side rails were observed on the top of Resident R1's bed. Review of Resident R1's comprehensive care plan failed to include measurable objectives and timetables with specific interventions/services for use of bed rails. Review of the clinical record indicated Resident R63 was admitted to the facility on [DATE]. Review of Resident R63's MDS dated [DATE], indicated diagnoses of anemia (too little iron in the blood), Parkinson's Disease (neuromuscular disorder causing tremors and difficulty walking), and depression. During an observation on 12/1/25, at 10:05 a.m. bilateral side rails were observed on the top of Resident R63's bed. Review of Resident R63's care plan dated 12/24/22, indicated the resident uses assist fails for bed mobility: bilateral 1/2 rails for mobility, repositioning and promote independence. Review of Resident R63's clinical record failed to reveal an ongoing accurate assessment for the resident's side rail usage. Review of the clinical record indicated Resident R92 was admitted to the facility on [DATE]. Review of Resident R92's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes mellitus (DM, a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and End-Stage Renal Disease (ESRD, an inability of the kidneys to filter the blood). During an observation on 12/1/25, at 10:06 a.m. bilateral enabler bars were observed on the top of Resident R92's bed. Review of Resident R92's clinical record failed to reveal an ongoing accurate assessment for the resident's bilateral enabler bar usage. Review of Resident R92's comprehensive care plan failed to include measurable objectives and timetables with specific interventions/services for use of enabler bars. During an interview on 12/3/25, at 1:08 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E1 confirmed that the facility failed to maintain accurate resident care plans and conduct ongoing accurate assessments to ensure that bedrails were used to meet residents' needs and the risks associated with bedrail usage for three of three residents (Residents R1, R63, and R92). 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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of personnel records and staff interview, it was determined that the facility failed to complete annual performance evaluation at least once every 12 months for four of four nurse aide (NA) personnel records (NA Employees E12, E13, E14, and E15). Findings include:Review of NA Employee E12's personnel record indicated a hire date of 7/6/10. Review of NA Employee E12's personnel record failed to include an annual performance evaluation at least once every 12 months as required.Review of NA Employee E13's personnel record indicated a hire date of 2/3/12. Review of NA Employee E13's personnel record failed to include an annual performance evaluation at least once every 12 months as required.Review of NA Employee E14's personnel record indicated a hire date of 3/6/25. Review of NA Employee E14's personnel record failed to include an annual performance evaluation at least once every 12 months as required.Review of NA Employee E15's personnel record indicated a hire date of 1/6/23. Review of NA Employee E15's personnel record failed to include an annual performance evaluation at least once every 12 months as required.Interview on 12/3/25, at 12:47 p.m. the Corporate Human Resources Employee E7 confirmed that the facility failed to complete annual performance evaluation at least every 12 months for four of four nurse aide (NA) personnel records (NA Employees E12, E13, E14, and E15). 28 Pa Code: 201.14 (b) Responsibility of licensee28 Pa Code: 201.18 (b)(1)(3) Management		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of the 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 required members for three of three quarters (Quarter one, two, three of 2025). Findings: Review of Quality Assessment and Assurance minutes sign in sheets and attendance records for Quarter One, Two and Three of 2025, failed to reveal the Infection Preventionist was in attendance. During an interview 12/4/25, at 1:30 p.m. Clinical Services Specialist Employee E5 confirmed that the facility failed to conduct Quality Assurance and Performance Improvement (QAPI) meetings at least quarterly with all the required committee members for three of three quarterly meetings (Quarter one, two, three of 2025), 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** Based on facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to prevent cross contamination during a dressing change for one of three residents (Resident R5), failed to ensure that contact precautions were ordered for two of five residents (Residents R36 and R82) and failed to ensure that contact precautions were care planned for one of five residents (Resident R82) Findings include: Review of facility policy Wound Dressing Change dated 10/13/25, indicated all wound care will be performed using medical aseptic (free from contamination) technique, unless otherwise ordered by physician. The purpose is to prevent contamination of the wound bed. Each area must be treated separately. Review of the facility policy Pediculosis (Lice) Care dated 10/13/25, indicated pediculosis is an infestation of the scalp, the hairy parts of the body, or clothing with adult lice, larvae, or nits. It is transmitted by direct contact with an infested person and indirectly by contact with their personal belongings (clothes, bedding, brush and comb, etc.). Precautions for employees consist of wearing gloves and/or gown if in close contact with infested person or things. Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/12/25, indicated diagnoses of anemia (too little iron in the blood), paraplegia (paralysis of the legs and lower body), and hyperlipidemia (high level of fat in the blood). Review of a physician order dated 10/8/25, indicated wound care: coccyx (tailbone), left ischium (the lower and back part of the hip bone), right ischium: cleanse all wounds with Dakins (an antiseptic wound cleanser) solution. Loosely pack with Dakins soaked gauze, use Optilock (an absorbent dressing) as needed for excess drainage. Cover with ABD pads (a highly absorbent dressing). Skin prep (a liquid that forms a protective barrier) to periwound (tissue surrounding a wound) for protection. Change BID (twice a day) or PRN (as needed) for soilage/displacement. Notify provider or wound nurse with any changes. During a dressing change observation on 12/4/25, from 10:03 a.m. to 10:25 a.m. Licensed Practical Nurse (LPN) Employee E3 cleansed the right ischium wound with Dakins-soaked gauze and used the same piece of gauze to cleanse the coccyx wound. During an interview on 12/4/25/25, at 10:30 a.m. LPN Employee E3 confirmed the above observations and that the facility failed to implement infection control practices to prevent cross contamination during a dressing change. Review of Resident R36's clinical record indicated admission to the facility on 7/15/25. Review of Resident R36's MDS dated [DATE]/25, indicated the diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), high blood pressure, and depression. Review of facility provided documentation dated 8/24/25, indicated that Resident R36 was found to have bugs that were later identified as lice in the hair. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R36's physician orders failed to include orders for contact isolation as required. Review of Resident R36's care plan indicated contact precautions for head lice. Review of Resident R82's clinical record indicated admission to the facility on [DATE]. Review of Resident R82's MDS dated [DATE], indicated the diagnoses of Parkinson's Disease (disorder of the nervous system that results in tremors), dementia, and high blood pressure. Review of facility provided documentation dated 5/10/25, indicated Resident R82 was discovered to have head lice found in the beard of the face. Treatment orders obtained from on call provider and resident was placed on contact precautions per facility infection control policy. Review of Resident R82's physician orders failed to include orders for contact isolation as required. Review of Resident R82's care plan failed to include interventions and identification of contact precautions. Interview on 12/4/25, at 10:11 a.m. the Director of Nursing confirmed that the facility failed to prevent cross contamination during a dressing change for one of three residents (Resident R5) and failed to ensure that contact precautions were ordered for two of five residents (Residents R36 and R82) and failed to ensure that contact precautions were care planned for one of five residents (Resident R82) 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.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, observations and staff interview, it was determined that the facility failed to determine whether it was safe to self-administer medications for one of six residents (Resident R25). Findings include: Review of the facility policy Self-Administration of Medications dated 10/13/25, indicated in order to maintain the residents' high level of independence, resident's who desire to self-administer medications are permitted to do so if the facility 's interdisciplinary team has determined the practice would be safe for the resident and other resident's of the facility and there is a prescriber's order to self-administer. Review of the admission record indicated Resident R25 was admitted to the facility on [DATE]. Review of Resident R25's Minimum Data Set (MDS- a periodic assessment of care needs) dated 11/17/25, indicated the diagnoses of malignant neoplasm of upper lobe, right bronchus or lung, respiratory failure and chronic kidney disease. Observation on 12/1/25, at 10:30 a.m. of Resident R25's room indicated a two medicine cup's at the bedside table, one with liquid and the other with three pills. Interview with Registered Nurse (RN) Employee E9 confirmed the cup with three pills were fish oil, zolofit and movantik and the liquid was MiraLax and confirmed she left the pills and liquid at the bedside unattended. Review of Resident R25's clinical record failed to have a physician order, assessment, or plan of care addressing self-administration of medications. Interview on 12/1/25, at 10:45 a.m. RN Employee E9 confirmed the medications were stored in the resident room inappropriately and that Resident R25 failed to have an assessment, physician order, or plan of care for self-administration of medications. 28 Pa code: 211.12(d)(1)(5) Nursing services.		

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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** Based on review of facility policies, clinical records, facility documents, and staff interviews it was determined that the facility failed to identify a scoop mattress (a specialty medical mattress with soft raised foam edges) as a possible restraint, and failed to assess the functional status of the individual resident to determine if the use of a scoop mattress is a restraint for one of three residents (Resident R63). Findings include: Review of facility policy Physical Restraint Policy and Procedure dated 10/13/25, indicated physical restraints are defined as any manual method of physical or mechanical device, material or equipment attached or adjacent to the elder's body that the individual cannot remove easily which restrict freedom of movement or normal access to one's body. Review of the clinical record indicated Resident R63 was admitted to the facility on [DATE]. Review of Resident R63's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/12/25, indicated diagnoses of anemia (too little iron in the blood), Parkinson's Disease (neuromuscular disorder causing tremors and difficulty walking), and depression. Section GG - Functional Abilities, Question GG0170A: Roll left and right, indicated the resident was coded 1 dependent, helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Review of a physician order dated 10/21/24, indicated resident provided a scoop mattress for positioning/comfort and safety while in bed. During an observation on 12/1/25, at 10:05 a.m. Resident R63's mattress was observed with bilateral (both sides) raised edges on the top and bottom portions. Review of Resident R63's clinical record failed to identify any assessments or ongoing evaluations for the usage of the scoop mattress. During an interview on 12/3/25, at 1:08 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E1 confirmed that the facility failed to identify a scoop mattress as a possible restraint and failed to assess the functional status of the individual to determine if the use of a scoop mattress is a restraint for Resident R63. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.8(e) Use of restraints. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(5) Nursing services.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop comprehensive care plans to meet resident care needs for one of five residents (Resident R92). Findings include: Review of facility policy Care Plan and Interdisciplinary Care Conferences dated 10/13/25, indicated the care plan is a working tool that is reviewed and revised at specific intervals and as needed to reflect response to care and changing needs and goals. Review of the clinical record indicated Resident R92 was admitted to the facility on [DATE]. Review of Resident R92's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/23/25, indicated diagnoses of high blood pressure, diabetes mellitus (DM, a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and End-Stage Renal Disease (ESRD, an inability of the kidneys to filter the blood). Review of a physician order dated 5/6/25, indicated to apply Dexcom G7 Sensor (a wearable continuous blood glucose monitor) transdermally (to the skin) every evening shift every 10 days for DM. Review of Resident R92's current care plan failed to include the development of goals and interventions related to the resident's wearable continuous blood glucose sensor. During an interview on 12/3/25, at 1:11 p.m. Registered Nurse Assessment Coordinator (RNAC) Employee E1 confirmed that the facility failed to develop a comprehensive care plan to meet resident care needs for Resident R92. 28 Pa Code: 201.14(a) Responsibility of licensee. 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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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** Based on review of resident clinical records, facility policy and staff interview it was determined the facility failed to provide consistent and complete communication with the dialysis (a machine that 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 two residents (Residents R13 and R92). Findings include: Review of the clinical record indicated Resident R92 was admitted to the facility on [DATE]. Review of Resident R92's MDS dated [DATE], indicated diagnoses of high blood pressure, diabetes mellitus (DM, a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and End-Stage Renal Disease (ESRD, an inability of the kidneys to filter the blood). Review of a physician order dated 11/5/25, indicated Resident R92 receives dialysis treatment at an outside facility every Monday, Wednesday, and Friday. Review of Resident R92s clinical record did not include complete communication forms for four days during the period of 11/1/25, through 11/30/25. The incomplete forms were on the following dates: 11/19/25, 11/21/25, and 11/25/25. No communication form was located for 11/5/25. During an interview on 12/3/25, at 2:20 p.m. Licensed Practical Nurse (LPN) Employee E2 confirmed the above dates did not include complete dialysis communication forms and that the facility failed to provide consistent and complete communication with the dialysis center for Resident R92. Review of the clinical record indicated that Resident R13 was admitted to the facility on [DATE]. Review of Resident R13's Minimum Data Set (MDS- a periodic assessment of care needs) dated 10/11/25, indicated with the diagnoses of end stage kidney disease (a condition where the kidney reaches advanced state of loss of function), dependance on renal dialysis and anxiety disorder. Review of R13's physician order dated 11/19/25, indicated the resident has dialysis one time a day every Tuesday, Thursday and Saturday. Review of Resident R13's Dialysis Communication Records indicated no completed communication records. Interview on 12/3/25 at 11:015 a.m. the Director of Nursing confirmed the facility failed to provide consistent and complete communication with the dialysis center for two of two residents reviewed (Residents R92, R13). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 211.10(c) Resident care policies. 28 Pa. Code: 211.12(d)(1)(3)(5) Nursing services.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to properly store medications in one of three medication rooms (Memory Lane Medication Room). Findings include: Review of facility policy Storage of Medications dated 10/13/25, indicated certain medications such as multiple dose injectable vials require an expiration date shorter than the manufacturer's expiration date to ensure medication purity and potency. During an observation on 12/4/25, at 9:14 a.m. of the Memory Lane Medication Room Refrigerator revealed two tuberculin multiple dose vial (a substance used in the tuberculin skin test (TST) to diagnose tuberculosis infection) that was opened and not labeled with the date opened as required. During an interview on 12/4/25, at 9:14 a.m. Licensed Practical Nurse (LPN) Employee E16 confirmed the above observation and that the facility failed to properly store medication in one of three medication rooms (Memory Lane Medication Room). 28 Pa. Code: 201(a) Responsibility of licensee. 28 Pa. Code: 211.9(a)(1)(k) Pharmacy services. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.		

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on a review of facility provided documents and staff interview, it was determined the facility failed to designate a qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control infections during the periods of 10/4/25, through 10/13/25, and 11/16/25, to present. Findings included: During an interview on 12/5/25, at 1:25 p.m. the Director of Nursing (DON) stated, I was the Infection Preventionist and Assistant Director of Nursing for the period of 10/13/25, - 11/16/25, when I became the Interim DON. Prior to my tenure IP Employee E16's last day of work was on 10/4/25. During an interview on 12/5/25, at 12:30 p.m. the DON confirmed that the facility failed to designate a qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control infections during the periods of 10/4/25, through 10/13/25, and 11/16/25, to present. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 201.19(3) Personnel records. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review and staff interview, it was determined that the facility failed to follow resident consent for pneumococcal vaccination and failed to administer the vaccination in a timely manner for one of five residents (Resident R65). Findings include: Review of facility policy Standing Orders for Administering Pneumococcal Vaccine to Adults dated 10/13/25, indicated staff will identify adults in need of vaccination with pneumococcal polysaccharide vaccine (PPSV - a vaccine that protects against 23 types of streptococcus pneumoniae bacteria). Record the date the vaccine was administered, the manufacturer and lot number, the vaccine site and route, and the name and title of the person administering the vaccine. If the vaccine was not given, record the reason for non-receipt of the vaccine. Review of the admission record indicated that Resident R65 was admitted to the facility on [DATE]. Review of R65's Minimum Data Set (MDS- a periodic assessment of care needs) dated 11/6/25, included diagnoses of high blood pressure, diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life). Review of Resident R65's immunization record failed to include evidence the resident was offered and received the pneumococcal vaccination. Further review of Resident R65's clinical record indicated a Resident Pneumococcal Vaccine Consent/Declination Form dated 8/30/23, that documented consent to the administration of the pneumococcal vaccine. Interview on 12/4/25, at 11:00 a.m. the Director of Nursing confirmed the consent was obtained; however, the vaccination was never administered to Resident R65 as requested and consented to and that the facility failed to follow resident consent for pneumococcal vaccination and failed to administer the vaccination in a timely manner for one of five residents (Resident R65). 28 Pa. Code 211.5(f) Clinical records		

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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. Based on review of facility education 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 E15). Findings include: Review of NA Employee E15's personnel record indicated a hire date of 1/6/23. Review of NA Employee E15's education documents on 12/3/25, at 12:00 p.m. failed to include evidence of required communication training. Interview on 12/3/25, at 2:30 p.m. the Clinical Services Specialist Employee E5 confirmed that the facility failed to provide training on effective communication for one of five staff members (NA Employee E15). 28 Pa Code: 201.14 (a) Responsibility of licensee. 28 Pa Code: 201.18 (b)(1) Management. 28 Pa Code: 201.20 (a)(6)(d) Staff development.		

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations and staff interview, it was determined that the facility failed to post complete contact information for State Long-Term Care Ombudsman program and complete contact information for State Survey Agency at the facility as required. Findings include: During observations completed on 12/4/25, State Long-Term Care Ombudsman information posted in the front hallway did not include the Ombudsman's email as required. This observation also revealed that the State Survey Agency (SSA) information posted in the front hallway did not include the SSA's address and email as required. During an interview on 12/4/25, at 11:40 a.m. the Clinical Service Specialist Employee E5 confirmed that the facility failed to post complete contact information for State Long-Term Care Ombudsman program and completed contact information for State Survey Agency as required. 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(e) Management.		