

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/18/2025
NAME OF PROVIDER OR SUPPLIER  Quality Life Services - Apollo		STREET ADDRESS, CITY, STATE, ZIP CODE  151 Goodview Drive Apollo, PA 15613	

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)
<p>F 0575</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>46167</p> <p>Based on observations, resident interview, and staff interview it was determined that the facility failed to have complete contact information for State Long-Term Care Ombudsman program posted at the facility.</p> <p>Findings include:</p> <p>During an interview on 3/18/25, at 11:32 a.m. Resident R2 asked State Agency for email of the Ombudsman, as it was not listed on the Ombudsman poster in the hallway.</p> <p>During an observation in Buttercup Hallway there was a poster with Ombudsman contact information which only consisted of the phone number, and did not have name, address, or email address listed.</p> <p>During an observation and interview on 3/18/24, at 2:27 p.m. The Nursing Home Administrator confirmed that the facility failed post the Ombudsman's name, address, and email address as required.</p> <p>28 Pa. Code: 201.14(a)Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(b)(3) Management.</p>

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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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>46167</p> <p>Based on review of facility policy, observation, and staff interview it was determined that the facility failed to maintain the confidentiality of residents' medical information on one of four units (Geriatric Rehabilitation Unit Back Medication Cart).</p> <p>Findings include:</p> <p>Review of facility policy HIPAA/HITECH Administrative Policy dated 6/3/24, indicated the facility is to protect residents' privacy rights and their individually identifiable health information as required by the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, the Health Information Technology for Economic and Clinical Health Act (HITECH) and all Federal regulations and interpretive guidelines promulgated thereunder.</p> <p>During an observation on 3/18/25, at 2:05: p.m. the Geriatric Rehabilitation Unit Back Medication Cart beside the nurse's station, was left unattended with the computer screen open with identifiable information any passerby could see resident personal and confidential information.</p> <p>During an interview on 3/18/25, at 2:07 p.m. Licensed Practical Nurse Employee E1 confirmed the above observation.</p> <p>During an interview on 3/18/25, at 2:16 p.m. the Director of Nursing confirmed that the facility failed to maintain the confidentiality of residents' medical information as required.</p> <p>28 Pa. code: 211.5(b) Clinical records.</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46167</p> <p>Based on a review of facility policy, clinical records, and staff interview, it was determined that the facility failed to develop a baseline care plan for one of three residents (Resident R1).</p> <p>Findings include:</p> <p>Review of facility policy Care Plan and Interdisciplinary Care Conferences dated 6/3/24, indicated that an individualized, interdisciplinary care plan is initiated within 24 hours for each resident as part of the care delivery process.</p> <p>Review of Resident R1's clinical record revealed hospital documentation dated 11/6/24, that stated that tracheostomy is present.</p> <p>Review of Resident R1's clinical record revealed that resident was admitted to the facility on [DATE].</p> <p>Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/20/24, indicated diagnoses of cancer (uncontrolled growth and spread of abnormal cells), malnutrition (lack of nutrients to the body), and muscle weakness.</p> <p>Review of Resident R1's clinical record revealed a physician's order dated 11/15/25, to provide supplemental oxygen as needed via trach (tracheostomy- a procedure to help air and oxygen reach the lungs by creating an opening into the windpipe from outside the neck ) mask at 40% at 5 liters per minute.</p> <p>Review of Resident R1's medical record failed to reveal that a baseline care plan was developed for tracheostomy care.</p> <p>During an interview on 3/18/25, at 2:16 p.m. the Director of Nursing confirmed that the facility failed to develop a baseline care plan for tracheostomy care within 24 hours as required for Resident R1</p> <p>28 Pa. Code: 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46167</p> <p>Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to obtain an order for a resident with a tracheostomy (a procedure to help air and oxygen each the lungs by creating an opening into the windpipe from outside the neck), to ensure proper tracheostomy care for one of three residents (Resident R1).</p> <p>Findings include:</p> <p>Review of facility policy Tracheostomy Care dated 6/3/24, indicated that tracheostomy care is performed a minimum of one time per shift.</p> <p>Review of Resident R1's clinical record revealed hospital documentation dated 11/6/24, that stated that tracheostomy is present.</p> <p>Review of Resident R1's clinical record revealed that resident was admitted to the facility on [DATE].</p> <p>Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 11/20/24, indicated diagnoses of cancer (uncontrolled growth and spread of abnormal cells), malnutrition (lack of nutrients to the body), and muscle weakness.</p> <p>Review of Resident R1's clinical record revealed a physician's order dated 11/15/25, to provide supplemental oxygen as needed via trach (tracheostomy) mask at 40% at 5 liters per minute.</p> <p>Review of Resident R1's clinical record revealed a Nursing Review assessment dated [DATE], which included a section entitled Current Medical Conditions and Treatments that stated Resident is receiving one or more of the following treatments: Tracheostomy Care was listed on the checklist; however it was not marked, which indicated that resident did not receive tracheostomy care.</p> <p>Review of Resident R1's clinical record revealed a nursing progress note dated 11/19/24, that stated the following: Bedside nurse observed daughter assisting resident suctioning. Daughter was putting saline down trach stoma (a surgical opening in the body), and resident was coughing up .Resident's daughter used tweezers to remove a dry secretion from the stoma site. When nurse confronted daughter and resident, the daughter stated that sometimes she uses long q tips to remove secretions he cannot cough up. Nurse instructed resident and daughter that the procedure they are describing for suctioning is not safe and could very well be harmful. Call placed to doctor to inform of resident and daughter suctioning and the tools they were using to do so. Regular full trach care has been ordered for this resident and resident and daughter communicated understanding that care should only be provided by nursing staff for resident's safety.</p> <p>Review of Resident R1's physician's orders did not reveal an order for trach care or suctioning prior to 11/19/25.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/18/25, at 2:16 p.m. the Director of Nursing confirmed that the facility failed to obtain a physician order for tracheostomy care and suctioning upon admission, therefore failed to complete tracheostomy care and suctioning as required.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 211.10(c) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.</p>		