STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395371	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Apollo	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, facility policy, clinical record review, and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision that resulted in an elopement (resident exits to an unsupervised or unauthorized area without the facility's knowledge) for one of four residents (Resident R1).Findings include: Review of facility policy Elopement Prevention dated 4/17/25, indicated the facility properly assesses residents and plan their care to prevent accidents related to wandering behavior or elopement. Should the resident's behavior warrant elopement prevention measures, a comprehensive elopement prevention plan will be documented as part of the care plan. Staff observations will be noted during the resident's stay and modifications will be made to the care plan and prevention techniques. Review of the Resident Assessment Instrument 3.0 User's Manual, effective October 2024, 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 intact8-12: moderately impaired0-7: severe impairment 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 9/3/25, indicated diagnoses of high blood pressure, dementia, and age-related cognitive decline. Question C0500 BIMS Summary Score indicated the resident scored a 4, severe impairment. Question 0200E Alarms indicated the resident used a wander/elopement alarm daily. Review of Resident R1's care plan dated 12/20/24, indicated resident is an elopement risk/wanderer as evidenced by impaired safety awareness. Interventions include resident is wearing a wanderguard, identify any patterns of wandering that resident exhibits, and provide resident with structured activities. Review of a physician order dated 5/12/25, indicated wanderguard (a wearable electronic monitoring device) on at all times. Check placement and skin integrity each shift. Change every 90 days. Review of facility submitted documents dated 8/19/25, indicated the following: At approximately 0925, Infection Preventionist Employee E1 and Assistant Director of Nursing (ADON) Employee E2 were notified by Hospice Nurse Aide (NA) Employee E3, that Resident R1 had walked into the personal care dining room. Hospice NA Employee E3 brought Resident R1 back into the SNF (Skilled Nursing Facility) building with the assistance of two other CNAs (Certified Nurse Aides). Resident R1 was assessed by an RN (Registered Nurse) and did not have any injuries or signs of distress. A head count was performed on the whole building, and all residents were accounted for. All exit doors were checked and were all found to be locked. The investigation was then initiated. Camera footage was reviewed that showed Resident R1 exiting a door on the side of the SNF building facing the personal care building @ 0919. Resident R1 was seen walking through the parking lot and attempting to open the door of a car parked in the parking lot. She then walked along the sidewalk and into the personal care building where Hospice NA Employee E3 had observed her enter the PCH (Personal Care Home) @ 0923. Upon further investigation, Resident R1 had walked through a break room door in the dining room. The door was not locked because the latch had been blocked by a paper towel. She then walked through the breakroom into the wheelchair supply room and out the exit door. Resident R1 was last seen walking towards the dining room at approximately 0910 by two nurses on the unit. Resident R1 was previously identified as being a high elopement/wandering risk and had a wander guard in place that was functioning appropriately. There were no wander guard sensors on the break room door as it had lock in place. When Resident R1 was brought back into the SNF building, her wander guard sounded and was functioning appropriately. The paper towel was immediately removed from the break room door and was verified to latch after determining elopement route. Maintenance was notified and applied a pin code lock onto the door. Review of facility documentation witness statements indicated the following: NA Employee E4 stated, I had just come back from a 15 minute break (9:22 a.m.) and was heading back towards room [ROOM NUMBER] when an employee from personal care alerted that Resident R1 had gotten out and was in personal care. NA Employee E5 and I immediately went over to get her. Her bracelet was on and working properly when we entered the smokers door. NA Employee E5 stated, Resident R1 got out from kitchen I believe, ended up on personal care side. Hospice lady came and got NA Employee E4 and I to bring her back over. Hospice NA Employee E3 stated, Around 9:30 a.m. on August 19, I was in the dining room of the personal care building. I looked down the hallway and saw Resident R1 walking down the hallway. I asked personal care staff to keep an eye on her and I went to the skilled building to notify staff. NA Employee E5 and NA Employee E4