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	11/13/2025

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 - Immediate jeopardy to resident health or safety 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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**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 the facility failed to provide adequate supervision for two residents resulting in elopement (resident exits to an unsupervised and unauthorized location without staff's knowledge). This failure created an immediate jeopardy situation for two of 33 residents (Residents R1 and R2) identified as having a high risk for wandering.Findings include: Review of facility policy Elopement Prevention dated 4/17/25, revealed 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. Admitting nurses or other staff members noting elopement risk and wandering behaviors must notify the nursing Unit Manager/Designee or the ADON (Assistant Director of Nursing). 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. If signaling device is indicated, obtain a physician's order for use of the signaling device and document the reason for application of the device in the resident's clinical record. Once the plan of care is determined, the nursing unit manager will notify the staff of the elopement risk and the interventions to be implemented. Photographs of the resident are provided to the receptionist. The receptionist will maintain the list of all residents at risk for elopement, including the resident's name, room number. This list will be distributed to the management team of the care community. Appropriate communication should occur with staff members who may be in contact with those residents. Review of Resident R1's clinical record revealed Resident R1 was admitted to the facility on [DATE], with active diagnoses of Metabolic Encephalopathy (alteration in consciousness caused by a chemical imbalance affecting the brain), altered mental status, Dementia (group of symptoms that affects memory, thinking and interferes with daily life), and Alzheimer's Disease (progressive disease that destroys memory and other important mental functions).Review of Resident R1's progress note dated 10/1/25, at 11:52 p.m. revealed, New admission this evening, resident noted to be wandering building with [his/her] cane, continuously going in and out of other resident's rooms, yelling up hallway at staff to help [his/her] roommate who was sick, staff doing what they could until MD (physician) contacted back, [he/she] would call dtr (daughter) and walk around with her on speaker phone, was telling [his/her] dtr that roommate was sick and no one was there to help, they weren't doing anything, so [he/she] would wander around and tell [his/her] dtr different things about not just [his/her] roommate but other residents as well. Trying to help [his/her] roommate as well, staff had to redirect [his/her] not to do so, told [resident] [he/she] could hurt [himself/herself] or accidentally hurt [his/her] roommate, to please allow staff to handle [his/her] roommate's condition. Review of Resident R1's clinical record revealed an admission Wandering/Elopement Risk Evaluation completed on 10/1/25, which consisted of the following questions and documented answers:1. Does the resident have a known history of wandering?Yes2. Behavior/Mood - Select the following, all that apply to resident Loss of self-controlExperiencing feelings of anger/fear of abandonment2a. Resident is exhibiting one or more of the behaviors/moods listed under 2 that could potentially contribute to their risk for wandering.3. Select from the following, all the changes that apply to the resident Change of roommateadmission within the last monthCaregiver or staff change3a. At least one or more of the circumstances under 3 are contributing to the resident's risk for wandering.4. Walk in room: self-performance Independent5. Does the resident use a device for ambulating?No.6. Select any of the following diagnosis that apply to the resident Other Dementia7. Which of the following medications is the resident taking?None of the above8. The following interventions are recommendedRe-evaluation if there is a change in their condition or circumstances Wandering Risk Evaluation Score: 23 - High Risk Review of Resident R1's behavior note, dated 10/3/25 at 2:57 p.m. revealed, Resident seemed to have increased agitation as well as increased anxiety. Seemingly lost, stating, 'I've lost my mind!' Resident was noted to be easily redirected and reassured by staff. Will continue to monitor. Review of Resident R1's progress note, dated 10/3/25, at 5:56 p.m. revealed, RN sup (Registered Nurse Supervisor) notified that patient was located sitting out side. patient was assisted back into the facility. RN sup completed a head to toe assessment. Vss (vital signs stable). Blood pressure 138/70, pulse 68, respirations 18, temp 97.9, oxygen saturation 98% room air, no s/s (signs or symptoms) of distress. No injuries noted at this time. Wander guard (wearable

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of job descriptions, clinical records and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) failed to effectively manage the facility to prevent the elopement of two resident (Residents R1 and R2), which created an immediate jeopardy situation for two of 33 residents.Findings include: The job description for the NHA specified the purpose of the position is to direct the day-to-day operations of the facility in accordance with current federal, state, and local standards governing long-term care facilities and to ensure that the highest degree of resident care and services are delivered and maintained. The job description for the DON specified the purpose of the position is to provide nursing management, set resident care standards for all direct care providers and provide completer supervision and management for the nursing department. Based on findings identified in this report, the facility failed to prevent the elopement of two residents (Residents R1 and R2), which placed the residents in Immediate Jeopardy. The NHA and the DON failed to fulfill their essential job duties to ensure the federal and state guidelines and regulations were followed. During an interview on 11/12/25, at 2:34 p.m. the NHA and DON were notified that they failed to effectively manage the facility to prevent the elopement of a resident, which created an immediate jeopardy situation for two of 33 residents. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1)(3)(e)(1) Management.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interview, it was determined that the facility failed to make certain that medical records on each resident are complete and accurately documented for one of four residents (Closed Resident Record CR1).A review of the clinical record indicated that Closed Resident Record CR1 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of kidney, major depressive disorder and hypertension (pressure in your blood vessels are too high). A review of the Minimum Data Set (MDS-periodic assessment of resident care needs) dated 7/30/25, indicated the diagnoses remained current.A review of Closed Resident Record CR1 nurse progress notes 9/30/25 indicating resident ceased to breath (CTB) on 9/26/25 at 1915.A review of Closed Resident Record CR1 nurse progress notes did not include documentation on 9/26/25. During an interview on 11/12/25, at 12:04 p.m. the Director of Nursing confirmed the facility failed to make certain that medical records on accurately documented for Closed Resident Record CR1 and each resident's records are complete as required. 28 Pa. Code: 211. 5(f)(g)(h) Clinical records.