| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395371 | A. Building<br>B. Wing | 06/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Quality Life Services - Apollo | 151 Goodview Drive<br>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 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 one of two residents sampled with facility-initiated transfers (Resident R1).Findings include: Review of facility Transfer of Resident to Another Care Community policy dated 4/16/26, indicated the purpose is to promote continuity of care during transfer. Review of Resident R1's admission record indicated resident was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS- periodic assessment of resident care needs) dated 5/21/26, indicated diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), high blood pressure, and fracture (a broken or cracked bone). Review of the clinical record indicated Resident R1 was transferred to the hospital on 5/14/26, and returned to facility on 5/21/26. Review of Resident R1'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 6/10/26, at 12:14 p.m. Registered Nurse Employee E2 stated, We usually document all the paperwork we send. For example, face sheet, medication list, vital signs, etc and confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for Resident R1. 28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights. |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, incident reports, hospital records, facility provided documents, resident interview, and staff interviews, it was determined that the facility failed to ensure that a resident was free from a preventable accident during a transfer in the facilities vehicle van, which resulted in actual physical harm (an abrasion to crown of head, abrasion to right knee, abrasion to left ankle, and three acute cervical (neck) fractures of C3, C4, and C5) for one of two residents (Resident R1).Findings include: Review of the facility Accidents and Incidents policy dated 4/16/26, indicated the facility will promote a safe environment for all residents. An accident/Incident is any happening, which is not consistent with routine operations or the routine care of the resident. Review of Resident R1's admission record indicated resident was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS- periodic assessment of resident care needs) dated 5/21/26, indicated diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), high blood pressure, and fractures (a broken or cracked bone). Review of documentation provided by the facility dated 5/14/26, stated the following: Resident was transported to neurology appointment 5/14/26, at 1:15 p.m. via facilities wheelchair van. CNA (certified nurse assistant) transporter and resident successfully made it to the appointment without incident. Once appointment was completed and resident was being transported back to facility, incident occurred when accelerating from a stoplight. Resident remained seated in wheelchair; however, the wheelchair had tipped backwards within van. CNA recognized issue immediately and pulled to the side of the road in a safe location. She exited the vehicle and opened the rear hatch to access the resident. She was able to successfully with the assistance of passerby lift the wheelchair and resident to an upright position. CNA reports no overt signs of substantial injury directly following incident. CNA then resecured resident with equipment after verifying the equipment was without fault. Resident and CNA report being approximately eight minutes from facility when transport was resumed following incident. At this point CNA reports resident complained of discomfort to neck and sternal area. When reentering facility at approximately 4:45 p.m. CNA immediately notified Licensed Practical Nurse assigned and Registered Nurse (RN) supervisor. Resident was assessed, observations noted include abrasion on crown of head, R knee and L ankle. RN contacted Certified Registered Nurse Practitioner (CRNP) to notify of incident. CRNP provided order to send out to hospital for further evaluation. Resident transferred to acute hospital. Description of Follow-up Action: DON (Director of Nursing) and NHA (Nursing Home Administrator) on 5/15/26, initiated investigation and internal plan of correction. Investigation included interview with CNA and obtaining of statement, inventorying and testing of securement equipment present in wheelchair van, CNA assisted re-enactment of securement and incident, visit to resident at acute hospital to obtain interview documentation, and development of education to be provided to all individuals who are permissible drivers. *UPDATE* Imaging at hospital resulted in C3-C5 fracture. *UPDATE* It is inconclusive what the root cause may have been. Transportation CNA during re-enactment displayed the correct procedure and use of securement system prior to re-education. The equipment was present and determined to function as intended during investigation. The wheelchair tipped backwards during acceleration from a stoplight. *UPDATE* All permissible drivers have received education regarding wheelchair securement system. *UPDATE* CNA displayed appropriate use of securement systems during re-enactment. CNA when questioned states she applied the securement in the same manor when transporting resident. Equipment during inspection found to be operating as intended. It is unclear how the wheelchair tipped, whether the CNA had inappropriately applied the system at that time or if the equipment faulted. Review of Physician orders dated 4/9/26, indicated Resident R1 had an appointment with a specialist on 5/14/26, at 2:00 p.m. Review of Resident R1's care plan dated 5/22/26, indicated<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | resident has an alteration in musculoskeletal status related to fractured neck. Review of a written statement dated 5/15/26, from Nurse Aide (NA) Employee E1 stated, I had resident strapped in van with all four straps. Was at a red light when I went to pull out the van jerked a little and the chair started to move back and tipped over. Resident was against the back. Four people stopped and helped me to put him back in chair (tip chair back up). I strapped him back in and brought him back. Review of an interview conducted by Director of Nursing (DON) dated 5/15/26, with Resident R1 stated, We were driving and she stopped. When she pulled up, I went back. I was laying on my back, the chair went with me. I hit my head on the left side against the door. Then my neck and chest hurt, but they got me up pretty quick. It only took about eight minutes to get back home. She (Registered Nurse Supervisor) sent me to the hospital about 45 minutes after we got back. During a review of Resident R1's progress notes revealed the following: 5/14/26 - Resident left for apt at 1:15 p.m. with wheelchair van with escort. 5/14/26 - Was reported to this nurse by NA Employee E1that she had resident in van for an appointment. States wheelchair was secured but at a stop light the chair tipped backwards and resident hit head on van door. Upon assessment, resident states he hit his head and his neck and chest hurt. Resident has an abrasion on crown of head, right knee, and left ankle. Resident states his feet flew up in the air. Spoke with CRNP and ordered Resident R1 to be sent to emergency room for evaluation of neck. 5/15/26 - Resident admitted to hospital with acute displaced fractures of C3, C4, and C5, osteomyelitis of right toe wound, white count elevated, and elevated lactic acid. During a review of Resident R1's progress notes dated 5/21/26, indicated resident returned to facility with new orders including a cervical collar (a collar that surrounds and stabilizes neck) on at all times and a follow up appointment. During a review of Resident R1's hospital records on 6/10/26, at 12:15 p.m. indicated on 5/14/26, Resident R1 had a CT scan (an advanced medical imaging procedure that combines a series of X-ray images taken from multiple angles) completed at the hospital that indicated acute displaced fractures of C3, C4, and C5. During a review of facility provided documentation labeled, May 2026 Approved Drivers List, indicated 13 approved drivers were on the list. During an interview on 6/10/26, at 12:21 p.m. Maintenance Director Employee E3 stated, A couple weeks ago we all got educated after the incident. I was not involved in any education and did not educate anyone on the safety mechanisms in the van, and failed to provide any documentation that the safety mechanisms were evaluated on a regular basis to ensure they were in working order. During an interview on 6/10/26, at 1:24 p.m. NA Employee E1 stated, I was on the approved list of drivers but now I'm not. I did not have any education or training by the facility on how to safely lock a resident into the van. I didn't have any training at all. I had to figure out how to strap a resident in the van myself. During an interview on 6/10/26, at 12:01 p.m. Resident R1 stated, I was in our van, stopped at a light. When we pulled out, all hell broke loose. I don't know what happened. The wheelchair went sideways and I flew back and hit my head on the back. I said I think I'm alright, but I guess I wasn't. People came to help, got me back into wheelchair, came back here and then sent me to hospital. I wear collar all the time. I feel like I've been rode hard and put away wet. Pain in my chest is about gone. They had seat belts on, that's what I can't figure out. Nobody can figure it out. Something malfunctioned and the driver doesn't know. They need to look into before it happens again. During an interview on 6/10/26, at 1:24 p.m. NA Employee E1 stated, I put him in, I did all the straps and the seat belt. It was a high-back wheelchair. When the light turned green, the van jerked and then I heard the straps pulling and the chair went backwards. The resident yelled. The seat belt was across the resident. I locked him in with four straps. He had leg rests on the wheelchair. You strap the wheelchair in the front of wheelchair at the bottom like where the leg rests go on and the back gets hooked to around same area. I heard the straps pulling and resident fell backwards. I got out of van and opened the back. By standards stopped and we tilt the chair back up to where it's to be. I redid everything and checked everything. I made sure he wasn't going to move. During an interview on 6/10/26, at 2:26 p.m. the Nursing Home Administrator (NHA) confirmed that no one was educated, trained, and no competencies were completed on the proper techniques of safely securing a resident<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | into the van prior to Resident R1's incident. NHA stated, All I can think of is that NA Employee E1 may have secured a tie down on a leg rest instead of the wheelchair frame. During an interview on 6/10/26, at 3:30 p.m. NHA confirmed that the facility van has not been serviced after the incident to ensure the safety mechanisms work appropriately and that the van will be placed out of service until a company can service the van. During an interview on 6/10/26, at 3:45 p.m. the Nursing Home Administrator and Director of Nursing confirmed that the facility failed to ensure that a resident was free from a preventable accident during a transfer in the facilities vehicle van, which resulted in actual physical harm (an abrasion to crown of head, abrasion to right knee, abrasion to left ankle, and three acute cervical (neck) fractures of C3, C4, and C5) for one of two residents (Resident R1). 28 Pa Code 201.14(a) Responsibility of licensee. 28 Pa Code 201.18(b)(1)(e)(1) Management. 28 Pa Code 201.29(a) Resident rights. 28 Pa Code 211.12(d)(1)(3)(5) Nursing services. |