STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395534	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Sarver	126 Iron Bridge Road Sarver, PA 16055

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to ensure that residents were free from significant medication errors for three of five residents (Resident R4, R5, and R9).Findings include: Review of facility policy Medication Administration dated 8/12/25, indicated that medications will be administered in accordance with written orders of licensed physicians, manufacturer's specifications, and professional standards of practice. A medication error occurs when a resident receives a medication at an incorrect time, does not receive a medication which was ordered. A locked Emergency Medication Kit is maintained by Quality Pharmacy and is kept in a designated medication room in the facility. Review of the clinical record indicated Resident R4's was admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS - mandated assessment of a resident's abilities and care needs) dated 1/5/26, included diagnoses of anxiety, depression, and diabetes (a condition that causes blood sugar to rise). Review of a physician's order dated 12/3/25, indicated for Resident R4 to receive Insulin Lispro Subcutaneous Solution Pen-Injector 100 unit/milliliter (ml), inject subcutaneously before meals and bedtime for diabetes.as per sliding scale:If less than 70, initiate hypoglycemia protocol,70-140 = 0 units141-180 = 1 units181-220 = 2 units221-260 = 3 units261-300 = 4 units301-340 = 5 units341-600 = 6 unitsGreater than 340, initiate hyperglycemic protocol, call physician. Review of Resident R4's progress note dated 1/13/26, at 1:27 a.m. revealed the resident did not receive Insulin Lispro before bedtime because unable to log into computer- too close to next dose to administer. Review of the clinical record indicated Resident R5's was admitted to the facility on [DATE]. Review of Resident R5's Minimum Data Set (MDS - mandated assessment of a resident's abilities and care needs) dated 1/5/26, included diagnoses of anxiety, depression, and diabetes (a condition that causes blood sugar to rise). Review of a physician's order dated 11/4/25, indicated for Resident R5 to receive Insulin Lispro (1 Unit Dial) Subcutaneous Solution Pen-Injector 100 unit/milliliter (ml), inject subcutaneously before meals and bedtime for diabetes as per sliding scale:If 0-140 = 0 units141-180 = 2 units181-220 = 4 units221-260 = 6 units261-300 = 8 units301-350 = 10 units351-400 = 12 units401-999 = 14 units and call physician Review of Resident R5's progress note dated 1/13/26, at 1:20 a.m. revealed the resident did not receive Insulin Lispro before bedtime because patient sleeping. Review of the clinical record indicated Resident R9's was admitted to the facility on [DATE]. Review of Resident R9's Minimum Data Set (MDS - mandated assessment of a resident's abilities and care needs) dated 12/20/25, included diagnoses of heart failure, high blood pressure, and atrial fibrillation (irregular heartbeat). Review of a physician's order dated 12/14/25, indicated for Resident R9 to receive 6.25 milligram (mg) Carvedilol by mouth two times a day for ventricular tachycardia (irregular heartbeat). Review of Resident R9's January 2026 Medication Administration Record (MAR) revealed Registered Nurse, Employee E1 documented see nurses note on 1/12/26, at 8:00 p.m. Review of Resident R9's progress note dated 1/13/26, at 2:11 a.m. revealed the resident's medication was (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not available in cart, needs reordered. A review of RN, Employee E1's witness state dated 1/13/26, stated During the scheduled evening medication administration, multiple medications listed as active were not available in the medication cart. At the time of administration, I was not informed that a supplemental emergency medication box was available for use within the facility. RN, Employee E1 stated The eMAR system settings for the evening medication pass did not display all medications that were due during the assigned administration timeframe. Following completion of initial medication pass, a subsequent review if the eMAR identified multiple medications that had not populated during the scheduled pass. This discrepancy was identified at approximately 1:00 a.m. During an interview on 2/23/26, at 9:51 a.m. LPN, Employee E2 stated medications must be administered an hour before or after the scheduled time it is ordered. LPN, Employee E2 stated if residents are sleeping, they must be awakened to take medications. On 2/23/26, at 11:33 a.m. RN, Employee E1 was unavailable for a phone interview. During an interview on 2/24/26, at approximately 2:00 p.m. information was disseminated to the Nursing Home Administrator and Director of Nursing that the facility failed to ensure that residents were free from significant medication errors for three of five residents (R4, R5, and R9.) 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.