

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395534	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Quality Life Services - Sarver		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984</p> <p>Based on review of facility policy, clinical record review and staff interview, it was determined that the facility failed to notify a physician of abnormal glucose levels as per physician's order for two out of five residents (Residents R20 and R33).</p> <p>Findings include:</p> <p>Review of the facility policy Physician Notification dated 12/1/23, indicated upon identification of a resident who has clinical changes, change in condition, or abnormal lab values, a licensed nurse will perform appropriate clinical observations and data collection and report to physician as indicated.</p> <p>Review of the facility policy Hypoglycemia Protocol dated 12/1/23, indicated for hypoglycemia (a blood glucose less than or equal to 70 mg/dl (milligrams/deciliter), and hyperglycemia a more common side effect, should recheck the blood sugar and notify the physician.</p> <p>Review of Resident R33's admission record indicated an admitted [DATE], with diagnoses of renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), heart failure (heart doesn't pump blood as well as it should), high blood pressure, and diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>Review of R33's Minimum Data Set (MDS- a periodic assessment of care needs) dated 9/5/24, indicated the diagnoses remain current.</p> <p>Review of Resident R33's current physician orders on 9/26/24, indicated Glucagon (medication to raise blood sugar) Emergency Kit, inject 1 mg subcutaneously as needed for hypoglycemia diabetes. Call physician.</p> <p>Review of Resident R33's progress notes dated 8/26/24, at 2:45 a.m. resident complained of not feeling well to Nurse Aide (NA). Resident was diaphoretic (sweating heavily), slurring his words. Upon assessment blood sugar was at 48 mg/dl. A cup of orange juice and carbohydrate snack were provided. Registered Nurse (RN) made aware.</p> <p>Further review of Resident R33's clinical record, failed to include notification to the physician of the abnormal blood glucose as required.</p> <p>(continued on next page)</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R20's admission record indicated she was originally admitted on [DATE], with diagnoses that included diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), chronic respiratory failure, and anemia.</p> <p>Review of Resident R20's MDS assessment dated [DATE], indicated that the diagnoses were current upon review.</p> <p>Review of Resident R20's physician order's dated 8/15/24, indicated to inject Humulin R Injection Solution 100 UNIT/ML(Insulin Regular(Human)). Inject as per sliding scale:</p> <p>70 - 150 = 0 Glucose < 70 follow hypoglycemia protocol;</p> <p>151 - 200 = 4</p> <p>201- 250 = 8</p> <p>251 - 300 = 12</p> <p>301 - 350 = 16</p> <p>351 - 400 =20 >400, give 24u and call provider if >400</p> <p>Review of Resident R20's blood glucose monitoring documentation for September 2024, indicated the following abnormal glucose levels:</p> <p>9/2 471</p> <p>9/15 419</p> <p>9/16 452</p> <p>9/17 416</p> <p>9/21 429</p> <p>9/24 482</p> <p>Review of Resident R20's clinical nurse notes, physician notes, and Certified Registered Nurse Practitioner (CRNP) documentation did not include a notification to the physician about the abnormal glucose levels on 9/2/24, 9/15/24, 9/16/24, 9/17/24, 9/21/24 and 9/24/24.</p> <p>During an interview on 9/26/24, at 1:00 p.m. Clinical Consultant Employee E2 confirmed the facility failed to notify the physician of abnormal glucose level as required for Resident R20.</p> <p>During an interview on 9/27/24, at 12:55 p.m. Clinical Consultant Employee E2 confirmed that the facility failed to notify a physician of abnormal glucose levels for as per physician's order for two out of five residents (Residents R20 and R33).</p> <p>(continued on next page)</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing Services.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of facility policy, clinical record review, facility provided documents, and staff interview, it was determined that the facility failed to thoroughly investigate a potential allegation of abuse/neglect for misappropriation of property for one of two residents reviewed (Resident R37).</p> <p>Findings include:</p> <p>Review of facility policy Resident Protection From Abuse, Neglect, Mistreatment or Exploitation dated 12/1/23, indicated misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. Abuse, neglect, misappropriation of property and exploitation will be identified through various methods including reports from employed or contracted staff. All reports of abuse, neglect, exploitation, mistreatment, and misappropriation of resident property will be investigated and documented. All investigations will be conducted thoroughly and will attempt to gather as much factual information as possible.</p> <p>Review of facility policy Management of Controlled Drugs dated 12/1/23, indicated to destroy the drug with another licensed staff member as witness. Staff member designated as witness to the destruction must actually witness the waste. Document the reason for the destruction on the controlled drug inventory in the space for that dose. Signature of person who poured and destroyed the drug and signature of witness must be entered in the space with the documentation of the destruction. Perform a complete count of all controlled drugs at the change of shifts or at any time in which narcotic keys are surrendered from one staff member to another. Count must be performed by two licensed nurses per state regulations. Both licensed nurses participating in the count must sign the individual inventory at the time of the count. If discrepancy is noted during the count, notify nursing supervisor immediately to initiate investigation.</p> <p>Review of the clinical record indicated Resident R37 was admitted to the facility on [DATE].</p> <p>Review of Resident R37's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/27/24, indicated diagnoses of high blood pressure, muscle wasting, and unsteadiness on feet.</p> <p>Review of a physician's order dated 8/10/23, indicated to administer Morphine Sulfate (a controlled pain medication) 10 milligrams sublingually (under the tongue) every two hours as needed for moderate pain or shortness of breath.</p> <p>Review of an event submitted by the facility dated 1/30/24, stated, During shift change this morning while off going and oncoming nurses were doing narcotic count, the oncoming nurse noted the color of the Morphine for Resident R37, that the color was not blue but a charcoal color. The oncoming nurse states when she counted the same cart on 1/26/24 that the Morphine was blue. Nurse alerted supervisor immediately.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Controlled Drug Record for Resident R37's Morphine Sulfate revealed the amount was adjusted from 20 milliliters (mL) to 18 mL with a documented reason of spillage/dehydration. No date, time, or witness signature were documented for this entry.</p> <p>Review of an additional entry to the Controlled Drug Record for Resident R37's Morphine Sulfate revealed the amount was adjusted from 18 mL to 16 mL with a documented reason of spillage/dehydration. No date or time were documented for this entry.</p> <p>Review of a written witness statement dated 1/31/24, completed by Licensed Practical Nurse (LPN) Employee E6 stated, On the days I have been scheduled on Pennsylvania [nursing unit] I have not had the narcotic keys and have not participated in count. I was on other halls when count was performed, so I did not notice any discrepancies. There have been times nurses don't want to do count at the end and say it's ok, and they next take the keys.</p> <p>Review of a written witness statement dated 1/31/24, completed by LPN E4 stated, On Sunday January 28, Registered Nurse (RN) Employee E10 had the Liberty [nursing unit] narc keys, and when she was being sent home at 11:00 p.m. she gave me the keys. She did not want to count the narcs. I went over to Liberty cart and counted them myself.</p> <p>During an interview on 9/27/24, at 9:50 a.m. when asked if additional statements were obtained regarding accusations that nursing staff refuses to perform end-of-shift narcotic count, the Nursing Home Administrator stated, I'm not sure, but I bet it was investigated because my Director of Nursing at the time was pretty good about that stuff.</p> <p>The facility failed to provide additional documentation to indicate the accusations that nursing staff refuse to perform end-of-shift narcotic count was thoroughly investigated.</p> <p>During an interview on 9/27/24, at 12:55 p.m. Clinical Consultant Employee E2 stated, We provided education to the nursing staff in March that end-of-shift narcotic count is a requirement.</p> <p>During an interview on 9/27/24, at 12:55 p.m. the NHA confirmed that the facility failed to thoroughly investigate a potential allegation of abuse/neglect for misappropriation of property as required.</p> <p>28 Pa. Code: 201.14 (a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.14 (c)(e) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18 (e)(1) Management.</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>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 three of seven residents sampled with facility-initiated transfers (Residents R28, R34, and R40).</p> <p>Review of facility policy Medical Emergency dated 12/1/23, indicated if transfer is required, complete transfer form and send appropriate documentation with the resident.</p> <p>Findings include:</p> <p>Review of the clinical record indicated Resident R28 was admitted to the facility on [DATE].</p> <p>Review of Resident R28's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/25/24, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and pain in left hip.</p> <p>Review of the clinical record indicated Resident R28 was transferred to hospital on 12/12/23 and returned to the facility on [DATE].</p> <p>Review of Resident R28'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.</p> <p>Review of the clinical record indicated Resident R34 was admitted to the facility on [DATE].</p> <p>Review of Resident R34's MDS dated [DATE], indicated diagnoses of anemia (too little iron in the blood), respiratory failure (a condition where the lungs cannot get enough oxygen into the blood), and depression (a constant feeling of sadness and loss of interests).</p> <p>Review of the clinical record indicated Resident R34 was transferred to the hospital on 2/9/24, and returned to the facility on [DATE].</p> <p>Review of Resident R34'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.</p> <p>Review of the clinical record indicated Resident R40 was admitted to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R40's MDS dated [DATE], indicated diagnoses of high blood pressure, asthma (a condition where the airways narrow and swell), and muscle weakness.</p> <p>Review of the clinical record indicated Resident R40 was transferred to the hospital on 6/27/24, and returned to the facility on [DATE].</p> <p>Review of Resident R40'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.</p> <p>During an interview on 9/26/24, at 10:07 a.m. the Nursing Home Administrator confirmed that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for three of seven residents sampled with facility-initiated transfers as required.</p> <p>28 Pa. Code 201.29 (a)(c)(3)(2) Resident rights.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for five of five residents (Residents R20, R28, R34, R40, and R67).</p> <p>Findings include:</p> <p>Review of the clinical record indicated Resident R28 was admitted to the facility on [DATE].</p> <p>Review of Resident R28's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 6/25/24, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and pain in left hip.</p> <p>Review of the clinical record indicated Resident R28 was transferred to hospital on 12/12/23 and returned to the facility on [DATE].</p> <p>Review of Resident R28's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE].</p> <p>Review of the clinical record indicated Resident R34 was admitted to the facility on [DATE].</p> <p>Review of Resident R34's MDS dated [DATE], indicated diagnoses of anemia (too little iron in the blood), respiratory failure (a condition where the lungs cannot get enough oxygen into the blood), and depression (a constant feeling of sadness and loss of interests).</p> <p>Review of the clinical record indicated Resident R34 was transferred to the hospital on 2/9/24, and returned to the facility on [DATE].</p> <p>Review of Resident R34's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE].</p> <p>Review of the clinical record indicated Resident R40 was admitted to the facility on [DATE].</p> <p>Review of Resident R40's MDS dated [DATE], indicated diagnoses of high blood pressure, asthma (a condition where the airways narrow and swell), and muscle weakness.</p> <p>Review of the clinical record indicated Resident R40 was transferred to the hospital on 6/27/24, and returned to the facility on [DATE].</p> <p>Review of Resident R40's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE].</p> <p>(continued on next page)</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R67's admission record indicated she was originally admitted on [DATE], with diagnoses that included encephalopathy (change in how your brain function), chronic kidney disease and acute respiratory failure with hypoxia (lungs have trouble exchanging oxygen and carbon dioxide with the blood).</p> <p>Review of Resident R67's 5-day MDS dated [DATE], indicated that the diagnoses were current upon review.</p> <p>Review of the clinical record indicated Resident R67 was transferred to the hospital on 7/7/24 and did not return.</p> <p>Review of Resident R67's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE].</p> <p>Review of Resident R20's admission record indicated she was originally admitted on [DATE], with diagnoses that included diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), chronic respiratory failure and anemia.</p> <p>Review of Resident R20's entry MDS dated [DATE], indicated that the diagnoses were current upon review.</p> <p>Review of the clinical record indicated Resident R20 was transferred to the hospital on 8/21/24, and returned to the facility on [DATE] and 9/8/24 and returned to the facility 9/13/24.</p> <p>Review of Resident R20's clinical record indicated the facility failed to include documented evidence that the facility provided a written transportation notification to the Office of Long-Term Care Ombudsman for the hospitalization on [DATE] and 9/8/24.</p> <p>During an interview on 9/26/24, at 10:07 a.m. the Nursing Home Administrator (NHA) stated, I notify the local Ombudsman, not the state Ombudsman.</p> <p>During an interview on 9/26/24, at 10:07 a.m. the NHA confirmed that the facility failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for five of five residents as required.</p> <p>28 Pa. Code 201.29 (a)(c)(3)(2) Resident rights.</p>

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of facility policy, clinical record review, and staff interviews, it was determined that the facility failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for five of five resident hospital transfers (Residents R20, R28, R34, R40, and R67).</p> <p>Review of facility policy Bed Holds dated 12/1/23, indicated upon transfer out, nursing will provide a copy of the Notice to the resident.</p> <p>Review of the clinical record indicated Resident R28 was admitted to the facility on [DATE].</p> <p>Review of Resident R28's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 6/25/24, indicated diagnoses of high blood pressure, hyperlipidemia (high levels of fat in the blood), and pain in left hip.</p> <p>Review of the clinical record indicated Resident R28 was transferred to hospital on 12/12/23 and returned to the facility on [DATE].</p> <p>Review of Resident R28's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 12/12/23.</p> <p>Review of the clinical record indicated Resident R34 was admitted to the facility on [DATE].</p> <p>Review of Resident R34's MDS dated [DATE], indicated diagnoses of anemia (too little iron in the blood), respiratory failure (a condition where the lungs cannot get enough oxygen into the blood), and depression (a constant feeling of sadness and loss of interests).</p> <p>Review of the clinical record indicated Resident R34 was transferred to the hospital on 2/9/24, and returned to the facility on [DATE].</p> <p>Review of Resident R34's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 2/9/24.</p> <p>Review of the clinical record indicated Resident R40 was admitted to the facility on [DATE].</p> <p>Review of Resident R40's MDS dated [DATE], indicated diagnoses of high blood pressure, asthma (a condition where the airways narrow and swell), and muscle weakness.</p> <p>Review of the clinical record indicated Resident R40 was transferred to the hospital on 6/27/24, and returned to the facility on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R40's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 6/27/24.</p> <p>Review of Resident R67's admission record indicated she was originally admitted on [DATE], with diagnoses that included encephalopathy (change in how your brain function), chronic kidney disease and acute respiratory failure with hypoxia (lungs have trouble exchanging oxygen and carbon dioxide with the blood).</p> <p>Review of Resident R67's MDS dated [DATE], indicated that the diagnoses were current upon review.</p> <p>Review of the clinical record indicated Resident R67 was transferred to the hospital on 7/7/24 and did not return.</p> <p>Review of Resident R67's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 7/7/24.</p> <p>Review of Resident R20's admission record indicated she was originally admitted on [DATE], with diagnoses that included diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), chronic respiratory failure and anemia.</p> <p>Review of Resident R20's MDS dated [DATE], indicated that the diagnoses were current upon review.</p> <p>Review of the clinical record indicated Resident R20 was transferred to the hospital on 8/21/24, and returned to the facility on [DATE] and 9/8/24 and returned to the facility 9/13/24.</p> <p>Review of Resident R20's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 8/21/24 and 9/8/24.</p> <p>During an interview on 9/25/24, at 1:30 p.m. Clinical Consultant Employee E2 confirmed that the facility failed to notify the resident or resident's representative of the facility bed-hold policy for five of five resident hospital transfers as required.</p> <p>28 Pa. Code 201.29 (a)(c)(3)(2) Resident rights.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984</p> <p>Based on clinical records and staff interview, it was determined that the facility failed to update a care plan for one of eight residents (Resident R123) to accurately reflect the current status of the resident.</p> <p>Findings include:</p> <p>Review of clinical record indicated Resident R123 was admitted to the facility on [DATE], with diagnoses that included atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow), hypertension and hypercholesterolemia (high amounts of cholesterol in the blood).</p> <p>Review of Resident R123's Minimum Data Set (MDS-a mandated assessment of a resident's abilities and care needs) assessment, dated 9/25/24, indicated the diagnoses remain current.</p> <p>Review of Resident R123's physician orders dated 9/17/24 indicated a 1800 milliliter (ml) fluid restriction.</p> <p>Review of Resident R123's Resident Care Plan Summary Report (report nurse aides used to know what kind of care to provide) dated 9/17/24, revealed no fluid restriction.</p> <p>During an interview on 9/26/24, at 1:30 p.m. Nursing Home Administrator confirmed the facility failed to revise care plan for Resident R123 as required.</p> <p>28 Pa. Code: 211.11(d) Resident care plan.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on review of facility policy, resident interview and observations, clinical record review, and staff interview it was determined that the facility failed to provide Activity of Daily Living (ADL) assistance for one of five residents observed (Resident R39).</p> <p>Findings include:</p> <p>The facility policy Activities of Daily dated 12/1/23, indicated a program of ADL's (eating, dressing, hygiene, elimination, and ambulation) will be provided to prevent disability and maintain resident's functional abilities. A program of assistance and instruction in ADL skills is implemented.</p> <p>Review of the admission record indicated Resident R39 was admitted to the facility on [DATE].</p> <p>Review of Resident R39's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/22/24, indicated the diagnoses of high blood pressure, dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), and legally blind. Section B1000 Vision - severely impaired. No vision or see only light, colors or shapes, eyes do not appear to follow objects. Section GG indicated requires partial to moderate assistance for eating.</p> <p>Review of Resident R39's physician orders dated 4/30/24, indicated patient to have all food items placed in separate bowls, coffee with a sipper lid, and all other drinks with lids and straws. She is assist from staff for all meals.</p> <p>Review of Resident R39's care plan dated 8/20/24, indicated eating/swallowing - staff to provide assistance as needed daily during mealtimes to promote independence, staff to encourage chin neutral, to be out of bed for all meals, consume at a slow rate, and small bites.</p> <p>During an observation on 9/25/24, at 12:30 p.m., Resident R39 was in a wheelchair next to the dining table. The lunch tray was sitting on the table with the corner of the tray angled in front of her with an empty bowl of tomato soup. There were other bowls on the tray, unopened and out of her reach. No staff were assisting resident.</p> <p>During an observation on 9/26/24, at 12:35 p.m. Resident R39 was in her wheelchair with the tray angled the same as the day prior. There was an empty bowl of tomato soup. There were other bowls on the tray, unopened and out of her reach. No staff were assisting the resident. Resident is legally blind and observed reaching hands toward table without successfully reaching any of the bowls.</p> <p>During an interview with Resident R39 on 9/26/24, at 12:35 p.m., indicated when asked if she was not hungry today, she replied Yes, I'm hungry, why? Is there more food there? Survey Agency (SA) indicated there were potatoes and other items on her tray. Resident replied Oh, potatoes. Yes, I'll have potatoes.</p> <p>During an interview with Nurse Aide (NA) Employee E8, on 9/26/24, at 12:37 p.m., was notified that Resident R39 was hungry and unaware of what was on her tray.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 9/26/24, at 12:37 p.m., indicated NA Employee E8 handed the bowl of potatoes to Resident R39, who immediately put the potato wedge to her mouth and indicated it was cold.</p> <p>During an interview on 9/26/24, at 12:37 p.m., NA Employee E8 confirmed Resident R39 was not assisted with her meal as required and that Resident R39 was unaware there were portions of the meal remaining, and that the items were out of her reach.</p> <p>During an interview on 9/27/24, at 1:00 p.m., Clinical Consultant Employee E2 confirmed the facility failed to provide ADL assistance for one of five residents observed (Resident R39).</p> <p>28 Pa. Code 211.12 (d)(1) Nursing services.</p> <p>28 Pa. Code: 201.29(b)(d)(j) Resident rights.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of facility policy, clinical record review, observations, and staff interviews, it was determined that the facility failed to provide appropriate care and services for one of two residents receiving intravenous therapy (Resident R34) and failed to monitor resident wounds and complete weekly skin assessments for two of five residents (Residents R37 and R52).</p> <p>Review of facility policy Midline Dressing Changes dated 12/1/23, indicated midline catheter (a thin, flexible tube that is inserted into a large vein in the upper arm, used to safely administer medication into the bloodstream) dressings will be changed at specified intervals, or when needed, to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings. Change midline catheter dressing 24 hours after catheter insertion, every 5-7 days, or if it is wet, dirty, not intact, or compromised in any way. Label with initials, date and time.</p> <p>Review of facility policy Overview of IV Therapy dated 12/1/23, indicated labels may be preprinted with date, time, gauge, initials or can simply be a piece of tape that contains the same information. All tubing must have a label or they are considered to be out of date and should be changed.</p> <p>Review of the facility Skin Integrity and Wound Management policy dated 12/1/23, indicated the implementation of an individual resident's skin integrity and wound management occurs within the care delivery process. Staff continually observes and monitor residents for changes and implements revisions to the plan of care as needed. It was indicated staff must perform skin inspections on admission and weekly by a licensed nurse and it must be documented in the resident's electronic record. Wound assessment and proper forms must be completed upon initial identification of altered skin integrity, weekly, and with any deterioration of wound.</p> <p>Review of the clinical record indicated Resident R34 was admitted to the facility on [DATE].</p> <p>Review of Resident R34's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/2/24, indicated diagnoses of anemia (too little iron in the blood), respiratory failure (a condition where the lungs cannot get enough oxygen into the blood), and depression (a constant feeling of sadness and loss of interests).</p> <p>Review of a physician's order dated 9/19/24, indicated Resident R34 had an IV catheter (intravenous - used for the administration of fluids directly into a vein) in her right upper extremity.</p> <p>Review of a physician's order dated 9/19/24, indicated to change Resident R34's IV catheter dressing every seven days on the night shift.</p> <p>Review of a physician's order dated 9/20/24, indicated to administer Ertapenem (a medication used to treat severe infections caused by bacteria) 1 gram intravenously in the afternoon for ten days.</p> <p>During an observation on 9/24/24, at 9:49 a.m. Resident R34's IV tubing did not have a date present and the end of the tubing that connects to the resident's IV catheter was observed connected to the side port of the IV tubing.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 9/24/24, at 9:51 a.m. Resident R34's right upper extremity midline dressing had no date present and was lifting away from her skin on the bottom.</p> <p>During an interview on 9/24/24, at 10:42 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed Resident R34's IV tubing did not have a date on it and was not being appropriately stored while not in use, and that Resident R34's midline catheter dressing did not have a date present and was lifting at the bottom.</p> <p>During an interview on 9/24/24, at 2:10 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to provide appropriate care and services for a resident receiving intravenous therapy as required.</p> <p>Review of the clinical record indicated Resident R37 was admitted to the facility on [DATE].</p> <p>Review of Resident R37's MDS dated [DATE], indicated diagnoses of high blood pressure, muscle wasting, and unsteadiness on feet.</p> <p>Review of a Weekly Skin & Wound Note dated 8/26/24, completed by Registered Nurse (RN) Employed E7 stated, Resident R37 was assessed for one or more wounds that are non-pressure related. Resident has a wound on the left leg shin. 8.25.24 is when the wound was found, acquired in-house. The current measurements are length: 0.2 centimeters (cm) width: 0.3 cm. This presents as a skin tear. The plan of care has been reviewed and updated. Resident's wound will be reassessed in one week.</p> <p>Review of a Weekly Skin & Wound Note dated 9/2/24, completed by RN Employee E7 stated, Resident R37 was assessed for one or more wounds that are non-pressure related. Resident has a wound on the left leg front of left shin. The current measurements are length: 0.3 cm width: 0.2 cm. The peri-wound area is normal skin tone. There is no drainage in the wound. This presents as a skin tear. The plan of care has been reviewed and updated. Resident wound will be reassessed in one week.</p> <p>Review of Resident R37's clinical record failed to reveal documentation of the resident's left shin skin tear for the weeks of 9/8/24, and 9/15/24.</p> <p>Review of Resident R52's admission record indicated she was admitted on [DATE].</p> <p>Review of Resident R52's MDS dated [DATE], indicated diagnoses of high blood pressure, Non Alzheimer 's Dementia (dementia caused by other diseases with symptoms forgetfulness, limited social skills, and impaired thinking abilities that interfere with daily functioning), and peripheral vascular disease (a condition in which narrowed blood vessels reduce blood flow to the limbs).</p> <p>Review of Resident R52's current physician orders indicated apply marathon (liquid skin protectant) every three days to right calf wound.</p> <p>Review of Resident R52's current care plan indicated monitor and document the location, size and treatment of any skin impairment that develops on me.</p> <p>Review of Resident R52's skin evaluations on 9/25/24, indicated the last measurements completed were on 9/10/24.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with LPN Employee E9 on 9/25/24, at 10:30 a.m. confirmed the measurements were not completed as required from 9/10/24, through 9/25/24.</p> <p>During an interview on 9/26/24, at 2:15 p.m. the NHA confirmed that the facility failed to monitor resident wounds and complete weekly skin assessments as required.</p> <p>28 Pa. Code 201.18 (b)(1) Management.</p> <p>28 Pa. Code 201.29(d) Resident rights.</p> <p>28 Pa. Code 211.10 (c)(d) Resident care policies.</p> <p>28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to properly assess pressure ulcers for two of three residents (Residents R2 and R60).</p> <p>Findings include:</p> <p>Review of the facility policy Skin Integrity and Wound Management - NU17 dated 12/1/23, indicated perform wound assessment and complete proper forms upon initial identification of altered skin integrity, weekly, and with any deterioration of the wound.</p> <p>Review of Resident R2's admission record indicated admission to the facility on [DATE].</p> <p>Review of Resident R2's Minimum Data Set (MDS - a periodic assessment of care needs) dated 7/23/24, indicated diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and depression.</p> <p>Review of Resident R2's clinical progress note Weekly Skin and Wound Note dated 9/10/24, indicated a pressure related wound to sacrum/coccyx/anal area was found acquired in-house on 7/10/14; Current measurements indicated length 1.0 cm (centimeters), width 0.3 cm; This presents as a stage 2 pressure injury; Residents wound(s) will be assessed in one week.</p> <p>Further review of Resident R2's clinical progress notes failed to indicated that a Weekly Skin and Wound Note was completed for week of 9/16 - 9/20/24.</p> <p>During an interview on 9/26/24, at 2:16 p.m., Clinical Consultant Employee E2 confirmed that Resident R2's wound was not clinically assessed and documented for the week of 9/16 - 9/20/24.</p> <p>Review of Resident R60's admission record indicated admission to the facility on [DATE].</p> <p>Review of Resident R60's MDS dated [DATE], indicated diagnoses of seizure disorder (a person experiences abnormal behaviors, symptoms, and sensations, sometimes including loss of consciousness), epilepsy (is a brain condition that causes recurring seizures), and neurogenic bladder (lack of bladder control due to a brain, spinal cord, or nerve problem).</p> <p>Review of Resident R60's current physician order dated 8/27/24, indicated Assessment: Weekly Skin check by licensed nurse.</p> <p>Review of Resident R60's current care plan dated 9/6/24, indicated assess, record, monitor my wound healing weekly. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed, and healing progress.</p> <p>Review of Resident R60's skin evaluations on 9/25/24, at 9:57 a.m. indicated the last measurements completed were on 9/6/24.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Licensed Practical Nurse (LPN) Employee E9 on 9/25/24, at 10:22 a.m. confirmed the measurements were not completed as required on 9/13/24, and 9/20/24.</p> <p>Interview with the Clinical Consultant Employee E2 on 9/27/24, at 1:00 p.m. confirmed the facility failed to properly assess pressure ulcers for two of three residents (Residents R2 and R60).</p> <p>28 Pa. Code 201.18 (b)(1) Management.</p> <p>28 Pa. Code 201.29(d) Resident rights.</p> <p>28 Pa. Code 211.10 (c)(d) Resident care policies.</p> <p>28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure appropriate treatment and services were provided for two of two residents (Residents R25 and R34) with an indwelling urinary catheter (a tube inserted in the bladder to drain urine).</p> <p>Review of facility policy Indwelling Urinary Catheter dated 12/1/23, indicated the catheter bag should have a privacy cover applied at all times unless it has one built in by the manufacturer.</p> <p>Review of the clinical record indicated Resident R25 was admitted to the facility on [DATE].</p> <p>Review of Resident R25's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/25/24, indicated diagnoses of obstructive uropathy (structural hindrance of normal urine flow), heart failure (heart doesn't pump blood as well as it should), and high blood pressure. Section H indicated an indwelling catheter was present.</p> <p>Review of Resident R25's current physician orders indicated a Coude catheter (a type of catheter with a curved tip for those with an enlarged prostate or blockage) 16 French 10 cc (cubic centimeters). Acetic Acid (antimicrobial) irrigation of 60ml's (milliliters) every shift.</p> <p>Review of Resident R25's care plan dated 8/1/24, indicated I am at risk for developing a urinary tract infection. Presence of an indwelling catheter.</p> <p>During an observation on 9/24/24, at 9:48 a.m., Resident R25 was in bed in with the drainage bag attached to the bottom of the bed frame without a protective dignity pouch. On the bedside table an irrigation set that was not dated, had a full container of clear solution with an irrigation syringe sitting inside it. Also in the tray was a container of acetic acid that was not dated when opened and was not in a secure location.</p> <p>During an interview on 9/24/24, at 9:50 a.m., Licensed Practical Nurse (LPN) Employee E4 confirmed the drainage bag was not covered as required and the irrigation kit had no date, was left in an unacceptable manner, and the acetic acid should have been in the treatment cart with the date opened on it.</p> <p>Review of the clinical record indicated Resident R34 was admitted to the facility on [DATE].</p> <p>Review of Resident R34's MDS dated [DATE], indicated diagnoses of anemia (too little iron in the blood), respiratory failure (a condition where the lungs cannot get enough oxygen into the blood), and depression (a constant feeling of sadness and loss of interests).</p> <p>Review of a physician's order dated 9/17/24, indicated Resident R34 had an indwelling foley catheter inserted.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R34's care plan dated 3/25/24, revealed interventions to place resident's catheter bag and tubing below the level of the bladder, without kinks and secured with a leg strap - facing away from the entrance of Resident R34's room.</p> <p>During an observation on 9/24/24, at 10:05 a.m. Resident R34's urinary catheter bag was observed without a privacy cover and attached to her bed on the left side, which was facing the entrance of the room.</p> <p>During an interview on 9/24/24, at 10:07 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed that Resident R34's catheter bag did not have a privacy cover and was positioned on the left side of her bed.</p> <p>During an interview on 9/24/24, at 2:15 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure appropriate treatment and services were provided for two of two residents (Residents R25 and R34) with an indwelling urinary catheter as required.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.29(a)(c)(d)(j) Resident rights.</p> <p>28 Pa. Code 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(1)(3)(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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of facility policy, observations, interviews, and clinical record review, it was determined that the facility failed to provide appropriate respiratory care for three of four residents (Residents R33, R34, and R40).</p> <p>Review of facility policy Oxygen Therapy via Nasal Cannula dated 12/1/23, indicated to replace cannula every seven days, date and store in plastic bag when not in use.</p> <p>Review of the admission record indicated Resident R33 was admitted to the facility on [DATE].</p> <p>Review of Resident R33's Minimum Data Set (MDS - a periodic assessment of care needs) dated 9/5/24, indicated diagnoses of renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), heart failure (heart doesn't pump blood as well as it should), and high blood pressure.</p> <p>Review of Resident R33's current physician orders indicated change nasal cannula and protective covers weekly. Every night shift every Tuesday, for prevention. CPAP (a continuous positive airway pressure machine used to keep airways open while you sleep) to be worn at bedtime. Setting 5-20 every evening and night shift.</p> <p>Review of Resident R33's current care plan indicated provide with CPAP as ordered.</p> <p>During an observation on 9/24/24, at 9:53 a.m. there was an oxygen concentrator beside bed, with oxygen nasal cannula tubing lying on the floor uncovered. The tubing had no date as required. Behind the bedside stand was Resident R33's entire CPAP machine with the end of the headgear tubing resting in a cobweb on the floor.</p> <p>During an interview on 9/24/24, at 9:55 a.m. Licensed Practical Nurse (LPN) Employee E4 confirmed the nasal cannula tubing was on the floor, unbagged, and without a date, and that the CPAP machine was on the floor with the headgear tubing resting in a cobweb on the floor.</p> <p>Review of the clinical record indicated Resident R34 was admitted to the facility on [DATE].</p> <p>Review of Resident R34's MDS dated [DATE], indicated diagnoses of anemia (too little iron in the blood), respiratory failure (a condition where the lungs cannot get enough oxygen into the blood), and depression (a constant feeling of sadness and loss of interests). Section O - Question O0110: Special Treatments, Procedures, and Programs indicated Resident R34 received oxygen therapy while a resident.</p> <p>Review of a physician's order dated 2/21/24, indicated to administer oxygen at 7 to 10 liters via oximizer (an oxygen delivery device that conserves oxygen by leveraging a built-in reservoir system) cannula, maintain oxygen saturation (amount of oxygen in the blood) between 88% - 92%.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395534	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/27/2024
NAME OF PROVIDER OR SUPPLIER Quality Life Services - Sarver		STREET ADDRESS, CITY, STATE, ZIP CODE 126 Iron Bridge Road Sarver, PA 16055	
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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>Review of a physician's order dated 6/3/24, indicated to administer DuoNeb Solution (an inhaled medication used to increase air flow into the lungs) 3 milligrams (mg)/3 milliliters (mL) inhale orally via nebulizer four times a day for difficulty breathing.</p> <p>Review of a physician's order dated 3/27/24, indicated to change oxygen tubing weekly every night shift every Tuesday.</p> <p>During an observation on 9/24/24, at 9:47 a.m. Resident R34's nasal cannula tubing and the humidification bottle (a medical device used to enhance moisture and reduce dryness of supplemental oxygen) did not have a date. Resident R34's nebulizer machine was present on a side table with the face mask hanging on the oxygen concentrator. No date was noted on the tubing and the face mask was not being stored in a plastic bag while not in use.</p> <p>Review of the clinical record indicated Resident R40 was admitted to the facility on [DATE].</p> <p>Review of Resident R40's MDS dated [DATE], indicated diagnoses of high blood pressure, asthma (a condition where the airways narrow and swell), and muscle weakness.</p> <p>Review of a physician's order dated 7/30/24, indicated to administer DuoNeb Solution 3 mg/3 mL inhale orally via nebulizer three times a day for difficulty breathing.</p> <p>During an observation on 9/24/24, at 9:44 a.m. Resident R40's nebulizer machine was present on a side table with the mouthpiece and medication cup laying on the table next to the machine. There was no date present on the tubing and the mouthpiece was not being stored in a plastic bag while not in use.</p> <p>During an interview on 9/24/24, at 10:09 a.m. Licensed Practical Nurse (LPN) E1 stated, I was just told to put plastic bags in the rooms with respiratory supplies.</p> <p>During an interview on 9/24/24, at 10:10 a.m. LPN Employee E1 confirmed that Residents R34 and R40 did not have their respiratory tubing dated and that the nebulizer set ups were not appropriately stored in a plastic bag while not in use.</p> <p>During an interview on 9/24/24, at 2:10 p.m. the Nursing Home Administrator confirmed that the facility failed to provide appropriate respiratory care for three of four residents as required.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.11 (a)(c)(d) Resident care plan.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on observations, review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to have accurate physician's orders for two of four residents with assist rails (Residents R25 and R26) and conduct ongoing accurate assessments for one of three residents (Resident R33).</p> <p>Findings include:</p> <p>Review of the facility policy Side Rail Evaluation NU16.55 dated 12/1/23, indicated the side rail evaluation will be completed upon admission, re-admission, or significant change. The facility will obtain a physician order for the side rail. The facility will develop a plan of care for the side rail use.</p> <p>Resident R25 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/25/24, indicated diagnoses of obstructive uropathy (structural hindrance of normal urine flow), heart failure (heart doesn't pump blood as well as it should), and high blood pressure.</p> <p>Review of Resident R25's physician orders on 9/26/24, at 12:58 p.m. failed to include orders for side rail use.</p> <p>Review of Resident R25's current care plan indicated I need to be evaluated for, and supplied adaptive equipment or devices as needed. Re-evaluate my use of them routinely and as needed for continued appropriateness, and to ensure least restrictive device or restraint. The plan of care failed to identify the use of side rails.</p> <p>Review of Resident R25's assessment on 6/28/24, failed to indicate Section 2b H side rail evaluation is blank and Section H side rail evaluation is the resident a candidate for side rails - answered No.</p> <p>Observation on 9/26/24, at 12:48 p.m. Resident R25 was resting in bed with rails on both side of the upper portion of the bed.</p> <p>Interview on 9/26/24, at 12:58 p.m. Licensed Practical Nurse (LPN) Employee E4 confirmed the rails were present on the Resident R25's bed.</p> <p>Resident R26 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/23/24, indicated diagnoses of heart failure (heart doesn't pump blood as well as it should), depression, and high blood pressure.</p> <p>Review of Resident R26's current physician orders indicated Mobility/positioning siderails 1/2 up bilaterally (both sides) for repositioning.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R26's current care plan indicated I need to be evaluated for, and supplied adaptive equipment or devices as needed. Re-evaluate my use of them routinely and as needed for continued appropriateness, and to ensure least restrictive device or restraint. The plan of care failed to identify what adaptive equipment or devices was in use.</p> <p>Review of Resident R26's assessment on 6/28/24, failed to indicate Section 2b H side rail evaluation is blank and Section H side rail evaluation is the resident a candidate for side rails - answered No.</p> <p>Observation on 9/26/24, at 1:00 p.m. Resident R26 was resting in her wheelchair. The bed in the room did not have side rails in place as ordered.</p> <p>Interview on 9/26/24, at 1:00 p.m. Resident R26 indicated she doesn't have side rails and does not want them.</p> <p>Interview on 9/26/24, at 1:05 p.m. Clinical Consultant Employee E2 confirmed the physician orders for the rails should have been discontinued, and they were not in use.</p> <p>Resident R33 was admitted to the facility on [DATE]. Review of Resident R33's MDS dated [DATE], indicated diagnoses of renal insufficiency (condition where the kidneys lose the ability to remove waste and balance fluids), heart failure, and high blood pressure.</p> <p>Review of Resident R33's physician orders dated 7/21/24 indicated bed mobility - enabler bars bilateral top bars to promote increased mobility and independence.</p> <p>Review of Resident R33's care plan dated 7/21/24, indicated maintain bilateral enabler bars. Bilateral top enabler bars to promote increased mobility/independence. Observe for injury or entrapment related to use of the support.</p> <p>rail and reposition me as needed to avoid injury.</p> <p>Review of Resident R33's assessment on 9/2/24, failed to indicate Section 2b H side rail evaluation is blank and Section H side rail evaluation is the resident a candidate for side rails - answered No.</p> <p>Observation on 9/26/24, at 1:00 p.m. Resident R33 was resting in the bed and had bilateral rails on the upper half of the bed.</p> <p>Interview on 9/26/24, at 1:10 p.m. LPN Employee E4 confirmed the rails were in place for Resident R33.</p> <p>Interview on 9/26/24, at 2:00 p.m. Clinical Consultant Employee E2 confirmed the facility failed to have accurate physician's orders for two of four residents with assist rails (Residents R25 and R26) and conduct ongoing accurate assessments for one of three residents (Resident R33).</p> <p>28 Pa. Code 201.18 (b)(1) Management.</p> <p>28 Pa. Code 201.29(d) Resident rights.</p> <p>(continued on next page)</p>		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on review of facility policy, clinical record review, controlled drug shift count record, and staff interview, it was determined that the facility failed to implement pharmacy procedures for the reconciliation of controlled drugs for one of two medication carts (Pennsylvania Medication Cart).</p> <p>Findings include:</p> <p>Review of facility policy Management of Controlled Drugs dated 12/1/23, indicated to destroy the drug with another licensed staff member as witness. Staff member designated as witness to the destruction must actually witness the waste. Document the reason for the destruction on the controlled drug inventory in the space for that dose. Signature of person who poured and destroyed the drug and signature of witness must be entered in the space with the documentation of the destruction. Perform a complete count of all controlled drugs at the change of shifts or at any time in which narcotic keys are surrendered from one staff member to another. Count must be performed by two licensed nurses per state regulations. Both licensed nurses participating in the count must sign the individual inventory at the time of the count. If discrepancy is noted during the count, notify nursing supervisor immediately to initiate investigation.</p> <p>Review of the clinical record indicated Resident R37 was admitted to the facility on [DATE].</p> <p>Review of Resident R37's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/27/24, indicated diagnoses of high blood pressure, muscle wasting, and unsteadiness on feet.</p> <p>Review of a physician's order dated 8/10/23, indicated to administer Morphine Sulfate (a controlled pain medication) 10 milligrams sublingually (under the tongue) every two hours as needed for moderate pain or shortness of breath.</p> <p>Review of the Controlled Drug Record for Resident R37's Morphine Sulfate revealed the amount was adjusted from 20 milliliters (mL) to 18 mL with a documented reason of spillage/dehydration. No date, time, or witness signature were documented for this entry.</p> <p>Review of an additional entry to the Controlled Drug Record for Resident R37's Morphine Sulfate revealed the amount was adjusted from 18 mL to 16 mL with a documented reason of spillage/dehydration. No date or time were documented for this entry.</p> <p>During an interview on 9/27/24, at 9:50 a.m. the Nursing Home Administrator confirmed that the facility failed to implement pharmacy procedures for the reconciliation of controlled drugs as required.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services.</p> <p>28 Pa. Code 211.19(a)(1)(k) Pharmacy services.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on review of facility policy and documentation, clinical record reviews, and staff interview it was determined that the facility failed to accurately document education and immunization administration related to pneumococcal vaccines for one of five residents (Resident R26).</p> <p>Findings include:</p> <p>Review of the facility policy Standing Orders for Administering Pneumococcal Vaccine to Adults dated 12/1/23, indicated identify adults in need of vaccination with pneumococcal vaccine. Screen all patients for contraindications to pneumococcal vaccine. Provide all patients with a copy of the most current federal Vaccine Information Statement (VIS). Administer the vaccination per order and record in the medical record the date, the manufacturer and lot number, the site and route, and the name of person administering it.</p> <p>Resident R26 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/23/24, indicated diagnoses of heart failure (heart doesn't pump blood as well as it should), depression, and high blood pressure.</p> <p>Review of Resident R26's immunization consent for pneumococcal record indicated initially on 4/12/24, daughter to call with information. On 9/26/24, the consent from 4/12/24, had not been addressed.</p> <p>Further review of Resident R26's chart indicated a second consent was signed on 5/20/24.</p> <p>Review of physician order dated 5/20/24, indicated to administer pneumococcal vaccine to Resident R26.</p> <p>Review of the clinical record failed to have evidence that the vaccination was administered.</p> <p>Interview with Clinical Consultant Employee E2 on 9/27/24, at 1:30 p.m. indicated the vaccination was never received due to the order being put into the computer; however, was not actually entered and scheduled to be given and that the facility failed to accurately document education and immunization administration related to pneumococcal vaccines for one of five residents (Resident R26).</p> <p>28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services.</p> <p>28 Pa. Code: 201.29(b)(d)(j) Resident rights.</p>		