

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/14/2025
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)		
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on a review of facility policy and staff interviews, it was determined the facility failed to designate a consistent qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control infections for 12 out of 14 months. Findings included: Review of facility Infection Prevention Program policy dated 10/13/25, indicated the infection program is comprehensive in that it addresses detection, prevention, and control of infections among residents and personnel. During entrance meeting on 11/12/25, at 9:30 a.m. Assistant Director of Nursing (ADON) was identified as the facilities Infection Preventionist (IP). During a review of the facilities Infection Control Program on 11/13/25, the ADON/IP Employee E10 stated, I just started in this role. I completed my infection control training but couldn't take a test and I couldn't print a certificate. During a review of IP certificates reveal the facility failed to have a certified IP on the following dates: - September 2024 - 6/26/25 - 7/26/25 - 8/19/25 - 10/11/25 - 11/13/25 On 11/13/25 the ADON/IP Employee E10 provided a Nursing Home Infection Preventionist Training Certificate dated 11/13/25. During an interview on 11/13/25, at 12:45 p.m. the Director of Nursing confirmed the above dates and that the facility failed to designate a qualified individual(s) onsite, who is responsible for implementing programs and activities to prevent and control infections for 12 out of 14 months. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(e)(1) Management.28 Pa. Code: 201.19(3) Personnel records.28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 395534	If continuation sheet Page 1 of 12

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observation, and staff interviews, it was determined that the facility failed to provide a dignified dining experience by failing to provide assistance with meals timely for one of six residents (Resident R42). Findings include: Review of the facility Activities of Daily Living policy dated 10/13/25, indicated a program of activities of daily (ADL) living is provided for residents. A program of assistance in ADL skills is implemented. Residents are encouraged to eat in the group dining room, when possible, for socialization. Review of the facility Your rights and Protections as a Nursing Home Resident policy dated 10/13/25, indicated a resident has the right to be treated with dignity and respect. Review of Resident R42's clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R42's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 9/2/24, indicated diagnoses of Huntington's Disease (a condition that leads to progressive degeneration of nerve cells in the brain), hyperlipidemia (a high level of fats in the blood), and dysphagia (difficulty swallowing). Section GG Functional Abilities GG0130 Eating was coded as a 2, indicating resident requires substantial maximal assistance and the helper does more than half the effort. During an observation on 11/12/25, at 12:06 p.m. six residents were sitting at a table together for lunch. All residents were served and started to eat their lunch at the same time except for Resident R42. During an interview on 11/12/25, at 12:09 p.m. Graduate Nurse Aide Employee E5 stated Resident R42's lunch was still on the lunch cart and We don't want to set it out and get cold until we can get to feeding him. He needs help to eat. During an interview on 11/12/25, at 12:10 p.m. Licensed Practical Nurse Employee E1 stated, They shouldn't have had everyone else eat in from of him. They should have brought him out to the table when they were ready to feed him, and all the residents were eating together at the same time. During an interview on 11/12/24, at 2:00 p.m. the Director of Nursing confirmed that the facility failed to provide a dignified dining experience by failing to provide assistance with meals timely for one of six residents (Resident R42). 28 Pa Code: 201.29(a) Resident rights.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined the facility failed to make certain a resident had an updated, person-centered care plan individualized to each specific resident's needs for one of five residents (Resident R39). Findings included: Review of the facility Resource: Audit to Assess Quality Care Provided policy dated 10/13/25, indicated care plans are modified when indicated. Care plan revision includes identification of changes in the individual's condition that require revised goals and care approaches. Review of Resident R39 clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R39's clinical record MDS (minimum data set a periodic assessment of resident needs) dated 9/25/25, indicated diagnosis of high blood pressure, coronary artery disease (damage or disease in the heart's major blood vessels), and unsteadiness on feet. Review of Resident R39's care plan initiated on 3/25/25, indicated resident transfers assist of two with handheld assist for my safety. Review of Resident R39's Physician Orders dated 4/22/25, indicated Activities/Mobility: Transfers with mechanical Sit to Stand lift with assist times two. During an interview on 11/14/25, at 9:45 a.m. Licensed Practical Nurse Assessment Coordinator Employee E9 reviewed Resident R39's care plan and stated that the transfer status should have been updated to reflect current physician orders. During an interview on 11/14/25, at 12:46 p.m. the Director of Nursing confirmed the facility failed to make certain a resident had an updated, person-centered care plan individualized to each specific resident's needs for one of five residents (Resident R39). 28 Pa. Code 201.24(e)(1)(5) Admissions Policy 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **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 notify physicians of increased Capillary Blood Glucose (CBG) levels for one of three residents reviewed (Residents R31), and failed to make certain that residents were provided appropriate treatment and care by failing to obtain an X-ray in an appropriate timeframe for one of four residents (Resident Closed Record (CR) R100). Findings include: Review of the facility policy Physician Notification dated 10/13/25, 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. Review of facility policy Your Rights and Protections as a Nursing Home Resident policy dated 10/13/25, indicated residents have the right to be treated with dignity and respect. You have the right to get proper medical care. Review of the admission record indicated Resident R31 admitted to the facility on [DATE]. Review of Resident R31's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/7/25, indicated the diagnoses of Parkinson's disease (disorder of the nervous system that results in tremors), diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and high blood pressure. Review of Resident R31's physician order dated 11/4/25, indicated Insulin Lispro (a short acting, manmade version of human insulin) Pen-injector 100 UNIT/ML (milliliter) inject as per sliding scale: if 0 - 140 = 0 units; 141 - 180 = 2units; 181 - 220 = 4 units; 221 - 260 = 6 units; 261 - 300 = 8 units; 301 - 350 = 10 units; 351 - 400 = 12units; 401 - 999 = 14 units give 14 units and call MD. Review of Resident R31's current care plan indicated resident will be free from any signs or symptoms of hyperglycemia (too much glucose in the blood) or hypoglycemia (not enough glucose in the blood) through the next review date. Intervention to administer resident's diabetes medications as ordered. Monitor for effectiveness and the occurrence of any side effects and report them to my physician. Review of Resident R31's CBG's results indicated the following:-11/7/25, at 11:58 a.m. CBG of 407.-11/8/25, at 11:31 a.m. CBG of 460. Review of Resident R31's clinical record failed to indicate the physician was notified of CBG's over 401 as ordered on 11/7/25, and 11/8/25. Interview on 11/14/25, at 10:27 a.m. the Director of Nursing confirmed that the facility failed to notify physicians of increased Capillary Blood Glucose (CBG) levels for one of three residents reviewed (Residents R31). Review of the clinical record indicated Resident R100 was admitted to the facility on [DATE] and was discharged from facility on 10/14/25. Review of Resident 's R100's Minimum Data Set (MDS - a periodic assessment of care needs) dated 10/14/25, indicated diagnoses of depression, unsteadiness on feet, and a right fracture of tibia (one (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the bones in a person's lower leg). During a review of Resident R100's clinical record on 11/13/25, at 2:01 p.m. indicated resident had a witnessed fall in her room on 9/25/25. Resident slid out of chair, while wearing a leg immobilizer. Resident was experiencing pain and was currently being treated for a tibia fracture. During a review of Resident R100's physician orders dated 9/25/25, indicated Xray to right lower extremity due to pain. During a review of Resident R100's progress notes on 11/14/25, at 9:01 a.m. indicated that a mobile x-ray was completed on 9/26/25. On 9/30/25, nursing staff determined that the x ray was completed on the wrong resident, notified physician and obtained a new order. Mobile X-ray completed new imaging on 9/30/25, five days later. During an interview on 11/14/25, 12:15 p.m. the Director of Nursing confirmed that the facility failed to make certain that residents were provided appropriate treatment and care by failing to obtain an X-ray in an appropriate timeframe for one of four residents (Resident R100). 28 Pa. Code 201.18 (b)(1) Management 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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, incident reports, facility documents, employee education, and staff interviews, it was determined that the facility failed to ensure that a resident was free from a preventable accident during a transfer for one of four residents (Resident R39). Findings include: Review of the facility Accidents and Incidents policy dated 10/13/25, indicated that the facility will promote a safe environment for all residents. An accident or incident is any happening, which is not consistent with routine operations or the routine care of the particular resident. Review of Resident R39 clinical record indicated the resident was admitted to the facility on [DATE]. Review of Resident R39's clinical record MDS (minimum data set a periodic assessment of resident needs) dated 9/25/25, indicated diagnosis of high blood pressure, coronary artery disease (damage or disease in the heart's major blood vessels), and unsteadiness on feet. Review of Resident R39's care plan dated 3/25/25, indicated transfers assist times two with handheld assist for my safety. Review of a written witness statement dated 4/17/25, from Licensed Practical Nurse (LPN) Employee E11 stated, Writer was passing medications on floor where resident resides. Residents call light going off for several minutes. Resident stated she needed to use the restroom. Resident scooted self to edge of bed and placed feet on the floor. Writer unable to locate any assistance. Resident knees began to buckle and sat on writers stabilized knee. Resident was able to get up and shifted to her wheelchair. Small skin tear noted to left lower extremity. Physician notified and new orders received for treatment of a skin tear. During an interview on 11/13/25, at 2:33 p.m. Nurse Aide (NA) Employee E12 stated that a residents transfer status could be located on the Kardex or in the computer. I would not transfer resident myself if they were a two person assist. They could fall and get hurt. You could injure them like a skin tear too. During an interview on 11/13/25, at 2:35 p.m. NA Employee E13 stated you could find transfer status on the computer or on paper at the nurse's station. If someone was an assist of two, I would not transfer them myself. They could fall. During an interview on 11/13/25, at 2:40 p.m. the Director of Nursing confirmed that the facility failed to ensure that a resident was free from a preventable accident during a transfer for one of four residents (Resident R39). 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.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, observations, and staff interview, it was determined that the facility failed to ensure direct care staff were aware of residents with fluid restriction orders to make certain acceptable parameters of nutritional status were maintained for one of four residents reviewed (Resident R27). Findings include: Review of the facility policy Fluid Restriction dated 10/13/25, indicated when a physician orders a fluid restriction due to specific clinical condition, close monitoring will be provided to maintain adequate hydration. The water pitcher is to be removed from the bedside. Dietary will determine desired beverages at meals and the remaining amount of fluids to be provided by nursing. Calculate amount allotted for each shift. Review of the admission record indicated Resident R27 was admitted to the facility on [DATE], with the diagnoses of anemia (the blood doesn't have enough healthy red blood cells), End Stage Renal Disease (ESRD - kidneys cease to function on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life), and heart failure (heart doesn't pump blood as well as it should). Review of Resident R27's physician's order dated 11/12/25, indicated a 1200 milliliter (ml) daily fluid restriction. The order failed to include allotted amount for each shift for nursing staff. Review of Resident R27's care plan dated 11/13/25, indicated resident has a nutritional problem related to ESRD and dialysis dependence. Intervention of fluid restriction 1200 mls per day. The care plan failed to include allotted amount for each shift for nursing staff. Observation on 11/14/25, at 9:30 a.m. Resident R27 was in bed with a water pitcher on the bedside stand and a can of ginger ale. Interview on 11/14/25, at 9:35 a.m. Licensed Practical Nurse (LPN) Employee E1 indicated Resident R27 is on a fluid restriction of 1200 ml a day and should not have a water pitcher in the room. When asked how much nursing is permitted to provide LPN Employee E1 could not provide an amount and indicated the order was for 1200 ml/day and was not broken down into each shift. Interview on 11/14/25, at 11:00 a.m. the Director of Nursing confirmed the facility failed to ensure direct care staff were aware of residents with fluid restriction orders to make certain acceptable parameters of nutritional status were maintained for one of four residents reviewed (Resident R27). 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to properly store medications in one of two medication rooms (Liberty Medication Room) and one of three medication carts (Market Place Medication Cart). Findings include: Review of facility policy Medication Storage in the Facility dated 8/18/25, indicated certain medications such as multiple dose vials, ophthalmic solutions, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency. During an observation on 11/12/25, at 11:45 a.m. of the Liberty Medication Room Refrigerator revealed a tuberculin multiple dose vial (a substance used in the tuberculin skin test (TST) to diagnose tuberculosis infection) that was opened and not labeled with the date opened as required. Interview on 11/12/25, at 11:46 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed the tuberculin multiple dose vial was opened and not labeled with the date opened as required. During an observation on 11/12/25, at 12:20 p.m. of the Market Place Medication Cart the following was observed: -Cyclosporine eye ointment (increases natural tear production) opened and without the date opened. -Budesonide (inhalant used to reduce inflammation to make breathing easier) solution opened and without the date opened. During an interview on 11/12/25, at 12:21 p.m. LPN Employee E2 confirmed the above observation and that the facility failed to properly store medication in one of three medication carts. During an interview on 11/12/25, at 2:00 p.m. the Director of Nursing confirmed the facility failed to properly store medications in one of two medication rooms (Liberty Medication Room) and one of three medication carts (Market Place Medication Cart). 28 Pa. Code: 211.9(a)(1)(k) Pharmacy services. 28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, observations, and staff interviews, it was determined that the facility failed to follow enhanced barrier precautions for one of two residents (Resident R25) with an indwelling foley catheter. Based on review of facility policy, clinical record review, observations, and staff interviews, it was determined that the facility failed to follow enhanced barrier precautions for one of two residents (Resident R25) with an indwelling foley catheter. Findings include: Review of the facility policy Enhanced Barrier Precautions dated 10/13/25, indicated enhanced barrier precautions (EBP) are used and expand the use of Personal Protective Equipment (PPE) to donning (putting on) of the gown and gloves during high-contact resident care activities that provide opportunities for transfers of multi-drug-resistant organisms to staff hands and clothing. Examples of high-contact resident care activities requiring EBP includes device care or use (central lines, urinary catheter, supra-pubic catheter, feeding tube or tracheostomy). Review of the admission record indicated that Resident R25 was admitted to the facility on [DATE], with the diagnoses of urinary tract infection, rib fractures, and neurogenic bladder (lack of bladder control due to a brain, spinal cord or nerve problem). Review of Resident R25's physician order dated 11/6/25, indicated foley catheter (a thin, flexible tube inserted into the bladder to drain urine) for neurogenetic bladder. Size 16 French (outer diameter of the tube) with 10 cc (cubic centimeter) balloon. Review of Resident R25's current care plan indicated resident has an Indwelling catheter for neurogenic bladder. Goal of remaining free from catheter-related trauma. Observation on 11/12/25, at 10:00 a.m. Resident R25 was observed in bed with an indwelling catheter bag attached to the bed. Interview on 11/12/25, at 10:05 a.m. Licensed Practical Nurse (LPN) Employee E1 confirmed Resident R25 had a foley catheter. Interview on 11/12/25, at 2:00 p.m. the Director of Nursing confirmed that Resident R25 was not on the EBP listing and did not have a physician order for EBP as required and that facility failed to follow enhanced barrier precautions for one of two residents (Resident R25) with an indwelling foley catheter. 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code: 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **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 influenza immunization and pneumococcal immunization were offered to one of five residents (Residents R31). Findings include: Review of the facility policy Standing Orders for Administering Influenza Vaccine to Adults dated 10/13/25, indicated to reduce morbidity and mortality from influenza by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Advisory Committee on Immunization Practices. Review of the facility policy Standing Orders for Administering Pneumococcal Vaccine to Adults dated 10/13/25, indicated to reduce morbidity and mortality from pneumococcal disease by vaccinating all adults who meet the criteria established by the Centers for Disease Control and Advisory Committee on Immunization Practices. Review of the admission record indicated Resident R31 admitted to the facility on [DATE]. Review of Resident R31's Minimum Data Set (MDS - a periodic assessment of care needs) dated 8/7/25, indicated the diagnoses of Parkinson's disease (disorder of the nervous system that results in tremors), diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and high blood pressure. Review of Resident R31's clinical record on 11/14/25, at 10:00 a.m. failed to include documented evidence that the influenza immunization and pneumococcal immunization were offered, administered, or declined by the resident. Interview on 11/14/25, at 12:00 p.m. the Director of Nursing confirmed that the facility failed to make certain that influenza immunization and pneumococcal immunization were offered to one of five residents (Residents R31). 28 Pa. Code: 201.14 (a) Responsibility of licensee. 28 Pa. Code: 201.18 (b)(1)(e)(1) Management. 28 Pa. Code: 211.10 (d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(2)(5) Nursing services.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observations, review of facility documentation, and staff interviews, it was determined that the facility failed to make certain that equipment was in safe operating condition for the facilities Automated External Defibrillator (AED-a portable, electronic device designed to diagnose and treat life-threatening cardiac arrhythmias) and crash cart (a supply cart used in an emergency). Findings include: Review of facility AED policy dated 10/13/25, indicated the AED will be available for use in emergency situations and its function maintained according to manufacturer recommendations. Daily maintenance includes checking the indicator to ensure that it is green (AED is ready for rescue). Perform maintenance to the AED monthly. During an observation of the facilities AED box on 11/12/25, at 12:05 p.m. revealed an AED with electrodes attached to the machine were present. An extra set of electrodes were in the AED box. The facility failed to provide documentation for the daily and monthly checks to ensure the AED is in working order. During an observation of the facilities crash cart, located on Liberty Nursing Unit, on 11/12/25, at 12:30 p.m. revealed the crash cart was checked on 9/27/25, 10/4/25, 10/20/25, 10/24/25, 10/27/25, and 11/10/25. During an interview on 11/12/25, at 12:44 p.m. Licensed Practical Nurse Employee E1 confirmed the above dates and stated that the crash cart should be checked daily by nursing staff. During an interview on 11/12/25, at 2:15 p.m. the Director of Nursing confirmed that the facility failed to make certain that equipment was in safe operating condition for the facilities Automated External Defibrillator and crash cart. 28 Pa Code: 201.14(a) Responsibility of licensee.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 11/14/2025
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)		
F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on review of facility education documents, and staff interview, it was determined that the facility failed to provide training on effective communication for one of five staff members (Nurse Aide (NA) Employee E3).Findings include:Review of facility provided documents and training records for NA Employee E3 on 11/14/25, indicated that NA Employee E3 was hired to the facility on 7/12/17, and failed to include education on effective communication as required.Interview on 11/14/25, at 1:00 p.m. the Nursing Home Administrator confirmed that the facility failed to provide training on effective communication for one of five staff members (NA Employee E3). 28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.18 (b)(1) Management.28 Pa Code: 201.20 (a)(6)(d) Staff development.		