

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395593	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/11/2024
NAME OF PROVIDER OR SUPPLIER Quality Life Services - Grove City		STREET ADDRESS, CITY, STATE, ZIP CODE 400 Hillcrest Avenue Grove City, PA 16127	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>40177</p> <p>Based on review of facility policy, observation, and staff interview, it was determined that the facility failed to maintain a clean homelike environment for one of two resident neighborhoods (2nd Floor).</p> <p>Findings include:</p> <p>Review of a facility policy dated 2/22/24, entitled Wheelchair Cleaning Policy, indicated the facility will provide clean, functional, and safe resident and facility owned wheelchairs through at least monthly cleaning or as needed.</p> <p>Observation of the 2nd Floor on 10/09/24, between 11:13 a.m. and 11:20 a.m. revealed concerns with four resident wheelchairs. Resident R8's wheelchair was observed to have dust and dried debris on the frame of his/her wheelchair. Resident R14's wheelchair was observed to have dried liquid and debris down the side of his/her wheelchair and on the frame of his/her wheelchair. Resident R55's wheelchair was observed to have dust and dried debris on the frame of his/her wheelchair. Resident R74 was observed to have a dried spaghetti noodle as well as other dried debris and dust on the edge of his/her wheelchair near and under the wheelchair cushion and on the frame of his/her wheelchair.</p> <p>During an interview on 10/09/24, at approximately 11:33 a.m. Registered Nurse (RN) Employee E1 confirmed that Residents R8, R14, R55, and R74's wheelchairs were unclean and with dried debris and dust. RN Employee E1 further stated that the nursing staff are responsible for cleaning the wheelchairs.</p> <p>28 Pa. Code 201.18(b)(1) Management</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 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** 40177</p> <p>Based on review of clinical record, observation, and staff interview, it was determined that the facility failed to ensure physician's orders were accurate and reflected the status and care provided to one of 21 residents reviewed (Resident R8).</p> <p>Findings include:</p> <p>Resident R8's clinical record revealed an admitted [DATE], with diagnoses that included stroke, diabetes, and dementia (loss of cognitive functioning affecting a persona memory and behaviors).</p> <p>Resident R8's clinical record revealed a task dated 12/16/20, indicating Resident R8 was to wear a left upper extremity resting hand splint for up to four hours twice a day and to check skin integrity before and after splint wearing. Further review of Resident R8's clinical record revealed it lacked a physician's order for the left upper extremity resting hand splint.</p> <p>Observation of Resident R8 on 10/09/24, at approximately 11:50 a.m. revealed he/she was wearing a left resting hand splint.</p> <p>During an interview on 10/10/24, at 2:44 p.m. the Nursing Home Administrator confirmed that Resident R8 was utilizing a left resting hand splint and there was no physician's order for the use of the left resting hand splint.</p> <p>28 Pa. Code 211.5(f)(i) Clinical records</p> <p>28 Pa. Code 211.12 (d)(1)(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** 40177</p> <p>Based on review of facility policy and clinical record, observations, and staff interview, it was determined that the facility failed to maintain proper care of respiratory equipment for one of two residents reviewed for respiratory services (Resident R35).</p> <p>Findings include:</p> <p>Review of a facility policy dated 2/22/24, entitled Oxygen Concentrator indicated to check inlet filter pad to be sure it is clean and in place and not to run the concentrator without a filter or with a dusty filter as this can cause damage to the concentrator and alter the oxygen concentration. Policy also indicated to remove, rinse, and pat dry the air intake filter weekly or more often if needed to keep clean and free of dust.</p> <p>Resident R35's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD - a lung disease that results in difficulty breathing, cough, and mucus production), dementia (loss of cognitive functioning affecting a persona memory and behaviors), and high blood pressure.</p> <p>Resident R35's physician's order dated 12/28/22, revealed that oxygen was ordered at two liters per minute every shift via nasal cannula (tubing that enters into the nostrils to administer oxygen). Further review of physician orders revealed an order dated 1/05/24, to clean oxygen filters every Friday on night shift.</p> <p>Observations on 10/08/24, at approximately 1:44 p.m. and 10/09/24, at approximately 11:25 a.m. revealed that Resident R35's oxygen concentrator had a filter on each side of the concentrator that contained a gray dusty substance.</p> <p>During an interview on 10/9/24, at approximately 11:32 a.m. Registered Nurse Employee E1 confirmed that the oxygen concentrator filters contained a gray dusty substance and should not as they are to be cleaned on a weekly basis.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0803</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>40177</p> <p>Based on review of facility policy and the facility's written menus, observation, and resident and staff interviews, it was determined that the facility failed to follow their planned menu for four of six meals (lunch meal 10/08/24, dinner meal 10/08/24, dinner meal 10/09/24, and lunch meal 10/10/24).</p> <p>Findings include:</p> <p>Review of a facility policy dated 2/22/24, entitled Menu Substitutions indicated that substitutions will be provided when an uncontrollable situation has temporarily made the item unavailable and all changes will be recorded on the menu extension sheets and menu substitution sheet. Policy further stated that if a substitution is required more than one time, the Registered Dietitian must sign off to make a permanent change along with a permanent adjustment to the spreadsheet.</p> <p>Review of the facility's written and printed menu for the lunch meal on 10/08/24, revealed that the residents were to receive herb marinated chicken thigh, rice pilaf, green beans, wheat bread, cherry crisp, and coffee/tea.</p> <p>Observation of the lunch meal on the resident's unit on 10/08/24, at 12:24 p.m. revealed that the facility prepared and served chicken breast, white rice, corn, white bread, and chocolate chip cookie.</p> <p>Interview with Resident R1 at the time of observation revealed the following: This happens frequently, not as bad as today, but something is usually always different.</p> <p>Review of the facility's written and printed menu for dinner meal on 10/08/24, revealed that the residents were to receive macaroni and cheese, stewed tomatoes, parslied cauliflower, pineapple chunks, and coffee/tea.</p> <p>Interview with Resident R1 on 10/9/24, at 11:45 a.m. revealed the residents did not get the parslied cauliflower for the dinner meal on 10/08/24, like the menu indicated.</p> <p>Review of the facility's written and printed menu for dinner meal on 10/09/24, revealed that the residents were to receive Italian wedding soup, saltines, ham and provolone sandwich, pasta salad, seasonal fruit choice, and coffee/tea.</p> <p>Interview with Resident R1 on 10/10/24, at 12:17 p.m. revealed the residents received macaroni salad instead of the pasta salad for the dinner meal on 10/08/24, like the menu indicated.</p> <p>Review of the facility's written and printed menu for lunch meal on 10/10/24, revealed that the residents were to receive baked crunchy ranch chicken thigh, baked sweet potato half, winter blend vegetable (broccoli and cauliflower), choice of roll, gingersnap cookie, and coffee/tea.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Observation of the lunch meal on the resident's unit on 10/10/24, at 12:17 p.m. revealed that the facility prepared and served baked chicken leg, sweet potato, broccoli, white bread, and cherry crisp cobbler.</p> <p>Interview with Resident R1 at the time of observation revealed the following: I can't remember the last time we received a dinner roll like it says, it is always a slice of bread. I don't know maybe the dinner rolls are too expensive and I crossed off the dessert for today, because it said it was going to be a gingersnap cookie and I don't care for those.</p> <p>During an interview on 10/09/24, at approximately 2:15 p.m. six of seven residents interviewed during a Resident Council meeting revealed that menus are not followed. Residents further indicated it was always a surprise what was under the lid when a meal was served.</p> <p>During an interview on 10/10/24, at approximately 10:30 a.m. the Dietary Manager stated they served chicken breast on Tuesday instead of the chicken thighs because the chicken thighs have too much fat on them and the residents don't care for them. He / she also stated they didn't serve the cherry crisp cobbler on Tuesday as scheduled because staff didn't realize it needed thawed out before they could cook it.</p> <p>During an interview on 10/10/24, at approximately 12:10 p.m. Nurse Aide (NA) Employees E2, E3, and E4 stated they are not aware of menu changes ahead of time and know what is served to the residents when they remove the lids from the trays.</p> <p>During an interview on 10/10/24, at approximately 1:30 p.m. the Nursing Home Administrator stated the Dietary Manager informs the Assistant Director of Nursing, or the first nurse he/she sees of any menu changes.</p> <p>During an interview on 10/11/24, at approximately 10:25 a.m. the Dietary Manager confirmed the menu was not followed as posted for the lunch meal 10/08/24, dinner meal 10/08/24, dinner meal 10/09/24, and lunch meal 10/10/24. The Dietary Manager stated some changes he/she was aware of and others the staff changed without prior approval. The Dietary Manager also confirmed that the facility does not use chicken thighs because of the fat, and the menus have not been updated to reflect that change.</p> <p>28 Pa. Code 211.6 (a) Dietary Services</p>		