

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

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Form Approved OMB
No. 0938-0391

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 11/18/2025
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based upon review of facility policies, observations, and staff interviews, it was determined that the facility failed to monitor sanitization chemicals for one of one three-compartment sinks; failed to ensure that food was stored in accordance with standards for food safety for four of four kitchen refrigerators, one of one solarium refrigerators, and one of one kitchen freezers; and failed to label food brought into the facility with the resident's name and use by date in one of five refrigerators. Findings include: Review of facility policy entitled Cleaning Dishes - Manual Dishwashing, dated 6/18/25, revealed the facility will check the sanitation sink often using a test strip to assure the level of sanitization solution is appropriate and that the facility will test the sanitizing solution in the sink using the manufacturer's suggested test strips to assure appropriate level. Review of facility policy entitled Food Storage, dated 6/18/25, revealed Refrigeration temperatures should be thermostatically controlled to maintain food temperatures at or below 41 degrees Fahrenheit (F) and freezer temperatures to keep food frozen solid (0 degrees F or below). The policy further revealed that each refrigerator / freezer will be supplied with a thermometer and monitored for appropriate temperatures at least two times each day. Facility policy also revealed that all foods should be covered, labeled, and dated before being and that refrigerated or frozen and items will be used within five days or discarded, unless frozen for future use. Observation on 9/23/25, of the main kitchen revealed one upright refrigerator unit that lacked a thermometer and evidence of the facility monitoring the temperature, and one milk cooler, one upright refrigerator, one walk-in refrigerator, and one walk-in freezer lacking evidence of routine temperature monitoring. Review of facility provided temperature logs from February 2025, through August 2025, for milk cooler lacked evidence of temperature checks for two of 56 twice daily checks for February, 17 of 62 twice daily checks for March, 45 of 60 twice daily checks for April, 38 of 62 twice daily checks for May, 54 of 60 twice daily checks for June, 60 of 62 twice daily checks for July, and 61 of 62 twice daily checks for August. Review of facility provided temperature logs from February 2025, through August 2025, for one upright refrigerator in the main kitchen lacked evidence of temperature checks for two of 56 twice daily checks for February, temperature log sheets for March, April, May, June, and July, and 56 of 62 twice daily checks for August. Review of facility provided temperature logs from February 2025, through August 2025, for one walk-in-cooler in the main kitchen lacked evidence of temperature checks for two of 56 twice daily checks for February, 17 of 62 twice daily checks for March, 44 of 60 twice daily checks for April, 37 of 62 twice daily checks for May, temperature log sheets for June, and July, and 57 of 62 twice daily checks for August. Review of facility provided temperature logs from February 2025, through August 2025, for one walk-in-freezer in the main kitchen lacked evidence of temperature checks for six of 56 twice daily checks for February, 20 of 62 twice daily checks for March, 45 of 60 twice daily checks for April, 35 of 62 twice daily checks for May, 33 of 60 twice daily checks for June, temperature log sheet for July, and 61 of 62 twice daily checks for August. During interview on 9/23/25, at approximately 10:55 a.m. Dietary Supervisor stated the one upright refrigerator was new and just put into service approximately a week or so ago and the staff did not ensure a thermometer was put into place and a temperature log was not implemented as required. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dietary Supervisor further confirmed that the one milk cooler, one upright refrigerator, one walk-in refrigerator, and one walk-in freezer lacked evidence of routine temperature monitoring as required. Observation of main kitchen on 9/23/25, revealed staff were utilizing the three-compartment sink to rinse, clean, and sanitize all dishware / kitchen utensils due to the mechanical dishwasher being out of service. Observation revealed there was no evidence of chemical test strips being readily available at the three-compartment sink to verify appropriate chemical sanitization levels, measured in parts-per-million (ppm). Observation also revealed the facility lacked evidence of any prior monitoring / documentation of routine chemical testing for the three-compartment sink. Review of facility provided dish machine temperature and sanitizer logs from June 2025, though September 2025, lacked evidence of wash cycle temperature checks for 40 of 90 three times daily checks for June, 35 of 93 three times daily checks for July, 47 of 93 three times daily checks for August, and 30 of 69 three times daily checks for September. Review of facility provided dish machine temperature and sanitization logs from June 2025 through September 2025, lacked evidence of final rinse cycle temperature checks for 40 of 90 three times daily checks for June, 35 of 93 three times daily checks for July, 46 of 93 three times daily checks for August, and 28 of 69 three times daily checks for September. Review of facility provided dish machine temperature and sanitization logs from June 2025 through September 2025, lacked evidence of sanitization chemical checks for 0 of 90 three times daily checks for June, 0 of 93 three times daily checks for July, 0 of 93 three times daily checks for August, and 0 of 69 three times daily checks for September. During an interview on 9/23/25, at 10:54 a.m. Dietary Aide Employee E5 stated he/she was washing all the dishes in the three-compartment sink because the dishwasher was down and normally they only wash the pots and pans in the three-compartment sink. During an interview on 9/23/25, at 10:57 a.m. Dietary Aide Employee E3 stated he/she has been here since March 2025 and was never told to check or document the chemical level in the three-compartment sink. During an interview on 9/23/25, at 11:00 a.m. Dietary Aide Employee E4 stated he/she has been here full-time since July 2025 and he/she knows that they are supposed to check and document the chemical level in the three-compartment sink, but has never seen anything to document this in. During an interview on 9/23/25, at 11:03 a.m. Dietary Supervisor confirmed he/she had to go and find testing strips for staff to use as they were not readily available, and he/she also confirmed the facility lacked any evidence of the chemical levels for the three-compartment sink being checked and documented as required. Observation of third floor solarium mini refrigerator / freezer on 9/24/25, at 9:41 a.m. revealed the unit lacked a thermometer and any evidence of temperatures or contents being monitored. The freezer contained an 8-ounce cool whip container with vegetable soup with no name and no date. The refrigerator contained two Activia yogurts with no name and an expiration date of 7/13/25, an empty box of chocolates and a 20-ounce bottle of orange cream cola with no name and no date. During an interview on 9/24/25, at 9:47 a.m. Licensed Practical Nurse (LPN) Employee E2 confirmed that the third-floor solarium mini refrigerator / freezer lacked a thermometer and evidence of temperature monitoring as well as items that were expired and contained no name and no date. LPN Employee E2 stated that this refrigerator is not to be used for resident items, and he/she was unaware that it contained anything at all. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(e)(2.1) Management		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to provide evidence that non-pharmacological interventions (interventions attempted to calm a resident other than medication) were attempted prior to the administration of a PRN (as needed) psychotropic (affecting the mind) medication for one of six residents reviewed for unnecessary medications (Resident R10). Findings include: Facility policy entitled Behavior Standard dated 6/18/25, revealed that the facility will identify, address and eliminate or reduce underlying cause of distressed behaviors and will develop interventions that are specific to the resident's interest, abilities, strengths, and needs. Resident R10's clinical record revealed an admission date of 8/22/25, with diagnoses that included congestive heart failure (CHF - a long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply causing blood and fluids collect in your lungs and legs over time), chronic obstructive pulmonary disease (COPD a condition that prevents airflow to the lungs resulting in difficulty breathing), and anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone). Resident R10's clinical record revealed a physician's order dated 8/22/25, with a discontinuation date of 9/22/25, for Lorazepam (anti-anxiety medication) 0.5 milligrams (mg) every 12 hours PRN for anxiety. Further review revealed another physician's order dated 9/22/25, with a discontinuation date of 12/21/25, for Lorazepam 0.5 mg every 12 hours PRN for anxiety. Resident R10's August 2025 Medication Administration Record (MAR) revealed that the PRN Lorazepam was used ten times (8/22/25, 8/24/25, 8/25/25, twice on 8/26/25, twice on 8/28/25, twice on 8/29/25, and 8/30/25). Review of the August MAR and clinical record progress notes revealed that there was no evidence of non-pharmacological interventions being attempted prior to the administration of the PRN Lorazepam three of the ten times it was used. Resident R10's September 2025 MAR revealed that the PRN Lorazepam was used 23 times (twice on 9/1/25, twice on 9/4/25, 9/5/25, twice on 9/7/25, 9/8/25, 9/9/25, 9/10/25, twice on 9/11/25, 9/12/25, 9/13/25, 9/14/25, 9/16/25, 9/18/25, 9/19/25, 9/20/25, 9/21/25, 9/23/25, 9/24/25, and 9/25/25). Review of the September MAR and clinical record progress notes revealed that there was no evidence of non-pharmacological interventions being attempted prior to the administration of the PRN Lorazepam 17 of the 23 times it was used. During an interview on 9/26/25, at 8:40 a.m. the Nursing Home Administrator confirmed that the facility lacked evidence of non-pharmacological interventions being attempted prior to the administration of a PRN anti-anxiety medication for each time it was administered for Resident R10. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of facility policies, and clinical records, and staff interview, it was determined that the facility failed to provide the Resident and/or resident representative with a written notice of the facility bed-hold policy (explanation of how long a bed can be held during a leave of absence and the cost per day) and failed to make certain that the necessary resident information was communicated to the receiving health care provider upon transfer to the hospital for two of four residents reviewed for hospitalization (Residents R5 and R11). Findings include: Facility policy entitled Notice of Bed Hold Policy at Time of Transfer Due to Hospitalization or Therapeutic Leave dated 6/18/25, revealed policy is provided to residents at the time of transfer of a resident for hospitalizations or therapeutic leave. Facility policy entitled Transfer of Resident To Another Care Community dated 6/18/25, revealed to promote continuity of care during transfer the facility will copy / prepare documents needed for transfer, including, but not limited to face sheet, advanced directive, current physician orders, current medication administration record, diagnosis list, history and physical, a list of all outstanding appointments, recent lab work, and other information as indicated. Resident R5's clinical record revealed an admission date of 2/21/25, with diagnoses that included rectal cancer, benign prostatic hyperplasia (BPH - a noncancerous enlargement of the prostate gland, which can result in frequent urination, difficulty starting or stopping urination and a weak urine stream), and diabetes (a health condition caused by the body's inability to produce enough insulin). Resident R5's clinical record revealed a progress note dated 05/14/2025, indicating Resident R5 was being transferred to the hospital from the wound clinic, where he/she was admitted . The clinical record lacked evidence indicating that Resident R5 and/or their representative were provided with a copy of the facility Bed Hold policy upon transfer or within twenty-four hours of transfer. Resident R5's clinical record revealed another progress note dated 6/3/25, indicating a transfer to the hospital. The clinical record lacked evidence that the resident's necessary clinical information was communicated to the receiving health care provider. During an interview on 09/26/2025, at 8:40 a.m. the Nursing Home Administrator (NHA) confirmed that Resident R5's clinical record lacked evidence that the resident and/or their representative were provided a copy of the facility bed-hold policy upon transfer or within twenty-four hours of transfer for the 5/14/25, hospitalization and that Resident R5's clinical record lacked evidence that necessary clinical information was communicated to the receiving health care provider for the 6/3/25, hospitalization. Resident R11's clinical record revealed an admission date of 7/19/21, with diagnoses that included heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), schizophrenia (mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), and high blood pressure. Resident R11's clinical record revealed a progress note dated 7/24/25, indicating a transfer to the hospital. The clinical record lacked evidence that the resident's necessary clinical information was communicated to the receiving health care provider. Resident R11's clinical record also lacked evidence indicating that Resident R11 and/or their representative were provided with a copy of the facility bed-hold policy upon transfer or within twenty-four hours of transfer. Further review revealed a progress note dated 8/11/25, indicating a transfer to the hospital. The clinical record lacked evidence that Resident R11 and/or their representative were provided with a copy of the facility bed-hold policy upon transfer or within twenty-four hours of transfer During an interview on 9/26/25, at 1:00 p.m. the NHA confirmed that Resident R11's clinical record lacked evidence that necessary clinical information was communicated to the receiving health care provider and the clinical record lacked evidence that the resident and/or their representative were provided with a copy of the facility bed-hold policy upon transfer or within twenty-four hours of transfer 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3)(2) Resident rights		

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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 policies, observations, and staff interviews it was determined that the facility failed to appropriately date and discard outdated medications for one of two medication rooms reviewed (third floor medication storage room). Findings include: Review of a facility policy entitled Storage of Medications dated 6/18/25, indicated that when the original seal of the manufacturer's vial is initially broken, the vial will be dated. The nurse will place a date opened sticker on the medication and enter the date opened and the new date of expiration. The expiration date of the vial will be 30 days unless the manufacturer recommends another date. Review of manufacturer's guidelines revealed that an open vial of Tubersol (a solution used for tuberculosis testing upon admission and employment) should be discarded within 30 days after opening. Observation of drug storage on 9/24/25, at approximately 3:26 p.m. of the third floor medication storage room refrigerator revealed one open vial of Tubersol with no date indicating when the vial was opened. During an interview at the time of observation, Registered Nurse Employee E1 confirmed that the open Tubersol vial lacked an opened date, and staff were unable to determine the discard date. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1) 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. Based on a review of facility policy and infection control guidelines, clinical records, observations, and staff interviews, it was determined that the facility failed to follow acceptable infection control practices regarding Transmission Based Precautions (TBP) during observation of a resident with COVID-19 for one of three residents reviewed for TBP (Resident R64). Findings include: Facility policy entitled Droplet Precautions with a policy review date of 6/18/25, indicated, droplet precautions should be used in addition to standard precautions for residents with infections that can be transmitted by droplets. Droplet transmission involves contact with the conjunctiva or mucus membranes of the nose or mouth of a susceptible person with large particle droplets containing microorganisms generated from a person who has a clinical disease or is a carrier of the microorganism. Droplets may be generated by the resident's coughing, sneezing, talking, or during the performance of procedures. Review of Pennsylvania Department of Health PAHAN dated 5/11/23, with a subject of Interim Infection Prevention and Control Recommendations for COVID-19 in Healthcare Settings Post visual alerts (e.g., signs, posters) at the entrance and in strategic places with instructions about current Infection Control Procedures (IPC). Resident R64's clinical record revealed an admission date of 5/13/25, with diagnoses that included Heart failure (Chronic condition in which the heart does not pump blood as well as it should), lack of coordination, muscle wasting, and Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). Resident R64's clinical record revealed a progress note dated 9/17/25, that Resident R64 had a fever of 102.4 degrees; COVID test positive; doctor and Infection Preventionist notified; Resident moved to another room to isolate; droplet isolation initiated and maintained. Observations on 9/23/25, at about 1:00 p.m., 9/24/25, at about 9:30 a.m., and 9/25/25, at 10:15 a.m., revealed Resident R64's room without any signage alerting persons entering the room of COVID positive resident and droplet precautions for infection control outside of the room visible. During an interview on 9/25/25, at about 11:15 a.m. the Infection Preventionist and Assistant Director of Nursing confirmed that Resident R64's room lacked signage of Droplet Precautions and COVID positive resident for a resident currently in isolation precautions for positive COVID-19. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services		