STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395735	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lifequest Nursing Center	2450 John Fries Highway Quakertown, PA 18951

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide care and services to maintain activities of daily living (eating) for one of 27 sampled residents. (Resident 35)Findings include:Clinical record review revealed that Resident 35 had diagnoses that included Parkinson's Disease and dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had cognitive impairments and was dependent on staff for activities of daily living (ADL), including personal hygiene, dressing, and eating. According to the care plan, the resident had an ADL self-care deficit with an intervention for staff to assist the resident with eating and personal hygiene. Observations on April 28, 2026, at 12:30 p.m., revealed Resident 35 in bed with his lunch tray. Resident 35 was attempting to feed himself, spilling food onto his chest/clothes. At 12:50 p.m., staff entered and stood next to Resident 35, fed him a few spoonfuls, and exited at 12:53 p.m. Resident 35 continued to attempt to feed himself, using his fingers, and spilling food down his face and onto his chest and clothing. Resident 35 was not assisted with the remainder of his meal. At 1:09 p.m., Resident 35 asked a nurse aide for help. The nurse aide left the room and returned at 1:20 p.m., and laid the resident down, the nurse aide did not assist Resident 35 to clean his face or chest/clothing that was stained with food.In an interview on April 30, 2026, at 3:53 p.m., Licensed Practical Nurse (LPN) 1 stated that Resident 35 was totally dependent on staff assistance for meals.In an interview on May 1, 2026, at 11:10 a.m., the Administrator and Registered Nurse Assessment Coordinator (RNAC) also confirmed that Resident 35 was dependent on staff for assistance with meals.28 Pa. Code 211.12(d)(1)(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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and interview, it was determined that the facility failed to provide restorative nursing services to improve or maintain range of motion on a consistent basis for one of 27 sampled residents. (Resident 35) Findings include:Clinical record review revealed that Resident 35 had diagnoses that included Parkinson's Disease, muscle weakness and dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had cognitive impairments and was dependent on staff for activities of daily living (ADL), including personal hygiene and eating. According to the care plan, the resident had an ADL self-care deficit with an intervention for staff to assist the resident with ADL's. On January 24, 2026, a Restorative Nursing Program (RNP) for passive range of motion during morning and evening care was recommended for Resident 35. Review of Resident 35's clinical record revealed there was a lack of documentation to support that the resident was offered or provided the passive range of motion RNP for 14 out of the last 30 days.In an interview on May 1, 2026, at 12:15 p.m., the Administrator confirmed that there was a lack of documented evidence that Resident 35 was offered the restorative nursing program with morning and evening cares.28 Pa. Code 211.12(d)(1)(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 clinical record review and facility documentation review, it was determined that the facility failed to ensure that staff provided adequate supervision in order to prevent falls for one of six residents at risk for falls. (Resident 102)Findings include:Clinical record review revealed that Resident 102 had diagnoses that included dementia, weakness, abnormalities of gait and mobility, and repeated falls. The Minimum Data Set assessment dated [DATE], indicated that the resident was cognitively impaired. A review of the care plan identified that the resident was at risk for falls. Review of the care plan further indicated that Resident 102 had an activities of daily living self care performance deficit with an intervention for staff to assist with ambulation. Review of a fall risk assessment dated [DATE], identified that Resident 102 was a high risk for falls.Review of facility documentation revealed that on December 29, 2025, the resident had fallen in the common area ambulating without assistance. On January 2, 2026, Resident 102 fell attempting to sit in a recliner another resident was occupying. On January 9, 2026, the resident fell again in the common area ambulating without assistance. On January 11, 2026, the resident fell in her room ambulating to the bathroom. On January 12, 2026, Resident 102 was lowered to the ground in the common area. On January 15, 2026, Resident 102 placed herself on the floor from a chair. On February 17, 2026, Resident 102 was found on the floor in the hallway. On February 26 and 27, 2026, Resident 102 was found on the bathroom floor. On March 5, 2026, the resident was found on the floor outside of her room doorway. On March 11, 2026, the resident fell again attempting to sit in a recliner another resident was occupying. On March 24, 2026, the resident fell against the fire door. On March 25 and 28, 2026, Resident 102 fell again trying to occupy a recliner chair. On March 30, 2026, the resident was found crawling on the floor. On April 1, 2026, Resident 102 fell once again trying to sit on a recliner chair. On April 4, 2026, Resident 102 fell twice, once outside and once bending to pick something up. On April 5 and 19, 2026, Resident 102 was again attempting to sit in a recliner chair and fell. On April 30, 2026, Resident 102 was again attempting to sit in a recliner that another resident was occupying and fell. Review of nursing documentation revealed that on February 15, 2026, Resident 102 was noted to be wandering and difficult to redirect. On February 18, 2026, Resident 102 was noted to be wandering non stop, pulling blankets off of other residents and nearly falling on multiple occasions while trying to move chairs and tables. On February 27, 2026, the resident was noted to be agitated. On March 4, 2026, Resident 102 was noted to be agitated and roaming non stop, moving chairs, nearly falling on several occasions, getting into the trash, and pulling things off the wall. On March 9, 2026, the resident was noted as anxious and wandering, and hard to redirect. On March 11 and 31, 2026, Resident 102 was noted to be very restless, anxious, and agitated and unable to be redirected. On April 1 and 2, 2026, Resident 102 was noted to be very agitated with an unsteady gait. On April 5, 2026, the resident was found self ambulating in the bathroom and urinating on the floor. On April 14, 2026, the resident was noted to ambulate with an unsteady gait, attempting to pick things up off the floor that were not there, and be restless. The facility failed to provide adequate supervision to prevent falls for a resident who had an unsteady gait requiring assistance from staff for walking and impulsive behavior and had fallen 21 times in four months.28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on clinical record review it was determined that the facility failed to attempt non-pharmacological interventions to alleviate pain prior to the administration of pain medication prescribed on an as needed basis for one of 27 sampled residents. (Resident 10)Findings include:Clinical record review revealed that Resident 10 had diagnoses that included opioid dependence and chronic pain syndrome. On March 18, 2026, the physician ordered for the resident to receive the narcotic pain medication, oxycodone-acetaminophen, every six hours as needed for moderate to severe pain. Review of Resident 10's care plan revealed the resident had chronic pain with an interventions for staff to provide rest periods, quiet, and a calm environment to facilitate relief when experiencing pain. Review of Medication Administration Records revealed that the resident received the as needed narcotic (oxycodone-acetaminophen) without documented evidence that non-pharmacological interventions were attempted prior to administration seven times in March 2026, and 18 times in April 2026.28 Pa. Code 211.9(a)(1) Pharmacy services.28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on review of facility records and staff interview, it was determined that the facility failed to electronically submit direct care staffing information in the Payroll Based Journal (PBJ) system for one of one quarter reviewed. (Quarter one)Findings include:Review of a PBJ staffing data report revealed that the facility did not submit data for Quarter one (October 1, 2025, to December 31, 2025). In an interview on April 30, 2026, at 1:50 p.m., the Administrator confirmed that the facility failed to submit staffing data to the Center for Medicare and Medicaid Services (CMS) for the PBJ report for Quarter one of 2026.28 Pa. Code 201.18(b)(3) Management.