STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395879	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Mercer	8221 Lamor Road Mercer, PA 16137

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** 41309 Based on review of facility policy and clinical records and facility documentation, and resident and staff interviews, it was determined that the facility failed to provide assistance with personal hygiene and showers for three of four residents reviewed (Residents R3, R4, and R5). Findings include: Review of facility policy entitled Showers with a revision date of March of 2020, revealed, A shower is provided for residents who are able to participate. Showers are given according to a pre-determined schedule and as needed. Observation of skin for redness, irritation, or irregularities is conducted during shower. Assist resident into shower and onto shower chair (resident may stand to shower if able). Remain with the resident. Assist resident with showering as needed. Document bath and personal care in Point Click Care. Resident R3's Minimum Data Set (MDS-periodic assessment of resident care needs) dated 12/27/24, indicated that Resident R3 required substantial/maximal assistance from staff for bathing. During an interview on 1/22/25, at 1:30 p.m. Resident R3 stated that he/she is not getting bathed and hasn't had a shower in 2-3 weeks. Review of Resident R3's physician orders revealed that he/she was to get a shower every Monday and Thursday afternoon and as needed. Shower/bath documentation under tasks section of the clinical record, for the last 30 days, revealed that Resident R3 only received one bed bath, and zero showers in the shower room over 30 days. During an interview on 1/22/25, at 1:40 p.m. Resident R4 reported that he/she does not get showered/ bathed routinely and that he/she has not received a shower/bath in two weeks. Review of Resident R4's physician orders revealed that he/she was to get a shower every Wednesday and Saturday afternoon and as needed. Resident R4's most recent quarterly MDS dated [DATE], indicated that he/she required dependent assistance from staff for bathing. Shower/bath sheets revealed that Resident R4 hadn't received a shower in the past 30 days. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident R5's MDS dated [DATE], indicated that Resident R5 required substantial/maximal assistance from staff for bathing. During an interview on 1/22/25, at 1:50 p.m. Resident R5 stated that he/she has not received a shower regularly and cannot remember when his/her last shower was. Review of Resident R5's physician orders revealed that he/she was to get a shower every Wednesday and Saturday on day shift and as needed. Shower/bath documentation in tasks for the last 30 days, revealed that Resident R5 only received one shower on 1/05/25, in the shower room and had been given Bed baths documented five times over 30 days. During an interview on 1/22/25, at 3:30 p.m. the Nursing Home Administrator and Regional Nurse confirmed that there was no evidence to determine that Residents R3, R4, and R5 were given a shower per their shower schedule on scheduled shower/bath days and the residents should be assisted by staff into the shower room unless he/she refuses. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41309 Based on review of clinical records and facility policy, and staff interview, it was determined that the facility failed to ensure evidence for provision of documentation of pressure ulcers for two of eight residents identified for pressure ulcers (Residents R1 and R2). Findings include: A facility policy entitled, Skin integrity and wound management with a policy and procedure review date of September 2, 2021, revealed, Perform skin inspection on admission and weekly by a licensed nurse. Document in PCC [Point Click Care]. Perform wound assessment and complete proper forms upon initial identification of altered skin integrity, weekly, and with any deterioration of wound. Review of Resident R1's clinical record revealed an admitted [DATE], with diagnoses that included obesity, reduced mobility, weakness, abnormalities of gait and mobility, and radiculopathy of the lumbar region (compressed nerve root of the lower back causing pain and numbness). Review of Resident R1's progress notes revealed that Resident R1 had developed a facility acquired Stage 2 (partial-thickness loss of skin) pressure ulcer on coccyx from 3/02/24. During an interview on 1/22/25, at approximately 1:15 p.m., Resident R1 stated that the facility does not regularly measure the pressure wound on his/her coccyx but does perform treatments. Review of Resident R1's progress notes revealed that documentation of weekly skin assessments for description and measurements were documented weekly until 5/22/24, then were documented 8/08/24, 12/18/24, 1/23/25, and 1/24/25. Review of Resident R1's clinical record revealed no evidence of weekly pressure ulcer documentation. Review of Resident R2's clinical record revealed an admitted [DATE], with diagnoses that included urinary tract infection, pressure ulcer of the sacral region, type 2 diabetes (long term condition in which the pancreas does not make enough insulin and the body cannot control blood sugar), and underweight. Review of Resident R2's progress notes revealed that Resident R2 was admitted to the facility with a Stage 4 (full thickness loss of skin and bone exposure) pressure ulcer on right sacrum. Review of Resident R2's progress notes revealed that an initial skin assessment and documentation of weekly skin assessments for description and measurements were not documented until 1/23/25. Review of Resident R2's clinical record revealed no evidence of weekly pressure ulcer documentation/assessments. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/24/25, at 2:30 p.m. the Regional Nurse confirmed that there was no evidence of documentation of weekly pressure ulcer assessments completed in Resident R1 and R2's clinical records. 28 Pa. Code 211.5(f)(iv)(ix) Medical records 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services