

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  396132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/20/2025
NAME OF PROVIDER OR SUPPLIER  Quality Life Services - Westmont		STREET ADDRESS, CITY, STATE, ZIP CODE  787 Goucher Street Johnstown, PA 15905	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>31760</p> <p>Based on review of facility policies, clinical records, and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from verbal abuse for one of 26 residents reviewed (Resident 19). This deficiency was cited as past non-compliance.</p> <p>Findings include:</p> <p>The facility's abuse policy, dated April 8, 2024, revealed that it is the policy of the facility to treat all residents with kindness, respect, and in a manner that is at all times free from abuse, neglect, misappropriation of property, exploitation, or mistreatment.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 19, dated October 29, 2024, revealed that the resident was understood, could understand others, exhibited no behaviors, was frequently incontinent of bladder, and always continent of bowel. Resident 19 had diagnoses that included a psychotic disorder (a group of mental health conditions characterized by a loss of touch with reality, leading to distorted perceptions, thoughts, and behaviors) and schizophrenia (a chronic mental illness characterized by significant disruptions in thought processes, perceptions, emotions, and behaviors).</p> <p>A nursing note for Resident 19, dated October 31, 2024, revealed that the resident had a registered nurse assessment completed for allegations of verbal abuse. There were no signs or symptoms of bodily injury noted.</p> <p>(continued on next page)</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility investigation documents for Resident 19, dated October 31, 2024, revealed that Resident 19 was verbally abused by Nurse Aide 1. The Nursing Home Administrator was on call with Registered Nurse Supervisor 2 regarding the behavior of Nurse Aide 1 towards residents. At that time, Registered Nurse Supervisor 2 stated that she had heard Nurse Aide 1 stating at approximately 10:00 p.m. on October 30, 2024, you can sit there with your d**k out and pi**ing on the floor. I'm not helping you. The Nursing Home Administrator and Director of Nursing questioned Registered Nurse Supervisor 2 why she did not pull Nurse Aide 1 off the floor and notify the Nursing Home Administrator and Director of Nursing regarding this. She replied that Nurse Aide 1 does not listen. The Nursing Home Administrator and Director of Nursing re-educated Registered Nurse Supervisor 2 on the facility's protocol for abuse reporting and timeline for abuse reporting. Upon further investigation, another nurse aide had stated that she heard Nurse Aide 1 say about keeping his d**k in his pants in the resident's room. Nurse Aide 1 was interviewed and reported that she stated to the resident, Do not take your penis out because you urinated on the floor. Resident 19 was interviewed but could not recall any issues or concerns of the matter. Nurse Aide 1 stated that she did not use swear words at the resident. Nurse Aide 1 was called and made aware of her suspension pending investigation. The residents on A Hall were interviewed. One resident stated that she heard a loud voice but could not make out what was said at the time that this occurred. No further issues were reported. All other residents reported that they did not hear or experience any staff member making inappropriate comments to them or any other resident.</p> <p>A statement completed by Nurse Aide 1, dated October 31, 2024, revealed that she told Resident 19 do not take your penis out because you urinated on the floor.</p> <p>A statement completed by Registered Nurse Supervisor 2, dated October 31, 2024, revealed that while she was in A Hall she heard Nurse Aide 1 say to Resident 19, You can sit there with your d**k out and pi**ing on the floor. I'm not helping you.</p> <p>Interview with the Nursing Home Administrator on February 19, 2025, at 9:30 a.m. confirmed that through their investigation that they were able to substantiate verbal abuse against Resident 19.</p> <p>Following notification of the incident that occurred on October 30, 2024, on October 31, 2024, the facility's corrective actions included:</p> <p>Nurse Aide 1 was suspended of her duties, and after the investigation her employment with the facility was terminated.</p> <p>An audit of residents was performed.</p> <p>Registered Nurse Supervisor 2 was re-educated regarding abuse.</p> <p>Re-education regarding abuse to staff was started.</p> <p>Daily random audits of residents were being completed, and interviews continue to ensure that no residents have been affected.</p> <p>The results of these audits will be brought to the Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F600 on November 7, 2024.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 201.29(j) Resident Rights.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>31760</p> <p>Based on review of facility policies, clinical records, investigation documents, and the Department of Health's Event Reporting System (ERS), as well as staff interviews, it was determined that the facility failed to ensure that staff reported allegations of verbal abuse in a timely manner for two of 26 residents reviewed (Resident 19, 136). This deficiency was cited as past non-compliance.</p> <p>Findings include:</p> <p>The facility's abuse policy, dated April 8, 2024, revealed that to protect the residents, the facility will implement procedures in the areas of screening, training, prevention, identification, investigation, protection, reporting/response, and corrective action. The following procedure will be implemented by the facility when an incident of abuse, neglect, exploitation or mistreatment including injuries of an unknown source, or misappropriation of resident property, and resident abuse, alleged or suspected. This includes allegations involving other residents, visitors, employees, or any other person. Any situation of abuse or suspected abuse will be reported as follows. The Nursing Home Administrator or Director of Nursing must be notified immediately.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 19, dated October 29, 2024, revealed that the resident was understood, could understand others, exhibited no behaviors, was frequently incontinent of bladder, and always continent of bowel. Resident 19 had diagnoses that included a psychotic disorder (a group of mental health conditions characterized by a loss of touch with reality, leading to distorted perceptions, thoughts, and behaviors) and schizophrenia (a chronic mental illness characterized by significant disruptions in thought processes, perceptions, emotions, and behaviors).</p> <p>A nursing note for Resident 19, dated October 31, 2024, revealed that the resident had a registered nurse assessment completed for allegations of verbal abuse. There were no signs/symptoms of bodily injury noted.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility investigation documents for Resident 19, dated October 31, 2024, revealed Resident 19 was verbally abused by Nurse Aide 1. The Nursing Home Administrator was on call with Registered Nurse Supervisor 2 regarding the behavior of Nurse Aide 1 towards residents. At that time, Registered Nurse Supervisor 2 stated that she had heard Nurse Aide 1 stating at approximately 10:00 p.m. on October 30, 2024, you can sit there with your d**k out and pi**ing on the floor. I'm not helping you. The Nursing Home Administrator and Director of Nursing questioned Registered Nurse Supervisor 2 as to why she did not pull Nurse Aide 1 off the floor and notify the Nursing Home Administrator and Director of Nursing regarding this. She replied that Nurse Aide 1 does not listen. The Nursing Home Administrator and Director of Nursing re-educated Registered Nurse Supervisor 2 on the facility's protocol for abuse reporting and timeline for abuse reporting. Upon further investigation of other staff members, another nurse aide had stated that she heard Nurse Aide 1 say about keeping his d**k in his pants in the resident's room. Nurse Aide 1 was interviewed and reported that she stated to the resident, Do not take your penis out because you urinated on the floor. Resident 19 was interviewed but could not recall any issues or concerns of the matter. Nurse Aide 1 stated that she did not use swear words at the resident. Nurse Aide 1 was called and made aware of suspension pending investigation. The residents in A Hall were interviewed. One resident stated that she heard a loud voice but could not make out what was said at the time that this occurred. No further issues reported. All other residents reported that they did not hear or experience any staff member making inappropriate comments to them or any other resident.</p> <p>A statement completed by Nurse Aide 1, dated October 31, 2024, revealed that she told Resident 19 do not take your penis out because you urinated on the floor.</p> <p>A statement completed by Registered Nurse Supervisor 2, dated October 31, 2024, revealed that while she was in A Hall she heard Nurse Aide 1 say to Resident 19, You can sit there with your d**k out and pi**ing on the floor. I'm not helping you.</p> <p>A quarterly MDS assessment for Resident 136, dated August 2, 2024, revealed that the resident was understood, could understand others, and had diagnoses that included a hip fracture and chronic obstructive pulmonary disease (COPD - a group of lung diseases that cause airflow obstruction and breathing problems).</p> <p>A nursing note for Resident 36, dated October 31, 2024, revealed that the resident had a registered nurse assessment completed for allegations of verbal abuse. There were no signs/symptoms of bodily injury noted.</p> <p>A statement completed by Nurse Aide 3, October 31, 2024, revealed that last night at 10:15 p.m. he heard Nurse Aide 1 yelling at Resident 136 because she spilled her water on herself. She said this is the second time you did this, if you would set the f**k up and stop playing with yourself you wouldn't make that happen.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Department of Health ERS report, dated October 31, 2024, revealed that the Nursing Home Administrator was notified at approximately 10:00 a.m. on October 31, 2024, that a nurse aide staff came to Registered Nurse Supervisor 4 reporting that she had received a written statement from another staff member that Resident 136 was verbally abused by Nurse Aide 1 on October 30, 2024. The Nursing Home Administrator and Director of Nursing contacted the staff member who had written the statement and asked what occurred. Nurse Aide 3 reported that he was coming down the hall at approximately 10:15 p.m. on October 30, 2024, and Resident 136 had rung her bell saying that she was soaked because she spilled water on herself. Nurse Aide 1 replied this is the second f*****g time that you spilled water on yourself. If you would stop playing with yourself this wouldn't have happened. The Nursing Home Administrator asked Nurse Aide 3 if he reported this to anyone, and he replied that he did not say anything to any other staff until his union representative came in at 6:00 a.m. At that time, the staff member stated that he needed to write a statement. The Nursing Home Administrator and Director of Nursing provided education on the abuse policy and reporting. Resident 136 was interviewed by the Director of Nursing, and she stated that she does not recall anything that had happened. Interviews with other staff were conducted and none heard of this discussion between Resident 136 and Nurse Aide 1. Nurse Aide 1 stated that she did not cuss at Resident 136 and had said that she replied to the resident, This is your second time that you spilled water on yourself. Nurse Aide 1 was made aware of suspension pending investigation.</p> <p>Interview with the Nursing Home Administrator on February 19, 2025, at 9:30 a.m. revealed that Nurse Aide 3 came to her on October 31, 2024, regarding the incident between Resident 136 and Nurse Aide 1. She indicated that during the investigation into that incident, she then became aware of the incident that occurred on October 30, 2024, with Resident 19 and Nurse Aide 1. She confirmed that Nurse Aide 3 and Registered Nurse Supervisor 2 did not immediately notify the Nursing Home Administrator and/or the Director of Nursing as per the facility's policy of the incidents involving Nurse Aide 1 and Residents 19 and 136 on October 30, 2024.</p> <p>Following notification of the incidents that occurred on October 30 and 31, 2024, the facility's corrective actions included:</p> <p>Nurse Aide 1 was suspended of her duties, and after the investigation her employment with the facility was terminated.</p> <p>An audit of residents was performed.</p> <p>Nurse Aide 3 was re-educated regarding abuse.</p> <p>Registered Nurse Supervisor 2 was re-educated regarding abuse.</p> <p>Re-education regarding abuse to staff was started.</p> <p>Daily random audits of residents were being completed, and interviews continue to ensure that no residents have been affected.</p> <p>The results of these audits will be brought to the Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F609 on November 7, 2024.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>19102</p> <p>Ensure each resident receives an accurate assessment.</p> <p>Based on a review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for three of 26 residents reviewed (Residents 14, 24, 32).</p> <p>Findings include:</p> <p>The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of MDS assessments, dated October 2024, indicated that the intent of Section N was to record the number of days, during the seven-day assessment period, that any type of injection, insulin, and/or select medications were received by the resident. Section N0415A was to be coded if the resident received an antipsychotic medication during the seven-day assessment period, and Section N0451K was to be coded if the resident received an anticonvulsant medication during the seven-day assessment period.</p> <p>Physician's orders for Resident 14, dated January 16, 2021, included an order for the resident to receive 100 milligrams (mg) of gabapentin (anticonvulsant medication) twice a day for rheumatoid arthritis (a chronic autoimmune disease that primarily affects the joints, causing inflammation, pain, and stiffness) and 300 mg of gabapentin at bedtime for rheumatoid arthritis. Medication Administration Records (MARs) for Resident 14, dated January and February 2025, revealed that staff administered 100 mg of gabapentin twice a day and 300 mg at bedtime from January 16 through February 19, 2025. However, Section N0415K1 of Resident 14's quarterly MDS assessment, dated February 3, 2025, was coded to indicate that the resident did not receive an anticonvulsant medication during the seven-day assessment.</p> <p>Physician's orders for Resident 24, dated January 10, 2025, included an order for the resident to receive 25 milligrams (mg) Seroquel (antipsychotic medication) every day. A quarterly MDS assessment for Resident 24, dated January 15, 2025, revealed that Section N0415A was coded indicating that the resident had not received an antipsychotic medication.</p> <p>Physician's orders for Resident 32, dated December 30, 2024, included an order for the resident to receive 100 mg of gabapentin three times a day for polyneuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet). MARs for Resident 32, dated December 2024 and January 2025, revealed that staff administered 100 mg of gabapentin three times a day from December 31 through January 3, 2025. However, Section N0415K1 of Resident 32's quarterly MDS assessment, dated January 3, 2025, was coded to indicate that the resident did not receive an anticonvulsant medication during the seven-day assessment.</p> <p>Interview with the Nursing Home Administrator on January 30, 2025, at 11:35 a.m. confirmed that MDS assessments for Residents 14, 24, and 32 were coded inaccurately.</p> <p>28 Pa. Code 211.5(f) Clinical Records.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>38012</p> <p>Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that resident-centered care plans were developed and implemented for one of 26 residents reviewed (Resident 6) who was on Enhanced Barrier Precautions (EBP) for having a surgically implanted drain.</p> <p>Findings include:</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated February 5, 2025, revealed that the resident was cognitively intact and dependent on staff for daily care tasks.</p> <p>Physician's orders for Resident 6, dated May 16, 2024, included an order that the resident may not be showered due to his surgically implanted percutaneous drain (gallbladder drain). Physician's order, dated June 12, 2024, included an order for the staff to flush the gallbladder drain vigorously daily.</p> <p>Observations of Resident 6 on February 18, 2024, at 10:08 a.m. revealed that the resident had a sign on his door indicating that he was on EBP and had personal protective equipment outside his door for staff to wear.</p> <p>There was no documented evidence that a care plan was developed to address Resident 6's care needs related to EBP.</p> <p>Interview with Nurse Aide 5 on February 18, 2025, at 10:08 a.m. revealed that Resident 6 was on Enhanced Barrier Precautions and that staff must wear a gown when entering his room and providing care for him.</p> <p>Interview with Nursing Home Administrator on February 20, 2025, at 10:29 a.m. confirmed that Resident 6's care plan did not address his care needs related to EBP.</p> <p>28 Pa. Code 201.24(e)(4) Admission Policy.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>19102</p> <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on clinical record reviews and staff interviews, it was determined that the facility failed to provide care and treatment in accordance with professional standards of practice, by failing to follow physician's orders to provide medications as ordered by the physician for two of 26 residents reviewed (Residents 24, 25) and failing to obtain a physician's order for fortified foods and health shakes for one of 26 residents reviewed (Resident 14).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 24, dated January 15, 2025, revealed that the resident was cognitively impaired and required maximum assistance from staff for her daily care needs.</p> <p>Physician's orders for Resident 24, dated December 28, 2024, included an order for the resident to receive 25 milligrams (mg) of Metoprolol (high blood pressure medication) daily and to hold the medication if the systolic (top number) blood pressure was less than 120 millimeters of mercury (mmHg) or the diastolic (bottom number) was less than 70 mmHg. However, the resident's Medication Administration Record (MAR) for January 2024 and February 2024 revealed that the resident was administered 25 mg Metoprolol on the following dates when her pressure was below the hold parameters: January 3 blood pressure was 118/70 mmHg; January 4 blood pressure was 110/70 mmHg; January 5 blood pressure was 102/72 mmHg; January 10 blood pressure was 110/76 mmHg; January 14 blood pressure was 116/90 mmHg; January 15 blood pressure was 104/68 mmHg; January 17 blood pressure was 110/80 mmHg; January 18 blood pressure was 114/80 mmHg; January 20 blood pressure was 118/80 mmHg; January 22 blood pressure was 112/82 mmHg; January 26 blood pressure was 118/64 mmHg; January 28 blood pressure was 112/72 mmHg; January 30 blood pressure was 114/83 mmHg; January 31 blood pressure was 110/75 mmHg; February 3 blood pressure was 110/78 mmHg; February 5 blood pressure was 108/82 mmHg; February 6 blood pressure was 102/74 mmHg; February 11 blood pressure was 126/76 mmHg; February 16 blood pressure was 104/80 mmHg; February 20 blood pressure was 106/80 mmHg.</p> <p>Interview with the Nursing Home Administrator on February 20, 2025, at 2:31 p.m. confirmed that Resident 24's Metoprolol was administered on the above dates when it should have been held.</p> <p>An admission MDS assessment for Resident 25, dated January 17, 2025, revealed that the resident was understood, could understand others, and had a diagnosis which included hypertension (elevated blood pressure). A care plan for the resident, dated January 13, 2025, revealed that the resident has hypertension, and when administering anti-hypertensive medications staff was to monitor for their effectiveness and any possible side effects such as orthostatic hypotension (a condition where blood pressure drops significantly when a person stands up from a sitting or lying position) and increased heart rate.</p> <p>Physician's orders for Resident 25, dated January 14, 2025, included an order for the resident to receive one five mg tablet of Amlodipine (used to treat high blood pressure) in the morning and staff was to hold the medication for a systolic blood pressure of less than 110 mmHg.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 25's MARs for January and February 2025 revealed that staff administered the one five mg tablet of Amlodipine upon arising on January 31, 2025, for a blood pressure reading of 98/60 mmHg and upon arising on February 5, 2025, for a blood pressure reading of 102/54 mmHg.</p> <p>Physician's orders for Resident 25, dated January 13, 2025, included an order for the resident to receive one 100 mg tablet of Atenolol (used to treat high blood pressure) two times per day and staff was to hold the medication for a systolic blood pressure of less than 110 mmHg or a heart rate less than 55 beats per minute (BPM).</p> <p>Resident 25's MARs for January and February 2025 revealed that staff administered the one 100 mg tablet of Atenolol upon arising on January 31, 2025, for a blood pressure reading of 98/60 mmHg; upon arising on February 5, 2025, for a blood pressure reading of 102/54 mmHg; at natural sleep time on January 25, 2025, for a blood pressure reading of 104/64 mmHg; and on February 9, 2025, for a blood pressure reading of 105/58 mmHg. However, review of the resident's clinical record, including the MARs, revealed no documented evidence that staff obtained the resident's heart rate prior to the natural sleep time administration of the one 100 mg tablet of Atenolol to determine if the medication should have been administered.</p> <p>Physician's orders for Resident 25, dated January 15, 2025, included an order for the resident to receive one 50 mg tablet of Hydralazine (used to treat high blood pressure) three times a day and staff was to hold the medication for a systolic blood pressure of less than 110 mmHg or a heart rate less than 55 BPM.</p> <p>Resident 25's MARs for January and February 2025 revealed that staff administered the one 50 mg tablet of Hydralazine upon arising on January 22, 2025, for a blood pressure reading of 109/46 mmHg; on February 5, 2025, for a blood pressure reading of 102/54 mmHg; before supper on January 25, 2025, for a blood pressure reading of 108/60 mmHg; on January 27, 2025, for a blood pressure reading of 90/50 mmHg; on February 8, 2025, for a blood pressure reading of 102/62 mmHg; at natural time of sleep on January 25, 2025, for a blood pressure reading of 104/64 mmHg; and on February 9, 2025, for a blood pressure reading of 105/58 mmHg. However, review of the resident's clinical record, including the MARs, revealed no documented evidence that staff obtained the resident's heart rate prior to the before supper and the natural sleep time administrations of the one 50 mg tablet of Hydralazine to determine if the medication should have been administered.</p> <p>Interview with Nursing Home Administrator on February 20, 2025, at 2:31 p.m. confirmed that Resident 25's one five mg tablet of Amlodipine, one five mg tablet of Amlodipine, and one 50 mg tablet of Hydralazine should not have been administered on the above dates, and confirmed that there was no documented evidence that the resident's heart rate was checked prior to the natural sleep time administration of the one 100 mg tablet of Atenolol and the before supper and the natural sleep time administrations of the one 50 mg tablet of Hydralazine.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 14, dated February 3, 2025, indicated that the resident was moderately cognitively impaired and had a weight loss. Physician's orders, dated February 1, 2024 and December 9, 2024, included orders for the resident to receive health shakes twice a day and a reduced concentrated sweets diet, soft and bite sized texture, fortified foods at meals, and bread.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Quality Life Services - Westmont		STREET ADDRESS, CITY, STATE, ZIP CODE  787 Goucher Street Johnstown, PA 15905	
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A nursing note, dated December 30, 2024, at 9:22 p.m. revealed that Resident 14 was readmitted from the hospital. A physician's order, dated December 30, 2024, included an order for the resident to receive a reduced concentrated sweets diet, soft and bite sized texture, and bread.</p> <p>A dietitian note, dated January 30, 2025, revealed that the resident had a weight loss and supplemental nutrition was ordered, which included health shakes twice a day and fortified foods at all meals.</p> <p>Interview with the Dietitian on February 19, 2025, at 2:29 p.m. revealed that she re-ordered the health shakes and fortified foods on January 30, 2025, when she realized that they were not ordered upon her re-admission from the hospital on December 30, 2024. She indicated that Resident 14 continued to receive health shakes twice a day and fortified foods with all meals, despite not having a physician's order.</p> <p>Interview with the Dietary Manager on February 19, 2025, at 2:50 p.m. confirmed that the resident continued to receive health shakes twice a day and fortified foods with all meals since her re-admission on December 30, 2024, according to her dietary supplement information.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>19102</p> <p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to monitor a resident's weight as recommended by the dietician for one of 23 residents reviewed (Resident 14). This deficiency was cited as past non-compliance.</p> <p>Findings include:</p> <p>The facility's policy regarding weights, dated April 8, 2024, revealed that if a weight is obtained and a five-pound weight loss or gain has occurred for individuals weighing greater than 100 pounds or a three-pound weight loss or gain occurred for individuals weighing less than 100 pounds, then a re-weight should be obtained within 24 hours of the first obtained weight. Staff were to ensure the individual was weighed on the same scale as previously used, and when the re-weight was obtained the weight should be documented in the medical record, stating that it was a re-weight and the previous weight should be struck out. All residents with a significant weight change would be assessed and referred to the dietitian for assessment.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 14, dated February 3, 2025, indicated that the resident was moderately cognitively impaired and had a weight loss.</p> <p>A weight record, dated December 13, 2024, revealed that Resident 14 weighed 127.4 pounds. A weight record dated January 1, 2025, revealed the resident's weight was 117.8 pounds.</p> <p>A dietitian note for Resident 14, dated January 9, 2025, revealed that the resident's weight was 117.8 pounds, the weight was more than a five pound difference from the previous weight, a re-weight had been requested and was pending, and she would re-assess the weight status when a re-weight was obtained. However, there was no documented evidence that a re-weight had been obtained after the January 9, 2025, dietitian note.</p> <p>On January 16, 2025, the resident's weight was 136.2 pounds (gain of 18.4 pounds); however, there was no documented evidence that a re-weight had been obtained until January 21, 2025, when the resident's weight was 116.4 pounds.</p> <p>An interview with the Director of Nursing and Nursing Home Administrator on February 19, 2025, at 11:54 a. m. confirmed that Resident 14 was not re-weighed according to the dietitian's recommendations or facility policy.</p> <p>Following the identification on October 18, 2024, that they were not obtaining re-weights, the facility's corrective actions included:</p> <p>A weight team was developed to improve weight obtainment by nursing staff, which included nursing staff and other staff members.</p> <p>Audits were started on all residents to ensure that re-weights recommended by the dietitian were obtained.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The results of these audits will be brought to the Quality Assurance Performance Improvement committee for further analysis and corrective actions if necessary.</p> <p>Review of the facility's corrective actions and interviews with staff regarding re-weights revealed that they were in compliance with F692 on February 1, 2025.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>31760</p> <p>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to maintain a complete and accurate accounting of controlled medications (medications with the potential to be abused) for one of 26 residents reviewed (Resident 33).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 33, dated December 23, 2024, revealed that the resident was understood, could understand others, and had a diagnosis of anxiety. A care plan for the resident, dated October 14, 2024, revealed that the resident uses anti-anxiety medications related to an anxiety disorder, and staff was to administer the anti-anxiety medications to the resident as ordered by the physician.</p> <p>Physician's orders for Resident 33, dated December 20, 2024, included an order for the resident to receive a one milligram (mg) tablet of Clonazepam (a narcotic medication used to prevent and treat anxiety disorders) every eight hours as needed.</p> <p>Resident 33's controlled drug logs for January and February 2025 revealed that staff signed out doses of Clonazepam for administration to the resident on January 7, 2025, at 7:07 p.m.; January 12, 2025, at 7:05 a.m.; January 14, 2025, at 8:20 a.m.; January 29, 2025, at 6:30 a.m.; January 29, 2025, at 8:00 p.m.; February 5, 2025, at 4:00 a.m.; and on February 8, 2025, at 9:30 a.m. However, the resident's clinical record, including the Medication Administration Records (MARs) and the nursing notes, revealed no documented evidence that the Clonazepam was administered to the resident on these dates and times.</p> <p>Interview with the Nursing Home Administrator on February 20, 2025, at 3:40 p.m. confirmed that there was no documented evidence that the Clonazepam was administered to Resident 33 on the above-mentioned dates and times.</p> <p>28 Pa. Code 211.9(j)(3) Pharmacy Services.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>31760</p> <p>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that non-pharmacological (non-medication) interventions were attempted prior to the administration of anti-anxiety medications for one of 26 residents reviewed (Resident 33).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 33, dated December 23, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included anxiety. A care plan for the resident, dated October 14, 2024, revealed that the resident uses anti-anxiety medications related to an anxiety disorder, and staff was to administer the anti-anxiety medications to the resident as ordered by the physician and that staff should attempt non-pharmacological interventions (e.g., massage, music, quiet time, reading, watching TV, etc.) before the resident is offered the as needed psychotropic medication (medications that affect the mind and behavior).</p> <p>Physician's orders for Resident 33, dated December 20, 2024, included an order for the resident to receive a one milligram (mg) tablet of Clonazepam (a narcotic medication used to prevent and treat anxiety disorders) every eight hours as needed.</p> <p>Resident 33's Medication Administration Records (MARs) for January and February 2025 revealed that staff administered the one mg tablet of Clonazepam for anxiousness/restlessness on January 1, 2025, at 6:15 a. m. and 7:36 p.m.; January 2, 2025, at 6:58 p.m.; January 3, 2025, at 7:50 a.m. and 7:19 p.m.; January 4, 2025, at 9:03 p.m.; January 5, 2025, at 9:03 p.m.; January 6, 2025, at 7:38 a.m. and 6:50 p.m.; January 8, 2025, at 7:19 a.m. and 7:29 p.m.; January 9, 2025, at 7:02 a.m. and 8:53 p.m.; January 10, 2025, at 8:37 a. m. and 8:52 p.m.; January 11, 2025, at 8:23 a.m. and 7:19 p.m.; January 12, 2025, at 6:45 p.m.; January 13, 2025, at 8:10 a.m. and 9:31 p.m.; January 14, 2025, at 7:37 p.m.; January 15, 2025, at 7:44 a.m. and 6:21 p. m.; January 16, 2025, at 8:14 a.m. and 8:43 p.m.; January 17, 2025, at 8:41 a.m. and 6:48 p.m.; January 18, 2025, at 7:56 a.m. and 8:03 p.m.; January 19, 2025, at 9:15 p.m.; January 20, 2025, at 5:18 a.m. and 8:08 p. m.; January 21, 2025, at 5:05 a.m. and 9:29 p.m.; January 22, 2025, at 7:30 p.m.; January 23, 2025, at 6:43 a.m. and 7:06 p.m.; January 24, 2025 at 7:25 a.m. and 6:24 p.m.; January 25, 2025, at 8:02 a.m. and 6:24 p. m.; January 26, 2025, at 8:00 a.m. and 6:30 p.m.; January 27, 2027, at 9:27 a.m. and 10:07 p.m.; January 28, 2025, at 9:21 a.m. and 9:26 p.m.; January 30, 2025, at 6:24 a.m. and 6:52 p.m.; January 31, 2025, at 8:15 a.m. and 6:45 p.m.; February 1, 2025, at 9:38 a.m. and 9:50 p.m.; February 2, 2025, at 9:12 a.m. and 9:07 p.m.; February 4, 2025, at 6:22 a.m. and 7:38 p.m.; February 5, 2025, at 6:45 p.m.; February 6, 2025, at 9:25 a.m. and 6:42 p.m.; February 7, 2025, at 8:35 a.m. and 7:04 p.m.; February 8, 2025, at 8:05 p.m.; February 9, 2025, at 7:57 a.m. and 7:25 p.m.; February 10, 2025, at 7:26 a.m. and 8:24 p.m.; February 11, 2025, at 9:16 a.m. and 9:08 p.m.; February 12, 2025, at 9:13 a.m. and 9:23 p.m.; February 13, 2025, at 8:45 a.m. and 9:23 p.m.; February 14, 2025, at 8:52 a.m. and 6:51 p.m.; February 15, 2025, at 8:41 a.m. and 9:03 p.m.; February 16, 2025, at 8:39 a.m. and 9:36 p.m.; February 17, 2025, at 8:48 a.m. and 6:49 p.m.; February 18, 2025, at 9:10 a.m. and 10:11 p.m.; February 19, 2025, at 7:33 a.m. and 6:42 p.m.; and on February 20, 2025, at 8:35 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There was no documented evidence that non-medication interventions were attempted prior to the administration of the as needed Clonazepam.</p> <p>Interview with the Nursing Home Administrator on February 20, 2025, at 3:21 p.m. confirmed that there was no documented evidence that staff attempted non-medication interventions prior to administering the as needed Clonazepam to Resident 33 on the above-mentioned dates and times.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>19102</p> <p>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to provide medication as ordered by the physician, resulting in significant medication errors for one of 26 residents reviewed (Resident 32).</p> <p>Findings include:</p> <p>The facility's policy regarding medication administration, dated April 8, 2024, indicated that facility was to administer medications to residents in a safe manner that correlated with their daily activity and natural schedules. The facility's policy regarding physician's orders, dated April 8, 2024, revealed that physician's orders were to be followed in accordance with good nursing principles and practice and were to be transcribed and carried out by the persons legally authorized to do so.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 32, dated January 3, 2024, indicated that the resident was alert and oriented, received insulin, and had diagnoses that included diabetes.</p> <p>Physician's orders for Resident 32, dated January 2, 2025, included an order for the resident to receive 5 units of Insulin Lispro (fast acting insulin) subcutaneously (beneath the skin) before meals for diabetes and to hold the insulin if the resident's blood sugar was less than 140 milligrams/deciliter (mg/dL).</p> <p>Resident 32's Medication Administration Records (MARs) for December 2024 and January 2025 revealed that the resident's blood sugar at 8:00 a.m. on February 4 was 133 mg/dL and February 6 was 124 mg/dL; at 11:00 a.m. on January 9 was 126 mg/dL, January 23 was 125 mg/dL, February 15 was 98 mg/dL, and February 15 was 98 mg/dL; and at 4:00 p.m. on February 1 was 114 mg/dL and February 6 was 83 mg/dL.</p> <p>There was no documented evidence that Resident 32's insulin was held according to the physician-ordered parameters on the dates and times above.</p> <p>Interview with the Nursing Home Administrator on February 20, 2025, at 2:31 p.m. confirmed that the Insulin Lispro was not held as ordered on the dates and times above.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 31760</p> <p>Based on observations and staff interviews, it was determined that the facility failed to ensure that food was served under sanitary conditions.</p> <p>Findings include:</p> <p>Observations in the main kitchen on February 18, 2025, at 9:01 a.m.; February 19, 2025, at 11:15 a.m.; and on February 20, 2025, at 8:51 a.m. revealed that there was an accumulation of dust and food debris, a clear drinking glass, a small red bowl, and a [NAME] Cup (a lightweight, easy-to-grip adapted drinking cup designed to prevent spills) under and behind the ice machine, and there was an accumulation of dust and food debris under the stove.</p> <p>Interview with the Dietary Manager on February 20, 2025, at 8:58 a.m. confirmed that there was an accumulation of dust and food debris, a clear a drinking glass, small red bowl, and a [NAME] Cup under and behind the ice machine, and an accumulation of dust and food debris under the stove.</p> <p>28 Pa. Code 211.6(f) Dietary Services.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>19102</p> <p>Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to maintain compliance with nursing home regulations and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies.</p> <p>Findings include:</p> <p>The facility's deficiencies and plans of corrections for State Survey and Certification (Department of Health) survey ending April 3, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending February 20, 2025, identified repeated deficiencies related to accuracy of Minimum Data Set (MDS) assessments (mandated assessment of a resident's abilities and care needs), development of comprehensive care plans, quality of care, preventing issues with the accountability of controlled medications (drugs with the potential to be abused), preventing significant medication errors, and food procurement-storing/preparing/serving food under sanitary conditions.</p> <p>The facility's plan of correction for a deficiency regarding a failure to ensure that MDS assessments were accurate upon submission, cited during the survey ending April 3, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F641, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to accurate MDS assessments.</p> <p>The facility's plan of correction for a deficiency regarding the development of a comprehensive person-centered care plan, cited during a survey ending April 3, 2024, revealed that audits would be completed. The results of the current survey, cited under F656, revealed that the QAPI committee was ineffective in correcting deficient practices related to the development of a comprehensive person-centered care plan.</p> <p>The facility's plan of correction for a deficiency regarding quality of care, cited during the survey ending April 3, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding quality of care.</p> <p>The facility's plans of correction for deficiencies regarding the failure to account for controlled medications, cited during the surveys ending April 3, 2024, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F755, revealed that the facility's QAPI committee was ineffective in correcting deficient practices related to the accountability of controlled medications.</p> <p>(continued on next page)</p>		

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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 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's plan of correction for a deficiency regarding failure to be free from significant medication errors, cited during the survey ending April 3, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F760, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding residents being free from significant medication errors.</p> <p>The facility's plan of correction for a deficiency regarding labeling and storing food under sanitary conditions, cited during the survey ending April 3, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F812, revealed that the QAPI committee was ineffective in correcting deficient practices related to food procurement-storing/preparing/serving food under sanitary conditions.</p> <p>Refer to F641, F656, F684, F755, F760, F812.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p>		