STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396132	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Westmont	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)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to notify the resident and the resident's representative, in writing regarding the reason for transfer to the hospital eight of 22 residents reviewed (Residents 3, 4, 5, 7, 17, 18, 32, 41). Findings include:A quarterly Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 3, dated January 30, 2026, revealed that the resident was cognitively impaired, required assistance from staff for all daily care needs, and had a diagnosis that included respiratory syncytial virus (RSV) pneumonia.Nursing notes for Resident 3, dated January 5, 2026, at 5:37 a.m., revealed that the resident was admitted to the local hospital with the diagnosis of deep vein thrombosis (DVT) (a clot in a vein).Nursing notes for Resident 3, dated January 23, 2026, at 12:35 p.m., revealed that the resident was coughing with her meal, unable to tolerate nectar thick liquids and respirations were even unlabored. Physician's orders for the resident to be sent to the local hospital for worsening respiratory conditions. The resident was admitted with diagnosis of RSV.There was no documented evidence for Resident 3 that a written notification of transfer was provided to the resident's responsible party on the dates listed above.A significant change MDS assessment for Resident 4, dated February 17, 20206, indicated that the resident was cognitively impaired, required maximum assistance from staff for her daily care needs and had diagnoses that included, chronic kidney disease.A nursing noted for Resident 4 dated September 11, 2025 at 12:19 p.m. revealed that the registered nurse was called the residents room where Resident 4 was minimally responsive. Resident had right upper thigh wound and the site had yellow drainage. Resident 4 was transported to the hospital where she was admitted with a diagnosis of infection of left hip wound.A nursing note for Resident 4 dated January 11, 2026 at 12:09 p.m. revealed that Resident 4 was lethargic and unable to maintain oxygen saturation. Resident 4 was transported to the hospital where she was admitted with a diagnosis of RSV.Review of Resident 4's clinical record revealed that there was no documented evidence that a written notification of transfer was provided to the resident's responsible party on the above mentioned dates. A quarterly MDS assessment for Resident 5, dated January 19, 2026, indicated that the resident was cognitively impaired, dependent on staff for his daily care needs and had diagnoses that included, arthritis and pain. A nursing note for Resident 5 dated September 20, 2025 at 12:19 p.m. revealed that the resident had intractable pain unrelieved with bedrest and ordered pain medication. Resident 5 was transported to the hospital where he was admitted with a diagnosis of urinary tract infection.A nursing note for Resident 5 dated January 12, 2026 at 8:45 p.m. revealed that the resident was crying out in pain when attempting to reposition in bed unrelieved with ordered pain medication. Resident 5 was transported to the hospital where he was admitted with a diagnosis of urinary tract infection.Review of Resident 5's clinical record revealed that there was no documented evidence that a written notification of transfer was provided to the resident's responsible party on the above mentioned dates. A quarterly MDS assessment for Resident 7, dated December 12, 2025, indicated that the resident was cognitively impaired, required assistance from staff for his daily care needs and had diagnoses that included, Parkinson's disease (a progressive neurodegenerative brain disorder affecting movement and central (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nervous system function).A nursing note for Resident 7, dated June 13, 2025 at 8:07 p.m. revealed that the resident had a change in mental status. Resident 5 was transported to the hospital where he was admitted with a diagnosis of change in mental status.A nursing note for Resident 7, dated August 22, 2025, at 7:34 a.m. revealed that the resident was having chest pain and asking for help. Resident 7 was transported to the hospital where he was admitted with a diagnosis of chronic congestive heart failure.A nursing note for Resident 7, dated October 29, 2025, at 7:25 a.m. revealed that the resident had a changes in behavioral status. Resident 7 was transported to the hospital where he was admitted with a diagnosis of metabolic encephalopathy (a syndrome of temporary or permanent brain dysfunction not caused by direct brain injury).A nursing note for Resident 7, dated November 28, 2025, at 12:17 p.m. revealed the resident had significant pain unrelieved with ordered pain medication. Resident 7 was transported to the hospital where he was admitted with a diagnosis of hydrocephalus (a medical condition involving the abnormal accumulation of cerebrospinal fluid within the brain's ventricles).A nursing note for Resident 7, dated December 7, 2025, at 9:36 a.m. revealed the resident had lethargy and weakness of the right side. Resident 7 was transported to the hospital where he was admitted with a diagnosis of generalized weakness.A nursing note for Resident 7, dated December 20, 2025, at 3:22 p.m. revealed that the the resident had a increased lethargy with marked weakness. Resident 7 was transported to the hospital where he was admitted with a diagnosis of acute cystitis (a sudden infection causing inflammation in the bladder).Review of Resident 7's clinical record revealed that there was no documented evidence that a written notification of transfer was provided to the resident's responsible party on the above mentioned dates. A quarterly MDS assessment for Resident 17, dated February 24, 2026, revealed that the resident was severely cognitively impaired, required assistance from staff for daily care needs, and had medical diagnoses that included kidney failure and Parkinson's disease. A nursing note for Resident 17 dated February 16, 2026, at 5:55 p.m. revealed that the resident was unable to hold her arms up, her hand grips were unequal, had a recent decrease in intake of food and fluids, had a headache and was somewhat lethargic. The physician was notified and ordered the resident to be sent to Conemaugh Hospital for evaluation. The resident was admitted with diagnosis of dehydration. There was no documented evidence for Resident 17 that a written notification of transfer was provided to the resident's responsible party.An admission MDS assessment for Resident 18, dated January 22, 2026, revealed that the resident is cognitively intact, requires assistance from staff for daily care needs, and has medical diagnosis that includes heart failure and high blood pressure. A nursing note for Resident 18 dated February 28, 2026, revealed that the resident was being evaluated for weakness and physician's orders were to send to local hospital. The resident was admitted with diagnosis of urinary tract infection and ambulatory dysfunction.There was no documented evidence for Resident 18 that a written notification of transfer was provided to the resident's responsible party.A quarterly MDS assessment for Resident 32, dated February 20, 2026, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had medical diagnoses that included heart failure and hypertension (high blood pressure).Nursing notes for Resident 32, dated November 2, at 5:00 a.m. and November 7, 2025, at 1:36 a.m. revealed that the resident complained of having shortness of breath and chest pain. Physician's orders were obtained each day to transfer the resident to the hospital for further evaluation and treatment.There was no documented evidence for Resident 32 that a written notification of transfer was provided to the resident's representative.An admission MDS assessment for Resident 41, dated January 5, 2026, revealed that the resident was cognitively intact, required assistance from staff for daily care needs and had medical diagnosis that included cellulitis of right lower limb (an infection in the limb).A nursing note for Resident 41, dated January 15, 2026, at 8:27 p.m., revealed that the residents femoral popliteal bypass surgical incision (a surgical procedure that creates a new pathway for blood flow around a blocked artery in the leg) was hard, large and tender. Physician's orders were to send to the local hospital and the resident was admitted .There was no documented evidence for Resident 41 that a written notification of transfer was provided to the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's responsible party.Interview with the Nursing Home Administrator on March 11, 2026, at 8:30 a.m. confirmed that for Resident's 3, 4, 5, 7, 17, 18, 32, 41 there was no evidence that a written notice of transfer was provided to the responsible parties. 28 Pa. Code 201.29(j) Resident Rights.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that medications were provided as ordered by the physician for one of 22 residents reviewed (Resident 18).Findings include: An admission Minimum Data Set (MDS) assessment (a mandatory assessment of a resident's abilities and care needs) for Resident 18, dated January 22, 2026, revealed that the resident is cognitively intact, requires assistance from staff for daily care needs, and has medical diagnosis that includes heart failure and high blood pressure. Physician's orders for Resident 18 dated January 20, 2026, included an order for the resident to receive 12.5 milligrams of Carvedilol two times a day and to hold if systolic blood pressure is less than 100 mmHg; if heart rate is less than 60 beats per minute; and call physician if systolic blood pressure is greater than 170 mmHg. A review of Resident 18's Medication Administration Record (MAR's)for January and February 2026 indicated that the residents blood pressure on January 23 was 186/73 mmHg, on January 30 was 176/76 mmHg, on January 31 was 176/76 mmHg, on February 1 was 180/70 mmHg, on February 10 was 181/67 mmHg. There was no evidence that the physician was notified on the above dates that the residents systolic blood pressure was greater than 170 mmHg. On February 2, 2026, the resident's blood pressure was 162/78 mmHg and heart rate was 54 beats per minute. However, according to the MAR, staff administered carvedilol on February 2, 2026, when the medication should have been held. Interview with Nursing Home Administrator on March 11, 2026, at 9: 27 a.m. confirmed that the physician should have been notified of elevated systolic blood pressures on the days mentioned above and that the medication should have been held for heart rate less than 60 beats per minute and it was not. 28 Pa. Code 211.12(d)(3)(5) Nursing services.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and medication package inserts, as well as observations and staff interviews, it was determined that the facility failed to label one bottle of eye drops with the opened date, in one of two medication carts reviewed (B cart), failed to label two vials of tuber sol (a solution injected into the body to detect tuberculosis) with the opened date, in one of one medication room refrigerator reviewed, and failed to discard expired medical supplies in one of one medication rooms reviewed. Findings include:The facility's policy regarding medication labeling and storage, dated [DATE], revealed that multi-dose medications that have been opened or accessed are to be dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open medication.Observations of the B medication cart on [DATE], at 09:24 a.m. revealed one bottle of Latanoprost Ophthalmic Solution .005 percent eye drops that were opened and not dated with the date they were opened.Observations in the medication room refrigerator on [DATE], at 09:27 a.m. revealed two open vials of tuber sol that were opened and not dated with the date they were opened.Observations in the medication room on [DATE], at 9:35 a.m. revealed that there were nine Huber needles (special needles used to access Medi ports, which are small medical devices implanted under the skin), that expired in November of 2024 and August of 2025, twenty-one intravenous starter kits that expired in January of 2023, February of 2024 and [DATE], and four, 22 gauge intravenous catheters (medical supplies used in the vein to provide fluids or medication), that expired in September of 2025.Interview with Licensed Practical Nurse 1 on [DATE]. 2025, at 9:45, confirmed that the bottle of eye drops and the two vials of tuber sol were not properly labeled with an expiration date, and that expired medical supplies should not be in circulation in the medication room.Interview with the Nursing Home Administrator on [DATE], at 10:08 a.m. confirmed that the multi-dose medications should have been labeled with an expiration date, and that that expired medical supplies should not be in the medication room.42 CFR 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals.28 Pa. Code 211.9(a)(1) Pharmacy 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 review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that proper infection control practices were followed while providing medications for one of 22 residents reviewed (Resident 25).Findings include:The facility's policy regarding medication administration, dated November 11, 2025, indicated that staff were to ensure that medications were administered as prescribed in accordance with nursing principles and practice while maximizing independence and choice by utilizing resident centered care policies.Observations during medication administration on March 11, 2026, at 6:47 a.m. revealed that Licensed Practical Nurse 1 prepared to administer medications to Resident 25 and obtained Fish Oil and Senna/Docusate from stock medication bottles (medication used for multiple residents). The nurse touched the capsules of Fish Oil and Senna/Docusate with her bare hands and placed the capsules into the cup of medications. She then picked up a pill that had fallen on the top of the medication cart, picked it up with her bare hands, and placed it into the cup of medications. She then administered the medications to Resident 25.Interview with Licensed Practical Nurse 1 on March 11, 2025, at 6:29 a.m. confirmed that she should not have touched the medication with her bare hands.Interview with the Director of Nursing on March 11, 2026, at 8:00 a.m. confirmed that staff were not to touch residents' medications with their bare hands.28 Pa. Code 211.12(d)(1)(5) Nursing services.