STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395371	A. BLDG: 00 B. WING:	04/15/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
QUALITY LIFE SERVICES - APOLLO STATE LICENSE NUMBER: **235502**	**151 GOODVIEW DRIVE** **APOLLO, PA 15613**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on an Abbreviated Survey in response to a complaint, and an incident completed on April 15, 2025, it was determined that Quality Life Services-Apollo was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0689 SS=D		F 0689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0689 SS=D	Continued from page 1 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	0689 - R 2 was transferred to a secure facility the following day. R 2 was not seen leaving the facility by the receptionist. Elopement binder available and up to date. Facility has wander guard system but R2 would not wear the wander guard bracelet. R 2's order has been fixed so that it is now visible on the treatment record and function and placement can be signed off as being verified. All residents who are identified as at risk for elopement will have their orders checked to ensure supplemental documentation is present and placement and function can be verified and documented on each resident's treatment record. Education to be provided to licensed nurses by the Director of Nursing, or designee, on the importance of ensuring supplemental documentation is completed in Point Click Care so that placement and function can be verified on each resident's treatment record. Each resident who has been identified as at risk of elopement will be audited for the next 60 days to	Completion Date: **05/01/2025** Status: **APPROVED** Date: **04/28/2025**

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F 0689 SS=D	Continued from page 2	F 0689	ensure supplemental documentation is completed in Point Click Care so that placement and function can be verified on each resident's treatment record. Results of audits will be reviewed at the month QAPI meeting for tracking and trending purposes. The facility Director of Nursing shall ensure compliance.	

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F 0689 SS=D	Continued from page 3 Based on review of facility documents, facility policy, clinical records, and staff interviews, it was determined that the facility failed to make certain each resident received adequate supervision that resulted in an elopement (leaving an area without permission) for one of 16 residents (Resident R1), and failed to make certain each resident received adequate monitoring of an elopement prevention device for one of 16 residents (Resident R2). Findings include: Review of facility policy "Elopement Prevention" last reviewed 6/3/24, indicated that the facility will properly assess residents and plan their care to prevent accidents related to wandering behavior or elopement. Should the resident's behavior warrant elopement prevention measures, a comprehensive elopement prevention plan will be documented as part of the care plan. Staff observations will be noted during the resident's stay and modifications will be made to the care plan and prevention techniques. If a Wanderguard (a device applied to	F 0689		

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F 0689 SS=D	Continued from page 4 the resident that alerts staff when they leave a safe area) is indicated, obtain a physician's order for use of the device and document the reason for application of the device in the resident's clinical record. A photograph of at risk residents are provided to the receptionist, who will also maintain the list of all residents at risk for elopement, including the resident's name, and room number. This list will be distributed to the management team of the care community. Appropriate communication should occur with staff members who may be in contact with those residents. Review of Resident R1's admission record indicated she was admitted to the facility on 9/17/13. Review of Resident R1's Minimum Data Set (MDS - periodic assessment of resident care needs) dated 4/1/25, included diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life) schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech and behavior), and Post	F 0689		

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F 0689 SS=D	Continued from page 5 Traumatic Stress Disorder (PTSD- a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event). Review of clinical record revealed that on 2/19/20, Resident R1's care plan included interventions for "elopement risk/wanderer as evidenced by a history of attempts to leave my home unattended, disoriented to place, impaired safety awareness, my aimless wandering". Interventions include but are not limited to "Identify any patterns of wandering that I exhibit: purposeful wandering, aimless, or attempting to escape. Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate, Resident refuses to maintain Wanderguard in place". Review of clinical record revealed a nursing progress note dated 4/2/25, that stated "This nurse received phone call from oncoming nurse at 6:53 p.m. in the parking lot. Nurse stated she saw Resident R1 in the parking lot in her rearview	F 0689		

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F 0689 SS=D	Continued from page 6 mirror. Nurse exited her car and assisted resident back into facility. Resident was hesitant and did not want to come back in, so two nurse aides and this writer assisted getting Resident back into the facility. Resident did not say what she was doing or how she exited the building. Resident assisted back into the facility by staff. Head to toe assessment performed on resident and resident's assessment is at her baseline. Wanderguard placement attempted. Resident refused; 2 staff members present when resident refused. 1:1 staff member assigned to resident at this time for resident safety". During an interview on 4/15/25, at 11:35 a.m. Director of Nursing (DON) stated that wandering behavior was not new for Resident R1, but that exit seeking was a new development. Resident R1 was placed on one-on-one supervision after she was found in the parking lot, and then transferred on 4/4/25, to a facility with a locked unit. DON stated that it was determined through a tour of the facility, and monitoring of all exit doors' function, that Resident R1 exited through the front door.	F 0689		

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F 0689 SS=D	Continued from page 7 DON stated that an investigation was completed after the elopement, and it was determined that Resident R1 was out of the facility about two to three minutes. DON confirmed that the facility failed to provide adequate supervision which resulted in an elopement for Resident R1. Review of Resident R2's admission record indicated he was admitted to the facility on 3/24/25. Review of Resident R2's MDS dated 3/24/25, included diagnoses of dementia, high blood pressure, and difficulty swallowing. Review of Resident R2's clinical record revealed a physician's order dated 3/24/25, for a Wanderguard to be on at all times. Check placement and skin integrity each shift. Review of Resident R2's clinical record failed to indicate that staff had checked the placement of Wanderguard since it was applied on 3/24/25.	F 0689		

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F 0689 SS=D	Continued from page 8 During an interview on 4/15/25, at 3:50 p.m. DON confirmed that the facility failed to conduct adequate monitoring of an elopement prevention device for Resident R2. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.	F 0689		

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P 2590	Building Plans. (a) A licensee or prospective licensee shall submit its plans for construction, alteration or renovation to the Department. The Department will post instructions for submissions on its public website. This REGULATION is not met as evidenced by:	P 2590	2590 - Facility Administrator, or designee shall notify the Department of Health of replacement of sewer line and removed flooring above sewer lines in kitchen. The facility Administrator will be educated by the corporate manager, or designee, on proper notifications to the Department of Health. The facility Administrator will audit the nursing facility operations for possible notification requirements to the Department of Health for one month then weekly for two months. Results of audits will be reviewed at the month QAPI meeting for tracking and trending purposes. The facility Administrator shall ensure compliance.	Completion Date: 05/01/2025 Status: APPROVED Date: 04/28/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

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P 2590	Continued from page 1 Based on observations and staff interviews it was determined that the facility failed to notify the Department of renovations made to the Main Kitchen. Findings include: During an observation on 4/15/25, at 9:00 a.m. a large freezer truck was noted to be in the facility parking lot. During an interview on 4/15/25, at 9:54 a.m. the Director of Nursing (DON) stated that there has been a problem with the plumbing in the Main Kitchen. During an interview on 4/15/25, at 11:47 a.m. Environmental Service Director (ESD) Employee E1 stated that there has been a problem with the plumbing in the Main Kitchen as the sewer pipes were corroded and sewage was leaking back into the ground. The floor has removed, and plumbing repaired, and is still under the construction process.	P 2590		

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P 2590	Continued from page 2 ESD Employee E1 stated that the Dietary Staff has been utilizing the kitchen in the adjacent Personal Care Home (PCH) to prepare food for the facility's residents. During an observation and interview on 4/15/25, at 12:28 p.m. the Dietary Staff was observed to be conducting tray line service in the Main Dining Room. Dietary Director Employee E2 stated that the Main Kitchen has been under construction since December 2024, and that they have been utilizing the kitchen at the adjacent PCH kitchen to prepare the food, then transporting the food back into the facility's Main Dining Room where they have set up the tray line. The PCH kitchen has a small freezer, therefore, they must rent a freezer truck in the parking lot to accommodate the food supply. Review of facility reported events conducted on 4/15/25, did not reveal that the facility notified the Department prior to starting the renovations. During an interview on 4/15/25, at 3:57 p.m. the	P 2590		

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P 2590	Continued from page 3 DON confirmed that the facility failed to notify the Department of renovations to the Main Kitchen prior to starting the renovations.	P 2590		

Certified End Page

QUALITY LIFE SERVICES - APOLLO

STATE LICENSE NUMBER: 235502

SURVEY EXIT DATE: 04/15/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY