STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395879	A. BLDG: 00 B. WING:	01/24/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
QUALITY LIFE SERVICES - MERCER STATE LICENSE NUMBER: **034102**	**8221 LAMOR ROAD** **MERCER, PA 16137**

(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 Complaint Survey completed on January 24, 2025, it was determined that Quality Life Services - Mercer was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0677 SS=D		F 0677		

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 0677 SS=D	Continued from page 1 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	Residents #3, 4, and 5 have had their showers. Other residents have been assessed to ensure showers are being given. Shower schedule will be reviewed to ensure that all residents are included in the schedule. Education will be provided by DON/designee to all nursing staff regarding shower schedule, documentation of showers, and ensuring showers are given according to the schedule. Initial audit will be completed to review resident's preference for shower and/or bed bath. Audits will be completed 3 times a week x 4 weeks on all shifts, by DON/designee, to ensure showers are being completed. Results of the audits will be reviewed at the Quality Assurance meeting.	Completion Date: **03/05/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0677 SS=D	Continued from page 2 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	F 0677		

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F 0677 SS=D	Continued from page 3 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.	F 0677		

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F 0677 SS=D	Continued from page 4 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 1/05/25, 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. Resident R5's MDS dated 11/05/24, 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	F 0677		

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F 0677 SS=D	Continued from page 5 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	F 0677		
F 0686 SS=E		F 0686		

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F 0686 SS=E	Continued from page 6 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	Residents # 1 and #2 had their wounds measured and documentation completed. A skin sweep will be completed of all residents by DON/designee to ensure all skin concerns are documented. Education will be provided to the DON by the Clinical Services Specialist. The DON will provide education to the staff RN's regarding process of evaluating wounds on a weekly basis. New admissions will be reviewed at the AM clinical meeting for skin concerns. Audits will be completed once a week for 4 weeks to ensure wounds are evaluated on a weekly basis. Results of the audits will be reviewed at the Quality Assurance meeting.	Completion Date: **03/05/2025** Status: **APPROVED** Date: **02/07/2025**

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F 0686 SS=E	Continued from page 7 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 admission date of 10/31/23, with diagnoses that included obesity, reduced mobility, weakness, abnormalities of gait and mobility, and radiculopathy	F 0686		

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F 0686 SS=E	Continued from page 8 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.	F 0686		

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F 0686 SS=E	Continued from page 9 Review of Resident R2's clinical record revealed an admission date of 1/11/25, 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. During an interview on 1/24/25, at 2:30 p.m. the	F 0686		

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F 0686 SS=E	Continued from page 10 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	F 0686		

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P 5520		P 5520		

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

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P 5520	Continued from page 1 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	1. The facility was unable to make corrective action for the (nurse aide ratio) for identified days that have already passed. All residents received care in accordance with their care plans and physician orders. 2. Director of nursing or designee will re-educate the labor manager and the Registered nurse supervisors on the 7/1/2024 requirements for Nurse Aide ratios. 3. Facility continues to offer incentives, competitive wages, and several other benefits in an effort to hire for all open positions. 4. Nursing home administrator, DON, and Labor manager will conduct daily staffing meetings Monday – Friday to review (nurse aide ratios) throughout the day, the following day, and the weekend. In the event of vacancies the Labor Manager or designee will follow staffing policies including offering open shifts to internal staff, contracted agency staff, and offering current staff to stay extra or start earlier. 5 Director of Nursing or designee	Completion Date: **03/05/2025** Status: **APPROVED** Date: **02/07/2025**

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P 5520	Continued from page 2	P 5520	will audit daily staffing ratios and along with all steps taken to fill vacancies 5 days a week and ongoing. 6. Results of the audits will be reviewed and recorded in the monthly Quality Assurance Performance Improvement meeting.	

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P 5520	Continued from page 3 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to ensure a minimum of one nurse aide (NA) per 10 residents on the day shift for 21 of 21 days (12/31/24 through 1/20/25); failed to ensure one NA per 11 residents on the evening shift for 10 of 21 days (12/31/24, 1/03/25, 1/07/25, 1/09/25, 1/11/25, 1/13/25, 1/14/25, 1/16/25, 1/17/25, and 1/18/25); and failed to ensure one NA per 15 residents on the overnight shift for 21 of 21 days reviewed for staffing (12/31/24 through 1/20/25). Findings include: Review of facility nursing staffing documents for the time period of 12/31/24, through 1/20/25, revealed the following NA shortages for the day shift: 12/31/24 facility census of 45 residents 4.00 NAs worked and 4.50 were required. 1/01/25 facility census of 42 residents 4.00	P 5520		

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P 5520	Continued from page 4 NAs worked and 4.20 were required. 1/02/25 facility census of 42 residents 4.00 NAs worked and 4.20 were required. 1/03/25 facility census of 44 residents 3.38 NAs worked and 4.40 were required. 1/04/25 facility census of 44 residents 4.25 NAs worked and 4.40 were required. 1/05/25 facility census of 44 residents 3.75 NAs worked and 4.40 were required. 1/06/25 facility census of 44 residents 4.00 NAs worked and 4.40 were required. 1/07/25 facility census of 44 residents 4.00 NAs worked and 4.40 were required. 1/08/25 facility census of 44 residents 4.00 NAs worked and 4.40 were required. 1/09/25 facility census of 44 residents 4.00 NAs worked and 4.40 were required. 1/10/25 facility census of 44 residents 4.00 NAs worked and 4.40 were required. 1/11/25 facility census of 45 residents 4.00 NAs worked and 4.50 were required. 1/12/25 facility census of 44 residents 3.00 NAs worked and 4.40 were required.	P 5520		

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P 5520	Continued from page 5	P 5520		

1/13/25 facility census of 44 residents 3.88 NAs worked and 4.40 were required.
1/14/25 facility census of 42 residents 4.00 NAs worked and 4.20 were required.
1/15/25 facility census of 42 residents 4.00 NAs worked and 4.20 were required.
1/16/25 facility census of 43 residents 4.00 NAs worked and 4.30 were required.
1/17/25 facility census of 43 residents 3.56 NAs worked and 4.30 were required.
1/18/25 facility census of 43 residents 4.00 NAs worked and 4.30 were required.
1/19/25 facility census of 42 residents 4.00 NAs worked and 4.20 were required.
1/20/25 facility census of 42 residents 4.00 NAs worked and 4.20 were required.

Review of facility nursing staffing documents for the time period of 12/31/24, through 1/20/25, revealed the following NA shortages for the evening shift:

12/31/24 facility census of 45 residents 4.00 NAs worked and 4.09 were required.

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	395879	A. BLDG: 00 B. WING:	01/24/2025

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QUALITY LIFE SERVICES - MERCER STATE LICENSE NUMBER: **034102**	**8221 LAMOR ROAD** **MERCER, PA 16137**

(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
P 5520	Continued from page 6 1/03/25 facility census of 44 residents 3.75 NAs worked and 4.00 were required. 1/07/25 facility census of 44 residents 3.75 NAs worked and 4.00 were required. 1/09/25 facility census of 44 residents 3.63 NAs worked and 4.00 were required. 1/11/25 facility census of 45 residents 3.88 NAs worked and 4.09 were required. 1/13/25 facility census of 44 residents 3.88 NAs worked and 4.00 were required. 1/14/25 facility census of 42 residents 3.50 NAs worked and 3.82 were required. 1/16/25 facility census of 43 residents 3.88 NAs worked and 3.91 were required. 1/17/25 facility census of 43 residents 3.75 NAs worked and 3.91 were required. 1/18/25 facility census of 43 residents 3.75 NAs worked and 3.91 were required. Review of facility nursing staffing documents for the time period of 12/31/24, through 1/20/25, revealed the following NA shortages the overnight shift:	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395879	A. BLDG: 00 B. WING:	01/24/2025

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P 5520	Continued from page 7	P 5520		

12/31/24 facility census of 45 residents 2.50
NAs worked and 3.00 were required.
1/01/25 facility census of 42 residents 2.50
NAs worked and 2.80 were required.
1/02/25 facility census of 42 residents 2.50
NAs worked and 2.80 were required.
1/03/25 facility census of 44 residents 2.50
NAs worked and 2.93 were required.
1/04/25 facility census of 44 residents 2.25
NAs worked and 2.93 were required.
1/05/25 facility census of 44 residents 2.25
NAs worked and 2.93 were required.
1/06/25 facility census of 44 residents 2.25
NAs worked and 2.93 were required.
1/07/25 facility census of 44 residents 2.25
NAs worked and 2.93 were required.
1/08/25 facility census of 44 residents 2.25
NAs worked and 2.93 were required.
1/09/25 facility census of 44 residents 2.50
NAs worked and 2.93 were required.
1/10/25 facility census of 44 residents 2.00
NAs worked and 2.93 were required.
1/11/25 facility census of 45 residents 2.25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
QUALITY LIFE SERVICES - MERCER STATE LICENSE NUMBER: 034102	8221 LAMOR ROAD MERCER, PA 16137

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P 5520	Continued from page 8 NAs worked and 3.00 were required. 1/12/25 facility census of 44 residents 2.25 NAs worked and 2.93 were required. 1/13/25 facility census of 44 residents 2.25 NAs worked and 2.93 were required. 1/14/25 facility census of 42 residents 2.25 NAs worked and 2.80 were required. 1/15/25 facility census of 42 residents 2.25 NAs worked and 2.80 were required. 1/16/25 facility census of 43 residents 2.25 NAs worked and 2.87 were required. 1/17/25 facility census of 43 residents 2.50 NAs worked and 2.87 were required. 1/18/25 facility census of 43 residents 2.63 NAs worked and 2.87 were required. 1/19/25 facility census of 42 residents 2.50 NAs worked and 2.80 were required. 1/20/25 facility census of 42 residents 2.25 NAs worked and 2.80 were required. During an interview on 1/22/25, at 2:30 p.m. the Nursing Home Administrator confirmed that the facility did not meet the minimum NA ratio	P 5520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5520	Continued from page 9 requirements on the above shifts and dates.	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 10 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	1. The facility was unable to make corrective action for the (Licensed Practical Nurse ratio) for identified days that have already passed. All residents received care in accordance with their care plans and physician orders. 2. Director of Nursing or designee will re-educate the Labor Manager and the RN Supervisors on the 7/1/2024 Licensed Practical Nurse ratio requirements. 3. Facility continues to offer incentives, competitive wages, and several other benefits in an effort to hire for all open positions. 4. Nursing Home Administrator, Director of Nursing, and Labor Manager will conduct daily staffing meetings Monday – Friday to review (Licensed Practical Nurse ratios) throughout the day, the following day, and the weekend. In the event of vacancies the Labor Manager or designee will follow staffing policies including offering open shifts to internal staff, contracted agency staff, and offering current staff to stay extra or start earlier.	Completion Date: **03/05/2025** Status: **APPROVED** Date: **02/07/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395879	A. BLDG: __00_____ B. WING: _____	01/24/2025

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QUALITY LIFE SERVICES - MERCER STATE LICENSE NUMBER: **034102**	**8221 LAMOR ROAD MERCER, PA 16137**

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P 5530	Continued from page 11	P 5530	5. Director of Nursing or designee will audit daily staffing ratios along with all steps taken to fill vacancies 5 days a week and ongoing. 6. Results of the audits will be reviewed and recorded in the monthly Quality Assurance Performance Improvement meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 12 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to ensure a minimum of one Licensed Practical Nurse (LPN) per 25 residents on the day shift for one of 21 days reviewed (1/01/25); failed to ensure one LPN per 30 residents on the evening shift for three of 21 days reviewed(1/01/25, 1/12/25, and 1/15/25); and failed to ensure one LPN per 40 residents on the overnight shift for 20 of 21 days reviewed (12/31/25 through 1/16/25, and 1/18/25 through 1/20/25). Findings include: Review of facility nursing staffing documents for the time period of 12/31/24, through 1/20/25, revealed the following LPN shortages for the day shift: 1/01/25 facility census of 42 residents 1.00 LPNs worked and 1.68 were required. Review of facility nursing staffing documents for the	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 13 time period of 12/31/24, through 1/20/25, revealed the following LPN shortages for the evening shift: 1/01/25 facility census of 42 residents 1.00 LPNs worked and 1.40 were required. 1/12/25 facility census of 44 residents 1.00 LPNs worked and 1.47 were required. 1/15/25 facility census of 42 residents 1.06 LPNs worked and 1.40 were required. Review of facility nursing staffing documents for the time period of 12/31/24, through 1/20/25, revealed the following LPN shortages for the overnight shift: 12/31/24 facility census of 45 residents 1.00 LPNs worked and 1.13 were required. 1/01/25 facility census of 42 residents 1.00 LPNs worked and 1.05 were required. 1/02/25 facility census of 42 residents 1.00 LPNs worked and 1.05 were required. 1/03/25 facility census of 44 residents 1.00 LPNs worked and 1.10 were required.	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 14	P 5530		

1/04/25 facility census of 44 residents 1.00
LPNs worked and 1.10 were required.
1/05/25 facility census of 44 residents 1.00
LPNs worked and 1.10 were required.
1/06/25 facility census of 44 residents 1.00
LPNs worked and 1.10 were required.
1/07/25 facility census of 44 residents 1.00
LPNs worked and 1.10 were required.
1/08/25 facility census of 44 residents 1.00
LPNs worked and 1.10 were required.
1/09/25 facility census of 44 residents 1.00
LPNs worked and 1.10 were required.
1/10/25 facility census of 44 residents 1.00
LPNs worked and 1.10 were required.
1/11/25 facility census of 45 residents 1.00
LPNs worked and 1.13 were required.
1/12/25 facility census of 44 residents 1.00
LPNs worked and 1.10 were required.
1/13/25 facility census of 44 residents 1.00
LPNs worked and 1.10 were required.
1/14/25 facility census of 42 residents 1.00
LPNs worked and 1.05 were required.
1/15/25 facility census of 42 residents 1.00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5530	Continued from page 15 LPNs worked and 1.05 were required. 1/16/25 facility census of 43 residents 1.00 LPNs worked and 1.08 were required. 1/18/25 facility census of 43 residents 1.00 LPNs worked and 1.08 were required. 1/19/25 facility census of 42 residents 1.00 LPNs worked and 1.05 were required. 1/20/25 facility census of 42 residents 1.00 LPNs worked and 1.05 were required. During an interview on 1/22/25, at 2:30 p.m. the Nursing Home Administrator confirmed that the facility did not meet the minimum LPN ratio requirements on the above shifts and dates.	P 5530		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 16 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	1. The facility was unable to make corrective action for direct care staff for identified days that have already passed. All residents received care in accordance with their care plans and physician orders. 2. Director of Nursing or designee will re-educate the Labor Manager and the RN supervisors on the 7/1/2024 for direct care staff PPD requirements. 3. Facility continues to offer incentives, competitive wages, and several other benefits in an effort to hire for all open positions. 4. Nursing Home Administrator, Director of Nursing, and Labor Manager will conduct daily staffing meetings Monday – Friday to review (PPD) throughout the day, the following day, and the weekend. In the event of vacancies the Labor Manager or Designee will follow staffing policies including offering open shifts to internal staff, contracted agency staff, and offering current staff to stay extra or start earlier. 5. DON or designee will audit daily	Completion Date: **03/05/2025** Status: **APPROVED** Date: **02/07/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 17	P 5640	staffing PPD along with all steps taken to fill vacancies 5 days a week and ongoing. 6. Results of the audits will be reviewed and recorded in the monthly Quality Assurance Performance Improvement meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5640	Continued from page 18 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to provide the minimum number of general nursing care hours of 3.2 hours of direct resident care hours per resident in a twenty-four-hour period for seven of 21 days reviewed (1/01/25, 1/03/25, 1/07/25, and 1/10/25, through 1/13/25). Findings include: Review of facility nursing staffing documents for the time period of 12/31/24, through 1/20/25, revealed that the hours of direct resident care was below the 3.2 minimum per patient per day (PPD) on the following dates: 1/01/25 3.14 PPD 1/03/25 3.13 PPD 1/07/25 3.19 PPD 1/10/25 3.19 PPD 1/11/25 3.14 PPD 1/12/25 2.95 PPD	P 5640		

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P 5640	Continued from page 19 1/13/25 3.19 PPD During a interview on 1/22/25, at 2:30 p.m. the Nursing Home Administrator confirmed that the facility did not meet the 3.2 minimum hours of direct resident care on above dates.	P 5640		

Certified End Page

QUALITY LIFE SERVICES - MERCER

STATE LICENSE NUMBER: 034102

SURVEY EXIT DATE: 01/24/2025

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