Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

June 12, 2025

[redacted] CHIEF EXECUTIVE OFFICER
QUALITY LIFE SERVICES-APOLLO LLC
[redacted]

RE: QUALITY LIFE SERVICES-APOLLO
153 GOODVIEW DRIVE
APOLLO, PA, 15613
LICENSE/COC#: 45531

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/15/2025, 04/29/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *QUALITY LIFE SERVICES-APOLLO* **License #**: *45531* **License Expiration**: *05/08/2025*

Address: *153 GOODVIEW DRIVE, APOLLO, PA 15613*

County: *WESTMORELAND* **Region**: *WESTERN*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *QUALITY LIFE SERVICES-APOLLO LLC*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *08/13/2001* **Issued By**: *PA Dept L & I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *44* **Waking Staff**: *33*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *04/29/2025*

Inspection Dates and Department Representative

04/15/2025 - On-Site: [redacted]

04/29/2025 - Off-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *26*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *2*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *26*

Diagnosed with Mental Illness: *3* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *18* **Have Physical Disability**: *0*

Inspections / Reviews

04/15/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/09/2025*

Inspections / Reviews *(continued)*

06/12/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *06/12/2025*

Reviewer: [redacted] **Follow-Up Type:** *Bypass Document Submission*

06/12/2025 - Bypass Document Submission

Submitted By: [redacted] **Date Submitted:** *06/12/2025*

Reviewer: [redacted] **Follow-Up Type:** *Not Required*

18 - Compliance With Laws

1. Requirements

2600.
18. Applicable Health and Safety Laws - A home shall comply with applicable Federal, State and local laws, ordinances and regulations.

Description of Violation

The Care Facility Carbon Monoxide Alarms Standards Act, enacted 06/23/16, requires carbon monoxide alarms to be installed in close proximity of, but not less than 15 feet from, any fossil fuel-burning device or appliance.
The home has a natural gas-burning hot water heater and furnace in the closet of the TV room in the lower level of the home and a natural gas-burning hot water heater and furnace on the first/main floor of the home. However, there was not a carbon monoxide detector installed 15 feet outside of and between resident rooms of either device.

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

In response to the violation on 04/15/2025 by the Pennsylvania Bureau of Human Service Licensing, immediate action was taken.
Maintenance Director [redacted] took Immediate action on 4/29/25 to correct the violation by installing the alarms.
***Installation of Carbon Monoxide Alarms:** - The facility installed carbon monoxide alarms at least 15 feet outside of and between resident rooms near the natural gas-burning hot water heaters and furnaces on both floors.*
To enhance the currently compliant operations:
***Ongoing Monitoring and Maintenance:** Carbon monoxide alarms will be mapped and tested monthly to ensure they remain operational (attached). A maintenance log will be kept, including records of routine monthly inspections, and battery replacements to correspond with daylight savings time and as needed.*
**Regulatory Reporting and Compliance: ** - Written documentation and pictures of the corrective actions are submitted to the Bureau of Human Service Licensing in this POC.*

***Person Responsible: ** The facility administrator and maintenance personnel will oversee the implementation and ensure sustained compliance. Any deficiencies will be corrected immediately, and findings will be documented and reviewed internally for continuous improvement purposes.*

Licensee's Proposed Overall Completion Date: *06/04/2025*

Implemented ([redacted] - 06/12/2025)

25b - Contract Signatures

2. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

Resident #1 was admitted into the home on [redacted] however, the resident did not sign the contract until [redacted]

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

Plan of Correction for Contract Signature Compliance

25b - Contract Signatures (continued)

***Completion Date:** June 9, 2025*

Corrective Action Steps:

*1. **Immediate Review and Completion of Resident Contracts:***

- The facility will ensure that all resident contracts are signed upon admission.

- Resident #1's contract has been reviewed and properly signed as of [redacted]

*2. **Implementation of Contract Signing Protocol:***

- A standardized admission checklist was developed and put in use to ensure all required signatures are obtained at the time of admission (attached)

- The administrator or designee will verify contract completion before finalizing admission paperwork.

*3. **Resident and Payer Notification Process: ***

- Residents and payers will be informed of the contract signing requirement during the admission process.

- Any delays in obtaining signatures will be documented and addressed immediately.

*4. **Regulatory Reporting and Documentation:***

- Documentation of corrective actions - (admission checklist attached) are submitted to the Bureau of Human Service Licensing here.

- Future inspections will include verification of compliance with contract signing regulations.

***Person Responsible: ***

The facility administrator will oversee implementation and ensure sustained compliance.

Licensee's Proposed Overall Completion Date: *06/06/2025*

Implemented ([redacted] - 06/12/2025)

63a - First Aid/CPR Training

3. Requirements

2600.

63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 4/5/25 and 4/6/25, there were 26 residents physically present in the home from 6:30 am to 2:00 pm. Staff Member A, hired [redacted] *Staff Member B, hired* [redacted] *and Staff Member C, hired* [redacted] *worked in the home; however, there were no staff members present in the home trained in first aid and certified in obstructed airway techniques and CPR.*

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

Plan of Correction for First Aid/CPR Training Compliance

Corrective Action Steps:

Immediate action was taken to ensure compliance certified in obstructed airway techniques and CPR is present at all times.

Staff Member A, B, and C were signed up for and completed an approved First Aid and obstructed airway techniques/ CPR certification course on 4/24/25 .

63a - First Aid/CPR Training (continued)

Verification and Documentation: ATTACHED

Certification records will be maintained for all trained staff.

Scheduling Adjustments:

At this time all direct care staff are certified in CPR and First Aid. Going forward, the facility will modify staff schedules as needed to ensure that a certified individual is present during all shifts.

***Ongoing Training and Compliance Monitoring:*

Annual refresher courses is required for all staff to maintain certification.

Staff training and annual renewal dates are entered into staff electronic record via Kronos Dimensions are automatically programed to alert the staff member and administrator of upcoming renewals via email.

Future training needs will be addressed at the home's periodic quality management reviews, beginning June, 2025.

Regulatory Reporting and Documentation:

Documentation of corrective actions, including training record/certifications, are included in this poc to the Bureau of Human Service Licensing.

Future inspections will include verification of compliance with first aid and CPR certification requirements.

Person Responsible: The facility administrator will oversee implementation and ensure sustained compliance.

Proposed Overall Completion Date: 06/06/2025

Licensee's Proposed Overall Completion Date: *06/06/2025*

Implemented ([redacted] - 06/12/2025)

85a - Sanitary Conditions

4. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

The home has multiple residents who require the use of blood glucose monitoring as per provider order. The home has a "house glucometer" (Prodigy Auto Code – SN: 51850-5958986) which the staff use when a resident's individual glucometer is inoperable, or supplies are not available in the home. On multiple dates, the home's "house glucometer" was used to check the blood sugar reading for multiple residents to include Resident #2 who was prescribed Insulin Lispro Injection solution before meals and at bedtime per sliding scale on 4/14/25 at 6:50 am, and Resident #3, prescribed Aspart FlexPen Subcutaneous Solution Pen-injector (100 units/ml four times a day per sliding scale) on 4/14/25 at 11:11 am.

85a - Sanitary Conditions (continued)

On 4/12/25 at 3:52 pm, Resident #2's blood sugar reading of 114mg/dl was taken by staff using Resident #3's glucometer and documented on Resident #2's April 2025 medication administration record (MAR).

Plan of Correction ***Accept (- 06/10/2025)***

Plan of Correction for Sanitary Conditions – Glucometer Use

Completion Date: June 9, 2025

Corrective Action Steps:

Elimination of Shared Glucometer Use:

The facility immediately discontinued and disposed of the shared glucometer in the presence of surveyors.

Procurement and Distribution:

Each resident requiring blood glucose monitoring was immediately issued and assigned an individual glucometer at the cost of the facility labeled with their name.

Infection Control Measures:

Staff will follow strict infection control protocols, including hand hygiene and glove use during blood glucose testing.

Staff Training and Compliance:

Policy updated. All Med techs have received training on 4/16/25 on the prohibition of shared glucometers and infection prevention protocols policy (attached)

Med Tech staff have read and reviewed the policy on Sanitary Conditions.

All new Med Techs will receive training on the prohibition of shared glucometers and infection prevention protocols policy.

Sanitary Conditions

Compliance med cart audits will be conducted monthly to ensure adherence to this policy (audit sheet training attached) any noncompliance will be corrected immediately and reported to the agency.

Regulatory Reporting and Documentation:

Documentation of corrective actions, including training records will be kept and are submitted with this POC to the Bureau of Human Service Licensing.

85a - Sanitary Conditions (continued)

Future inspections will include verification of compliance with this policy.

Person Responsible: The facility administrator staff will oversee implementation and ensure sustained compliance.

Licensee's Proposed Overall Completion Date: *06/06/2025*

Implemented (- 06/12/2025)

85d - Trash Receptacles

5. Requirements

2600.
85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

A small trash can in the shared bathroom between Resident Bathroom #33 and #34 was ¼-filled with trash, however the trash can did not have a lid.

Plan of Correction ***Accept (- 06/10/2025)***

Immediate Replacement of Trash Receptacle:

A new covered trash receptacle was immediately placed in the shared bathroom between Resident Bathroom #33 and #34. (picture attached)

All receptacles meet regulatory requirements to prevent insect and rodent penetration.

Ongoing Monitoring and Maintenance:

Maintenace supervisor will inspect all kitchen and bathroom and outdoor trash receptacles during monthly safety rounds to ensure the presence of covered trash receptacles in all required areas

Housekeeping staff will conduct daily inspections with their cleaning duties to confirm that all kitchen and bathroom and outdoor trash receptacles remain covered.

Any damaged or missing lids will be replaced immediately.

Staff Training and Compliance:

Staff have received training on proper waste disposal and the importance of covered trash receptacles.

Regulatory Reporting and Documentation:

Documentation of corrective actions, including pictures shall be kept and are included in this plan of correction and submitted to the Bureau of Human Service Licensing.

Future inspections will include verification of compliance with trash receptacle regulations.

85d - Trash Receptacles (continued)

Person Responsible: The facility administrator and Housekeeping/Maintenace supervisor will oversee implementation and ensure sustained compliance.

Licensee's Proposed Overall Completion Date: *06/06/2025*

Implemented ([redacted] - 06/12/2025)

85e - Trash Outside Home

6. Requirements

2600.
85.e. Trash outside the home shall be kept in covered receptacles that prevent the penetration of insects and rodents.

Description of Violation

At 9:00 am, the large dumpster in the parking lot of the home was half-filled with trash and garbage bags; however, the lid on the left side was open, leaving the dumpster uncovered.

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

Plan of Correction for Outdoor Trash Receptacle Compliance

Completion Date: June 9, 2025

Corrective Action Steps:

Immediate Correction of Dumpster Lid:

The facility will ensure that all outdoor trash receptacles, including the large dumpster in the parking lot, remain covered at all times.

The lid on the left side of the dumpster was immediately secured upon inspection and will be secured properly to prevent exposure to insects and rodents.

Verification and Documentation:

Facility staff will conduct daily visual inspections to confirm that all outdoor trash receptacles are properly covered.

Ongoing Monitoring and Maintenance:

Maintenace/housekeeping staff will be assigned to check the dumpster lid each shift.

Any damaged or malfunctioning lids will be repaired or replaced immediately.

Staff Training and Compliance:

Staff received training on proper waste disposal and the importance of keeping outdoor trash receptacles covered.

Monthly audits will be conducted during safety committee rounds ensure adherence to this policy.

85e - Trash Outside Home (continued)

Regulatory Reporting and Documentation:

Documentation of corrective actions, were submitted in this POC to the Bureau of Human Service Licensing.

Future inspections will include verification of compliance with outdoor trash receptacle regulations.

Person Responsible: The facility administrator and Maintenance/housekeeping supervisor will oversee implementation and ensure sustained compliance.

Licensee's Proposed Overall Completion Date: *06/06/2025*

Implemented ([redacted] - 06/12/2025)

183d - Prescription Current

7. Requirements

2600.
183.d. Only current prescription, OTC, sample and CAM for individuals living in the home may be kept in the home.

Description of Violation

The home's medication cart contained a bottle of Metoprolol Succinate ER 25mg, labeled for Resident #5. However, there was no current or previous prescribed medication order for this medication on record.

Repeated Violation - 10/11/23, et al.

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

Plan of Correction for Medication Compliance
Completion Date: June 9, 2025

Corrective Action Steps:
Immediate Removal of Unprescribed Medication:

The bottle of Metoprolol Succinate ER 25mg labeled for Resident #5 was immediately removed from the medication cart in the presence of the inspector.

Verification and Documentation:

Medication records were reviewed on 6/6/25 to confirm that all medications stored in the facility have a current prescription order.

A log will be maintained to document medication audits and corrective actions taken.

Staff Training and Compliance Monitoring:

Staff responsible for medication management have received training on proper medication storage and prescription verification.

Monthly audits will be conducted to ensure ongoing compliance with medication regulations shall be conducted

183d - Prescription Current (continued)

and verified by Administrator. Documentation shall be kept

Resident Medication Review Process:

Any discrepancies will be addressed immediately with the prescribing provider.

Regulatory Reporting and Documentation:

Documentation of corrective actions, including audit results and staff training records, will be submitted to the Bureau of Human Service Licensing.

Future inspections will include verification of compliance with prescription medication regulations.

Person Responsible: The facility administrator will oversee implementation and ensure sustained compliance.

Licensee's Proposed Overall Completion Date: *06/09/2025*

Implemented ([redacted] - 06/12/2025)

185a - Implement Storage Procedures

8. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

Resident #2 was prescribed Insulin Lispro Injection solution before meals and at bedtime per sliding scale (131-180 = 2 units, 181-240 = 4 units, 241-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, 401-999 = 12 units). However, the blood sugar reading of 118 mg/dl on 4/15/25 at 7:53 am, was recorded as 2:45 am.

Resident #4 was prescribed Insulin Aspart FlexPen Subcutaneous Solution Pen-injector 100unit/ml subcutaneously four times a day per sliding scale (70-150 mg/dl = 0 unit, 151-200 mg/dl = 2 units, 201-250 mg/dl = 4 units; 251-300 mg/dl = 6 units, 301-350 mg/dl = 8 units, 351-400 mg/dl = 10 units, 401-450 mg/dl = 12 units - Administer 12 units, re-check in one hour and if still above 300 mg/dl call the provider).
There were multiple blood glucose readings recorded on the resident's April 2025 medication administration record (MAR) which were not recorded on the resident's glucometer to include the following: 4/1/25 at 6:53 pm, blood sugar reading 196 mg/dl; 4/2/25 at 7:11 pm, blood sugar reading 234 mg/dl; 4/4/25 at 4:27 pm, blood sugar reading 179 mg/dl; 4/10/25 at 3:52 pm, blood sugar reading 250 mg/dl; and 4/11/25 at 3:06 pm, blood sugar reading 246 mg/dl.

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

Plan of Correction for Medication Storage and Record Discrepancies

Completion Date: June 9, 2025

Corrective Action Steps:

185a - Implement Storage Procedures (continued)

Immediate Review and Correction of Medication Storage and Access Protocols:

New policy and procedure requiring weekly cross-checking of Glucometer reading against the MAR (attached)

Staff are required to verify blood glucose readings directly from the resident's glucometer before recording them in the MAR.

Staff Training and Compliance Monitoring:

All staff responsible for medication administration have received mandatory retraining on proper documentation and insulin administration protocols (attached)

Weekly cross-check audits will be conducted per policy to ensure ongoing compliance with medication storage and record-keeping requirements.

Any discrepancies will be addressed immediately with the prescribing provider.

Regulatory Reporting and Documentation:

Documentation of corrective actions, including audit results and staff training records, will kept and copies will be submitted to the Bureau of Human Service Licensing as requested.

Future inspections will include verification of compliance with medication storage and administration regulations.

Person Responsible: The facility Administrator will oversee implementation and ensure sustained compliance.

Licensee's Proposed Overall Completion Date: *07/01/2025*

Implemented ([redacted] - 06/12/2025)

187d - Follow Prescriber's Orders

9. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #2 was prescribed Insulin Lispro Injection solution before meals and at bedtime per sliding scale (131-180 =2 units, 181-240 4 units, 241-300= 6 units, 301-350= 8 units, 351-400= 10 units, 401-999= 12 units).
On multiple dates and times, the resident was administered insulin; however, there was no indication of a blood sugar reading prior to administration of the medication, including the following:
- On 4/4/25 at 12:00 pm, the home documented a blood sugar reading of 167 mg/dl = 2 units administered, but no reading was done.
- On 4/11/25 at 12:00 pm, the documented blood sugar reading was131mg/dl = 2 units administered, but a reading was not obtained.

Repeated Violation - 10/11/23, et al.

187d - Follow Prescriber's Orders (continued)

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

Plan of Correction for Compliance with Prescriber's Orders

Completion Date: June 9, 2025

Corrective Action Steps:

Staff Training and Compliance Monitoring:

All staff responsible for medication administration have received mandatory retraining on following insulin administration and documentation protocols including following prescribers' orders 2600.187(d) (attached)

Weekly cross-check audits will be conducted per policy to ensure ongoing compliance with medication storage and record-keeping requirements.

Any discrepancies will be addressed immediately with the prescribing provider.

Regulatory Reporting and Documentation:

Documentation of corrective actions, including audit results and staff training records, will kept and copies will be submitted to the Bureau of Human Service Licensing as requested.

Future inspections will include verification of compliance with medication storage and administration regulations.

Person Responsible: The facility Administrator will oversee implementation and ensure sustained compliance.

Licensee's Proposed Overall Completion Date: *06/09/2025*

Implemented ([redacted] - 06/12/2025)

225c - Additional Assessment

10. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
1. Annually.
2. If the condition of the resident significantly changes prior to the annual assessment.
3. At the request of the Department upon cause to believe that an update is required.

Description of Violation

Resident #4's most recent annual assessment of care needs, completed 1/13/25, does not address the resident's need for a trapeze assistive device attached to the resident's bed for turning, positioning and transferring out of bed.

Repeated Violation - 10/11/23, et al.

225c - Additional Assessment (continued)

Plan of Correction ***Accept ([redacted] - 06/10/2025)***

Plan of Correction for Annual Assessment Compliance
Completion Date: June 9, 2025
Corrective Action Steps:

Immediate Update of Resident #4's Assessment:

Resident #4's RASP was immediately revised to include the trapeze assistive device for turning, positioning, and transferring out of bed. (attached)

Implementation of Assessment Review Protocol:

Assessment alerts are automatically generated in PCC 10 days prior to due date. Each Resisident plan is reviewed semi-annually and annually according to schedule

Staff Training and Compliance Monitoring:

Administrator conducting assessments received review of regulations on documenting assistive device needs on RASP by Surveyor [redacted] on 4/15/25.

Resident Care Plan Review Process:

Staff receives RASP training annually. Administrator developed a flow chart to assist with RASP development procedures upon condition changes (attached. The Flow Chart is hanging in the breakroom and medication room for easy staff access and shall be kept.

Regulatory Reporting and Documentation:

Documentation of corrective actions, including updated assessments and staff training records, will be submitted to the Bureau of Human Service Licensing.
Future inspections will include verification of compliance of regulations.

Person Responsible: The facility administrator oversees implementation of RASPs and will ensure sustained compliance.

Licensee's Proposed Overall Completion Date: *06/09/2025*

Implemented ([redacted] - 06/12/2025)