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

January 12, 2026

[redacted]
QUALITY LIFE SERVICES-MERCER, LLC
[redacted]

RE: QUALITY LIFE SERVICES-MERCER
8221 LAMOR ROAD
MERCER, PA, 16137
LICENSE/COC#: 45542

[redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 08/21/2025 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-MERCER* **License #**: *45542* **License Expiration**: *09/01/2026*

Address: *8221 LAMOR ROAD, MERCER, PA 16137*

County: *MERCER* **Region**: *WESTERN*

Administrator

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

Legal Entity

Name: *QUALITY LIFE SERVICES-MERCER, LLC*

Address: [redacted]

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

Certificate(s) of Occupancy

Type: *C-1* **Date**: *02/07/1997* **Issued By**: *DOH*

Staffing Hours

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

Inspection Information

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

Reason: *Incident* **Exit Conference Date**: *08/31/2025*

Inspection Dates and Department Representative

08/21/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *64* **Residents Served**: *22*

Special Care Unit

In Home: *Yes* **Area**: *SDCU* **Capacity**: *36* **Residents Served**: *22*

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0*

Are 60 Years of Age or Older: *22*

Diagnosed with Mental Illness: *0*

Diagnosed with Intellectual Disability: *0*

Have Mobility Need: *22*

Have Physical Disability: *0*

Inspections / Reviews

08/21/2025 Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/27/2025*

10/24/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *01/05/2026*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *10/28/2025*

Inspections / Reviews *(continued)*

12/29/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *01/05/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *01/12/2026*

01/12/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *01/05/2026*

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

185a Storage procedures

1. Requirements

2800.
185.a. The residence 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 [redacted] is prescribed [redacted], give 1 tablet by mouth at bedtime for [redacted]. However, on or about [redacted], staff person A removed 26 tablets of this medication from the pharmacy blister pack and replaced them with [redacted] tablets. The Loratadine 10mg was administered to resident [redacted] on multiple occasions including [redacted], and [redacted] all at 8:00 p.m.

Plan of Correction ***Accept[redacted] - 10/24/2025)***

When it became known to the facility (7) that Staff Member A replaced Resident [redacted]. tablets with [redacted]. tablets, 7-17-2025. An investigation was completed by the NHA (Nursing Home Administrator), DON (Director of Nursing) and PCHA (Personal Care Home Administrator) on 7-21-2025 and the investigation concluded that Staff Member A did switch out Resident [redacted]. tablets for [redacted]. tablets. Last shift worked by Staff Member A was on 7-13-2025. On 7-21-2025, Staff Member A admitted to taking the [redacted]. Staff Member A was terminated from [redacted] employment on 7-21-2025; the local State Police were notified of the incident as well as the Board of Nursing 7-21-2025. The PCHA (Personal Care Home Administrator) informed the resident as to what happened regarding Staff Member A and [redacted] medications as well as the residents POA on 7-21-2025.

An audit was be completed by Director of Nursing and Assistant Director of Nursing on 7-18-2025, which included personal care and assisted living narcotics and no other concerns were found.

Education will be completed with all staff by the Personal Care Administrator/Wellness Director on 10-29-25 reviewing appropriate procedure for narcotic count for change of shift, and appropriate protocol for signing out narcotics.

Licensee's Proposed Overall Completion Date: *10/15/2025*

Implemented [redacted] - 01/12/2026)

187d Follow prescriber's orders

2. Requirements

2800.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident [redacted] is prescribed [redacted], give 1 tablet by mouth at bedtime for [redacted]. However, on or about [redacted], staff person A removed 26 tablets of this medication from the pharmacy blister pack and replaced them with [redacted] tablets. The [redacted] was administered to resident [redacted] on multiple occasions including [redacted], and [redacted] all at 8:00 p.m.

Plan of Correction ***Accept[redacted] - 12/29/2025)***

When it became known to the facility (7/17/25) that Staff Member A replaced Resident [redacted]. tablets with [redacted]. tablets, Staff Member A. An investigation was initiate (7/17/25) and was completed by the NHA (Nursing Home Administrator), DON (Director of Nursing) and PCHA (Personal Care Home Administrator) (7/21/25) and the investigation concluded that Staff Member A did switch out Resident [redacted].

187d Follow prescriber's orders (continued)

tablets for [redacted]. tablets. Staff Member A was terminated from [redacted] employment ([redacted]); the local State Police were notified of the incident on (7/17/25) as well as the Board of Nursing on (7/21/25). The PCHA informed the resident as to what happened regarding Staff Member A and [redacted] medications as well as the residents POA (7/17/25).

The DON met with all LPN's and RN's by 7/21/25 and complete education on proper storage procedures and the importance of following prescriber's orders for all resident medications.

Licensee's Proposed Overall Completion Date: *12/23/2025*

Implemented [redacted] 01/12/2026)