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

September 2, 2026

[redacted], CEO
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 04/16/2026, 04/17/2026, 04/21/2026 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**: *05/08/2026*

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

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

Administrator

Name: [redacted] **Phone**: **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**: *08/13/2002* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *26* **Waking Staff**: *20*

Inspection Information

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

Reason: *Renewal, Complaint* **Exit Conference Date**: *04/21/2026*

Inspection Dates and Department Representative

04/16/2026 - On-Site: [redacted]
04/17/2026 - On-Site:
04/21/2026 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *80* **Residents Served**: *23*

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**: *23*

Diagnosed with Mental Illness: *2* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *3* **Have Physical Disability**: *0*

Inspections / Reviews

04/16/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/15/2026*

Inspections / Reviews *(continued)*

07/30/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/20/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *08/04/2026*

07/31/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/20/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/21/2026*

09/02/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/20/2026*

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

25a - Written Contract and Review

1. Requirements

2600.
25.a. Prior to admission, or within 24 hours after admission, a written resident-home contract between the resident and the home shall be in place. The administrator or a designee shall complete this contract and review and explain its contents to the resident and the resident's designated person if any, prior to signature.

Description of Violation

Resident #3 did not have a resident-home contract completed.

Plan of Correction ***Accept ([redacted] - 07/21/2026)***

2600.25(a)
Immediate review and completion of resident #3 home contract on 4/22/2026 review with #3 Signatures properly completed and placed in #3 chart. The Administrator will ensure that contact implementation and ensure sustained compliance prior to admission or within 24 hours after admission, A standardized admission checklist was developed and put in use to ensure all required resident home contracts are completed. The Administrator will oversee implementation and ensure sustained compliance

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 09/02/2026)

66a - Staff Training Plan

2. Requirements

2600.
66.a. A staff training plan shall be developed annually.

Description of Violation

The home does not have a staff training plan for 2026.

Plan of Correction ***Accept ([redacted] - 07/30/2026)***

2600.66(a)
Effective 4/24/2026 action was taken to ensure compliance of staff training; records will be maintained for all staff ongoing with training and compliance monitoring. Every staff will have a binder and checklist placed on front of binder with trainings completed. An annual staff training plan checklist will be kept in employee files Future training needs will be addressed periodic quality management reviews and Relias training monthly by all staff.

DIRECTED PLAN:
The staff training plan shall include the following in accordance with 2600.66b:
(1)The name, position and duties of each direct care staff person.
(2) The required training courses for each staff person.
(3) The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Proposed Overall Completion Date: 07/30/2026

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 09/02/2026)

66a - Staff Training Plan *(continued)*

85a - Sanitary Conditions

3. Requirements

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

Description of Violation

On 4/16/26, at approximately 12:45 p.m., there was a semi transparent plastic container approximately one third full of urine on the night stand next to the resident's recliner .

On 4/16/26, at 12:56 p.m., there were approximately 10 cigarette butts on the ground of the Smoke Shack. The Smoke Shack was the home's designated smoking area.

On 4/21/26, at 9:55 a.m., there was a strong odor of urine in resident #5's private resident room. There was a urine stain approximately 2 x 2 feet in size on the resident's sheets.

Plan of Correction ***Accept ([redacted] - 07/30/2026)***

2600.85 (a)
The plastic container full of urine on the resident's nightstand was immediately removed on the day of the inspection. The area was sanitized.
The urine-stained sheet in resident number 5's room was immediately removed and placed in laundry.
All other resident rooms were audited by the PC Administrator to ensure that no other residents had the same concern. All other rooms were found to be clear.
Education was provided by the PC Administrator on 6/22/2026 to PC Staff reviewing Regulation 2800.85 (a) and that urine containers should not be kept on nightstands or over the bed tables and that any bed linen that is contaminated with anything should be changed immediately and new linen applied to the bed. Documentation of education will be kept on file.
Resident room audits will be completed by the PC Administrator or designee 5 times per week for 1 week beginning 6-22-26 and continuing through 6-26-26, then 1 time per week for 4 weeks beginning 6-29-26 and continuing through 7-20-26 to ensure ongoing compliance.
Results of the audits will be recorded and reviewed in QAPI meeting.

All cigarette butts on the ground of the smoke shack were immediately disposed of on the day of the inspection.
Education was provided by the PC Administrator on 6/22/2026 to PC staff reviewing Regulation 2800.85 (a) and that cigarette butts should not be thrown on the ground and should be disposed of appropriately in the cigarette butt receptacle.
An appropriate receptacle to dispose of cigarette butts was placed at the smoking hut on 6/19/2026
An audit will be performed by the PC Administrator or designee 5 times per week for 1 week beginning 6-22-26 and continuing through 6-26-26 then 1 time per week for 4 weeks beginning 6-29-26 and continuing through 7-20-26 to ensure no cigarette butts are on the ground at the smoking hut.
Results of the audits will be recorded and reviewed in QAPI meeting.

Licensee's Proposed Overall Completion Date: *07/30/2026*

85a Sanitary Conditions *(continued)*

Implemented ([redacted] - 09/02/2026)

127a Portable Space Heaters

4. Requirements

2600.
127.a. Portable space heaters are prohibited.

Description of Violation

At approximately 11:00 a.m., on 4/16/26 there were two off-white Best Comfort Space Heaters located in the lower level's secured unit's activity room.

Plan of Correction ***Accept ([redacted] - 07/30/2026)***

2600.127(a)

On 4/16/2026 at 4pm Two off-white Best Comfort Space Heaters located in lower level where immediately removed.
PC administrator reviewed and reinforced policy prohibiting space heaters.
Education was completed for PC Staff on 4/22/2026 by the PC Administrator regarding fire safety and the prohibition of portable heating devices in the Personal Care Home. Documentation of education will be kept on file.
Environmental safety rounds will be completed by PC Administrator 3 times per week for 2 weeks starting on 6-22-26 through 7-3-26 then monthly times 1 month to check for unauthorized heating devices.
Results of the audits will be recorded and reviewed at the QAPI meeting.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 09/02/2026)

130e Hearing Impairment

5. Requirements

2600.
130.e. If one or more residents or staff persons are not able to hear the smoke detector or fire alarm system, a signaling device approved by a fire safety expert shall be used and tested so that each resident and staff person with a hearing impairment will be alerted in the event of a fire.

Description of Violation

Resident #4 is unable to hear the fire alarm system. The home does not have a signaling device, approved by a fire safety expert and tested to ensure that resident #4 is alerted in the event of a fire.

Plan of Correction ***Accept ([redacted] - 07/30/2026)***

2600.130(e)
An appropriate signaling device approved by a fire safety expert was obtained and installed for the affected

130e Hearing Impairment (continued)

resident on 6/22/2026 by maintenance.
All other residents were reviewed by the PC Administrator immediately to determine if there are any other residents requiring a specialized fire alarm. Currently there are no other residents identified.
Education was provided by the PC Administrator or designee on 6/24/2026 reviewing the residents identified requiring specialized fire alert device and the proper working of the fire alert device.
The specialized fire alert devices will be assessed by the PC Administrator or designee with each fire drill to ensure working condition.
All new residents will be assessed on admission for the need of an appropriate fire alert signaling device.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 09/02/2026)

130h - Inoperable Smoke Detector

6. Requirements

2600.
130.h. The home's emergency procedures shall indicate the procedures that will be immediately implemented until the smoke detector or fire alarms are operable.

Description of Violation

The home's emergency procedures do not indicate what procedures will be implemented when a smoke detector or fire alarm is inoperable.

Plan of Correction ***Directed ([redacted] - 07/31/2026)***

2600 130 (h)
All smoke detectors and fire alarms in the facility were tested to verify proper operation on 6/19/2026 by maintenance.
Education will be provided by the PC Administrator or designee to PC staff on 6/19/2026 reviewing the protocol on what should be done if a fire alarm and/or smoke detector is malfunctioning. Education will be kept on file.
Fire alarms and smoke detectors will be assessed with each fire drill to ensure they are functioning properly.
Results of the audits will be reviewed at the QAPI meeting

All smoke detectors and fire alarms in the facility were tested to verify proper operation on 6/19/2026 by maintenance. Education will be provided by PC Administrator or designee to PC staff on 6/19/2026 reviewing the protocol on what should be done if a fire alarm and/or smoke detector is malfunctioning. Education will be kept on file. Fire alarms and smoke detectors will be assessed with each fire drill to ensure they are functioning properly. In the event that a fire alarm or smoke detector becomes inoperable the facility will immediately be placed on fire watch protocol until the issue is corrected. Results of audits will be reviewed at the QAPI meeting.

Proposed Overall Completion Date: 07/31/2026

The Administrator shall ensure that the above procedures are included in the written Emergency Preparedness Plan.
[redacted] 7/31/26

130h - Inoperable Smoke Detector *(continued)*

Directed Completion Date: *07/31/2026*

Implemented ([redacted] - 09/02/2026)

132a - Monthly Fire Drill

7. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

There were no fire drills conducted In February or March for the calendar year of 2026.

Plan of Correction ***Accept ([redacted] - 07/30/2026)***

2600.132(a)
April 28 2026 on 1st shift PC Administrator conducted an unannounced fire drill which was documented and placed in monthly binder
A monthly fire drill will be conducted at least once a month moving forward on varying shifts and varying times.
Maintenance Director will be educated on monthly fire drill process by the PC Administrator on 6/25/2026.
Documentation of education will be kept on file.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 09/02/2026)

132d - Evacuation

8. Requirements

2600.
132.d. Residents shall be able to evacuate the entire building to a public thoroughfare, or to a fire-safe area designated in writing within the past year by a fire safety expert within the period of time specified in writing within the past year by a fire safety expert. For purposes of this subsection, the fire safety expert may not be a staff person of the home.

Description of Violation

On 10/28/25, a fire safety expert established a safe evacuation time of 5 minutes and 7 seconds. However, multiple fire drills had an evacuation time exceeding 5 minutes and 7 seconds to include, the fire drill conducted on 1/25/25, had an evacuation time of 5 minutes and 48 seconds, on 5/5/25, an evacuation time of 5 minutes and 35 seconds, and on 7/25/25, an evacuation time of 13 minutes.

Plan of Correction ***Accept ([redacted] - 07/30/2026)***

2600-132 (d)
A fire drill with full evacuation will be completed by 7/23/2026 by a fire safety expert.
Full evacuation will be completed annually.
Education will be provided to the PC Administrator and the Maintenance Director by the Clinical Services Consultant regarding what is "safe evacuation time" that has been established by a fire safety expert on 6/24/2026
Documentation of education will be kept on file.
Results of the evacuation time will be reviewed in QAPI.

132d - Evacuation *(continued)*

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 09/02/2026)

132e - Fire Drill Sleeping Hours

9. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

There were no fire drills conducted during sleeping hours from August 2025 through March 2026.

Plan of Correction ***Accept ([redacted] - 07/30/2026)***

2600-132 (e)
The PC Administrator will conduct a fire dill during sleeping hours on 7/9/2026 and once every 6 months to ensure compliance with regulatory requirements.
Documentation of the drill will be completed and maintained.
Maintenance Director will be educated by the PC Administrator on 7/6/2026 regarding fire drill compliance during sleeping hours every 6 months. Education will be kept on file.
Results of the fire drill will be reviewed at the QAPI meeting.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 09/02/2026)

132g - Fire Drills Days/Times

10. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The were two staff members scheduled for work during the 10:00 p.m., to 6:00 a.m., shift on multiple dates to include 4/21/26, through 4/23/26. However, there were no fire Drills held from January 25, 2025, through April 17, 2026, that were conducted with two staff members during the 10:00 p.m., to 6:00 a.m., shift.

Plan of Correction ***Directed ([redacted] - 07/31/2026)***

2600-132 (g)
A revised fire drill schedule was developed on April 27 2026 to ensure drills are conducted on varying times and days of the week and at different times of the day and night.
Education will be completed on April 26, 2026 by the PC Administrator with the Maintenance Director regarding new fire drill schedule to include varying times. Education will be kept on file.
Results of the fire drills will be reviewed at the QAPI meeting.

A revised fire drill schedule was developed on April 27, 2026 to ensure drills are conducted on varying times and days of the week and at different times of the day and night. Education will be completed on April 26 2026 by PC

132g Fire Drills Days/Times (continued)

Administrator with the Maintenance Director regarding new fire drill schedule to include varying times. Education will be kept on file. A Sleeping hour fire drill was conducted on 7/30/2026 at 5:45am

Proposed Overall Completion Date: 07/31/2026

The Administrator shall ensure fire drills conducted during sleeping hours only use the minimum staffing numbers for that shift. [redacted] 7/31/26

Directed Completion Date: *07/31/2026*

Implemented ([redacted] - 09/02/2026)

143a - Emergency Medical Plan

11. Requirements

2600.
143.a. The home shall have a written emergency medical plan that includes the following:
1. The hospital or source of health care that will be used in an emergency. This shall be the resident's choice, if possible.
2. Emergency transportation to be used.
3. An emergency-staffing plan.

Description of Violation

The home does not have a written emergency medical plan.

Plan of Correction ***Accept ([redacted] - 07/30/2026)***

2600 143 (a)
A written emergency medical plan to include, hospital or source of health care that will be used in an emergency, emergency transportation to be used, and emergency staffing plan will be implemented by 6 23 26.
Education will be provided by the PC Administrator to PC staff on 7/2/2026 regarding the facility's emergency medical plan and their responsibility during an emergency. Education will be kept on file.
The emergency medical plan will be reviewed annually by the PC Administrator or designee and will be revised as necessary.
The emergency medical plan will be reviewed annually at the QAPI meeting.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 09/02/2026)

183b - Meds and Syringes Locked

12. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 4/16/26, at approximately 12:45 p.m., there was a cardboard box containing multiple medications to include, Chlorohexidine Gluconate 4% Solution, Antiseptic Skin Cleaner and Medline Remedy Clinical Antifungal Powder. However, the medications were unattended/unsecured location in a cardboard box on the floor of the Semi Private

183b - Meds and Syringes Locked (continued)

resident bathroom.

Plan of Correction ***Accept ([redacted] - 07/30/2026)***

2600.183(b)
The cardboard box containing multiple medications was immediately removed from the resident's bathroom floor during the inspection. The medications were checked with the medication administration record and the medications not on the record were destroyed per QLS policy.
Education was provided by the PC Administrator to PC staff on 6/29/2026 regarding regulation 2600.183 (b), medication procedures, and proper storage of medications. Education will be kept on file.
All resident rooms were audited by the PC Administrator on the day of inspection and found to be clear of medications.
Resident room audits will be completed by the PC Administrator or designee 5 times per week for 1 week beginning 6-22-26 and continuing through 6-26-26, then 1 time per week for 4 weeks beginning 6-29-26 and continuing through 7-20-26 to ensure ongoing compliance.
Results of the audits will be recorded and reviewed in QAPI meeting.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 09/02/2026)

185a - Implement Storage Procedures

13. 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 #6 was prescribed insulin aspart flexpen subcutaneous Pen Injector 100 unit / ML inject as per sliding scale. If 0 - 69 = 0u start hypoglycemic protocol, 70 - 149 = 0u, 150 - 200 = 3u, 201 – 250 6u, 251 - 300 = 9u, 301 - 350 = 12u, 351 - 400 = 15 unit, 400 + = 18 unit If greater than 401 Administer 18 unit recheck in one hour call MD. On 4 19 2026 at breakfast time the residents medication administration record indicated a blood glucose measurement of 142. However, the residents blood glucometer indicated a blood glucose measurement of 443 for that corresponding date and time.

Resident #7 was prescribed insulin as part Flexpen subcutaneous solution pen injector 100 units per/Mill inject as per sliding scale if 0 - 69 = 0U, If below 70 start hypoglycemic protocol 70 - 150 = 0, 151 - 200 = 2u, 201 - 250 = 4u, 251 - 300 = 8u, 301 - 350 = 8u, 351 - 400 = 10u, 401 - 450 = 12u administered 12 units recheck in one hour if still above 300 call MD. On 4/20/26 at breakfast The resident's medication administration record indicated blood glucose reading of 224. However, the resident's blood glucometer had a blood glucose reading of 235.

Plan of Correction ***Accept ([redacted] - 07/30/2026)***

2600.185(a)
1. Unable to correct this deficient practice as it has already occurred
2. An audit will be completed by the personal care administrator or designee of all resident's with physician orders for use of a glucometer to validate whether the glucose readings match the documentation recorded in the medication administration record.

185a Implement Storage Procedures (continued)

3. All Med techs will receive training on glucose testing and recording by the personal care administrator by 6/26/2026

4. A weekly audit will be completed by the personal care administrator or designee of all residents using glucometers to ensure blood sugar taken is recorded accurately in the medication administration record as well as matches the glucometer.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 09/02/2026)

186a - Authorized Prescriber

14. Requirements

2600.
186.a. Each prescription medication must be prescribed in writing by an authorized prescriber. Prescription orders shall be kept current.

Description of Violation

On 4/16/26, at approximately 12:45 p.m., there was a partially used container of Chlorohexidine Gluconate 4% Solution Located in the semi private bathroom of resident quarry malice. However, There was no valid prescriber order for this medication.

Plan of Correction ***Accept ([redacted] - 07/30/2026)***

2600.186(a)

1.The medication solution was immediately removed from the resident's bathroom and properly disposed of according to facility policy and pharmacy guidelines.

2.An audit will be completed by the personal care administrator or designee by 6/24/2026 to ensure all orders are active and current as well as to ensure no discontinued medication are in resident rooms.

3. Education to be given to med tech and aides that all medications must have an active order. Staff were re educated on proper medication storage requirements, verifying physician orders before administration, and procedures for identifying and removing discontinued or unauthorized medication by the personal care administrator on 6/24/2026

4. Weekly audits will be completed for thirty days by the personal care administrator or designee to ensure medications are not stored in residents' room and that no discontinued medications are present.

Results of the audits will be record and reviewed in QAPI meeting

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 09/02/2026)

224a - Preadmission Screen Form

15. Requirements

2600.
224.a. A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

Description of Violation

Resident #3 was admitted to the home; however, the resident's preadmission screening form was not completed.

224a Preadmission Screen Form *(continued)*

Plan of Correction ***Accept ([redacted] - 07/30/2026)***

2600.224(a)

1.The resident # 3 preadmission screening was completed 7/2/2026 to ensure all required information was obtained and documented.

2. An audit of all prescreen will be completed by the personal care administrator or designee by 6/26/2026

3. A admission checklist has been implemented by the personal care administrator to ensure that all required documents including the preadmission screening form are completed prior to admission.

4. The personal care administrator will be educated by the clinical services specialist by 6/26/2026 on the requirements of and time frame completion of preadmission screener.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 09/02/2026)

225a - Assessment 15 Days

16. Requirements

2600.

225.a. A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

Description of Violation

The most recent assessment for resident #2 was dated [redacted]

Plan of Correction ***Accept ([redacted] - 07/30/2026)***

2600.225(a)

1. Upon identification of the deficiency residents # 2 written assessment was reviewed and a current assessment was completed on 6/23/2026

2. The residents current need, level of functioning, and service required were evaluated to ensure appropriate care 6/19/2026?

3. The Administrator will be educated on Pennsylvania Personal Care home regulations regarding admission and annual assessment requirements by the Clinical Services Specialist.

4. A tracking system will be developed and maintained by the personal care administrator or designee to ensure that all resident assessments are completed timely and documented on the required DHS forms.

5. The Administrator will conduct monthly audits of resident's records for 90 days to verify that all required assessments are completed and maintained in accordance with regulations. Any discrepancies identified will be corrected.

Results of the audits will be recorded and reviewed in QAPI meeting.

Licensee's Proposed Overall Completion Date: *07/30/2026*

Implemented ([redacted] - 09/02/2026)