STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395870	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quality Life Services - Markleysburg	252 Main Street Markleysburg, PA 15459

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to develop and/or update person-centered care plans related transfer and bed mobility assistance levels for three of 17 residents (Residents R1, R2, R3) that resulted in the actual harm of a nasal fracture and knee fracture for one of four residents (Resident R1) . This was identified as past noncompliance.Findings include: Review of facility policy Care Plan and Interdisciplinary Care Conferences dated 6/9/25, indicated the care plan is a working tool that is reviewed and revised at specific intervals and as needed to reflect response to care and changing needs and goals. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 3/8/26, included diagnoses of quadriplegia (paralysis of all four limbs), history of a stroke, and a seizure disorder. Review of Section GG: Functional Abilities indicated that Resident R1 was totally dependent on staff (Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity). Review of a physician order dated 2/19/26, indicated Resident R1 required an assist of two with a mechanical lift for transfers. Further review of the physicians' orders failed to reveal an order related to bed mobility prior to 3/20/26. Review of Resident R1's plan of care for ADL (activities of daily living) failed to include information regarding bed mobility requirements prior to 3/20/26. Review of Resident R1's Kardex (document that outlines the patients' ADLs, continence levels, and behaviors, as well as physician, advanced directives, diet, and allergies) utilized by nurse aide staff dated 3/14/26, failed to include directions to nurse aide staff regarding bed mobility requirements. Review of Resident R1's physical therapy Discharge summary dated [DATE], indicated that the therapy recommendation for bed mobility was, Total Dependence. During an interview on 4/1/26, at approximately 1:30 p.m. the Director of Nursing confirmed that Resident R1's care plan and Kardex were not updated with the physical therapy recommendation of total dependence and the MDS documentation of dependence for bed mobility. Review of a progress note dated 3/15/26, at 11:26 p.m. indicated, Called to resident's room to find resident laying on floor next to the wall. He was laying prone with face into the floor. His left arm was under his torso. He is alert, asking for help. He yells out when touched or palpated in any way. Resident assisted to supine position (face-up body, lying flat on the back) and assessed. Bloody face cleaned. Laceration noted to left brow, bridge of nose and chin. Review of facility submitted information dated 3/16/26, indicated that on 3/15/26, at 10:00 p.m., Resident R1 was having care provided by [Nurse Aide Employee E1] on 3/15/26 at 10pm. While providing, the care became combative per [NA Employee E1] causing him to fall out of bed. Resident was assessed by RN supervisor and new orders for x-rays to be obtained in the morning from the provider. Resident sustained two fractures: 1. nondisplaced fracture junction of the lateral mid third of the right patella (central portion of the outer side of the kneecap). 2. Nondisplaced, nondepressed nasal bone fracture (fractured nose without movement of the bones out of place). Review of an undated employee statement written by NA Employee E1, indicated, I was not aware of the x2 assist (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0656 Level of Harm - Actual harm Residents Affected - Few	with him. During an interview on 4/1/26, at approximately 1:00 p.m. the Director of Nursing confirmed that the information provided to the nurse aides who provide care did not include Resident R1's bed mobility requirements. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), muscle weakness, and unsteadiness on feet. Review of a physician order dated 1/9/26, indicated Resident R2 required Transfer with assist of 2 staff members. Review of Resident R2's plan of care for ADL (activities of daily living) self-performance deficit indicated, Use a front wheeled walker to transfer with me with staff assistance x1. Further review of the plan of care failed to reveal an update to the care plan related to the physician's order dated 1/9/26, which indicated the need for assistance of two staff members for transfers. Review of Resident R2's Kardex dated 3/17/26, indicated Resident R2 required, Transfer with assist of 2 staff members with FWW (front-wheeled walker). Review of a progress note dated 3/18/26, at 6:52 a.m. indicated, Resident was being transferred to WC (wheelchair), and she did not stand so nurse aid lowered her to the ground. No injury noted, the resident was in care of nurse aid for the entire incident. Review of facility submitted information dated 3/18/26, indicated that on 3/18/26, at 6:40 a.m., indicated, [Resident R2] was being transferred to her WC on the morning of 3/18/26 by GNA (graduate nurse aide) [Employee E2]. She did not stand so nurse aid lowered her to the ground. Per Kardex (task/order) resident is an assist of 2 for transfers. GNA attempted transfer without assistance. Review of a facility incident report dated 3/18/26, indicated, Investigation initiated due to transfer with assist x1. Kardex states should be assist x2.Review of the clinical record indicated Resident R3 was readmitted to the facility on [DATE], after having sustained a left hip fracture at a previous facility. Review of facility census information indicated Resident R3 had resided at this facility since 4/11/14, until discharge on [DATE]. Review of the MDS dated [DATE], included diagnoses of Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking), hip fracture, and history of a stroke. Review of a physician order dated 2/18/26, indicated Resident R3 required Transfers with assist of 2 staff members and FWW WBAT (front-wheeled walker, weight bearing as tolerated). Review of Resident R3's plan of care initiated 2/19/26, failed to include documentation of required transfer assistance until 3/19/26. Review of Resident R3's Kardex dated 2/19/26, through 3/19/26, indicated, Transfer / ambulate with SUP (supervision) and Rollator (four-wheeled walker). Review of Resident R3's clinical record indicated that transfers with supervision and a Rollator was her documented assistance level prior to discharge on [DATE], and subsequent hip fracture, from a prior outside hospital admission requiring these updated levels of assistance. On 3/16/26/24, the facility initiated a plan of correction that included:-Review of all residents' assistance levels by physical therapy staff.-Audit of all residents' transfer and bed mobility assistance levels, and updates where necessary.-Education to all nursing staff to reiterate the need to review the Kardex prior to providing care.-Education to nursing staff responsible for care plan and Kardex updates on verification of needed assistance levels.-New process developed with the clinical team to ensure newly admitted residents and those with a change in required assistance levels are updated timely.-Audits of staff provided care were completed and remain ongoing.-Audit information and education to be reviewed at the Quality Assurance and Performance and Improvement committee. During an electronic interview on 4/2/26/26, at 3:34 p.m. the Director of Nursing confirmed that the facility failed to develop and/or update person-centered care plans related transfer and bed mobility assistance levels for three of 17 residents, this failure resulted in the actual harm of a nasal and knee fracture for Resident R1. This was identified as past noncompliance. 28 Pa. Code 211.12(d)(5) Nursing services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and documents, clinical record review, and staff interview, it was determined that the facility failed to provide adequate supervision to prevent falls for two of four residents (Resident R1 and R2) that resulted in the actual harm of a nasal fracture and knee fracture for one of four residents (Resident R1).Findings include: Review of the facility policy, Falls: Care During and After dated 6/9/25, indicated, All residents experiencing a fall will receive appropriate care and investigation and interventions will be conducted by the interdisciplinary team. Included in the procedure were the following steps: 5. Remove any causes to fall and implement preventative measures to prevent reoccurrence. 6. Update care plan to reflect new interventions. Review of the American Congress of Rehabilitation Medicine - Caregiver Guide and Instructions for Safe Bed Mobility published 4/28/17, indicated bed mobility refers to activities such as scooting in bed, rolling, side-lying to sitting, and sitting to lying down. Review of the clinical record indicated Resident R1 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 3/8/26, included diagnoses of quadriplegia (paralysis of all four limbs), history of a stroke, and a seizure disorder. Review of Section GG: Functional Abilities indicated that Resident R1 was totally dependent on staff (Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity). Review of a physician order dated 2/19/26, indicated Resident R1 required an assist of two with a mechanical lift for transfers. Further review of the physicians' orders failed to reveal an order related to bed mobility prior to 3/20/26. Review of Resident R1's plan of care for ADL (activities of daily living) failed to include information regarding bed mobility requirements prior to 3/20/26. Review of Resident R1's Kardex (document that outlines the patients' ADLs, continence levels, and behaviors, as well as physician, advanced directives, diet, and allergies) utilized by nurse aide staff dated 3/14/26, failed to include directions to nurse aide staff regarding bed mobility requirements. Review of Resident R1's physical therapy Discharge summary dated [DATE], indicated that the therapy recommendation for bed mobility was, Total Dependence. Review of a progress note dated 3/15/26, at 11:26 p.m. indicated, Called to resident's room to find resident laying on floor next to the wall. He was laying prone with face into the floor. His left arm was under his torso. He is alert, asking for help. He yells out when touched or palpated in any way. Resident assisted to supine position (face-up body, lying flat on the back) and assessed. Bloody face cleaned. Laceration noted to left brow, bridge of nose and chin. Bleeding stopped. PEARRL (pupillary response test, standing for Pupils Equal, And Round, Regular in Size, Reactive to Light and Accommodation), grips equal and strong. Abrasion noted to LUQ (left upper quadrant), Laceration left great toe. Bilateral knees red. Resident was nude as CNA (nurse aide) providing care was giving him a bed bath. Resident unable to state what happened. He can follow commands such as squeezing fingers or moving arms but is resistant to passive ROM (range of motion). Resident assisted back to bed via lift and assist of five staff.[Medical provider] made aware. Instructed to perform routine Neuro checks (systematic assessments to evaluate brain function, nervous system integrity, and mental status) and obtain x-ray of left shoulder due to resident's complaints of pain. Review of a physician's order dated 2/18/26, indicated Resident R1 was ordered Tramadol (an opiate pain medication) every eight hours as needed for pain. Review of Resident R1's MAR (medication administration record) revealed that prior to the date of the fall from 3/1/26, through 3/14/26, Resident R1 received (2) doses during the entire time frame. Review of Resident R1's MAR (medication administration record) revealed that after the date of the fall from3/15/26, through 3/31/26, Resident R1 received (11) doses during the entire time frame. Review of facility submitted information dated 3/16/26, indicated that on 3/15/26, at 10:00 p.m., Resident R1 was having care provided by [Nurse Aide Employee E1] on 3/15/26 at (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	10pm. While providing, the care became combative per [NA Employee E1] causing him to fall out of bed. Resident was assessed by RN supervisor and new orders for x-rays to be obtained in the morning from the provider. Resident sustained two fractures: 1. nondisplaced fracture junction of the lateral mid third of the right patella (central portion of the outer side of the kneecap). 2. Nondisplaced, nondepressed nasal bone fracture (fractured nose without movement of the bones out of place). Review of an undated employee statement written by NA Employee E1, indicated, I had went to [Resident R1's] room to wash him up. He had tube feeding on him so I started cleaning him up. We were all done and I rolled him towards me to finish with his linens and brief to pull them out more. After a few seconds of having him rolled he stared yelling and getting combative. He had started coming off the bed because he was upset. I tried to catch him but he was too heavy. So, I tried to lower him the best I could. Soon as he came down onto the ground, I ran and got the nurse and I yelled for everyone to come, it was an emergency. I feel as that his bed was too small. If he had a bigger bed he wouldn't have been able to throw himself off the edge of it. Also, I had no knowledge of him being a x2 assist. I've saw people do them their selves and he doesn't really give me a hard time when I do have him so I was not aware of the x2 assist with him. During an interview on 4/1/26, at approximately 1:00 p.m. the Director of Nursing confirmed that the information provided to the nurse aides who provide care did not include Resident R1's bed mobility requirements. Review of the clinical record indicated Resident R2 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of dementia (a group of symptoms that affects memory, thinking and interferes with daily life), muscle weakness, and unsteadiness on feet. Review of a physician order dated 1/9/26, indicated Resident R2 required Transfer with assist of 2 staff members. Review of Resident R2's plan of care for ADL (activities of daily living) self-performance deficit indicated, Use a front wheeled walker to transfer with me with staff assistance x1. Further review of the plan of care failed to reveal an update to the care plan related to the physician's order dated 1/9/26, which indicated the need for assistance of two staff members for transfers. Review of Resident R2's Kardex dated 3/17/26, indicated Resident R2 required, Transfer with assist of 2 staff members with FWW (front-wheeled walker). Review of a progress note dated 3/18/26, at 6:52 a.m. indicated, Resident was being transferred to WC (wheelchair) and she did not stand so nurse aid lowered her to the ground. No injury noted, the resident was in care of nurse aid for the entire incident. Review of facility submitted information dated 3/18/26, indicated that on 3/18/26, at 6:40 a.m., indicated, [Resident R2] was being transferred to her WC on the morning of 3/18/26 by GNA (graduate nurse aide) [Employee E2]. She did not stand so nurse aid lowered her to the ground. Per Kardex (task/order) resident is an assist of 2 for transfers. GNA attempted transfer without assistance. Review of a facility incident report dated 3/18/26, indicated, Investigation initiated due to transfer with assist x1. Kardex states should be assist x2. Review of written documentation as GNA was unavailable for interview, revealed GNA was unaware of transfer status. During an interview on 4/2/26, at 3:34 p.m. the Director of Nursing confirmed the facility failed to provide adequate supervision to prevent falls for two of four residents that resulted in the actual harm of a nasal fracture and knee fracture for one of four residents. 28 Pa. Code: 201.14 (a) Responsibility of Licensee28 Pa. Code: 201.20 (a)(1) Staff Development28 Pa. Code: 211.10 (b)(c)(d) Resident Care Policies28 Pa. Code: 211.12 (d)(2)(3)(5) Nursing Services

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on a review of facility documentation, cited deficiencies from a previous survey, review of plans of correction documentation, and staff interview, it was determined that the facility's Quality Assurance and Performance Improvement (QAPI) program failed to correct previously cited deficiencies.Findings include: Review of the facility policy, Quality Assurance and Performance Improvement (QAPI)Plan dated 6/9/25, indicated it provides an ongoing, systematic evaluation and improvement process to help ensure that each of the nursing homes and other operational are meeting the organization's quality standards. The facility's deficiencies and plan of correction for the State Survey and Certification (Department of Health) for the following surveys, revealed the facility developed a plan of correction that included quality assurance systems to ensure the facility-maintained compliance with cited nursing home regulations. Review of the facility's deficiencies and plan of corrections for the State Survey and Certification (Department of Health) survey ending 12/18/25, revealed the facility developed a plan of correction that included quality assurance systems to ensure that the facility-maintained compliance with cited nursing home regulations. Review of the plan of correction for survey ending 12/18/25, revealed the following: Employee E3 was suspended pending investigation for possible neglect due to resident R1 injury.Resident R1's bed mobility status was changed in the Kardex to reflect assistance of 2 staff for care.Director of nursing reviewed all other residents bed mobility statuses to ensure proper assistance is being provided. Any updates noted were updated in the Kardex at this time.Resident's bed mobility will be reviewed weekly during the weekly RISK Meetings by the IDT.Education provided to staff by director of nursing on reviewing their residents's assignments Kardex at the beginning of their shift to ensure they are providing safe/appropriate care and following the resident's plan of care.Audits of staff reviewing the Kardex at the beginning of their shift will be completed by director of nursing or designee as follows:5 employees a day x 5 days x one week,5 employees a day x 4 days x one week,5 employees a day x 3 days x one week,5 employees a day x 2 days x one week to ensure compliance for resident safety and decrease risk for accidents.The results of the audits will be reviewed and recorded in monthly QAPI meeting. During the survey process the following was revealed: -Resident R1's Kardex and care plan were not updated with documented therapy recommendations and Minimum Data Set results. This failure caused Nurse Aide Employee E1 to unknowingly provide care alone, rather than the recommended two-person assist, with the result of Resident R1 sustaining knee and nasal fractures. -Resident R2's Kardex and care plan were not updated with the physician's order requiring two staff members for resident transfers. This failure caused Nurse Aide Employee E2 to unknowingly attempt to transfer Resident R2 alone, rather than the recommended two-person assist, with the result of Resident R2 being required to be lowered to the floor. During an interview on 4/2/26, at 3:34 p.m. the Director of Nursing confirmed that facility failed to correct quality deficiencies and make certain that plans to improve the delivery of care and services effectively addressed concerns identified. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management