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	06/04/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and review of facility documents it was determined that the facility failed to protect a resident from abuse and neglect for one of two residents reviewed (Resident R1).Findings include:Review of facility policy Resident Protection from Abuse, Neglect, Mistreatment, or Exploitation dated 5/1/26 and 6/9/26, indicated the facility treats all residents with kindness, respect and in a manner that is at all times free from any form of abuse, neglect, misappropriation of property, exploitation, or mistreatment. ?Abuse' is defined as the willful infliction of harm, unreasonable confinement, intimidation or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. ?Verbal Abuse' is defined as any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend or disability. ?Mental Abuse' is defined as humiliation, harassment, threats of punishment or deprivation. ?Neglect' is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, indicated that a BIMS (Brief Interview of Mental Status) is a brief screener that aids in detecting cognitive impairment. Scores from a BIMS assessment suggest the following distributions:13 - 15: cognitively intact8 - 12: moderately impaired0 - 7: severe impairmentReview of the clinical record indicated Resident R1 was admitted to the facility on [DATE], with diagnoses that include need for assistance with personal care, high blood pressure, and vascular dementia (decline in thinking and memory skills caused by damaged or blocked blood vessels in the brain).Review of Resident R1's MDS dated [DATE], revealed the diagnoses remain current. Further review of the MDS, Section C, Cognitive Patterns; Question C0500 indicated Resident R1 had a BIMS of 04, indicating severe impairment. Section H: Bladder and Bowel, Question H0300 Urinary Continence, indicated Resident R1 was occasionally incontinent (involuntary loss of bladder/bowel control resulting in leakage of urine or stool) of urine; Question H0400 Bowel Continence, indicated Resident R1 was always incontinent.Review of facility documents indicated on 4/13/26, between 7:00 - 9:00 p.m. Resident R1 was talking with a family member on the telephone and had to use the restroom. Resident R1 put the phone down without hanging up. The family member reported Resident R1 was starting to panic because they felt like they were going to have an accident, so they told them to go find a nurse, so they sat the phone down without hanging up. The family member was able to overhear the conversation when Nurse Aid (NA) Employee E1 answered Resident R1's request for assistance to the restroom very rudely and told them to get in the bathroom and he would be in to help. NA Employee E1 was then heard stating very sternly, that he told Resident R1 earlier that they better not get feces on the toilet seat and that they know how to use the bathroom. Resident R1's family (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	member was very upset and called the facility to report it.Review of Resident R1's Kardex Report (quick-reference summary card or file that nurse aids use to see important resident care information, i.e. transfer status, Activities of Daily Living (ADLs) and any assistance needed) dated 4/10/26, indicated for transferring: hand hold staff assistance, Review of the care plan dated 11/3/25, indicated to check on the resident at least every two hours and assist with toileting as needed. Observe for patterns of incontinence and evaluate for toileting schedule if indicated.NA Employee E1 was unavailable for interview.Review of NA Employee E1's employee file indicated they were hired on 5/2/24. They last received Abuse training on 2/27/26, through a company that provides computer training for employees.During an interview on 6/4/26, at 9:00 a.m. the Nursing Home Administrator (NHA) stated NA Employee E1 was suspended from work but quit the next day before their employment could be terminated. The NHA confirmed the facility failed to protect a resident from abuse and neglect for Resident R1.Pa. 28 Code 201.18(b)1)(2)Management