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	07/31/2025

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

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on review of facility policy, resident record, investigation documents, and staff interview, it was determined that the facility failed to report an allegation of neglect for one of four sampled residents (Resident R33).Findings include:A review of the facility Resident Protection From Abuse, Neglect, Mistreatment Or Exploitation policy dated 6/11/24, indicated that residents will be free from any form of neglect and the facility will report all allegations of abuse/neglect and will notify the PA Department of Health/Long Term Care Division via the electronic reporting system. A review of Resident R33's admission record indicated the resident was re-admitted on [DATE], with diagnoses that included multiple sclerosis (a chronic neurological disorder where the immune system attacks healthy cells), and neuromuscular dysfunction of the bladder (nerves that carry messages back and forth between the bladder and the spinal cord and brain do not function normally).A review of Resident R33's Minimum Data Set assessment (MDS -a periodic assessment of resident care needs) dated 2/11/25, indicated that the diagnoses were current upon review and the resident was alert, oriented, and cognitively intact.During an observation on 7/29/25 revealed Resident R33 had a suprapubic catheter (a tube used to drain urine from the bladder into a drainage bag) in place.A review of a physician order dated 2/6/25, indicated to empty the catheter every two hours and document. A review of a facility grievance form dated 4/14/25, indicated Resident R33 stated that morning the CNA did not empty his bag and did not want to get sick due to this. His bag was emptied for 1300cc (cubic centimeters) and is usually 500cc. This concern was investigated and signed by the Director of Nursing, and corrective action was taken.A review of reports submitted to the local state field office did not include Resident R33's allegation of neglect.During an interview on 7/29/25, at 1:45 p.m. the Assistant Director of Nursing (ADON) confirmed that the facility failed to report Resident R33's allegation of neglect as required.28 Pa Code: 201.14 (a) Responsibility of management.28 Pa Code: 201.18 (e)(1) Management.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Based on the review of professional standards of practice, facility policy, clinical record review and staff interview, it was determined that the facility failed to develop and implement care and services consistent with professional standards of practice to prevent the development of a pressure ulcer that developed into a Stage III pressure ulcer (full thickness skin loss that extends into the subcutaneous or fat layer) to the right lateral ankle and a Stage I pressure ulcer (non-blanchable reddened area) to the right inner and outer aspect of the right knee from a immobilizer brace worn due to a fracture. This resulted in actual harm for one of two residents (Resident R3).Findings include:Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e. , support surfaces, repositioning, and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement, and wound cleansing; using adjunctive therapies; and considering possible surgical repair. According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, standardized pressure ulcer risk assessment, and care planning and implementation to address the areas of risk. Review of the facility policy Preventive Skin Care, dated 6/9/25, with a previous review date of 6/11/24, indicated the facility will provide the highest quality of skin care possible and promote preventive measures for skin integrity. From admission, weekly skin assessments will be completed by the nursing staff and documented in the electronic clinical record. Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE], with diagnoses which included respiratory failure, Traumatic Brain Injury with loss of consciousness, bipolar disorder, communication deficit, bilateral cataracts, repeated falls, dizziness, abnormal posture, and a fracture of the right ankle dated 3/15/25. Review of Resident R3's quarterly Minimum Data Set (MDS - a periodic assessment of resident care needs) dated 5/7/25, indicated the diagnoses remained current. Section GG0110(Activities of Daily Living (ADL's) assistance indicated Resident R3 required physical assistance of two staff for bed mobility. Review of Resident R3's clinical record identified that on 3/15/25, Resident R3 had developed a fracture of his right ankle from another resident pushing his wheelchair and his leg getting trapped under the wheelchair causing a fracture which had been identified by the facility and the facility provided the information. On 3/17/25, Resident R3 was assessed by the Orthopedic Physician and a T scope brace (adjustable knee brace to control range of motion) was placed for immobilization of the fracture. Review of a Physician order dated 3/17/25, stated Resident to wear brace to RLE (right lower extremity) at all times, except for hygiene. Review of Resident R3's clinical record did not include documentation of skin checks being completed to the right leg until 4/2/25 due to a skin impairment, 16 days after the T brace was placed.Review of Resident R3's Treatment Administrative Record (TAR) dated 4/1/25, through 4/9/25, identified four of 21 opportunities of missed documented assessments of skin, with no documented issues identified.Review of the clinical record indicated that on 4/9/25, Resident R3 had developed a Stage I pressure ulcer of his right inner aspect of the knee measuring 3 centimeters (cm) x 1 cm x < 0.1 cm area and a 1 cm x 1.5 cm x <0.1cm area of the right outer aspect of the right knee, related to a medical device. A Stage III pressure ulcer was identified of the right lateral ankle measuring 9.5 cm x 3.5 cm x 0.2 cm with 90% of the tissue of the wound being slough (dead tissue). The brace was removed.Review of care plan for Resident R3 on 3/17/25, failed to reveal evidence the facility updated resident's care plan with individualized interventions to address resident's decreased mobility status, need for skin assessments and higher risk for developing pressure ulcers. During an interview on 7/29/25, at 10:00 a.m., Nurse Aide (NA) Employees E22 and E23, stated that skin checks are performed during routine care and findings are to be reported to the nurse.During an interview on 7/29/25, at 11:13 a.m., Registered Nurse (RN) Employee E20 stated that skin assessments are to be documented weekly in the residents TAR and any findings addressed immediately.During an interview on 7/29/25, at 1:48 p.m., the Director of Nursing confirmed that the facility failed to ensure that interventions to prevent pressure ulcers were implemented which resulted in actual harm to Resident R3 who developed Stage I and Stage III pressure ulcers to the right leg from a medical device (T Brace). 28 Pa. Code 211. 10(c)(d) Resident care policies28 Pa. Code 211.12(c)(d)(1)(3)(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** Number of residents sampled: Number of residents cited: (continued on next page)

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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	Based on a review of facility policies, clinical records, investigation report and staff interviews, it was determined that the facility failed to ensure that the environment was free of accident hazards for one of two residents (Resident R3) resulting in harm when hot soup spilled onto Resident R3's right upper, inner thigh area causing a second- degree burn measuring 2 cm x 1.5 cm x <0.1 cm blister requiring treatment. Findings include:Review of the facility policy Accidents and Incidents dated 6/9/25, with a previous review date of 6/11/24, indicated that if an accident/incident occurs involving a resident are reported and investigated for corrective actions and quality improvement. The facility policy regarding hot liquid safety was not provided.The facility provided food temperatures identified the soup at 170 degrees Fahrenheit.Review of the clinical record indicated Resident R3 was admitted to the facility on [DATE], with diagnoses which included respiratory failure, Traumatic Brain Injury with loss of consciousness, Bipolar disorder, Communication deficit, bilateral cataracts, repeated falls, dizziness, abnormal posture and anxiety, a fracture of the right ankle dated 3/15/25. Review of Resident R3's quarterly Minimum Data Set (MDS - a periodic assessment of resident care needs) dated 5/7/25, indicated the diagnoses remained current. Section GG0110(Activities of Daily Living (ADL's) assistance indicated Resident R3 required physical assistance of one staff for eating. Review of Resident R3's plan of care prior to the incident indicated Resident R3 required assistance of one staff for eating. Care plan interventions included lids were to be provided with hot items (hot beverages and/or soup, etc.)Review of Resident R3's physician orders dated 5/6/25, indicated Resident R3 required supervision with a divided plate with Dycem (non -slip mat) to prevent it sliding, all drinks to be in sippy cups, all hot liquids to have a plastic lid with straws in all liquids including soups.Review of a restorative nursing progress note dated 6/10/25, indicated Resident R3's need for the divided plate with Dycem under, all liquids in a sippy cup with oversight and cueing and assist of one staff.Review of a progress note dated 7/25/25, at 5:30 p.m., indicated that Resident R3 had yelled out when he spilled soup on his leg, Resident R3 stated it was hot or similar words and when assessed his right upper, inner thigh had a large, reddened area with no blister at that time.Review of facility submitted information dated 7/25/25, indicated that Resident R3 was in the dining room when it was witnessed, he had soup in his hand (resident was seated at the table) and spilled it on his leg (upper thigh area).Review of Licensed Practical Nurse (LPN) Employee E2's statement indicated that Resident R3 had yelled out help, ouch and the LPN Employee E2 saw that Resident R3 had spilled soup in his lap and had cleaned him up and then she notified the RN Supervisor.Review of the facility investigation report dated 7/25/25, indicated that on Saturday 7/26/25, a 2cm x 1,5 cm x <0.1 cm blister had developed and Silvadene (topical antibiotic cream used to prevent and treat infections associated with second and third-degree burns) was ordered. The indicated interventions to prevent re-occurrence were reviewed onsite and appeared to be unchanged from Resident R3's unfollowed previous orders; supervision with meals and lids served with hot liquids.During an interview on 7/29/25, at 9:45 a.m., Dietary Manger Employee E26 indicated that lids on bowls/cups are communicated to dietary and are placed on the resident meal ticket.During an interview on 7/29/25, at 10:00 a.m., Nurse Aide (NA) Employees E22 and E23 stated, the dietary ticket usually has meal aide needs on the ticket and the resident care plans also indicate special or adaptive equipment.During an interview on 7/29/25, at 1:00 p.m., the Director of Nursing (DON) stated, on the submitted event with Resident R3's plan of care with meals would be different from the current, unfollowed interventions. when asked how the current interventions were identified as being an adjustment after the incident occurred. The DON also confirmed that Resident R3 should have had lid on the soup and the resident should have been assisted with meals which resulted in actual harm when hot soup spilled onto Resident R3's right upper, inner thigh area causing a second- degree burn measuring 2 cm x 1.5 cm x <0.1 cm blister requiring treatment. 28 Pa. Code 201.18(b)(1) Management. 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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on clinical record reviews and staff interview, it was determined that the facility failed to ensure proper monitoring and documentation of behaviors for one of three residents (Resident R51).Findings include:Review of the clinical record indicated Resident R51 was admitted to the facility on [DATE], with diagnoses which included a stroke, lung disease, and falls. Review of a progress note dated 7/1/25, indicated Resident R51 touched Resident R41 and when asked he stated he wanted to and that she did not give permission, but he wanted to do it. Review of a facility provided document dated 7/1/25, indicated that Resident R51 had inappropriately touched Resident R41's breast under her clothing. The investigation indicated Resident R51 was asked if he had increased sexual drives and he stated he did not know and was asked to go a Behavioral Health Unit but refused. The facility physician notified and provided medication for hypersexual behaviors.Review of Resident R51's Medication Administration Record (MAR) for July 2025, indicated that Medroxyprogesterone (hormone used to decrease sexual drive in men)10mg was ordered daily for sexual dysfunction. The MAR or Treatment Administration Record (TAR) did not include monitoring of sexual behaviors.Review of the clinical record did include Psychiatrist visit on 7/16/25.Review of Resident R51's clinical record did not include documentation of any behavior monitoring being done by any staff, including nursing, social services, or nursing assistants. Resident R51 was not being monitored of his whereabouts to make certain he could not sexually abuse any other women residents in the building and his room was next to two rooms containing female residents.During an interview on 7/30/25, at 11:25 a.m., the Director of Nursing confirmed that the facility failed to ensure proper monitoring and documentation of behaviors for one of three residents (Resident R51). 28 Pa Code 201.18(b)(2) Management28 Pa Code 211. 12(d)(1)(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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and facility incidents, it was determined that the facility failed to ensure that residents' clinical records were complete and accurately documented for two of six residents reviewed (Resident R41 and R42).Review of facility policy Elopement Prevention reviewed 6/11/24 and 6/9/25, indicated the facility properly assess residents and plan of care to prevent accidents related to wandering behavior or elopement. Upon admission, readmission, quarterly, and as needed, nurses will complete a Wandering Risk Assessment. Photographs of the resident are provided to the receptionist. The receptionist will maintain the list of all residents at risk for elopement, including the resident's name, and room number.Review of facility policy Accidents and Incidents reviewed 6/11/24 and 6/9/25, indicated an accident/incident is any happening which is not consistent with routine operations or the routine care of the particular resident. Review of facility policy Resident Change in Condition or Status reviewed 6/11/24 and 6/9/25, indicated documentation must be provided in the resident record: any assessment of the resident and findings, all applicable diagnostics, all applicable interventions, and all communication. All documentation provided must indicate the time at which it happened.The facility did not have a policy regarding documentation in the clinical record.Review of the clinical record indicated Resident R41 was admitted to the facility on [DATE], with diagnoses that included epilepsy (seizure disorder - sudden surges of abnormal and excessive electrical activity in your brain that temporarily causes changes in awareness and muscle control, behavior and senses), obesity, and dysphagia (difficulty swallowing).Review of Resident R41' s Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 6/17/25, indicated the diagnoses remain current. Review of a facility reported incident dated 7/1/25, Resident R51 touched Resident R41 in an inappropriate sexual manner, ‘groping right breast'. The residents were immediately separated by staff who witnessed the incident.Review of the progress notes revealed documentation of the following:- On 7/1/25, at 9:42 a.m. Residents separated immediately from common area. Resident R41 was assessed, and no injuries were noted. Resident R41 was asked if she was okay and she stated yes. Family and proper channels to be notified.- On 7/3/25, at 7:57 a.m. Care plan reviewed and updated this date to alleged abuse.Review of the care plan indicated the following interventions:- On 11/21/16, Monitor me for indicators of discomfort or distress.- On 8/26/24, Position me out of reach from other residents to protect me. Review of the clinical record indicated Resident R42 was admitted to the facility on [DATE], with diagnoses that included encephalopathy (abnormal brain function), depression, and alcohol dependence with alcohol-induced persisting amnestic disorder (severe memory disorder caused by chronic alcohol consumption). Review of the MDS dated [DATE], indicated the diagnoses remain current.Review of a facility reported incident dated 6/24/25, indicated Resident R42 was seen outside of the facility and brought back inside by staff. Resident stated he climbed out a resident room [ROOM NUMBER] window to get some air. During an observation on 7/30/25, at 9:06 a.m. Maintenance Director Employee E1 measured the windows in room [ROOM NUMBER] from floor to windowsill. There are two windows, one window was 55 inches from floor to windowsill, the second window is 40 inches from the floor to the windowsill and contained a window air conditioning unit in the left sliding panel.Review of the Nursing Review assessment completed 3/26/25, indicated Resident 42 was at risk for wandering or elopement.Review of the Nursing Review assessment completed 4/20/25, indicated Resident 42 was not at risk for wandering or elopement.Review of the Nursing Review assessment completed 7/17/25, indicated Resident R42 was not at risk for wandering or elopement. Review of the care plan indicated the following interventions:- On 8/31/21, Distract me from wandering by offering me pleasant diversions, activities, food, television, or books- On 8/31/21, Monitor my location frequently. Document any wandering behavior.During an interview on 7/28/25, at 1:03 p.m. Resident R42 denied being outside the facility and denied that he went out a window. During an interview on 7/30/25, at 8:50 a.m. the Director of Nursing (DON) confirmed the facility failed to ensure documentation was accurate and complete for Resident R41 and Resident R42 following incidents that occurred in the facility. 28 Pa. Code 211.5(f) Clinical records.

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide the required 80 square feet of space per resident for 16 of 25 rooms.During an observation of the facility floor plan on 7/30/25, at 2:15 p.m. the below room findings were as follows: room [ROOM NUMBER] (2 beds) 72.69 square feet per resident bed.room [ROOM NUMBER] (2 beds) 73.40 square feet per resident bed.room [ROOM NUMBER] (2 beds) 71.37 square feet per resident bed.room [ROOM NUMBER] (4 beds) 69.52 square feet per resident bed.room [ROOM NUMBER] (3 beds) 70.67 square feet per resident bed.room [ROOM NUMBER] (2 beds) 73.70 square feet per resident bed.room [ROOM NUMBER] (2 beds) 74.61 square feet per resident bed.room [ROOM NUMBER] (2 beds) 71.61 square feet per resident bed.room [ROOM NUMBER] (3 beds) 76.52 square feet per resident bed.room [ROOM NUMBER] (4 beds) 77.06 square feet per resident bed.room [ROOM NUMBER] (3 beds) 70.91 square feet per resident bed.room [ROOM NUMBER] (2 beds) 71.90 square feet per resident bed.room [ROOM NUMBER] (2 beds) 66.12 square feet per resident bed.room [ROOM NUMBER] (2 beds) 64.92 square feet per resident bed.room [ROOM NUMBER] (3 beds) 78.40 square feet per resident bed.room [ROOM NUMBER] (3 beds) 71.56 square feet per resident bed. During an interview on 7/31/25, at 12:02 p.m. the Nursing Home Administrator confirmed that the room sizes were less than 80 square feet as required. 28 Pa. Code: 205.20(f) Resident bedrooms

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Number of residents sampled: Number of residents cited: Based on review of staff education records and staff interview, it was determined that the facility failed to conduct at least 12 hours of in-service education, within 12 months of their hire date anniversary, for nurse aides as required for five of five nurse aides (Employees Employee E2, E3, E4, E5 and E6). Findings include:Review of facility provided documents and training records revealed the following staff members did not have 12 hours of in-service education: NA Employee E2 had a hire date of 5/9/11, with approximately four hours of in-service education between 5/9/24, and 5/9/25.NA Employee E3 had a hire date of 1/7/15, with approximately five hours of in-service education between 1/7/24 and 1/7/25.NA Employee E4 had a hire date of 3/2/22, with approximately five hours of in-service education between 3/2/24 and 3/2/25.NA Employee E5 had a hire date of 6/30/23, with approximately nine hours of in-service education between 6/30/24 and 6/30/25.NA Employee E6 had a hire date of 5/9/24, with approximately seven hours of in-service education between 5/9/24 and 5/9/25.During an interview on 7/31/25, at approximately 11:45 a.m., the Director of Nursing confirmed that the facility failed to provide the required 12 hours annual in-service education within 12 months of their hire date anniversary for five of five nurse aides. 28 Pa. Code: 201.14(a) Responsibility of Licensee. 28 Pa. Code: 201.20(c) Staff Development.