STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395378	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quincy Retirement Community	6596 Orphanage Road Waynesboro, PA 17268

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 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. Based on facility policy review, clinical record review, employee file review, and staff interviews, it was determined that the facility displayed past non-compliance in its failure to provide adequate supervision and assistance devices to prevent accidents, which resulted in harm as evidenced by a fall and fractured nose for one of three residents reviewed (Resident 1).Findings include: Review of facility policy, titled Falls Management Program, dated December 29, 2025, revealed, in part, The facility will ensure the resident environment remains as free of accident hazards as possible. [Facility] is committed to promoting resident autonomy by providing an environment that remains as free of accident hazards as possible. Each resident is assisted in attaining or maintaining their highest practicable level of function through providing each resident with adequate supervision and assistance devices and functional programs as appropriate to prevent accidents. Review of facility policy, titled Wheelchair Mobility Policy, dated December 30, 2025, revealed, in part, Residents who use wheelchairs shall do so in a manner that promotes safety, dignity, and independence while preventing injury. Wheelchair mobility may be self-propelled by the resident or assisted by staff, based on the resident's needs. Foot pedals/footrests must be properly positioned and in place prior to staff assisting with wheelchair propulsion, unless clinically contraindicated and documented in the resident's plan of care. Review of Resident 1's clinical record revealed diagnoses that included history of falling, muscle weakness, acute and chronic respiratory failure and chronic obstructive pulmonary disease (COPD-a type of progressive lung disease characterized by long term respiratory symptoms and airflow limitations). Review of Resident 1's clinical record progress notes revealed that he had a witnessed fall on December 28, 2025, at 12:45 PM. The nurse's note dated December 28, 2025, at 3:28 PM, indicated that the Resident was lying on the floor in the hallway outside the dining room on his left side. Other staff were noted to be with the Resident. The note indicated that Resident 1 was alert per his normal status and answered questions appropriately. Resident 1 was noted to have an abrasion to his forehead, and his nose was swollen and deviated to the right with no bleeding noted. Resident 1 denied pain. Neurological checks were initiated and were noted to be within normal limits. Resident 1 was noted to be able to move his arms and legs per his norm with no complaints or abnormalities noted. Resident 1 was assisted into his wheelchair with no issues or complaints. Resident 1's provider was notified, and an order was given to obtain facial x-rays and to continue neurological checks per the facility protocol. Resident 1's Responsible Party was notified of the fall, injuries, and new orders. Review of Resident 1's x-ray reports dated December 28, 2025, revealed an acute and depressed fracture of the distal third aspect of the bridge of the nose. Review of Employee 1's (Nurse Aide) witness statement regarding Resident 1's fall dated December 28, 2025, indicated Resident 1 was rolling out of dining room. His feet got tangled up and he fell. Review of Employee 2's (Nurse Aide) witness statement regarding Resident 1's fall dated December 28, 2025, indicated that Resident 1 was sitting in front of the dining room doorway and that when Employee 1 (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 0689 Level of Harm - Actual harm Residents Affected - Few	pushed his chair to move him to get other residents through his foot got caught in the wheel and he fell out of the chair. The witness statement also indicated that Resident 1 does not wear leg rests because he self-propels throughout the day. Review of Employee 3's (Licensed Practical Nurse) witness statement indicated that Employee 4 (Registered Nurse) spoke to Employee 3 on December 28, 2025, at the time of Resident 1's fall. The statement indicated that Employee 3 reported he was on the medication cart passing medications when he looked down the hallway toward the dining room and observed Employees 1 and 2 assisting residents out of the dining room. Employee further indicated that he saw Employee 1 pushing Resident 1 in his wheelchair when his foot became caught, causing Resident 1 to fall forward out of the wheelchair onto the floor. Employee 3 further reported that Employee 2 was standing nearby and appeared to be attempting to alert Employee 1 as he heard Employee 2 call out immediately right before the fall but confirmed that he was unable to clearly hear what was said by Employee 2. During an interview with the Nursing Home Administrator (NHA) and Assistant Director of Nursing (ADON) on January 12, 2025, at 10:00 AM, the NHA indicated that they immediately began the investigation into potential neglect and implemented an immediate plan to prevent the same scenario from recurring. The NHA confirmed that Resident 1 typically self-propelled through the facility in his wheelchair using his feet, so no leg rests were on the wheelchair. Review of the facility's immediate plan of correction, revealed the following:1) Resident [1] assessed immediately by Registered Nurse on December 28, 2025, after fall, and treatment orders obtained. Fall incident investigation initiated and on December 29, 2025 was reported to the Department of Health, state police, area Office on Aging, Department of Aging. Alleged perpetrator placed on administrative leave pending investigation outcome.2) The Assistant Director of Nursing or designee will conduct an audit of current residents who utilize a wheelchair for mobility to ensure that each chair has a designated set of leg rests present for use. Audit will be completed by December 30, 2025. Any discrepancies will be addressed. 3) The Assistant Director of Nursing or designee will provide re-education to current healthcare staff on the requirement to utilize foot pedals/ leg rests when assisting wheelchair propulsion and education on the policy for Wheelchair Mobility. Staff education will be completed by January 1, 2026.4) The Nursing Home Administrator or designee will conduct ongoing audits three times weekly for four weeks then three times monthly for two months to ensure that chairs have footrests and observe staff providing wheelchair propulsion for residents to ensure adherence to the Wheelchair Mobility Policy. These audits will be forwarded to the Quality Assurance Performance Improvement Committee for review and recommendations.5) Date of compliance: January 1, 2026. Review of facility plan of correction revealed that the house-wide audit was completed by the Assistant Director of Nursing on December 30, 2025, education was completed by January 1, 2026 and ongoing audits were initiated and continue. Staff interviews with Employees 6 (Nurse Aide), 7 (Licensed Practical Nurse), 8 (Nurse Aide), and 9 (Nurse Aide) on January 12, 2026, indicated they had recently received training regarding the use of leg rests when staff are propelling a resident in their wheelchair. Random tours of the facility completed on January 12, 2026, between 9:35 AM and 11:30 AM, failed to reveal any staff propelling residents in wheelchairs without the presence of leg rests. During a final interview with the NHA on January 12, 2025, at 12:00 PM, she indicated that Employee 1 should have applied leg rests if she was going to be moving or transporting Resident 1 in his wheelchair. The NHA further indicated that the nurse aide denied moving the wheelchair, even though two other staff members indicated in their statement that they observed this occurring. The NHA indicated that she believes Employee 1 did not intend to harm the Resident, but that she failed to identify all the potential safety hazards, which resulted in the unfortunate accident. Employee 1 was terminated on January 2, 2026. During an (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	onsite survey on January 12, 2025, resident records were reviewed, staff were interviewed, and observations were conducted which revealed no concerns with resident safety. 201.14(a) Responsibility of licensee.201.18(b)(1) Management.201.20(a)(1) Staff development.211.10(d) Resident care policies.211.12(d)(1)(2)(3) Nursing services.