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	02/07/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 37116 Based on clinical record review and resident and staff interviews, it was determined that the facility failed to ensure that the resident assessment accurately reflected the resident's status for three of 21 residents reviewed (Residents 1, 13, and 64). Findings include: Review of Resident 1's November 2024 MAR (Medication Administration Record - form used to document physician orders as well as when and how medications are administered to a resident) revealed an ongoing order for Olanzapine (antipsychotic medication) twice daily, effective September 14, 2024. Review of Resident 1's December 26, 2024, quarterly MDS (Minimum Data Set - an assessment tool to review all care areas specific to the resident such as a resident's physical, mental or psychosocial needs) revealed that this assessment was not coded to indicate that she had received antipsychotic medications since admission/entry, reentry, or the prior OBRA assessment (Omnibus Budget Reconciliation Act - set federal standards for nursing home care), whichever was more recent. Review of Resident 1's MDS assessment completion and submission schedule revealed that a comprehensive OBRA assessment was completed on October 28, 2024. In an email received from the Nursing Home Administrator (NHA) on February 6, 2025, at 10:32 AM, she acknowledged that the aforementioned MDS assessment was coded incorrectly and provided a corrected version. Review of a physician encounter report dated September 24, 2024, revealed that Resident 13 had an active colostomy (surgical procedure that bypasses part of the colon and redirects feces to come out of a new hole in the abdomen). Review of Resident 13's September 2024 TAR (Treatment Administration Record) revealed orders for colostomy care every shift, effective September 11, 2024. Review of Resident 13's September 25, 2024, quarterly MDS revealed that it was not coded to indicate that Resident 13 had an ostomy (including colostomy). In email correspondence received from the NHA on February 7, 2025, at 9:27 AM, she revealed that presence of Resident 13's colostomy should have been noted on the aforementioned MDS assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident 64 on February 3, 2025, at 11:02 AM, she revealed that she was receiving wound care for an open area on her left heel. Review of wound consult report dated December 5, 2024, revealed that the wound on Resident 64's left heel was reclassified as a diabetic ulcer (slow healing wounds that develop due to nerve damage, poor circulation, or injury in people with diabetes) associated with type 2 diabetes mellitus (impairment in the way the body regulates and uses sugar [glucose] as a fuel, resulting in too much sugar circulating in the bloodstream). Review of Resident 64's December 17, 2024, quarterly assessment revealed it was not coded to indicate that Resident 64 had a diabetic ulcer. In an email received from the NHA on February 7, 2025, at 9:27 AM, she confirmed that MDS errors existed and would be addressed. 28 Pa. Code 211.12(1)(3)(5) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for 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** 33305 Based on staff interview and record review, it was determined that the facility failed to develop a comprehensive care plan that included a history of urinary tract infections (UTI's) for one of 21 records reviewed (Resident 43). Findings include: A review of the clinical record for Resident 43 revealed diagnoses that included history of UTI's and Non-Alzheimer's Dementia (a group of cognitive disorders that cause memory loss, confusion, and other symptoms observed with Alzheimer's disease but have different underlying causes). A review of the clinical record for Resident 43 revealed admission to the facility on [DATE]. Resident 43 was admitted with a diagnoses of UTI. Resident 43 was ordered Macrobid (antibiotic) 100 mg (milligram) for 10 days. The clinical record also revealed that Resident 43 had a UTI on February 9, 2024. Resident 43's Urologist (a doctor who specializes in the urinary tract system) ordered Nitrofurantoin MCR (antibiotic) 50 mg capsule by mouth daily as a preventive measure due to a history of UTI's. A review of Resident 43's care plan failed to reveal a care plan with a focus on UTI's. During an interview with the Nursing Home Administrator (NHA) on February 5, 2025, at 11:00 AM, the NHA confirmed the comprehensive care plan with a focus on UTI's should have been developed for Resident 43. 211.12(d)(1)(5) Nursing services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 37116 Based on observation, clinical record review, and staff interview, it was determined that the resident care plan was not reviewed and revised to reflect the resident's current status for one of 21 residents reviewed (Resident 10). Findings include: Review of Resident 10's clinical record revealed diagnoses that included type 2 diabetes mellitus (impairment in the way the body regulates and uses sugar [glucose] as a fuel, resulting in too much sugar circulating in the bloodstream) and stage 3 chronic kidney disease (moderate loss of kidney function). Review of Resident 10's active care plan on February 4, 2024, at 1:00 PM, revealed that she was careplanned for having an indwelling catheter (device inserted into the bladder for drainage). Review of hospital notes dated October 26, 2024, revealed that Resident 10's foley catheter was removed on that date. Observation of Resident 10 on February 4, 2025, at 9:37 AM, failed to reveal the presence of a catheter. Review of Resident 10's February 2025 MAR and TAR (Medication and Treatment Records) failed to reveal any orders for an indwelling catheter. In email correspondence received from the Nursing Home Administrator on February 7, 2025, at 9:27 AM, she confirmed that a care plan issue existed. Review of Resident 10's care plan on February 7, 2025, at 9:00 AM, revealed that it had been updated and information regarding Resident 10 having an indwelling catheter had been removed. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49123 Based on clinical record review and resident and staff interviews, it was determined that the facility failed to ensure that residents' medical records were complete and accurately documented for one of 18 residents reviewed (Resident 5). Findings include: Review of Resident 5's clinical record revealed diagnoses that included fracture of the left ulna (break of the bone in the forearm) and anxiety disorder (excessive and persistent worrying). Review of Resident 5's January TAR (Treatment Administration Record - form used to document physician orders as well as when and how treatments are administered to a resident) revealed the following order was not documented as being completed on the dates noted: splint - three times a day, ensure left arm splint on left arm at all times; not documented day shift January 28 and 29, 2025; evening shift January 25, 30, and 31, 2025; and night shift January 23, 24, and 31, 2025, and February 5, 2025. During an interview with Resident 5 on February 4, 2025 at 10:41 AM, it was revealed she wears the brace at all times since having her cast removed about two weeks ago. Email correspondence with the Nursing Home Administrator (NHA) on February 6, 2025, at 3:38 PM, revealed the facility had no additional information to provide in regard to the missing documentation. The NHA stated it was the expectation of the facility that documentation be completed accurately. 28 Pa. Code 211.5(f) Clinical records 28 Pa. Code 211.12(d)(1)(5) Nursing services