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	02/25/2026

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review and staff interview, it was determined the facility failed to notify a representative of the Office of the State Long-Term Care Ombudsman for one of one residents reviewed for hospitalization (Resident 55).Findings Include: Review of Resident 55's clinical record revealed diagnoses that included metabolic encephalopathy (acute brain dysfunction caused by systemic illness) and sequelae of cerebral infarction (physical, cognitive, and psychological disabilities resulting from brain tissue damage). Further review of Resident 55's clinical record revealed that on December 26, 2025, and January 1, 2026, Resident 55 was transferred out of the facility to the hospital and was subsequently admitted to the hospital. Review of the facility's Ombudsman transfer/discharge reporting documentation for the months of December 2025 and January 2026 revealed that Resident 55 was not on the list for either month. During an interview on February 25, 2026, at 12:09 PM, with the Nursing Home Administrator (NHA), it was confirmed that Resident 55 was not on the list for December 2025 and January 2026. The NHA stated that there had been a change in computer programs and residents that had elected to be a bed-hold were not generating on the transfer/discharge list. The NHA also stated that they were working on fixing the issue and that it was the expectation of the facility that transfers/discharges be accurately reported to the ombudsman's office. 28 Pa Code 201.14(a) Responsibility of licensee28 Pa Code 201.18(b)(3) 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

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	02/25/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on facility policy review, clinical record review, facility documentation review, and staff interview, it was determined that the facility failed to ensure that residents receive necessary treatment and services, consistent with professional standards of practice, to identify pressure ulcers and to promote healing of a pressure ulcer for one of two residents reviewed for pressure ulcers (Resident 59).Findings include: Review of facility policy, titled Wound Care, dated December 29, 2025, revealed, in part, Health Center Registered nurse will assess, document, and notify the physician of a new pressure injury no later than the end of the following shift from the time the wound is found. Consult the dietician for all residents at risk for or with skin breakdown or wounds. Nutritional goals should be established. In addition, the policy indicated black heels that are intact and without signs and symptoms of infection or fluctuation are treated with pressure redistribution. No dressing is necessary. Float heels. May apply protective barrier twice a day and as needed. Review of Resident 59's clinical record revealed diagnoses that included unstageable pressure ulcer of left heel (an ulcer that has full thickness tissue loss in which the base of the wound is covered by slough [yellow, tan, gray green, or brown] and/or eschar [tan, brown, or black]), Alzheimer's Disease (a progressive mental deterioration due to generalized degeneration of the brain, characterized by memory lapses, confusion, emotional instability, and progressive loss of mental ability), and Type II Diabetes (disease that occurs when your blood glucose, also called blood sugar, is too high, but does not usually require the use of insulin) with polyneuropathy (a condition in which multiple nerves are damaged leading to weakness, numbness, and impaired function in various parts of the body). Review of Resident 59's skin check form dated August 19, 2025, at 3:19 PM, created by Employee 1 (Licensed Practical Nurse) and revised by Employee 2 (Registered Nurse), indicated that a new pressure ulcer had been identified on Resident 59's left heel. In the clinical suggestions section of the form, suggestion 1. If new onset or worsening, notify provider was not marked. Review of Resident 59's progress notes revealed a corresponding skin check progress note dated August 19, 2025, at 3:19 PM, written by Employee 2, which indicated Resident 59 had a new in-house acquired skin issue to her left posterior heel identified as an unstageable pressure ulcer/injury due to dry scabbed area. The wound measured 1 centimeter (cm) long by 1 cm wide by 0 cm deep, and the surrounding skin was normal in color and temperature and had no swelling noted. The note indicated that the area was cleansed with povidone iodine and no dressing applied. The note further indicated that Resident 59's shoes appeared too small, shoes removed, slipper socks in place to prevent further irritation.will offload pressure. The note failed to reveal that Resident 59's physician was made aware of the new pressure ulcer. Review of Resident 59's progress notes revealed an orders administration note dated August 22, 2025, at 2:58 PM, written by Employee 1, that indicated that Resident 59's weekly skin evaluation was not completed as ordered and that Employee 1 was unable to complete due to time. Review of Resident 59's skin check form dated August 29, 2025, at 11:56 AM, created by Employee 3 (Licensed Practical Nurse) indicated that Resident 59 was noted to have a new unstageable pressure ulcer/injury to her left heel. In the clinical suggestions section of the form, suggestion 1. If new onset or worsening, notify provider was not marked. Review of Resident 59's progress notes revealed a corresponding skin check progress note dated August 29, 2025, at 11:55 AM, written by Employee 3 (Licensed Practical Nurse) that indicated Resident 59 had a new in-house acquired skin issue to her left posterior heel identified as an unstageable pressure ulcer/injury. The wound measured 1 cm long by 1 cm wide by 0 cm deep and was dry and intact with 100% eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown or tan in color, and may appear scab-like) noted. The note failed to reveal that Resident 59's (continued on next page)

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	02/25/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician was made aware of the new pressure ulcer. Review of Resident 59's progress notes revealed a progress note dated September 4, 2025, at 4:50 PM, written by Employee 4 (Registered Nurse) that indicated Resident 59 complained of discomfort to her left heel after a recent fall. The note further indicated that upon assessment, after the fall, Resident 59 was noted to have an open wound measuring 1.5 cm long by 1.5 cm wide with a pink moist center on her left heel. The note further indicated that the area was cleansed, collagen was applied and was covered with a silicone dressing. Review of Resident 59's fall incident report dated September 4, 2025, at 4:45 PM, revealed that her physician was made aware of the fall and resulting in an open wound to her left heel. Review of Resident 59's physician order history confirmed that a treatment order for her left heel pressure ulcer was obtained from her physician on September 4, 2025. Review of Resident 59's progress notes revealed a nutrition dietary note dated October 13, 2025, at 12:08 PM, written by Employee 5 (Dietician) that indicated Resident 59 was noted to have an unstageable pressure injury to her left heel based on Resident 59's October 9, 2025, skin check. The note further indicated that Employee 5 made recommendation to add a protein supplement to promote wound healing. Further review of Resident 59's clinical record failed to reveal any documentation that nursing staff had notified the facility dietician of Resident 59's pressure ulcer/injury between August 19, 2025, and October 13, 2025. During a staff interview with the Nursing Home Administrator on February 25, 2026, at 2:02 PM, she confirmed that nursing staff should have notified Resident 59's physician and the dietician at the time that Resident 59's left heel pressure ulcer was identified. In addition, she confirmed that on August 19, 2025, Employee 2 applied a treatment that was not ordered by Resident 59's physician or part of the physician approved facility wound protocols. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.10(c)(d) Resident care policies.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.