Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

September 4, 2025

[redacted], ADMINISTRATOR
QUINCY RETIREMENT COMMUNITY
[redacted]

RE: QUINCY RETIREMENT COMMUNITY
6596 ORPHANAGE ROAD
QUINCY, PA, 17247
LICENSE/COC#: 30652

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/29/2025 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *QUINCY RETIREMENT COMMUNITY* **License #**: *30652* **License Expiration**: *08/29/2026*

Address: *6596 ORPHANAGE ROAD, QUINCY, PA 17247*

County: *FRANKLIN* **Region**: *CENTRAL*

Administrator

Name: [redacted] **Phone**: [redacted] **Email**: [redacted]

Legal Entity

Name: *QUINCY RETIREMENT COMMUNITY*

Address: [redacted]

Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *05/28/1975* **Issued By**: *Labor and Industry*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *24* **Waking Staff**: *18*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal* **Exit Conference Date**: *07/29/2025*

Inspection Dates and Department Representative

07/29/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *52* **Residents Served**: *24*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *0*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *24*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *0* **Have Physical Disability**: *0*

Inspections / Reviews

07/29/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/28/2025*

08/28/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/04/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/05/2025*

Inspections / Reviews *(continued)*

09/04/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *09/04/2025*

Reviewer: [redacted] **Follow-Up Type**: *Not Required*

88a - Surfaces

1. Requirements

2600.
88.a. Floors, walls, ceilings, windows, doors and other surfaces must be clean, in good repair and free of hazards.

Description of Violation

On 7/29/25, there were multiple dark stains on the carpet of resident room #104. The stains ranged from 6 inches to 12 inches in diameter.

Plan of Correction ***Accept (- 08/28/2025)***

On 7/29/2025, the Executive Director notified of Director of Environmental Services (DES) that resident room #104's flooring need to be replaced asap due to no stains not able to be removed by our housekeeping team shampooing it anymore. Re-education to on- site staff was conducted by PC administrator on 7/29/25. On 7/30/25 the flooring company was contacted by our DES & installation was scheduled to be completed in 1 day on 8/1/25. Flooring was completed as scheduled on 8/1/25. Re-education on process for floor care was conducted to all PC Staff on 8/18/2025. PC Administrator or designee will conduct audits of resident rooms weekly starting 8/24/25 for 4 weeks & then monthly for 2 months to confirm compliance. Audit results will be reported to Quality Assurance in September, October & November.

Licensee's Proposed Overall Completion Date: *08/27/2025*

Implemented (- 09/04/2025)

91 - Telephone Numbers

2. Requirements

2600.
91. Emergency Telephone Numbers - Telephone numbers for the nearest hospital, police department, fire department, ambulance, poison control, local emergency management and personal care home complaint hotline shall be posted on or by each telephone with an outside line.

Description of Violation

There are no emergency telephone numbers to include the nearest hospital and fire department on or by the telephone in resident room #106.

Repeated Violation - 7/30/24, et al

Plan of Correction ***Accept (- 08/28/2025)***

The required Emergency Phone Number List was immediately place beside phone in room #106 by PC Aide Staff. Re-education was conducted to on-site staff by PC Administrator on 7/29/2025. Re-education was conducted on 8/18/2025 to all PC staff. PC administrator or designee will conduct weekly audits starting 8/24/25 for 4 weeks & then monthly audits for 2 months to confirm ongoing compliance. Audits will be reported to Quality Assurance in September, October, & November.

Licensee's Proposed Overall Completion Date: *08/27/2025*

Implemented (- 09/04/2025)

101j7 - Lighting/Operable Lamp

3. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:

101j7 - Lighting/Operable Lamp *(continued)*

7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Residents #1, #2 and #3 do not have access to a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept (- 08/28/2025)***

Director of Environmental Services was on-site when this violation was found & immediately ordered touch lights to be placed on wall at head of beds on 7/29/25. On-site education was conducted by PC Administrator & DES on 7/29/25 to all staff on-site. Touch Lamps were immediately placed by head of bed in rooms & that had an available receptacle within head of bed. Room already had in place a permanent over the bed wall mounted light with a pull cord within reach to resident, but a touch lamp was also placed on stand beside bed. On 8/4/2025 wall touch lights were delivered & placed in room PC staff Designee will conduct audits starting 8/24/2025 of functional light source by head of bedside on all resident rooms weekly for 4 weeks & then monthly for 2 months to confirm ongoing compliance. audits will be reported to quality assurance in September, October, & November.

Licensee's Proposed Overall Completion Date: *08/27/2025*

Implemented (- 09/04/2025)

171b5 - First Aid Kit

4. Requirements

2600.
171.b. The following requirements apply whenever staff persons or volunteers of the home provide transportation for the resident:

5. The vehicle must have a first aid kit with the contents as specified in § 2600.96 (relating to first aid kit).

Description of Violation

The first aid kit in the bus used to transport residents does not include eye protection.

The first aid kit in the van used to transport residents does not include scissors. .

Plan of Correction ***Accept (- 08/28/2025)***

On- site re-education was provided by Executive Director to on-site transportation dept staff on 7/29/25. The missing required items were immediately ordered by the Director of Environmental Serviced (DES) on 7/29/25. The missing items were received & put into first aid kits on 8/1/25 by Transportation Supervisor. An audit was completed on all vehicles by Transportation Supervisor on 8/1/25. on the spot Re-education to all transportation staff re: the requirements needed in the first aid kits, securing the first aid kit, & the inspection of the checklist was completed by Transportation Supervisor on 8/18/2025. Weekly vehicle audits will be conducted by Transportation Supervisor or transportation staff designee weekly for 3 months starting on 8/18/2025. Audit results will be reported to Quality Assurance in September, October, & November.

Licensee's Proposed Overall Completion Date: *08/27/2025*

Implemented (- 09/04/2025)

185a - Implement Storage Procedures

5. Requirements

2600.

185a - Implement Storage Procedures *(continued)*

185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

Description of Violation

On 7/17/25, at 8:00 AM, the blood sugar reading in resident #4's glucometer was 260. However, the documented blood sugar reading in resident #4's July 2025 medication administration record (MAR) was 92.

On 7/21/25, at 11:43 AM, the blood sugar reading in resident #4's glucometer was 229. However, there was no documented blood sugar reading resident #4's July 2025 MAR.

Resident #6 is prescribed FT ClearLax powder as needed for constipation. However, on 7/29/25, this medication was not available in the home.

Plan of Correction ***Accept ([redacted] - 08/28/2025)***

On 7/21/2025 upon realizing the Libre sensor was not storing accurate blood sugar readings, PC staff designee took immediate action & notified the Libre Sensor Customer Service Line Directly & spoke to their customer service representative for trouble shooting of the device. After multiple trouble shooting tests, they were unable to diagnose the issue & stated it had passed the tests. Education was provided to all pc staff regarding current libre sensor issues. Audits were conducted by PC administrator on 7/21/25 & no other pc residents presently using libre 3 sensor. Re-education given to all on-site pc staff on 7/29/25 on medication ordering & receiving of medication & glucometer accuracy by PC Administrator. Tracking tool was created by PC Administrator & education to all pc staff on 8/18/2025 to ensure prescriptions are delivered in a timely manner to ensure all medications are given as prescribed per md orders. on 8/18/2025 PC Lead Care Giver contacted resident #4's Endocrinologist to notify them of need for a different device due to current libre 3 not storing required blood sugar readings. Order was received for new Libre 2 sensor on 8/18/2025. New order immediately sent to Health Direct Pharmacy & we were informed resident #4's insurance would not cover a new device at this time & would be an out-of-pocket cost of $155. 84. PC Administrator contacted Health Direct & gave the approval for Pharmacy to send new sensor & PC facility would pay the cost to be in compliance with DHS regulations. New device received by pharmacy & placed on resident #4 on 8/20/25. Tracking tool was created by PC Administrator. 8/18/2025 to ensure prescriptions are delivered as ordered per md orders. Ongoing audit of medication order/receipt & glucometer verifications will be conducted by PC staff designee weekly & as needed for 3 months starting 8/24/2025.

Licensee's Proposed Overall Completion Date: *08/27/2025*

Implemented ([redacted] - 09/04/2025)

187d - Follow Prescriber's Orders

6. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #4

187d - Follow Prescriber's Orders (continued)

is prescribed Utymax 1 packet with orders to take by mouth once daily mixed in 120 ml of water. However, on 7/29/25 at 9:01 AM, this medication was not administered to resident #4 because the medication was not available in the home.

Resident #5 is prescribed blood sugar checks before each meal, three times a day and Novolog insulin with orders to administer 8 units SQ before lunch and supper, and to hold if blood sugar readings are <120. However, on 7/4/25, 7/12/25, 7/26/25 and 7/27/25 at 11:31 AM, resident #5 was not administered insulin. There were no blood sugar readings for these dates and times on the resident's glucometer and no documented blood sugar readings for these dates and times on the resident's July 2025 medication administration record.

Resident #6 is prescribed Polyethylene glycol 3350: 17 gram/dose oral powder with orders to take by mouth once daily in 8oz of fluid daily for constipation. However, on 7/27/25, 7/28/25 and 7/29/25 at 9:01 AM, this medication was not administered because the medication was not available in the home.

Resident #6 is prescribed Ocusoft Lid scrub pads with orders to use one both eyes: pad to wipe both eyes once daily for dry eye syndrome. However, on 7/14/25 and 7/15/25 at 11:01 AM, this medication was not administered because the medication was not available in the home.

Repeated Violation - 7/30/24, et al

Plan of Correction ***Accept ([redacted] - 08/28/2025)***

Audit was conducted by PC Lead care Giver on 7/29/25 to ensure Resident #4, #5, & #6's medications were immediately checked with current MD orders to ensure all medications had been delivered by pharmacy & nothing was missing. On site education conducted by PC Administrator to all on-site staff on 7/29/25. Pharmacy education conducted by PC Lead Care Giver on 7/29/25. On-site re-education conducted by PC Administrator to all PC staff on 8/18/25 re: proper documentation w/ LOA residents & their medications. PC staff designee will conduct Pharmacy Delivery/ Medication cart, MD order & proper documentation of medication administration when residents go loa w/ family weekly x 4 weeks & then monthly x 2months to confirm compliance starting 8/24/25. Audit Findings will be reported to Quality Assurance in September, October, & November by PC Administrator.

Licensee's Proposed Overall Completion Date: *08/27/2025*

Implemented ([redacted] - 09/04/2025)

251b - Record Entries Legible

7. Requirements

2600.
251.b. The entries in a resident's record must be permanent, legible, dated and signed by the staff person making the entry.

Description of Violation

Correction fluid was used on multiple incident reports sent to the Department including the following:

- *10/24/24 and 4/16/25 and incident reports for resident #7*
- *4/8/25 and 10/24/25 incident reports for resident #8*
- *10/26/24 incident report for resident #9*
- *10/12/24 incident report for resident #10*

251b - Record Entries Legible (continued)

Plan of Correction ***Accept ([redacted] - 08/28/2025)***

on 7/29/25 DHS Surveyor conducted in-house education to PC Administrator & Executive Director regarding the use of correction tape not being permitted. Re-education was provided to all PC staff on site regarding requirements regarding resident records on 7/29/25. Audit completed by PC Administrator on 7/30/25 no other record violations found. Re-education was conducted to all PC staff on 8/18/2025. Continued audits will be conducted monthly for 3 months by PC administrator or PC staff designee starting 8/24/2025. Future incident reports will all be submitted electronically to ensure proper resident record requirements. Audit results will be reported to Quality Assurance in September, October, & November.

Licensee's Proposed Overall Completion Date: *08/27/2025*

Implemented ([redacted] - 09/04/2025)