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

May 13, 2026

, EXECUTIVE DIRECTOR
QUINCY RETIREMENT COMMUNITY
6596 ORPHANAGE ROAD
QUINCY VILLAGE,
WAYNESBORO, PA, 17268

RE: PARKER HOUSE ASSISTED LIVING
6596 ORPHANAGE ROAD
WAYNESBORO, PA, 17268
LICENSE/COC#: 33317

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 03/31/2026, 04/01/2026, 04/02/2026 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *PARKER HOUSE ASSISTED LIVING* **License #**: *33317* **License Expiration**: *04/24/2027*

Address: *6596 ORPHANAGE ROAD, WAYNESBORO, PA 17268*

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

Administrator

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

Legal Entity

Name: *QUINCY RETIREMENT COMMUNITY*

Address: *6596 ORPHANAGE ROAD, QUINCY VILLAGE,* [redacted] *ED, WAYNESBORO, PA, 17268*

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

Certificate(s) of Occupancy

Type: *I-2* **Date**: *01/18/2017* **Issued By**: *Quincy Township*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *69* **Waking Staff**: *52*

Inspection Information

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

Reason: *Renewal* **Exit Conference Date**: *04/02/2026*

Inspection Dates and Department Representative

03/31/2026 - On-Site: [redacted]

04/01/2026 - On-Site: [redacted]

04/02/2026 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served**: *46*

Special Care Unit

In Residence: *Yes* **Area**: *Building #2* **Capacity**: *16* **Residents Served**: *16*

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *47*

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

Have Mobility Need: *23* **Have Physical Disability**: *0*

Inspections / Reviews

03/31/2026 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *04/23/2026*

Inspections / Reviews *(continued)*

04/27/2026 POC Submission

Submitted By: [redacted]
Date Submitted: *05/13/2026*
Reviewer: [redacted]
Follow Up Type: *POC Submission*
Follow Up Date: *05/04/2026*

04/28/2026 POC Submission

Submitted By: [redacted]
Date Submitted: *05/13/2026*
Reviewer: [redacted]
Follow Up Type: *Document Submission*
Follow Up Date: *05/15/2026*

05/13/2026 Document Submission

Submitted By: [redacted]
Date Submitted: *05/13/2026*
Reviewer: [redacted]
Follow Up Type: *Not Required*

65a Fire Safety-1st day

1. Requirements

2800.
65.a. Prior to or during the first work day, all direct care staff persons including ancillary staff persons, substitute personnel and volunteers shall have an orientation in general fire safety and emergency preparedness that includes the following:

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the residence's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Description of Violation

Staff Member A, whose first day of work was [redacted] completed an online fire safety course. However, this training was not specific to the residence.

1. Evacuation procedures.
2. Staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable.
3. The designated meeting place outside the building or within the fire-safe area in the event of an actual fire.
4. Smoking safety procedures, the residence's smoking policy and location of smoking areas, if applicable.
5. The location and use of fire extinguishers.
6. Smoke detectors and fire alarms.
7. Telephone use and notification of emergency services.

Plan of Correction ***Accept ([redacted] - 04/28/2026)***

Plan of Correction
Regulation: 2800.65(a) – Staff Orientation in Fire Safety and Emergency Preparedness
Violation: Staff Member A did not receive residence-specific fire safety orientation on or before the first day of work. Training completed was general in nature and not specific to the residence.
1. How the violation was corrected for the specific individual(s):
Staff Member A received a comprehensive, residence-specific fire safety and emergency preparedness orientation during orientation. The training was not completed on first day of employment, but it was verified to have been completed on [redacted] This training included all required elements:
• Evacuation procedures specific to the residence
• Staff duties and responsibilities during fire drills and emergencies
• Designated meeting location outside the residence
• Smoking policy and designated smoking areas (if applicable)
• Location and use of fire extinguishers
• Smoke detectors and fire alarm systems in the residence
• Telephone use and procedures for notifying emergency services
Documentation of this training has been completed and placed in the employee's personnel file.
2. What measures will be put into place to prevent recurrence:

65a Fire Safety 1st day (continued)

The facility has implemented the following measures:

- *An audit was completed by HR on 4/27/2026 of all current employees to verify training had been completed. Any employees missing the training were met with and received the education. Education was performed by Assisted Living Administrator on 4/28/26.*

• A standardized Fire Safety Orientation Checklist specific to the residence was developed on 4/24/26 and will be used for all new hires. The checklist will be initiated on the next new employee orientation dated 5/5/26.
• All direct care staff will receive residence specific orientation on or before their first day of work starting with the next NEO (new employee orientation) on 5/5/26.
• Staff will not be permitted to work independently until this orientation is completed and documented.
• The Administrator or designee will be responsible for ensuring compliance with orientation requirements.
• Starting 5/5/26 on first day of work in the Assisted Living, employees will be educated on location specifically fire safety policies and procedures.
3. How the corrective actions will be monitored:
Starting on 5/5/26 the Administrator or designee will review each new employee's file prior to the employee working independently to ensure that all required orientation documentation is complete. Ongoing compliance will be maintained through routine oversight of the onboarding process.
4. Date of compliance:
Audits will be brought to Quality Management meetings for review and recommendations as appropriate.
The facility will achieve full compliance by 5/15/2026

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented (█ - 05/13/2026)

85a Sanitary conditions

2. Requirements

2800.
85.a. Sanitary conditions shall be maintained.

Description of Violation

On 3/31/26 at approximately 2:15 PM, the following rooms on the Secure Dementia Care Unit (SDCU) were observed having fecal matter in the living areas and bathrooms:

- *Resident bedroom #212 was observed having feces on the floor in the living room area leading to the bathroom and the bathroom had a large puddle of feces on the floor in front of the toilet.*
- *Resident bedroom #210 was observed having fecal matter smeared on the toilet seat.*
- *Resident bedroom #207 was observed having fecal matter smearedon the toilet seat.*

Plan of Correction ***Accept (█ - 04/27/2026)***

Plan of Correction
Regulation: 2800.85(a) Sanitary Conditions

85a Sanitary conditions (continued)

Violation: Sanitary conditions were not maintained on the Secure Dementia Care Unit (SDCU), as fecal matter was observed in resident rooms #212, #210, and #207 on 3/31/26.
1. How the violation was corrected for the specific situation:
Immediately upon discovery on 3/31/26, housekeeping and care staff were notified and all affected areas (resident rooms #212, #210, and #207) were promptly cleaned and disinfected in accordance with facility infection control procedures.
Soiled surfaces, including floors and bathroom fixtures, were thoroughly sanitized, and proper personal protective equipment (PPE) was utilized during cleanup.
Residents were assessed, and appropriate care was provided to ensure their hygiene and safety needs were met.
2. What measures will be put into place to prevent recurrence:
The facility has implemented the following measures:
• An audit was conducted to ensure bathrooms in all residents to ensure they are clean and sanitary by the administrator on 4/17/2026.
3. How the corrective actions will be monitored:
Staff have been re-educated by the Administrator on maintaining sanitary conditions, including immediate cleanup of bodily fluids and frequent monitoring of resident living areas, especially on the Secure Dementia Care Unit by 4/20/2026
4. Date of compliance:
The Administrator or designee will conduct a weekly audit for X4 weeks (w1-4/24/2026, w2-5/1/2026, w3- 5/8/2026, w4- 5/15/2026) and then a monthly audit X2 (M1- 6/14/2026, M2- 7/14/2026) to ensure bathrooms and resident rooms are clean and sanitary. Audits will be brought to Quality Management meetings for review and recommendations as appropriate.
The facility will achieve full compliance by 5/15/2026

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented (- 05/13/2026)

127a Portable space heaters

3. Requirements

2800.
127.a. Portable space heaters are prohibited.

Description of Violation

On 3/31/26 at 1:30 PM, an electric portable space heater was in the mechanical room of building #2.

Plan of Correction ***Accept (- 04/27/2026)***

Plan of Correction
Regulation: 2800.127(a) – Portable Space Heaters
Violation: A portable electric space heater was observed in the mechanical room of Building #2 on 3/31/26 at approximately 1:30 PM.
1. How the violation was corrected for the specific situation:

127a Portable space heaters (continued)

The portable space heater was immediately removed from the mechanical room on 3/31/26 upon discovery. The item was taken out of service and removed from the facility to ensure compliance with regulations prohibiting portable space heaters.
2. What measures will be put into place to prevent recurrence:
The facility has implemented the following measures:
• An audit by the administrator or designee of all areas within the building was conducted to ensure no additional unauthorized heaters are present by 4/17/2026
.
3. How the corrective actions will be monitored:
Staff have been re-educated by the administrator on the prohibition of portable space heaters within the facility by 4/20/2026
4. Date of compliance:
The Administrator or designee will conduct monthly (m1-4/24/2026, m2- 5/24/2026, m3- 6/23/2026) routine environmental rounds to ensure that no portable space heaters are present in the facility.
Any prohibited items identified will be removed immediately, and staff will be re-educated as necessary. Monthly environmental audit results will be brought to Quality Management meetings and any variances addressed.
The facility will achieve full compliance by 5/15/2026.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented (- 05/13/2026)

185a Storage procedures

4. Requirements

2800.
185.a. The residence 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

Resident #1 is prescribed blood sugar monitoring one time a day every Monday, Wednesday and Friday.

- *On 3/16/26 at 8:30 AM, Resident #1's March 2026 Medication Administration Record (MAR) did not record a blood sugar measurement, however, the glucometer assigned to Resident #1 recorded a blood sugar of 113.*
- *On 3/27/26 , Resident #1's March 2026 MAR recorded a blood sugar of 136, however the glucometer assigned to Resident #1 recorded a blood sugar of 134.*

Plan of Correction ***Accept (- 04/27/2026)***

Plan of Correction
Regulation: 2800.185(a) – Storage Procedures
Violation: The facility failed to ensure accurate documentation and proper procedures for the use of medical equipment. Resident #1's glucometer readings did not consistently match documentation on the Medication Administration Record (MAR), and one reading was not recorded on the MAR.
1. How the violation was corrected for the specific situation:
Resident #1's glucometer readings and MAR documentation were immediately reviewed. Staff responsible for

185a Storage procedures (continued)

medication administration were educated regarding the discrepancies and re-educated on proper procedures for blood glucose monitoring and accurate documentation.
Current orders for blood glucose monitoring were verified, and staff were instructed to ensure all future readings are recorded accurately and in real time on the MAR.
2. What measures will be put into place to prevent recurrence:
The facility has implemented the following measures:
• An audit of all current residents receiving blood glucose orders was completed on 4/17/2026 by the administrator and nursing to identify discrepancies between glucometer documentation and glucometer readings.
3. How the corrective actions will be monitored:
The Administrator will reeducate nursing and med techs on the requirements of the Glucometer Testing policy. Re-education will focus on the glucometer reading accuracy and documentation accuracy by 4/20/2026
4. Date of compliance:
The Administrator, or designee will conduct an audit weekly X4 weeks (w1-4/24/2026, w2-5/1/2026, w3- 5/8/2026, w4- 5/15/2026) and then monthly X2 months (M1- 6/14/2026, M2- 7/14/2026) to ensure MAR blood sugar readings match and are present in each resident's blood glucose monitoring machine. Audits will be brought to the Quality Management meetings for review and recommendations as appropriate.
The facility will achieve full compliance by 5/15/2026.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented (█ - 05/13/2026)

187b Date/time of med admin

5. Requirements

2800.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #1 is prescribed Carbidopa Levodopa 25-30 T, give 1 tablet orally three times a day. Resident #1's March 2026 Medication Administration Record does not include the initials of the staff person who administered this medication on 3/4/26, at Midday.

Resident #1 is prescribed Acetaminophen 325 MG, give 2 tablets orally three times a day. Resident #1's March 2026 MAR does not include the initials of the staff person who administered this medication on 3/4/26, at Midday.

Plan of Correction ***Accept (█ - 04/27/2026)***

Plan of Correction
Regulation: 2800.187(b) – Date/Time of Medication Administration
Violation: Medication administration was not properly documented at the time of administration. Resident #1's March 2026 MAR did not include staff initials for medications administered on 3/4/26 at Midday.
1. How the violation was corrected for the specific situation:
The MAR for Resident #1 was reviewed immediately upon discovery. The staff member responsible for the

187b Date/time of med admin (continued)

medication pass on 3/4/26 was identified and re-educated by the administrator regarding the missing initials.
2. What measures will be put into place to prevent recurrence:
The facility has implemented the following measures:
• Current audit of eMAR completed on 4/17/2026 to ensure all medications have complete and accurate documentation at time of administration.
3. How the corrective actions will be monitored:
All medication administration staff have been re-educated by the Administrator on proper MAR documentation requirements, including the requirement to initial at the time medications are administered by 4/20/2026
4. Date of compliance:
The Administrator or designee will conduct weekly x4 weeks (w1-4/24/2026, w2-5/1/2026, w3- 5/8/2026, w4- 5/15/2026) and then monthly x 2 (M1- 6/14/2026, M2- 7/14/2026) MAR/TAR audits to confirm accuracy and completeness. Any variances will be addressed with the staff through re-education and corrective action.
The facility will achieve full compliance by 5/15/2026.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented (- 05/13/2026)

227g Support plan - signatures

6. Requirements

2800.
227.g. Individuals who participate in the development of the support plan shall sign and date the support plan.

Description of Violation

Resident #1 participated in the development of support plan on However, the resident did not sign and date the support plan.
Resident #2 participated in the development of support plan on However, the resident did not sign and date the support plan.
Resident #3 participated in the development of support plan on However, the resident did not sign and date the support plan.

Plan of Correction ***Accept (- 04/28/2026)***

Plan of Correction
Regulation: 2800.227(g) – Support Plan Signatures
Violation: Residents who participated in the development of their support plans did not sign and date the plans (Residents #1, #2, and #3).
1. How the violation was corrected for the specific situation:
Residents (and/or POA) 1, #2, and #3 were approached to review their current support plans. Each resident was provided with the opportunity to sign and date their respective support plan on 4/17/26.
For any resident unable or unwilling to sign, documentation was completed to reflect the reason, in accordance with facility policy.
2. What measures will be put into place to prevent recurrence:
The facility has implemented the following measures:

227g Support plan signatures (continued)

Current audit of all resident support plans was conducted by the administrator to ensure all support plans have been signed and dated at time of completion.by 4/17/2026
3. How the corrective actions will be monitored:
Staff have been re educated by administrator on the requirement that all individuals participating in the development of the support plan must sign and date the document by 4/20/2026
4. Date of compliance:
The Administrator or designee will review all newly developed and updated support plans to ensure compliance. Monthly audits will be conducted x 3 months (m1 4/24/2026, m2 5/24/2026, m3 6/23/2026) to review any new support plans for accuracy and completion.
The facility will achieve full compliance by 5/15/2026.

Licensee's Proposed Overall Completion Date: *05/15/2026*

Implemented (- 05/13/2026)