

Department of Human Services
Bureau of Human Service Licensing

January 26, 2021

██████████ OWNER
RURAL LIVING INC
220 REGENT COURT, SUITE E-1
STATE COLLEGE, PA 16801

RE: WYNWOOD HOUSE AT GREENHILLS
301 FARMSTEAD LANE
STATE COLLEGE, PA, 16803
LICENSE/COC#: 24323

Dear ██████████,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/02/2020 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,
Michele Moskalczyk
Human Services Licensing Supervisor

Enclosure
Licensing Inspection Summary (LIS)

cc: Pennsylvania Bureau of Human Service Licensing

**Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY**

Facility Information

Name: WYNWOOD HOUSE AT GREENHILLS License #: 24323 License Expiration Date: 12/13/2021
Address: 301 FARMSTEAD LANE, STATE COLLEGE, PA 16803
County: CENTRE Region: NORTHEAST

Administrator

Name: [REDACTED] Phone: 8142349898 Email: [REDACTED]

Legal Entity

Name: RURAL LIVING INC
Address: 220 REGENT COURT, SUITE E-1, STATE COLLEGE, PA, 16801
Phone: 8142349898 Email: [REDACTED]

Certificate(s) of Occupancy

Type: C-2 LP Date: 04/03/1997 Issued By: L&I

Staffing Hours

Resident Support Staff: 0 Total Daily Staff: 42 Waking Staff: 32

Inspection

Type: Partial Notice: Unannounced BHA Docket #:
Reason: Incident Exit Conference Date: 01/05/2021

Inspection Dates and Department Representative

12/02/2020 - On-Site: [REDACTED]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: 50 Residents Served: 40

Secured Dementia Care Unit

In Home: No Area: Capacity: Residents Served:

Hospice

Current Residents: 2

Number of Residents Who:

Receive Supplemental Security Income: 0 Are 60 Years of Age or Older: 39
Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 1
Have Mobility Need: 2 Have Physical Disability: 0

Inspections / Reviews

1/20/2021 - POC Submission

Lead Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *01/27/2021*

1/26/2021 - Document Submission

Lead Reviewer: [REDACTED] Follow-Up Type: *Not Required*

42b - Abuse

1. Requirements

2600.

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident #2 crawled into bed with resident #1 and touched [REDACTED]. [REDACTED] got up, used bathroom and then was sitting on the edge of Resident #1 bed. Resident #1 is unsure of date but confirmed it was around [REDACTED]. Resident #1 was upset because of this event. Resident #2 was moved for comfort and safety of Resident #1.

Plan of Correction**Accept**

Compliance with 2600.42.b ensures protection of residents from abuse and neglect.

Resident #2 had moved into said personal care home on [REDACTED]. Within 24 hours of moving into the personal care home, it was determined that the resident was wandering throughout the facility and appeared to have difficulty locating [REDACTED] room. On 11/07/2020, the resident was placed on every 30 min checks and signage was implemented as a cue to deter wandering. On 11/09/2020, a doorbell was placed at the resident door to alert staff to check resident for wandering activity. All of these interventions were put into place PRIOR to the facility being notified on 11/19/2020 by the local Area Agency on Aging that Resident #1 had reported to them the aforementioned incident of abuse. The case worker from the Area Agency on Aging had notified the local police. Upon notification by the Area Agency on Aging, the facility reported the abuse to DHS, the physician for Resident #1 and Resident #2, and the appropriate family members of both. All reporting was completed within the acceptable timeframes. On 11/20/2020, Resident #2 was moved to a room in a different hallway per the request of Resident #1. No further incidents have been reported.

Corporate review of the incident determined that the facility staff handled this incident appropriately. The facility evaluated the resident timely, determined quickly that interventions were necessary related to the confusion and wandering behaviors that Resident #2 was exhibiting upon moving into the facility, and had implemented those interventions. The facility reported the incident to all required parties within the regulatory time requirements. No further incidents were reported to the facility. The facility will continue to follow all current practices to identify and / or report abuse and will act similarly in the future for like incidents.

The facility administrator will be responsible for monitoring ongoing compliance.

Completion Date: 01/19/2021

Update - 01/20/2021

Please send/Attach proof of staff training regarding abuse and neglect.

Document Submission**Implemented**

Staff re-education completed utilizing power point available from PA Department of Aging titled Older Adults Protective Services Act. This training resource was accessed through a link on the PA DHS website. Power point and staff training sign-in sheet have been attached.