Department of Human Services
Bureau of Human Service Licensing

May 14, 2021

PRESIDENT AND CEO
WYNCOTE AID II OPCO LLC
330 N WABASH AVENUE,SUITE 3700
CHICAGO, IL 60611

RE: WYNCOTE PLACE
240 BARKER ROAD
WYNCOTE, PA, 19095
LICENSE/COC#: 14254

Dear

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/22/2021, 04/23/2021 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Sincerely,

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: *WYNCOTE PLACE* **License #**: *14254* **License Expiration Date**: *04/05/2022*
Address: *240 BARKER ROAD, WYNCOTE, PA 19095*
County: *MONTGOMERY* **Region**: *SOUTHEAST*

Administrator

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

Legal Entity

Name: *WYNCOTE AID II OPCO LLC*
Address: *330 N WABASH AVENUE,SUITE 3700, CHICAGO, IL, 60611*
Phone: [redacted] **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *07/02/1997* **Issued By**: *CWOPA L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *84* **Waking Staff**: *63*

Inspection

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:
Reason: *Renewal* **Exit Conference Date**: *04/23/2021*

Inspection Dates and Department Representative

04/22/2021 - On-Site: [redacted]
04/23/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *60* **Residents Served**: *42*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *entire home* **Capacity**: *60* **Residents Served**: *42*

Hospice

Current Residents: *8*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *41*
Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*
Have Mobility Need: *42* **Have Physical Disability**: *2*

Inspections / Reviews

04/22/2021 - Full

Lead Inspector: [redacted] **Follow-Up Type:** *POC Submission* **Follow-Up Date:** *05/13/2021*

5/11/2021 - POC Submission

Lead Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *05/14/2021*

5/14/2021 - Document Submission

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

25b - Contract Signatures

1. **Requirements**

2600.

25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted], for resident #1 was not signed by the resident or the resident's surrogate.

Plan of Correction **Accept**

Plan of Correction:

• On [redacted] the Executive Director (ED) presented the resident-home contract, dated [redacted], to the resident and residents designated person. The document was subsequently signed by both individuals on 5/3/2021. (Document A1- Resident #1 contract signed/dated)

• The ED, Care Services Manager (CSM), and Community Relations Manager (CRM) were educated on 4/30/2021 by the Regional Director of Care Services on the requirements stated within regulation 2600.25b. (Document A2- In-service)

• The ED and/or designee will audit the resident-home contracts of current residents by 5/14/2021 to identify the need for required signatures. Contracts requiring signatures will be presented by the ED/or designee to the appropriate party for signing. (Document A3- Audit Tool)

• The ED and/or designee will audit five resident-home contracts weekly x 12 weeks to validate the presence of required signatures (Document A4- Audit tool)

• Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.

• Completion Date: 5/14/2021

(see attached documents and audit tools A1)

Completion Date: *05/14/2021*

Document Submission **Implemented**

Audit of current resident charts to identify need for required signatures. Contracts requiring signatures presented to resident for signing, if able.

41e - Signed Statement

1. **Requirements**

2600.

41.e. A statement signed by the resident and, if applicable, the resident's designated person acknowledging receipt of a copy of the information specified in subsection (d), or documentation of efforts made to obtain signature, shall be kept in the resident's record.

Description of Violation

Resident #1's record did not contain a statement signed by the resident or the resident's surrogate acknowledging receipt of a copy of the resident rights and complaint procedures.

41e - Signed Statement *(continued)*

Plan of Correction **Accept**

• On [redacted] the ED presented the resident and the residents designated person a copy of the resident rights and complaints procedures. Subsequently, on 5/3/2021_ a signed statement of receipt was collected by the ED and placed n Resident #1's record. (Document B1- Signed/dated statement of receipt)
• The ED, CSM, and CRM were educated on 4/30/2021, by the Regional Director of Care Services on the requirements stated within regulation 2600.41e. (Document B2- In-service)
• The ED and/or designee will audit current resident records by 5/14/2021 noting the presence or absence of the resident's rights and complaint procedures signed statement of receipt. If not present, the ED or designee will present the resident and resident's designated person with the resident rights and compliant procedures, along with the corresponding statement of receipt for their signature. The statement will be then placed within the resident record Document B3 – Audit tool)
• The ED and/or designee will audit five resident records weekly x 12 weeks to validate the presence of a resident's rights and complaint procedures signed statement of receipt (Document B4- Audit tool)
• Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.
• Completion Date: 5/14/2021
See attached documents B1 audit tools, documentation and in-services

Completion Date: *05/14/2021*

Document Submission **Implemented**

Audit of all current resident files to determine resident signature present and acknowledging, if able, resident rights and complaint procedures

65a - FS Orientation 1st Day

1. **Requirements**

2600.
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 home'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.

65a - FS Orientation 1st Day *(continued)*

Description of Violation

Staff person A, whose first day of work was [redacted] did not receive orientation on the following topics:
(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 home'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**

Plan of Correction:
• On [redacted]_ the ED provided staff person A with orientation to the requirements stated within regulation 2600.65a. Topics included: Evacuation procedures, staff duties and responsibilities during fire drills, as well as during emergency evacuation, transportation and at an emergency location if applicable, the designated meeting place outside the building or within the fire-safe area in the event of an actual fire, smoking safety procedures, the home's smoking policy and location of smoking areas, if applicable. the location and use of fire extinguishers, smoke detectors, fire alarms and telephone use and notification of emergency services. (Document C1 – orientation checklist)
• The ED, CSM, and CRM were educated on _4/30/021_, by the Regional Director of Care Services on the requirements stated within regulation 2600.65a. (Document C2- In-service)
• The ED and/or designee will audit the personnel files of current staff by 5/14/2021 to identify the need for required orientation as per 2600.65a. Staff identified without this orientation will be provided orientation by the ED or designee and their personnel file will be updated accordingly. (Document C3- Audit Tool)
• The ED and/or designee will audit five personnel records weekly x 12 weeks to validate the presence of 2600.65a required orientation topics. (Document C4- Audit tool)
• Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.
• Completion Date: 5/14/2021
See attachments C1 - D1 for inservices and audit tools

Completion Date: *05/14/2021*

Document Submission **Implemented**

Audit of all personnel files to ensure all required orientations present in a staff members file.

65b - Rights/Abuse 40 Hours

1. **Requirements**

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
1. Resident rights.
2. Emergency medical plan.
3. Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
4. Reporting of reportable incidents and conditions.

65b - Rights/Abuse 40 Hours *(continued)*

Description of Violation

Staff person A completed his/her 40th scheduled work hour on [redacted] However, this staff person did not complete training in the following topics:
(1) Resident rights.
(2) Emergency medical plan.
(3) Mandatory reporting of abuse and neglect under the Older Adult Protective Services Act
(35 P.S. § 10225.101 10225.5102).
(4) Reporting of reportable incidents and conditions.

Plan of Correction **Accept**

• On [redacted]_ the ED provided staff person A with orientation to the requirements stated within regulation 2600.65b. Topics included: Resident rights, emergency medical plan, mandatory reporting of abuse and neglect under the Older Adult Protective Services Act, and reporting of reportable incidents. (Document D1- orientation checklist)
• The ED, CSM, and CRM were educated on _4/30/2021, by the Regional Director of Care Services on the requirements stated within regulation 2600.65b. (Document D2- In-service)
• The ED and/or designee will audit the personnel files of current staff by 5/14/2021 to identify the need for required orientation as per 2600.65b. Staff identified without this orientation will be provided orientation by the ED or designee and their personnel file will be updated accordingly. (Document D3- Audit Tool)
• The ED and/or designee will audit five personnel records weekly x 12 weeks to validate the presence of 2600.65b required orientation topics. (Document D4- Audit tool)
• Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.
• Completion Date: 5/_14_/2021
See attachments C1-D1 for in-services, audit tools and documentation

Completion Date: *05/14/2021*

Document Submission **Implemented**

Audit of all personnel files to ensure required orientations as per regulation 2600.65(b) are present in each staff member's file.

101j7 - Lighting/Operable Lamp

1. **Requirements**

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

Resident #2 does not have access to a source of light that can be turned on/off at bedside.

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

Plan of Correction **Accept**

Plan of Correction:

• Resident #2 suffered no adverse effect from this finding.

• On _4_/_23_/2021__ the ED provided resident #2 with an operable lamp at bedside.

• The CSM, CRM, Resident Care Partners (RCPs) and licensed nurses were educated on _4_/_30_/2021__, by the ED on the requirement of an operable lamp at bedside, as per 2600.101j #7. (Document E1 – In -service)

• On _4/_26/2021 the (Interim Maintenance Manager) conducted an audit of occupied resident rooms, validating the presence of an operable light source at bedside. (Document E2- Audit Tool)

• The ED and/or designee will audit five occupied resident rooms weekly x 12 weeks to validate the presence of an operable light source at bedside. (Document E3- Audit Tool)

• Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.

• Completion Date: 5/_14_/2021

see attachments E1 for audit tools, documentation ans in-services

Completion Date: *05/14/2021*

Document Submission **Implemented**

All resident rooms audited for operable bedside lamp on 4/30 2021. Audits ongoing until September

185a - Implement Storage Procedures

1. **Requirements**

2600.

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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

On 4/23/21 at 7:47, resident #4's glucometer reads 190, this blood sugar reading is recorded on the Medication Administration Record as 194.

On 4/22/21 at 16:55, resident #4's glucometer reads 402, this blood sugar reading is recorded on the Medication Administration Record as 432.

On 4/18/21 resident #4's PM blood sugar reading is recorded on the Medication Administration Record as 216 but there is no reading on the glucometer for the evening on that day.

On 4/12/21 at 16:40, resident #4's glucometer reads 190, this blood sugar reading is recorded on the Medication Administration Record as 194.

On 4/4/21 at 8:26, resident #4's glucometer reads 238, this blood sugar reading is recorded on the Medication Administration Record as 232.

On 4/3/21 at 8:47, resident #4's glucometer reads 180, this blood sugar reading is recorded on the Medication Administration Record as 194.

On 4/2/21 at 8:27, resident #4's glucometer reads 215, this blood sugar reading is recorded on the Medication Administration Record as 212.

Plan of Correction **Accept**

• Resident #4 suffered no adverse effect from these findings.
• The diabetic trained medication technicians and licensed nurses were educated on _4_/_27_/_2021_, by the CSM, as per the requirements within regulation 2600.185a and Resident #4's glucometer manufacturer instructions for use. Document F1- In- service)
• As of _4_/_22_/_2021_, resident # 4 is the only resident within the community utilizing a blood glucose meter, therefore, no other blood glucose meter readings and/or corresponding documentation can be audited/validated in response to this violation.
• The CSM and or designee will conduct a Medication Administration Record (MAR) to blood glucose meter audit weekly x 12 weeks to validate documentation accuracy. (Document F2- Audit Tool)
• Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.
see attachment F1 for audit tools, documentation and in-services

Completion Date: *05/14/2021*

Document Submission **Implemented**

On going audits until September 2021.

2. **Requirements**

2600.
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.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #2 is prescribed Acetaminophen 325 mg as needed. On 4/23/21, this medication was not available in the home.

Plan of Correction **Accept**

• Resident #2 suffered no adverse effect from this finding.
• On _4_/_23_/_2021_ resident #2's Acetaminophen was delivered to the home. (Document G1 – Delivery manifest).
• The ED, CSM, and CRM were educated on __4/_30_/2021__, by the Regional Director of Care Services on the requirements stated within regulation 2600.185a. (Document G2- In-service)
• On _4_/27__/_2021_ the CSM conducted a medication audit validating the presence of current resident medications. Unavailable medications were then ordered by the CSM (Document G3- Audit Tool)
• The CSM and/or designee will audit the medications of five residents weekly x 12 weeks to validate the availability of their medications within the home. (Document G4- Audit Tool)
• Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.
• Completion Date: 5/14/2021
See attachment G1 for audit tools, in-services and documentation

Completion Date: *05/14/2021*

Document Submission **Implemented**

On going audits until September 2021

187a - Medication Record

1. **Requirements**

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
1. Resident's name.
2. Drug allergies.
3. Name of medication.
4. Strength.
5. Dosage form.
6. Dose.
7. Route of administration.

Description of Violation

Resident #4 is prescribed Collagenese Santyl Ointment. However, resident's #4 medication administration record does not has this medication listed.

187a - Medication Record *(continued)*

Plan of Correction **Accept**

• Resident #4 suffered no adverse effect from this finding.

• On 4_/23_/2021_ resident #4's MAR was updated to reflect ordered Collagenese Santyl Ointment (Document H1- Updated MAR)

• The ED, CSM, and CRM were educated on _4_/30__/2021_, by the Regional Director of Care Services on the requirements stated within regulation 2600.187a. (Document H2- In-service)

• On __2/27__/2021__ the CSM conducted a medication order audit validating the presence of ordered resident medications on the MAR. Medications noted not transcribed to the MAR were done so by the CSM at time of audit. Document H3- Audit Tool)

• The CSM and/or designee will audit the medications of five residents weekly x 12 weeks to validate the presence of their corresponding MAR transcriptions. (Document H4- Audit Tool)

• Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.

• Completion Date: 5/_14_/2021

See attachment H1 for audit tools, documentation and in services

Completion Date: *05/14/2021*

Document Submission **Implemented**

On going audits until September 2021

191 - Resident Right to Refuse

1. **Requirements**

2600.

191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #1, admitted [redacted], has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Plan of Correction **Accept**

• On _5/3/2021 resident #1 was educated to their right to refuse medications. (Document I1 – Resident rights, signed copy)

• The ED, CSM, and CRM were educated on _4_/30/2021__, by the Regional Director of Care Services on the requirements stated within regulation 2600.191. (Document I2- In-service)

• The ED and/or designee will audit current resident records by _5/14/2021noting the presence or absence of the resident's rights signed statement of receipt. If not present, the ED or designee will present the resident and resident's designated person with the resident rights along with the corresponding statement of receipt for their signature. The statement will be then placed within the resident record. (Document B3 – Audit tool used again)

• The ED and/or designee will audit five resident records weekly x 12 weeks to validate the presence of a resident's rights signed statement of receipt (Document B4- Audit tool used again)

• Results of the audit will be discussed during monthly QI meetings. The QI Committee will determine if continued auditing is necessary based on three consecutive months of compliance. Monitoring will be on-going.

• Completion Date: 5/14_/2021

See attachments I-1 for audit tools, documentation and in-services.

Completion Date: *05/14/2021*

191 - Resident Right to Refuse *(continued)*

Document Submission **Implemented**

All current resident files audited to ensure the signature of each resident, when able, acknowledging understanding of their right to question or refuse a medication.