Department of Human Services
Bureau of Human Service Licensing

April 11, 2022

[redacted]
RURAL LIVING INC
[redacted]

RE: WYNWOOD HOUSE AT PENNS VALLEY
122 WYNWOOD DRIVE
CENTRE HALL, PA, 16828
LICENSE/COC#: 22997

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 12/15/2021 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 PENNS VALLEY* **License #**: *22997* **License Expiration**: *06/14/2022*

Address: *122 WYNWOOD DRIVE, CENTRE HALL, PA 16828*

County: *CENTRE* **Region**: *NORTHEAST*

Administrator

Name: [redacted] **Phone**: *8143649770* **Email**: [redacted]

Legal Entity

Name: *RURAL LIVING INC*

Address: *220 REGENT COURT, SUITE E-1, STATE COLLEGE, PA, 16801*

Phone: *8143649770* **Email**: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *04/25/2005* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *38* **Waking Staff**: *29*

Inspection Information

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

Reason: *Complaint, Incident* **Exit Conference Date**: *01/03/2022*

Inspection Dates and Department Representative

12/15/2021 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *40* **Residents Served**: *37*

Secured Dementia Care Unit

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

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *37*

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

Have Mobility Need: *1* **Have Physical Disability**: *0*

Inspections / Reviews

12/15/2021 - Partial

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/21/2022*

Inspections / Reviews *(continued)*

03/22/2022 - POC Submission

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *03/29/2022*

04/11/2022 - Document Submission

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

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 10/18/21 resident #1 did not receive the medication Hydrocodone acetaminophen at 8am, 12noon, or 5pm. On 10/19/21 resident #1 did not receive the medication Hydrocodone acetaminophen at 8am or 12noon. The missed medication was due to a miscommunication with the resident's pharmacy. The medication error was not reported to the department's regional office timely.

Plan of Correction ***Accept***

The initial complaint was that the family brought in the expired medication and then the staff administered the expired medication. There was technically no dose missed, as the family brought in their own medications to give. It would appear it was missing, because the MAR showed it to be because family gave it after medication did not arrive from the pharmacy due to hospice billing (because that only covers 14 days instead of the 30 days that the prescription was written for). A report was sent in as requested by your regional office as concern for the family and educating them on not bringing in medications without discussing with staff and that no citation would be given, as this was a learning experience. The family administered the medication. and staff was told not to document as administered because they didn't administer it.

Administrators will continue to send reportable incidents as they always do. The Corporate Administrator will continue to monitor.

Completion Date: *03/21/2022*

Document Submission ***Implemented***

All medication errors will be reported to the regional office within 24 hours. All reportable incidents will also be sent to the Corporate Administrator to monitor.

This POC is complete.

187d - Follow Prescriber's Orders

1. Requirements

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

Description of Violation

On 10/18/21 resident #1 did not receive the medication Hydrocodone acetaminophen at 8am, 12noon, or 5pm. On 10/19/21 resident #1 did not receive the medication Hydrocodone acetaminophen at 8am or 12noon. The home didn't following the prescriber's orders.

Plan of Correction ***Accept***

According to the investigation, there was nothing more the staff could've done any differently. When the medication was not received, a call was immediately placed to the pharmacy to see what the issue was. The issue was that resident was on hospice and that hospice only pays for 14 days' worth at a time. The prescription was written for 30-days and when the pcp was notified, they questioned because it was believed to be too soon for a new one. It was then reported to the pcp about billing, in which they understood the situation and then wrote for a 14 day script. The family took it upon themselves to bring in medication to give. There was nothing differently the staff could've done

187d - Follow Prescriber's Orders (continued)

to get the medication in a more timely manner. The prescriber did not suggest anything different when it was reported or reported any concerns. Hospice took over ordering the script.

POC completed 10/20/21
Completion Date: *03/21/2022*

Document Submission ***Implemented***

According to the investigation, there was nothing more the staff could've done any differently. When the medication was not received, a call was immediately placed to the pharmacy to see what the issue was. The issue was that resident was on hospice and that hospice only pays for 14 days' worth at a time. The prescription was written for 30-days and when the pcp was notified, they questioned because it was believed to be too soon for a new one. It was then reported to the pcp about billing, in which they understood the situation and then wrote for a 14 day script. The family took it upon themselves to bring in medication to give. There was nothing differently the staff could've done to get the medication in a more timely manner. The prescriber did not suggest anything different when it was reported or reported any concerns. Hospice took over ordering the script.

Hospice continued to take over managing the prescriptions they pay for. Family education was provided on the importance of not bringing in medications from home without approval from nursing. Resident moved to a new facility.

POC completed on 10/20/21