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

April 8, 2025

EM RURAL LIVING LLC

RE: THE WYNWOOD HOUSE AT GREEN HILLS
301 FARMSTEAD LANE
STATE COLLEGE, PA, 16803
LICENSE/COC#: 23227

,

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 01/28/2025 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,

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE WYNWOOD HOUSE AT GREEN HILLS* **License #**: *23227* **License Expiration**: *10/25/2025*

Address: *301 FARMSTEAD LANE, STATE COLLEGE, PA 16803*

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

Administrator

Name: **Phone**: **Email**:

Legal Entity

Name: *EM RURAL LIVING LLC*

Address:

Phone: **Email**:

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**: *32* **Waking Staff**: *24*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *02/13/2025*

Inspection Dates and Department Representative

01/28/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *45* **Residents Served**: *29*

Secured Dementia Care Unit

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

Hospice

Current Residents: *1*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *28*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *2*

Have Mobility Need: *3* **Have Physical Disability**: *0*

Inspections / Reviews

01/28/2025 Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/07/2025*

03/18/2025 - POC Submission

Submitted By: **Date Submitted**: *04/04/2025*

Reviewer: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *03/25/2025*

Inspections / Reviews *(continued)*

03/27/2025 POC Submission

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

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *04/04/2025*

04/08/2025 Document Submission

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

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

Several ceiling blocks were missing in hallway [redacted] and there was plastic covering other parts of this hallway ceiling. Staff person F reported that 2 weeks prior, a pipe from the sprinkler system burst after freezing and flooded the hall and several resident rooms. The residents affected had to be moved to other available rooms in the home. This incident was not reported to the Department.

Plan of Correction ***Directed [redacted] - 03/26/2025)***

The residents were given the choice if they wanted to move rooms while area was worked on. According to requirements, it only needs to be reported when damage to the home makes it uninhabitable overnight or we have to relocate residents. The rooms are and have been habitable. We do not feel that this should be a violation. Even though we do not agree with violation, an incident report was sent in by administrator on 3/5/25 after noting that this was cited during the inspection.

The plan moving forward is for the Administrator and/or Administrative Assistant to send a reportable to DHS of any facility damage caused by the sprinkler system or water pipes within the twenty- hour period per DHS regulations. This will be effective immediately

This POC is complete.

Proposed Overall Completion Date: 03/25/2025

Directed: The administrator or designee will provide education with all staff regarding reporting requirements. A written record of this education with staff signatures will be provided to the department. The administrator or designee will develop a policy detailing the staff responsible for reviewing and reporting required incidents. All future incidents will be reported as required.

Directed Completion Date: *04/04/2025*

Implemented [redacted] - 04/08/2025)

42b - Abuse

2. 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

On [redacted] at approximately 10:45am., staff person A heard Resident [redacted] crying for help from their room. Staff persons A and B entered Resident [redacted] bathroom and found the resident lying across the toilet face down. Staff person A reported the resident's upper body was stuck between the toilet and wall and their legs were tangled in their wheelchair and was crying and appeared to have difficulty breathing. Staff person A asked staff person B for help with lifting Resident [redacted] up. Staff person B proceeded to yell at Resident [redacted] for not using their call bell for assistance. After

42b - Abuse (continued)

Resident ██ was placed back in their wheelchair, staff person A reported that neither staff person B, nor staff person C assessed Resident ██ for injuries. Staff also did not contact the on-call administrator or call 911. Approximately 6 hours later, during the second shift, staff person D noted Resident ██ appeared to be in discomfort and asked the resident if they were in pain. Resident ██ who is diagnosed with expressive aphagia, nodded "yes" and began to cry. Staff person D reported that when they started their shift at approximately 2:30pm, staff person B told them that Resident ██ had a "simple fall" and was "ok". When Staff person A explained to Staff person D how Resident ██ was found in their bathroom, staff person D immediately called 911 then reported the incident to Staff person E by phone. Resident ██ was sent to the hospital for evaluation and was diagnosed with a ██████. Staff persons B and C failed to provide immediate care or seek medical attention for Resident ██ after they had an unwitnessed fall in their bathroom.

Plan of Correction ***Accept ██ - 03/27/2025)***

Staff person E received a call around 2:30pm from Staff person D reporting resident had a fall and appeared to be uncomfortable and noticed some bruising. Family was also in earlier after noted fall. Staff person E suggested calling 911 to send out after assessing resident. The home did not initially think it was a suspected form of negligence, as management was under the impression that when discomfort was noticeable and reported by resident, call was made to on-call and 911 was called. A reportable was sent to the state of fall. It was not until 1/10/25 that home was informed of the investigation going on. That a staff (who was not at the home during the fall) member went to the police a few times until they initiated an investigation. As soon as the home became aware, it was reported to the Office of Aging and DHS. The family was confused to what happened and reported resident did want to return to the building after rehab. After the investigation from office of aging (where nothing was founded) and the on cite visit from DHS, it was decided that Staff person B would be terminated from position after suggestion from inspector. Staff person B was terminated on ██ and will not be eligible for rehire at the any of the communities. The Administrator did an extensive education on 2/11/25 on how all falls require a call to the on-call management no matter if there are noted injuries or none noted. Disciplinary action will be taken if policy not followed in an attempt to prevent this and ensure that compliance is being maintained.

The plan of correction moving forward is that any fall with or without injury must be reported to the Administrator and/or Administrative Assistant. Medication Tech has the authority to call 911 prior to calling Administration if they assess the situation as an emergency. Administration on call will notify family immediately after Residents safety is attended to. Effective date of 2/13/2025. Employee education on abuse/negligence will be completed by all staff within one week, 4/1/2025. Will email a copy of staff education when completed.

Please see attachment titled-GH 2-11-25 education

Proposed Overall Completion Date: 03/25/2025

Licensee's Proposed Overall Completion Date: *03/25/2025*

Implemented ██ - 04/07/2025)

81b - Resident Personal Equipment

4. Requirements

2600.

81b - Resident Personal Equipment *(continued)*

81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Two grab bars with openings measuring 17"x 5" were noted on Resident [redacted] bed. The grab bars were not covered.

Plan of Correction ***Accept [redacted] - 03/10/2025)***

The administrative assistant immediately covered the grab bar on resident [redacted] bed while inspectors were still on site 1/28/25. Administrator and/or administrative assistant will check enabler bars Monday through Friday beginning 1/29/25 to ensure that compliance is being maintained. The administrator will oversee. Resident [redacted] enabler bars were removed on 2/24/25 as [redacted] was admitted to hospice services and now has a low hospital bed. Please see attachment titled GH-enabler audit.

This POC is completed.

Licensee's Proposed Overall Completion Date: *03/05/2025*

Implemented [redacted] - 04/07/2025)

85a - Sanitary Conditions

5. Requirements

2600.
85.a. Sanitary conditions shall be maintained.

Description of Violation

During a Narcotic count review, staff person F poured the pills into an ungloved hand instead of using a pill counter or donning a pair of gloves.

Plan of Correction ***Accept ([redacted] 03/10/2025)***

The administrator was the one that accidentally poured the pills into an ungloved hand during the inspection on 1/28/25 knowing that gloves should have been put on prior to pouring the pills into the pill counter. An education was given to all medtechs on 2/11/25 and covered this policy of gloving when having to utilize a pill counter for narcotics. The Administrator and/or administrative assistant will continue to monitor to ensure that compliance is being maintained.
Please see attachment titled GH-2-11-25 education

This POC is complete.

Licensee's Proposed Overall Completion Date: *03/06/2025*

Implemented ([redacted] - 04/07/2025)

88a - Surfaces

6. 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

During a physical cite inspection it was noted several ceiling blocks missing in hallway [redacted] directly outside of resident rooms. In addition, plastic was covering other areas of the ceiling in the same hallway. Staff person F reported that in the previous 2 weeks, a pipe from the sprinkler system burst after freezing and flooded several resident rooms. The

88a - Surfaces (continued)

residents affected had to be moved to other available rooms in the home.

Plan of Correction ***Accept (- 03/18/2025)***

There was a pipe that burst on 1/22/25 and was immediately handled and the home was not uninhabitable. The home was advised by the contractors to keep the ceiling blocks out so that the area could dry properly, and the area did not cause any hazards. The home was doing what was advised by the professionals and after insurance approval and estimates, the contractors were able to schedule the repairs for week of 3/3/25.

This POC is complete.

Licensee's Proposed Overall Completion Date: *03/06/2025*

Implemented - 04/07/2025)

121a - Unobstructed Egress

7. Requirements

2600.
121.a. Stairways, hallways, doorways, passageways and egress routes from rooms and from the building must be unlocked and unobstructed.

Description of Violation

On the egress in the Activities Room leading to the Exit door to the patio was blocked by tables and chairs.

Repeat Violation

Plan of Correction ***Accept - 03/10/2025)***

The table was moved to the right immediately by the administrator on 1/28/25 while inspectors were still on site. After investigation, there was an activity scheduled the day prior, and the activities director did not move the table back to where it was originally at. The administrator spoke with the activity's director on 1/29/25 and reminded that area needs to be put back as it was prior to activity and that no doors can be blocked, even though the door in that room is not utilized as an exit. The administrator will continue to conduct building walk throughs and will check to ensure that compliance is being maintained. Please see attachment titled GH-egress pic

This POC is complete.

Licensee's Proposed Overall Completion Date: *03/06/2025*

Implemented 04/07/2025)

133.1 - Exit Signs

8. Requirements

2600.
133.1. Exit Signs - The following requirements apply for a home serving nine or more residents: Signs bearing the word ''EXIT'' in plain legible letters shall be placed at all exits.

Description of Violation

The Exit door in the Activities Room which leads to the patio does not have an Exit sign. The fence enclosing the patio has a gate for exiting the property and can be used in an emergency. On the day of the inspection, a sign indicating "THIS IS NOT AN EXIT" was taped to the door.

133.1 Exit Signs (continued)

Plan of Correction ***Directed - 03/26/2025)***

The home was advised in previous inspection to not utilize the gated patio as an exit, and we were told to put "This is not an exit" on the window. We do not utilize it as an exit with the coded gate. This inspection is advising us to do the opposite of what the previous inspections have instructed. The home does not feel it should be cited for this as the home has implemented what it was instructed to do by previous inspectors. I attached the previous picture that was approved after placing a not an exit sign on door.

Proposed Overall Completion Date: 03/25/2025

Directed: An exit sign will be posted over the door that leads to the patio exit. The exit sign will not be removed unless the home receives written approval from local code enforcement and a fire safety expert that the door can be marked as not an exit. The administrator or designee will complete an audit on all exits and ensure that exit signs are in place.

Directed Completion Date: *04/04/2025*

Implemented - 04/07/2025)

142a - Secure Medical Care

9. Requirements

2600.
142.a. The home shall assist the resident to secure medical care if a resident's health status declines. The home shall document the resident's need for the medical care, including updating the resident's assessment and support plan.

Description of Violation

On at approximately 10:45am, Ancillary staff person A and Direct Care staff person B entered Resident s bathroom and found the resident lying across the toilet face down. Staff person A reported the resident's upper body was stuck between the toilet and wall and their legs were tangled in their wheelchair. Staff person A reported that Resident was crying and appeared to have difficulty breathing. Resident was placed back in their wheelchair; however, Staff person B did not assess Resident for injuries or call 911. Approximately 6 hours later Resident was sent to the hospital by another staff person and was diagnosed with a .

Plan of Correction ***Accept (- 03/27/2025)***

Staff person E received a call around 2:30pm from Staff person D reporting resident had a fall and appeared to be uncomfortable and noticed some bruising. Family was also in earlier after noted fall. Staff person E suggested calling 911 to send out after assessing resident and also spoke to resident's son who was in agreeance. The home did not initially think it was a suspected form of negligence, as management was under the impression that when discomfort was noticeable and reported by resident, call was made to on call and 911 was called. A reportable was sent to the state of fall. It was not until 1/10/25 that home was informed of the investigation going on. That a staff (who was not at the home during the fall) member went to the police a few times until they initiated an investigation. As soon as the home became aware, it was reported to the Office of Aging and DHS. The family was confused to what happened and reported resident did want to return to the building after rehab. After the investigation from office of aging (where nothing was founded) and the on cite visit from DHS, it was decided that Staff person B would be terminated from position after suggestion from inspector. Staff person B was terminated on and will not

142a Secure Medical Care (continued)

be eligible for rehire at the any of the communities. The Administrator did an extensive education on 2/11/25 on how all falls require a call to the on call management no matter if there are noted injuries or none noted. Disciplinary action will be taken if policy not followed in an attempt to prevent this and ensure that compliance is being maintained.

The plan of correction moving forward is that any fall with or without injury must be reported to the Administrator and/or Administrative Assistant. Medication Tech has the authority to call 911 prior to calling Administration if they assess the situation as an emergency. Administration on call will notify family immediately after Residents safety is attended to. Effective date of 2/13/2025. Employee education on abuse/negligence will be completed by all staff within one week, 4/1/2025. Will email a copy of staff education when completed.

Please see attachment titled GH 2 11 25 education

Licensee's Proposed Overall Completion Date: *03/25/2025*

Implemented - 04/07/2025)

185a - Implement Storage Procedures

10. 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.

Description of Violation

On at 7:30am the for Resident indicated a blood sugar level of was documented on the Medication Administration Record (MAR) and on at 10:00pm, the glucometer indicated a level of was documented on the MAR.

Plan of Correction ***Accept - 03/10/2025)***

The Administrator and/or administrative assistant began daily checks of the glucometers against the documentation in the MAR daily Monday through Fridays and when the errors seem to be nonexistent, then will be checked weekly on Mondays. An education was also given to Medtechs by Administrator on 3/6/25. The administrator and/or administrative assistant will continue to monitor to ensure that compliance is being maintained. Please see attachment titled GH glucometer audits 1 29 to present.

This POC is complete.

Licensee's Proposed Overall Completion Date: *03/06/2025*

Implemented - 04/07/2025)

187d - Follow Prescriber's Orders

11. Requirements

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

187d Follow Prescriber's Orders *(continued)*

Description of Violation

The Medication Administration Record (MAR) for Resident indicates they are to receive of at 7:30am. The Prescriber's order was not followed as Staff person E documented on the MAR that the medication was administered at 9:28 am. which was confirmed by Resident

Resident has an order for 3 times daily. On , the medication was not available for administration at 8:00 pm, at 8am, and at 3:00pm. Resident has an order for . On through through through , and , resident was not administered the medications as prescribed.

Repeat Violation

Plan of Correction ***Accept - 03/10/2025)***

The MedTech was running behind schedule on 1/28/25 and did administer the scheduled Allopurinol at 9:28am instead of the scheduled 7:30am and was noted during on cite inspection on 1/28/25. PCP notified as well as family of late administration by administrator on 1/28/25. All med techs were educated by administrator on 2/11/25 as a refresher to the correct administration of medication times.

was delivered in time from pharmacy and was available on sight for the evening dose on 1/8/25. The PCP and family were notified of the missed dose and staff was educated on 2/11/25 on the ordering process of medications and when they should be ordered to prevent running out of medications prior to receiving refills. The Administrator and/or administrative assistant will monitor and continue with routine monthly med cart audits and will look over cart every Friday to ensure that compliance is being maintained. The PCP was notified by administrator on 1/28/25 to clarify continuing or discontinuing order. Multiple calls have been made to the MD in regard to order and order was suspended until clarification could be made as of 1/28/25. The was discontinued by MD. An education was given to medtechs on 2/11/25 by administrator on reporting when medications are not available, and the administrator and/or administrative assistant will continue monthly med cart audits to ensure compliance is being maintained and prevent this from occurring in the future.

Please see attachment titled delivery 1/28/25
Please see attachment titled discontinue order
Please see attachment titled GH 2 11 25 education

Licensee's Proposed Overall Completion Date: *03/06/2025*

Implemented 04/07/2025)

225c - Additional Assessment

12. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident has 2 grab bars on their bed. The annual Resident Assessment and Support Plan for Resident dated 6/14/2024 does not indicate the following information: The specific need for the device, The intended use, Any risks associated with the device, The resident's ability to use the device safely for the intended purpose, Identification of the

225c - Additional Assessment (continued)

specific device to be used, and if a cover is required to meet FDA guidelines.

Plan of Correction ***Accept (- 03/10/2025)***

The Resident Assessment and Support Plan was updated to show enabler bars with all required information. After investigation by management, the family brought in the bars and did not notify management. Family was educated to report anything brought into the building's management. The RASP was updated by Administrator on 1/28/25 and then discontinued on 2/24/25 enabler bars were removed due to being admitted to hospice and hospice providing a low hospital bed. Please see attachment titled GH-Resident RASP.

This POC is complete.

Licensee's Proposed Overall Completion Date: *03/06/2025*

Implemented (- 04/07/2025)

252 - Record Content

13. Requirements

2600.
252. Content of Resident Records - Each resident's record must include the following information:
  2. Race, height, weight, color of hair, color of eyes, religious affiliation, if any, and identifying marks.

Description of Violation

The records for Resident admitted 12/10/24, do not indicate identifying marks if any.

Plan of Correction ***Accept - 03/10/2025)***

The Administrator of the building conducted an audit on all charts on 2/4/25 to make sure that all residents had an entry for identifying marks. The Administrator and/or administrative assistant will conduct an audit after all new admissions to ensure that compliance is being maintained. There have been no new admissions to the building as of 3/5/25. Please see attachment titled GH-identifying mark audit.

This POC is complete.

Licensee's Proposed Overall Completion Date: *03/05/2025*

Implemented (04/07/2025)