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

November 3, 2025

[redacted]
EM RURAL LIVING LLC
[redacted]

RE: THE WYNWOOD HOUSE AT PENNS VALLEY
122 WYNWOOD DRIVE
CENTRE HALL, PA, 16828
LICENSE/COC#: 23226

[redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/29/2025 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,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *THE WYNWOOD HOUSE AT PENNS VALLEY* **License #**: *23226* **License Expiration**: *09/16/2025*

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

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

Administrator

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

Legal Entity

Name: *EM RURAL LIVING LLC*

Address: [redacted]

Phone: [redacted] **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: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal* **Exit Conference Date**: *07/29/2025*

Inspection Dates and Department Representative

07/29/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *40* **Residents Served**: *33*

Secured Dementia Care Unit

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

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *33*

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

Have Mobility Need: *5* **Have Physical Disability**: *1*

Inspections / Reviews

07/29/2025 Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/29/2025*

08/27/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *09/29/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/04/2025*

Inspections / Reviews *(continued)*

09/09/2025 POC Submission

Submitted By: [redacted] **Date Submitted:** *09/29/2025*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *10/01/2025*

11/03/2025 Document Submission

Submitted By: [redacted] **Date Submitted:** *09/29/2025*

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

65f - Training Topics

1. Requirements

2600.
65.f. Training topics for the annual training for direct care staff persons shall include the following:
2. Instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan.

Description of Violation

Direct care staff person A did not receive training in the topic of instruction on meeting the needs of the residents as described in the preadmission screening form, assessment tool, medical evaluation and support plan during the 2024 training year.

Plan of Correction ***Directed [redacted] - 09/05/2025)***

Human Resources completed audits on current employees on 7/30/2025. HR will be conducting audits on employee training at the end of every year to ensure all training is completed. Audits for 2025 will start in December of 2025.

Proposed Overall Completion Date: 08/28/2025

Directed: In addition to the above plan of correction, the administrator or designee will have Staff Person A complete training in the topic of meeting the needs of residents as described in the preadmission screening form, assessment tool, medical evaluation, and support plan. This training will be applied to the 2024 training year and be in addition to the training requirement for the 2025 training year.
Audits completed by the administrator or designee will be completed by the end of each month on all trainings provided to staff regarding regulation 65f. These audits will be documented with date of audit, person completing the audit, the training audited, names of any staff that missed the scheduled training, and scheduled make-up date for staff that missed the training.

Directed Completion Date: *09/29/2025*

Implemented ([redacted] - 10/23/2025)

66b - Training Plan Content

2. Requirements

2600.
66.b. The plan must include training aimed at improving the knowledge and skills of the home's direct care staff persons in carrying out their job responsibilities. The staff training plan must include the following:
3. The dates, times and locations of the scheduled training for each staff person for the upcoming year.

Description of Violation

The home's 2025 training plan does not include the proposed training date for each training to be completed.

Plan of Correction ***Accept[redacted] - 09/05/2025)***

Human resources updated the training plan so that there is no empty boxes on 7/30/2025. HR will continue to add a proposed date for all trainings or TBA if the training hasn't been scheduled.

Proposed Overall Completion Date: 08/28/2025

Licensee's Proposed Overall Completion Date: *08/28/2025*

Implemented [redacted] - 10/23/2025)

81b - Resident Personal Equipment

3. Requirements

2600.
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

A raised toilet seat in shared bathroom by room [redacted] was broken and wrapped with tape to hold in place.

Plan of Correction ***Directed [redacted] - 09/05/2025)***

Maintenance replaced the toilet seat on 8/4/2025 . The building nurse will do building walk throughs weekly to check for damaged equipment. Nurse or administrative assistant will then submit a maintenance order and maintenance will repair.

Proposed Overall Completion Date: 08/28/2025

Directed: In addition to the above plan of correction, weekly walk throughs completed by the nurse will be documented for 4 weeks with the date, person completing the check, and any issues identified.

Directed Completion Date: *10/01/2025*

Implemented [redacted] 09/29/2025)

85a - Sanitary Conditions

4. Requirements

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

Description of Violation

There were dried feces on the toilet seat in the bathroom of room [redacted].

Plan of Correction ***Directed [redacted] - 09/05/2025)***

Toilet seat was cleaned on 7/29/2025 and will be cleaned by housekeeper once weekly and checked by RA's daily, each shift to ensure cleanliness starting 7/30/2025.

Proposed Overall Completion Date: 08/28/2025

Directed: In addition to the above plan of correction, the administrator or designee will do weekly audits on 3 bedrooms a week to check for sanitary conditions. These audits will be completed for 4 weeks and be documented with the name of the person doing checks, rooms that were checked, date that the check was completed, and if any issues were identified. RA's daily checks will include immediate notification of unsanitary conditions to housekeeping staff for immediate cleaning.

Directed Completion Date: *10/01/2025*

Implemented ([redacted] - 11/03/2025)

85d - Trash Receptacles

5. Requirements

2600.

85d - Trash Receptacles *(continued)*

85.d. Trash in kitchens and bathrooms shall be kept in covered trash receptacles that prevent the penetration of insects and rodents.

Description of Violation

At approximately 9:13a.m., there was a full, uncovered, unattended trash can in the shared bathroom used by residents in rooms [redacted] and [redacted]

Plan of Correction ***Directed [redacted] 09/05/2025)***

The administrator placed a new trash can with a lid in the bathroom on 7/29/2025. Nurse will ensure lids are on trashcans during weekly walk throughs which started on 7/30/2025.

Proposed Overall Completion Date: 08/28/2025

Directed: In addition to the above plan of correction, weekly walk throughs completed by the nurse will be documented for 4 weeks with the date, person completing the check, and any issues identified.

Directed Completion Date: *10/01/2025*

Implemented [redacted] - 09/29/2025)

86b - Bathroom

6. Requirements

2600.
86.b. A bathroom that does not have an operable, outside window shall be equipped with an exhaust fan for ventilation.

Description of Violation

At 9:34 a.m., the exhaust fan located on the west wing's common bathroom was inoperable and would not turn on and there is no window in the bathroom.

Plan of Correction ***Directed [redacted] - 09/09/2025)***

Maintenance contacted PCBI Allen and we are waiting for them to come in and fix. Administrator will update when completed. 9/3/2025 update- contacted PCBI Allen. Still waiting for them to fix.

Proposed Overall Completion Date: 09/03/2025

Directed: In addition to the above plan of correction, the exhaust fan will be fixed and operational by 9/12/2025. A weekly audit of all bathrooms will be completed for 3 weeks by the administrator or designee. This will be documented with the name of the person doing the checks, bathrooms checked, date, and if any issues were identified. Any exhaust fan that is not working will be repaired within 3 days.

Directed Completion Date: *09/29/2025*

Implemented [redacted] - 09/29/2025)

101j6 - Mirror

7. Requirements

2600.

101j6 Mirror *(continued)*

101.j. Each resident shall have the following in the bedroom:

Description of Violation

At approximately 3:15 p.m., there was no mirror in the bedroom of resident [redacted]

Plan of Correction ***Directed*** [redacted] ***- 09/05/2025)***

A mirror was placed in room by building nurse on 8/4/2025. Nurse will ensure each room has a mirror during weekly walk through which started on 7/30/2025.

Proposed Overall Completion Date: 08/28/2025

Directed: In addition to the above plan of correction, weekly walk throughs completed by the nurse will be documented for 4 weeks with the date, person completing the check, and any issues identified.

Directed Completion Date: *10/01/2025*

Implemented [redacted] ***- 09/29/2025)***

101j7 - Lighting/Operable Lamp

8. 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

At approximately 3:16 p.m. resident [redacted] *does not have access to a source of light that can be turned on/off at bedside. The table with a lamp was approximately 6 feet from the bed.*

Plan of Correction ***Directed*** [redacted] ***- 09/05/2025)***

A Clip on lamp was placed on windowsill by building nurse on 8/4/2025 so It can be reached by resident from bed. The building nurse will ensure each room has a lamp during weekly walk throughs which started on 7/30/2025.

Proposed Overall Completion Date: 08/28/2025

Directed: In addition to the above plan of correction, weekly walk throughs completed by the nurse will be documented for 4 weeks with the date, person completing the check, and any issues identified.

Directed Completion Date: *10/01/2025*

Implemented ([redacted] ***- 09/29/2025)***

102i - Soap Dispenser

9. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

At approximately 9:20 a.m., There was an unlabeled used bar of soap in the shared bathroom used by residents in rooms [redacted] *&* [redacted].

102i - Soap Dispenser *(continued)*

Plan of Correction ***Directed [redacted] - 09/05/2025)***

Bar soap was discarded by building nurse on 7/29/2025 and residents were given labeled hand soap for each resident. Administrator will ensure soaps are labeled during weekly walk through which started on 7/30/2025.

Proposed Overall Completion Date: 08/28/2025

Directed: In addition to the above plan of correction, weekly walk throughs completed by the administrator will be documented for 4 weeks with the date, person completing the check, and any issues identified.

Directed Completion Date: *10/01/2025*

Implemented ([redacted] - 09/29/2025)

102k - No Common Towel

10. Requirements

2600.
102.k. Use of a common towel is prohibited.

Description of Violation

At approximately 9:00 a.m., there was a used unlabeled towel in the shared bathroom used by residents of Rooms [redacted] & [redacted]

At 9:18 a.m., there was a mint green towel hanging in the shared bathroom near room [redacted] There were no paper towels, mechanical hand dryer or other sanitary means of hand drying in this bathroom. The towel bars were not labeled indicating which residents the towels belonged to.

Plan of Correction ***Directed [redacted] - 09/05/2025)***

Towel bars in all shared bathrooms were labeled on 7/30/2025. Building nurse will ensure all towel bars are labeled during weekly walk through which started on 7/30/2025.

Proposed Overall Completion Date: 08/28/2025

Directed: In addition to the above plan of correction, weekly walk throughs completed by the nurse will be documented for 4 weeks with the date, person completing the check, and any issues identified.

Directed Completion Date: *10/01/2025*

Implemented [redacted] 09/29/2025)

103e - Left Overs

11. Requirements

2600.
103.e. Food served and returned from an individual's plate may not be served again or used in the preparation of other dishes. Leftover food shall be labeled and dated.

Description of Violation

At 10:30a.m., there were 6 bags of waffles that were unlabeled, and undated in the deep freezer in the activity room.

103e Left Overs *(continued)*

Plan of Correction ***Directed (09/05/2025)***

All food items were labeled on 7/30/2025. Dining service director will check the freezers to ensure all items are labeled during weekly building visit. Dining service director started checking these on 8/6/2025 during already scheduled weekly Wednesday visits.

Proposed Overall Completion Date: 08/28/2025

Directed: All dietary staff will be educated on the 103e requirements.

Directed Completion Date: *10/01/2025*

Implemented (- 09/29/2025)

103f - Refrigerator/Freezer Temps

12. Requirements

2600.
103.f. Food requiring refrigeration shall be stored at or below 40°F. Frozen food shall be kept at or below 0°F. Thermometers are required in refrigerators and freezers.

Description of Violation

At 10:30a.m., the freezer located in the activities room did not have a thermometer to monitor the temperature.

Repeat Violation:

Plan of Correction ***Directed (09/05/2025)***

Thermometer was located on 7/30/2025. Dining service director will check the freezers to ensure each freezer has a thermometer. Dining service director started checking these on 8/6/2025 during already scheduled weekly Wednesday visits.

Proposed Overall Completion Date: 08/28/2025

Directed: In addition to the above plan of correction, the administrator or designee will complete weekly checks for 4 weeks on all freezers and refrigerators in the home to ensure a thermometer is present and the temperature is within required degrees. These checks will be documented with the freezer/refrigerator checked, person completing checks, date of check, and any issues identified.

Directed Completion Date: *10/01/2025*

Implemented - 09/29/2025)

125a - Combustible Storage

13. Requirements

2600.
125.a. Combustible and flammable materials may not be located near heat sources or hot water heaters.

Description of Violation

At 9:17a.m., there was a towel hanging on a pipe leading to the hot water heater in the laundry room.
At 2:38 p.m., a can of Lysol aerosol, a container of Comet cleaning abrasive, and another cleaner were stored on top of a water heater in the kitchen.

125a Combustible Storage (continued)

Plan of Correction ***Directed [redacted] - 09/05/2025)***

Towel was removed during inspection on 7/29/2025 and nurse is checking laundry rooms during weekly walk through which started on 7/30/2025.

Proposed Overall Completion Date: 08/28/2025

Directed: In addition to the above plan of correction, all staff will be educated on combustible and flammable material storage.

Directed Completion Date: *09/19/2025*

Implemented [redacted] - 09/29/2025)

131e - Accessible Extinguishers

15. Requirements

2600.
131.e. Fire extinguishers shall be accessible to staff persons. Fire extinguishers shall be kept locked if access to the extinguisher by a resident could cause a safety risk to the resident. If fire extinguishers are kept locked, each staff person shall be able to immediately unlock the fire extinguisher in the event of a fire emergency.

Description of Violation

At 4:15 p.m., a fire extinguisher in the facility's smoking area was stored behind a ladder and not accessible in the event of a fire.

Plan of Correction ***Directed [redacted] - 09/05/2025)***

The fire extinguisher in the smoking section was behind a ladder. The ladder was removed by the building nurse on 7/30/2025. Building nurse will ensure easy access to fire extinguishers during weekly walk through which started on 7/30/2025.

Proposed Overall Completion Date: 08/28/2025

Directed: In addition to the above plan of correction, the administrator or designee will complete daily checks on all fire extinguishers for 2 weeks to ensure they are accessible. These checks will be documented with date, person completing the checks, and any issues identified.

Directed Completion Date: *09/23/2025*

Implemented [redacted] - 09/29/2025)

162c - Menus Posted

16. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

The home's menu for the weeks of [redacted] and [redacted] were not posted.

162c Menus Posted *(continued)*

Plan of Correction ***Directed [redacted] - 09/05/2025)***

Menu's were posted on 7/29/2025 during the inspection and Dining service director started checking these on 8/6/2025 during [redacted] already scheduled weekly Wednesday visits.

Proposed Overall Completion Date: 08/28/2025

Directed: In addition to the above plan of correction, the Administrator or designee will complete weekly audits for 4 weeks to ensure the current week's menu, and a menu prepared for 1 week in advance are posted in a conspicuous and public place in the home.
Education will be provided to all staff on the requirement for posting of menus. Documentation of completed audits and education will be kept by the home and available for review by the Department. The weekly menu audits will be added to the home's quality management review pro*cess.*

Directed Completion Date: *10/01/2025*

Implemented [redacted] 09/29/2025)

183b - Meds and Syringes Locked

17. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

At 2:30p.m.,[redacted] was unlocked, unattended, and accessible in Resident [redacted]'s room and [redacted] was unlocked, unattended, and accessible in Resident [redacted] room. Neither resident is assessed to self administer medication.

Plan of Correction ***Directed [redacted] - 09/05/2025)***

Medications were removed from residents room by building nurse on 7/29/2025 during the inspection. Nurse will do monthly checks on resident rooms to ensure no medications are being kept in resident rooms which started on 7/30/2025.

Proposed Overall Completion Date: 08/28/2025

Directed: In addition to the above plan of correction, training will be provided to all staff regarding this regulation and their responsibilities if any medication is seen unlocked in a room.

Directed Completion Date: *09/19/2025*

Implemented [redacted] - 11/03/2025)

183e - Storing Medications

18. Requirements

2600.
183.e. Prescription medications, OTC medications and CAM shall be stored in an organized manner under proper conditions of sanitation, temperature, moisture and light and in accordance with the manufacturer's instructions.

183e - Storing Medications *(continued)*

Description of Violation

At 2:40p.m., opened [redacted] pens were being stored in the refrigerator. According to the manufacturer's instructions the pens are to be stored at room temperature once opened. Resident [redacted] insulin pen was opened but not dated with the date that it was opened.

Repeat violation: [redacted] *&* [redacted]

Plan of Correction ***Directed ([redacted] - 09/05/2025)***

Medication Technicians received an additional training on insulin storage on 7/30/2025 and education materials were hung in the medication room on 7/30/2025.

Proposed Overall Completion Date: 08/28/2025

Directed: In addition to the above plan of correction, the administrator or designee will complete weekly checks for 4 weeks on all insulin is being stored in accordance with the manufacturer's recommendations. These checks will be documented with the date, person completing the check, and any issues identified.

Directed Completion Date: *10/01/2025*

Implemented [redacted] - 10/23/2025)

185a - Implement Storage Procedures

19. 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

Resident [redacted] is prescribed [redacted] as needed. At 3:15p.m., the medication was not available in the home.

Plan of Correction ***Directed [redacted] 09/05/2025)***

a medication cart audit was completed on 8/9/2025 and will be completed monthly and nurse will ensure all medications ordered are available and stored properly at the facility.

Proposed Overall Completion Date: 09/03/2025

Directed: In addition to the above plan of correction, all staff that pass or are trained to pass medications will be educated regarding policy ordering resident medications. Weekly audits will be completed on each medication cart for 4 weeks to ensure all medications are available. These audits will be documented with the date, person completing the audit, cart that was audited, and any issues identified. If any medication is missing, steps to secure the medication will be immediately taken and documented.

Directed Completion Date: *10/01/2025*

Implemented [redacted] - 09/29/2025)

252 - Record Content

21. Requirements

252 Record Content *(continued)*

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

Resident [redacted] record does not include the resident's eye, hair color, or identifiable marks.

Plan of Correction ***Directed [redacted] - 09/05/2025)***

Resident's hair and eye color were added to the application on 7/29/2025. Identifying mark was listed on the resident face sheet at the time of inspection which is attached. Building nurse will ensure completion of hair and eye color on application during move ins starting 7/30/2025. Please see attached face sheets for all residents who moved in after resident [redacted].

Proposed Overall Completion Date: 09/03/2025

Directed: In addition to the above plan of correction, the administrator or designee will audit all resident records to ensure that all information required under regulation 252 is in each resident record. This audit will be documented with date, person completing the audit, resident record audited, and any issues identified.

Directed Completion Date: *09/16/2025*

Implemented [redacted] - 11/03/2025)