

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

June 23, 2026

[REDACTED]  
EM RURAL LIVING LLC  
[REDACTED]

RE: THE WYNWOOD HOUSE AT  
NITTANY VALLEY  
294 DISCOVERY DRIVE  
BOALSBURG, PA, 16827  
LICENSE/COC#: 23224

[REDACTED],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 04/01/2026, 04/27/2026, 04/30/2026, 05/04/2026, 05/08/2026, 06/02/2026 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]  
Human Services Licensing Supervisor

cc: Pennsylvania Bureau of Human Service Licensing

**Facility Information**

Name: THE WYNWOOD HOUSE AT NITTANY VALLEY License #: 23224 License Expiration: 09/26/2026  
 Address: 294 DISCOVERY DRIVE, BOALSBURG, PA 16827  
 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: 1 2 Date: 12/16/2015 Issued By: DLI

**Staffing Hours**

Resident Support Staff: 0 Total Daily Staff: 44 Waking Staff: 33

**Inspection Information**

Type: Partial Notice: Unannounced BHA Docket #:  
 Reason: Complaint, Incident Exit Conference Date: 06/02/2026

**Inspection Dates and Department Representative**

04/01/2026 On Site: [REDACTED]  
 04/27/2026 Off Site: [REDACTED]  
 04/30/2026 Off Site: [REDACTED]  
 05/04/2026 Off Site: [REDACTED]  
 05/08/2026 Off Site: [REDACTED]  
 06/02/2026 Off Site: [REDACTED]

**Resident Demographic Data as of Inspection Dates**

**General Information**  
 License Capacity: 40 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: 29  
 Diagnosed with Mental Illness: 0 Diagnosed with Intellectual Disability: 0  
 Have Mobility Need: 15 Have Physical Disability: 0

Inspections / Reviews

04/01/2026 Partial

Lead Inspector: [REDACTED] Follow-Up Type: *POC Submission* Follow-Up Date: *06/18/2026*

06/16/2026 - POC Submission

Submitted By: [REDACTED] Date Submitted: *06/17/2026*  
Reviewer: [REDACTED] Follow-Up Type: *Document Submission* Follow-Up Date: *07/01/2026*

06/23/2026 - Document Submission

Submitted By: [REDACTED] Date Submitted: *06/17/2026*  
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 [REDACTED] the facility's fire alarm system activated and notified the Boalsburg Fire Department. The fire department responded and determined that it was a false alarm due to a dry false system trip. The facility did not notify the Department of the incident until [REDACTED]

### Plan of Correction

Accept [REDACTED] - 06/16/2026)

On 5/4/26, the facility submitted the retroactive incident report to the Department regarding the false fire alarm activation that occurred on 4/8/26. The facility immediately audited its internal maintenance logs for the Boalsburg location to ensure no other unreported emergency responder visits had occurred. Moving forward, the facility has ensured that all incident reports are filed within the strict 24-hour state regulatory window, regardless of whether the event is determined to be a false alarm.

### Plan to Safely Maintain Residents-

All current residents have been safely maintained. To ensure resident safety and maintain continuous regulatory alignment, an immediate review of the facility's fire safety log was conducted to confirm the dry system trip was entirely resolved by maintenance personnel and that the system remains fully operational. No residents were placed in jeopardy during the delayed notification window.

### Systemic Changes to Prevent Recurrence-

To prevent a recurrence of delayed reporting, the facility has implemented a mandatory administrative override protocol. A "First Responder Notification Protocol" chart has been physically posted directly next to the community fire panel and the administrator's desk as a visual trigger.

### QA Plan to Monitor Performance-

The Executive director or designee will conduct a weekly audit of the facility's physical visitor/maintenance logs and compare them directly against the DHS submissions. This audit will occur for the 60 days to ensure absolute compliance with the 24-hour notification mandate. The results of these bi-weekly audits will be reviewed during quarterly Quality Assurance (QA) committee meetings to determine if further staff training or operational adjustments are necessary.

Licensee's Proposed Overall Completion Date: 07/03/2026

Implemented [REDACTED] - 06/23/2026)

## 42y - Health Care Choice

### 2. Requirements

2600.

42.y. A resident has the right to choose his own health care providers without limitation by the home. This includes the right to select the resident's own pharmacist provided that the pharmacy agrees to supply medications in a way that is compatible with the home's system for handling and assisting with the self-administration of resident medications.

42y Health Care Choice (continued)

Description of Violation

On [redacted] the facility instituted a pharmacy provider charge of [redacted] for any resident that chooses to use a pharmacy other than the facility's partner pharmacy, Life Tree. The pharmacy fee is excessive and limits a resident's ability to choose their own health care.

Plan of Correction

Accept [redacted] - 06/16/2026)

On 6/8/2026, the facility immediately ceased assessing the [redacted] monthly administrative fee to any resident utilizing an outside pharmacy provider. An internal financial audit was conducted for the period beginning March 1, 2026, to present. All residents/families identified as having been charged this fee will be issued a full refund or direct account credit no later than 06/30/2026. Documentation of these refunds will be maintained in the facility business office for state review.

2. Plan to Safely Maintain Residents

All current residents have been protected. A formal correction notice will be mailed/emailed to all residents and designated representatives by 6/12/2026, clarifying that residents retain the absolute right to choose their own pharmacy provider without any administrative surcharge, provided the pharmacy meets the packaging compliance standards of the facility.

3. Systemic Changes to Prevent Recurrence

The facility has implemented a policy review lock. No new house rules, addendums, or letters altering resident billing structures or service fees related to health care providers will be issued without a direct regulatory compliance review by the Regional Director of Operations and Executive leadership to ensure alignment with Pa. Code Chapter 2600. The facility's standard admission agreement will be audited to ensure no such fees are present.

4. QA Plan to Monitor Performance

The Regional Director of Operations or designee will review the facility's monthly billing census and accounts receivable logs every month for the next six (6) months to verify that zero ancillary or administrative pharmacy fees are being applied to residents using outside providers. The results of these audits will be logged and reviewed during quarterly Quality Assurance (QA) meetings.

Licensee's Proposed Overall Completion Date: 12/31/2026

Implemented [redacted] 06/23/2026)

60a - Staff/Support Plan

3. Requirements

2600.

60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

The home routinely staffs the 11:00 p.m. to 7:00 a.m. with two staff persons. From [redacted] the home had 29 residents in the building and 15 residents that require assistance to evacuate in the event of an emergency. 8 residents require the assistance of two staff persons to evacuate, and 7 residents require the assistance of 1 2 staff persons to evacuate. In the event of an emergency the home must evacuate to the outside of the building. 2 staff persons are not enough staff to meet the residents' needs from 11:00 p.m. to 7:00 a.m. in the event of an emergency.

Plan of Correction

Accept [redacted] - 06/16/2026)

Upon receipt of the administrative citation regarding night shift staffing ratios and evacuation capabilities, facility

**60a - Staff/Support Plan (continued)**

leadership immediately scheduled a formal evaluation of emergency egress to ensure absolute alignment with state guidelines.

On June 3, 2026, the facility coordinated and executed a supervised, live-action emergency fire drill and safety inspection directly in conjunction with the Boalsburg Fire Department, led by Fire [REDACTED]. The objective was to test whether a baseline night-shift staffing complement of exactly two (2) personnel could safely execute the facility's emergency preparedness protocols.

- Total Number of Staff Participating: 2 On-Duty Personnel
- Total Evacuation Time Achieved: 6 minutes and 13 seconds
- Maximum Allowable Regulatory Egress Time: 10 minutes and 0 seconds
- Primary Safe Area Designation: The Outside of the Building (per 55 Pa. Code § 2600.132(d))

[REDACTED] formally signed and certified that the two participating staff members demonstrated exceptional coordination, clear structural knowledge of emergency protocols, and complete competency in managing the resident population. This live-action trial conclusively proves that a trained, two-person night staff is entirely sufficient to clear the structure well within the legally mandated 10-minute regulatory window.

PART II: Systemic Plan of Correction & Implementation Matrix

Specific Action Steps to Correct and Prevent Recurrence Individual Responsible Completion / Implementation Date  
Official Fire Chief Certification & Safe Area Designation:

The facility secured the formal, signed Fire Evacuation Time/Fire Safe Area Designation form (55 Pa.Code § 2600.132(d)) from [REDACTED] of the Boalsburg Fire Department. This document officially validates that a 2-person staff safely achieves the egress mandate. This certification is maintained in the facility's compliance log.  
Regional Director of Operations / Executive Director Completed  
June 3, 2026

Mandatory Emergency Response Re-Education:

All night-shift personnel (11:00 p.m. to 7:00 a.m.) will undergo mandatory, documented re-education focusing on rapid-egress techniques, prioritizing residents requiring two-person physical assistance, and utilizing standardized evacuation pathways to maintain the certified 6-minute baseline. Resident Care Director (RCD) Within 30 Days

By July 10, 2026

Dynamic Mobility Review & Threshold Matrix:

The facility has implemented an ongoing internal monitoring matrix. If the number of high-acuity residents (those requiring two-person physical assistance) increases beyond a specific risk threshold that would jeopardize the 10-minute egress window, the building's schedule will dynamically scale to add a third night-shift staff member proactively. Executive Director / Resident Care Director Immediate & Ongoing

Implemented June 11, 2026

Enhanced Mobility Classification Reviews:

In alignment with DHS standards, the Resident Care Director will review all resident mobility profiles (Independent, Minimal, Moderate, and Total Assistance) monthly. This ensures that staffing levels directly match the real-time physical evacuation needs highlighted in the BHSL citation text. Resident Care Director (RCD) Monthly

PART III: Quality Assurance & Monitoring Mechanism

60a - Staff/Support Plan (continued)

To ensure the ongoing effectiveness of this Plan of Correction, the facility has integrated these safety metrics.

1. The Executive Director or designee will review all monthly unannounced fire drill logs to verify that the evacuation time to the outside of the building consistently remains under the 10-minute maximum allowable timeline under 2-person night-shift conditions.
2. A copy of the Fire Department's annual certification forms and timed-trial logs will be presented to the Quality Assurance Committee quarterly to assess long-term staffing sufficiency patterns against changing building census counts.
3. Any drift in drill times exceeding 8 minutes will automatically trigger an immediate operational audit, staff retraining, or an adjustment to the night-shift staffing complement.

Licensee's Proposed Overall Completion Date: 06/16/2026

Implemented [REDACTED] - 06/23/2026)