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

August 14, 2026

[redacted], OWNER
EM RURAL LIVING LLC
[redacted]

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

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 07/08/2026 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]

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: *C 2 LP* **Date**: *04/25/2005* **Issued By**: *Dept of L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *29* **Waking Staff**: *22*

Inspection Information

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

Reason: *Renewal, Complaint, Incident* **Exit Conference Date**: *07/08/2026*

Inspection Dates and Department Representative

07/08/2026 On Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *40* **Residents Served**: *25*

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**: *25*

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

Have Mobility Need: *4* **Have Physical Disability**: *1*

Inspections / Reviews

07/08/2026 - Full

Lead Inspector: [redacted] **Follow Up Type**: *POC Submission* **Follow Up Date**: *07/31/2026*

Inspections / Reviews *(continued)*

07/24/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/11/2026*

Reviewer: [redacted] **Follow Up Type:** *POC Submission* **Follow Up Date:** *07/31/2026*

08/05/2026 POC Submission

Submitted By: [redacted] **Date Submitted:** *08/11/2026*

Reviewer: [redacted] **Follow Up Type:** *Document Submission* **Follow Up Date:** *08/12/2026*

08/14/2026 Document Submission

Submitted By: [redacted] **Date Submitted:** *08/11/2026*

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

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The residence shall immediately report suspected abuse of a home served in the resident's in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

On 7/05/26 at 8:00 a.m., resident #1 was discovered missing from the home. Resident #1 was later found at a nearby farmhouse approximately two miles away at 11:53 a.m. An investigation into the incident determined that resident #1 had eloped from the home on 7/04/26 at 8:55 p.m. The home did not immediately contact the Area Agency on Aging on 7/05/26 to report the incident and did not send a Mandatory Abuse Report Form within 48 hours.

Plan of Correction ***Accept ([redacted] - 08/05/2026)***

Immediate Action: Resident #1 was located safely on 7/05/26 and assessed for injuries. The Area Agency on Aging (AAA) Protective Services and BHSL were notified immediately upon discovery of the oversight, and the Mandatory Abuse Report Form was submitted. (see attached)

Homes policy regarding Mandatory Abuse and Incident Reporting was reviewed. A secondary check protocol was established requiring the On-Call Supervisor/Administrator to be notified immediately of any resident missing >15 minutes to ensure AAA and DHS reporting deadlines are met within mandated timeframes.

Staff Retrained 7/8/26: All administrative, supervisory, and direct care staff will be retrained on § 2600.15(a) mandatory reporting guidelines, the 6 Pa. Code § 15.21 reporting requirements, and immediate notification protocols for suspected neglect/elopement.
The incident occurred on a Sunday, and I wasn't aware I had to call immediately.
attached: confirmation that the incedent report was faxed to the Area Agency on Aging was notified by fax on 7/6/26 at 0835 am. this is within the 48 hours. The report for DHS was was faxed 6/5/26 @ 1246 pm.
New policy attached
training session attached

Proposed Overall Completion Date: 07/24/2026

Licensee's Proposed Overall Completion Date: *07/24/2026*

Implemented ([redacted] - 08/11/2026)

25c8 - Smoking

2. Requirements

2600.
25.c. At a minimum, the contract must specify the following:
8. The home's rules related to home services, including whether the home permits smoking.

Description of Violation

The resident-home contract dated [redacted] for resident #2 does not include the current home rules for smoking.

Plan of Correction ***Accept ([redacted] - 08/05/2026)***

The Resident-Home Contract for Resident #2 was updated on 7/20/2026 to include an addendum detailing the home's current smoking rules. Resident #2 signed and received a copy of the updated contract.

25c8 Smoking (continued)

The Resident Contract intake checklist was updated to mandate that the current Smoking Policy Addendum is attached to every incoming and existing contract during annual reviews or policy updates.
Admissions and administrative staff responsible for resident contracting were retrained on § 2600.25(c)(8) contract requirements.
The Administrator or Designee will audit 100% of current resident charts to ensure all contracts contain current home rules by 7/24/26, including smoking rules. Quarterly chart audits will monitor ongoing compliance. New contract attached.

Proposed Overall Completion Date: 07/24/2026

Licensee's Proposed Overall Completion Date: *07/24/2026*

Implemented ([redacted] - 08/11/2026)

28f - Resident's Funds and 30-day Refund

3. Requirements

2600.
28.f. Within 30 days of either the termination of service by the home or the resident's leaving the home, the resident shall receive an itemized written account of the resident's funds, including notification of funds still owed the home by the resident or a refund owed the resident by the home. Refunds shall be made within 30 days of discharge.

Description of Violation

Resident #3 was discharged from the home on [redacted] The home did not issue a refund to the resident's estate until [redacted]

Plan of Correction ***Accept ([redacted] - 08/05/2026)***

Immediate Action: A written itemized financial accounting and final refund check were issued to the estate of Resident #3 on [redacted]
On 7/14/26 The home's Discharge Protocol was revised to include a financial discharge trigger. The Business Office Manager will be formally notified on Day 1 of any discharge to ensure accounting and refunds are processed within 20 days, guaranteeing delivery prior to the 30 day statutory deadline.

The Administrator and financial/billing staff were retrained on § 2600.28(f) regarding strict 30 day refund timelines for discharged residents by 7/24/2026.

Proposed Overall Completion Date: 07/24/2026

Licensee's Proposed Overall Completion Date: *07/24/2026*

Implemented ([redacted] - 08/11/2026)

42b - Abuse

4. 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.

42b - Abuse *(continued)*

Description of Violation

On 7/5/26 at approximately 8:00 a.m., staff discovered that resident #1 was not in their room and could not be found in any area of the home or the grounds. Police were notified immediately and at approximately 11:53 a.m. the resident was located at a nearby farmhouse 2.3 miles away. Information obtained by a monitoring system in the home indicated resident #1 returned to the home with family on 7/04/26 at 8:30 p.m. and left their bedroom at 8:55 p.m. The monitoring system indicated no further activity in the resident's room until the morning of 7/05/26 when staff went to look for the resident. The Police report indicates that staff told police the resident had not been checked on after they were returned by family at 8:30 p.m. on 7/04/26. The home's contract states that two-hour resident checks are provided by staff for resident safety. Staff person A reported that resident #4 inquired about resident #1 on the morning of 7/05/26 and that is how staff became aware that resident #1 wasn't in the home. Resident #1 has a diagnosis of dementia and the resident's assessment dated [redacted] indicates the resident requires supervision in unfamiliar places. The resident was missing from the home from approximately 8:55 p.m. on 7/04/26 until being found on 7/05/26 at 11:53 a.m.

Plan of Correction ***Accept ([redacted] - 08/05/2026)***

Immediate Action: Resident #1 was evaluated by medical personnel upon return on 7/05/26. An immediate Support Plan meeting was held, and Resident Support Plan/RAI was updated to reflect enhanced supervision, door wander-guard monitoring were placed on all exit doors on 7/6/26, and updated safety protocols.

Systemic Reform: The home instituted a mandatory physical 2-hour Resident Check Log. Direct care staff must physically verify each resident every two hours during night shifts and document the check immediately. An automated door alarm/monitoring system audit was implemented to ensure sensors are functional.

Staff Retraining: Direct care staff will be retrained by 7/24/2026 on § 2600.42(b) prohibition of neglect, the critical duty of completing 2-hour resident safety checks as specified in resident contracts, and proper shift handoff communication regarding resident whereabouts.

Monitoring & Quality Assurance: The Administrator/Designee will conduct randomized monthly night-shift audits of the 2-Hour Resident Check Logs, Wander-guard and exit door alarm functionality will be tested daily.

Proposed Overall Completion Date: 07/24/2026

Licensee's Proposed Overall Completion Date: *07/24/2026*

Implemented ([redacted] - 08/11/2026)

103e - Left Overs

5. 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 2:35 p.m., there were the following unlabeled, undated items in refrigerator #1: A bag of sliced ham, a bag of bacon, a bag of shredded parmesan cheese, and six plastic squeeze bottles of salad dressings. At 2:40 p.m., there was an unlabeled, undated bag of frozen chicken fried steak and an unlabeled, undated bag of frozen chicken fingers in

103e Left Overs (continued)

freezer #1.

Repeated Violation: 07/29/2025

Plan of Correction ***Accept (- 08/05/2026)***

Immediate Action: On 7/08/26, all unlabeled and undated food items identified in Refrigerator #1 and Freezer #1 (ham, bacon, parmesan cheese, salad dressings, chicken fried steak, chicken fingers) were immediately discarded.

Systemic Reform: 7/7/26 Food service procedures were modified to enforce an "Immediate Label Rule": any opened or prepared food package must be labeled with the item name, opened date, and discard date before being placed back into refrigeration/freezer units.

Staff Retraining: 7/7/26 All dietary and care staff involved in food handling will be retrained on § 2600.103(e) requirements regarding labeling, dating, and discarding food. cooks daily task and sign off sheet binder instilled to follow requirements.

Monitoring & Quality Assurance: As of 7/7/2026 The Dietary Director or administration will perform audits for logging compliance. The Administrator will conduct weekly unannounced kitchen inspections to prevent recurrence.

Licensee's Proposed Overall Completion Date: *07/24/2026*

Implemented (- 08/11/2026)

103f - Refrigerator/Freezer Temps

6. 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 2:45 p.m., there was no thermometer located in freezer #3.

Repeated Violation: 07/29/2025

Plan of Correction ***Accept (- 08/05/2026)***

Immediate Action: A certified food safe thermometer was placed inside Freezer #3 on 7/07/26, and the temperature was verified to be at or below 0°F.

Systemic Reform: 7/7/2026 The daily Temperature Log was updated to explicitly list Freezer #3 by location. Secondary backup thermometers were placed in dietary stock for immediate replacement if a thermometer breaks or is displaced.

Staff Retraining: 7/7/2026 Dietary staff were retrained on § 2600.103(f) requiring working thermometers in all refrigeration and freezer units at all times and logging temperatures twice daily.

Monitoring & Quality Assurance: 7/7/2026 The Dietary Director/Designee will audit all cold storage units twice

103f - Refrigerator/Freezer Temps (continued)

daily during temperature checks. The Administrator will verify all units during weekly environment checks.

Licensee's Proposed Overall Completion Date: *07/24/2026*

Implemented ([redacted] - 08/11/2026)

103g - Storing Food

7. Requirements

2600.
103.g. Food shall be stored in closed or sealed containers.

Description of Violation

At 2:35 p.m., a bag of broccoli in refrigerator #1 was opened and unsealed and a bag of chicken fried steak was opened and unsealed in freezer #1.

Plan of Correction ***Accept ([redacted] - 08/05/2026)***

Immediate Action: The unsealed bags of broccoli in Refrigerator #1 and chicken fried steak in Freezer #1 were immediately transferred to airtight, sealed, food-grade storage containers on 7/08/26.

Systemic Reform: On 7/8/2026 Commercial zip-top bags and airtight food containers were restocked in the kitchen. Staff were instructed that unsealed original packaging must be folded, clipped, or transferred to sealed containers prior to storage.

Staff Retraining: 7/08/2026 All dietary staff were retrained on § 2600.103(g) regarding strict food sealing standards to prevent cross-contamination.

Monitoring & Quality Assurance: 07/08/2026 The Dietary Director will inspect all refrigerator and freezer contents daily after meal preparation shifts. The Administrator will include container sealing checks during weekly facility audits.

Licensee's Proposed Overall Completion Date: *07/24/2026*

Implemented ([redacted] - 08/11/2026)

121a - Unobstructed Egress

8. 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

At 12:30 p.m., residents seated at a table during the lunch meal blocked egress to the door leading to the back area of the home.

Plan of Correction ***Accept ([redacted] - 08/05/2026)***

Immediate Action: At 12:30 p.m. on 7/08/26, dining room seating was immediately reconfigured to remove all obstructions and clear a 36-inch continuous exit pathway to the back doorway.

121a - Unobstructed Egress (continued)

Systemic Reform: Dining room floor markings/spacing guidelines were established to define table and chair placement, ensuring pathways to exit doors remain unobstructed during mealtimes regardless of resident seating choices.

Staff Retraining: 07/08/2026 All direct care and dietary staff were retrained on § 2600.121(a) ensuring all stairways, hallways, doorways, and egress routes remain unlocked and completely clear at all times.

Monitoring & Quality Assurance: 7/8/2026 The Administrator/Designee will conduct audits daily, ensuring all exit doors remain unobstructed.
on 7/08/2026 door was labled as not a exit.

Licensee's Proposed Overall Completion Date: *07/24/2026*

Implemented ([redacted] - 08/11/2026)

125a - Combustible Storage

9. Requirements

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

Description of Violation

At 2:50 p.m., in the home's kitchen pantry carboard cartons were being stored on a shelf within 2 inches of the home's hot water heater. Also, two-gallon size bottles of bleach were stored on the floor next to the hot water heater, as well as a container of drain opener, and a bottle of insect spray was found on top of the hot water heater.

Repeated Violation: 07/29/2025

Plan of Correction ***Accept ([redacted] - 08/05/2026)***

Immediate Action: On 7/08/26, cardboard cartons were removed from the shelf near the hot water heater. Bleach, drain opener, and insect spray were immediately removed from the top and surrounding floor of the hot water heater and relocated to a locked chemical storage cabinet.
Chemical storage was restricted strictly to dedicated, locked housekeeping closets.

Staff Retraining: 7/08/20260All staff (dietary, housekeeping, maintenance, care staff) will be retrained on § 2600.125(a) prohibition of combustible/flammable storage near heat and water heating sources.

Monitoring & Quality Assurance: Maintenance Supervisor/Designee will perform daily physical checks of utility areas and hot water heater enclosures. as of 7/10/26 The Administrator will audit utility rooms during weekly facility inspections.

Licensee's Proposed Overall Completion Date: *07/24/2026*

Implemented ([redacted] - 08/11/2026)

182c - Medication Administration

10. Requirements

2600.

182c Medication Administration *(continued)*

182.c. Medication administration includes the following activities, based on the needs of the resident:

Description of Violation

On 7/08/26 at approximately 11:30 a.m., Staff person C opened medications for multiple residents in the medication room, dispensing them into individual plastic cups with the resident's first name on them. Staff person B stacked the individual cups to prepare for the medication passes during the lunch service.

Plan of Correction ***Accept ([redacted] - 08/05/2026)***

Immediate Action: Staff Persons were instructed to stop pre pouring and stacking medications immediately on 7/08/26. The pre poured medications were disposed of per home destruction protocols, and medications were re dispensed individually at the time of administration.

Systemic Reform: on 7/09/26 Home Medication Administration Policy was revised to strictly prohibit "pre pouring" or dispensing medications for multiple residents into stacked cups prior to pass time. Med Techs must prepare and administer medications for one individual resident at a time directly at the time of administration.

Staff Retraining: All certified Medication Technicians and nurses will be retrained on § 2600.182(c) and safe medication administration standards (one resident, one pass, no pre pouring). completed 7/09/2026

Monitoring & Quality Assurance: starting 7/9/2026, The Administrator or Medication Supervisor will perform monthly unannounced medication pass observations.

Proposed Overall Completion Date: 07/24/2026

Licensee's Proposed Overall Completion Date: *07/24/2026*

Implemented ([redacted] - 08/14/2026)

183e - Storing Medications

11. 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.

Description of Violation

On 7/08/26, at approximately 2:59 p.m., resident #6 's Novolog 100 unit Flex Pen, stored in the medication cart was opened but not dated with the date that the medication was first used. According to the manufacturer's instructions, the medication must be discarded 28 days after the first use.

Repeated Violation: 07/29/2025

Plan of Correction ***Accept ([redacted] - 08/05/2026)***

Immediate Action: On 7/08/26, Resident #6's Novolog Flex Pen was reviewed. Because the exact open date could not be verified, the pen was safely destroyed per policy, and a new Novolog Flex Pen was obtained from the pharmacy and labeled with the current open date and calculated 28 day expiration date.

183e - Storing Medications (continued)

Systemic Reform: Auxiliary on 7/08/2026 "DATE OPENED: ___ / DISCARD DATE: ___" stickers were placed in all medication carts. Med Techs are required to affix and fill out this label on all multi-dose vials, insulin pens, eye drops, and topicals prior to first use.

Staff Retraining: 7/10/2026 All Medication Technicians and nursing staff will be retrained on § 2600.183(e) and manufacturer instructions regarding dating multi-dose/insulin items upon opening.

Monitoring & Quality Assurance: The Medication Supervisor/Designee will perform weekly cart audits of all multi-dose medications and insulin pens to verify proper open/expiration dating.

Licensee's Proposed Overall Completion Date: *07/24/2026*

Implemented ([redacted] - 08/14/2026)

184a - Resident's Meds Labeled

12. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #6 is prescribed Novolog 100 unit /ML on a sliding scale three times daily, with instructions to administer: 0-79= 0 units, 80-150 = 4, 151-200 = 6, 201-250 = 8 units, 251-300 =10 units, and greater than 300 = 12 units. The Pharmacy label on the medication is incorrect, as it omits the 0-79 = 0 units and adds instructions to administer the insulin before meals.

Repeated Violation: 12/30/2025

Plan of Correction ***Accept ([redacted] - 08/05/2026)***

Immediate Action: On 7/08/26, the pharmacy was contacted immediately to correct the prescription label on Resident #6's Novolog Insulin to match the physician's order exactly (including the "0-79 = 0 units" parameter and removing non-ordered timing text). A corrected label was delivered and applied.

Systemic Reform: The home implemented a mandatory "Label vs. Order Audit" upon receipt of any new or re-ordered medication from the dispensing pharmacy. Med Techs/Nurses must cross-check the pharmacy label against the current Physician's Order / MAR before placing any medication in the cart.

Staff Retraining: 7/08/26 Medication staff were retrained on § 2600.184(a) requiring pharmacy labels to match original physician orders verbatim.

Monitoring & Quality Assurance: The Medication Supervisor will audit 100% of new pharmacy deliveries weekly and conduct monthly audits of 20% of all cart medication labels against MARs. starting 7/8/26

Licensee's Proposed Overall Completion Date: *07/24/2026*

Implemented ([redacted] - 08/14/2026)

185a - Implement Storage Procedures

13. 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 #7 is prescribed Tramadol HCL 50 mg and instructed to take three tablets by mouth daily. On 7/08/26 at approximately 3:23 p.m., the resident's narcotic count log for their 11:30 a.m. administration, indicated 7 tablets remaining, but the resident's medication card contained 6 tablets. One tablet was given at 11:40 a.m. on 7/05/26 and documented on the Medication Administration Log but the narcotic count log was not updated.

The home's Medication Destruction policy documents that controlled substance destruction must be witnessed and signed off by two staff persons, one of whom must be a Medication Technician, a Supervisor, Administrator or a LPN/RN. At approximately 3:23 p.m., staff person C dropped a Tramadol 50 mg tablet on the floor and immediately destroyed the medication without another staff person being present.

Plan of Correction ***Accept ([redacted] - 08/05/2026)***

Immediate Action: On 7/08/26, an immediate physical count of Resident #7's Tramadol was conducted. The discrepancy was corrected, reconciled on the Narcotic Count Sheet with explanatory documentation, and reported to the Administrator. Staff Person was verbally counseled regarding narcotic disposal regulations.

Systemic Reform: 7/09/26 Controlled substance policy was reviewed. Dropped or damaged controlled substances MUST be placed in a secure, tamper-evident container or medication cup until a second witness (Med Tech, Supervisor, RN/LPN, or Administrator) is present to co-sign the destruction log prior to disposal.

Staff Retraining: 7/09/2026 All Medication Technicians will be retrained on § 2600.185(a) controlled substance accountability, accurate shift counts, and two-person witness destruction protocols.

Monitoring & Quality Assurance: Shift-to-shift Narcotic Count sheets will be audited daily by the Medication

Licensee's Proposed Overall Completion Date: *07/24/2026*

Implemented ([redacted] - 08/14/2026)

187b - Date/Time of Medication Admin.

14. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #7 is prescribed Tramadol HCL 50 mg tablets to be administered every six hours as needed. On 7/08/26, the resident's medication administration record does not include Staff person C's initials for the administration of the medication on 7/07/26 at 3:30 p.m. as documented on the narcotic count log.

Plan of Correction ***Accept ([redacted] - 08/05/2026)***

Immediate Action: On 7/08/26, Staff Person was counseled regarding missing initials for Resident #7's 7/07/26 administration. The Narcotic Log was cross-referenced to verify the medication was administered, and appropriate

187b Date/Time of Medication Admin. (continued)

administrative documentation was placed in the record.

Systemic Reform: 7/08/2026 The home re emphasized the mandatory rule: "Medications must be initialed on the MAR immediately at the time of administration, never pre initialed or initialed retroactively at shift end."

Staff Retraining: All Medication Technicians were retrained on § 2600.187(b) requirements for real time documentation on the MAR and Narcotic Log simultaneously on 7/8/26.

Monitoring & Quality Assurance: The Medication Supervisor will conduct daily end of shift MAR audits for missing initials across all shifts.

Licensee's Proposed Overall Completion Date: *07/24/2026*

Implemented ([redacted] - 08/14/2026)