STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396120	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wyncote Care Center	208 Fernbrook Avenue Wyncote, PA 19095

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility policies, observations, and staff interviews, it was determined that the facility failed to implement enhanced barrier precautions for three of the six residents reviewed. (Resident R2, Resident R3, and Resident R4).Findings include: Review of the facility policy titled Enhanced Barrier Precautions, August 2022, revealed: Enhanced barrier precautions are utilized to prevent the spread of multi -drug resistant organisms (MDRO's to residents. Under policy Implementation: EBP's (Enhanced Barrier Precautions) employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Review of Resident R2's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnosis retention of urine and benign prostatic hyperplasia without lower urinary tract symptoms (enlargement of the prostate gland). Review of Resident R2's physician's order dated March 17, 2026, revealed an order for foley catheter and enhanced barrier precautions for multidrug-resistant organism (MDRO) risk. Review of Resident R3's clinical record revealed that the resident was admitted to the facility on [DATE], with a diagnosis of sepsis (infection of the blood). A physician order dated March 27, 2026, included Transmission-Based Precautions for contact precautions due to an Methicillin-Resistant Staphylococcus aureus (MRSA) wound on the resident's right lower extremity (RLE). Review of Resident R4's clinical record revealed that the resident was admitted to the facility on [DATE]. According to the Director of Nursing, Resident R4 had an open pelvic drain and was placed on enhanced barrier precautions. On April 1, 2026, at 9:36 a.m., an interview was conducted in Resident R3's room, where a sign indicated Enhanced Barrier Precautions rather than Transmission-Based Precautions. When asked if the employee who provided direct morning care that day was wearing a gown and appropriate PPE, Resident R3 responded, No, staff only wore gloves. Observation conducted on April 1, 2026, at 9:51 a.m. revealed that nursing aide Employee E3 was providing direct morning care to Resident R2 without wearing required personal protective equipment (PPE), specifically a gown. This observation was confirmed by the Director of Nursing, Employee E2. Employee E2 educated Employee E3 and assisted them in putting on the gown during the direct care activity. On April 1, 2026, at 9:51 a.m., an observation revealed that licensed nurse Employee E4 was administering medication to Resident R4 without wearing enhanced barrier precautions. An interview conducted after the medication administration revealed that Employee E4 was applying a clonidine patch, which had direct contact with the resident's skin and required the use of EBP PPE. When questioned about why Resident R4 was on EBP, Employee E4 was unable to provide an answer. This was confirmed by the Director of Nursing, Employee E1, who educated Employee E4 that Resident R4 had an open pelvic drain and that EBP was required. On April 1, 2026, at 10:08 a.m., an observation and interview were conducted with the Director of Nursing, Employee E2, in the laundry room. During the observation, Laundry Director Employee E6 was folding clean laundry with housekeeping staff Employee E7. When questioned about whether both staff should be wearing PPE, Employee E6 retrieved a reusable apron and gloves from the soiled laundry room and gave them to Employee E7. Employee E6 ensured the PPE provided was clean. When asked about PPE requirements for folding laundry, the Laundry Director could not provide a clear answer. The Director of Nursing was also (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unsure of Infection Control practices. During the observation, Employee E7 attempted to wear the gown incorrectly, as one would a jacket, rather than over the front of the body. The Director of Nursing provided assistance and redirected Employee E7 on the proper way to wear the gown. On April 1, 2026, at 10:43 a.m., an interview with the Director of Nursing, Employee E2, who also serves as the facility's Infection Preventionist, revealed that the facility did not have a tracking system for antibiotic surveillance forms. The facility had new ownership as of May 2025, and Employee E2 became the Director of Nursing and Infection Preventionist in September 2025. It was reported that all infections were being reported to the Patient Safety Authority on a case-by-case basis. Employee E2 retains all infection information and is familiar with the cases from memory; there were no surveillance forms readily available for review. Following this, Employee E2 created a Nosocomial Infection Tracking Log for the past three months: January, February, and March 2026. On April 1, 2026, at approximately 1:30 p.m., Resident R3's clinical record was reviewed with the Director of Nursing (DON) to clarify why the physician order indicated that Resident R3 was on Transmission-Based Precautions (TBP), while the sign outside the resident's door indicated Enhanced Barrier Precautions (EBP). The DON confirmed that the TBP order needed to be updated and that Resident R3 should be on EBP, as TBP was no longer required. During this review, the DON confirmed that surveillance tracking was not available. For MRSA. Surveillance data was not readily available for periods prior to January 2026. Additionally, a current listing of residents requiring EBP and TBP was not readily available. Review of facility IPCP documents revealed that there were no Infection Control Committee (ICC) meeting minutes for review. There was no evidence of input from the required ICC members. There was no evidence of reporting surveillance data, HAI rates, or infection control compliance metrics to the ICC. There was no evidence an annual infection control risk assessment or the development of annual goals and performance measures. 28 Pa. Code 211.10 (d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(5) Nursing services.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on review of the facility's infection control policies and procedures and staff interview, it was determined that the facility failed to implement an antibiotic stewardship program for 10 of 10 months (May 2025 -March 2026).Findings include: Review of the Facility policy titled Antibiotic Stewardship revised December 2016, revealed Antibiotic will be prescribed and administered to resident under guidance of the facility's antibiotic stewardship program. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. Review of the Facility policy titled Antibiotic Stewardship- Review and Surveillance of antibiotic use and outcomes, last revised December 2016 revealed Antibiotic usage and outcome data will be collected and documented using a facility approved antibiotic surveillance tracking form. The data will be used to guide decision for improvement of individual resident antibiotic prescribing practices and faculty - wide antibiotic stewardship. The information will include: resident name and medical record number; unit and room number; date symptoms appeared; name of antibiotic, start date of antibiotic, pathogen identified; site of infection; date of culture; stop date; total days of therapy; outcome; and adverse events. On April 1, 2026, at 10:43 a.m., an interview with the Director of Nursing, Employee E2, who also serves as the facility's Infection Preventionist, revealed that the facility did not have a tracking system for antibiotic surveillance forms. The facility had new ownership as of May 2025, and Employee E2 became the Director of Nursing and Infection Preventionist in September 2025. It was reported that all infections were being reported to the Patient Safety Authority on a case-by-case basis. Employee E2 retains all infection information and is familiar with the cases from memory; there were no surveillance forms readily available for review. Following this, Employee E2 created a Nosocomial Infection Tracking Log for the past three months: January, February, and March 2026. Facility Nosocomial Infection Tracking Logs for the months of January, February and March 2026, were reviewed. Nosocomial is defined as an infection does not present on admission, also referred to as healthcare-associated infections. Review of the January 2026 tracking log revealed that one infection was recorded. The recorded infection did not include a resident name or room number; location of infection; symptoms of the infection; any diagnostic testing obtained; the dose, route, frequency and duration of the prescribed antibiotic; or an evaluation of the treatment effectiveness. Review of the February 2026 tracking log revealed that three infections were recorded. The recorded infections did not include the location of infections; symptoms of the infections; any diagnostic testing obtained; the dose, route, frequency and duration of the prescribed antibiotic; or an evaluation of the treatment effectiveness. Further review of the February 2026 tracking log revealed that one resident had an upper respiratory infection. There was no evidence that the resident was tested for current disease threats, including influenza, RSV (Respiratory syncytial virus) and COVID-19. Review of the March 2026 tracking log revealed that six infections were recorded. Two of the infections did not include the location of infections; three did not include any diagnostic testing obtained; and non of the recorded infections included the dose, route, frequency and duration of the prescribed antibiotic; or an evaluation of the treatment effectiveness. Further review of the March 2026 tracking log revealed that two residents had an upper respiratory infection. There was no evidence that the resident was tested for current disease threats, including influenza, RSV (Respiratory syncytial virus) and COVID-19. Continued review of infection control data revealed that there were no tracking logs provided that monitored community acquired infections (infections that were present upon admission or re-admission) and no tracking of any antibiotics that were prescribed to treat those infections. Further review of infection control data revealed no evidence of the facility's antibiotic use protocol(s) that guide antibiotic prescribing practices (i.e., documentation of the indication, dose, and duration of the antibiotic; review of laboratory reports to determine if the antibiotic is indicated or needs to be adjusted; an infection assessment tool or management algorithm for use when prescribing) and a system to monitor antibiotic use (i.e., antibiotic use reports provided by the (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pharmacy and lab, antibiotic resistance reports). 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.12(c)(d)(3) Nursing services

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on a review of select facility policies and staff interviews, it was determined that the facility failed to ensure that the Infection Preventionist fulfilled the required duties and responsibilities of the position.Findings include: Review of facility policy, Antibiotic Stewardship - Staff and Clinician Training and Roles dated December 2016, revealed, under the responsibilities of Director of Nursing (DON) and Infection Preventionist (IP), Administrative and management personnel with clinical oversight responsibilities will receive initial orientation and ongoing training on: the facility's antibiotic program; the rationale for judicious use of antibiotics; common clinical conditions and associated pathogens treated at the facility; how to access the current facility antibiogram; how to access the list of antimicrobial agents available through the pharmacy formulary; how to use surveillance tools to monitor infectious rates, antibiotic usage patterns and outcomes; how and when to gather to present to the infection prevention and control committee for scheduled meetings; and individual roles and responsibilities in maintaining antibiotic stewardship. On April 1, 2026, at 10:43 a.m., an interview with the Director of Nursing (DON), Employee E2, who also serves as the facility's Infection Preventionist (IP), revealed and confirmed that she is a full-time DON and a part-time IP. The facility has currently hired an Assistant Director of Nursing who is undergoing training to become an IP. Review of the facility 2026 - Infection Control Plan dated March 31, 2026, revealed, The Infection Preventionist (IP), who is the ADON, in collaboration with the Infection Control Committee (ICC), conducts an annual Infection Control Program Risk Assessment. Continued review revealed that The Risk Assessment is used to: Identify potential risks for acquiring and/or transmitting infections; Evaluate and prioritize risks based on likelihood and impact; and Develop strategies to mitigate or eliminate identified risks. Continued review of the facility 2026 - Infection Control Plan revealed that duties of the Infection preventionist include: Development, implementation, monitoring, and enforcement of the evidence-based infection control plan, program, policies, and practices; Performance of an annual risk assessment with input from the ICC; Development of annual goal set points using prioritized risks from the risk assessment; Maintenance of IPCP data for tracking, trending, and reporting to committees and leadership; Performance of an annual IPCP evaluation and reporting outcomes to the ICC, and Implementation of necessary precautions and containment strategies in response to infectious disease threats. Further review of the facility 2026 - Infection Control Plan revealed, The Infection Control Committee (ICC) is a multidisciplinary group responsible for oversight of the IPCP. Membership of the ICC includes: Medical staff, Administration, Nursing staff, Infection Preventionist (ADON), Laboratory personnel, Pharmacy staff, Physical therapy /maintenance personnel, and A community member who is not an employee, agent, or contractor of the facility. Responsibilities of the ICC include: Reviewing and approving the Infection Control Plan, Risk Assessment, and infection control policies at least annually; Reviewing surveillance data, HAI rates, and infection control compliance metrics; Recommending and monitoring quality improvement initiatives; Addressing issues related to emerging pathogens and communicable diseases; and Reviewing and approving cleaning, disinfection, and sterilization products and practices used within the facility. Review of the facility assessment, dated last review December 12, 2025, revealed that the facility had one infection control nurse/preventionist and that the infection preventionist was also the Director of Nursing. There was no information included in the assessment regarding the amount of time required to fulfill the responsibilities and duties specifically for the role of the infection preventionist, or any determination of the resources it needs for its IPCP (Infection Prevention and Control Program), and ensure that those resources are provided for the IPCP to be effective. Review of facility IPCP documents revealed that infection surveillance data was not readily available and that no data was available prior to January 2026. Continued review revealed that a listing of residents requiring Enhanced Barrier Precautions (EBP) and Transmission Based Precautions (TBP) was not (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	readily available. There was no evidence of staff oversight to ensure that practices, such as hand hygiene and adherence to use of Personal Protective Equipment (PPE) was implemented. Refer to F880. Review of facility infection tracking logs revealed that they failed to contain location of infections; symptoms of the infections; any diagnostic testing obtained; the dose, route, frequency and duration of the prescribed antibiotics; or an evaluation of the treatment effectiveness. Review of infection control data revealed no evidence of: the facility's antibiotic use protocol(s) that guide antibiotic prescribing practices (i.e., documentation of the indication, dose, and duration of the antibiotic; review of laboratory reports to determine if the antibiotic is indicated or needs to be adjusted; an infection assessment tool or management algorithm for use when prescribing) and a system to monitor antibiotic use (i.e., antibiotic use reports provided by the pharmacy and lab, antibiotic resistance reports). Refer to F881. There was no evidence that the facility has any systems or protocols in place to monitor for current disease threats, including influenza, RSV (Respiratory syncytial virus) and COVID-19. Review of facility IPCP documents revealed that there were no Infection Control Committee (ICC) meeting minutes for review. There was no evidence of input from the required ICC members. There was no evidence of reporting surveillance data, HAI rates, or infection control compliance metrics to the ICC. There was no evidence an annual infection control risk assessment or the development of annual goals and performance measures. The facility failed to ensure that the Infection Preventionist had the necessary time and resources provided to fulfill the responsibilities and duties of the position. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(e)(1) Management.28 Pa. Code: 201.19(3) Personnel records.28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on facility policy, clinical record review, and staff interviews, it was determined that the facility failed to ensure that, before offering the influenza immunization, each resident or the resident's representative received education regarding the benefits and potential side effects of the immunization for five of five records reviewed (R1, R2, R3, R4, R5).Findings include: Review of the facility policy titled Influenza, Prevention and Control of Seasonal, undated, revealed that this facility follows current guidelines and recommendations for the prevention and control of seasonal influenza. Under the Vaccination section, bullet 3 further stated, Systematic strategies to improve staff vaccination rates may include: providing incentives, providing vaccine at no cost to staff, improving access (offering vaccination at work and during work hours), requiring personnel to sign a declaration form to acknowledge that they have been educated about the benefits and risks of vaccination, and mandating influenza vaccination for staff without contraindication. Review of consents forms for the influenza vaccines and review of clinical record for Resident R1, R2, R3, R4, R5), revealed no documented evidence that that Resident R1, R2, R3, R4, R5)., were provided with education on influenzas vaccines prior to the administration or refusing of the vaccine. The form constrained a check box declaring that Vaccination Information Sheets (VIS) has been received; however, when requested to see a copy of the VIS sheet. DON confirmed that there is no VIS sheet available for review. Interview with the Director of Nursing, Employee E2, conducted on April 1, 2026, at 10:43 a.m., confirmed that the consent form contained a check box stating that Vaccination Information Sheets (VIS) have been received. However, when requested, a copy of the VIS sheet was not available for review. The DON confirmed that no VIS sheet was available, which indicated there was no evidence of education provided to residents regarding influenza vaccines prior to administration for Residents R1, R2, R3, R4, and R5. 28 Pa. Code 201.18(e)(1) Residents rights