

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396120	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/05/2026
NAME OF PROVIDER OR SUPPLIER Wyncote Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 208 Fernbrook Avenue Wyncote, PA 19095	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interviews with staff, it was determined that the facility failed to maintain a safe, sanitary, and comfortable environment for residents in the facility, related with safe maintenance of two of two dryers. Findings include: On January 2, 2026, at 1:44 p.m., during observational tour of the Laundry room, it was detected that the lint of the two dryers was not removed from the lint compartment; and the lint layer was thick. There was no lint removal log available for review. At the time of the finding the same was confirmed with the Supervisor of Housekeeping, and the Administrator of the facility. 28 Pa Code 201.18(b)(1)(3) Management		

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview with staff, it was determined that the facility failed to ensure that MDS (minimum data set, a federally required resident assessment completed at a specific interval) assessment was completed accurately for one of twenty-one residents reviewed. (Resident R9) Findings include: Review of CMS's RAI Version 3.0 Manual revealed that CH 3: MDS Items [O] October 2025 Page O-1 SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS Intent: The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received or performed during the specified time periods. Under Item Rationale Health-related Quality of Life The treatments, procedures, and programs listed in Item O0110, Special Treatments, Procedures, and Programs, can have a profound effect on an individual's health status, self-image, dignity, and quality of life. Planning for Care Reevaluation of special treatments and procedures the resident received or performed, or programs that the resident was involved in during the 14-day look-back period is important to ensure the continued appropriateness of the treatments, procedures, or programs. Review of Resident R9's clinical record revealed that Resident R9 was admitted to the facility on [DATE], with diagnosis of but not limited to Malignant Neoplasm of the Breast, Cerebral Infraction, Non-Hodskins's Lymphoma. Further review of Resident R9's clinical record revealed a physician's order for: Hospice consultation and treatment dated September 8, 2025. Review of Hospice contract revealed that the contract was signed by daughter who was the POA (Power of Attorney) on September 10, 2026. Review of significant change MDS (minimum data set, a federally required resident assessment completed at a specific interval) dated September 16, 2025, revealed that Section O - Special Treatments, Procedures, and Programs, K1. Hospice care was coded No (not on hospice) Interview with RNAC (Registered Nurse Assessment Coordinator) Employee E3 conducted on January 2, 2025, at 11:23AM revealed that Resident R9's Hospice contract was signed on September 10, 2025, and that hospice services started on the day the contract was signed. Further interview with Employee E3 confirmed that when she completed Resident R9's significant change MDS dated [DATE], she coded No on Section O - Special Treatments, Procedures, and Programs, K1. Hospice care. 28 Pa. Code 211.10(a) Resident assessment		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, review of clinical records, review of facility policy and interview with staff, it was determined that the facility failed to develop a person-centered care plan related to skin breakdown for two of twenty-one residents reviewed. (Resident R7 and Resident R8) Findings include: Review of facility policy on Care Planning revealed that under section Purpose: To ensure that each resident at Wyncote Care Center receives individualized person-centered gear through the development implementation and ongoing review of an interdisciplinary care plan in compliance with CMS and Pennsylvania Department of Health requirements. Under section Policy statement: Wyncote Care Center shall develop and maintain a comprehensive resident centered care plan for each resident care plans are based on assessments resident goals and preferences physician orders and ongoing clinical evaluation Care planning is an interdisciplinary process and care plans must be actively implemented and followed by all staff. Review of Resident R8's clinical record revealed that Resident R8 was admitted to the facility on with diagnosis of End Stage Renal Disease, Dependent on Dialysis. Review of Resident R8's oral health assessment dated [DATE], revealed that Resident R8 had four or more decayed or broken teeth/roots. Further review of Resident R8's clinical record revealed that there was no care plan developed to address Resident R8's missing teeth. Observation on Resident R8 conducted on December 29, 2025, at 1:23PM revealed that Resident R8 had one visible front tooth. Interview with Resident R8 conducted at the time of the observation revealed that he only has three teeth. Further Resident R8 also revealed that he was not able to chew the food that he likes because he does not have teeth. Interview with Director of Nursing Employee E2, conducted on December 31, 2025, at 10:46AM confirmed that there oral/dental care plan was not developed for Resident R8. Review of Resident R7's clinical record revealed that Resident R7 was admitted to the facility on [DATE], with diagnoses of but not limited to Type 2 Diabetes Mellitus with Diabetic Peripheral Angiopathy (failure of the body to produce insulin), and Disorder of Arteries. Review of Resident R7's progress note dated December 3, 2025, revealed that CNA (nurse aide) staff asked RN (registered nurse) supervisor to assess the resident's right top of foot area, as there is redness on the left aspect of the red foot area that was not seen there last Monday (12/1/2025) when she was with the resident. RN assessed the area: -localized redness, size of quarter, tender to touch, pain (3/10 as per pt). No broken skin observed. Further review of Resident R7's clinical record revealed that there was no care plan addressing Resident R7's potential for skin breakdown on the top of Resident R7's right foot. Observation on Resident R7's right foot conducted with DON (Director of Nursing) Employee E2 conducted on December 31, 2025, at 10:50 AM revealed a skin breakdown with a round dark reddish-brown scab over it, the size of a quarter on top of Resident R7's right foot. Interview of the Director of Nursing, Employee E2 conducted at the time of the observation confirmed that Resident R7 had a skin breakdown on top of Resident R7's right foot. Follow-up interview with Director of Nursing, Employee E2 conducted on December 31, 2025, at 11:46AM confirmed that there was no care plan addressing Resident R7's skin breakdown on top of his right foot. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observations, clinical record review, and staff interviews, it was determined that the facility failed to revise the care plan for enteral nutrition for one out of 16 residents reviewed. (Resident R26) Findings include: Review of clinical records revealed that Resident R26 was admitted in the facility on December 1, 2025. R26 had diagnoses that included Dysphagia (difficulty swallowing food or liquids, making it hard for them to move from the mouth through the throat and into the stomach), Anemia (a condition where the blood lacks enough healthy red blood cells or hemoglobin, impairing oxygen transport, leading to fatigue, weakness, pale skin, and shortness of breath, often caused by iron deficiency, blood loss, or inherited disorders) and ,Gastrostomy Status (Gastrostomy status means a person has a surgically created opening (a stoma) into their stomach, usually to place a feeding tube (G-tube) for nutrition, fluids, or medication when they can't eat by mouth. It's a coded medical status, indicating the presence of this artificial opening for long-term access, requiring specific care for the site). Review of physician order dated December 1, 2025, for Resident R26 revealed an order to administer Tube Feed formula of Glucerna 1.2, at 45mls/hour, continuous every shift, until Osmolite is available. Review of physician order dated December 9, 2025, for Resident R26 revealed an order to administer Osmolite 1.5, 45mls/hour, Continuous, every shift Review of physician order dated December 18, 2025, for R26 revealed an order to administer Osmolite 1.5 45mls/hour, every shift, continuous; Ok (Agreed) to substitute Jevity 1.5 if Osmolite is not available. Review of physician order dated December 29, 2025, for Resident R26 revealed an order to administer two times a day Osmolite 1.5, at 55mls/hour for 12 hours overnight or until total volume infused; up at 1900, off at 0700; total volume to be infused: 660ml Review of Resident R26's care plan revealed under its focus area: The resident has a swallowing problem related to dysphagia, H/O (history of) PD, Peg tube placement on prior hospital-admission; Date Initiated: 12/02/2025; Revision on: 12/07/2025. Continued review of the resident's care plan revealed under its goal area: The resident will maintain weight and nutritional balance through the review date. Date Initiated: 12/02/2025, Target Date: 03/22/2026. The resident will have clear Lungs, no signs and symptoms of aspiration through the review date. Date Initiated: 12/02/2025; Revision on: 12/07/2025. The interventions stated to achieve the goal were All staff to be informed of resident's special dietary and safety needs. Date Initiated: 12/02/2025; Monitor for shortness of breath, choking, labored respirations, lung congestion; Date Initiated: 12/02/2025. Refer to Speech therapist for Swallowing Evaluation, Date Initiated: 12/02/2025 On January 5, 2026, at 11:52 a.m., review of the care plan of Resident R26, revealed that no care plan revision was made to the Peg tube-related focus, goals, and interventions based on different orders to administer different tube feedings, dated December 1, 2025; December 9, 2025; and December 18, 2025, respectively. At the time of the findings, interview with the Director of Nursing confirmed the same.28 Pa Code 211.10 (d) Resident care policies		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and staff interview, it was determined that the facility failed to provide assistance with toileting for one of 21 residents reviewed. (Resident R23) Findings include: Review of Resident R23's clinical record revealed that Resident R23 was admitted to the facility on [DATE], with diagnosis of but not limited to Hemiplegia/Hemiparesis (paralysis/weakness to one side of the body). Review of Resident R23's MDS (Minimum Data Set, a federally required resident assessment completed at a specific interval) dated October 2, 2025, Section C - Cognitive Pattern C0500 BIMS (brief interview for mental status) summary score was coded 11 indicating that Resident R23 was moderately impaired of cognition; Section GG - Functional Abilities, GG0130. Self-Care C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement was coded 04. Supervision or touching assistance, Section H - Bladder and Bowel, H0300. Urinary Continence was coded 2. Frequently incontinent, H0400. Bowel Continence was coded 2. Frequently incontinent. Review of Resident R23's care plan for incontinence of bowel and bladder at times related to Impaired Mobility. Further review of the care plan revealed that the resident requires assistance with ADLs (activities of daily living) r/t (related to) impaired mobility Date Initiated: 07/18/2024. The goal was for ADL care needs will be met through next review date and intervention included to: Provide assistance as required for completion of ADL tasks. Date Initiated: 07/18/2024. Observation of Resident R23's room conducted on December 29, 2025, at 11:44 AM together with Director of Nursing (DON) Employee E2 revealed that Resident R23's was in his room sitting on his bed, in street clothes. Further observation revealed a strong odor of urine coming from resident's room. Interview with Employee E2 conducted at the time of the observation confirmed that there was strong odor of urine in Resident R23. Further, Employee E2 revealed that Resident R23 tries to go to the bathroom on his own but sometimes doesn't make it to the bathroom. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(5) Nursing services		