

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396120	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/14/2026
NAME OF PROVIDER OR SUPPLIER: WYNCOTE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 208 FERNBROOK AVENUE WYNCOTE, PA 19095		
STATE LICENSE NUMBER: 232102				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0600 SS=D	Based on an Abbreviated Survey in response to two reported incidents completed April 14, 2026, it was determined that Wyncote Care Center was not in compliance with the following Requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations related to the health portion of the survey process	F 0600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0600 SS=D	Continued from page 1 483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 0600	1. A thorough investigation of allegations of abuse was conducted for Resident R1 and R2. Interviews and witness statements as applicable with other staff and/or residents completed for alleged abuse for Resident R1 and R2. Employee E3, nurse aide, was terminated based on multiple allegations and refusal to provide statement. Employee E4, nurse aide was found to be not involved with Resident R1 based on facility investigation. 2. Facility will ensure that there will be strictly zero tolerance for any resident abuse and neglect. Any allegations of abuse or neglect will be thoroughly investigated. Appropriate corrective action plans will be taken such as disciplinary action/terminations. 3. All staff will be reeducated on abuse/neglect policy and procedures as part of the facility's mandatory abuse and neglect training. All new hires will also be educated on topics of abuse/neglect policy and procedures as part of facility's orientation.	Completion Date: 05/13/2026 Status: APPROVED Date: 05/08/2026

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F 0600 SS=D	Continued from page 2	F 0600	4. The Administrator/Designee will monitor the frequency and pattern of all abuse allegations and follow up investigations. Any areas of non-compliance will be addressed in QAPI for two quarters or until substantial compliance is met.	

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F 0600 SS=D	Continued from page 3 Based on review of facility policy, review of clinical records, observation, and staff interviews, it was determined the facility failed to ensure that residents were free from abuse for two of 2 residents reviewed related physical and verbal abuse allegations (Resident R1, Resident R2). Findings include: Review of facility policy titled "Abuse, Neglect and Exploitation Policy" dated May 1, 2025, revealed "Wyncote Care Center maintains zero tolerance for abuse, neglect, exploitation, involuntary seclusion and misappropriation of resident property. All residents have to the right to be free from such conduct". Review of Facility Education titled "Annual in-service training: abuse, neglect and exploitation", undated, "Abuse: The willful infliction of injury, intimidation punishment, or deprivation that leads to harm or the risk of harm. This encompasses physical, emotional, sexual, and verbal abuse." Review of Resident R1's clinical record revealed resident was admitted to the facility on November 24, 2020, with a diagnosis of dementia (progressive disease of the brain resulting in loss of reality). Review of Resident R1's quarterly MDS (Minimum Data	F 0600		

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F 0600 SS=D	Continued from page 4 Set- assessment of resident's care needs), dated January 1, 2026, revealed resident's BIMS (Brief interview for Mental Status) of 15, indicating resident cognitively intact. Review of facility investigation dated February 19, 2026, at 11:10 p.m., revealed resident statement "A couple nights ago there were 2 people who came to change me. A black man maybe in his 50's and a kind of heavy-set black woman. I told them I didn't want to get changed but they went ahead and turned me violently. In fact, the man hit me- maybe I slugged first. There is no excuse for violence. It was late at night in the evening at about 10:30 p.m. They refused to listen to me, and they insisted in a violent way to change me. Every time they tried to turn me, I resisted. He gripped me with a very strong grip, but I couldn't break him. I never gave in, but they continued to. There was a lot of swearing by me and him, she has a bad temper too. I don't know his name, but I recognize him. He was in charge, but she went along. The woman is the person who took care of me tonight (Employee E3)". Further review of facility investigation revealed statement from Employee E5, Nursing Supervisor, "Resident R1 denies any pain or injury related to this event. No visible bruising noted. Also, the male nursing assistant [Resident R1] was referring to is [Nurse aide, Employee E4], identified by [Employee E3]". Interview with Employee E2, Director of Nursing on April	F 0600		

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F 0600 SS=D	Continued from page 5 14, 2026, revealed "[Nurse aide Employee E3] was terminated based on multiple allegations and refused to provide a statement and [Nurse aide, Employee E4] was not terminated because he provided a statement and since he had no other allegations, they did not terminate employment". Review of information reported to the State Survey Agency revealed "Upon investigation, the male nursing assistant (Employee E4) did not appear to be involved in the incident. The allegation against the female nursing assistant (Employee E3) was substantiated and she was subsequently terminated". Review of Resident R2's clinical record revealed resident was admitted to the facility on September 21, 2022, with diagnosis of cerebral infarction (disrupted blood flow to the brain). Review of Resident R2's Significant Change MDS (Minimum data set) dated December 23, 2023, revealed resident's BIMS (Brief interview for mental status) score of 9, indicating moderately cognitively impaired. Review of facility investigation dated February 19, 2026, revealed Resident R2's statement, dated February 19, 2026, at 11:10 p.m., "She hit me (referring to Employee E3, Nursing aide), she slapped my wrist three times and then she grabbed my glasses. It just happened."	F 0600		

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F 0600 SS=D	Continued from page 6 Review of documentation submitted to the State Survey Agency for Employee E3, Nursing assistant, revealed "Based on the Resident's statement and demonstration of the incident, there is sufficient concern regarding inappropriate physical interaction. The allegation was taken seriously and reported according to facility policy." "Findings: substantiated". Review of facility reported incident, dated February 19, 2026, at 11:10 p.m., revealed "Allegation is substantiated". Interview with Employee E1, Nursing Home Administrator on April 14, 2026, at 12:13 p.m., confirmed all findings. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.29(d) Resident Rights	F 0600		
F 0610 SS=D		F 0610		

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F 0610 SS=D	Continued from page 7 483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0610	1. A thorough investigation of allegations of abuse was conducted for Resident R1 and Resident R3. Interviews and witness statements as applicable with other staff and/or residents completed for alleged abuse for Resident R1 and R3. 2. A review of facility investigation procedures was reevaluated. Facility administration will ensure thorough investigations including but not limiting to collecting witness statements and conducting staff/resident interviews for any alleged abuse cases are completed. 3. The Director of Nursing was educated and in-serviced by the Administrator on ensuring a complete and thorough investigation is complete for all allegations of resident abuse. Statements and interviews to be conducted where applicable and ensure timely reporting of incidents and documentation to the Administrator and the Department of Health. 4. The Administrator/Designee will monitor all reportable incidents	Completion Date: 05/13/2026 Status: APPROVED Date: 05/08/2026

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F 0610 SS=D	Continued from page 8	F 0610	pertaining to resident abuse/neglect and any identified non-compliance with reporting procedures will be reported to the QAPI committee.	

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F 0610 SS=D	Continued from page 9 Based on staff interviews, review of facility documentation and the review of clinical records, it was determined that the facility failed to ensure that a complete and through investigation was completed related to abuse allegations for 2 out of 3 residents reviewed (Resident R1 and Resident R3). Findings include: Review of facility policy titled "Abuse, Neglect and Exploitation Policy" dated May 1, 2025, revealed "Wyncote Care Center maintains zero tolerance for abuse, neglect, exploitation, involuntary seclusion and misappropriation of resident property. All residents have to the right to be free from such conduct". Review of Facility Education titled "Annual in-service training: abuse, neglect and exploitation", undated, "Abuse: The willful infliction of injury, intimidation punishment, or deprivation that leads to harm or the risk of harm. This encompasses physical, emotional, sexual, and verbal abuse." Further review revealed "Protocol for responding to abuse: Documentation must be objective and factual, including details of who, what, when, where and witness statements." Review of Resident R1 clinical record revealed resident was admitted to the facility on November 24, 2020, with a diagnosis of dementia (progressive disease of the brain).	F 0610		

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F 0610 SS=D	Continued from page 10 Review of Resident R1's Quarterly MDS (Minimum Data Set), dated January 1, 2026, revealed resident's BIMS (Brief interview for Mental Status) of 15, indicating resident cognitively intact. Review of facility investigation dated February 19, 2026, at 11:10 p.m., revealed resident statement "A couple nights ago there were 2 people who came to change me. A black man maybe in his 50's and a kind of heavy-set black woman. I told them I didn't want to get changed but they went ahead and turned me violently. In fact, the man hit me- maybe I slugged first. There is no excuse for violence. It was late at night in the evening at about 10:30 p.m. They refused to listen to me, and they insisted in a violent way to change me. Every time they tried to turn me, I resisted. He gripped me with a very strong grip, but I couldn't break him. I never gave in, but they continued to. There was a lot of swearing by me and him, she has a bad temper too. I don't know his name, but I recognize him. He was in charge, but she went along. The woman is the person who took care of me tonight (Nurse aide, Employee E3)". Further review of facility investigation revealed statement from Employee E5, Nursing Supervisor, "Resident R1 denies any pain or injury related to this event. No visible bruising noted. Also, the male nursing assistant resident R1 was referring to is Employee E4, nursing assistant identified by Employee E3, nursing assistant".	F 0610		

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F 0610 SS=D	Continued from page 11 Further review of facility investigation revealed no documented evidence of statements from other staff or other residents on the unit regarding concerns of abuse or incident. Interview with Employee E2, Director of Nursing on April 14, 2026, at 11:30 a.m. confirmed no interviews with other staff or residents completed after the reported incident. Review of Resident R3's clinical record revealed resident was admitted to the facility on February 2, 2026 with diagnosis of fracture to left fibula (broken leg). Review of Resident R3's Admission MDS (Minimum Data Set), dated February 8, 2026, revealed resident's BIMS (Brief interview for Mental Status) of 15, indicating resident cognitively intact. Review of Resident R3's Comprehensive Care Plan, date initiated April 6, 2026, "Resident exhibits behavioral concerns, including verbal aggression such as cursing at other residents and staff. The resident demonstrates inappropriate verbal behavior, including cursing directed toward other residents and staff." Interventions include: "Staff will monitor and document all episodes of verbal aggression, including triggers and frequency. Provide redirection and verbal cues when inappropriate language begins. Encourage the resident to use appropriate words to	F 0610		

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F 0610 SS=D	Continued from page 12 express needs and feelings. Maintain a calm, non-confrontational approach when responding to the resident." Review of facility grievance, dated March 11, 2026, revealed that Resident R3 "States Nurse (Employee E6, registered nurse) was being unprofessional said he cursed at him. Resident became very upset and began to yell at Employee E6. Resident said he was talking to another resident and Employee E6 chimed in. States he had no reason to speak to him, and he shouldn't be around people if he is going to be unprofessional." Further review of facility grievance revealed "resolution of grievance/complaint: Complaint investigated by ADON (Assistant Director of Nursing) and administration. Findings confirmed inappropriate and unprofessional communication by employees toward resident. The facility employee was terminated in accordance with facility policy. Resident informed that the concern was addressed and corrective action taken." Review of facility investigation revealed statement from Employee E7, Assistant Director of Nursing, revealed "I was in my office when I heard a commotion coming from the hallway near the nursing station. Upon listening, I heard a staff nurse, "you heard me, boy," while walking away down the hallway from the resident. The resident was positioned near the nursing station in the hallway at the	F 0610		

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F 0610 SS=D	Continued from page 13 time. Following the statement, I heard the resident respond, "What you call me? No physical contact observed. My observation was limited to what I heard and positioning of the individuals in the hallway". Further review of facility investigation revealed statement from Employee E8, Social Worker, revealed "I came upstairs for my rounds. In the mist of my rounds, I heard a loud commotion between Resident R3 and Employee E6, Registered Nurse. I heard the Registered Nurse (Employee E6) call Resident R3 a boy. I then took the resident into the rehab room to calm him down". Further review of facility investigation revealed no documented evidence of statement from Resident R3 or other residents on the nursing unit regarding concerns of abuse or incident. Interview with Employee E2, Director of Nursing on April 14, 2026, at 11:30 a.m. confirmed no interviews were conducted with other residents or Resident R3 after the reported incident. Upon request for investigation, Employee E2, Director of Nursing stated, "well I have to run around and collect all the pieces of information from everyone because it's not all together some of it is with the social worker, some of it is with the ADON (Assistant Director of Nursing) and some of it is in my office in piles that I have to sift through".	F 0610		

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F 0610 SS=D	Continued from page 14 28 Pa. Code:201.18(a)(1)(3) Management 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing Services	F 0610			



Certified End Page

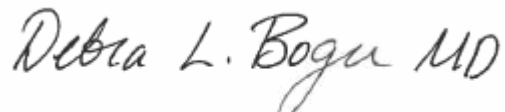
WYNCOTE CARE CENTER

STATE LICENSE NUMBER: 232102

SURVEY EXIT DATE: 04/14/2026

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY