STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396015	A. Building B. Wing	01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Woods at Huntingdo	360 Westminster Drive Huntingdon, PA 16652

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 31760 Based on a review of clinical records and facility reports, as well as staff interviews, it was determined that the facility failed to have adequate supervision and interventions in place to prevent elopement for two of two residents reviewed (Residents 1, 2) who were identified as at risk for elopement. This deficiency was cited as past non-compliance. Findings include: A nursing note for Resident 1, dated January 15, 2024, at 3:23 p.m., revealed that the resident arrived at the facility at 2:00 p.m. via wheelchair with a diagnosis of altered mental status. His mobility status was supervision with a folding wheeled walker. He was alert to self and knew that he was about 10 miles past his house. Discharge plans for the resident was for short-term rehabilitation and return home when he is ready for discharge. An Elopement Risk for Resident 1, dated January 15, 2024, at 3:12 p.m., revealed that the resident scored a 10, indicating that the resident was at risk for elopement. A nursing note for Resident 1, dated January 15, 2024, at 4:17 p.m., revealed that the resident's elopement score was a 10, so a roam-alert device (monitors wandering residents or high-risk residents, while maintaining their dignity to move freely about a facility) was placed on his left wrist. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note for Resident 1, dated January 15, 2024, at 8:04 p.m., revealed that the resident was seen directly before the incident by the registered nurse ambulating (walking) with his walker in the main crossway of the nursing station and dining room. At approximately 5:30 p.m. the resident was wearing a crew neck sweatshirt with holes, blue plaid pajama pants, a red hat, and New Balance sneakers. The resident stated that he needed to head home to get a fire started. The registered nurse informed the resident that it was too cold out tonight and that his grandson was taking care of the wood stove at his home and that we would love for him to stay the night with us due to the weather being bad. The resident stated, You gotta do what you gotta do. The resident asked for directions, and the nurse informed him that all of the doors were secured. He stated, I might not even be able to go if I can't find my truck. The resident remained in the main area at this time. The Wanderguard was in place on his left wrist. The registered nurse then went to the administration hallway to obtain items from the printer, returned to the main area, and the resident was not seen. The registered nurse then informed staff to be cognizant of his where abouts, because he was beginning to exit seek. Rounds were made around the 300 and 400 halls to make all staff aware, and then the 100 and 200 halls. The resident was not seen. No alarms had sounded to indicate an exit from the building. The registered nurse asked the receptionist if the resident had approached the front. She was in the process of uploading the resident's photo to the chart at that time. The resident's picture was reviewed, and the resident was not recognized at that time. Staff search was being conducted as the resident approached the back door of the 400 hall at approximately 5:50 p.m. and was let in by the licensed practical nurse. When questioned on what he was doing the resident giggled and said, I was just going for my moonlit stroll; it's not that cold out. The nurse asked how he got out of the building and the resident stated that he was let out the front door. Wanderguards were checked and were functioning. A building-wide security check was performed. Maintenance and administration were made aware of the situation and the on-call provider was made aware. The resident's son was updated and was very understanding. A second Wanderguard was placed on the resident, and frequent visual checks continue to be performed. The facility investigation documents, dated January 15, 2024, revealed that while standing at the medication cart the licensed practical nurse heard a knock on the door near the back nursing station. Resident 1 was observed standing outside. The licensed practical nurse let the resident in the door and notified the registered nurse. Resident 1 was reoriented and checked for injuries. Resident 1 stated, I was out on my moonlight walk. When asked how he got outside he stated, I walked out to the front and the lady let me out the doors. A witness statement completed by Receptionist 1, dated January 15, 2024, revealed that two nurses came to her asking if she saw Resident 1 go out the front door, because she was not aware of what he looked like. She said that she did not see him walk out and that it was possible he went out with visitors. She never heard an ankle monitor go off. At 7:30 p.m. Receptionist 1 added that upon someone looking at the camera footage, she clearly left Resident 1 out the door, not knowing that he was a resident. An interdisciplinary team note for Resident 1, dated January 16, 2024, revealed that the resident was new to the facility as of last evening. Staff provided a Wanderguard at the time of the admission assessment. Frequent monitoring in the common areas was being provided. The staff was made aware of the resident's exit-seeking behavior. Maintenance reviewed the camera footage and identified that the resident was permitted to go out the front door by the receptionist. When Resident 1 was located, the registered nurse supervisor assessed him and no injuries were identified. All Wanderguard equipment was checked throughout the building and was working properly. Frequent checks were continued. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Receptionist 1 on January 23, 2024, at 11:55 a.m. revealed that the main entrance is staffed 8:00 a.m. to 8:00 p.m. through the week and from 8:00 a.m. to 4:00 p.m. on Saturday and Sunday. She indicated that after they leave, the doors are locked and you need a code to get out. She also indicated that nursing would advise the receptionist if a resident had a Wanderguard so that they could put a picture in the book that is kept at the desk. She stated that he was a new resident and that she had not yet received a photo of him and was not familiar with him. She indicated that she did not hear any alarms going off that night. Interview with the Director of Environmental Services on January 23, 2024, at 12:55 p.m. revealed that the receptionist has a button to open the main doors whenever a visitor leaves the facility. He indicated that when that button is pushed it deactivates the Wanderguard system. He indicated that he watched the camera footage from that night and Receptionist 1 left two visitors out the main door, then Resident 1 came into view and was also left out the door. She must not have heard the alarm. He revealed that he got the Wanderguard bracelet that was on the resident and checked it at the main doors and it worked appropriately. Following the incident on January 15, 2024, the facility's corrective actions included: Placing a second Wanderguard on the resident and performing frequent checks. Roam alert log was verified to be accurate and current residents with roam alerts accounted for. Doors and alarms were inspected by Director of Environmental Services and verified in working order. Residents with roam alert orders were verified to be accurate. Introduced a procedure for elopement-risk resident identification process. Education was initiated to current employees on elopement policy, nursing employees were educated on identification of elopement risk resident process, and receptionist employees were educated on roam alert binder and exit monitoring process. Education of in-house staff was completed on January 15, 2024, and remaining staff upon next scheduled shift. The Director of Environmental Services and/or designee will complete an audit of all exit doors daily for one week, three times per week for two weeks, and one time a week for two weeks, and monthly for one month. The results of these audits will be brought to Quality Assurance Performance Improvement (QAPI) committee for further analysis and corrective actions if necessary. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated November 23, 2023, revealed that the resident was understood, understands, and had a diagnosis which included dementia. A care plan for the resident, dated November 23, 2023, revealed that the resident has impaired decision with a diagnosis of dementia and that the resident ambulates (walks) independently with a folding wheeled walker. Physician's orders for the resident, dated May 30, 2023, included an order for the staff to check the placement of the resident's roam alert every shift, and to check the roam alert battery weekly. An Elopement Risk for Resident 2, dated November 22, 2023, revealed that the resident scored a 10, indicating that he was a risk for elopement. A nursing note for Resident 2, dated January 17, 2024, revealed that the resident walked out the emergency exit on the 200 Hall during a fire alarm. The fire alarm was activated for approximately three minutes when the nurse aide found the resident knocking on the (unlocked due to fire alarm) door to be let back in. The nurse aide notified the registered nurse and the licensed practical nurse. No injuries were noted to the resident. A nursing note at 5:20 a.m. revealed that the writer was notified by the nurse aide at 1:20 a.m. that the resident was found outside of the building knocking on the emergency exit door in the back of the 200 Hall to be let back into the building. The incident occurred during a fire alarm when the door alarms and Wanderguards do not function properly. The resident was promptly assisted back inside the building by the nurse aide at the time he was found. The Wanderguard was in place and functioning properly in the absence of the fire alarm sounding. The facility investigation documents, dated January 17, 2024, at 1:20 a.m. revealed that the resident stated that he walked out the door and it closed behind him. He stated that he turned back around immediately and tried to get back in. When asked why he went out the door he said he saw the flashing lights and was looking for his truck. Interview with the Director of Environmental Services on January 23, 2024, at 12:55 p.m. revealed that when the fire alarms activate it unlocks the exit door magnets, so that you can exit in the event of a fire or other emergency. He indicated that the door that Resident 2 went out did not have the Wanderguard system on, that it only had the magnet locking system on where you must wait 15 seconds before opening the door to exit. He indicated that when opening the door, it will still sound an alarm. He indicated that after that incident he went out and bought small window alarms until he could get larger alarms installed on the doors. Following the incident on January 17, 2024, the facility's corrective actions included: Verified the resident accountability census was complete and all residents were accounted for. Initiated staff monitoring to round exit doors until installation of an updated alarming system. Education was initiated to current employees on emergency procedure process to include checking exit doors as a response to a fire alarm. Additional door alarms were placed on exit doors to alert staff upon opening. Education of in-house staff and installation was completed on January 17, 2024. Remaining education was to be completed upon next scheduled shift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Environmental Services and/or designee will complete an audit of all exit doors daily for one week, three times per week for two weeks, and one time a week for two weeks, and monthly for one month. The results of these audits will be brought to QAPI committee for further analysis and corrective actions if necessary. Interviews with the facility's nursing staff revealed that they received re-education on identification of the elopement-risk resident process, on the emergency procedure process that included checking exit doors as a response to a fire alarm, and on the additional alarms placed on the exit doors. Interviews with the facility's receptionists revealed that they received re-education on the roam alert binder and exit monitoring process. An interview with the Nursing Home Administrator, as well as a review of the facility's corrective actions, revealed that the facility was in compliance with F689 on January 20, 2024. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(5) Nursing services.