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Form Approved OMB
No. 0938-0391

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	03/14/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 38012 Based on a review of facility policies, clinical records, and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from sexual abuse for one of four residents reviewed (Resident 2). This was cited as past non-compliance. Findings include: The facility's abuse policy, dated January 22, 2025, revealed that each resident would be provided with a safe environment where they are not subject to mental, physical, verbal, and sexual abuse. Residents shall be protected from mistreatment, neglect, exploitation, and misappropriation of property. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated February 10, 2025, indicated that the resident was severely cognitively impaired, was rarely understood and could sometimes understand others, was ambulatory, and had diagnoses that included vascular dementia (memory loss). Review of information submitted by the facility, dated March 7, 2025, indicated that Maintenance Worker 1 was observed by Nurse Aide 2 and Nurse Aide 3 to be straddling Resident 2 while she was seated in her recliner chair, hugging the resident, and rubbing the resident's flank area under her shirt. Investigative interview statements from Maintenance Worker 1, dated March 10, 2025, revealed that he did give Resident 2 a hug because he felt bad she did not have any visitors, but that he could not recall if his hand was under her shirt or not. Nurse Aide 2 then took out her personal cell phone and recorded a video of Maintenance Worker 1 hugging and stroking the resident's flank area with his hand under her shirt. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Investigative interview statements from Nurse Aide 2, dated March 7, 2025, revealed that while she was walking past Resident 2's room she observed Maintenance Worker 1 standing over Resident 2 straddling her legs. She stated that it seemed odd and that she then went back to that area to see what he was doing and she then observed him standing next to her straddling the arm rest of the chair that the resident was sitting in. Nurse Aide 1 then grabbed Nurse Aide 2 so that she could confirm that what she saw was what was actually occurring. When the two nurse aides returned to the resident's doorway, they saw Maintenance Worker 1 with his hand under Resident 2's shirt and he was rubbing her side. She stated that Maintenance Worker 1 continued to look over his shoulder toward the door way. She stated that it was at that time that she took out her personal cell phone and recorded what was occurring because she did not think that anyone would believe her. Investigative interview statements from Nurse Aide 3, dated March 7, 2025, indicated that Nurse Aide 2 grabbed her and said that she witnessed Resident 2 touch Maintenance Worker 1's privates. She stated that when she looked into Resident 2's room she observed Maintenance Worker 1 standing to the left of Resident 2 while she was sitting in her recliner chair and they were hugging and that his hand was on her right side at her hips and was under her shirt. Interview with the Nursing Home Administrator on March 15, 2025, at 10:47 a.m. revealed that Maintenance Worker 1 was immediately removed from the building pending the investigation and that he was terminated from employment. Following the incident on March 7, 2025, the facility's corrective actions included: On March 7, 2025 Resident 2 had a Registered Nurse assessment completed and no injuries were identified. The Social Services Director interviewed the resident and no ill emotional effects were identified. Maintenance Worker 1 was placed on administrative leave immediately on March 7, 2025. The police, Area Agency on Aging, and the PA Department of Health were notified immediately. All residents residing in the nursing facility were assessed by a Registered Nurse and no injuries were identified. All residents were interviewed by licensed staff and the social services director and none identified concerns related to sexual behavior. The Director of Nursing or designee educated all staff by March 10, 2025, regarding the facility's abuse policy and reporting abuse. The Social Services Director will conduct an audit weekly for four weeks and monthly for two months. Any identified allegations will be immediately reported to the Nursing Home Administrator or designee. Results of these audits will be forwarded to quarterly quality assurance meetings for review and recommendations. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 201.29(j) Resident Rights.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 38012 Based on review of facility policies, clinical records, and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from being recorded on a personal cell phone without their permission for one of four residents reviewed (Resident 2). Findings include: The facility's abuse policy, dated January 22, 2025, revealed that each resident would be provided with a safe environment where they are not subject to mental, physical, verbal, and sexual abuse. Residents shall be protected from mistreatment, neglect exploitation, and misappropriation of property. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated February 10, 2025, indicated that the resident was severely cognitively impaired, was rarely understood and could sometimes understand others, was ambulatory, and had diagnoses that included vascular dementia (memory loss). Review of information submitted by the facility, dated March 7, 2025, indicated that Maintenance Worker 1 was observed by Nurse Aide 2 and Nurse Aide 3 to be straddling Resident 2 while she was seated in her recliner chair, hugging the resident, and rubbing the residents flank area under her shirt. Investigative interview statements from Maintenance Worker 1, dated March 10, 2025, revealed that he did give Resident 2 a hug because he felt bad she did not have any visitors, but that he could not recall if his hand was under her shirt or not. Nurse Aide 2 then took out her personal cell phone and recorded a video of Maintenance Worker 1 hugging and stroking the resident's flank area with his hand under her shirt. Investigative interview statements from Nurse Aide 2, dated March 7, 2025, revealed that while she was walking past Resident 2's room she observed Maintenance Worker 1 standing over Resident 2 straddling her legs. She stated that it seemed odd and that she then went back to that area to see what he was doing and she then observed him standing next to her straddling the arm rest of the chair that the resident was sitting in. Nurse Aide 1 then grabbed Nurse Aide 2 so that she could confirm that what she saw was what was actually occurring. When the two nurse aides returned to the resident's doorway, they saw Maintenance Worker 1 with his hand under Resident 2's shirt and he was rubbing her side. She stated that Maintenance Worker 1 continued to look over his shoulder toward the door way. She stated that it was at that time that she took out her personal cell phone and recorded what was occurring because she did not think that anyone would believe her. The resident's face was not visible in the video and the resident could not be identified in the video. Investigative interview statements from Nurse Aide 3, dated March 7, 2025, indicated that Nurse Aide 2 grabbed her and said that she witnessed Resident 2 touch Maintenance Worker 1's privates. She stated that when she looked into Resident 2's room she observed Maintenance Worker 1 standing to the left of Resident 2 while she was sitting in her recliner chair and they were hugging and that his hand was on her right side at her hips and was under her shirt. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Nursing Home Administrator on March 15, 2025, at 10:47 a.m. revealed that employees were not to use their personal cell phones for any reason during working hours and that Nurse Aide 2 should not have recording a video of Resident 2, no matter the circumstances. She stated that Nurse Aide 2 stated that she knew she should not have recorded anything prior to showing her the video. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 201.29(j) Resident Rights.