| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 396015 | A. Building<br>B. Wing | 04/08/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westminster Woods at Huntingdo | 360 Westminster Drive<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>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 neglect for one of three residents reviewed (Resident 1). Findings include: The facility's abuse policy, dated December 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 1, dated February 2, 2026, indicated that the resident was cognitively intact, was understood and could understand others, was dependent on staff for daily care needs, was incontinent of bowel and bladder and had diagnoses that included vascular Amyotrophic Lateral Sclerosis (a progressive, fatal neurodegenerative disease that destroys motor neurons in the brain and spinal cord, causing loss of movement, speech and breathing). Information submitted by the facility, dated March 17, 2026, revealed that on the evening of March 16, 2026 Resident 1 alleged that he did not receive proper care and had not been changed since about 5:00 p.m. The Nurse Aide assigned to provide his care was Nurse Aide 4. Nurse Aide 2 reported to this to Registered Nurse 1. A registered nurse assessment was conducted on March 16, 2026, at 11:56 p.m. and Registered Nurse 1 noted that Resident 1's brief was saturated, as well as his bedding. It was also noted that his call bell was not within reach, it was located at the top of his bed. A skin assessment revealed an area on the back of Resident 1's left thigh measuring 10.0 cm x 0.1 cm that was purple and did not blanch; an 8.0 cm x 0.1 cm red blanchable area on his left thigh; an open excoriated area on his abdominal fold measuring 5.0 cm x 0.1cm; and an open excoriated area on his right groin that measured 7.0 cm x 0.3 cm. Investigative interview statement from Nurse Aide 2, dated March 17, 2025, revealed that Resident 1 called out to her and stated that he had been laying in his bed for 6 hours and no one came to help him. Nurse Aide 2 and Nurse Aide 3 changed all urine saturated bed linen and the incontinence brief and it was also noted that Resident 1 had a bowel movement. Resident 1 received incontinence care, and all of his bedding was changed to fresh linen. Investigation documents revealed that the Director of Nursing was notified March 17, 2026, at 8:30 a.m. and the Medical Doctor was notified with no new orders being received. Nurse Aide 4 was immediately placed on leave pending investigation. Pennsylvania Department of Health, Area Agency on Aging and the local police were notified of the event. Resident 1 is care planned as his own representative and did not want his spouse notified. Investigation documents revealed an interview with Nurse Aide 4 on March 17, 2026, that confirmed she did not provide care to Resident 1 because he always rings his call bell when he needs care. She did not provide care because he did not ring his call bell. The facility's investigation included interviews with all residents that Nurse Aide 4 cared for on March 16, 2026, and there were no further concerns. A skin assessment for Resident 1 completed March 19, 2026, revealed that all areas of concern were resolved. Education was provided to staff regarding resident care and the importance of ensuring all personal belongings and call bells are within reach prior to leaving a resident's room. Investigation documents revealed that due to Nurse Aide 4 not providing care to Resident 1 the allegation of neglect<br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was substantiated and Nurse Aide 4 was terminated. Interview with the Nursing Home Administrator on April 8. 2026, at 2:45 p.m. confirmed that Resident 1 should have had care provided to him and he did not and that the allegation of neglect was substantiated and Nurse Aide 4 was terminated from employment. 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. |