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	06/09/2026

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. Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure a safe environment for one of four residents reviewed (Resident 2) resulting in aspiration. This deficiency is being cited as past non-compliance. Findings include: A comprehensive minimum data set (MDS) assessment (mandated to assess the resident abilities and care needs) for Resident 2, dated May 11, 2026, revealed that the resident was severely cognitively impaired, required assistance from staff, and had a mechanical diet. A care plan for activities of daily living, dated July 3, 2025, indicated that Resident 2 required set-up by staff to eat, needed to be encouraged to eat meals in the dining room, and to supervise meals and monitor for pocketing of food. A speech therapy discharge summary for Resident 2, dated April 23, 2026, recommended skilled treatment interventions focused on education and training patient and caregivers in safe swallowing strategies in order to safely tolerate least restrictive diet. It was also recommended for the patient to sit at an assist table to help utilize safe swallowing strategies, including rate modification. A nursing note for Resident 2, dated May 15, 2026, at 8:05 p.m. revealed that the resident's dinner tray was sitting at the side of her bed with a small amount of mashed potatoes eaten. She was checked and it was noticed that she had mashed potatoes in her mouth. Resident 2 was gurgling, her eyes were fixed, and she was diaphoretic. Staff immediately sat the resident up and instructed for her to cough and get it out. She coughed until her breathing sounded clear again. A nursing note for Resident 2, dated May 15, 2026, at 8:15 p.m. revealed that the resident was observed gurgling indicating evidence that she had aspirated. Resident 2's lung sounds were diminished in the bases. Resident 2 continued to cough. The Physician's Assistant was contacted. New orders were obtained for a chest x-ray and 40 milligrams Prednisone (corticosteroid medication used to reduce inflammation) daily for five days. A provider's note dated May 18, 2026, at 4:30 p.m. indicated that Resident 2 was evaluated for follow up as she was having wheezing and cough over the weekend. She was found to have pneumonia and was started on scheduled duo nebs (breathing treatment, Robitussin (cough suppressant), and Augmentin (antibiotic medication). She was seen today sitting outside her room and denies any shortness of breath or pain at this time. A witness statement dated May 15, 2026, by Nurse Aide 1 indicated that Resident 2 was not coming to the dining room, her tray was set up at bedside, and Nurse Aide 1 left the room. An interview with Director of Nursing June 9, 2026, at 4:47 p.m. revealed that Resident 2's care plan was multiple pages long and staff did not scroll down enough to see that she also required supervision while eating. The care plan was changed to a language that was easier to read. The Director of Nursing confirmed that Resident 2 should have been supervised while eating on May 15, 2026, as was not. Following the incident on May 15, 2026, the facility's corrective actions included: 1. Involved resident's care plan/Kardex was updated to include eating support interventions by May 20, 2026. 2. The Director of Nursing or designee conducted an audit of current residents to ensure readability of interventions on residents' Kardex by June 5, 2026 3. Education records, dated May 21, 22, and 23 2026, revealed the Director of Nursing or designee will provide re-education to current nurse aides on locating and visualizing the Kardex by May 25, 2026. 4. The Director of Nursing or designee will conduct audits on three nurse aides weekly for four weeks, then monthly for two (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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(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	months to ensure capability of viewing and understanding of Kardex interventions. Results of audits would be brought to QAPI for review and recommendations. Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F689 on June 5, 2026. 28 Pa. Code 211.12(d)(5) Nursing services.