

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  396015	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/16/2024
NAME OF PROVIDER OR SUPPLIER  Westminster Woods at Huntingdon		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>48809</p> <p>Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to provide confidentiality of residents' personal health information during medication administration for one of 31 residents reviewed (Resident 48).</p> <p>Findings include:</p> <p>The facility policy regarding privacy of health information, dated March 26, 2024, indicated that the facility was to protect the confidentiality of a resident's health information.</p> <p>Observations during medication administration on May 14, 2024, at 8:21 a.m. revealed that Licensed Practical Nurse 3 walked away from her medication cart to take the blood pressure of Resident 48 without securing her computer screen. Resident 48's personal health information was visible on the computer screen, which was facing the hallway. Upon return to the cart after obtaining the blood pressure, Licensed Practical Nurse 3 retrieved medication to administer to Resident 48 and again left the computer screen unsecured with Resident 48's personal health information visible and facing the hallway.</p> <p>Interview with Licensed Practical Nurse 3 on May 14, 2024, at 8:27 a.m. confirmed that she should have covered Resident 48's personal information on the computer screen when leaving the medication cart.</p> <p>Interview with the Director of Nursing on May 16, 2024, at 8:41 a.m. confirmed that the computer screen with residents' personal health information should have been covered when the nurse was not attending the medication cart.</p> <p>28 Pa. Code 211.5(b) Clinical Records.</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>28177</p> <p>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to provide care and treatment in accordance with professional standards of practice by failing to further assess an elevated blood pressure for one of 31 residents reviewed (Resident 29).</p> <p>Findings include</p> <p>The facility's policy regarding vital signs, dated March 26, 2024, revealed that vital signs are a measure of a resident's condition that assist in providing necessary services. The American Medical Association, Best Practice guidelines for blood pressure, dated December 2018, revealed that providers need to be aware of blood pressures that are out of range so they can act rapidly to intervene as appropriate.</p> <p>An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 29, dated March 26, 2024, revealed that the resident was moderately cognitively impaired, usually understood and understands, and had diagnoses that include chronic kidney disease and primary hypertension (high blood pressure). Physician orders for Resident 29, dated April 10, 2024, included an order for the resident to receive 20 milligrams (mg) of Lisinopril (used to treat high blood pressure) twice a day and 6.25 mg of Carvedilol (used to treat high blood pressure) twice a day for hypertension.</p> <p>A physician's assistant note for Resident 29, dated April 22, 2024, indicated that the resident was currently being followed for both orthostatic hypotension (low blood pressure when standing quickly) and essential hypertension (abnormally high blood pressure), in addition to syncopal (fainting) episodes and related falls.</p> <p>Review of Resident 29's clinical record for May 12, 2024, indicated that at 8:40 p.m. her blood pressure was 139/94 millimeters of mercury (mm/Hg) and at 8:51 a.m. her blood pressure was recorded as 197/86 mm/Hg.</p> <p>The American College of Cardiology and the American Heart Association determined that a normal blood pressure is 120/80 mm/Hg.</p> <p>There was no documented evidence in Resident 29's clinical record for May 13, 2024, that the elevated blood pressure of 197/86 mm/Hg was reassessed.</p> <p>Interview with Registered Nurse 1 on May 16, 2024, at 10:20 a.m. confirmed that Resident 29 has variable blood pressures; however, an elevated pressure of 197/86 mm/Hg would warrant a recheck and evaluation of the resident. Further assessment would include, rechecking the blood pressure with a different type of cuff, administering blood pressure meds as ordered and then rechecking the blood pressure with in an hour, alerting the MD as needed, and documentation in the residents progress notes.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Licensed Practical Nurse 2 on May 16, 2024, at 12:01 p.m. confirmed that she works with Resident 29 and if she obtained a blood pressure reading of 197/86 mm/Hg she would immediately retake the pressure with a different type of cuff or an automatic style cuff and if it was still elevated, she would alert the registered nurse to call the doctor and document any findings in the resident's progress notes.</p> <p>Interview with the Director of Nursing on May 16, 2024, at 3:30 p.m. confirmed that Resident 29 had an elevated blood pressure that warranted further assessment, which was not done, and should have been.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>48809</p> <p>Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to ensure that the residents' environment remained as free of accident hazards as possible by transporting a resident without leg rests for one of 31 residents reviewed (Resident 47).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a federally-mandated assessment of a resident's abilities and care needs) for Resident 47, dated March 29, 2024, revealed that the resident was cognitively impaired, required moderate assistance for all of her care, and used a wheelchair.</p> <p>Observations on May 13, 2024, at 11:44 a.m. revealed that Registered Nurse 4 pushed Resident 47 in a wheelchair without any leg/foot rests from her room through the hallway and into the dining room while the resident elevated her feet. The leg/foot rests were not on the resident's wheelchair.</p> <p>An interview with Registered Nurse 4 on May 13, 2024, at 11:47 a.m. revealed that she was aware that leg rests were to be used when transporting Resident 47 in her wheelchair.</p> <p>An interview with the Director of Nursing on May 13, 2024, at 2:34 p.m. confirmed that staff, agency staff, and hospice staff should be using leg/footrests on wheelchairs when residents are being transported in their wheelchairs.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>42079</p> <p>Based on review clinical records, as well as staff interviews, it was determined that the facility failed to ensure that monthly pharmacy medication reviews were completed for two of 31 residents reviewed (Residents 3, 14).</p> <p>Findings include:</p> <p>The facility policy regarding Consultant Pharmacist report, dated March 26, 2024, indicated that the comments and recommendations concerning medication therapy were to be communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review. Recommendations were to be acted upon and documented by the facility staff and/or prescriber. If the prescriber does not respond to recommendations directed to him/her within 30 days from the date the facility receives the recommendations, the Director of Nursing and/or the consultant pharmacist may contact the Medical Director.</p> <p>Review of the clinical records for Resident 3 and Resident 14 revealed no documented evidence that the monthly review of medications by the pharmacist were addressed by the physician or designee in December 2023 and January 2024.</p> <p>Interview with the Director of Nursing on May 16, 2024, at 2:57 p.m. confirmed that there was no documented evidence that the December 2023 and January 2024 monthly medication reviews for Residents 3 and 14 were addressed by the medical provider.</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy Services.</p> <p>28 Pa. Code 211.12(d)(3) Nursing Services.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>42079</p> <p>Based on facility policy, federal regulations, and clinical record reviews, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from unnecessary medications for one of 31 residents reviewed (Resident 14).</p> <p>Findings include:</p> <p>The facility policy regarding Consultant Pharmacist report, dated March 26, 2024, indicated that comments and recommendations concerning medication therapy would be communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review. Recommendations were to be acted upon and documented by the facility staff and/or prescriber. If the prescriber does not respond to recommendations directed to him/her within 30 days from the date the facility receives the recommendations, the Director of Nursing and/or the consultant pharmacist may contact the Medical Director.</p> <p>Federal Regulations require that as-needed orders for psychotropic drugs be limited to 14 days. Except when the attending physician or prescribing practitioner believes that it is appropriate for the as-needed order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the as-needed order.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 14, dated November 6, 2023, revealed that the resident was severely cognitively impaired, required assistance with daily care needs, and had diagnoses that included depression and dementia.</p> <p>Physician's orders for Resident 14, dated December 14, 2023, included an order for the resident receive a 5 milligram (mg) injection of Zyprexa (an antipsychotic) daily as needed for combativeness. There was no documented evidence that the order was discontinued after 14 days.</p> <p>A January 2024 medication administration record for Resident 14 revealed that the resident was administered a</p> <p>5 mg injection of Zyprexa on January 1 and 24, 2024.</p> <p>A review of clinical records, including physician progress notes and consultant pharmacist recommendations to the physician for December 2023 and January 2024, for Resident 14 revealed no documented rationale for the long-term use of Zyprexa as needed, as required by federal regulations.</p> <p>An interview with the Director of Nursing on May 16, 2024, at 3:30 p.m. confirmed that there was no documented rationale for the long-term use of as-needed Zyprexa by the attending physician or by a psychiatric consultant.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>48809</p> <p>Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that medications were properly secured in the medication cart, failed to ensure that controlled medications were stored in a separately locked, permanently-affixed compartment in one of two medication refrigerators reviewed (Main), failed to label medications with the date they were opened in one of two medication rooms reviewed (Main Medication Room) and in one of two medication carts reviewed (200 hall).</p> <p>Findings include:</p> <p>The facility's policy regarding the security of the medication cart, dated March 26, 2024, indicated that the nurse was to secure the medication cart during the medication pass to prevent unauthorized entry, and the medication cart was to be securely locked at all times when out of the nurse's view.</p> <p>Observations on May 14, 2024, at 8:21 a.m. revealed that a medication cart in the hallway was unlocked and unattended by Licensed Practical Nurse 3 when she went into Resident 47's room to take his blood pressure and again at 8:25 a.m. when she took medications to the resident.</p> <p>Interview with Licensed Practical Nurse 3 on May 14, 2024, at 8:27 a.m. confirmed that her medication cart should have been locked when unattended.</p> <p>Interview with the Director of Nursing on May 16, 2023, at 8:01 a.m. confirmed that the medication cart should have been locked when unattended by Licensed Practical Nurse 3.</p> <p>The facility's policy regarding medication storage, dated March 26, 2024, indicated that medications and biologicals are to be stored safely, securely and properly.</p> <p>Observations of the Main medication room refrigerator on May 15, 2024, at 3:49 p.m. revealed that there was a narcotic storage box containing five (2mg/ml) bottles of Ativan (a controlled medication used to treat anxiety) that was not permanently affixed inside the refrigerator.</p> <p>An interview with Registered Nurse 5 on May 15, 2024, at 4:00 p.m. confirmed that the narcotic storage box was not permanently affixed inside the refrigerator.</p> <p>An interview with the Assistant Director of Nursing on May 15, 2024, at 4:51 p.m. confirmed that the narcotic storage box was not permanently affixed inside the refrigerator, and it should have been.</p> <p>The facility's policy regarding medication administration, dated March 26, 2024, revealed that once opened, a multi-dose vial was to have the date it was opened recorded on the container.</p> <p>An undated package insert for Tubersol (used to test for tuberculosis - a bacterial infection) revealed that once entered/opened, the vial was to be discarded after 30 days.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observations in the Main medication room refrigerator on May 15, 2024, at 3:52 p.m. revealed that an opened vial of Tubersol was not properly labeled with the date it was opened.</p> <p>An interview with Registered Nurse 5 on May 15, 2024, at 4:00 p.m. confirmed that the opened vial of Tubersol was not properly labeled with the date it was opened.</p> <p>An interview with the Assistant Director of Nursing on May 15, 2024, at 4:51 p.m. confirmed that an opened vial of Tubersol was not properly labeled with the date it was opened, and it should have been.</p> <p>An undated package insert for Insulin Lispro (a medication used to treat diabetes) revealed that once opened, the pen was to be discarded after 28 days.</p> <p>Observations in the Medication Cart for 200 Hall on May 14, 2024, at 11:19 a.m. revealed that an opened Insulin Lispro pen for Resident 65 was not properly labeled with the date it was opened.</p> <p>An interview with Licensed Practical Nurse 2 on May 15, 2024, at 11:25 a.m. confirmed that the opened Insulin Lispro pen for Resident 65 was not properly labeled with the date when it was opened, and it should have been.</p> <p>An interview with the Assistant Director of Nursing on May 16, 2024, at 8:01 a.m. confirmed that an opened Insulin Lispro pen should have been dated when opened and discarded after 28 days.</p> <p>28 Pa. Code 211.9(a)(1)(k) Pharmacy Services.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		