

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 04/03/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>48809</p> <p>Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the resident's responsible party was notified about changes in diet consistencies for one of 34 residents (Resident 10) reviewed and failed to notify the urologist regarding symptoms of a urinary tract infection (UTI) for one of 34 residents (Resident 22).</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 10, dated March 11, 2025, indicated that the resident was cognitively intact, was dependent on staff for care needs, and had a mechanically altered diet.</p> <p>A nurse's note for Resident 10, dated October 4, 2024, revealed that the resident was observed choking on water during medication administration and was downgraded from thin liquids to nectar thick as a nursing measure.</p> <p>A note from speech therapy, dated October 29, 2024, revealed that Resident 10 was safe to ingest nectar thick liquids.</p> <p>There was no documented evidence that Resident 10's responsible party was notified of the resident's diet consistency downgrade to nectar thickened liquids after the incident on October 4, 2024, and after receiving speech therapy on October 29, 2024.</p> <p>Interview with the Director of Nursing on April 1, 2025, at 12:48 p.m. confirmed that there was no documented evidence that the resident's responsible party was notified that Resident 10's diet consistency was downgraded.</p> <p>A significant MDS assessment for Resident 22, dated November 28, 2024, revealed that the resident was cognitively intact, required assistance with daily care tasks, and had an indwelling (foley) urinary catheter.</p> <p>A urology consult for Resident 22, dated December 12, 2024, revealed that the resident was to have a voiding trial and to notify the urologist if the resident developed any UTI symptoms.</p> <p>(continued on next page)</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing note for Resident 22, dated December 19, 2024, revealed that the resident was having symptoms of lower back pain, urinary frequency, and that the foley catheter was reinserted.</p> <p>There was no documented evidence that the urologist was notified regarding the UTI symptoms.</p> <p>Interview with the Director of Nursing on April 2, 2025, at 12:21 p.m. confirmed that there was no documented evidence in Resident 22's clinical record that the facility called the urologist to notify him about the UTI symptoms.</p> <p>28 Pa. Code 211.12(d)(1)(3) Nursing Services.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>51989</p> <p>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to develop a care plan for a Peripherally Inserted Central Line (PICC) to treat an infection that required the use of intravenous antibiotics for one of 34 residents reviewed (Resident 66).</p> <p>Findings include:</p> <p>According to admission paperwork for Resident 66, dated March 19, 2025, the resident was admitted from the hospital for further care of his left heel wound on March 19, 2025. Physician's orders for Resident 66, dated March 19, 2025, included an order for the resident to receive 1 gram of Ertapenem (antibiotic) once daily through his PICC line.</p> <p>There was no documented evidence in Resident 66's clinical record to indicate that a care plan was developed for the care and treatment of a PICC line, infection, or IV antibiotics.</p> <p>Interview with the Nursing Home Administrator on April 2, 2025, at 9:02 a.m. confirmed that a care plan for Resident 66's PICC line, infection, and IV antibiotics was not developed.</p> <p>28 Pa. Code 201.24(e)(4) Admission Policy.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>48809</p> <p>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for one of 34 residents reviewed (Resident 16).</p> <p>Findings include:</p> <p>A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 16, dated January 22, 2025, revealed that the resident was understood, could understand others, and had diagnoses that included heart failure and high blood pressure.</p> <p>Physician's orders for Resident 16, dated August 17, 2024, included orders for the resident to receive 6.5 milligrams (mg) of Carvedilol (treats high blood pressure) once a day, to be held if his apical pulse (a pulse point on your chest that gives the most accurate reading of your heart rate) is less than 50 beats per minute (bpm), and to administer 5 mg lisinopril (treats high blood pressure) daily.</p> <p>A review of the January, February, and March 2025 Medication Administration Record (MAR) for Resident 16 revealed the following:</p> <p>On January 6, 2025, no apical pulse was obtained and the carvedilol dose was administered when it should have been held according to the physician's orders.</p> <p>On January 22 and 30, 2025, the lisinopril was held, and should have been administered according to physician's orders.</p> <p>On February 13 and 23, 2025, the lisinopril was held, and should have been administered according to physician's orders.</p> <p>On March 23, 2025, the resident's apical pulse was 71 bpm, and the carvedilol dose was held when it should have been administered according to the physician's orders.</p> <p>Interview with the Director of Nursing on April 3, 2025, at 12:47 p.m. confirmed that the carvedilol and lisinopril were not administered to Resident 16 per physician's orders on the dates listed.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>42079</p> <p>Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that a privacy cover was provided for one of 34 residents reviewed (Resident 54) who had an indwelling urinary catheter.</p> <p>Findings include:</p> <p>The facility's policy regarding indwelling urinary catheters (a flexible tube inserted and held in the bladder to drain urine) insertion indicators, dated January 22, 2025, revealed that indwelling urinary catheters must be covered and placed below the bladder for proper drainage.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 54, dated March 13, 2025, revealed that the resident was cognitively intact, had an indwelling urinary catheter, and had diagnoses that included obstructive uropathy (normal flow of urine through the urinary tract is blocked) and benign prostatic hyperplasia (BPH - enlarge prostate).</p> <p>Physician's orders for Resident 54, dated March 7, 2025, included an order for the resident to have an indwelling urinary catheter due to neurogenic bladder (a condition that causes loss of bladder control due to damage to the nervous system), to be changed as needed for dislodgement, blockage, or leakage. A care plan, dated March 27, 2025, indicated that Resident 54 required an indwelling urinary catheter related to a neurogenic bladder.</p> <p>Observations of Resident 54 on March 31, 2025, at 11:17 a.m. revealed that the resident was in his wheelchair being transported by Nurse Aide 1 from the 400 hall to the 300 hall. This catheter collection bag did not have a cover and urine was visible. Interview with Nurse Aide 1 on March 31, 2025, at 11:30 a.m. confirmed that there was not a privacy bag on the urine collection bag, and she had been looking for one since this morning.</p> <p>Interviews with the Director of Nursing on April 1, 2025, at 2:28 p.m. confirmed that Resident 54's catheter tubing should not have been in contact with the fall mat.</p> <p>28 Pa. Code 211.12(d)(1)(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>42079</p> <p>Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to store medication appropriately for one of 34 residents reviewed (Resident 23).</p> <p>Findings include:</p> <p>The facility's policy regarding medication storage, dated January 22, 2025, indicated that medications for internal use were stored in medication carts or other designated areas.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 23, dated March 20, 2025, indicated that the resident was cognitively intact, usually understood and could usually understand, required assistance from staff for daily care needs, and was receiving antipsychotic medication.</p> <p>Physician's orders for Resident 23, dated January 13, 2025, included an order for the resident to receive 25 milligrams (mg) of Seroquel (antipsychotic medication) daily for psychosis.</p> <p>Interview and observations of Resident 23 on March 31, 2025, at 10:55 a.m. revealed that she was in her room and she stated that her only concern was a pink pill on the floor by her toilet. There was a round pink/orange pill on the floor in her bathroom.</p> <p>Interview with Licensed Practical Nurse 2 on March 31, 2025, at 11:17 a.m. confirmed that the medication was identified as 25 mg of Seroquel and Resident 23 was scheduled to receive the medication in the evening. Licensed Practical Nurse 2 further explained that Resident 23 was the only resident in that room that used the toilet, and her morning medication were crushed and served with pudding or applesauce.</p> <p>Interview with the Director of Nursing on April 1, 2025, at 2:28 p.m. confirmed that medication should not be on the floor.</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy Services.</p> <p>28 Pa. Code 211.12(d)(1) Nursing Services.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>42079</p> <p>Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to store and prepare food in accordance with professional standards for food service safety by failing to store food under sanitary conditions, failing to store frozen foods appropriately, failing to keep kitchen equipment clean and sanitary, and failing to have staff wear appropriate hair restraints during food preparation and tray line service.</p> <p>Findings include:</p> <p>The facility's policy regarding food labeling and dating, dated January 22, 2024, revealed staff were to properly seal the container of bulk freezer items like frozen vegetables to maintain their integrity.</p> <p>Observations in the kitchen's walk in freezer on March 31, 2025, at 9:20 a.m. revealed that there was an opened box of frozen fish fillets that was exposed to the air. Interview with the Dietary Director at the time of the observation confirmed that the box of frozen fish should have been sealed and removed the box to have staff cover the fish filets.</p> <p>The facility's policy regarding sanitizing equipment, dated January 22, 2024, revealed that equipment used in meal preparation was thoroughly cleaned and sanitized preventing injury and food-borne illness.</p> <p>Observations in the facility's kitchen on March 31, 2025, at 9:33 a.m. revealed that the deep fryer in the meal preparation area had a large amount of floating fried debris on the oil and the surrounding area. The deep fryer was not used for the morning meal and was turned on and heating up for use during the lunch and dinner meals. Interview with the Dietary Director at the time of the observation confirmed that the deep fryer should have been cleaned after use.</p> <p>The facility's policy regarding dress code guidelines, dated January 22, 2024, revealed that men with beards or full mustaches are not permitted in food production and a beard net must be worn.</p> <p>Observations of the work/prep space in the kitchen during tray line on April 3, 2024, at 11:15 a.m. revealed that two staff were prepping drinks and trays for trays for residents that ate in their rooms. Dietary Staff 3 had a full beard and mustache and was not wearing a beard restraint. Interview with the Dietary Director on March 3, 2025, at 11:24 p.m. revealed that the dietary staff were to have facial hair restraints while in the kitchen.</p> <p>28 Pa. Code 211.6(f) Dietary Services.</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>38012</p> <p>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that each resident was offered and/or received the pneumococcal vaccine (prevents bacterial pneumonia) for one of 34 residents reviewed (Resident 5), and failed to ensure that each resident was offered and/or received the influenza vaccine for two of 34 residents reviewed (Residents 11, 14).</p> <p>Findings include:</p> <p>The facility's policy regarding vaccines, dated January 22, 2025, revealed that the resident or the resident's representative have the opportunity to accept or refuse immunization.</p> <p>A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 5, dated January 16, 2025, indicated that the resident was cognitively intact and that the resident's pneumococcal was not up to date.</p> <p>A pneumococcal vaccine authorization form signed by Resident 5, dated November 19, 2024, revealed that she wanted to have the pneumococcal vaccine.</p> <p>An interview with the Registered Nurse Assessment Coordinator on April 3, 2025, at 11:34 a.m. confirmed that Resident 5 did not receive a pneumococcal vaccine and that she should have.</p> <p>A quarterly MDS assessment for Resident 11, dated February 20, 2025, revealed that the resident was cognitively intact and that her flu vaccine was not up to date.</p> <p>A flu vaccine consent form for Resident 11, dated October 2, 2024, revealed that the resident consented to receive the flu vaccine; however, a review of Resident 11's clinical record revealed that she did not receive the flu vaccine.</p> <p>An interview with the Director of Nursing on April 3, 2025, at 11:28 a.m. confirmed that Resident 11 did not receive the flu vaccine and should have.</p> <p>A quarterly MDS assessment for Resident 14, dated February 19, 2025, revealed that the resident was understood, could understand, was cognitively intact, and was dependent on staff for her daily care tasks. Section O0250 A of the MDS (Influenza Vaccination) revealed that the resident did not receive the influenza vaccine in this facility for this year's influenza vaccination season due to being offered but declining the vaccine.</p> <p>Review of Resident 14's clinical record revealed that there was no documented evidence that the resident was offered the influenza vaccine for the 2024-2025 flu season.</p> <p>Interview with the Director of Nursing on April 3 at 12:29 p.m. confirmed that there was no documented evidence that Resident 14 was offered the seasonal influenza vaccine for 2024-2025 flu season.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 201.18(b)(1) Management.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		