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	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Woods at Huntingdo	360 Westminster Drive Huntingdon, PA 16652

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to complete a thorough investigation for a choking incident that occurred for one of 17 residents reviewed (Resident 17). Findings include:A facility policy for abuse and neglect dated January 9, 2026 , revealed that events involving evidence or reports of physical, sexual, mental or verbal abuse involuntary seclusion, neglect and misappropriation or resident's property shall be thoroughly investigated including obtaining statements from all potential persons who might have had contact with the resident in the previous 24 hours or within the timeframe that has been identified. A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 17, dated April 2, 2026, revealed that the resident was cognitively impaired, required a mechanically altered diet, did not have coughing or choking during meals or when swallowing medication, was dependent on staff with daily care needs, and required partial assistance while eating. A care plan for Resident 17 for a swallowing problem, dated August 7, 2025, revealed that the resident is to be fed at assist table when spouse is not feeding her. A nurse's note for Resident 17 dated December 29, 2025, at 5:16 p.m. revealed that the resident was in her room after dinner. She vomited and began to choke on her vomit requiring the nurse aide to pull the mucus and vomit from her mouth, and the resident was transferred to the emergency room for evaluation.A nurse's note for Residet 17 dated January 2, 2026, at 6:22 p.m. revealed that the nurse aide was feeding the resident and was unable to clear her throat. The nurse aide had to perform the Heimlich maneuver to open the airway and brought up a moderate amount of food.A nurse's note for Resident 17 dated April 29, 2026, at 6:04 p.m. revealed that the resident was being fed in the dining room by staff and began to choke on a portion that was fed to her. The Licensed Practical Nurse had to give back blows until food was coughed out. A review of the clinical records for Resident 17 revealed no documented evidence that an investigation was completed for the above choking incidents. Interview with the Director of Nursing and the Nursing Home Administrator on May 7, 2026, at 10:20 a.m. revealed that there was information in a nursing note and that they did not do an investigation into the above incidents. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.10(d) Resident Care Policies. 28 Pa. Code 211.12(d)(5) Nursing Services.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of investigative reports, and residents' clinical records, observations, as well as staff interviews, it was determined that the facility failed to ensure physician's orders were followed for four of 30 residents Reviewed (Residents 1, 22, 33, and 55). Findings include:A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated March 19, 2026, indicated that the resident was severely cognitively impaired and required supervision or touching assistance for eating, had a unexpected weight loss, and had diagnoses that included malnutrition. A nutritional care plan dated March 22, 2026 indicated that supplements were to be administered as ordered.Physician's orders for Resident 1, dated October 4, 2025 , included an order for the resident to receive a magic cup (nutrient-dense, high-calorie frozen dessert) twice a day for a recent significant weight loss, with additional orders to instructions to include the amount consumed.A review of Resident 1's Medication Administration Record, dated January and May 2026, revealed) that there was no documentation of the amount consumed.Interview with the Director of Nursing on May 6 2026 at 2:09 and 2:21 p.m. confirmed that there was no documentation of the amount of magic cup consumed. A quarterly MDS assessment dated [DATE], for Resident 22, revealed that the resident was cognitively intact, required substantial assistance from staff for daily care, had diagnoses that included diabetes, and received insulin injections.A diabetes care plan for Resident 22, dated September 24, 2025, revealed that physician's orders for diabetes medication would be followed.Physician's orders for Resident 22, dated July 8, 2025, included an order for the physician to be notified if the resident's blood glucose level was below 70 milligrams per deciliter (mg/dL) or above 350 mg/dL.Review of Resident 22's medication administration record for March 2026, revealed that on March 7, 2026, at 6:30 a.m. the resident's blood sugar was 376 mg/dL, on March 8, 2026, at 6:30 a.m. the resident's blood sugar was 357 mg/dL, on March 9, 2026, at 6:30 a.m. the resident's blood sugar was 373 mg/dL, on March 12, 2026 at 6:30 a.m. the resident's blood sugar was 380 mg/dL, and on March 13, 2026 at 6:30 a.m. the resident's blood sugar was 401 mg/dL.There was no documented evidence in Resident 22's clinical record that the physician was notified of the resident's blood sugar levels on the above dates and times.Interview with the Director of Nursing on May 4, 2026, at 1:06 p.m. confirmed that the physician was not notified of Resident 22's blood sugar levels on the above dates and times and should have been per the physician's orders.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 33, dated April 1, 2026, revealed that the resident was understood, could understand others but was confused at times, and had diagnoses that included dementia and heart disease.Physician's orders for Resident 33, dated July 8, 2025, included an order for staff to administer one 2.5 milligram (mg) tablet of amlodipine (medication to treat high blood pressure) one time a day, and staff was to hold the medication if the systolic blood pressure (SBP, the top number of a blood pressure reading) was less than 140 millimeters of mercury (mmHg).Review of the Medication Administration Record (MAR) for Resident 33, for the months of March, April, and May 2026, revealed that staff administered one 2.5 mg tablet of amlodipine to the resident on March 10, 2026, with a documented SBP of 139, on March 12, 2026, with a SBP of 121, April 1, 2026, with SBP of 126 mmHg, and May 4, 2026, with SBP of 117 mmHg, despite the physician's orders to hold the amlodipine when SBP less than 140 mmHg. Interview with the Director of Nursing on May 6, 2026, at 1:59 p.m. confirmed that the medications were given but should have been held per physician's orders. A quarterly MDS assessment for Resident 55, dated March 17, 2026, revealed that the resident was cognitively intact, required substantial assistance from staff for daily care, had diagnoses that included chronic obstructive pulmonary disease (COPD) (a progressive long-term lung disease that makes it difficult to breath due to damaged airways).A COPD care plan for Resident 55, dated July 29, 2025, revealed that the resident was to receive aerosol or bronchodilators (a medication that relaxes (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the muscles around the airways in the lungs to help improve breathing).Physician's orders for Resident 55, dated February 3, 2026, , included an order for the resident to receive trelegy ellipta inhalation aerosol Powder Breath activated 100-62.5-25 mcg/act and to inhale 1 puff orally one time a day for COPD and to rinse and spit after use.Observations of Licensed Practical Nurse (LPN) 1 administering trelegy ellipta to Resident 55 on May 5, 2025, at 8:07 a.m. revealed that LPN 1 did not have the resident rinse and spit after administration per physician's orders.Interview with LPN 1 on May 5, 2025, confirmed that she did not have the resident swish and spit because he never does it.Interview with the Director of Nursing on May 5, 2026, at 10:010 a.m. confirmed that LPN 1 should have followed physician's order and had the resident swish and spit after inhalation.28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review, as well as staff interviews, it was determined that the facility failed to notify the resident's representative in writing regarding the reason for transfer to the hospital and to ensure that a bed-hold notice was provided to the resident's responsible party for one of 17 residents reviewed (Resident 23).Findings Include: A nursing note for Resident 23 dated February 6, 2026, revealed that the resident was found lethargic, mumbling, diaphoretic, unable to answer questions appropriately, and pupils were non-reactive and fixed. She was subsequently sent to the emergency room for evaluation. Review of Resident 23's clinical record revealed no documented evidence that the resident representative notified in writing of the transfer to the hospital on the above dates and times, and that a bed hold notice was not provided at the time of the transfer. Interview with the Nursing Home Administrator on May 6, 2026, at 10:09 a.m. revealed that she did not notify the resident's representative of the hospital transfer for the resident's above, and that the bed hold notice was not provided at the time of the transfer. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(2) Management.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on a review of facility policy and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that that the physician was notified of a weight change for two of 30 residents reviewed (Residents 1 and 22).Findings Include: A facility policy regarding weights, dated December 29, 2025, revealed that variances of plus or minus five pounds or more for residents over 100 pounds requires a reweigh in 24 hours, a report by the charge nurse to the physician, dietician, and responsible party. The dietician will initiate approaches to remedy the change in weight.A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated March 19, 2026, indicated that the resident was severely cognitively impaired and required supervision or touching assistance for eating, had a unexpected weight loss, and had diagnoses that included malnutrition. A nutritional care plan for the resident, dated March 22, 2026 indicated the Registered Dietitian would monitor weights and average meal intakes.On November 5, 2025, Resident 1's weight was 135.8 pounds, then on November 12, 2025, Resident 1 weighed 125.0 pounds. Resident 1 had 10.8 lb. weight loss in one week. On December 3, 2025 Resident 1 weighed 129 pounds, then on December 10, 2025 Resident 1 weighed 117.8 pounds. Resident 1 had a 11.2 pound weight loss in one week.There was no documented evidence in the clinical record to indicate that Resident 1 was reweighed within 24 hours. There was no documented evidence that the charge nurse, physician, or dietitian was made aware of the weight loss.Interview with the Director of Nursing on May 6 2026 at 2:09 p.m. and 2:21 p.m. respectively, confirmed that there was no documented evidence that the charge nurse, physician, or dietitian was made aware of Resident 1's weight loss in November and December, 2025, or that a reweigh was completed per facility policy. A quarterly MDS assessment for Resident 22, March 31, 2026, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included kidney failure and heart failure. Care plan for Resident 22 dated March 19, 2026, revealed that the resident is at risk for weight fluctuations due to diuretic use, and his weight is to be monitored per physician's orders. Physician's order for Resident 22 dated March 11, 2026, revealed that the resident is to be weighed every Wednesday and the physician is to be notified if there is an increase in 3 pounds in 24 hours or an increase of 5 pounds in a week. A review of the weight records for Resident 22 revealed that on April 29, 2026, he weighed 229 pounds and on May 2, 2026, he weighed 236.4 pounds, an increase of 7.4 pounds in three days. There was no documented evidence that the physician was notified of the weight increase. Interview with the Director of Nursing on May 7, 2026, at 9:04 a.m. revealed that there was no documented evidence that the physician was notified of the resident's weight increase and he should have been. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on clinical record review and staff interview, it was determined that the facility failed to ensure that residents were assessed and received trauma-informed care to eliminate or mitigate triggers for residents with the diagnosis of Post Traumatic Stress Disorder (PTSD) (a mental and behavioral disorder that develops related to a terrifying event) for one of 30 residents reviewed (Resident 4).Findings include: A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated April 4, 2026, indicated that the resident was cognitively intact, was dependent on staff for daily care needs, and had diagnoses that included depression, anxiety, and PTSD. A review of Resident 4's care plan, dated July 16, 2025, indicated that the resident had PTSD, anxiety, and Traumatic Brain Injury. There was no documented evidence the facility identified Resident 4's specific triggers that could re-traumatize the resident or implement measures as to how facility staff could prevent or minimize triggers from occurring. Interview with the Social Worker on May 6, 2026, at 2:13 p.m. confirmed that she did not do an assessment for PTSD triggers and stated that it was not completed because the old computer system did not have the assessment program. 28 Pa Code 201.24(e)(4) admission Policy. 28 Pa Code 211.12(a)(d)(3)(5) Nursing Services. 28 Pa. Code 211.16(a) Social Services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of clinical records and staff interviews, it was determined that the facility failed to ensure the accountability of controlled medications for one of 30 residents reviewed (Resident 3).Findings include:An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated February 8, 2026, indicated that the resident was cognitively intact, required assistance from staff for all daily care needs, and was taking opioid medication. A care plan for Resident 3 dated January 29, 2026, indicated that she would display pain by yelling out. Nursing was to assess her pain and administer pain medications as ordered. Physician's orders for Resident 3, dated February 3, 2026 , included an order for the resident to receive one 5 milligram (mg) tablet of Oxycodone (narcotic pain medication) every four hours as needed for pain. A review of Resident 3's Controlled Drug Record (a legally required document that tracks every transaction of the medication to prevent diversion and ensure regulatory compliance), dated February through April 2026, revealed that 5 mg of oxycodone was signed out on the controlled drug record on February 4, 2026, at 6:04 a.m.; February 14, 2026, at 3:37 a.m. and 11:00 a.m.; April 4, 2026, at 6:50 a.m.; and April 7, 2026, at 5:30 a.m. However, there was no documented evidence in the medication administration record that medication was administered to the resident on the dates and times listed. Interview with the Director of Nursing on May 7, 2026, at 2:38 p.m. confirmed that there was no documented evidence in Resident 3's clinical record that the oxydocone was administered on the dates and times above, and there should have been. 28 Pa. Code 211.9(h) Pharmacy Services. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.