STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395160	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Saxonburg	223 Pittsburgh St Saxonburg, PA 16056

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record, and staff interview it was determined that the facility failed to have the responsible party sign financial papers for one of two residents (Resident R2).Findings include: Review of facility policy Resident Rights dated 2/19/25, indicated: The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Information about resident rights will be given to the resident understands to the extent possible, considering impediments which may be created by the resident's health and mental status. Review of Resident R2 was admitted [DATE]. Review of Resident R2 MDS (minimum data set - a periodic assessment of resident needs) dated 8/28/25, indicated diagnosis of Multiple Sclerosis (is a disease that causes breakdown of the protective covering of the nerves) muscle wasting and atrophy (is the wasting or thinning of your muscle mass), and hyperlipidemia (excess of lipids or fats in your blood). Question C0500 BIMS Summary Score revealed Resident R2's score to be 11, moderately impaired. Review of Resident R2 clinical record indicated a NOMNC (Notice of Medicare non-coverage - a form given to residents or resident responsible party to notify of ending insurance coverage) was signed by the resident on August 29, 2025. No further information was noted in the clinical record that the responsible party was informed of the ending of Medicare coverage. During an interview on 11/13/25, at 3:26 p.m. Nursing Home Administrator, confirmed that Resident R2 had a BIMS 11 which is moderately impaired, and moderately impaired residents should not sign NOMNC's, and the facility failed to have the responsible party sign financial papers. 28 Pa. Code 201.18(b)(2) Management.28 Pa. Code 201. 29 (a) Resident rights.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility provided documents, clinical records and staff interviews, it was determined that the facility failed to ensure that a resident's legal surrogate (power of attorney) was utilized for legal action of non-payment of bills for one of two residents (Resident R1).Findings include: Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2025, indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aids in detecting cognitive impairment). The BIMS total score suggests the following distributions: 13-15: cognitively intact 8-12: moderately impaired 0-7: severe impairment Review of the clinical record revealed that Resident R1 was admitted to the facility on [DATE]. Review of Resident 1's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 4/22/25, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and anxiety (a feeling of worry, nervousness, or unease).Question C0500BIMS Summary Score revealed Resident R1's score to be 10, indicative of moderate cognitive impairment. Review of Resident R1's clinical record revealed that a Power of Attorney (giving authority to another person to act in all legal or financial matters on another person's behalf) Form was uploaded into the electronic health record on 3/6/24, and identified Resident R1's son as her Power of Attorney (POA). Review of Facility [NAME] Statements revealed that an invoice was sent to Resident R1 on 5/1/25, with a balance due of $26,827.00, and the same invoice was also sent to R1's POA on the same date. Additional invoices dated 6/1/25, 7/1/25, and 8/1/25, were also sent with the above balance. Two copies were sent on each date, one to Resident R1 and the other copy to the resident's POA. Review of a resident representative concern from Former Activities Director Employee E4 dated 10/12/25, stated the following: On 6/26/25, I personally witnessed NHA accompanied by a sheriff's deputy, verbally and psychologically abusing Resident R1, in the middle of a public hallway. NHA repeatedly told the resident at least seven times that she owed the facility $26,000, stating, 'We issue 30-day notices like candy around here to people who owe money.' The resident was visibly distraught, crying, and repeatedly stated she did not understand why she was being held or what the debt referred to. During an interview on 11/12/25, at 1:54 p.m. the NHA stated that the local sheriff had come in on the day in question with papers. NHA explained that Resident R1 had to spend down $26,000 to qualify for Medicaid, and that the family wasn't compliant with paying her bills, therefore the sheriff was serving her papers for the unpaid balance. The sheriff had come in and asked to be taken to Resident R1's room, and at the time Resident R1 was listed in the medical chart as her own responsible party. The NHA confirmed that Resident R1 does have a POA who is authorized to handle her bills, and that the facility failed to utilize the resident POA for legal action of non-payment of bills for Resident R1. 28 Pa. Code 201.14(b) Responsibility of licensee.28 Pa. Code 201.18(b)(1)(2)(3) Management.

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observations and staff interview, it was determined that the facility failed to post complete contact information for State Long-Term Care Ombudsman program, and accessible, and complete contact information for State Survey Agency at the facility as required. Findings include: During observations completed on 11/13/25, State Long-Term Care Ombudsman information posted in the front hallway did not include the Ombudsman's name, address, or email as required. This observation also revealed that State Survey Agency (SSA) contact information was listed approximately six feet from the floor in small print and did not include email, or current address, and did not include a statement that residents may file a complaint with SSA concerning any suspected violation of State and Federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directive requirements, and requests for information regarding returning to the community as required. During interview, on 11/13/25, at 2:06 p.m. the Nursing Home Administrator confirmed that the facility failed to post complete contact information for State Long-Term Care Ombudsman program, and accessible, and complete contact information for State Survey Agency as required. 28 Pa. Code: 201.14(a)Responsibility of licensee.28 Pa. Code: 201.18(e) Management.

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility provided documents, clinical records, and staff interviews, it was determined the facility failed to ensure a resident was free from mental abuse and intimidation for one of two residents reviewed (Resident R1), which resulted in psychosocial harm and mental anguish related to the reasonable person concept. Findings include: Review of facility's policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property dated 2/19/25, revealed the facility will not tolerate abuse, neglect, and exploitation of its residents. The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, pain or mental anguish. This includes verbal abuse. Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2025, indicated that a Brief Interview for Mental Status (BIMS), is a screening test that aids in detecting cognitive impairment). The BIMS total score suggests the following distributions:13-15: cognitively intact8-12: moderately impaired0-7: severe impairment Review of Resident R1's clinical record revealed Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Quarterly MDS (Minimum Data Set, periodic assessment of resident care needs) dated 4/22/25, indicated diagnoses of high blood pressure, Dementia (group of symptoms that affects memory, thinking and interferes with daily life), and Anxiety (feeling of worry, nervousness, or unease). Further review of the MDS assessment revealed question C0500BIMS Summary Score revealed Resident R1's score to be 10, indicative of moderate cognitive impairment. Review of Resident R1's clinical record revealed that a Power of Attorney (giving authority to another person to act in all legal or financial matters on another person's behalf) Form was uploaded into the electronic health record on 3/6/24, and identified Resident R1's son as his/her Power of Attorney (POA). Review of facility [NAME] Statements revealed an invoice was sent to Resident R1 on 5/1/25, with a balance due of $26,827.00, with a duplicate invoice sent to Resident R1's POA on the same date. Further review of facility billing statements revealed additional invoices dated 6/1/25, 7/1/25, and 8/1/25, were also sent with the same outstanding balance. Two copies were sent on each date, one to Resident R1 and the other copy to the resident's POA. Review of written statement dated 6/27/25, revealed a Meeting was held with Assistant Nursing Home Administrator (ANHA) about the approach with Resident R1 on 6/26/25. It was reiterated residents should be pulled into room or private area to discuss personal matters. ANHA did explain she understood she should have pulled resident into the room but the sheriff was adamant and she was nervous in the situation/moment. ANHA was given the customer service policy and educated on proper customer service with residents. Review of employee file revealed that the Assistant Nursing Home Administrator was promoted to Nursing Home Administrator (NHA) on 9/4/25 and will hence forth be identified as NHA. Review of resident representative concern from Former Activities Director Employee E4 dated 10/12/25, revealed the following: On 6/26/25, I personally witnessed NHA accompanied by a sheriff's deputy, verbally and psychologically abusing Resident R1, in the middle of a public hallway. NHA repeatedly told the resident at least seven times that she owed the facility $26,000, stating, 'We issue 30-day notices like candy around here to people who owe money.' The resident was visibly distraught, crying, and repeatedly stated [he/she] did not understand why [he/she] was being held or what the debt referred to. During an interview on 11/12/25, at 9:56 a.m. Resident R1 was unable to verbalize any recounting of the event or of her feelings regarding said event. As resident has a diagnosis of dementia, and a BIMS score of 10, and there was a void of expression of feelings regarding the event, a reasonable person concept was applied to demonstrate the reaction that a reasonable person in the resident's position would have to the same event. During an interview on 11/12/25, at 10:45 a.m. Resident R1's family member stated that the facility had been sending letters to the POA that $26,000 was owed to the facility, and that the POA had paid the bill in full sometime in August 2025. During an interview on 11/12/25, at 11:47 a.m. Employee E1 stated that she was present in the hallway when the above incident occurred. Employee E1 revealed she was concerned about the location this occurred since it was in a public space and the matter appeared to be private in nature. Resident R1 was asked to sign paperwork, and resident appeared confused, and was asking questions. Someone from law enforcement in uniform was there and resident didn't appear to understand, and [he/she] became tearful, I thought it was questionable that resident could have signed [his/her] own papers given [his/her] mental status. Employee E1 stated it was the NHA who confronted Resident R1. During an interview on 11/12/25, at

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	395160	A. Building B. Wing	11/13/2025

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Embassy of Saxonburg	223 Pittsburgh St Saxonburg, PA 16056

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility provided documents, clinical records, and staff interviews, it was determined that the facility failed to report an allegation of abuse for one of two residents (Resident R1).Findings include: Review of the facility's policy Abuse, Neglect, Exploitation and Misappropriation of Resident Property dated 2/19/25, indicated that the facility will not tolerate abuse, neglect, and exploitation of its residents. The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, pain or mental anguish. This includes verbal abuse. Facility staff should immediately report all such allegations to the Administrator. The Administrator or his/her designee will notify the Department of Health of the alleged violations involving Abuse, Neglect, exploitation, mistreatment of a resident, or misappropriation of resident property and injuries of unknown source as soon as possible, but in no event later than 24 hours from the time the incident/allegation was made known by the staff member. Review of the clinical record revealed that Resident R1 was admitted to the facility on [DATE]. Review of Resident 1's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 4/22/25, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and anxiety (a feeling of worry, nervousness, or unease). Review of a resident representative concern dated 10/12/25, stated the following: On 6/26/25, I personally witnessed the Nursing Home Administrator (NHA) accompanied by a sheriff's deputy, verbally and psychologically abusing Resident R1, in the middle of a public hallway. NHA repeatedly told the resident at least seven times that she owed the facility $26,000, stating, 'We issue 30-day notices like candy around here to people who owe money.' The resident was visibly distraught, crying, and repeatedly stated she did not understand why she was being held or what the debt referred to. Following the event, I reported the incident to Former Director of Nursing (FDON) Employee E3 , who instructed all witnesses to complete written statements, which we did. During our 3:00 p.m. stand-down meeting later that day, I again stated that the event constituted abuse. FDON Employee E3 confirmed that it would be 'handled the same as any other abuse allegation'. During an interview via telephone on 11/12/25, at 2:32 p.m. Former Director of Nursing (FDON) Employee E3 stated that she had not been a witness to the above altercation but was aware of the situation as some employees had voiced their concern over how it happened. FDON Employee E3 stated that she asked employees To fill out a statement if they felt it was abuse to give me the facts. But I got zero statements. During an interview via telephone on 11/12/25, at 3:01 p.m. Former Activities Director (FAD) Employee E4 stated that he was present in the hallway during the above incident and confirmed that the sheriff, the NHA, and Resident R1 were all in the hallway during the conversation. FAD Employee E4 described Resident R1 to be confused and tearful during the altercation. FAD Employee E4 stated that he filled out a written statement regarding the incident as he felt it to be emotional/mental abuse and slid it underneath FDON Employee E2's door the same day of the event. He stated that he was later told by FNHA Employee E2 that the incident would not be considered abuse, and that it was implied that if he liked his job he should shut up. During an interview via telephone on 11/12/25, at 4:04 p.m. Former Social Worker (FSW) Employee E5 confirmed that she was a witness to the incident, and that it took place in the hallway. She stated that Resident R1 had a POA, and that he should have been the one involved and not Resident R1 as she has dementia. FSW Employee E5 stated that the information regarding Resident R1's POA was definitely in the chart. FSW Employee E5 stated that she filed out a witness statement with the details of the event and put it underneath FDON Employee E3's door the same day of the incident. FSW Employee E5 stated that the resident was tearful during the incident, and when she saw her less than an hour later she was still tearful. FSW Employee E5 stated that she had never seen a sheriff come into a facility to handle bills before, and that Resident R1 would absolutely feel intimidated with the sheriff being there. FSW Employee E5 added that about a week after the incident the FNHA Employee E2 came into morning meeting and closed the door and told her that she was disappointed with how the witnesses worked together and that they accused the NHA of abuse, and If we didn't like it, we could leave. A review of incidents submitted to the State Agency conducted on 11/12/25, did not include the staff-to-resident abuse allegation on 6/26/25. During an interview on 11/13/25, at 1:50 p.m. the NHA confirmed that the facility failed to report an allegation of abuse for one of two residents (Resident R1). 28 Pa Code: 201.14 (a)(c) Responsibility of management28 Pa Code: 201.18 (b)(1)(e)(1)

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	395160	A. Building B. Wing	11/13/2025

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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 - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, facility provided documents, clinical records, and staff interviews , it was determined that the facility failed to identify and investigate an incident of possible abuse for one of two incidents (Resident R1).Findings include: Review of the facility's policy Abuse, Neglect, Exploitation and Misappropriation of Resident Property dated 2/19/25, indicated that the facility will not tolerate abuse, neglect, and exploitation of its residents. The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, pain or mental anguish. This includes verbal abuse. Facility staff should immediately report all such allegations to the Administrator. The Administrator or his/her designee will notify the Department of Health of the alleged violations involving Abuse, Neglect, exploitation, mistreatment of a resident, or misappropriation of resident property and injuries of unknown source as soon as possible, but in no event later than 24 hours from the time the incident/allegation was made known by the staff member. Once the administrator and Department of Health are notified, an investigation of the allegation violation will be conducted. The investigation must be completed within five working days, unless there are special circumstances. The person investigating the incident should generally take the following actions:Interview the resident, the accused and all witnesses. Witnesses generally include anyone who: witnesses or heard the incident; came in close contact with the resident the day of the incident, and employees who worked closely with the accused employee(s) and /or alleged victim the day of the incident.Obtain a statement from the resident, if possible, the accused, and each witness. Obtain all medical reports and statements from physicians and/or hospital, if applicable. Review the resident's records.If the accused is an employee, then review his/her employment records. Evidence of the investigation should be documented. After the completion of the investigation, all of the evidence should be analyzed, and the administrator (or his/her designee) will make a determination regarding whether the allegation or suspicion is substantiated. In the case of staff-to resident abuse, neglect, exploitation, mistreatment of a resident or misappropriation of resident property, the facility will follow the facility's procedure for disciplining or dismissing an employee, depending upon the circumstances and results of the investigation. Review of the clinical record revealed that Resident R1 was admitted to the facility on [DATE]. Review of Resident 1's MDS (Minimum Data Set, periodic assessment of resident care needs) dated 4/22/25, indicated diagnoses of high blood pressure, dementia (a group of symptoms that affects memory, thinking and interferes with daily life), and anxiety (a feeling of worry, nervousness, or unease). Review of Resident R1's clinical record revealed that a Power of Attorney (giving authority to another person to act in all legal or financial matters on another person's behalf) Form was uploaded into the electronic health record on 3/6/24, and identified Resident R1's son as her Power of Attorney (POA). Review of Facility [NAME] Statements revealed that an invoice was sent to Resident R1 on 5/1/25, with a balance due of $26,827.00, and the same invoice was also sent to R1's POA on the same date. Additional invoices dated 6/1/25, 7/1/25, and 8/1/25, were also sent with the above balance. Two copies were sent on each date, one to Resident R1 and the other copy to the resident's POA. Review of a facility document dated 6/27/25, stated that Meeting was had with Assistant Nursing Home Administrator (ANHA) about the approach with Resident R1 on 6/26/25. It was reiterated that residents should be pulled into room or private area to discuss personal matters. ANHA did explain she understood she should have pulled her into the room but that the sheriff was adamant and she was nervous in the situation/moment. [NAME] was given the customer service policy and educated on proper customer service with residents. Review of employee file revealed that the Assistant Nursing Home Administrator was promoted to Nursing Home Administrator (NHA) on 9/4/25, and will hence forth be identified as NHA. Review of a resident representative concern dated 10/12/25, stated the following: On 6/26/25, I personally witnessed the Nursing Home Administrator (NHA) accompanied by a sheriff's deputy, verbally and psychologically abusing Resident R1, in the middle of a public hallway. NHA repeatedly told the resident at least seven times that she owed the facility $26,000, stating, 'We issue 30-day notices like candy around here to people who owe money.' The resident was visibly distraught, crying, and repeatedly stated she did not understand why she was being held or what the debt referred to. Following the event, I reported the incident to Former Director of Nursing (FDON) Employee E3 , who instructed all witnesses to complete written statements, which we did. During our 3:00 p.m.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the activities program is directed by a qualified professional. Based on review of facility documentation and staff interview it was determined that the facility failed to employ a qualified actives director from October 6, 2025. Findings include: Review of facility documentation: job description Activity Director: The primary purpose of your job position is to plan, organize, develop, direct and implement the overall operation of the Activity Department in accordance with current, federal, state, and local standards, guidelines and regulations, our established policies and procedures, and as may be directed by the Administrator, to assure that an on-going program of activities is designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. During an interview on 11/13/25, at 10:30 a.m. Activity Director Employee E8 indicated her previous employment was as a Nurse Aide, and they did not have prior experience in an activity program. Review of Activity Director Employee E8 file failed to include documentation meeting federal standards. During an interview on 11/13/25, at 3:26 p.m. Nursing Home Administrator confirmed that the facility failed to employ a qualified activities director. 28 Pa. Code 201.9(3) Personnel policies and procedures.