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	03/14/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, staff and resident interviews, it was determined that the facility failed to ensure that residents were free from mental and verbal abuse which caused a resident to experience severe psychosocial harm (embarrassment, humiliation) because of the abuse (Resident R1). This situation created an Immediate Jeopardy situation for one of six residents reviewed (Resident R1). Findings Include: Review of the facility provided policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property review date of 1/21/26, indicated This facility will not tolerate Abuse, Neglect, and Exploitation of its residents or the Misappropriation of Resident Property. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain, or mental anguish. Abuse includes deprivation by an individual, including caretaker of goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being. It includes verbal abuse, physical abuse, and mental abuse. In the case of staff abuse, the facility will follow the procedure for discipling or dismissing an employee, depending upon the circumstances and results of the investigation. Review of the clinical record revealed Resident R1 was admitted to the facility on [DATE], with diagnoses of acquired absence of left leg above knee, acquired absence of right leg above knee, and opioid dependence. Review of Resident R1's Minimum Data Set (MDS - mandated assessment of a resident's abilities and care needs) dated 1/20/26, revealed the diagnoses were current. Section C- Cognitive Pattern Brief Interview for Mental Status (BIMS) revealed a score of 15, cognitively intact. Review of Resident R1's care plan dated 8/12/24, indicated to encourage verbalization of feelings and fears through active listening. Review of Resident R1's physician order dated 12/9/25, indicated to administer 10 mg, oxycodone HCl oral tablet, every four hours related to opioid dependence. It was indicated to administer at 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8 p.m. During an interview on 3/13/26, at 8:45 a.m. Resident R1 stated on 3/11/26, he was requesting his pain medications and Licensed Practical Nurse (LPN), Employee E2 refused to give him his medication. It was indicated when LPN, Employee E2 told him she wouldn't help, he began yelling and screaming for help. The Nursing Home Administrator (NHA) threatened to have my a** kicked and to be physically harmed. Resident R1 stated the NHA came down and told me, I sound like an idiot, and if I had legs he would beat my a** right now. Resident R1 indicated the NHA was screaming out his medical history and the Director of Maintenance E4 had to pull and remove the NHA out of his room twice. Resident R1 stated he does not feel safe while the NHA is in the facility. The resident said there were multiple witnesses and he felt embarrassed and humiliated. Later, when LPN, Employee E2 entered the resident's room she flicked me off behind the curtain and when I confronted LPN, Employee E2, did it to my face, thinking it was a joke. Resident R1 stated he wrote a letter detailing the events and provided it RN Supervisor, Employee E3, the only person I trust. Resident R1 stated the facility did nothing and didn't investigate. During an interview on 3/13/26, at 8:48 a.m. Resident R3 confirmed she observed the altercation between the NHA and Resident R1. It was indicated the NHA physically threatened Resident R1. It was indicated the NHA mentioned his medical information and said he knows he's an (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	addict. Resident R3 stated the Director of Maintenance, Employee E4 had to carry him away twice. Resident R3 stated it was by far the worst thing I witnessed, and I was a social worker. Review of Resident R3's MDS dated [DATE], Section C-Cognitive Pattern Brief Interview for Mental Status (BIMS) revealed a score of 15, cognitively intact. During an interview on 3/13/26, at 8:54 a.m. Resident R4 was asked if she witnessed an incident on the morning of 3/11/26. Resident R4 indicated she was eating breakfast in her room, with her tray in front of her when she heard yelling and screaming. Resident R4 indicated the yelling lasted for about 20 minutes. During an interview on 3/13/26, at 8:55 a.m. Resident R13 was asked if he witnessed an incident on the morning of 3/11/26. Resident R13 stated he was in his room eating breakfast at the time and he heard commotion and yelling. It was indicated the yelling went on for about 20 minutes. Resident R13 stated, It was a bit ridiculous, sounded like someone was fighting the way they were exchanging words. During an interview on 3/13/26, at 8:57 a.m. Certified Occupation Therapy Assistant, Employee E5 stated he entered the facility five minutes after the incident took place. COTA, Employee E5 stated I mean it's unbelievable, especially with it being the NHA, he's supposed to set the tone. COTA Employee E5 stated the NHA continued to work the remainder of the day on 3/11/26. It was indicated the NHA is intimidating and he was aggressive with an ombudsman that came in. COTA, Employee E5 stated He has a short fuse, shouldn't be in that role. During an interview on 3/13/26, at 9:15 a.m. the Director of Maintenance, Employee E4 confirmed he had to remove the NHA out of the resident's room to deescalate the situation. During an interview on 3/13/26, at 9:23 a.m. the Director of Nursing (DON) stated she was working on a cart on 3/11/26, when she was notified Resident R1 was screaming and wanting to speak with her. The DON stated the NHA was coming in to the facility and asked him to see the resident. The DON confirmed the facility failed to protect Resident R1 from verbal abuse, which caused a resident to experienced severe psychosocial harm (embarrassment, humiliation) because of the verbal abuse. During an interview on 3/13/26, at 9:37 a.m. LPN, Employee E2 indicated on 3/11/26, Resident R1 started screaming for his medications and she notified him his pain medication was scheduled every four hours. The resident kept screaming, and LPN, Employee E2 said I never even stepped foot into room. LPN, Employee E2 stated she told Resident R1 your pain administration is every four hours, I can take an hour before or after. LPN, Employee E2 stated he kept screaming, and I simply told him, the ball is in your court so if you want to keep screaming, I don't have to come in. LPN, Employee E2 indicated she told the resident until you calm down, I am not coming in. LPN, Employee E2 stated I went outside to cool down, I was shaky, I went outside to smoke a cigarette. It was indicated the NHA came into the facility, and she notified him of the situation, and stated she told him I am not entering room until he calms down. It was indicated you could hear Resident R1 screaming, having behaviors, and cursing. LPN, Employee E2 indicated she was trying to tell Resident R1 people were still sleeping. LPN, Employee E2 stated she gathered info about pain medication, then continued with med pass. It was indicated the NHA knocked on door frame and opened Resident R1's door a little more to try to converse with him, and Resident R1 started screaming. LPN, Employee E2 was asked what was witnessed, and stated I put my headphone in and was listening to one of my podcasts, zoning it all out. It was indicated the NHA and Resident R1 were screaming, the NHA was telling him he needed to calm down, and the Director of Maintenance arrived and stuck around. LPN, Employee E2 indicated she entered Resident R1's room to try to get him to calm down. LPN, Employee E2 stated I said, listen I am preparing your meds, so we are done with the situation, it's not late one hour before one hour after. It was indicated Resident R1 apologized. LPN, Employee E2 stated I said regardless, you don't talk to human beings like that. When asked how long the interaction with the NHA and Resident R1 went on for, LPN, Employee E2 responded, It felt like an eternity, maybe 10-15 minutes. LPN, Employee E2 was asked if she gave Resident R1 the middle finger on 3/11/26 and responded, I may have. Review of Resident R1's letter on 3/13/26, dated 3/11/26, stated on Wednesday, 3/11/26, I am reporting 7:00 a.m. to 8:30 p.m. verbal and attempted physical abuse from the NHA and feel unsafe with him around. It was revealed (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	that a HIPPA violation of personal information was being yelled at in the hall by the same person. There are multiple witnesses. The names of witnesses were not provided to protect against retaliation, the jobs, and safety. Will be reporting to police if something is not done for threats on safety and health. It was indicated LPN, Employee E2 on same day and time was giving middle finger behind curtain, basically telling me to f**ck myself and when called out about it she did it to my face, thinking it was joke. Will be reporting to police if something is not done for threats on safety and health. During a phone interview on 3/13/26, at 10:09 a.m. Registered Nurse (RN), Employee E3 confirmed Resident R1 gave her a written concern on 3/11/26, regarding the abuse/neglect that took place. RN, Employee E3 said I have it in my work bag. Here is what he said, and I did hear it from several other employees that worked that day. It was indicated the only time the resident acts out is if he is not getting his medications on time, everyone knows he likes to get meds on time, very particular. RN, Employee E3 stated I really like Resident R1, he likes to joke, he has a funny personality. RN, Employee E3 stated From what I heard, it was pretty bad. On 3/13/26, at 1:31 p.m., Interim NHA, Employee E12 and the DON were made aware of Immediate Jeopardy (IJ) related to the facility, which failed to ensure that residents were free from mental and verbal abuse which caused a resident to experienced severe psychosocial harm (embarrassment, humiliation) because of the abuse (Resident R1). This situation created an Immediate Jeopardy situation for one of six residents reviewed (Resident R1). On 3/13/26, at 5:02 p.m. an acceptable Corrective Action Plan was received which included the following interventions: Immediate Action:-Root cause of this Immediate Jeopardy is that staff failed to follow facility abuse policy. -3/13/26, Resident R1 will be assessed for adverse outcomes related to abuse/neglect allegation from 3/11/26. Resident offered coping and trauma support by RN Supervisor or designee on 3/13/26. -Facility would ensure appropriate services are provided to residents if adverse outcomes occurred from abuse/neglect on 3/13/26 by Mobile DON or designee. -Assess all residents for abuse/neglect via assessment or interview on 3/13/26, by Mobile DON or designee for indications of fear, trauma or abuse/neglect. -Physician/POA if applicable will be notified of any adverse findings and medical record updated. -Care plans will be reviewed and updated as appropriate by Mobile DON or designee by 3/13/26. -Facility would ensure appropriate services are provided to residents if adverse outcomes occurred from abuse/neglect. Will also be reported to appropriate agencies on 3/13/26, by Mobile DON or designee. -All residents will be assessed or interviewed on 3/13/26, by Mobile DON or designee, including head to toe skin assessments, and findings will be documented in residents' medical records. The attending physicians will be notified of any negative results. Facility would ensure appropriate services are provided to residents if adverse outcomes occurred from abuse/neglect. -Interview staff by Regional Director of Operation or designee by 3/16/26, for allegations of abuse/neglect that have not been reported in the last 30 days. 30 days of incidents will be reviewed by Mobile DON or designee by 3/16/26, to ensure no incidents occurred that went unreported. If incidents are noted that meet criteria, they will be immediately reported. -Review the Abuse/Neglect Policy and deemed appropriate and what to do if alleged perpetrator is DON or NHA, update if needed. Included in staff education will include corporate compliance number for staff to utilize should the DON/NHA be involved or feel uncomfortable reporting to facility leadership. -All house staff and will be re-educated by 3/16/26, Regional Director of Operations or designee on the abuse/neglect policy and will include corporate compliance number for staff to utilize should the DON/NHA be involved or feel uncomfortable reporting to facility leadership. -Audits will be conducted starting 3/16/26, for resident's care needs to ensure no abuse or neglect is identified 3-5 residents 3x a week for 4 weeks. 5 days a week nursing documentation will be reviewed by Mobile DON or designee to ensure no incidents occurred that were unreported to administration. -Review all audits and policy changes related to immediate jeopardy at Ad Hoc QA meeting on 3/16/26. -Upon completion of audits, QAPI committee will review all findings. Resident R1 was assessed on 3/13/26. No adverse outcomes related to abuse/neglect allegation from 3/11/26 reported. Resident care plan was updated to offer emotional support and coping as needed. No adverse outcomes were noted for (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident R1. Resident R1 was offered emotional support and care plan was updated. 52/52 residents were assessed for abuse/neglect. 27/52 Residents with BIMS of 12 or higher were interviewed and reports of abuse/neglect were identified. 25/52 Residents with BIMS of 11 or lower were assessed for indications of fear, trauma, or abuse/neglect. 0/52 Residents had no indication of abuse/neglect that has occurred. 0/52 Residents were identified with any adverse findings. Resident R1's care plan was reviewed and updated on 3/13/26, to include interventions of offering coping and support as needed when resident is dealing with difficult situations. No adverse outcomes noted from abuse/neglect. Facility reported Resident R1's abuse/neglect on 3/13/26, and notified the appropriate agencies such as police and AAA on 3/13/26. 0/52 Residents had no indication of abuse/neglect that has occurred, no other reports were indicated. 58/68 Staff were interviewed for allegations of abuse and neglect that had not been reported in last 30 days. Staff failed to indicate any other abuse/neglect concerns other than the incident that occurred on 3/11/26, with resident R1. No new incidents were identified. Remaining 10/68 staff will be interviewed prior to start of next shift.Abuse policy was reviewed by Interim NHA, and revisions included the compliance hotline number to call if facility leadership is alleged perpetrators. 59/68 in-house staff were educated on abuse, reporting, and the compliance hotline number if leadership is involved in allegation. During in-person interviews conducted on 3/14/26, 17/17 staff members confirmed they were educated on abuse, reporting, and the compliance hotline number if leadership is involved in allegation. During phone interviews conducted on 3/14/26, from 10:40 a.m. to 11:09 a.m. 11/11 staff members confirmed they were educated on abuse, reporting, and the compliance hotline number if leadership is involved in allegation. Facility continues to educate staff via Carefeed, telephone, and in person prior to the start of their next shift. Facility will conduct audits starting on Monday, 3/16/26, for resident's care needs to ensure no abuse or neglect is identified 3-5 residents 3x a week for 4 weeks. 5 days a week nursing documentation will be reviewed by Mobile DON or designee to ensure no incidents occurred that were unreported to administration for resident care needs to ensure no neglect/abuse is identified. Facility will review audits and policy changes at Ad Hoc QA meeting that will be conducted on Monday, 3/16/26, inclusive of all IDT people and staff. Upon completion of all audits, the facility will review audits in monthly QAPI committee meeting. The Immediate Jeopardy was lifted on 3/14/26, at 12:13 p.m. when the action plan implementation was verified. During an interview on 3/14/26, at 1:37 p.m. the Director of Nursing and Interim NHA, Employee E12, confirmed the facility failed to ensure that residents were free from mental and verbal abuse which caused a resident to experience severe psychosocial harm (embarrassment, humiliation) because of the abuse (Resident R1). This situation created an Immediate Jeopardy situation for one of six residents reviewed (Resident R1). 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(d)(1)(3)(e)(1) 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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy, employee files, facility documents, staff interviews, it was determined that the facility failed to ensure all staff had a criminal background check prior to working in the facility for one of seven staff members (Social Worker, Employee E1). The facility failed to identify incidents of abuse/neglect, and timely report and investigate allegations of abuse/neglect for one of six residents (Resident R1). The facility put other residents at risk for abuse/neglect from the Nursing Home Administrator (NHA) and Licensed Practical Nurse LPN), Employee E2, by allowing the staff members to continue to work after abuse/neglect occurred. This failure created an immediate jeopardy situation.Findings include: Review of the facility provided policy titled Abuse, Neglect, Exploitation and Misappropriation of Resident Property review date of 1/21/26, indicated This facility will not tolerate Abuse, Neglect, and Exploitation of its residents or the Misappropriation of Resident Property. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain, or mental anguish. Abuse includes deprivation by an individual, including caretaker of goods and services that are necessary to attain or maintain physical, mental, and psychosocial well-being. It includes verbal abuse, physical abuse, and mental abuse. It is the policy of the facility to undertake background checks of all employees and to retain on file applicable records of current employees regarding such checks. The check must be completed prior to hiring a new employee. All alleged violations involving abuse and neglect will be investigated. Facility staff should immediately report allegations to the administration and Department of health. In cases where crime is suspected, staff should report the dame to law enforcement. Residents interested in family members, or other people may contact members of the administration or the facility's nursing staff at any time with concerns related to abuse and neglect. A person may also file a grievance. After notification, an investigation of the alleged violation will be conducted. Interview and obtain statements from the residents, the accused, and all witnesses. Evidence of the investigation should be documented. In the case of staff abuse, the facility will follow the procedure for discipling or dismissing an employee, depending upon the circumstances and results of the investigation. It is the policy of the facility that each of its own operated homes treat all residents with kindness, respect and in a manner that is at all times free from any form of abuse, neglect, misappropriation of property, exploitation, or mistreatment. To protect our residents, each of our homes will implement procedures in the areas of screening, training, prevention, identification, investigation, protection, reporting/response and corrective action. The facility has developed and implemented personnel and other policies to ensure that all staff are qualified and meet all regulatory standards for hire. In addition, we screen our employed contracted prior to employment, Employed staff, upon hire and at least annually through in-service education will receive training on issues related to abuse prohibition and prevention. We provided adequate supervision of our staff to identify inappropriate behaviors and to ensure that care/services are provided safely and as needed. We provide appropriate information to our staff of those residents with potential for aggressive behavior. Abuse and neglect will be identified through various methods such as reports from employed or contracted staff, utilization of resident incident reports, review prior incidents and any patterns of staff behaviors. Allegations involving residents, visitors, employees, or any other person must be reported to the Administrator or Director of Nursing (DON) immediately. The Administrator or DON will notify the Department of Health via electronic reporting system within 24 hours of the incident and complete an on-line PB-22 if directed to do. The County Area Agency on Aging will be contacted and a verbal report of allegation of abuse will be submitted within 24 hours of the event. All written reports shall include, at a minimum, the name and age of the resident, address of resident representative, address of the home, nature of the alleged offense, and any specific comments or observations that are directly related to the alleged incident and individuals involved. All investigation will be conducted thoroughly and will attempt to (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	gather as much information as possible. If a specific employee is suspected of abuse of a resident, the home shall immediately implement a plan of supervision or, where appropriate, reassignment, suspension or where appropriate, reassignment, suspension or termination of employment of the employee. The Elder Justice Care Act requires each owner, operator, employee, manager, agency, or contractor of a nursing home facility (a covered individual) to report any responsible suspicion of a crime no later than (2) hours after forming the suspicion. In addition to reporting all obligations described above, covered individuals must report any reasonable suspicion of a crime to the Department of Health and to the local police serving the community where the resident is receiving care. Review of Social Worker, Employee E1 employee file on 3/12/26, at 2:26 p.m. revealed a hire date of 1/27/26. Review of Social Worker, Employee E1's criminal background check revealed it was completed on 3/12/26. During an interview on 3/12/26, at 3:05 p.m. the Director of Nursing (DON) and Nursing Home Administrator (NHA) confirmed the facility failed to ensure all staff had a criminal background check prior to working in the facility for one of seven staff members (Social Worker, Employee E1). Review of the clinical record revealed Resident R1 was admitted to the facility on [DATE], with diagnoses of acquired absence of left leg above knee, acquired absence of right leg above knee, and opioid dependence. Review of Resident R1's Minimum Data Set (MDS - mandated assessment of a resident's abilities and care needs) dated 1/20/26, revealed the diagnoses were current. Section C- Cognitive Pattern Brief Interview for Mental Status (BIMS) revealed a score of 15, cognitively intact. During an interview on 3/13/26, at 8:45 a.m. Resident R1 started on 3/11/26, he experienced abuse/neglect from LPN, Employee E2 and the Nursing Home Administrator. Resident R1 stated he does not feel safe while the NHA is in the facility. Resident R1 stated he wrote a letter detailing the events and provided it to RN Supervisor, Employee E3, the only person I trust that same day. Resident R1 stated the facility did nothing and didn't investigate, and the alleged perpetrators continued to work. During an interview on 3/13/26, at 8:57 a.m. Certified Occupation Therapy Assistant (COTA), Employee E5 stated he entered the facility five minutes after the incident took place. COTA, Employee E5 stated I mean it's unbelievable, especially with it being the NHA, he's supposed to set the tone. COTA Employee E5 stated the NHA continued to work the remainder of the day on 3/11/26. It was indicated the NHA is intimidating and he was aggressive with an ombudsman that came in. He has a short fuse, shouldn't be in that role. COTA, Employee E5 stated Social Worker, Employee E1 is the NHA's wife, it's all a cover up, they all came from the same place and revealed the DON is married to the Director of Maintenance, Employee E4. During an interview on 3/13/26, at 9:15 a.m. the Director of Maintenance, Employee E4 confirmed he had to remove the NHA out of the resident's room to deescalate the situation on the morning of 3/11/26, and the NHA continued to work that day. Review of facility incidents failed to include the allegation of abuse/neglect that occurred to Resident R1 on 3/11/26. Review of information submitted to the State Agency on 3/11/26, and 3/12/26, failed to include Resident R1's incident of abuse/neglect. During an interview on 3/13/26, at 9:23 a.m. the Director of Nursing stated she was working on a cart on 3/11/26, when she was notified Resident R1 was screaming and wanting to speak with her. The DON stated the NHA was coming into the facility and asked him to see the resident. When asked how the facility was protecting Resident R1 from the alleged perpetrators, the DON indicated the NHA does not go down the hall where Resident R1 resides, that the NHA separates himself from the hall all together. The DON stated the NHA reached out to corporate. The DON stated, I knew about the verbal altercation, that's why we reached out to corporate, we were told not to call police by corporate. I know we had to do things, but corporations told us that is not what we do. The DON confirmed LPN, Employee E2 and the NHA continued to work in the facility and were not suspended. The DON confirmed the facility failed to timely report, investigate, notify the appropriate agencies, and protect residents from abuse/neglect from recurring for Resident R1. The DON stated I know what we had to do, corporation told me no. During an interview on 3/13/26, at 10:04 a.m. the Director of Nursing (DON) stated the NHA was just suspended, pending investigation. A total of two days, after the alleged abuse/neglect occurred to (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident R1. Review of Resident R1's letter dated 3/11/26, stated on Wednesday, 3/11/26, I am reporting 7:00 a.m. to 8:30 p.m. verbal and attempted physical abuse from the NHA and feel unsafe with him around. It was revealed that a HIPPA violation of personal information was being yelled at in the hall by the same person. There are multiple witnesses. The names of witnesses were not provided to protect against retaliation, the jobs, and safety. Will be reporting to police if something is not done for threats to safety and health. It was indicated LPN, Employee E2 on same day and time was giving middle finger behind curtain, basically telling me to f*ck myself and when called out about it she did it to my face, thinking it was joke. It was revealed RN, Employee E3 was made aware of the incident involving NHA and LPN, Employee E2 on 3/11/26. During a phone interview on 3/13/26, at 10:09 a.m. Registered Nurse, Employee E3 confirmed Resident R1 gave her a written concern on 3/11/26, regarding the abuse/neglect that took place. RN, Employee E3 stated I have it in my work bag. RN, Employee E3 stated When I came into work on Wednesday, I did hear other staff and the DON talking about this. RN, Employee E3 stated I wasn't sure who to give it to, didn't want to give it to NHA since it was against him. RN, Employee E3 stated I want to help out, I just don't know where to go with it. On 3/13/26, at 1:31 p.m., Interim NHA, Employee E12 and the DON were made aware of Immediate Jeopardy (IJ) related to implementation of the facility's abuse policy. The Interim NHA, Employee E12 was provided with the IJ Template, the facility failed to ensure all staff had a criminal background check prior working in the facility for one of seven staff members (Social Worker, Employee E1). The facility failed to identify incidents of abuse/neglect, and timely report and investigate allegations of abuse/neglect for one of six residents (Resident R1). The facility put other residents at risk for abuse/neglect from the Nursing Home Administrator and Licensed Practical Nurse, Employee E2, by allowing the staff members to continue to work after abuse/neglect occurred. A corrective action plan was requested. On 3/13/26, at 5:02 p.m. an acceptable Corrective Action Plan was received which included the following interventions: Immediate Action:-Root cause of this Immediate Jeopardy is that staff failed to follow facility abuse policy. -3/13/26, Resident R1 will be assessed for adverse outcomes related to abuse/neglect allegation from 3/11/26. Resident offered coping and trauma support by RN Supervisor or designee on 3/13/26. -Facility would ensure appropriate services are provided to residents if adverse outcomes occurred from abuse/neglect on 3/13/26 by Mobile DON or designee. -Assess all residents for abuse/neglect via assessment or interview on 3/13/26, by Mobile DON or designee for indications of fear, trauma or abuse/neglect. -Physician/POA if applicable will be notified of any adverse findings and medical record updated. Care plans will be reviewed and updated as appropriate by Mobile DON or designee by 3/13/26. -Facility would ensure appropriate services are provided to residents if adverse outcomes occurred from abuse/neglect. Will also be reported to appropriate agencies on 3/13/26, by Mobile DON or designee. -All residents will be assessed or interviewed on 3/13/26, by Mobile DON or designee, including head to toe skin assessments, and findings will be documented in residents' medical records. The attending physicians will be notified of any negative results. Facility would ensure appropriate services are provided to residents if adverse outcomes occurred from abuse/neglect. -Interview staff by Regional Director of Operation or designee by 3/16/26, for allegations of abuse/neglect that have not been reported in the last 30 days. 30 days of incidents will be reviewed by Mobile DON or designee by 3/16/26, to ensure no incidents occurred that went unreported. If incidents are noted that meet criteria, they will be immediately reported. -Review the Abuse/Neglect Policy and deemed appropriate and what to do if alleged perpetrator is DON or NHA, update if needed. Included in staff education will include corporate compliance number for staff to utilize should the DON/NHA be involved or feel uncomfortable reporting to facility leadership. -All house staff and will be re-educated by 3/16/26, Regional Director of Operations or designee on the abuse/neglect policy and will include corporate compliance number for staff to utilize should the DON/NHA be involved or feel uncomfortable reporting to facility leadership. -Regional Director of Operations or designee will educate HR or designee that criminal background checks are to be completed prior to hire. All staff HR files will be (continued on next page)

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	395160	A. Building B. Wing	03/14/2026

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

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	audited by HR or designee by 3/16/26, to ensure all background checks are present. Should a file be found without a criminal background check on 3/13/26, employee will not return to work until one is completed. -Audits will be conducted for 4 weeks starting 3/16/26, for HR files to ensure all criminal background checks are in existing employee files and all new hires will be audited to ensure a criminal background check is completed prior to start date. -Audits will be conducted starting 3/16/26, for resident's care needs to ensure no abuse or neglect is identified 3-5 residents 3x a week for 4 weeks. 5 days a week nursing documentation will be reviewed by Mobile DON or designee to ensure no incidents occurred that were unreported to administration. -Review all audits and policy changes related to immediate jeopardy at Ad Hoc QA meeting on 3/16/26. -Upon completion of audits, QAPI committee will review all findings. Resident R1 was assessed on 3/13/26. No adverse outcomes related to abuse/neglect allegation from 3/11/26 reported. Resident care plan was updated to offer emotional support and coping as needed. No adverse outcomes were noted for Resident R1. Resident R1 was offered emotional support and care plan was updated. 52/52 residents were assessed for abuse/neglect. 27/52 Residents with BIMS of 12 or higher were interviewed and reports of abuse/neglect were identified/ 25/52 Residents with BIMS of 11 or lower were assessed for indications of fear, trauma, or abuse/neglect. 0/52 Residents had no indication of abuse/neglect that has occurred. 0/52 Residents were identified with any adverse findings. No adverse outcomes noted from abuse/neglect. Facility reported Resident R1's abuse/neglect on 3/13/26 and notified the appropriate agencies such as police and Area on Agiing (AAA) on 3/13/26. No further abuse/neglect incidents were identified that required reporting. 58/68 Staff were interviewed for allegations of abuse and neglect that had not been reported in last 30 days. Staff failed to indicate any other abuse/neglect concerns other than the incident that occurred on 3/11/26, with resident R1. No new incidents were identified. Remaining 10/68 staff will be interviewed prior to start of next shift. Abuse policy was reviewed by Interim NHA, and revisions included the compliance hotline number to call if facility leadership is alleged perpetrators. 59/68 in-house staff were educated on abuse, reporting, and the compliance hotline number if leadership is involved in allegation. During in-person interviews conducted on 3/14/26, 17/17 staff members confirmed they were educated on abuse, reporting, and the compliance hotline number if leadership is involved in allegation. During phone interviews conducted on 3/14/26, from 10:40 a.m. to 11:09 a.m. 11/11 staff members confirmed they were educated on abuse, reporting, and the compliance hotline number if leadership is involved in allegation. Facility continues to educate staff via Carefeed, telephone, and in person prior to the start of their next shift. HR Director was educated on 3/13/26, that criminal background checks must be completed prior to the start date. Audit of 68/68 staff employee files revealed all background checks were completed. No further files were found without background checks. Starting 3/16/26, the HR Director will conduct weekly audits to ensure all criminal background checks are in existing employee files and all new hires are screened before starting date. Facility will conduct audits starting on Monday, 3/16/26, for resident care needs to ensure no neglect/abuse is identified 3-5 residents 3x a week for 4 weeks. 5 days a week nursing documentation will be reviewed by Mobile DON or designee to ensure no incidents occurred that were unreported to administration. Facility will review audits in monthly QAPI committee meeting. The Immediate Jeopardy was lifted on 3/14/26, at 12:13 p.m. when the action plan implementation was verified. During an interview on 3/14/26, at 1:37 p.m. the Director of Nursing and Interim NHA, Employee E12, confirmed the facility failed to ensure all staff had a criminal background check prior working in the facility for one of seven staff members (Social Worker, Employee E1). The facility failed to identify incidents of abuse/neglect, and timely report and investigate allegations of abuse/neglect for one of six residents (Resident R1). The facility put other residents at risk for abuse/neglect from the Nursing Home Administrator and Registered Nurse, Employee E2, by allowing the staff members to continue to work after abuse/neglect occurred. This failure created an immediate jeopardy situation. 28 Pa. Code 201.14(c) Responsibility of licensee.28 Pa. Code 201.18(e)(1) Management.28 Pa. Code 211.12(d)(5) Nursing services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, observation, and interviews with staff, it was determined that the facility failed to make certain residents were provided necessary treatment and services, consistent with professional standards of practice, for a pressure ulcer (PU/PIs- injuries to skin and underlying tissue resulting from prolonged pressure on the skin) for one of four residents (Resident R2).Findings include: Review of facility's policy, Pressure Injury Prevention and Management dated 1/8/25, last reviewed 1/21/26, indicated the facility is to provide treatment and services to heal the pressure ulcer/injury. Interventions for preventions will be implemented for all residents who have ap reassure injury. Interventions will be documented in the care plan and communicated to all relevant staff. Review of the clinical record revealed that Resident R2 was admitted to the facility on [DATE], with diagnoses with abnormal posture, paraplegia, and a pressure ulcer of the right ankle. Review of Resident R2's Minimum Data Set (MDS, periodic assessment of resident care needs) dated 2/12/26, indicated the diagnoses were current. Review of Section M: Skin Conditions indicated the presence of a Stage III (full-thickness skin loss) pressure ulcer. Review of Resident R2's care plan initiated 2/8/26, indicated to encourage to turn and position every two hours and as needed, and to float heels while in bed. Review of Resident R2's physician order dated 2/8/26, indicated to apply offloading boots when in bed. Review of Resident R2's physician order dated 2/12/26, indicated to turn and reposition every two hours. Review of Resident R2's Documentation V2 Report for February 2026, failed in include evidence the resident was turned and repositioned each shift for a total of 39 times. Review of Resident R2's Documentation V2 Report for March 2026, failed in include evidence the resident was turned and repositioned each shift for a total of 17 times. During an interview on 3/12/26, 10:01 a.m. Resident R2 stated he only gets out of bed once a day and confirmed he needs assistance with turning and repositioning. Resident R2 stated they do it for me maybe twice a shift. Resident R2 was observed lying in bed, without the offloading boots intact. The offloading boots were observed sitting in a chair. Resident R2 indicated staff have not offered to put on the offloading boots today. During an interview on 3/12/26, at 10:13 a.m. Licensed Practical Nurse (LPN), Employee E2 confirmed the resident's offloading boots were not on as ordered. During an interview on 3/12/26, at 10:55 a.m. the Director of Nursing (DON) stated if a resident at risk for pressure ulcers or has wounds upon admission, interventions are entered upon admission such as turning and repositioning, air mattress, wedges, or bunny boots. The DON stated it is expected all interventions are documented vat least each shift. The DON confirmed the facility failed to document the offloading boots were applied while in bed each shift for Resident R1. During an interview on 3/12/26, at approximately 3:05 p.m. the Nursing Home Administrator and the Director of Nursing confirmed that the facility failed to make certain residents were provided necessary treatment and services, consistent with professional standards of practice, for a pressure ulcer for one of four residents (Resident R2). 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of facility policy,, clinical records, and staff interviews, it was determined that the facility failed to ensure a physician completed the initial visits for three of four residents (Resident R5, R7, and R8).Findings include: Review of the facility's Physician Visits and Physician Delegation policy dated 6/1/24, last reviewed 1/21/26, indicated a physician assistant (PA), Nurse Practitioner (NP), and Clinical Nurse Specialist (CNS), may not perform initial comprehensive visits. Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE], with diagnoses of anxiety, depression, and lung cancer. Review of Resident R5's late entry note entered on 3/1/26, effective 2/25/26, revealed an initial visit was completed by Certified Registered Nurse Practitioner, Employee E20 for the resident's admission. The facility failed to ensure a physician completed the initial visit. Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE], and readmitted [DATE], with diagnoses of gastroparesis, anemia, and esophagitis with bleeding. Review of Resident R7's progress note dated 2/19/26, indicated the resident was readmitted to the facility. Review of Resident R7's late entry note entered on 2/25/26, effective 2/23/26, entered by CRNP, Employee E20, revealed the resident was assessed. The resident was discharged home from the facility on 1/28/26. The facility failed to ensure a physician completed the initial visit. Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE], with diagnoses of emphysema, dependence on oxygen, and alcohol dependence with withdrawal. Review of Resident R8's late entry note entered on 6/26/26, effective 6/25/26, entered by CRNP, Employee E20, revealed the resident was for an initial visit. The facility failed to ensure a physician completed the initial visit. During an interview on 3/13/26, at approximately 1:37 p.m. the Director of Nursing and Interim Nursing Home Administrator, Employee E12 information was disseminated that the facility failed to ensure a physician completed the initial visits for three of four residents (Resident R5, R7, and R8). 28 Pa. Code: 211.5(f)(g)(h) Clinical records.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on review of facility policy, resident observations, resident and staff interviews, it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for six residents (Residents R2, R3, R9, R10, R11, and R12).Findings include: Review of the facility policy Sufficient Nursing Staffing Policy dated 1/15/26, indicated it is the policy of this facility to maintain staffing practices that are consistent with federal regulations, state law, and professional standards of practice, while supporting safe and effective care. During an interview on 3/12/26, at 10:01 a.m. Resident R2 indicated the facility is understaffed. We are not showered. reason given; they (staff) just don't do it. Yesterday resident went to the doctor's office and did not give shower prior to going, didn't have wound on buttocks dressed, letting resident sit on buttocks for day. Resident tries to get staff to get resident out of bed, they won't do it. Once resident is put down in evening, on days they are out of bed, resident will be there until the next evening. During an interview on 3/12/26, at 12:11 p.m. Nurse Aide (NA) Employee E6 indicated there is not enough staff to turn and reposition residents, from what I hear from floors, it's hard to find someone to help when you need two people to assist. During an interview on 3/13/26, at 1:10 p.m. when asked if they felt the facility maintained enough staff to care for resident needs, Resident R9 indicated there are not enough staff. The past few months we aren't getting out of bed because there is not enough staff. We are not getting regular showers. Resident is scheduled showers every Tuesday and Friday and indicated they look forward to those showers and despite not receiving proper care, the facility doesn't charge any less to live there. During an interview on 3/13/26, at 1:13 p.m. when asked if they felt the facility maintained enough staff to care for resident needs, Resident R10 indicated it happens frequently that they don't have enough staff to put us back to bed if we get up on daylight. During an interview on 3/13/26, at 1:25 p.m. Resident R3 requested to speak with survey agency. Resident R3 indicated there is not enough staff. They plug other staff into the nurse aide spots but they don't give any care. They aren't on the floors. During an interview on 3/13/26, at 1:40 p.m. Resident R11 requested to speak with survey agency. Resident R11 indicated they have Lyme's disease (bacterial infection related to ticks), and their skin becomes very itchy. Indicated they have only received five showers in the past six weeks and are supposed to have two per week. Also indicated there have been days when they have not been cleaned up at all. There is just not enough help most days. During an interview on 3/13/26, at 1:50 p.m. Resident R12 indicated not having a problem with showers but has waited over an hour for staff to get a portable oxygen tank for resident to leave the room. During an interview on 3/14/26, at 9:20 a.m. NA Employee E6 was folding sheets in the laundry area. Indicated they are not working on the floor. During an interview on 3/14/26, at 9:34 a.m. NA Employee E7 indicated the facility lies on the staffing sheet. They put names on there that aren't really working or doing patient care. We never have enough staff. During an interview on 3/14/26, at 9:40 a.m. NA Employee E8 indicated they were the facility cook and had been pulled to the floor a few moments ago. Indicated they work the floor as a NA two days a week, but the facility tries to pull employee frequently and employee refuses indicating they were scheduled to work in the kitchen. During an interview on 3/14/26, at 9:45 a.m. Licensed Practical Nurse (LPN) Employee E9 indicated we have two maybe three aides today, census is 52. When asked to clarify, LPN indicated they pulled the cook from the kitchen who is also an NA. Basically, we only have one aide in each hallway (front and back hallways). During an interview on 3/14/26, at 9:48 a.m. LPN Employee E10 indicated honestly, they put names on the staffing sheet of employees who do not really help with care, they just walk up and down the hallway. Review of the initial staffing sheet provided on 3/14/26, indicated the following staff were scheduled for the 6:00 a.m. - 2:00 p.m. shift: NA Employee E7, NA Employee E11, NA Employee E8, NA Employee E1, and NA Employee E6. During interviews with facility staff on 3/14/26, between 9:20 a.m. and 11:00 a.m. it (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was discovered the following staff were actually working as follows for the 6:00 a.m. - 2:00 p.m. shift: NA Employees E7 and E11 were true NA's assigned for care. NA Employee E8 was actually the cook who was pulled from the kitchen area to give care. NA Employee E1 was actually the social worker who was pulled to give care. NA Employee E6 did not provide care; however, was discovered folding sheets in the laundry area. During an interview with the Interim Nursing Home Administrator Employee E12 on 3/14/26, at 11:05 a.m. the staffing sheet provided was questioned for being inaccurate to who was actually on the floors. Employee indicated they would look at the sheet and provide a revised staffing sheet. Review of the revised staffing sheet on 3/14/26, at 11:20 a.m. indicated the following staff were working as follows for the 6:00 a.m. - 2:00 p.m. shift: NA Employees E7 and E11, NA Employee E8 from 8:30 a.m. -2:00 p.m., NA Employee E13 from 9:30 a.m. - 10:00 p.m. who is actually an Activity Aide, NA Employee E1 who is the social worker, and NA Employee E6 who did not provide care but folding linens in the laundry room. During an interview with Human Resource Employee E14 on 3/14/26, at 11:30 a.m. it was verified that neither Social Worker Employee E1 or [NAME] Employee E8 had NA job descriptions or NA orientation in their employee files. During an interview on 3/14/26, at 11:35 a.m. the Interim Nursing Home Administrator confirmed that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for six residents (Residents R2, R3, R9, R10, R11, and R12). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(e)(6) Management.28 Pa. Code: 211.12(d)(1)(2)(3)(4)(f.1)(i)(2) Nursing services.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on staff interviews and review of employee files it was determined that the facility failed to employ a qualified Food Service Director to manage the daily operations of the Dietary Department for three out of three months (January 2026 through March 2026).Findings include: During an interview on 3/12/26 at 9:57 a.m. Kitchen Manager, Employee E21 had been employed as the Kitchen Manager since she started at the facility on 1/28/26, and that she was not a Certified Dietary Manager. A review of Kitchen Manager, Employee E21 employee file revealed a hire date of 1/21/26. The Kitchen Manager was a Nurse Aide. During an interview on 7/21/24, at 1:40 p.m., the Interim Nursing Home Administrator (NHA), Employee E12 and Director of Nursing (DON) confirmed that the facility failed to provide documented evidence that Kitchen Manger, Employee E21 met the qualifications for the position of Food Service Director. Pa Code: 201.18(e)(6) Management.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on a review of a job description, facility and clinical records, and staff interviews, it was determined that the Nursing Home Administrator (NHA) did not effectively manage the facility to make certain that residents were free from abuse and failed to make certain the facility implemented its abuse policies, creating an immediate jeopardy situation.Findings include: The job description for the NHA specified the primary purpose of the job position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality care can be provided to our residents at all times. Based on the findings in this report that identified that the facility failed to effectively manage the facility to make certain that residents were free from abuse and failed to make certain the facility implemented its abuse policies, resulting an immediate jeopardy situation. The facility failed to provide fundamental principal that apply to treatment and care provided to facility residents. The facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, and facility policies. 28 Pa Code 201.14(a) Responsibility of licensee.28 Pa Code 201.18(b)(1)(e)(1) Management.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on review of facility documents and staff interview, it was determined that the facility failed to accurately complete the Facility Assessment. Findings include: A review of the Facility Assessment, dated 3/26/25 revealed the facility did not complete the template to indicate accurate information on:-In the section titled, List of Key Personnel were the previous Nursing Home Administrator, the previous Director of Nursing, and the previous Assistant Director of Nursing.-In the section titled Census indicated time period of 2025 year to date.-In the section titled Information about our residents has not been reviewed since 3/26/25. During an interview on 3/14/26, at approximately 1:00 p.m. the Interim Nursing Home Administrator Employee E12 confirmed that the facility failed to accurately complete the Facility Assessment and that all the information about our residents was from last time employee worked at facility.28 Pa. Code 201.18(b)(3)(e)(2) 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of clinical records and staff interview, it was determined that the facility failed to appropriately and timely document progress note in the clinical record for four of four residents (Residents R5, R6, R7, and R8).Findings include: Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE], with diagnoses of anxiety, depression, and lung cancer. Review of Resident R5's late entry note entered on 3/1/26, effective 2/25/26, a total of four days later, revealed an initial visit was completed for the resident's admission. The facility failed to timely document in the resident's clinical record. Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE], with diagnoses of dementia, tremor, and history of falling. Review of Resident R6's late entry note entered on 3/13/26, effective 3/5/26, a total of eight days later, revealed the resident was seen for a right shoulder injection. The facility failed to timely document in the resident's clinical record. Review of the clinical record indicated Resident R7 was admitted to the facility on [DATE], with diagnoses of gastroparesis, anemia, and esophagitis with bleeding. Review of Resident R7's late entry note entered on 1/23/26, effective 1/19/26, a total of four days later, revealed the resident was seen for increased swelling to bilateral lower extremities. The facility failed to timely document in the resident's clinical record. Review of the clinical record indicated Resident R8 was admitted to the facility on [DATE], with diagnoses of emphysema, dependence on oxygen, and alcohol dependence with withdrawal. Review of Resident R8's late entry note entered on 2/25/26, effective 2/23/26, a total of two days later, revealed the resident was seen at the request of staff for nausea, vomiting, and diarrhea. The facility failed to timely document in the resident's clinical record. During an interview on 3/13/26, at approximately 1:37 p.m. the Director of Nursing information was disseminated that the facility failed to appropriately and timely document progress note in the clinical record for four of four residents (Residents R5, R6, R7, and R8). 28 Pa. Code: 211.5(f)(g)(h) Clinical records.

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	03/14/2026

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 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on review of facility education documents, and staff interview, it was determined that the facility failed to provide training on effective communication for five of five staff members (Registered Nurse (RN) Employee E15, and Nurse Aides (NA) Employee E8, NA E16, NA E17 and, NA E18).Findings include: Review of facility provided employee listing of hires prior to 3/13/25, indicated the following employees were hired on the following dates:RN Employee E15 - hire date of 5/15/24.NA Employee E8 - hire date of 10/30/23.NA Employee E16 - hire date of 2/29/24.NA Employee E17 - hire date of 9/10/24.NA Employee E18 - hire date of 12/4/24. Review of facility provided documents and training records for RN Employee E15, and NA's Employee E8, NA E16, NA E17 and, NA E18, failed to include education on effective communication as required. Interview on 3/14/26, at 1:00 p.m. the Interim Nursing Home Administrator Employee E12 confirmed that the facility failed to provide training on effective communication for five of five staff members (Registered Nurse (RN) Employee E15, and Nurse Aides (NA) Employee E8, NA E16, NA E17 and, NA E18). 28 Pa Code: 201.14 (a) Responsibility of licensee.28 Pa Code: 201.18 (b)(1) Management.28 Pa Code: 201.20 (a)(6)(d) Staff development.