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	06/01/2026

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, closed resident records, business office documents, and staff interview it was determined that the facility failed to convey funds credited to a resident's family for one of three closed resident records (Closed Resident Record CR3).Findings include: The facility Resident trust fund policy dated 1/16/26, indicated that the facility shall establish and maintain a system that ensure full, complete and separate accounting of each residents' account funds. Review of Closed Resident Record CR3's admission record indicated she was admitted to the facility on [DATE]. Review of Closed Resident Record CR3's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 9/21/25, indicated she had diagnoses upon admission that included lung cancer, diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), and hyperlipidemia (elevated lipid levels within the blood). Review of Closed Resident Record CR3's clinical nurse note dated 10/30/25, indicated staff called to Resident CR3's room by family stating they think she is gone. Staff assessed her and Resident CR3 was without apical pulse for a full minute, no respirations, pupils fixed and dilated. Resident CR3 has ceased to breathe at 9:28am. Hospice and DON notified. Daughter and son-in-law present at time of death and condolences given. Review of facility business office documents dated 5/28/26, indicated Closed Resident Record CR3 had a credit of $650 owed to her family. Review of Closed Resident Record CR3's clinical records and business office records did not indicate a credit issued to Resident CR3's family. During an interview on 5/28/26, at 11:56 a.m. Business office manager (BOM) Employee E1 confirmed that the facility failed to convey funds credited to a Closed Resident Record CR3's family as required. 28 Pa. Code 211.5(d) Clinical records. 28 Pa Code: 201.18(e)(1) Management.

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 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, facility documentation, clinical records, staff and resident representative interview, it was determined that the facility failed to protect a cognitive impairment resident (Resident R1) from non-consensual sexual contact by Closed Record Resident CR2 (Resident CR2) who had a history of sexually inappropriate behaviors with Resident R1. This failure resulted in an Immediate Jeopardy situation for one of 58 residents, when Resident CR2 was found exposing genitals to Resident R1, and Resident R1's hands were on Resident CR2's genitals. Findings Include: Review of facility policy Abuse, Neglect, and Exploitation dated [DATE], indicated that abuse can be identified as verbal, physical, mental, and sexual. The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves establishing a safe environment that supports, to the extent possible, a resident's consensual; relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to sexual contact will be made. The facility will make efforts to ensure all residents are protected from abuse, during and after an investigation of abuse. Examples include but are not limited to:Responding immediately to protect the alleged victim and integrity of the investigation. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed. Increased supervision of the alleged victims and residents. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator. Providing emotional support and counseling to the resident during and after the investigation as needed. Review of Resident R1's clinical record indicated that she was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated [DATE], indicated diagnoses of Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior) dementia (a decline in cognitive function that interferes with daily life), and bipolar disorder (a mental condition marked by alternating periods of elation and depression). Further review of MDS Section C- Cognitive Patterns, C0500 BIMS Summary Score indicated Resident R1 scored a 9, moderately impaired. Review of Resident R1's care plans dated [DATE], indicated she had impaired cognition for daily decision making. Review of Resident CR2's clinical record indicated that he was admitted to the facility on [DATE]. Review of Resident CR2's MDS dated [DATE], indicated diagnoses of high blood pressure, kidney disease, and age-related cognitive decline. Further review of MDS Section C- Cognitive Patterns, C0500 BIMS Summary Score indicated a score of 14, cognitively intact. Review of a written statement from Registered Nurse (RN) Employee E2 dated [DATE], indicated the following: [Resident CR2] went into [Resident R1's] room at approximately 3:25 p.m. and was bent over resident who was in bed. His hand (right) was under her covers near her breasts. He [Resident CR2] was bent over her face with his face. Later at approximately 5:30 p.m. he was back in the room bent over [Resident R1] with his hand under her covers near her breasts. Review of Resident R1's clinical progress note dated [DATE], at 10:00 a.m. was labeled Late Entry, and stated that Resident R1 had a fall in her room the evening of [DATE]. Shortly after her fall, a male resident [Resident CR2] entered resident's room to check on her to see if she was okay. Staff saw male resident in [Resident R1's] room and thought they saw his hands under her bed sheets near her chest area. Both residents deny any touching occurred. It was made known at the time of this report to this writer that this male resident and Resident R1 are friends and he normally pushes her to dining/activities and they visit together/eat meals together in dining room. Staff have witnessed the two residents kiss one another. [Resident R1] and male resident were kept separate and rooms are already a distance away from one another. Families of both residents were notified as well as physician. RN supervisor did skin assessment of [Resident R1]. Male resident was interviewed immediately, and he stated they are friends and have (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	kissed but no touching. RN supervisor also spoke with [Resident R1]. [Resident R1] states they are in a friendly relationship, have kissed but not touched. Both residents feel safe around one another and in the facility. Both families have been consulted with to see their preferences for intervention as well so that we are considering residents' rights. [Resident R1's] family specifically stated they want their mom to be happy and have meaningful relationships, however, until they can meet the male resident, they would like some boundaries put into place: no kissing, touching or private visiting in each other's rooms. This writer spoke to both residents regarding the boundaries put into place for right now, but that they could continue to eat meals together in the dining room and go to activities together. Nursing staff and Medical Director/Physician present and informed of boundaries to follow as well so that it is monitored. Both residents' care plans updated accordingly. Review of Resident R1's care plan dated [DATE] stated Resident desires to have a meaningful relationship with another resident. The following activities have been consented upon by both residents involved and/or guardians of listed residents: residents may go to meals and activities with male resident; no private in-room visits until family has had time to meet male resident; family wants mom to have meaningful relationships and for her to be happy. Review of Resident CR2's clinical progress note dated [DATE], at 10:54 a.m. stated the following: [Resident CR2] was with [Resident R1] coming up the hall from breakfast, this resident attempted to follow Resident R1 into her room, I informed this resident that he could not go into her room because she was going to lay down, this resident stated ok, but then went to kiss [Resident R1] on the lips, i informed this resident that he could not do this at this time and he stated like hell I can't I again told him and he said watch me and leaned down and kissed [Resident R1] on the lips. Review of Resident CR2's clinical progress note from Former Nursing Home Administrator (FNHA) Employee E3 dated [DATE], at 9:55 p.m. stated the following: Was notified by staff that constant re-direction is not working with resident. He continues to go into female resident's [Resident R1] room, witnessed by staff, and when asked to leave the room, gets angry. Starting at 9:30 p.m., resident is being placed on a 1-on-1 (direct supervision at all times from a dedicated assigned employee). This writer spoke to aides and RN supervisor of instruction. Doctor also notified. Should resident continue to not follow direction on specific boundaries put in place, discussions of a 30-day discharge will be had. A review of Resident CR2's clinical record conducted on [DATE], failed to reveal that CR2 had been placed on 1-1 supervision as indicated in the note above. Review of Resident R1's clinical progress note dated [DATE], at 10:03 p.m. stated Notified by nurse aide that resident (R1) had a bruise of unknown origin on the underside of her right breast. Upon assessment 5 cm (centimeter) round, reddish colored bruise noted. When questioned resident stated that she had a fall a couple days ago, she described herself slipping down out of her chair, unsure if her breast was injured at that time. She does not recall any other incident at this time. Denies pain/discomfort. Review of Resident CR2's clinical progress note dated [DATE], at 12:14 p.m. stated Resident was non-compliant with not kissing or touching Resident R1 after lunch today. He was again redirected by Nurse Aide (NA). Review of Resident CR2's clinical progress note dated [DATE], at 12:31 p.m. stated When confronted by nurse aide, this resident became angry that he was informed again that they are not allowed to kiss, he then went up to his room and [Resident R1] went to her room. Review of Resident R1's Physician's progress note dated [DATE], at 8:05 p.m. stated the following: New issue for resident has developed where she has created a friendship with a male resident that has created new challenges in terms of boundaries, the male resident wanting to cross personal boundaries, Resident (R1) is not against but needing to protect both residents. Family has been notified. Review of documentation provided by the facility revealed that Resident CR2 was placed on 15-minute checks on [DATE], whereas staff had to document that they observed him every 15 minutes to ensure his whereabouts. Review of Resident CR2's clinical progress note dated [DATE], at 2:07 p.m. stated the following: Resident (CR2) and [Resident R1] coming up the hallway when I looked up and noted [Resident CR2] to be kissing [Resident R1] in front of her room, DON (Former Director of Nursing Employee E4) also witnessed kissing. Review of Resident CR2's chart revealed that a diagnosis of (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	dementia was added on [DATE]. Review of documentation provided by the facility on [DATE], stated the following: Male resident (CR2) walked in Female Resident R1's room pulled pants down and Female Resident (R1) touched him. Housekeeper walked into the room and summoned nurse to room. He (CR2) was seen in the hall 5 mins (minutes) prior. Male Resident (CR2) placed on one to one (supervision) and remains on it. Review of a written statement from Housekeeping Employee E5 dated [DATE], stated [Resident CR2] was leaning over the bed. His hand was under the blankets [of Resident R1]. Notified the LPN (Licensed Practical Nurse Employee E6) and she went down to the room. Review of a written statement from LPN Employee E6 dated [DATE], stated Was charting when housekeeping came up to me and said, 'You may want to get that male resident out of [Resident R1's] room.' I went to [R1's] room and saw [Resident CR2] standing at the top of her bed with his pants slightly down and [Resident R1] was holding on to his penis. I said to [Resident CR2] 'You need to come with me. You know you are not permitted in [Resident R1's room].' He fixed his pants and walked up the hall with me. I then went to the DON (Director of Nursing) DON, and I went to the Administrator. Review of Resident CR2's clinical record revealed a note from Social Services dated [DATE], that stated This writer and the administrator (NHA) called resident's POA (power of attorney- giving authority to another person to act in all legal or financial matters on another person's behalf) to inform him of the interaction between the resident and a female resident. POA states that it may be one sided and that she [Resident R1] may have invited him in. Try to explain that cognitively that is not a possibility. And also stated that Administrator explained that the facility would like to transfer him to another facility unless he would prefer for resident to discharge home, and Administrator tried to explain the situation and that it was for the safety of the residents. Review of Resident CR2's clinical record failed to reveal that his care plan was updated to include the incident on [DATE]. Review of Resident CR2's clinical record revealed that he was discharged to home with family on [DATE]. During an interview on [DATE], at 10:45 a.m. NA Employee E7 stated that she was Resident R1's nurse aide on [DATE] when Resident CR2 was in her room with his pants down and Resident R1 was touching Resident CR2's penis. NA Employee E7 stated Staff found male resident with his pants down. I had only seen them previously holding hands and kissing, did not see the event that day. I was on a break. I'm glad I didn't see anything, I washed her hands real good afterwards. During an interview on [DATE], at 11:25 a.m. Housekeeping Employee E5 confirmed that she had seen Resident CR2 in Resident R1's room on [DATE]. I saw his hand under her covers near her groin area. I asked him, 'What are you doing?' and he moved his hand and I left to get help. Housekeeping Employee E5 added that she had not seen this behavior before but I didn't feel it was appropriate and so she reported it. During an interview on [DATE], at 11:43 a.m. LPN Employee E6 confirmed that she was the nurse assigned to Resident R1 on the day of the [DATE] incident, and that Resident CR2 was on 15-minute checks at the time of the event. Fifteen minutes is a long time to check in between when someone is ambulatory (able to move about freely). I was told by Housekeeping that [Resident CR2] was in [Resident R1's] room, I saw him [Resident CR2] at the head of the bed with, pants down and she (Resident R1) was holding on to his penis. I told him he needed to come with me now, he came willingly. He isn't allowed in her room. Housekeeping said his hand was underneath her blankets. He (Resident CR2) is the Former DON (Employee E4's) uncle and she knew of all the kissing that had happened before and she would say 'This is cute'. She (Former DON Employee E4) didn't take it seriously, which I feel is a conflict of interest. She's [Resident R1] very child-like, not all there. He (Resident CR2) knows what he is doing because he can go to her room. Her (Resident R1) family didn't want him near her. They were not giving the blessing of the relationship. I've known her (Resident R1) for nine years. She isn't capable of making her own decisions, she has Alzheimer's. State Agency asked LPN Employee E6 if either resident had seen by psychiatric services after the incident on [DATE], to which she replied No. During an interview on [DATE], at 1:40 p.m. the NHA stated that he was the NHA at the time of the incident on [DATE], and that he ensured that the facility placed Resident CR2 on one-to-one supervision after the [DATE] incident to prevent further (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	situations. The NHA also stated that Resident CR2 was the uncle of Former DON Employee E4 and described it as a conflict of interest in reference as to how the previous incidents were handled. During an interview on [DATE], at 8:35 a.m. the NHA confirmed that Resident R2 had not received any 15-minute checks, or one-on-supervision until [DATE], when every 15-minute checks began, and on [DATE] when the one-on-one supervision began. During an interview on [DATE], at 8:47 a.m. the NHA confirmed that the last psychiatric evaluation for Resident R1 was on [DATE], and that the last psychiatric evaluation for Resident CR2 was on [DATE], and that there had not been any referrals for either resident for follow up after the [DATE] incident. NHA also confirmed that individuals with Alzheimer's, and dementia cannot consent to sexual activity. On [DATE], at 9:30 a.m. the Immediate Jeopardy template was provided to the facility administration, and a Corrective Action Plan was requested. State Agency called Resident R1's Representative for interview. Representative unavailable, left message to return phone call. During an interview on [DATE], at 10:58 a.m. LPN Employee E8 stated she had been assigned to one-on-one visits with Resident CR2 after the incident on [DATE], and described it as It was the most boring eight hours of my life, and stated that resident was compliant with the direct supervision and did not display any behaviors or attempts to find Resident R1. During an interview on [DATE], at 11:12 a.m. NA Employee E9 stated that she had also been assigned to one-on-one supervision with Resident CR2 and stated that He never gave me a hard time, and was easily redirected. Review of Resident CR2 revealed no behaviors or sexual advances had occurred after one-on-one supervision was implemented on [DATE]. On [DATE], at 3:07 p.m. an acceptable Corrective Action Plan was received which included the following interventions: Resident CR2 has been discharged from facility on [DATE]. Resident R1 has been placed on the Psych list to be seen on [DATE], via video visit. Medical doctor is completing a physical assessment on [DATE]. Resident R1's Care plan was updated on [DATE], to include:Encourage resident to express any feelings of fear. Document any abnormal behaviors or moods. A full house audit of interviewable residents was completed by Social Services by [DATE]. Residents were interviewed regarding witnessing or experiencing abuse. No interview reflected abuse of any nature, all residents know who to report abuse should they ever experience or witness it. Non-interviewable residents were assessed by the DON/designee by [DATE] for signs or symptoms of fear trauma, neglect or abuse of any nature. No assessments reflected abuse of any nature, all residents remained at psychosocial baseline. No residents were deemed to have an immediate need to be added to the psychiatry list scheduled for [DATE]. Any future residents will be added to that list if needed. All [NAME]'s law checks were validated on [DATE], all residents have one present and uploaded to their chart. Facility will continue to run sex offender checks prior to admission.30 days of progress notes were reviewed on [DATE] by Regional Director of Clinical operations and none were reflective of any other resident witnessing or experiencing abuse. Abuse and Neglect policy was reviewed by Administrator on [DATE] and deemed current and appropriate. Administrator and Director of Nursing were educated by Regional Director of Clinical Operations on [DATE].Nursing staff will be educated on changes in mood or cognitive changes. Social Worker will be educated on [NAME]'s Law Checks. On unwanted aggressive/sexual behaviors.Social Worker will be educated on identifying resident fears. Beginning [DATE], Director of Nursing/designee will review progress notes five times per week to ensure no unwanted behaviors have occurred and update plans of care as deemed necessary if applicable should any reflect behaviors. Beginning on [DATE], Director of Nursing/designee will interview or assess ten residents weekly to ensure all remain free of abuse or unwanted behaviors. Audits will continue for four weeks. Results will be reviewed by QAPI (Quality Assurance and Performance Improvement) to determine further needs of audits. Review of residents at IDT (interdisciplinary team) Clinical will be completed by the Director of Nursing, or designee, at morning meeting five days per week to identify any aggressive behaviors identified. During a telephonic interview on [DATE], at 5:51 p.m. Resident R1's Representative stated that family was aware of the relationship between Resident R1 and Resident CR2, and replied She should have never been left alone with him. He should have never (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	touched her. and replied She is not able to make these decisions when State Agency asked about consenting to a physical relationship. She hasn't had any relations with men since her husband died eight to ten years ago. I can't believe that she would want this to happen. We were okay with them eating lunch together, but the touching is different. You know he [Closed Record Resident CR2] is the Director of Nursing's (Former DON Employee E4) uncle? Makes you question how the whole thing was handled. Review of facility documents, and clinical documentation on [DATE] revealed the following: Resident CR2 was discharged on [DATE] Resident R1 was evaluated by psychiatric services and medical doctor on [DATE].Resident R1's [DATE] Psychiatric evaluation indicated that BIMS score is now a 5 which is indicative of severe cognitive impairment. Resident R1 care plan was updated.30 out of 30 verbal residents were interviewed for abuse concerns, and 29 out of 29 non-interviewable residents were assessed for abuse concerns with both a physical skin check as well as an assessment of behaviors. No new concerns identified.59 out of 59 residents were verified to have had [NAME]'s Law screening completed. However, 36 were not completed until Plan of Correction was implemented on [DATE].Abuse policy was reviewed.30 days of progress notes verified as being reviewed by staff for potential concerns regarding abuse. No new concerns identified.75 of 81 employees received education on abuse and/or changes in mood or cognitive changes/identifying fears and [NAME] Law checks as appropriate. The remaining staff are to be educated before the beginning of their next shift.18 employees were interviewed who verified that they received the appropriate education. Audits to begin on [DATE]. Additionally, facility developed a screening tool for Sexual Urges and screened 30 out of 30 verbal residents for potential concerns with inappropriate sexual behaviors. During an interview on [DATE], at 10:37 a.m. Dietary Employee E10 confirmed that she received education on abuse. When State Agency asked if residents with dementia could consent to sexual activity, she said No. But isn't that obvious? During an interview on [DATE], at 11:39 a.m. Social Worker Employee E11 confirmed that residents with dementia cannot provide consent for sexual activities, and neither can their families. I don't think she (Resident R1) really did get what was happening. She is like a giggly teenager, she's childlike. The Immediate Jeopardy was lifted on [DATE], at 12:20 p.m. when the action plan implementation was verified. During an interview on [DATE], at 1:45 p.m. information was disseminated to the NHA that the facility failed to protect a cognitively impaired resident (Resident R1) from non-consensual sexual contact by Resident CR2 who had a history of sexually inappropriate behaviors with Resident R1 on [DATE], [DATE], [DATE], [DATE], and [DATE]. This failure occurred when the following concerns were not addressed: The facility failed to initiate one-on-one supervision on [DATE], when Former NHA Employee E3 indicated that constant re-direction was not effective to protect Resident R1 and that one-on-one supervision should begin. The facility failed to adhere to Physician's guidance documented on [DATE], that Male resident wanting to cross personal boundaries, Resident (R1) is not against but needing to protect both residents. The facility failed to ensure that Former DON Employee E4's relationship to Resident CR2 was not a factor in implementing any interventions to protect Resident R1. The facility failed to honor Resident R1's family's wishes to not have any kissing, touching, or private visiting between Resident R1 and Resident CR2 as per documentation on [DATE]. The facility failed to provide a timely medical and psychiatric evaluation for Resident R1 after incident on [DATE]. As the above inappropriate, sexual contact would reasonably cause anyone to have psychosocial harm, it can be determined that the reasonable person in these residents' position would have experienced severe psychosocial harm- dehumanization, and humiliation- as a result of sexual abuse. (Resident R1) The above failures resulted in an Immediate Jeopardy situation for one of 58 residents, when Resident CR2 was found exposing his genitalia to Resident R1, who had her hand placed on Resident CR2's genitalia on [DATE]. During an interview on [DATE], at3:35 p.m. the DON confirmed that the facility failed to investigate the bruise on Resident R1's breast that was described in [DATE], to rule out if it was obtained from a fall or from the incident on [DATE], when Resident CR2 was found with his hand on her breast area. 28 Pa. Code 201.14(a) Responsibility of licensee28 Pa. Code 201.18(b)(1) Management28 Pa. Code 211.10 (d) Resident care policies

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident clinical records, reports submitted to the State, and staff interview, it was determined that the facility failed to report allegations of sexual abuse for two of three sampled resident records (Resident R1 and Closed Resident Record CR2).Findings include: Review of the facility provided policy titled Abuse, Neglect, and Exploitation dated 3/13/26, indicated that 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, physical or sexual abuse. Sexual Abuse is non-consensual sexual contact of any type with a resident. The facility will have written procedures including reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes. Report immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Review of Resident R1's admission record indicated she was admitted on [DATE]. Review of Resident R1's MDS assessment (Minimum Data Set: MDS - a periodic assessment of care needs) dated 4/21/26, indicated she had diagnoses that included COPD (chronic obstructive pulmonary disease: a disease characterized by persistent respiratory symptoms involving breathlessness, coughing, and obstructed airflow to the lungs), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and dementia (a chronic or persistent disorder of mental processes caused by brain disease or injury associated with memory disorders, personality changes, and impaired reasoning). Review of Resident R1's care plans dated 8/22/25, indicated she had impaired cognition for daily decision making. Review of Resident R1's clinical nurse notes dated 4/7/26, indicated staff have witnessed the two (Resident R1 and Closed Resident Record CR2) kiss one another. Resident R1 and Closed Resident Record CR2 were kept separate and rooms are already a distance away from one another. Families of both residents were notified as well as physician. RN supervisor did skin assessment of Resident R1. Closed Resident Record CR2 was interviewed immediately, and he stated they are friends and they have kissed but no touching. RN supervisor also spoke with Resident R1 and she stated they are in a friendly relationship, have kissed but not touched. Review of Resident R1's clinical nurse notes indicated no concerns on 4/25/26 related to kissing. Review of Closed Resident Record CR2's admission record indicated he was admitted on [DATE]. Review of Closed Resident Record CR2's MDS assessment dated [DATE], indicated she had diagnoses that included age related cognitive decline, chronic kidney disease (a loss of kidney function resulting in the swelling of feet, fatigue, high blood pressure and changes in urination), hypertension (a condition impacting blood circulation through the heart related to poor pressure) and anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry). Review of Closed Record Resident CR2's clinical progress note dated 4/9/26, at 10:54 a.m. stated the following: [Closed Record Resident CR2] was with [Resident R1] coming up the hall from breakfast, this resident attempted to follow Resident R1 into her room, I informed this resident that he could not go into her room because she was going to lay down, this resident stated ok, but then went to kiss [Resident R1] on the lips, i informed this resident that he could not do this at this time and he stated like hell I can't I again told him and he said watch me and leaned down and kissed [Resident R1] on the lips. Review of Closed Record Resident CR2's clinical progress note dated 4/13/26, at 12:31 p.m. stated When confronted by nurse aide, this resident became angry that he was informed again that they are not allowed to kiss, he then went up to his room and [Resident R1] went to her room. Review of Closed Resident Record CR2's care plan (continued on next page)

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	06/01/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 4/20/26, indicated Resident R2 had been observed displaying sexually inappropriate behavior that included kissing. Review of Closed Resident Record CR2s clinical nurse note dated 4/25/26, indicated Resident R1 and Resident R2 were coming up the hallway when staff observed and noted Closed Resident Record CR2 to be kissing Resident R1 in front of her room, DON (Director of Nursing) also witnessed the kissing. Review of alleged abuse allegations submitted to the State field office did not include the sexual abuse incident involving Resident R1 and Closed Resident Record CR2 on 4/25/26. During an interview on 5/27/26, at 1:40 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to report allegations of sexual abuse for incident on 4/25/26, involving Resident R1 and Closed Resident Record CR2 as required. During an interview on 6/1/26, at 3:35 p.m. the DON confirmed that the facility failed to report allegations of sexual abuse for the incidents on 4926, and 4/13/26, involving Resident r1 and Closed Record Resident CR2 as required. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 211.10(d) Resident care policies.28 Pa. Code: 201.18 (b) (1) (e) (1) Management.28 Pa. Code: 211.12 (d) (1) (2) (5) Nursing services.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, facility documents, and staff interview, it was determined that the facility failed to conduct a thorough investigation involving an allegation of resident abuse for two of three sampled resident records (Resident R1 and Closed Resident Record CR2).Findings include: Review of the facility provided policy titled Abuse, Neglect, and Exploitation dated 3/13/26, indicated that 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, physical or sexual abuse. Sexual Abuse is non-consensual sexual contact of any type with a resident. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include: identifying staff responsible for the investigation; exercising caution in handling evidence that could be used in a criminal investigation; investigating different types of alleged violations; identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and providing complete and thorough documentation of the investigation. Review of Resident R1's admission record indicated she was admitted on [DATE]. Review of Resident R1's MDS assessment (Minimum Data Set: MDS - a periodic assessment of care needs) dated 4/21/26, indicated she had diagnoses that included COPD (chronic obstructive pulmonary disease: a disease characterized by persistent respiratory symptoms involving breathlessness, coughing, and obstructed airflow to the lungs), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and dementia (a chronic or persistent disorder of mental processes caused by brain disease or injury associated with memory disorders, personality changes, and impaired reasoning). Review of Resident R1's care plans dated 8/22/25, indicated she had impaired cognition for daily decision making. Review of Resident R1's clinical nurse notes dated 4/7/26, indicated staff have witnessed the two (Resident R1 and Closed Resident Record CR2) kiss one another. Resident R1 and Closed Resident Record CR2 were kept separate and rooms are already a distance away from one another. Families of both residents were notified as well as physician. RN supervisor did skin assessment of Resident R1. Closed Resident Record CR2 was interviewed immediately, and he stated they are friends and they have kissed but no touching. RN supervisor also spoke with Resident R1 and she stated they are in a friendly relationship, have kissed but not touched. Review of Resident R1's clinical progress note dated 4/10/26, at 10:03 p.m. stated Notified by nurse aide that resident (R1) had a bruise of unknown origin on the underside of her right breast. Upon assessment 5 cm (centimeter) round, reddish colored bruise noted. When questioned resident stated that she had a fall a couple days ago, she described herself slipping down out of her chair, unsure if her breast was injured at that time. She does not recall any other incident at this time. Denies pain/discomfort. Review of Resident R1's clinical nurse notes indicated no concerns on 4/25/26 related to kissing. Review of Closed Resident Record CR2's admission record indicated he was admitted on [DATE]. Review of Closed Resident Record CR2's MDS assessment dated [DATE], indicated she had diagnoses that included age related cognitive decline, chronic kidney disease (a loss of kidney function resulting in the swelling of feet, fatigue, high blood pressure and changes in urination), hypertension (a condition impacting blood circulation through the heart related to poor pressure) and anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry). Review of Closed Record Resident CR2's clinical progress note dated 4/9/26, at 10:54 a.m. stated the following: [Closed Record Resident CR2] was with [Resident R1] coming up the hall from breakfast, this resident attempted to follow Resident R1 into (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her room, I informed this resident that he could not go into her room because she was going to lay down, this resident stated ok, but then went to kiss [Resident R1] on the lips, i informed this resident that he could not do this at this time and he stated like hell I can't I again told him and he said watch me and leaned down and kissed [Resident R1] on the lips. Review of Closed Record Resident CR2's clinical progress note dated 4/13/26, at 12:31 p.m. stated When confronted by nurse aide, this resident became angry that he was informed again that they are not allowed to kiss, he then went up to his room and [Resident R1] went to her room. Review of Closed Resident Record CR2's care plan dated 4/20/26, indicated Closed Resident Record CR2 had been observed displaying sexually inappropriate behavior that included kissing. Review of Resident R2's clinical nurse note dated 4/25/26, indicated Resident R1 and Closed Resident Record CR2 were coming up the hallway when staff observed and noted Closed Resident Record CR2 to be kissing Resident R1 in front of her room, DON (Director of Nursing) also witnessed the kissing. Review of alleged abuse allegations documents investigated by the facility did not include evidence of a thorough abuse investigation. The records did not include witness statements, residents' assessments, other resident interviews, and notification to the families involving the incident with Resident R1 and Closed Resident Record CR2 on 4/25/26. During an interview on 5/27/26, at 1:40 p.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to conduct a thorough investigation involving an allegation of resident abuse that occurred on 4/25/26, for Resident R1 and Closed Resident Record CR2 as required. During an interview on 6/1/26, at 3:25 p.m. the DON confirmed that the facility failed to conduct a thorough investigation involving allegations of resident abuse that occurred on 4/9/26, 4/10/26, and 4/13/26, for Resident R1 and Closed Record Resident CR2 as required. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18 (b)(1) Management.28 Pa. Code: 211.10 (c)(d) Resident Care policies.28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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), and Director of Nursing (DON) 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 and DON 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.