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	06/30/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility provided documents, clinical records and staff interviews, it was determined that the facility failed to ensure that a resident's legal surrogate (power of attorney) was provided access to medical records for one of two residents (Resident R51).Findings include: Review of the clinical record revealed that Resident R51 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS - periodic assessment of resident care needs) dated 12/10/25, included diagnoses of neurogenic bladder (bladder problems due to disease or injury of the nervous system involved in the control of urination), anemia (too little iron in the body causing fatigue), and history of a stroke. Review of information submitted to the state survey agency on 6/12/26, indicated that a request for patient health information was submitted on 12/19/25. We reached out to the custodian on 12/31/2025. The custodian submitted incomplete records on 01/04/2026.From 01/21/2026 through 05/26/2026, we made multiple attempts to contact the custodian via phone calls, voicemails, and a HIPAA (Health Insurance Portability and Accountability Act of 1996) Violation Notice. Despite these efforts, the requested records remain outstanding. To date, the [facility] still has not released the records without any valid justification for such delay. Review of Resident R51's electronic medical record failed to reveal information related to the request for medical records. Review of an electronic communication dated 6/24/26, at 12:16 p.m. indicated the facility closed record failed to reveal information related to the request for medical records. During an interview on 6/25/26, at approximately 1:20 p.m. the Regional Director of Operations confirmed the request was received by a previous Nursing Home Administrator. The Regional Director of Operations confirmed the facility's legal department approved the release of information, but that the medical records had not been provided to the requestor by the facility. During an interview on 6/25/26, at approximately 1:30 p.m. the Regional Director of Operations and the Nursing Home Administrator confirmed the facility failed to ensure that a resident's legal surrogate (power of attorney) was provided access to medical records for one of two residents. 28 Pa. Code 201.14(b) Responsibility of licensee.28 Pa. Code 201.18(b)(1)(2)(3) 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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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of facility policies, employee file review, observations, and staff interviews it was determined that the facility failed to prohibit and prevent retaliation, as defined at section 1150B(d)(1) and (2) of the Social Security Act for five of fifteen staff members (Terminated Employees E1, E2, E3, E4, and E5) (Staff interviews to remain confidential).Findings Include: Review of the United States Social Security Act, Section 1150B indicated that:(d) Additional Penalties for Retaliation.-(1) In general.-A long-term care facility may not-(A) discharge, demote, suspend, threaten, harass, or deny a promotion or other employment-related benefit to an employee, or in any other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done by the employee; or(B) file a complaint or a report against a nurse or other employee with the appropriate State professional disciplinary agency because of lawful acts done by the nurse or employee, for making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to subsection (b)(1).(2) Penalties for retaliation.-If a long-term care facility violates subparagraph (A) or (B) of paragraph (1) the facility shall be subject to a civil money penalty of not more than $200,000 or the Secretary may classify the entity as an excluded entity for a period of 2 years pursuant to section 1128(b), or both.(3) Requirement to post notice.-Each long-term care facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of employees under this section. Such sign shall include a statement that an employee may file a complaint with the Secretary against a long-term care facility that violates the provisions of this subsection and information with respect to the manner of filing such a complaint. Review of the facility-provided Employee Handbook effective 4/1/20, indicated under the section entitled Disciplinary Procedures Disciplinary actions remain in effect for a twelve-month rolling calendar period. Review of the facility-provided Employee Handbook effective 4/1/20, indicated under the section entitled Policy for Detecting and Preventing False Claims and Statements, Including Whistleblower Protections:Disciplinary ActionIf it is determined that an employee has violated these policies, then disciplinary action will be taken, up to and including termination of employment. This applies to a failure to timely and fully report violations, and for interfering with another person's attempt to report. Anti-Retaliation[Facility] prohibits any retaliatory action against an employee for making a good faith report of a violation of this policy to [facility] or any government agency. During an observation on 6/25/26, at 12:41 p.m. of a staff lounge area a posting was displayed relating to the reporting of possible abuse and neglect of nursing home residents. The posting stated, An LTC (long-term care) facility cannot punish or retaliate against you for lawfully reporting a crime under this law. Examples of punishment or retaliation include firing/discharge, demotion, threatening these actions. During the survey conducted onsite on 6/22/26, and 6/23/26, 15 staff members were interviewed by the State Survey Agency surveyor, with only two interviews not being interrupted by the Nursing Home Administrator, the Interim Director of Nursing, or the social services employee (whose office was being utilized). On 6/23/26, a staff member stated to the surveyor that a paper with a phone number had been placed by the surveyor's computer who would like to speak to the surveyor. Upon observation, there was not a paper with a phone number present. Conversation with the staff member confirmed she had asked a nurse to place the phone number there. During an interview with the staff member who wanted to speak to the surveyor, they stated that the Interim Director of Nursing had called them and wanted to know why the staff member wanted to speak to the surveyor. Subsequently, the staff member contacted the surveyor again to inform the surveyor that they had been terminated for professionalism. The staff member stated that they had been terminated via a voicemail, and when they called into the facility and asked for a reason why they had been terminated, had been told, We will get back to you on that. The staff member stated additional staff members had been terminated. On 6/25/26, the surveyor returned to the facility and requested a list of names for the staff members that had been terminated, or would be terminated, since the survey (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	began on 6/22/26. The facility administration provided a list of six staff members. The employee files were requested for those staff members. Review of the personnel files for the six listed employees revealed: Terminated Employee E1: No disciplinary actions in the previous 12-month rolling calendar present. One performance evaluation completed, revealed all sections were documented as meets expectations or exceeds expectations. Terminated Employee E2: One disciplinary action in the previous 12-month rolling calendar present, for attendance. Last two performance evaluations revealed all sections were documented as meets expectations or exceeds expectations. Terminated Employee E3: One disciplinary action in the previous 12-month rolling calendar present, for not taking a meal break. No performance reviews were present. Terminated Employee E4: Performance section of the personnel file was empty. No performance reviews or disciplinary actions were present. Terminated Employee E5: No disciplinary actions in the previous 12-month rolling calendar present. Last two performance evaluations revealed all sections were documented as meets expectations or exceeds expectations. Terminated Employee E6: No disciplinary actions present. One performance evaluation completed, revealed all sections were documented as meets expectations or exceeds expectations. During an interview on 6/25/26, the Nursing Home Administrator (NHA) was asked the reasons for the terminations. Terminated Employee E1: Reason provided was professionalism. NHA stated that Employee E1 had refused to complete an admission on a new resident. When asked if there was information documented in the personnel file about Employee E1 refusing to complete the admission, the NHA confirmed that there was not. Terminated Employee E2: Reason provided was professionalism. NHA stated that Employee E2 had been aggressive with the NHA, and the Regional Human Resources staff member had to speak to her. When asked if there was information documented in the personnel file about Employee E2 being counseled by the Regional Human Resources staff member, the NHA confirmed that there was not. Terminated Employee E3: Reason provided was professionalism. NHA stated that several infractions were brought to her attention and stated that Employee E3 incited a verbal riot. When asked if there was information documented in the personnel file about Employee E3's infractions or the verbal riot, the NHA confirmed that there was not. Terminated Employee E4: Reason provided was professionalism. NHA stated Employee E4 also incited a verbal riot. When asked if there was information documented in the personnel file about Employee E4's behavior, the NHA confirmed that there was not. Terminated Employee E5: Reason provided was professionalism and job abandonment. NHA stated Employee E5 called off of work knowing that there was not sufficient staff for the residents. During this interview, the Nursing Home Administrator confirmed that the sixth employee was not being terminated. Confidential interviews completed during the survey included the following information:Staffing has been horrible. They make up names and numbers on the schedule. All day light called off because they cannot handle this. One nurse has over 30 residents. We keep telling them, they don't care. On 6/11/26, about eleven residents did not get medications. Stated she was told Interim DON took her phone number to the office. She said she was being grilled as to why she wanted to speak to the surveyor. Staffing has been a big issue, they are taking no effort to fix. Sometimes only 2-3 aides on the floor. Management doesn't care, they just leave it unsafe. It isn't possible to do all of the showers. I can have 15-20 residents. It's hard enough to be overwhelmed and we have Regional Director of Operations and the (Interim Director of Nursing) yelling at us. Many times when they are in the building and won't help. Confirmed she feels retaliated against. When asked about staffing, stated, There is a problem. There is not enough. Over a year ago, it was wonderful, but about six months ago it started dropping. Call lights are long. We are doing so much, it has been a very bad effect. Residents are waiting to be changed, especially if they need two people, because there is no one to help. It is very hard to give showers. It's scary, I don't know what I am coming into. I've had 20 residents; I'm running until my body gives out. I will just cry. At this point, NA became tearful and apologetic. I feel guilty, I don't want to leave, but I don't know what to do. I feel helpless. People getting fired. It seems to be a cluster of things since you guys came. We went without Agency for so long, and it hurt the facility for (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	so long and now it is a retaliation with people that are making complaints. Yesterday, a nurse and CNA, I think she was a CNA got fired. Yesterday there is somebody from corporate, she is standing in as the DON and the like head person. [Interim DON] told me along with somebody else literally to our faces, if we don't start keeping our mouths shut, the place will be shut down and we will all be out of a job and that they are weeding out everybody and I don't know what she meant by that, but it wasn't in any good tone or way, it's somehow got worse and right now, this week, there's agency, and we're stressed about losing our jobs. There was so much talk yesterday and so much going on it's hard to remember everything, it was keep your mouth closed and the more people complain that to the state the worse this is going to be. [Interim DON] said, Whoever calls the state will be immediately terminated. This was yesterday around 3 right after the nurse was escorted out like she was a criminal. Nothing was said or talked about why she was getting escorted out, she told them she was calling somebody about the staffing and this was retaliation. I'm afraid to speak to [Surveyor] at work, she's very nice but it's just because of the retaliation that's going on. Afraid for my job. Everything else is out in the open with our staffing and stuff .I hope that Agency continues so we are not so horribly staffed. More times than 1 where it was there by myself with 55+ patients and a dozen times or more it was just the 2 of us. I've never been in that situation. I don't want to leave the facility. I hope that something can be resolved for everybody, including the residents .and now the tension is horrible, it's not good for anybody. Stated that the facility is very short staffed. Has had 18 residents on her own. When asked what care isn't being done, stated they would like to be able to complete more rounds, give showers as needed, and be able to respond to call lights more quickly. Stated also that some residents aren't getting treatments because there are not nurse aides available to assist rolling patients to do dressing changes. Stated they were present on 6/11/26, and the social services employee working as a nurse was very stressed out, she's constantly being pulled. When asked about staffing, stated, There is none. It's just a lot. Nurses just as bad as the CNAs. Stated they have worked many 18 hour days, had 18-21 residents at a time. Stated residents are not getting sufficient showers, up in time for appointments, or being gotten out of bed for activities. Stated there they are unable to train new staff because they have to work so fast to get their job duties done due to having too many residents. Didn't come to work on 6/11/26 due to unsafe staffing. It's been bad for a while. This week they have two CNAs scheduled on shift. Stated residents are not getting regular showers, snacks are not getting passed. They are being touched only once or twice per shift. Confirmed that wound treatments are not being completed due to lack of staffing. It's horrible. I have 15-18 per day. Stated residents are not receiving showers regularly. Stated they were told by administrative staff, All you guys do is complain, complain. Why don't you do something about it. The last two weeks have been horrid. Stated that Interim Director of Nursing stated if they found out you called the state it is immediate termination with no warning. You have to call the corporate number first. Stated Interim Director of Nursing said she knows who is calling state. It's rough here. During an interview on 6/25/26, at approximately 1:30 p.m. the Regional Director of Operations and the Nursing Home Administrator were made aware that facility failed to prohibit and prevent retaliation for five of fifteen staff members. 28 Pa. Code: 201.14(a)(c) Responsibility of Licensee.

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on review of the Resident Assessment Instrument User's Manual, clinical records, and staff interview, it was determined that the facility failed to make certain that comprehensive Minimum Data Set assessments were completed in the required time frame for six of 24 residents (Resident R3, R6, R27, R15, R17, R20, and R37).Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2025, indicated that an admission MDS assessment was to be completed no later than 14 days following admission, and annual MDS assessment was to be completed no later than Assessment Reference Date (ARD). Resident R3 had an admission date of 4/20/26, with an MDS completion date of 5/15/26. Resident R6 had an Annual MDS ARD of 4/22/26, with an MDS completion date of 5/13/26. Resident R15 had an Annual MDS ARD of 4/2/26, with an MDS completion date of 6/4/26. Resident R17 had an admission date of 3/20/26, with an MDS completion date of 4/3/26. Resident R20 had an Annual MDS ARD of 4/22/26, with an MDS completion date of 5/13/26. Resident R37 had an admission date of 4/6/26, with an MDS completion date of 4/21/26. During an interview on 6/23/26, at approximately 5:30 p.m. the Regional Director of Operations confirmed that the facility failed to make certain that MDS assessments were completed in the required time frame for six of 24 residents. 28 Pa. Code: 211.5(f) Clinical records.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 clinical records, observations, and staff interview, it was determined that the facility failed to provide prescribed treatment and services related to the care of pressure ulcers for four of five residents (Resident R6, R16, R26, and R44).Findings include: The facility policy Pressure Ulcer Prevention and Management dated 3/13/26, indicated the facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. Review of the clinical record indicated Resident R6 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS, periodic assessment of resident care needs) dated 4/22/26, included diagnoses of paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), multiple sclerosis (a disease that affects central nervous system), and diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Review of Section M: Skin Conditions, indicated Resident R6 was at risk of pressure ulcer development, and at the time of the assessment had one Stage IV pressure ulcer (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) and two Stage III pressure ulcers (full-thickness skin and tissue loss). Review of Resident R6's Braden Scale assessments dated 4/25/26, indicated Resident R6 was at high risk for pressure ulcer development. Assessment completed on 6/5/26, indicated Resident R6 was at low risk for pressure ulcer development. Review of a wound nurse practitioner report dated 6/23/26, revealed the presence of a Stage IV pressure ulcer on the right ischium, a Stage IV pressure ulcer on the coccyx, and a Stage III pressure ulcer on the left ischium. Review of physician orders dated 4/29/26-6/2/26, 6/5/26-6/9/26, and 6/10/26, indicated for staff to cleanse and reapply a dressing to Resident R6's coccyx wound daily. Review of the Treatment Administration Record (TAR) for May and June 2026 failed to indicate that dressing changes were completed on the following dates (Resident R6 was present in the facility for all dates, no refusals of wound care documented): 5/2/26, 5/5/26, 5/12/26, 5/19/26, 6/2/26, 6/9/26, 6/11/26, 6/13/26, 6/17/26, 6/22/26, and 6/26/26. Review of physician orders dated 4/29/26-6/2/26, 6/5/26-6/9/26, indicated for staff to cleanse and reapply a dressing to Resident R6's posterior thigh wounds daily. Orders dated 6/10/26, indicated to cleanse left thigh and reapply a dressing and to cleanse right ischium and reapply a dressing. Review of the TAR for May and June 2026 failed to indicate that dressing changes were completed on the following dates (Resident R6 was present in the facility for all dates, no refusals of wound care documented): 5/2/26, 5/5/26, 5/12/26, 5/19/26, 6/2/26, 6/9/26, 6/11/26, 6/13/26, 6/17/26, 6/22/26, and 6/26/26. Review of the clinical record indicated Resident R16 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), heart failure (a progressive heart disease that affects pumping action of the heart muscles), and muscle wasting. Review of Section M: Skin Conditions, indicated Resident R16 was at risk of pressure ulcer development, and at the time of the assessment had no pressure ulcers. Review of Resident R16's Braden Scale assessments dated 6/7/26, indicated Resident R16 was at moderate risk for pressure ulcer development. Review of a wound nurse practitioner report dated 6/23/26, revealed the presence of a facility acquired Stage III pressure ulcer on the left buttock, a Stage III facility acquired pressure ulcer on the right buttock, and an unstageable (obscured full-thickness skin and tissue loss) pressure ulcer on the coccyx. Review of physician orders dated 6/3/26-6/14/26, indicated for staff to cleanse and reapply a dressing to Resident R16's left and right buttocks wounds daily. Review of physician orders dated 6/17/26, indicated for staff to cleanse and reapply a dressing to Resident R16's left and right buttocks wounds every other day. Review of the TAR for June 2026 failed to indicate that dressing changes were completed on the following dates (Resident R16 was present in the facility for (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	all dates, no refusals of wound care documented): Documentation on 6/10/26, 6/11/26. 6/5/26, was coded to view the progress note. Review of the associated progress notes failed to indicate if the dressing change was completed. Review of the clinical record indicated Resident R26 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of multiple sclerosis, high blood pressure, and neurogenic bladder (bladder problems due to disease or injury of the nervous system involved in the control of urination). Review of Section M: Skin Conditions, indicated Resident R6 was at risk of pressure ulcer development, and at the time of the assessment had one Stage IV pressure ulcer and two Stage III pressure ulcers. Review of Resident R26's Braden Scale assessments dated 5/14/26, indicated Resident R26 was at moderate risk for pressure ulcer development. Review of a wound nurse practitioner report dated 6/23/26, revealed the presence of a Stage IV pressure ulcer on the coccyx. Review of a physician order dated 4/22/26-5/14/26, indicated for staff to cleanse and reapply a dressing to Resident R6's coccyx wound daily. Review of physician orders dated 5/14/26-5/26/26, indicated for staff to cleanse and apply a wound vac dressing to Resident R6's coccyx wound daily. Review of a physician order dated 5/27/26-6/10/26, 6/10/26-6/17/26, 6/17/26-6/24/26, indicated for staff to cleanse and reapply a dressing to Resident R6's coccyx wound daily. Review of the TAR for May and June 2026 failed to indicate that dressing changes were completed on the following dates (Resident R26 was present in the facility for all dates, no refusals of wound care documented): 5/5/26, 5/12/26, 5/14/26, 5/19/26, 5/26/26, 5/28/26, 6/1/26, 6/4/26, 6/10/26, 6/11/26, and 6/24/26. Documentation on 5/1/26, 5/16/26, 5/29/26, 6/20/26, was coded to view the progress note. Review of progress note dated 5/1/26, at 1:01 p.m. indicated Resident R26 was out for an appointment. No further notes indicated if the dressing change was completed upon her return. Review of the associated progress note dated 5/16/26, at 11:55 a.m. indicated Resident R26 was out of bed. No further notes indicated if the dressing change was completed. Review of the associated progress note dated 5/29/26, at 1:47 p.m. indicated Not able to get to it this shift. Review of the associated progress note on 6/20/26 failed to indicate if the dressing change was completed. Review of the clinical record indicated Resident R44 was admitted to the facility on [DATE]. Review of the MDS dated [DATE], included diagnoses of lymphedema (the build-up of fluid in soft body tissues), high blood pressure, and coronary artery disease (CAD, damage or disease in the heart's major blood vessels). Review of Section M: Skin Conditions, indicated Resident R6 was at risk of pressure ulcer development, and at the time of the assessment had three Stage II (Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis) pressure ulcers. Review of Resident R44's Braden Scale assessments dated 4/28/26, indicated Resident R44 was at low risk for pressure ulcer development. Review of a wound nurse practitioner report dated 6/23/26, revealed the presence of two facility acquired Stage II pressure ulcers on the right thigh. Review of physician orders dated 5/13/26-6/17/26, indicated for staff to cleanse and reapply dressings to Resident R44's left and right daily. Review of physician orders dated 6/17/26, indicated for staff to cleanse and reapply dressings to Resident R44's left and right twice daily. Review of the TAR for May and June 2026 failed to indicate that dressing changes were completed on the following dates (Resident R44 was present in the facility for all dates, one refusal of wound care documented was documented on 6/8/26): 5/14/26, 5/21/26, 5/22/26, 5/25/26, 5/28/26, 5/29/26, 6/11/26, 6/13/26, 6/14/26, 6/15/26, 6/18/26 daylight, 6/21/26 evening, 6/22/26 evening. Documentation on 6/20/26, was coded to view the progress note. Review of the associated progress note on 6/20/26 failed to indicate if the dressing change was completed. During an interview on 6/25826, at 10:06 a.m. the Medical Director confirmed that she was not notified by facility staff about wound treatments not being completed. During an interview on 6/25/26, at approximately 1:30 p.m. the Regional Director of Operations and the Nursing Home Administrator confirmed the facility failed to provide prescribed treatment and services related to the care of pressure ulcers for four of five residents. 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 16 of 20 residents interviewed and/or observed (R3, R4, R5, R6, R10. R16, R17, R26, R30, R32, R39, R46, R47, R48, R49, and R50).Findings include: Review of the facility policy Sufficient Nursing Staffing Policy dated 3/13/26, 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 observation on 6/22/26, at 7:38 a.m. Resident R30's call light was observed to have been alarming for approximately ten minutes. At 7:39 a.m. a nurse aide walked by without looking into room to ensure resident safety. During an observation on 6/22/26, at 7:43 a.m. the Regional Director of Operations answered the call light. During an interview on 6/23/26, at approximately 2:00 p.m. Resident R46 was noted to be malodorous. When asked if there was sufficient facility staffing, stated, Not to hear them talk about it. During an observation on 6/23/26, at approximately 2:03 p.m. Resident R3 was noted to have long, unclean fingernails. During an interview on 6/23/26, at approximately 2:30 p.m. when asked if the facility maintained sufficient staff to provide resident care, Resident R48 stated, They need more. Observation at this time revealed Resident R48 to have dirty fingernails and unclean clothing on. During an interview on 6/23/26, at 3:33 p.m. Resident R10 stated that sometimes there is not enough staff. During an interview on 6/23/26, at approximately 4:00 p.m. when asked if the facility maintained sufficient staff to provide resident care, Resident R16 stated, Not all the time. When asked about call light response, stated, It depends on how many people are working. During an observation on 6/23/26, at 4:17 p.m. Resident R49 was observed to have long, unclean fingernails. Resident R49 stated, They took me to PT (physical therapy) and brought me back to the place where they watch TV and I was stuck there. My doctor said not to stay in my wheelchair a long time. I just got back into bed just now. During an interview on 6/23/26, at 4:20 p.m. Resident R50 was asked if he felt the facility maintained sufficient staff for resident care, and he began to laugh. Resident R50 stated, The staff are good, but there's not enough. During an observation on 6/23/26, at approximately 4:30 p.m. Resident R4 was noted to have facial hair, and greasy, unbrushed hair. During an interview on 6/23/26, at 4:32 p.m. Resident R17 was asked if she remembers a day when she did not receive her medications, and responded, It did happen. Got some of them it was very late. When asked if she felt the facility maintained enough staff to provide resident care, Resident R17 stated, Less recently, over the weekend wit was really bad. Resident R17 confirmed she had to provide assistance to her roommate over the weekend due to a lack of staff. During an interview on 6/23/26, at approximately 4:40 p.m. when asked if the facility maintained sufficient staff to provide resident care, Resident R6 stated, No. When asked about call light response she stated that it can be a couple hours. When asked if she received her showers, Resident R6 stated, If there is only three people they won't do your shower at all. The other day, I have a colostomy bag, it was getting full. I told somebody, they never came back. I told two people it was going to bust. It did, it was all over me, it was very messy. When asked about the party she had scheduled, she stated she had arranged with her family to celebrate her birthday and Father's Day for her husband, but here were no aides at all. I called my daughter and told her we have to cancel it because there's no one to get me out of bed. It was disturbing. During an interview on 6/23/26, at approximately 4:51 p.m. when asked if the facility maintained sufficient staff to provide resident care, Resident R26 stated, Oh no When asked if she received her showers, Resident R26 stated, Sometimes you get them, but there have been times there is not enough staff. During an interview on 6/23/26, at approximately 4:55 p.m. Resident R5 was asked if she remembers a day when she did not receive her medication, and responded, Yes. When asked if she felt the facility maintained sufficient staff to care (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	06/30/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for residents, Resident R5 responded No, and exaggeratedly shook her head negatively. When asked about call light response, Resident R5 stated, I push the button through the night because I went in my pants and they never did come. They put a diaper on me and forget about me. I need two people. I have to wait a long time for two people. I thought I was going to poop myself this morning. When asked if she received her showers, Resident R5 laughed. During an interview on 6/23/26, at 5:02 p.m. Resident R39 was asked if she remembers a day when she did not receive her medications, and responded, Yes. They didn't have no help, I kept telling them I have a bad heart. When asked if she felt the facility maintained enough staff to provide resident care, Resident R39 stated, Sometimes. When asked about call light response, Resident R39 stated, Sometimes they don't even come in period. they never respond. We sit here day and night in pee and poop. When asked if she consistently received her showers, Resident R39 shook her head negatively and stated, No. You get a bed bath when they feel like it, and I mean when they feel like it. During an interview on 6/23/26, at approximately 5:05 p.m. Resident R47 was asked if she remembered a day when she did not receive her medication, and she responded, Yes, it did happen. Resident R47 stated she did not receive her morning medication until approximately 1:00 p.m. Resident R47 further stated, I'm not supposed to go to the bathroom by myself but if I didn't, I would never go. I feel not seen and not heard. Am I even worth it, it makes me feel like nothing. During an interview on 6/23/26, at approximately 5:15 p.m. when asked if he remembered a day that he did not receive his medications, Resident R32 stated he got most of them but they were received very late. When asked if the facility maintained sufficient staff for resident care, he stated, Maybe not. When asked about call light response times, Resident R32 stated, sometimes they are all too busy with somebody else. When I urinate in the bottle because I don't' get to get to the bathroom, I hit that (call light) and some of them, they don't' come fast. Sometimes in the morning they don't come. That guy in the bed next to me starts to yell out, I need help. I need to go to the bathroom. Observation at this time revealed Resident R32 to have a brown substance under his fingernails. During confidential interviews completed between 6/22/26, through 6/25/26, revealed: Staffing is horrible. They make up numbers and no one is here. Confirmed that all nursing staff called off on 6/21/26, because they can't handle this. One nurse has over thirty (residents). We keep telling them and they don't care. On the eleventh (6/11/26), eleven or more residents did not get their medications. [Nurse] worked over 24 hours; [Nurse] worked over 20 hours. Stated that the staff do not have time to give showers and stated that the shower book is being documented as if they are given. There is no time to interact with the residents. They get them up and dressed, and they are done. Staff member confirmed the facility is still taking new admissions.Stated they have not come due to unsafe staffing. Stated, It's been bad for a while. This week they have only two CNAs (nurse aides) scheduled. Stated that due to low staffing showers are not getting done, snacks are not being passed, resident are being touched only once or twice per shift, wound treatments are not being done due to lack of staffing, and housekeeping staff have to assist in passing meal trays. Staff member confirmed the facility is still taking new admissions.It's rough here.It's horrible and confirmed she often has 15-18 residents per day on daylight shift. Stated showers are not getting done and that call light response times are long, but they are doing their best.Confirmed she has called off due to lack of staffing and not wanting to be the only nurse aide for approximately 60 residents. Stated she was told by administrative staff, All you do is complain, complain. Why don't' you do some thigh about it? Stated, The last two weeks have been horrid. Staff member confirmed the facility is still taking new admissions.When asked if they felt there was enough staff working at the facility, stated Sometimes enough, sometimes not. The weekend was a disaster. Environmental Services staff helped by passing out and collecting trays for breakfast and lunch. They answered call lights, but there was not much they could do, Sunday (6/21/26) was the worst I have seen it.There is a problem. There is not enough. Over a year ago, it was wonderful, but about six months ago it started dropping. Call lights are long. We are doing so much, it has been very bad. Residents are waiting to be changed, especially if they need two people, because there is no one to help. It is very hard to give showers. It's scary, I (continued on next page)

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	395160	A. Building B. Wing	06/30/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	don't know what I am coming into. I've had 20 residents, I'm running unit my body gives out. I will just cry. At this point, NA became tearful and apologetic. I feel guilty, I don't want to leave, but I don't know what to do. I feel helpless. During an interview on 6/22/26, at approximately 3:00 p.m. Registered Nurse (RN) Employee E1 confirmed she worked from 6/20/26, at 9:17 a.m. until 6/21/26, at 9:12 a.m. Stated she was supposed to leave at 1:30 a.m., but could not leave as there was no other registered nurses. Stated when she punched in, there were only two nurse aides presents. Registered Nurse Employee E1 confirmed she was both the RN Supervisor and a cart nurse. Stated that even though there was not sufficient staff, she received an admission at approximately 1:30 a.m. During an interview on 6/25826, at 10:06 a.m. the Medical Director confirmed that she was aware of the staffing deficiencies at the facility. The Medical Director stated that while the troops have been rallied, she stated that the facility has not been effective in implementing changes. During an interview on 6/25/26, at approximately 1:30 p.m. the Regional Director of Operations and the Nursing Home Administrator confirmed 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 16 of 20 residents interviewed and/or observed. 28 Pa. Code: 201.20(a)(c)(d) Staff Development28 Pa. Code: 211.12(c)(d)(1)(2)(5) Nursing Services

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of clinical records, facility policy, and staff and resident interviews, it was determined that the facility failed to ensure the complete and timely administration of a prescribed medications for 48 of 59 residents (Resident R1 through R48).Findings include: Review of facility policy Medication Administration dated 3/13/26, indicated, Medications are administered by licensed nurses, or other staff who are legally authorized to do so il this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Review of the Medication Admin Audit Report dated 6/11/26, indicated: Resident R1 had six medications ordered to be administered at 8:00 a.m., that were documented as administered at 3:32 p.m. Resident R2 had four medications ordered to be administered at 7:00 a.m. and two medications ordered to be administered at 8:00 a.m., that were documented as administered at 10:09 a.m. Resident R3 had two medications ordered to be administered at 7:00 a.m., that were documented as administered at 10:51 a.m. Resident R4 had nine medications ordered to be administered at 7:00 a.m., that were documented as administered at 10:22 a.m. Resident R5 had 17 medications ordered to be administered at 8:00 a.m., that were documented as administered between 11:18 a.m. and 11:30 a.m. Resident R6 had 14 medications ordered to be administered at 8:00 a.m., that were documented as administered at 8:40 a.m. and 8:41 a.m. Resident R7 had one injectable medication ordered to be administered at 8:00 a.m., that was documented as administered at 9:41 a.m. Resident R8 had 13 medications ordered to be administered at 8:00 a.m., that were documented as administered between 10:29 a.m. and 10:31 a.m. Resident R8 had one medication to be administered at 12:00 p.m. that was documented as administered at 3:26 p.m. Resident R9 had six medications ordered to be administered at 8:00 a.m., that were documented as administered at 9:22 a.m. Resident R8 had one medication to be administered at 12:00 p.m. that was documented as administered at 2:28 p.m. Resident R10 had six medications ordered to be administered at 8:00 a.m., that were documented as administered at 10:54 a.m. Resident R11 had five medications ordered to be administered at 7:00 a.m., that were documented as administered at 9:01 a.m. Resident R12 had three medications ordered to be administered at 7:00 a.m., that were documented as administered at 8:58 a.m. Resident R13 had five medications ordered to be administered at 7:00 a.m., that were documented as administered at 8:56 a.m. Resident R14 had six oral medications ordered to be administered at 8:00 a.m., that were documented as administered at 11:42 a.m. and 11:43 a.m. Resident R14 had two ophthalmic medications ordered to be administered at 8:00 a.m., that were documented as administered at 3:29 p.m. Resident R15 had 16 medications ordered to be administered at 7:00 a.m., that were documented as administered at 9:40 a.m. and 9:41 a.m. Resident R16 had two medications ordered to be administered at 12:00 p.m. that were documented as administered at 2:18 p.m. Resident R17 had 13 medications ordered to be administered at 7:00 a.m., that were documented as administered at 1:37 p.m. Resident R17 had three medications ordered to be administered at 12:00 p.m. that was documented as administered at 3:25 p.m. Resident R18 had eleven medications ordered to be administered at 8:00 a.m., that were documented as administered at 9:39 a.m. and 9:40 a.m. Resident R18 had one ophthalmic medication ordered to be administered at 12:00 p.m., that was documented as administered at 2:28 p.m. Resident R19 had two medications ordered to be administered at 8:00 a.m. that were documented as administered at 10:36 a.m. Resident R20 had five medications ordered to be administered at 7:00 a.m., that were documented as administered at 1:00 p.m. Resident R21 had two medications ordered to be administered at 7:00 a.m. that were documented as administered at 9:46 a.m. Resident R22 had 14 medications ordered to be administered at 8:00 a.m., that were documented as administered at 9:44 a.m. Resident R22 had one medication ordered to be administered at 12:00 p.m. and one to be administered at 1:00 p.m., both documented as administered at 2:24 p.m. Resident R23 had three medications ordered to be administered at 8:00 a.m., that were documented as (continued on next page)

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	395160	A. Building B. Wing	06/30/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered at 10:27 a.m. Resident R23 had one medication ordered to be administered at 12:00 p.m. that was documented as administered at 3:25 p.m. Resident R24 had seven medications ordered to be administered at 7:00 a.m. that were documented as administered at 8:13 a.m. Resident R24 had one medication ordered to be administered at 12:00 p.m. that was documented as administered at 2:38 p.m. Resident R25 had four medications ordered to be administered at 8:00 a.m., that were documented as administered at 9:52 a.m. Resident R26 had eight medications ordered to be administered at 7:00 a.m. that were documented as administered at 8:39 a.m. and 8:40 a.m. Resident R26 had two medications ordered to be administered at 12:00 p.m. that were documented as administered at 2:39 p.m. Resident R27 had eleven medications ordered to be administered at 8:00 a.m., that were documented as administered at 9:06 a.m. Resident R27 had one medication ordered to be administered at 12:00 p.m. that was documented as administered at 2:20 p.m. Resident R28 had four medications ordered to be administered at 8:00 a.m., that were documented as administered at 11:39 a.m. Resident R29 had ten medications ordered to be administered at 8:00 a.m., that were documented as administered at 9:16 a.m. Resident R29 had four medications ordered to be administered at 12:00 p.m. that were documented as administered between 2:26 p.m. and 2:28 p.m. Resident R30 had one medication ordered to be administered at 7:00 a.m. and twelve medications ordered to be administered at 8:00 a.m., and one medication that was ordered to be administered at 12:00 p.m., that were documented as administered at 3:36 p.m. Resident R31 had nine medications ordered to be administered at 7:00 a.m., that were documented as administered at 3:23 p.m. Resident R32 had ten medications ordered to be administered at 8:00 a.m., one medication ordered to be administered at 11:00 a.m., and one medication that was ordered to be administered at 12:00 p.m., that were documented as administered at 3:31 p.m. and 3:32 p.m. Resident R33 had four medications ordered to be administered at 7:00 a.m., that were documented as administered at 11:33 a.m. Resident R34 had ten medications ordered to be administered at 7:00 a.m., that were documented as administered at 8:35 a.m. and 8:36 a.m. Resident R33 had one medication ordered to be administered at 11:00 a.m., that was documented as administered at 2:41 p.m. Resident R35 had five medications ordered to be administered at 8:00 a.m., that were documented as administered at 9:43 a.m. Resident R36 had 15 medications ordered to be administered at 8:00 a.m., that were documented as administered at 9:55 a.m. Resident R35 had one medication ordered to be administered at 12:00 p.m., that was documented as administered at 2:45 p.m. Resident R37 had six medications ordered to be administered at 7:00 a.m., that were documented as administered at 11:18 a.m. Resident R38 had seven medications ordered to be administered at 7:00 a.m., that were documented as administered at 9:40 a.m. Resident R38 had two medications ordered to be administered at 12:00 p.m. that were documented as administered at 2:28 p.m. Resident R39 had five medications ordered to be administered at 7:00 a.m., that were documented as administered at 11:57 a.m. Resident R39 had one medication ordered to be administered at 7:00 a.m. and 12:00 p.m. that were documented as administered at 3:30 p.m. and 3:21 p.m. Resident R40 had ten medications ordered to be administered at 7:00 a.m., that were documented as administered at 12:17 p.m. and 12:18 p.m. Resident R41 had two medications ordered to be administered at 7:00 a.m. that were documented as administered at 10:17 p.m. Resident R41 had twelve medications ordered to be administered at 8:00 a.m., that were documented as administered at 10:18 a.m. Resident R41 had one medication ordered to be administered at 12:00 p.m., that was documented as administered at 3:18 p.m. Resident R42 had four medications ordered to be administered at 8:00 a.m., that were documented as administered at 10:46 a.m. Resident R42 had one medication ordered to be administered at 11:00 a.m., that was documented as administered at 3:27 p.m. Resident R43 had two medications ordered to be administered at 7:00 a.m., that were documented as administered at 3:22 p.m. Resident R44 had twelve medications ordered to be administered at 7:00 a.m., that were documented as administered at 8:21 a.m. Resident R45 had ten medications ordered to be administered at 8:00 a.m., that were documented as administered at 9:26 a.m. Resident R46 had eleven medications ordered to be administered at 7:00 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a.m., that were documented as administered at 10:49 a.m. Resident R46 had one medication ordered to be administered at 12:00 p.m. and one medication ordered to be administered at 1:00 p.m., that were documented as administered at 3:18 p.m. Resident R47 had six medications ordered to be administered at 8:00 a.m., that were documented as administered at 1:30 p.m. and 1:32 p.m. Resident R47 had two medications ordered to be administered at 12:00 p.m. and one medication taht was ordered to be administered at 2:00 p.m. that were documented as administered at 3:24 p.m. Resident R48 had five medications ordered to be administered at 7:00 a.m., that were documented as administered at 1:01 p.m. Resident R49 had six medications ordered to be administered at 7:00 a.m., that were documented as administered at 8:09 a.m. Resident R49 had two medications ordered to be administered at 12:00 p.m., that were documented as administered at 2:44 p.m. During an interview on 6/25826, at 10:06 a.m. the Medical Director confirmed that she was not notified by facility staff about missing and/or late medications on 6/11/26. During an interview on 6/25/26, at approximately 1:30 p.m. the Nursing Home Administrator confirmed that the facility failed to ensure the complete and timely administration of a prescribed medications for 48 of 59 residents. 28 Pa. Code 201.14 (a) Responsibility of Licensee28 Pa. Code 211.9 (a)(1)(d) Pharmacy services28 Pa. Code 211.10 (c) Resident Care Policies28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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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. Based on review of facility documents, clinical records, and staff interview, it was determined that the facility failed to make certain that medical records on each resident are completely and accurately documented.Findings Include:Review of the Medication Administration Audit Report for 6/11/26, indicated Licensed Practical Nurse (LPN) Employee E2 provided the following medications and treatments between 2:00 p.m. and 4:00 p.m.-83 oral medications-2 topical medications-7 injected medications-1 intravenous medication-6 inhaled medications-4 ophthalmic medications-4 blood sugar assessments-8 nutritional supplements provided-1 tuberculosis test assessed-29 pain assessments-6 skilled nursing assessments-3 whole body skin assessments-2 vital sign assessments-1 weight assessment During an interview on 6/25/26, at 12:50 p.m. LPN Employee E1 confirmed she did not provide all of the medications and treatments. LPN Employee E2 stated LPN Employee E3 had also provided some of the medications and treatments. LPN Employee E2 stated that she was told by the former Director of Nursing to just sign off on them since they were given. LPN Employee E2 stated, I did what I was told to do. Who am I to question the Director of Nursing? During an interview on 6/25826, at 10:06 a.m. the Medical Director confirmed that she was not notified by facility staff about medications not being received on 6/11/26. During an interview on 6/25/26, at approximately 1:30 p.m. the Nursing Home Administrator and the Regional Director of Operations confirmed that the facility failed to make certain that medical records on each resident are completely and accurately documented. 28 Pa. Code: 211.5(f)(g)(h) Clinical records.