

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Embassy of Saxonburg		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>46336</p> <p>Based on facility policy, observation and staff interview, it was determined that the facility failed to maintain the personal dignity for a resident during the dressing change observation (Resident R42).</p> <p>Findings include:</p> <p>Review of the facility policy Resident Rights dated 3/27/24, indicated the resident has a right to be treated with respect and dignity.</p> <p>During an observation of a dressing change on 6/30/24, at 10:15 a.m. Licensed Practical Nurse (LPN) Employee E5 performed the treatment and then took a marker from her pocket and dated the dressing after placing the outer dressing to Resident R42's abdomen.</p> <p>During an interview on 6/30/24, at 10:25 a.m. LPN Employee E5 confirmed that the facility failed to provide a dignified experience during the dressing change.</p> <p>28 Pa. Code: 201.29 (a)(b)(c) Resident Rights</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35785</p> <p>Based on review of facility policy, clinical records, incident reports, State reportable incidents, and staff interview it was determined that the facility failed to report an incident of resident-to-resident abuse altercation for one out of five sampled residents (Residents R24).</p> <p>Findings include:</p> <p>The facility Abuse, neglect and exploitation policy last reviewed 3/27/24, indicated that the facility will provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect and exploitation. The facility will have written procedures to assist staff in identifying different types of abuse. This includes certain resident to resident altercations. Reporting of all alleged violations to the Administrator, State agency, adult protective services and all other required agencies within specified time frames, which includes not later than 24-hours if the event that caused the allegation do not result in serious bodily injury.</p> <p>Review of Resident R24's admission record indicated he was admitted on [DATE].</p> <p>Review of Resident R24's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 3/14/24, indicated that he had diagnoses that included Parkinson's disease, chronic obstructive pulmonary disease (COPD: a disease characterized by persistent respiratory symptoms involving breathlessness, coughing, and obstructed airflow to the lungs), Neurocognitive disorder with lewy bodies (a progressive form of dementia characterized by memory loss and progressive or persistent loss of intellectual functioning associated with protein deposits in nerve cells in the brain), and hypertension (a condition impacting blood circulation through the heart related to poor pressure).</p> <p>Review of Resident R24's clinical nurse progress note dated 5/5/24, indicated that Resident R24 was slapped on the cheek by Resident R15 during dinner. Nurse aide reported that Resident R15 said Resident R24 was going to [NAME] him and this is why he hit him. Nurse aide reported that it was not a hard slap. Resident R24 has no marks on his cheek. Daughter, Doctor and Assistant Director of Nursing (ADON) Employee E7 were notified.</p> <p>Review of incident report dated 5/5/24, indicated Resident R24 was assessed and found without injury. Resident R24 and Resident R15 were separated.</p> <p>Review of reports submitted to the local State field office from May 2024 to June 2024 did not include the resident ro resident altercation involving Resident R24.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/1/24, at 2:01 p.m. Registered Nurse (RN) Employee E3 stated the following: I do remember the note about Resident R24. I was at the nurses' station. A Nurse aide told me they were pushing residents out of the dining room. Resident R24 and Resident R15 were in the hallway. Resident R15 said Resident R24 stole his car and Resident R15 reached out and smacked Resident R24 on the cheek. I assessed him. Resident R24 had a red mark. I notified family. I believe I did an incident report under risk management. I got a statement from everyone that was present. I reported the incident to Assistant Director of Nursing (ADON) Employee E7.</p> <p>During an interview on 7/1/24, at 2:30 p.m. the Director of Nursing (DON) confirmed that the facility failed to report an incident of resident to resident abuse altercation involving Resident R24 as required.</p> <p>28 Pa Code: 201.14 (a) Responsibility of Management.</p> <p>28 Pa Code: 201.18 (e)(1) Management.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on review of facility policy, clinical records, observations, and staff interviews it was determined that the facility failed to ensure that a resident's care plan was updated and revised to reflect the resident's specific care needs for one of four residents (Resident R56).</p> <p>Findings include:</p> <p>Review of facility policy Comprehensive Care Plans dated 3/27/24, indicated the care plan will describe, at a minimum, the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and resident specific interventions that reflect the resident's needs.</p> <p>Review of the admission record indicated Resident R56 was admitted to the facility on [DATE].</p> <p>Review of Resident R56's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/10/24, indicated the diagnoses of unspecified dementia with unspecified severity and other behavioral disturbances (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), impulse disorder (conditions that make it difficult to control your actions or reactions), and pain.</p> <p>Review of Resident R56's physician order dated 6/30/24, indicated ceftriaxone (an antibiotic) one-gram intramuscular injection every night for urinary tract infection.</p> <p>Review of Resident R56's progress notes dated 6/30/24, at 10:29 p.m. indicated labs showed elevated white blood cells, resident's antibiotic was administered intramuscularly in the right arm.</p> <p>Review of Resident R56's care plan on 7/2/24, at 10:20 a.m. failed to include a plan of care for urinary infection and treatment with intramuscular antibiotic.</p> <p>Interview on 7/2/24, at 10:23 a.m. Licensed Practical Nurse Assessment Coordinator (LPNAC) Employee E11 confirmed the Resident R56's care plan failed to include the urinary tract infection and treatment with antibiotic and that the facility failed to ensure that a resident's care plan was updated and revised to reflect the resident's specific care needs for one of four residents (Resident R56).</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on facility policy, observation, clinical record review, and staff interview, it was determined that the facility failed to provide treatment and services to prevent further decrease in range of motion for one of three residents (Resident R41).</p> <p>Findings include:</p> <p>Review of the facility policy Prevention of Decline in Range of Motion dated 3/27/24, indicated the facility will provide treatment and care in accordance with professional standards of practice. This includes appropriate equipment (braces or splints).</p> <p>Review of the admission record indicated R41 was admitted to the facility on [DATE].</p> <p>Review of Resident R41's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/31/24, indicated the diagnoses of dementia (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), anxiety, and high blood pressure.</p> <p>Review of Resident R41's current physician orders on 7/2/24, indicated washcloth to be put between resident's left fingers and palm for protection from fingernails. Orders failed to include an order for a left-hand palm guard.</p> <p>Review of Resident R41's care plan dated 6/26/24, failed to indicate instructions for left fingers and palm protection.</p> <p>Observation on 6/30/24, at 12:50 p.m. Resident R41 was observed in room with a palm guard (a splint that protects the palm) on the left hand.</p> <p>Observation on 7/2/24, at 11:22 a.m. Resident R41 was observed in the dining room with a palm guard on the left hand.</p> <p>Interview on 7/2/24, at 11:22 a.m. Nurse Aide (NA) Employee E10 indicated Resident R41 always has the palm guard on her left hand and wasn't sure when it's supposed to be applied or removed.</p> <p>Interview on 7/2/24, at 2:00 p.m. the Director of Nursing indicated we didn't know she even had the left palm guard, her family must have brought it, and confirmed the facility failed to provide treatment and services to prevent further decrease in range of motion for one of three residents (Resident R41).</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984</p> <p>Based on facility policy, clinical and facility record review, facility provided documents and staff interviews, it was determined that the facility failed to provide adequate supervision for two of six residents, resulting in a fall for one of six residents (Resident R24), and resulting in potential interaction with an unsecured disinfectant for one of six residents (Resident R56).</p> <p>Findings include:</p> <p>Review of facility policy Accidents and Supervision dated 3/27/24, indicated the resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes identifying hazards and implementing interventions to reduce hazards and risks.</p> <p>Review of the Resident Assessment Instrument 3.0 User's Manual effective October 2019, indicated that a Brief Interview for Mental Status (BIMS) is a screening test that aides in detecting cognitive impairment. The BIMS total score suggests the following distributions:</p> <p>13-15: cognitively intact</p> <p>8-12: moderately impaired</p> <p>0-7: severe impairment</p> <p>Review of the Admission Record indicated Resident R24 was admitted to the facility on [DATE].</p> <p>Review of Resident R24's Minimum Data Set (MDS - a periodic assessment of care needs) dated 6/14/24, indicated the diagnoses of Dementia (a group of symptoms that affects memory, thinking and interferes with daily life), Parkinsonism (to brain conditions that cause slowed movements, rigidity (stiffness) and tremors) and unsteadiness on feet.</p> <p>Section C: Cognitive Patterns, Question C0500 indicated a BIMS score of 3 - severe cognitive impairment.</p> <p>Review of fall risk evaluation form dated 4/8/24, indicated that Resident R24 had a score of 14 indicating high fall risk.</p> <p>Review of Resident R24's physician order dated 5/30/24, indicated OOB(out of bed) with assist of two.</p> <p>Review of facility provided documents dated 6/7/24 revealed Resident R24 was taken to the shower room by a NA(nurse aide) and placed on a shower chair toilet. She left to get supplies and help another NA pass trays. Resident pulled call light, another NA went to assist and found resident on the floor. No injuries noted.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the admission record indicated Resident R56 was admitted to the facility on [DATE].</p> <p>Review of Resident R56's MDS dated [DATE], indicated the diagnoses of unspecified dementia with unspecified severity and other behavioral disturbances (a general term for loss of memory, language, problem solving and other thinking abilities that are severe enough to interfere with daily life), impulse disorder (conditions that make it difficult to control your actions or reactions), and pain.</p> <p>Section C: Cognitive Patterns, Question C0500 indicated a BIMS score of 3 - severe cognitive impairment.</p> <p>Review of Resident R56's care plan dated 6/12/24, indicated resident lacks safety awareness.</p> <p>Observation on 7/1/24, at 10:22 a.m. Resident R56 was seated at the dining room table alone, (no staff were in the room). A chemical spray bottle was on the table within reach of the resident.</p> <p>Interview on 7/1/24, at 10:23 a.m. Dietary Manager Employee E1 confirmed the spray bottle was an unsecured chemical within Resident R56's reach and it should not have been left there.</p> <p>During an interview on 7/1/24, at 2:10 p.m. Director of Nursing confirmed the facility failed to provide adequate supervision for two of six residents, resulting in a fall for one of six residents (Resident R24), and resulting in potential interaction with an unsecured disinfectant for one of six residents (Resident R56).</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on review of facility documents, clinical records and staff interviews it was determined that the facility failed to identify and meet residents' highest practicable psych-social needs for one of six residents (Resident R33).</p> <p>Findings include:</p> <p>Review of the facility policy Behavioral Health Services dated 3/27/24, indicated it is the facility's policy to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning. The facility will monitor the resident closely for expressions or indications of distress and ensure appropriate follow-up assessments.</p> <p>Review of the admission record indicated Resident R33 was admitted to the facility on [DATE].</p> <p>Review of Resident R33's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/6/24, indicated the diagnoses of diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), high blood pressure, and heart failure (heart doesn't pump blood as well as it should).</p> <p>Review of the care plan dated 5/30/24, indicated Resident R33 displays depressive behaviors.</p> <p>Review of Resident R33's progress note dated 6/28/24, at 2:15 p.m. indicated Resident at first wanted to refuse her medication this morning stating I do not want things to keep me healthy. I want to die. I have nothing to live for except my sister.</p> <p>Further review of Resident R33's progress notes on 7/1/24, at 11:00 a.m. failed to include any documentation that she was monitored after making a statement of wanting to die three days prior.</p> <p>Observation on 6/30/24, at 1:19 p.m. Resident R33 sitting up in wheelchair sleeping.</p> <p>Interview on 6/30/24, at 1:20 p.m. Nurse Aide (NA) Employee E9 indicated She's been depressed lately.</p> <p>Interview on 7/2/24, at 2:00 p.m. the Director of Nursing confirmed that the facility failed to identify and meet residents' highest practicable psych-social needs for one of six residents (Resident R33).</p> <p>28 Pa. Code: 201.29 (a)(b)(c) Resident Rights</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>46336</p> <p>Based on review of facility policy, observations and staff interview it was determined that the facility failed to date opened medications and properly store medications in one of three medication carts observed (Middle medication cart).</p> <p>Findings include:</p> <p>Review of facility policy Storage of Medications dated 3/27/24, indicated the facility shall store all drugs and biologicals in a safe, secure, and orderly manner.</p> <p>Observation on 6/30/24, 8:40 a.m. the Middle medication cart indicated the following medications stored in the drawer without a date and time on the insulin pens, indicating date opened as required for Resident R33's Lispro insulin pen (a short acting, manmade version of human insulin), and Tresiba (an ultralong-acting insulin).</p> <p>Interview on 6/30/24, 8:40 a.m. Licensed Practical Nurse (LPN) Employee E5 verified the two medications were not dated when opened as required.</p> <p>Interview on 6/30/24, at 2:00 p.m. the Director of Nursing confirmed that the facility failed to date opened medications and properly store medications in one of three medication carts observed (Middle medication cart).</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>41984</p> <p>Based on observations and staff interview, it was determined that the facility failed to properly label and date food products in the reach-in cooler and walk- in freezer and failed to maintain sanitary conditions which created the potential for cross contamination (Main Kitchen).</p> <p>Findings include:</p> <p>During an observation of the main designated kitchen on 6/30/24, at 9:05 a.m. the following was observed:</p> <ul style="list-style-type: none"> - 6 sandwiches no label or date (reach in cooler) - 1 salad, not covered no label or date - 4 foam containers, no label or date - 2 bags (reach in freezer), not secured, no label or date - 6 bags hoagie buns (walk in freezer), no label or date - 2 boxes, magic cup, ice cream (walk in freezer) on the floor <p>During an observation of the dish room on 6/30/24, at 10:00 a.m. the following was observed:</p> <ul style="list-style-type: none"> -Dietary employee drying dishes with a towel <p>During an interview on 7/1/24 at 1:30 p.m. Dietary Manager E1 confirmed that the facility failed to properly label and date food products and practice proper infection control in the dish room which created the potential for food borne illness.</p> <p>28 Pa. Code: 201.18(b)(1) Management.</p> <p>28 Pa. Code: 211.6(c) Dietary services.</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46336</p> <p>Based on facility policy, clinical record review, observation, and staff interview, it was determined that the facility failed to prevent cross contamination during a dressing change for one of four residents (Resident 42) and failed to provide a safe and sanitary environment to help prevent the potential for cross contamination in the sole shower room.</p> <p>Findings include:</p> <p>Review of facility policy Dressing Change, Dry/Clean dated 3/27/24, indicated facility nurses will position the resident and adjust clothing to provide access to affected area. Pull glove over soiled dressing and discard into plastic bag. Wash and dry hands thoroughly. Put on clean gloves. Use clean technique (a set of practices used in healthcare to reduce the number of microorganisms and prevent contamination).</p> <p>Review of facility policy Infection Prevention & Control Program dated 3/27/24, indicated the facility will provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections.</p> <p>Review of the admission record indicated Resident R42 was admitted to the facility on [DATE].</p> <p>Review of Resident R42's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/22/24, indicated the diagnoses of diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), schizophrenia (characterized by thoughts or experiences that seem out of touch with reality, disorganized speech or behaviors, and decreased participation in activities of daily living), and surgical wound.</p> <p>Review of Resident R42's physician order dated 6/27/24, indicated to cleanse abdominal wound with Dakins 1/4 strength solution (wound cleanser), pack with Dakins moistened gauze cover with an abdominal pad daily.</p> <p>Observation on 6/30/24, at 10:15 a.m. of Resident R42's dressing change indicated Licensed Practical Nurse (LPN) Employee E5 removed soiled dressing, placed in trash can, moved trash can closer to the bed with her hands, donned new gloves and proceeded to pack wound with her fingers. LPN did not wash her hands prior to putting on the new gloves. During the treatment Resident R42's gown touched the open wound on three occasions contaminating the site.</p> <p>During an interview on 6/30/24, at 10:25 a.m. LPN Employee E5 confirmed not washing her hands prior to putting on new gloves as required, packing the wound with her fingers, and that the gown contaminated the open wound on three occasions.</p> <p>Observation of the sole shower room on 6/30/24, at 9:30 a.m. indicated the following:</p> <ul style="list-style-type: none"> -Shower room stall with a gallon jug of soap, without a lid, on the floor. -A bucket on the floor under the shower chair, <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395160	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Embassy of Saxonburg		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-A bottle of shampoo on the shower bench, a dirty washcloth on the floor, and a dirty towel on the shower bench.</p> <p>-The shower stall on the left had shower chair with a bucket attached underneath that had a brown substance smeared all over it.</p> <p>-The floor by the back door had a brown substance on it.</p> <p>Interview and tour on 6/30/24, at 9:40 a.m. LPN Employee E6 confirmed the observations of the shower room and indicated it was maintained as required to prevent cross contamination.</p> <p>Interview on 6/30/24, at 2:00 p.m. the Director of Nursing confirmed the facility failed to prevent cross contamination during a dressing change for one of four residents (Resident 42) and failed to provide a safe and sanitary environment to help prevent the potential for cross contamination in the sole shower room.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.</p>		