

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 06/04/2025
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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984</p> <p>Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the receiving health care provider for two of three residents sampled with facility-initiated transfers (Residents R28 and R61), failed to notify the resident or resident's representative of the facility bed-hold policy (an agreement for the facility to hold a bed for an agreed upon rate during a hospitalization) for three of three resident hospital transfers (Residents R28, R41, and R61), and failed to notify the Office of the State Long-Term Care Ombudsman upon transfer to the hospital for three of three resident hospital transfers (Resident R28, R41, and R61).</p> <p>Findings include:</p> <p>Review of facility policy Transfer and Discharge reviewed 2/19/25, indicated the facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand.</p> <p>Review of the clinical record indicated Resident R28 was admitted to the facility on [DATE].</p> <p>Review of Resident R28's Minimum Data Set (MDS - a periodic assessment of care needs) dated 5/14/25, indicated diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), hypertension (condition where the force of blood pushing against your artery walls is consistently too high) and chronic kidney disease.</p> <p>Review of the clinical record indicated Resident R28 was transferred to the hospital on 5/21/25, and returned to the facility on ,d+[DATE].</p> <p>Review of Resident R28's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of Resident R28's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 5/21/25.</p> <p>(continued on next page)</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 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/3/25, at 1:54 p.m. the Director of Nursing (DON) confirmed that there was no evidence that the necessary information was communicated to the receiving health care institution or provider upon transfer, and that the facility failed to notify the resident or resident representative of the facility bed-hold policy for Resident R28.</p> <p>Review of the clinical record indicated Resident R41 was admitted to the facility on [DATE].</p> <p>Review of Resident R41's MDS dated [DATE], indicated diagnoses of high blood pressure, coronary artery disease (damage or disease in the heart's major blood vessels), and abnormal posture.</p> <p>Review of the clinical record indicated Resident R41 was transferred to the hospital on 1/26/25, and returned to the facility on [DATE].</p> <p>Review of Resident R41's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 1/26/25.</p> <p>During an interview on 6/3/25, at 2:21 p.m. the DON confirmed that facility failed to notify the resident or resident representative of the facility bed-hold policy for Resident R41.</p> <p>Review of the clinical record indicated Resident R61 was admitted to the facility on [DATE].</p> <p>Review of Resident R61's MDS dated [DATE], indicated diagnoses of cerebral infarction (the death of brain tissue caused by a disruption in blood flow), hypertension (condition where the force of blood pushing against your artery walls is consistently too high) and muscle weakness.</p> <p>Review of the clinical record indicated Resident R61 was transferred to the hospital on 4/25/25, and returned to the facility on [DATE].</p> <p>Review of Resident R61's clinical record revealed no documented evidence that the facility had communicated specific information to the receiving health care provider for the residents transferred and expected to return, which included the resident's care plan goals, advanced directive information, specific instructions for ongoing care, resident representative information, and all information necessary to meet the resident's specific needs at the receiving facility.</p> <p>Review of Resident R61's clinical record failed to include documented evidence that the resident or the resident's representative were provided with written information about the facility's bed hold policy at the time of the transfer to the hospital on 4/26/25.</p> <p>During an interview on 6/3/25, at 2:13 p.m. the DON confirmed that there was no evidence that the necessary information was communicated to the receiving health care institution or provider upon transfer, and that the facility failed to notify the resident or resident representative of the facility bed-hold policy for Resident R61.</p> <p>A request to review facility documents on 6/4/25, of the facility's compliance in notifying the State Ombudsman Office revealed the facility failed to provide documented evidence of notifying the State Ombudsman Office of resident hospital transfer for the time period 1/2025 through 4/2025 for Residents R28, R41 and R61.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/4/25, at 9:39 a.m. the DON confirmed that the facility failed to provide documented evidence that the Office of the State Long-Term Care Ombudsman was notified upon transfer to the hospital for three of three residents (Resident R28, R41, and R61).</p> <p>28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48546</p> <p>Based on a review of facility policy, Resident Assessment Instrument (RAI) User's Manual, clinical records, and staff interviews, it was determined that the facility failed to ensure that Minimum Data Set (MDS - a periodic assessment of care needs) assessments accurately reflected the resident's status for three of three residents (Resident R66).</p> <p>Findings include:</p> <p>The Resident Assessment Instrument (RAI) User's Manual, which gives instructions for completing Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated the following instructions:</p> <p>Section A2105: Discharge Status: This item documents the location to which the resident is being discharged at the time of discharge. Select the two-digit code that corresponds to the resident's discharge status. Code 01, Home/Community: if the resident was discharged to a private home, apartment, board and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person.</p> <p>Review of the clinical record indicated Resident R66 was admitted to the facility on [DATE].</p> <p>Review of Resident R66's MDS dated [DATE], indicated diagnoses of anxiety, hyperlipidemia (high levels of fat in the blood), and underweight. Section A2105 was entered as 04, which indicated Resident R66 was discharged to a Short-Term General Hospital.</p> <p>Review of a nursing progress note dated 5/3/25, stated, 1140 resident arrived via stretcher with 2 attendants. Shortly after daughter & husband arrived at door daughter immediately stated this wouldn't work, it is way too far for her dad to drive & he has to see his wife every day. She stated that she knows that there are other facilities much closer & she wants her mom transferred. Explained that the auth is only good for this facility therefore we would have to contact the insurance company for a new auth & the other facility for admission process which likely wouldn't happen till Monday/Tuesday d/t (due to) the weekend. Daughter verbalized understanding & stated she would let me know what they were going to do shortly. Upon f/u (follow up) with daughter, daughter stated she was going to take her mom AMA, she stated she was a nurse & she is aware of the process. She also stated that she was in contact with the admissions director at another facility & they are working to get her an auth for admission ASAP. Reviewed AMA paperwork with daughter, daughter verbalized understanding & completed paperwork. Daughter & husband assisted resident to dress, transfer & get in car, left facility without incident 1315.</p> <p>During an interview on 6/4/25, at 9:16 a.m. the Director of Nursing (DON) stated, The person who filled out the MDS flipped the entrance and discharge status, it should be coded that she went home.</p> <p>During an interview on 6/4/25, at 9:16 a.m. the DON confirmed that the facility failed to ensure that MDS assessments accurately reflected the resident's status for Resident R66.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 211.5(f) Medical records.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41984</p> <p>Based on clinical record review and staff interview it was determined that the facility failed to make certain that residents were provided appropriate treatment and care for two of eight sampled residents (Resident R39, and R61).</p> <p>Findings include:</p> <p>Review of Resident R39's admission record indicated resident was admitted on [DATE], with diagnoses of high blood pressure, Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions), and encounter for other orthopedic aftercare.</p> <p>Review of Resident R39's quarterly MDS assessment (MDS-Minimum Data Set assessment: periodic assessment of resident care needs) dated 4/29/25, indicated that the diagnoses were current upon review.</p> <p>During an observation on 6/2/25, at 12:40 p.m. Resident R39 was observed with knee immobilizer braces on both legs.</p> <p>Review of Resident R39's clinical record failed to reveal a physician's order or a care plan for the use and management of the knee immobilizer.</p> <p>During an interview on 6/4/25, at 10:42 a.m. Therapy Director (TD) Employee E3 stated that Resident R39 was required to have knee immobilizers on at all times, but that they can be removed in bed for skin checks to ensure that skin is free from any abrasions. TD Employee E3 believed, that knee immobilizer can be removed for showering.</p> <p>During an interview on 6/4/25, at 11:46 a.m. the Director of Nursing (DON) confirmed that the facility failed to implement a physician's order and care plan for appropriate use and management of Resident R39's knee immobilizer.</p> <p>Review of Resident R61's admission record indicated he was originally admitted on [DATE], with diagnoses that included cerebral aneurysm (bulge or weakening in the wall of a blood vessel in the brain), hypertension and muscle weakness.</p> <p>Review of Resident R61's quarterly MDS assessment dated [DATE], indicated that the diagnoses were current upon review.</p> <p>Review of Resident R61's physician order's dated 2/26/25 indicated NPO (nothing by mouth) diet, NPO texture, NPO consistency.</p> <p>Review of Resident R61's physician order's dated 2/26/25 indicated to administer Hydroxyzine HCl Oral Tablet 25 MG (Hydroxyzine HCl). Give 1 tablet by mouth at bedtime for anxiety disorder.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident R61's physician order's dated 4/29/25 indicated to administer Bactrim DS Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim) Give 1 tablet by mouth every 12 hours.</p> <p>During an interview on 6/3/25, at 1:45 p.m. the DON confirmed that Resident R61's physician's orders were not followed as required.</p> <p>28 Pa. Code: 211.10(c)(d) Resident care policies.</p> <p>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46167</p> <p>Based on review of facility policy, resident record review, and staff interviews, it was determined that the facility failed to provide trauma survivors with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for one of three residents (Resident R39).</p> <p>Findings include:</p> <p>Review of facility policy Trauma Informed Care, dated 2/19/25, indicated that the facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident, and will be added to the resident's care plan.</p> <p>Review of the clinical record indicated Resident R39 was admitted to the facility on [DATE].</p> <p>Review of Resident R39's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/29/25, indicated diagnoses of high blood pressure, Post Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event and may have triggers that can bring back memories of trauma accompanied by intense emotional and physical reactions), and encounter for other orthopedic aftercare.</p> <p>Review of Resident R 39'S clinical record revealed an Initial Social Service History dated 4/23/25, that contained the following information:</p> <p>Have you had difficult experiences in your life? If so, would you like to discuss? Resident R39 was assaulted by a man and therefore feels uncomfortable having any mal care takers.</p> <p>What happens when you feel that you are reliving the experience? Anxious</p> <p>Are there any triggers that make you feel as if you are reliving the stressful experience? Male caretakers.</p> <p>Review of Resident R39's care plan on 6/3/25, failed to completely address PTSD by identifying the trigger of male care givers, and that Resident R39 should not have them.</p> <p>During an interview on 6/3/25, at 2:42 p.m. the Nursing Home Administrator confirmed that the facility failed to provide trauma survivors with trauma informed care to eliminate or mitigate triggers that may cause re-traumatization of the resident for one of three residents (Resident R39).</p> <p>28 Pa. Code: 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code: 201.18(b)(1) Management.</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>46167</p> <p>Based on facility policy, observations and staff interview, it was determined that the facility failed to properly label and date food products, in the Main Kitchen. (Main Kitchen).</p> <p>Findings include:</p> <p>Review of facility policy Dating for Dry Food Storage, dated 2/19/5, indicated that when receiving foods from delivery, assure the foods are packaged with a shipping label. If the food item is a shelf stable item, and left in the original container/box it was shipped in with a dated label, it does not require additional label or dating. If a food item that is shelf stable is removed from the original packaging/box from shipment, the item must have a date marked that it was received.</p> <p>During an observation in the Main Kitchen on 6/2/25, at 9:15 a.m. the following was noted:</p> <p>An opened bag of lettuce was in the tray line refrigerator with no label or date.</p> <p>Two cans of tuna with no receive date in the dry storage area.</p> <p>An open bag of garlic, and a bag of celery with no label or date in the walk-in refrigerator.</p> <p>Two apple pies with no receive date in the walk-in freezer.</p> <p>During an interview on 6/2/25, at 9:30 am the Assistant Dietary Manager Employee E2 confirmed that the facility failed to properly label and date food products in the Main Kitchen.</p> <p>Pa Code 201.14(a) Responsibility of licensee.</p> <p>Pa Code 201.18(b)(3) Management.</p>		