| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395160 | A. Building<br>B. Wing | 04/23/2026 |

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

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>Based on review of the facility's job descriptions, observations, and staff interviews, it was determined that the facility failed to ensure the consistent services of a full-time Director of Nursing (40 or more hours a week) in the facility.Findings Include: Review of the facility provided Director of Nursing (DON) job description, signed and dated 12/22/25, indicated that the DON position purpose was, to plan, organize, develop, and direct the overall operation of the Nursing Service Department in accordance with current federal, stated, local standards, guidelines, and regulations that govern the facility, and as may be directed by the Administrator and the Medical Director, to ensure the highest level of quality care is maintained at all times. Job duties include assist the designated Infection Control Coordinator, monitor the planning, conducting, and scheduling of timely in-service training classes, ensure that a sufficient number of licensed practical and/or registered nurses and nurse aides are scheduled and working during all shifts. Information reported to the State Department of Health indicated that the Director of Nursing started at the facility on 12/22/26. During an interview on 4/22/26, at 9:58 a.m. the Director of Nursing stated Monday to Friday during daylight shift she completes DON duties and cannot be on a medication cart. The DON indicated she acts as RN Supervisor and DON two to three times a week and sometimes is assigned a medication cart. The DON stated it's hard to do all the things. It was indicated she typically works 12 to 16 hours, 6-7 days a week. The DON confirmed she is also responsible for nursing education and Infection Preventionist. During an interview on 4/23/26, at 8:57 a.m. the DON was observed working on the floor and stated she was assigned to work as an aide for daylight shift. During an interview and observation on 4/23/26, at 9:17 a.m. Resident R2 was calling out for help while the DON was assisting surveyors. The DON yelled across the hallway to the resident that she'll be right there. The DON confirmed she was assigned the C Wing Hallway and was providing direct resident care. During an interview on 4/23/26, at 10:04 a.m. Licensed Practical Nurse (LPN) Social Worker, Employee E5 confirmed she was assigned to a cart on C Wing and the DON is working as the nurse aide. It was indicated the DON works on the medication cart sometimes. During an observation on 4/23/26, at 10:11 a.m. the DON was observed providing care to Resident R2. During an interview on 4/23/26, at 11:32 a.m. the Nursing Home Administrator and confirmed the facility failed to ensure the consistent services of a full-time Director of Nursing (40 or more hours a week) in the facility. 28 Pa Code 201.3 Definitions.28 Pa Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(e)(6) Management.28 Pa. Code 211.12(b)(c)(d) Nursing Services. |

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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on review of facility policy, observations and staff interview, it was determined that the facility failed to properly store, label and date food items in the Main kitchen which created the potential for food borne illness.Findings include: Review of the facility policy Dating for Food Storage dated 3/16/26, and previously dated 1/21/26, indicated that when receiving foods from delivery, assure the foods are packaged with a shipping label. If the food item is removed from the original packaging/box from shipment, the item must have a date marked that it was received. In addition to labeling, dating items requires special attention. All foods that require time and temperature control should be labeled with the following: common name of food, date the food was made, use by date. If the food is not used within the days allowed to be held it must be discarded. Items that are being stored in the freezer must be labeled, dated, sealed in the same manner and may store for the period of time per guidelines. During a observation in the Main Kitchen in the walk-in freezer on 4/20/26, at 10:10 a.m. the following was observed: an opened bag of tater tots with no label, or date marked to indicate what date it was opened, two bags of frozen noodles that were not labeled, or marked with a received date, three grocery bags of ice cream cups with no label or receive date, a plastic container of kielbasa and sauerkraut that had the lid off-center (not sealed) with a use-by date of 4/10/26. During an observation in the Main Kitchen I stand-up freezer on 4/20/26, at 10:16 a.m. a bag of potatoes was observed with no label, or receive date. During an interview on 4/20/26, at 10:19 a.m. Kitchen Manager Employee E6 confirmed the above findings, and stated that the ice cream was brought in by a resident's family and it would not fit into the freezer in the nursing unit that is provided for resident use. Kitchen Manager Employee E6 informed that storing resident food in the freezer is not appropriate as chain of custody of the food and food safety is not guaranteed. Kitchen Manager Employee E6 confirmed that the facility failed to properly label, date, and store food items that created a potential for food borne illness. 28 Pa. Code: 201.18(b)(1) Management.28 Pa. Code: 201.14(a) Responsibility of licensee. |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observe each nurse aide's job performance and give regular training.<br><br>Based on review of facility policy, personnel records and staff interviews, it was determined that the facility failed to complete annual performance evaluations for four of five nursing staff (Nurse Aide (NA) Employees E10, E11, E12, and E13).Findings include: Review of facility Employee Performance Evaluations policy dated 3/16/26, indicated all employees receive timely, fair, and consistent performance evaluations. After 90 days, performance evaluations are conducted annually. Review of NA Employee E10's personnel record indicated a hire date of 2/7/24. Last employee performance evaluation was dated 6/20/24. Review of NA Employee E11's personnel record indicated a hire date of 10/30/23. Last employee performance evaluation was dated 11/11/24. Review of NA Employee E12's personnel record indicated a hire date of 2/29/24. Last employee performance evaluation was dated 8/7/24. Review of NA Employee E13's personnel record indicated a hire date of 6/22/23. Last employee performance evaluation was dated 6/24/24. Review of personnel records did not include an annual performance evaluation based on the date of hire for NA Employees E10, E11, E12, and E13. During an interview on 4/22/26, at 9:20 a.m. Human Resource Employee E4 stated, We are behind in evaluations and are trying to get caught up, and confirmed that the facility failed to complete annual performance evaluations for four of five nursing staff personnel records (Employees E10, E11, E12, and E13). 28 Pa Code: 201.20 (a)(b)(d) Staff development. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on review of a resident representative's concern, and staff interview, it was determined that the facility failed to ensure that residents have the right to communication and access to persons and services inside the facility. for one of two residents (Resident R64).Findings include: Review of a Resident Representative concern dated 3/17/26, stated that a bill was received on behalf of her mother (Resident R64) who was a resident at the facility. The Resident Representative had questions, and concerns with her bill, and stated: I called them and they don't answer their phone. I went in and spoke to a young girl, and I told her the problem and gave her my name and phone number, and nobody ever got back to me. If this is a legitimate bill, then why can't they explain why we owe this amount? During an interview on 4/22/26, at 2:49 p.m. the Nursing Home Administrator (NHA) stated that the Business Office Manager that would be able to explain the bill no longer worked at the facility, and that the NHA is now handling these concerns. However, the NHA was not made aware that the Resident Representative needed to speak with someone regarding billing, therefore she had not addressed these concerns. NHA noted that failure to return phone calls and answer questions failed to ensure that residents have ease with communication to persons inside the facility. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(e)(1) Management.28 Pa. Code: 201.29(a)Resident Rights. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide documentation that residents or resident representatives were given the opportunity to formulate an advance directive (a written instruction such as a living will or durable power of attorney for health care for when the individual is incapacitated) for two of three residents reviewed (Resident R4 and R5).Findings include: Review of facility Residents' Rights Regarding Treatment and Advance Directives policy dated 3/16/26, indicated that the facility will support and facilitate a resident's right to request, refuse or discontinue medical or surgical treatment and to formulate advance directives. On admission, the facility will determine if the resident has executed an advance directive and if not, determine whether the resident would like to formulate an advance directive. The facility will provide the residents or resident representative information on formulating advanced directives. Review of the clinical record indicated Resident R4 was admitted to the facility on [DATE]. Review of Resident R4's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/7/26, indicated diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), high blood pressure, and anxiety. Review of the clinical record failed to reveal an advanced directive or documentation that Resident R4 was given the opportunity to formulate an Advance Directive. Review of the clinical record indicated Resident R5 was admitted to the facility on [DATE]. Review of Resident R5's Minimum Data Set (MDS - a periodic assessment of care needs) dated 2/12/26, indicated diagnoses of high blood pressure, chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), and paraplegia (partial or complete paralysis of the lower half of the body). Review of the clinical record failed to reveal an advanced directive or documentation that Resident R5 was given the opportunity to formulate an Advance Directive. During an interview on 4/22/26, at 12:30 p.m. Social Worker Employee E5 stated, I don't have it documented anywhere, and confirmed that the facility failed to provide documentation that residents or resident representatives were given the opportunity to formulate an advance directive for two of three residents reviewed (Resident R4, and R5). 28 Pa. Code: 201.29(b) Resident rights. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of clinical records, and staff interview, it was determined that the facility failed to notify the physician of a change in condition for one of three residents (Resident R1).Findings include:Review of facility policy Notification of Changes dated 3/16/26, and previously dated 1/21/26, indicated that the facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. This may include a significant change in the resident's physical, mental or psychosocial. condition such as deterioration in health, and a transfer or discharge of the resident from the facility. Review of the clinical record revealed Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/31/26, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and chronic pain. Review of the clinical record revealed a progress note dated 3/19/26, that stated Resident R1's daughter requested that resident be sent to the emergency room as she was having difficulty breathing. Resident was found sitting in her wheelchair on oxygen, audible wheezing heard. Updated daughter on resident's condition, and requested she be sent to the emergency room. Review of Resident R1's clinical record did not reveal that the change of condition and hospital transfer were communicated to the physician. During an interview on 4/23/26, at 11:43 a.m. the Nursing Home Administrator confirmed that the facility failed to notify the physician of a change in condition that required hospitalization. 28 Pa. Code: 211. 12(d)(1) Nursing services. |

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| F 0627<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to ensure that discharge documentation was on record for one of three closed resident records (Closed Resident Record R64).Findings include: Review of facility policy Transfer and discharge date d 3/16/26, and previously dated 1/21/26, indicated that for transfer to another provider, for any reason, the following information must be provided to the receiving provider: contact information of the practitioner who is responsible for the care of the resident; resident representative information, including contact information; advance directive information; and all other information necessary. Review of Closed Resident Record R64's admission record indicated she was admitted on [DATE]. Review of Closed Resident Record R64's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 8/24/25, indicated she had diagnoses that included hyperlipidemia (elevated lipid levels within the blood), hypertension (a condition impacting blood circulation through the heart related to poor pressure), dysphagia (difficulty swallowing), and macular degeneration (a vision impairment affecting the macula). Review of Closed Resident Record R64's care plans dated 8/20/25, indicated to notify doctor of discharge plans, and staff will work with resident to facilitate safe discharge. Review of Closed Resident Record R64's clinical nurse note dated 9/12/25, indicated Closed Resident Record R64 discharged at this time with son to Assisted living facility. Scripts sent too , and discharge paperwork sent with son. Review of Closed Resident Record R64's clinical nurse notes, physician orders, and physician assessment documents did not include an order to discharge to Assisted Living/ Personal care. During an interview on 4/23/26, at 10:10 a.m. the Nursing Home Administrator (NHA) confirmed that the facility failed to ensure that discharge documentation was on record for Closed Resident Record R64's including an physician order to discharge to Assisted Living as required. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.29 (a)(c)(2) Resident rights. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 one of three residents sampled with facility-initiated transfers (Residents R1), and failed to provide a transfer notice to a representative of the Office of the Long-Term Care Ombudsman Division for one of three residents (Resident R1).Findings include: Review of facility policy Transfer and discharge date d 3/16/26, and previously dated 1/21/26, indicated that for transfer to another provider, for any reason, the following information must be provided to the receiving provider: contact information of the practitioner who is responsible for the care of the resident; resident representative information, including contact information; advance directive information; and all other information necessary to meet the resident's needs. Review of the clinical record revealed Resident R1 was admitted to the facility on [DATE]. Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/31/26, indicated diagnoses of high blood pressure, diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and chronic pain. Review of the clinical record indicated Resident R1 was transferred to the hospital on 3/19/26, and returned to the facility on 3/23/26. Review of Resident R1'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. Review of Resident R1's clinical record, the facility failed to include documented evidence that the facility provided a written transfer notification to the Office of Long-Term Care Ombudsman for the hospitalization on 3/19/26. During an interview on 4/23/26, at 9:16 a.m. the Director of Nursing confirmed that there was no evidence that the necessary information was communicated to the receiving health care institution or provider upon transfer. During an interview on 4/23/26, at 11:43 a.m. the Nursing Home Administrator 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 one of three residents (Resident R1) 28 Pa. Code: 201.14(a)Responsibility of licensee.28 Pa. Code: 201.29 (a)(c.3)(2) Resident rights. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>Based on policy review, and staff interview, it was determined that the facility failed to ensure that the nutrition services provided met professional standards of quality for comprehensive care plan development for two of twelve months (March and April 2026).Findings Include: Review of the facility's policy Nutritional Management dated 3/1/26, and previously dated 1/21/26, indicated that monitoring of the resident's condition and care plan interventions will occur on an ongoing basis. Examples of monitoring include:Interviewing resident and/or resident representative to determine if their goals and preferences are being metDirectly observing the residentInterviewing the direct care staff to gain information about the resident, the interventions currently in place, what their responsibilities are for reporting on these interventions, and possible suggestions for changes if necessary During a telephonic interview on 4/22/26, at 12:46 p.m. Registered Dietitian (RD) Employee E7 confirmed that she has worked from home for the past two months, as she now works in Ohio and does not come into the building. She stated that she accesses records remotely and communicates needs to the Director of Nursing via email but does not come in to observe residents or conduct interviews with staff, residents, or families, and that current practices failed to meet professional standards of quality for comprehensive care plan development. 28 Pa. Code 201.18 (b) (1) Management28 Pa. Code 211.12 (d) (3) Nursing services |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, activity documentation, resident council group interview, and resident and staff interviews, it was determined that the facility failed to provide an ongoing program of activities to meet the interests and support the physical, mental, and psychosocial well-being of each resident for one of three residents (Resident R15) and failed to have sufficient activity staff. Findings include:<br><br>Review of facility policy Activity last reviewed 3/16/26, indicated the facility will provide an ongoing program to support residents in their choice of activities on their comprehensive assessment, care plan, and preference. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident as well as support their physical, metal, and psychosocial well-being. Activities will encourage both independence and interaction within the community.<br><br>During a review of the facility's April 2026 activity calendar the following was revealed:<br><br>- Monday, 4/13/26 1:30 p.m. Bingo in Dining Room<br><br>- Wednesday, 4/15/26 1:30 p.m. Bingo in Dining Room<br><br>Review of the admission record indicated Resident R15 admitted to the facility on [DATE], and readmitted [DATE], with diagnoses of paraplegia, insomnia (difficulty falling or staying asleep), and muscle weakness.<br><br>Review of Resident R15's care plan dated 1/14/22, revealed the resident enjoys activities including bingo, trivia, and socials. It was indicated to provide the resident with the activity calendar and to inform the resident of any changes.<br><br>Review of Resident R15's Quarterly activity Participation Review dated 11/16/25, revealed Resident R15 enjoys bingo.<br><br>Review of Resident R15's MDS dated [DATE], revealed the diagnoses were current.<br><br>During an interview on 4/20/26, at 10:45 a.m. Resident R15 revealed a concern related to activities. It was indicated the facility usually has bingo three times a week, and bingo was only offered once last week.<br><br>Review of Resident R15's Documentation Survey Report v2 April 2026, revealed documentation that the resident participated in a social activity for one of 21 days. The facility failed to document activities that were provided for Resident R15.<br><br>During an interview on 4/21/26, at 1:06 p.m. the Director of Activities, Employee E9 confirmed bingo was cancelled last Wednesday. Director of Activities, Employee E9 stated every Monday and Wednesday bingo is scheduled and on Saturdays residents call bingo themselves. Director of Activities, Employee E9 stated it is difficult to document activities.<br><br>During an interview on 4/21/26, at 1:23 p.m. the Director of Activities, Employee E9 stated she is the only employee in the activity department, and she also helps on the floor as a nurse aide as well at<br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | times.<br><br>During a resident council group interview on 4/21/26, at 1:31 p.m. two out of seven residents voiced concerns about insufficient activity staff and missing bingo activities for a week.<br><br>During an interview on 4/21/26, at 2:25 p.m. the Nursing Home Administrator confirmed that the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for one of three residents (Resident R15).<br><br>28 Pa. Code: 201.18 (b)(3) Management |

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| | 395160 | A. Building<br>B. Wing | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, facility provided documents, and staff interviews, it was determined the facility failed to maintain an environment free of potential accident hazards and provide safe bed mobility for one of two residents (Resident R32), and that the facility failed to ensure leg rests were applied to a resident's wheelchair prior to moving resident for one of two residents (Resident R53). Findings include:<br><br>Review of facility policy Accidents and Supervision last reviewed 3/16/26, indicated the resident environment will remain free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents.<br><br>Review of Resident R32's admission record indicated she was admitted on [DATE].<br><br>Review of Resident R32's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 4/15/26, indicated she had diagnoses that included anxiety disorder (a medical condition creating a sense of acute fear, restlessness, and worry), hyperlipidemia (elevated lipid levels within the blood), and diabetes (metabolic disorder impacting organ function related to glucose levels in the human body).<br><br>Review of Resident R32's care plans dated 4/20/26, indicated that Resident R32's was occasionally incontinent of bowel and bladder and requires assistance with toileting needs.<br><br>Review of Resident R32's clinical nurse notes dated 4/22/26, indicated Resident R32 paid caregiver asked staff to come speak to resident about an incident that occurred this morning. Staff went to Resident R32's room where she and her paid caregiver were present and gave a statement about an incident that happened this morning. Resident R32 gave this nurse a detailed description of what occurred which was transcribed onto paper and signed by the resident. Resident R32's paid caregiver also gave a written statement. This nurse took Resident R32's statement and immediately notified DON and regional administrator. Resident R32 was asked abuse questions, and her son was also notified.<br><br>During an interview on 4/23/26, at 9:00 a.m. the Nursing Home Administrator (NHA) stated that the facility received an abuse allegation from Resident R32 around breakfast time on 4/22/26.<br><br>During an interview on 4/23/26, at 9:06 a.m. Resident R32 was asked about the abuse incident and she stated: yes. the aide was Nurse Aide Employee E21. She was like a gazelle. Moving fast. She was like a wild woman. She said I rang the bell twice. I did not. She said she was pestered. She was hysterical with me. I asked her to go to the bathroom and she went ahead and changed me, and in the process, she was pretty rough. She told me to roll to the left. And I hit my head on the dresser. I feel no pain right now. I'm waiting for another aide now. My roommate was here but she went home. Observations of Resident R32 indicated no bruising or pain. Resident R32's dresser was observed near her window.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a phone interview on 4/23/26, at 10:20 a.m. Nurse Aide Employee E21 was asked about the incident on 4/22/26 with Resident R32 and stated: I sent the DON my statement. its ok to get a statement. Um, the only thing i can think of on the morning I got there at 6 a.m. I check everyone that does stay in the bed. I asked Resident R32 to check and if she needed the bed pan. Resident R32 said 'oh i guess so.' I rolled Resident R32 over and I put Resident R32 on the bed pan. I washed her up and gave her morning care. Resident R32 told me not to bother her after breakfast. She never said anything to me about hurting her. she is pretty stiff and may have pain. Nurse Aide Employee E21 was asked if she rolled Resident R32 away from her and towards the dresser, was the resident rolled twice and Nurse Aide Employee E21 stated: yes, i think Resident R32 was. She never said she bumped her head. Once rolled to put Resident R32 on the bed pan and once to get her off. Resident R32 was fine the rest of the day. We were talking about how she goes fast on the toilet. Resident R32 biggest thing was not bothering her early in the morning. Nurse Aide Employee E21 was asked if Resident R32 had any indication of pain? no. Nurse Aide Employee was asked if Resident R32 ever made any allegation like that before? no. never said anything. she has not been there long.<br><br>During an interview on 4/23/26, at 10:28 a.m. Licensed Practical Nurse (LPN) Employee E18 was asked if residents are rolled away or towards staff during bed care? you roll towards you.<br><br>During an interview on 4/23/26, at 11:43 a.m. information was disseminated to the Nursing Home Administrator (NHA), and interim Nursing Home Administrator (NHA) Employee E22 that the facility failed to maintain an environment free of potential accident hazards and provide safe bed mobility for Resident R32 as required.<br><br>Review of the clinical record revealed Resident R53 was admitted to the facility on [DATE].<br><br>Review of Resident R53's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/19/26, indicated diagnoses of adult failure to thrive, unsteadiness on feet, and muscle wasting and atrophy. Section GG0120. Mobility Devices revealed the resident utilizes a wheelchair.<br><br>During an observation on 4/23/26, at 10:07 a.m. Resident R53 was observed sitting in a wheelchair without leg rests at the nursing station. Emergency Medical Services (EMS) transport, Employee E17 arrived to transport Resident R53 and began pushing the resident in his wheelchair down the hallway without leg rests.<br><br>During an interview on 4/23/26, at 10:08 a.m. EMS transport, Employee E17 confirmed he failed to apply Resident R53's leg rests prior to pushing the resident down the hallway. EMS transport, Employee E17 confirmed he failed to ensure the resident's environment remained free of accident hazards.<br><br>During an interview on 4/23/26, at 10:13 a.m. the Nursing Home Administrator confirmed that the facility failed to provide adequate assistance to ensure a safe environment for one of two residents (Resident R53).<br><br>28 Pa. Code: 201.14(a) Responsibility of licensee.<br><br>28 Pa. Code: 211.10(d) Resident care policies.<br><br>28 Pa. Code: 211.12(d)(1)(5) Nursing Services. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical record review, and staff interview, it was determined that the facility failed to ensure that a resident with an enteral feeding tube (a tube inserted in the stomach through the abdomen) received appropriate treatment and services to prevent potential complications for one of two residents (Residents R10). Findings include: Review of the facility policy Enteral Nutrition dated 3/1/26, and previously dated 1/21/26, indicated that the dietitian, with input from the physician, nurse, and resident/representative, will determine the calorie, protein, nutrient and fluid needs and evaluate whether the resident's current intake is adequate to meet those nutritional needs; identify the appropriate enteral nutrition to be administered and give direction regarding the need for additional fluids to be administrated. The physician will be involved in the decision regarding the use of enteral feeding, and document the reason for the decision. The dietitian is responsible for routinely assessing residents who are receiving enteral feedings to verify how the resident is tolerating the feeding tube, the nutritional outcome of the enteral feedings, and if nutrition by other means should be introduced. Review of the clinical record indicated Resident R10 was admitted to the facility on [DATE]. Review of Resident R10's Minimum Data Set (MDS - a periodic assessment of care needs) dated 4/9/26, indicated diagnoses of stroke (when blood flow to the brain is blocked or a vessel ruptures causing rapid brain cell death), difficulty swallowing, and high blood pressure. Section K0520 indicated that resident received nutrition from a feeding tube while a resident. Review of Resident R10's clinical record revealed a Medical Nutrition and Hydration Evaluation dated 3/26/26 from Registered Dietitian (RD) Employee E7 that indicated the following:Resident required 1575-1890 calories per dayWas NPO (received nothing by mouth; no food or drink)Received a enteral feeding of Jevity 1.2 (a type of tube feeding formula) at 30 milliliters (ml) per hour continuously.Current tube feed formula provided 864 caloriesRecommendation to increase rate of formula to goal rate of 65 ml per hour for 20 hours per day to provide 1560 calories per day Review of Resident R10's physician order dated 4/1/26, stated to provide Glucerna (a type of tube feeding formula formulated to control blood sugar) @ 30ml continuously. Review of the above order revealed that the order does not specify what type/strength of Glucerna to provide. Review of Resident R10's clinical record revealed an additional Medical Nutrition and Hydration Evaluation dated 4/9/26 from RD Employee E7 that indicated the following:Resident required 1550-1860 calories per dayWas NPOReceived a enteral feeding of Glucerna at 30 ml per hour continuouslyCurrent tube feed formula provided 720 caloriesRecommendation to continue tube feeding as ordered Review of the above indicated that Resident R10 is receiving 830 to 1,140 calories less than the estimated required needs. During an observation on 4/22/26, at 10:42 a.m. Resident R10 was found to be resting in bed with tube feeding of Glucerna 1.5 infusing at 30 ml per hour. During an interview on 4/22/26, at 10:45 a.m. the Director of Nursing (DON) stated that the physician didn't want to increase the rate of the tube feeding as resident had trouble tolerating the feeding in the hospital, however there was no documentation in the clinical record indicating this decision. During an observation on 4/22/26, at 10:55 a.m. in the Central Supply room, several cases of Glucerna 1.5 were noted, and no other type of Glucerna was observed. Review of the above RD Employee E7's note dated 4/9/26, revealed that calories for Glucerna were calculated to be 720 calories, however as Glucerna 1.5 is being utilized, the calories provided are 1,080, and the above calculations are not accurate. During a telephonic interview on 4/22/26, at 12:39 p.m. RD Employee E7 confirmed that Resident R10 is not receiving the required amount of calories and that this was done under the advisement from Community Registered Dietitian (CRD) Employee E8, who does not work at this facility, but follows Resident R10 in the community. RD Employee E7 confirmed that the facility failed to document this in the clinical record. State Agency (SA) reviewed RD Employee E7's note from 4/9/26 with RD Employee E7 and clarified that it was documented that<br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | she received 720 calories, however if resident was receiving Glucerna 1.5, she would be receiving 1080 calories per day, not 720, and that she failed to calculate the tube feeding accurately. RD Employee E7 clarified that Glucerna comes in two formulas: Glucerna 1.2, and Glucerna 1.5, and that the facility failed to specify what formula to provide in the written order. During a telephonic interview on 4/23/26, at 10:26 a.m. Community Registered Dietitian (CRD)Employee E8 stated that she had made the recommendation to place Resident R10 on Glucerna, but confirmed that she failed to specify if resident was to receive Glucerna 1.2 or 1.5, and stated that she intended for Resident R10 to have the 1.2 formula. SA informed CRD Employee E8 that resident was receiving the 1.5 formula, and not the 1.2 that she had intended. CRD Employee E8 confirmed that the facility failed to provide the correct formula, which transpired from the order not being written correctly. 28 Pa. Code: 201.18(b)(1) Management. 28 Pa. Code: 211.10(c) Resident care policies.28 Pa. Code: 211.12(d)(1)(5) Nursing services. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, staff interview, and observations, it was determined that the facility failed to provide appropriate respiratory care for two of two residents (R14 and R44).Findings Include:<br><br>Review of facility policy Oxygen Administration dated 3/16/26, indicated oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences. Change oxygen tubing weekly and as needed. Change humidifier bottles when empty. Keep delivery system in plastic bag when not in use.<br><br>Review of facility policy Comprehensive Care Plans dated 3/16/26, indicated the facility will develop and implement a comprehensive person-centered care plan for each resident.<br><br>Review of the clinical record indicated Resident R14 was admitted to the facility on [DATE], with diagnoses of heart failure (a progressive heart disease that affects pumping action of the heart muscles), respiratory failure, and morbid obesity with alveolar hypoventilation (a breathing disorder that affects some people who have obesity).<br><br>Review of Resident R14's physician order dated 4/7/26, indicated administer one liter of oxygen every shift.<br><br>Review of Resident R14's physician order dated 4/8/26, indicated apply BIPAP (non-invasive mechanical ventilation device that helps patients breathe by delivering two levels of air pressure) via full mask with settings of 15 (IPAP-Inspiratory Positive Airway Pressure) and 8 (EPAP-Expiratory Positive Airway Pressure) for bedtime and naps.<br><br>Review of Resident R14's physician order dated 4/11/26, indicated to change tubing and humidification every night shift, every Saturday.<br><br>Review of Resident R14's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 4/14/26, indicated the diagnoses were current. Section O Special Treatments, Procedure and Programs O0110, C1 Oxygen Therapy was marked as while a resident and non-invasive mechanical ventilation was marked as while a resident.<br><br>During an observation on 4/20/26, at 10:12 a.m. Resident R14 was lying in bed with oxygen on. The nasal cannula tubing was undated and the humidification bottle dated 4/13/26, was empty.<br><br>Review of Resident R14's care plan on 4/22/26, failed to include a care plan for the resident's oxygenation use.<br><br>During an interview on 4/22/26, at 11:29 a.m. Registered Nurse (RN) Supervisor, Employee E1 confirmed the facility failed to implement a care plan for Resident R14's oxygen use.<br><br>Review of the clinical record indicated Resident R44 was admitted to the facility on [DATE].<br><br>Review of Resident R44's MDS dated [DATE], indicated diagnoses of heart failure (a progressive<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | heart disease that affects pumping action of the heart muscles), diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time), and chronic obstructive pulmonary disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness). Section O Special Treatments, Procedure and Programs O0110, C1 Oxygen Therapy is marked as while a resident.<br><br>During an observation on 4/20/26, at 11:30 a.m. Resident R44 was lying in bed with oxygen on. The oxygen nasal cannula and humidification bottle were not dated.<br><br>Review of physician order dated 3/29/24, indicated Oxygen at two liters per minute via nasal cannula (NC- a lightweight, flexible tube used to deliver oxygen to people with breathing difficulties), every shift.<br><br>Review of physician order dated 12/28/25, indicated change humidifier and tubing each week on Sundays.<br><br>During a review of Resident R44's care plan interventions revised on 8/8/25, indicated oxygen two liters per minute via NC as needed for shortness of breath.<br><br>During an interview on 4/20/26, at 11:47 a.m. Licensed Practical Nurse (LPN) Employee E2 stated the nasal cannula and humidification bottle was missing dates and should be changed weekly. LPN Employee E2 confirmed that the facility failed to provide appropriate respiratory care for Resident R44.<br><br>During an interview on 4/22/26, at 12:44 p.m. Registered Nurse (RN) Employee E1 confirmed that Resident R44's oxygen care plan was not updated to reflect the current plan of care.<br><br>During an interview on 4/22/26, at 2:30 p.m. the Nursing Home Administrator confirmed the facility failed to provide appropriate respiratory care for two of two residents (R14 and R44).<br><br>28 Pa. Code: 201.14(a) Responsibility of licensee.<br><br>28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff and resident interviews it was determined that the facility failed to meet residents pain needs for one of three residents reviewed (Resident R7).Findings Include: Review of the facility policy Pain Management dated 3/16/26, indicated the facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based upon the evaluation, the facility in collaboration with the attending physician/prescriber, otherhealth care professionals and the resident and/or the resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission. Review of the clinical record revealed Resident R7 was admitted to the facility on [DATE], with diagnoses of low back pain, anxiety, and chronic pain. Review of Resident R7's care plan dated 3/20/26, revealed the resident was experience pain or the resident was at risk for pain and discomfort. Interventions included to administer pain medications as ordered, observe for side effects and effectiveness. Complete pain assessment, and observe for pain each shift. Review of Resident R7's physician order dated 3/20/26, indicated to administer 325 milligram (mg) Tylenol, give two tablets every six hours as needed for pain. Review of Resident R7's physician order dated 3/20/26, indicated to administer 5 milligram (mg) Oxycodone HCL oral capsule, by mouth every six hours as needed for low back pain. The order was discontinued on 3/21/26, at 1:53 a.m. Review of Resident R7's physician order dated 3/21/26, indicated to administer 5 mg Oxycodone HCL oral capsule, by mouth every six hours for pain. The order was discontinued on 3/23/26. Review of Resident R7's clinical record failed to include evidence the facility monitored and assessed resident R7's pain each shift from 3/21/26, to 3/23/26. Review of Resident R7's Medication Administration Record for March 2026, revealed the facility failed to administer the resident's 5 mg Oxycodone, every six hours for pain as ordered from 3/21/26, to 3/23/26. Review of Resident R7's physician order dated 3/23/26, indicated to administer 5 milligram (mg) Oxycodone HCL oral capsule, by mouth every 12 hours as needed for low back pain. Review of Resident R7's progress note dated 3/24/26, at 10:26 a.m. the resident was lying in bed and stated she did not feel well. Resident R7 stated she had a lot of pain in her hips. Review of Resident R7's Medication Administration Record for March 2026, revealed the facility administer 5 mg of oxycodone on 3/24/26, for 8/10 pain, which was effective. Review of Resident R7's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/27/26, indicated the diagnoses were current. Section J0220. indicated a pain assessment interview should be conducted and revealed the resident had pain in the last five days , almost constantly, and it almost constantly effects the resident's sleep, participation in rehabilitation therapy sessions, and limits their day-to-day activities. It was indicated the resident's pain intensity was scored a 8/10. During an interview on 4/21/26, at 9:49 a.m. Resident R7 stated a concern related to her pain medication. Resident R7 stated it took a little for her medication to arrive to the facility. Resident R7 indicated she was in pain after being transported to the facility. It was indicated the prior facility couldn't send her pain medication with her. Resident R7 indicated she arrived at the facility around 8:00 p.m. on Friday and didn't receive any of her oxycodone until Tuesday. Resident R7 indicated she experience increased pain, which was more than usual and she laid in bed all weekend. The resident revealed the facility provided her with Tylenol, and she when she asked for ibuprofen as well, she was told she did not have an order for it. During an interview on 4/21/26, at 1:31 p.m. Licensed Practical Nurse (LPN), Employee E2 stated the facility has an emergency medication box for medications that are not available. It was indicated when staff receive report for a resident being admitted to the facility, it is always asked if the resident receives narcotics and a script can be sent to pharmacy. It was indicated if there is a medication that is unavailable then a script can be sent to pharmacy for a one-time code to pull it from the emergency<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | box. LPN, Employee E2 stated staff are expected to pull from emergency supply until pharmacy delivers the medication. During an interview on 4/22/26, at 10:56 a.m. Registered Nurse Supervisor, Employee E1 confirmed Resident R7's was not assessed each shift per her care plan, and the facility failed to administer scheduled pain medications as ordered from 3/21/26, to 3/23/26. During an interview on 4/22/26, at 11:33 a.m. the Nursing Home Administrator confirmed the facility failed to meet residents pain needs for one of three residents reviewed (Resident R7). |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care or services that was trauma informed and/or culturally competent.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, clinical records, and staff interview 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 two residents (Resident R43).Findings include: Review of facility policy Trauma Informed Care dated 6/3/1/26, and previously dated 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 retraumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the residents, and will be added to the resident's care plan. Review of the clinical record indicated Resident R43 was admitted to the facility on [DATE]. Review of Resident R43 MDS (minimum data set - a periodic assessment of care needs), dated 3/18/26, indicated diagnosis of PTSD (a mental health condition that caused by an extremely stressful or terrifying event) high blood pressure, and insomnia. Review of Resident R43 care plan for PTSD identified that a traumatic event occurred, but failed to identify triggers for Resident R43 as related to PTSD. During an interview on 4/22/26, at 2:57 a.m. Social Worker Employee E5 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 Resident R43. 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1) Management. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395160 | A. Building<br>B. Wing | 04/23/2026 |

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

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| F 0740<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, resident clinical records, and staff interviews, it was determined that the facility failed to ensure a resident received appropriate behavioral health management to maintain the highest practicable well-being for one of four sampled residents (Resident R50).Findings include: Review of the facility policy Behavioral Health Services dated 3/16/26, indicated the facility will ensure all residents receive necessary behavioral health services to assist them in reaching and maintain their highest level of mental and psychosocial functioning. The facility will ensure the necessary behavioral health care services are person-centered and reflect the resident's goal for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety. Review of the admission record indicated Resident R50 admitted to the facility on [DATE]. Review of Resident R50's care plan dated 3/6/23, indicated to monitor, document, and report as needed adverse reactions related to antidepressant therapy such as changes in behavior or mood such as insomnia. Review of Resident R50's physician order dated 12/25/25, indicated to administer 3 milligram (mg) by mouth at bedtime, Review of Resident R50's Minimum Data Set (MDS - a periodic assessment of care needs) dated 3/19/26, indicated the diagnoses unspecified dementia (unspecified) with other behavioral disturbances, depression, and schizoaffective disorder ( mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania). Section C0500 indicated a Brief Interview for Mental Status (BIMS - is a screening test that aids in detecting cognitive impairment) score of 14, no cognitive impairment. Section D0150. Resident Mood Interview question C. revealed the resident had trouble falling asleep or staying asleep 12-14 days (nearly every day) in the last two weeks. Review of Resident R50's clinical record revealed the resident was revaluated by psych on 4/14/26. It was indicated the resident reported ongoing insomnia that has shown no relief in four years. He is requesting an increase in his melatonin. Plan to increase melatonin at this time. Staff was instructed to continue to monitor and notify for any new or worsening symptoms. The resident was ordered to add diagnoses of insomnia and to discontinue current order of melatonin and start 6 mg of melatonin every night for sleep disorder. It was revealed the plan and education was reviewed and provided to the resident and nursing staff. During an interview and observation on 4/20/26, at 11:29 a.m. Resident R50 stated she is shaky all the time and not getting much sleep at night. The resident indicated the last time he got good sleep was five years ago. The resident was observed with visible tremors. During an observation on 4/21/25, at 10:10 a.m. Resident R50 was observed resting in bed with a sheet over his head. Review of Resident R50's physician orders on 4/22/26, failed to reveal the resident's melatonin was increased to 6 mg as ordered. During an interview on 4/22/26, at 12:01 p.m. Nurse Practitioner, Employee E19 confirmed the facility failed to increase Resident R50's melatonin to 6 mg as ordered as of 4/14/26, a total of nine days. During an interview on 4/22/26, at 1:38 p.m. Regional Director of Clinical Operations, Employee E20 confirmed the facility failed to ensure a resident received appropriate behavioral health management to maintain the highest practicable well-being for one of four sampled residents (Resident R50). 28 Pa. Code 201.18(b)(1)(3)(e)(1) Management 28 Pa. Code 211.12(c)(d)(3) Nursing services |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, and staff interviews, it was determined that the facility failed to provide evidence that the licensed pharmacist's medication regimen was reviewed and acted upon timely for one of five sampled residents (Resident R8).Findings include: The facility Medication reconciliation policy last reviewed on 3/16/26, indicated that monthly reconciliation processes included providing pharmacy consultation access to all medications areas and records for completion of pharmacy services activities. Respond to any medication irregularities reported by pharmacy consultant. Review of Resident R8's admission record indicated he was admitted on [DATE]. Review of Resident R8's MDS assessment (Minimum Data Set assessment: MDS -a periodic assessment of resident care needs) dated 4/8/26, indicated he had diagnoses that included hypertension (a condition impacting blood circulation through the heart related to poor pressure), diabetes (metabolic disorder impacting organ function related to glucose levels in the human body), and dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury associated with memory disorders, personality changes, and impaired reasoning), and depression (a state of consistent sadness and loss of interest interfering in daily life activities). Review of Resident R8's care plans dated 4/20/26, indicated he had a depression diagnosis, administer medications as ordered, and monitor for side effects. Review of Resident R8's physician orders indicated the following:Lorazepam concentrate 0.5ml sublingually every four hours as needed for anxiety for 60 days starting 3/16/26.Fentanyl patch apply 25mcg/ transdermal every 72 hours for pain management starting 11/24/25.Morphine 10mg sublingually every 2 hours as needed for pain starting 9/15/25. Review of Resident R8's pharmacist medication review dated 2/9/26, indicated a medication regimen review took place with a recommendation from Pharmacy requiring a response. The medication and details of the recommendation were not documented. Review of Resident R8's clinical records did not include a response to the 2/9/26 pharmacy recommendation from the physician. During an interview on 4/23/26, at 11:38 a.m. the Nursing Home Administrator (NHA), Interim Nursing Home Administrator (NHA) Employee E22, and Mobile Director of Nursing (DON) Employee E23 confirmed that the facility failed to provide evidence that the licensed pharmacist's report of a medication regimen was reviewed and acted upon timely for Resident R8 as required. 28 Pa. Code 211.2(d)(3) Physician services 28 Pa Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(3)(5) Nursing services |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to properly store medical supplies in one of one medication storage rooms (Main Storage Room), and failed to store one of six residents' medications securely (Resident R45).<br><br>Findings:<br><br>Review of facility Medication Storage policy dated [DATE], indicated that medication and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier.<br><br>Review of the admission record indicated Resident R45 admitted to the facility on [DATE], with diagnoses of adult failure to thrive, urinary tract infection, and anxiety.<br><br>Review of Resident R45's MDS dated [DATE], revealed the diagnoses were current.<br><br>Review of Resident R45's physician order dated [DATE], indicated to apply 1% Fungicure External Solution to fingernails topically two times a day for fungal for four weeks.<br><br>During an observation on [DATE], at 10:07 a.m. Resident R45's bottle of Fungicure External Solution was observed unsecured on the resident's bedside table.<br><br>During an interview on [DATE], at 10:10 a.m. Licensed Practical Nurse, Employee E18 confirmed Resident R45's medication was not secured.<br><br>During a medication storage room review on [DATE], at 9:50 a.m. the following supplies were observed and expired:<br><br>Four lavendar colored lab tubes (used to draw blood) expired [DATE].<br><br>One mint colored lab tube expired [DATE].<br><br>Two pink colored lab tubes expired [DATE].<br><br>Thee black foam for wound dressing expired [DATE], [DATE], and [DATE].<br><br>One black foam kit was opened.<br><br>Two [NAME] Foam Dressing (used to treat wounds) expired [DATE].<br><br>Seven Drape File Dressing expired [DATE], [DATE], [DATE], and [DATE].<br><br>Two wound vac canisters expired [DATE], and [DATE].<br><br>One large foam kit expired [DATE]<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on [DATE], at 9:38 a.m. Registered Nurse (RN) Employee E3 confirmed the above expired supplies and stated the supplies should have been disposed of after the expiration date.<br><br>28 Pa Code: 211.9 (a)(1) Pharmacy services.<br><br>28 Pa code: 211.12 (d) (1) (5) Nursing services. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, clinical record review, observation, and staff interviews, it was determined that the facility failed to prevent cross contamination and implement appropriate transmission-based precautions for one of three residents (Residents R3).Findings Include: Review of the facility policy Enhanced Barrier Precautions (EBP) last reviewed 3/16/26, indicated Enhanced Barrier precautions are an infection control intervention designed to reduce transmission of multidrug resistant organisms (MDRO) that employs targeted gown and gloves use during high contact resident care activities. An order for enhanced barrier precautions will be obtained for residents with wounds. Gloves and gowns are made available immediately near or outside the resident's room. Review of the facility policy Clean Dressing Change last reviewed 3/16/26, indicated it is the facility policy to provide wound care in a manner to decrease potential for infection and/or cross contamination. After removing existing dressing, remove gloves, pulling inside out over the dressing. Discard into appropriate receptables and wash hands and put on clean gloves. Cleanse the wound as ordered, taking care not to contaminate other skin surfaces or other surfaces of the wound. Review of the admission record indicated Resident R3 was admitted to the facility on [DATE]. Review of Resident R3's Minimum Data Set (MDS - a periodic assessment of care needs) dated 1/27/26, indicated diagnoses of high blood pressure, diabetes (high sugar in the blood) and anxiety. Review of Resident R3's physician orders dated 2/19/26, indicated to cleanse hypergranulated tissue to area above left knee with wound cleanser, pat dry, apply xeroform, calcium alginate and super absorbent dressing daily and as needed. Observation completed on 4/22/26, at 12:55 p.m. of the entrance of Resident R3's room door failed to include signage posted that indicated the resident was ordered enhanced barrier precautions for her open wound. Review of Resident R3's physician orders on 4/22/26, failed to include an order for enhanced barrier precautions (EBP). During an observation completed on 4/22/26, at 12:59 p.m. Registered Nurse (RN) Employee E24 confirmed Resident R3 did not have an order for enhanced barrier precautions. During the observation of Resident R3's dressing change, RN, Employee E24 failed to remove her gloves and wash her hands after removing the resident's old dressing and before applying a clean one. RN, Employee E24 confirmed she failed to implement enhance barrier precautions and prevent cross contamination during a dressing change. During an interview on 4/22/26, at 1:08 p.m. Nursing Home Administrator confirmed Resident R3 should be in enhanced barrier precautions and the facility failed to prevent cross contamination during a dressing change for one of three residents (Resident R3). 28 Pa. Code: 201.14(a) Responsibility of licensee.28 Pa. Code: 201.18(b)(1)(e)(1) Management.28 Pa. Code: 211.10(c)(d) Resident care policies.28 Pa. Code: 211.12(d)(1)(2)(5) Nursing services. |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility documentation, and staff interviews, it was determined that the facility failed to make certain that equipment was in safe operating condition for one of one of the facilities crash cart (a cart that contains supplies in the event of an emergency), (Main Nursing Unit).Findings include: During a review of facility provided documentation labeled Embassy of Saxonburg, indicated the emergency cart is to be checked by the night shift Registered Nurse (RN) Supervisor daily. Check expiration dates and replace missed items. During a review of facility provided documentation labeled Embassy of Saxonburg revealed missing signatures on the following dates: [DATE] were missing [DATE], [DATE], and [DATE] signatures.February 2026 were missing [DATE], [DATE], and [DATE] signatures.[DATE] were missing [DATE], [DATE], [DATE], and [DATE] signatures. During an observation of the facilities crash cart, located at the Main Nurses Station, on [DATE], at 9:40 a.m. revealed the following supplies to be expired: (1) Ambu bag (a handheld manual resuscitator used to provide positive pressure ventilation) - was opened and expired [DATE].(1) Suction Cath-N-Glove kit was opened. During an interview on [DATE], at 9:50 a.m. Registered Nurse (RN) Employee E3 confirmed the missing signatures and the expired/open supplies on the crash cart. 28 Pa Code: 201.14(a) Responsibility of licensee. |