

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2025
NAME OF PROVIDER OR SUPPLIER Embassy of Huntingdon Park		STREET ADDRESS, CITY, STATE, ZIP CODE 1229 Warm Springs Avenue Huntingdon, PA 16652	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on review of facility policy and clinical record reviews, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders regarding medication administration were followed for one of seven residents reviewed (Resident 2). Findings include: The facility policy for medication administration dated July 10, 2025, indicated that medications are administered by licensed nurses, or other staff that are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 2, dated June 24, 2025, revealed that the resident was cognitively intact, required assistance with personal care needs, and had diagnoses that included heart failure. Physician's orders for Resident 2 dated October 31, 2024, included an order for the resident to receive 50 milligrams (mg) of Metoprolol Succinate (medication used to treat high blood pressure) every day for hypertension (high blood pressure). A nurse's note for Resident 2 dated March 6, 2025, revealed that the physician was in the facility, reviewed the resident's medications, and gave orders to decrease the resident's Metoprolol to 25 mg daily. Review of the Medication Administration Record (MAR) for Resident 2 revealed that the resident did not receive the 25 mg of Metoprolol Succinate daily between March 7, 2025 and July 28, 2025. Physician's orders for Resident 2, dated July 28, 2025, included an order for the resident to receive 25 mg of Metoprolol Succinate every day for hypertension (high blood pressure). Interview with Nursing Home Administrator on August 19, 2025, at 9:46 p.m. confirmed that Resident 2's order for 50 mg of Metoprolol was decreased to 25 mg daily on March 6, 2025; however the new order was never added to the MAR and the resident did not receive any Metoprolol Succinate between March 7 and July 28, 2025. 28 Pa. Code 211.12(d)(1)(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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that treatments for pressure ulcers were provided as ordered by the physician for one of seven residents reviewed (Resident 3). Findings include: The facility's policy for wound management, dated July 10, 2025, indicated that wound treatments would be provided in accordance with physician's orders, including the cleansing method, type of dressing, and frequency of dressing change. A quarterly Minimum Data Set (MDS) assessment for Resident 3, dated July 16, 2025, revealed that the resident was understood and could understand, was cognitively impaired, was incontinent of bowel and bladder, and was at risk for developing pressure ulcers. A nursing note, dated August 15, 2025, at 8:30 p.m. revealed that Resident 3 had a fluid filled blister to the right abdomen measuring 1.5 x 1.5 centimeters (cm). Physician's orders, dated August 15, 2025, included an order for skin prep (protective barrier) to be applied to the blister on her abdomen every day and evening shift. The resident's care plan, dated August 16, 2025, included that the resident was to avoid tight clothing and treatments to the blister were to be completed as ordered by the physician. Resident 3's Treatment Administration Records (TAR's) for August 2025, revealed that there was no documented evidence that the treatment to the blister on Resident 3's abdomen was completed every day and evening shift as ordered by the physician. Interview with the Nursing Home Administrator on August 19, 2025, at 7:42 p.m. confirmed that there was no documented evidence that Resident 3's treatments to the blister on her abdomen were completed as ordered by the physician. 28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		