STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395569	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Hillsdale Park	383 Mountain View Drive Hillsdale, PA 15746

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 48809 Based on a review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to provide a reasonable accommodation of needs by failing to ensure that the call bell was within reach for one of 33 residents reviewed (Resident 27). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 27, dated December 13, 2024, indicated that the resident was cognitively impaired and required maximum assistance for transfers and toileting. The resident's current care plan indicated that the resident had recent falls, and staff were to ensure the call bell was within reach. The facility's call bell policy, dated November 8, 2024, indicated that the call bell would be within easy reach and secured if needed. Observations of Resident 27 on March 3, 2025, at 10:38 a.m. revealed that the resident was sitting in his wheelchair in the middle of his room with his call bell lying on his bed out of the resident's reach. Interview with Resident 27 at that time revealed that he does not get help when needed because his call bell has been out of reach. Interview with Nurse Aide 1 at that time revealed that Resident 27 was capable of using his call bell and it should have been placed within her reach. Interview with the Nursing Home Administrator on March 4, 2025, at 10:25 a.m. confirmed that the call bell should have been within Resident 27's reach. 28 Pa. Code 211.12(d)(5) 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 47819 Based on review of facility policies, clinical records, and investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from abuse for one of 33 residents reviewed (Resident 54). Findings include: The facility's policy for abuse, dated November 8, 2024, indicated that the facility will not tolerate abuse, neglect, and exploitation of its residents or the misappropriation of resident property. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful meant the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 54, dated February 11, 2025, revealed that the resident was rarely understood, could rarely understand, and had diagnoses that included Alzheimer's disease and Down's syndrome. A care plan for Resident 54, dated January 29, 2024, revealed that the resident was at high risk for elopement and had impaired cognitive function. Interventions for Resident 54 indicated that if she was wandering in a potentially unsafe area or situation redirect to safer area and offer diversional activities. A quarterly MDS assessment for Resident 56, dated November 11, 2024, revealed that the resident was understood and could understand others, and had diagnoses that included dementia. A care plan for Resident 56, dated April 15, 2024, revealed that she exhibited behaviors that included physically abusive attacks on staff and/or other residents, scratching, refusal of care and meals, and yelling and screaming. Interventions for Resident 56 included redirecting residents who were attempting to enter her room because this upsets her. A nursing note for Resident 54, dated August 11, 2024, at 7:23 p.m. revealed that the nurse aide brought Resident 54 to the nurse after the nurse aide witnessed Resident 56 grabbing her by her arm and screaming at her to get out of her room. The licensed practical nurse looked at Resident 54's left inner arm, and there were three fingernail prints on her arm. The facility report, dated August 11, 2024, at 6:50 p.m. indicated that Resident 54 was attempting to get into Resident 56's room. Resident 56 then grabbed Resident 54's arm causing three scratch marks. The nurse aide removed Resident 54 from the room. A nursing note for Resident 54, dated August 23, 2024, at 1:32 p.m. revealed that the nurse was notified that the resident was witnessed lying in Resident 56's bed. Resident 56 was observed hitting Resident 54 on her waist. No injuries were noted, and staff removed Resident 56 from her room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse aide witness statement, dated August 23, 2024, revealed that she walked into the room after she heard Resident 54 yelling for help. She observed Resident 56 and another resident standing over top of Resident 54 slapping her and yelling, Get out! The residents were separated, and the registered nurse was notified. There was no documented evidence in Residents 54's clinical record to indicate that she was being monitored for wandering. A nursing note for Resident 54, dated September 5, 2024, at 3:43 p.m., revealed that the nurse aide brought Resident 54 to the nurse after the nurse aide witnessed Resident 56 grabbing her by her arm and screaming at her to get out of her room. The licensed practical nurse looked at Resident 54's left inner arm, and there were three fingernail prints on her arm. A nursing note for Resident 54, dated September 5, 2024, at 7:55 p.m., revealed that Resident 54's left arm remained slightly pink where fingernail marks occurred from the altercation earlier. The resident was observed staying in her room for a long time after the incident and if you stated her name, she would jump and become very fidgety. There was no documented evidence in Residents 54's clinical record to indicate that she was being monitored for wandering. Interview with the Nursing Home Administrator on March 6, 2025, at 9:56 a.m. confirmed that Resident 56 had multiple abusive interactions with Resident 54 and that there was no documented evidence that staff was monitoring Resident 54 when wandering. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 201.29(j) Resident Rights.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48941 Based on a review of facility policies, clinical record reviews, and staff interviews, it was determined that the facility failed to ensure that a resident's baseline care plan included information regarding the resident's immediate care needs for one of 33 residents reviewed (Resident 74). Findings include: A facility policy for baseline care plans, dated November 8, 2024, indicated that the facility will develop a baseline care plan within 48 hours of a resident's admission that includes the minimum healthcare information necessary to properly care for a resident including, but not limited to, initial goals based on admission orders and physician's orders. Interventions shall be initiated that address the resident's current needs including any special needs such as for intravenous therapy (administration of fluids and/or medications directly into a person's vein). A nursing note for Resident 74, dated February 25, 2025, at 4:23 p.m., revealed that the resident was admitted to the facility on [DATE], with diagnoses that included a diabetic foot ulcer (a wound to the foot due to a complication of diabetes) and peripheral vascular disease (a disease causing poor blood circulation to lower limbs). She had a peripherally inserted central catheter (PICC - a thin tube inserted into a vein and used long term for the administration of fluids and/or medications) in her right upper arm for maintenance at that time. Physician's orders for Resident 74, dated February 25, 2025, included orders for the staff to maintain the resident's PICC and flush each port every 12 hours with 5 milliliters (ml) of normal saline followed by 5 ml of Heparin (an anticoagulant medication used to keep intravenous catheters open and flowing freely); for the registered nurse to change the PICC dressing, extension set, and cap every seven days on the day shift and as needed for leakage, blockage and/or soilage; and for staff to measure the external catheter length from insertion site to the end of the injection cap in centimeters (cm) on admission, with each dressing change every seven days on the day shift and as needed. Review of Resident 74's clinical record revealed no documented evidence that a baseline care plan was developed to address the resident's PICC and related PICC care. Interview with the Nursing Home Administrator on March 5, 2025, at 12:17 p.m. confirmed that there was no documented evidence that a baseline care plan was developed to address Resident 74's PICC and related PICC care. 28 Pa. Code 211.12(d)(1) Nursing Services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48941 Based on review of facility policies, clinical records, and staff interviews, it was determined that the facility failed to develop a comprehensive care plan that included specific and individualized interventions to address the care needs of residents for one of 33 residents reviewed (Resident 29). Findings include: The facility's policy for Comprehensive Care Plans, dated November 8, 2024, indicated that the facility develops and implements a comprehensive, person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs. The comprehensive person-centered care plan is developed within seven days of the completion of the required comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs). The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 29, dated February 4, 2025, revealed that the resident was cognitively impaired, required assistance with care needs, was receiving hospice services, and had a diagnosis of Alzheimer's disease. Physician's orders for Resident 29, dated February 6, 2025, revealed that the resident was admitted to 365 Hospice on February 4, 2025. Review of Resident 29's clinical record revealed that there was no documented evidence that a care plan was developed to address the resident's need for hospice services. An interview with the Nursing Home Administrator on March 5, 2025, at 9:31 a.m. confirmed that there was no documented evidence that a care plan was developed to address Resident 29's need for hospice services. 28 Pa. Code 201.24(e)(4) Admission Policy. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 48809 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for two of 33 residents reviewed (Residents 9, 31). Findings include: The facility's policy for Comprehensive Care Plans, dated November 8, 2024, indicated that the facility develops and implements a comprehensive, person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs. The comprehensive person-centered care plan is developed within seven days of the completion of the required comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs). The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated January 18, 2025, revealed that the resident was cognitively impaired, was rarely understood, and could rarely understand others. A care plan, dated October 13, 2021, revealed that hospice was to be notified if the resident goes into cardiac arrest. Physician's orders for Resident 9, dated July 19, 2024, revealed that the resident was discharged from hospice care. Interview with the Nursing Home Administrator on March 5, 2025, at 9:31 a.m. confirmed that the resident was no longer on hospice and her care plan should have been updated to reflect that. A quarterly MDS assessment for Resident 31, dated January 16, 2025, revealed that the resident was cognitively intact, required assistance with care needs, had no pressure ulcers or wounds, and had diagnoses that included diabetes, peripheral vascular disease (a disease causing poor blood circulation to lower limbs), and acquired absence of the left leg below the knee. A skin integrity care plan for Resident 31, dated May 9, 2019, included an intervention for a stump shrinker to be worn to shape the amputation site for a possible prosthesis (an artificial body part) and an intervention for contact precautions (used to prevent the spread of infection passed through direct contact with an infected person or their environment) related to Methicillin-resistant Staphylococcus aureus (MRSA) infection (type of staph bacteria resistant to many antibiotics making treatment difficult). Review of Resident 31's clinical record revealed no documented evidence that the resident continued to wear a stump shrinker and no documented evidence that the resident had a MRSA infection requiring contact precautions. Interview with the Nursing Home Administrator on March 6, 2025, at 9:55 a.m. confirmed that Resident 31's care plan should have been revised to reflect that the stump shrinker was no longer used and that the resident was no longer on contact precautions for MRSA. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48941 Based on review of clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that physician's orders regarding wound treatments were followed for one of 33 residents reviewed (Resident 74). Findings include: A nursing note for Resident 74, dated February 25, 2025, at 4:23 p.m. revealed that the resident was admitted to the facility on [DATE], with diagnoses that included a diabetic foot ulcer (a wound to the foot due to a complication of diabetes) and peripheral vascular disease (a disease causing poor blood circulation to lower limbs). Physician's orders for Resident 74, dated March 1, 2025, included orders to cleanse the resident's right lateral diabetic foot ulcer with normal saline (a sterile solution used for the moistening of wound dressings and wound debridement), apply betadine (a solution used to treat and prevent infection) to the base of the wound, and secure with abdominal dressing (used for a wound with large amounts of drainage or used as padding for pressure points and cushioning) and rolled gauze (used to hold the dressing in place) daily and as needed. Observations of Resident 74's wound care on March 5, 2025, at 10:08 a.m. revealed that Licensed Practical Nurse 2, with gloved hands, cleansed the resident's right lateral foot with normal saline, removed her gloves, washed her hands, applied new gloves, applied betadine to the wound, and left the wound open to air. Interview with Licensed Practical Nurse 2 on March 5, 2025, at 11:52 a.m. revealed that she was not aware that the wound to Resident 74's right lateral foot was to be covered with an abdominal dressing and wrapped with rolled gauze. Interview with the Nursing Home Administrator on March 5, 2025, at 12:22 p.m. confirmed that the order for Resident 74's wound to her right lateral foot included an order to cover the wound with abdominal dressing and wrap with rolled gauze. She confirmed that the wound should have been covered and wrapped. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 47819 Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to provide proper positioning in a wheelchair for one of 33 residents reviewed (Resident 38). Findings include: An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 38, dated November 29, 2024, revealed that the resident was cognitively impaired, required assistance with daily care needs, and had diagnoses that included Alzheimer's dementia and depression. Physician's orders for the resident, dated September 17, 2024, included orders for the resident to be seated in a Broda chair (modified wheelchair) at all times when out of bed with bolsters bilaterally to trunk, skil-care back pillow, and leg rests on during transport and off after transport. Observations on March 3, 2025, at 10:19 a.m. revealed that Resident 38 was sitting in a Broda chair in the activity room, and she was leaning to the right side with her head lying on the armrest. Observations on March 6, 2025, at 10:40 a.m. revealed that Resident 38 was in a Broda chair in the activity room, and she was leaning to the right side with her head lying on the armrest. Interview with the Director of Rehabilitation on March 6, 2025, at 10:40 a.m. confirmed that the bilateral bolsters were not in place on Resident 38's Broda chair per physician orders. Interview with the Nursing Home Administrator on March 6, 2025, at 11:19 a.m. confirmed that Resident 38 did not have the bilateral bolsters to prevent the resident from leaning. 28 Pa. Code 211.12(d)(5) Nursing Services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48941 Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the environment remained as free of accident hazards as possible for one of 33 residents reviewed (Resident 14). Findings include: A facility policy for resident alarms, dated November 8, 2024, indicated that the use of alarms does not eliminate the need for adequate supervision of the resident. Wander/elopement alarms alert staff when the resident nears or exits an area or building. When alarms are utilized, additional monitoring shall be provided, including but not limited to verifying alarms are used in accordance with the resident's care plan and verifying alarms are working properly. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 14, dated November 10, 2024, indicated that the resident was cognitively impaired, required assistance with care needs, and had diagnoses that included Alzheimer's dementia. A care plan for the resident, dated March 11, 2024, revealed that the resident was a high risk for elopement due to recent exit-seeking behaviors and wandering. Interventions included a wanderguard to reduce the risk of elopement and to check the device for proper functioning per facility protocol. Physician's orders for Resident 14, dated December 4, 2024, included an order for the resident to have a wanderguard in place for safety. A nursing note for Resident 14, dated February 8, 2025, at 9:21 p.m. revealed that the resident had an episode of increased confusion during the first half of the shift and stated she was going home, packing her belongings, and wandering through the hallways. There was no documented evidence in Resident 14's clinical record to indicate that the wanderguard was checked for proper functioning per the facility policy and the resident's plan of care. Interview with the Nursing Home Administrator on March 6, 2025, at 11:59 a.m. confirmed that there was no documented evidence that Resident 14's wanderguard was monitored to verify that it was working properly and it should have been. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(1)(e)(1) Management. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48941 Based on review of clinical records, as well as observations and staff interviews, it was determined that the facility failed to flush a PICC line (a tube placed in a vein that can be used to deliver fluids and/or medications) as ordered by the physician for one of 33 residents reviewed (Resident 74). Findings include: A nursing note for Resident 74, dated February 25, 2025, at 4:23 p.m. revealed that the resident was admitted to the facility on [DATE], with diagnoses that included a diabetic foot ulcer (a wound to the foot due to a complication of diabetes) and peripheral vascular disease (a disease causing poor blood circulation to lower limbs). She had a peripherally inserted central catheter (PICC - a thin tube inserted into a vein and used long term for the administration of fluids and/or medications) in her right upper arm for maintenance at that time. Physician's orders for Resident 74, dated February 25, 2025, included orders for the staff to maintain the resident's PICC and flush each port every 12 hours with 5 milliliters (ml) of normal saline followed by 5 ml of Heparin (an anticoagulant medication used to keep intravenous catheters open and flowing freely). Observations of Resident 74's PICC dressing change on March 5, 2025, at 9:50 a.m. revealed that after the PICC dressing was applied, Registered Nurse 3 flushed the resident's PICC with one syringe containing 5 ml of normal saline. Interview with Registered Nurse 3 on March 5, 2025, at 12:13 p.m. confirmed that she flushed Resident 74's PICC with normal saline and did not flush the PICC with the 5 ml of heparin per the physician's orders. She indicated that she was not aware that the PICC was to be flushed with heparin as well. Interview with the Nursing Home Administrator on March 5, 2025, at 12:17 p.m. confirmed that Registered Nurse 3 should have flushed Resident 74's PICC with the 5 ml of heparin per the physicians orders and she did not. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48809 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain a complete and accurate accounting of controlled medications (medications with the potential to be abused) for one of 33 residents reviewed (Resident 46). Findings include: The facility's policy regarding medication administration, dated November 8, 2024, indicated that staff were to document that medication was given on the appropriate line of the resident's Medication Administration Record (MAR). Physician's orders for Resident 46, dated November 20, 2023, included an order for the resident to receive a 1 milligram (mg) tablet of Ativan (an anti-anxiety medication) every six hours as needed. Resident 46's controlled drug records for January and February 2025 revealed that a 1 mg dose of Ativan was signed-out on January 21, 2025, at 7:50 a.m. and February 28 2025, at 8:00 a.m.; however, the resident's clinical record, including the MAR, contained no documented evidence that the Ativan was actually administered to the resident. Interview with the Director of Nursing on March 16, 2025, at 12:44 p.m. confirmed that there was no documented evidence that the doses of Ativan that were signed-out by the nurse on the above dates were actually administered to Resident 46. 28 Pa. Code 211.9(h) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 48809 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that non-pharmacological (non-medication) interventions were attempted prior to the administration of as needed anti-anxiety medications for one of 33 residents reviewed (Resident 46). Findings include: A quarterly Minimum Date Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 46, dated February 1, 2025, indicated that the resident was cognitively impaired, was understood and was able to be understood by others, and had physical behaviors directed toward others. The resident's care plan dated January 14, 2024, revealed that staff were to minimize the potential for disruptive behaviors by offering tasks that divert attention. Physician's orders, dated February 4, 2025, and February 19, 2025, included an order for the resident to receive 1 milligram (mg) of Ativan (an anti-anxiety medication) every six hours as needed for agitation. Resident 46's Medication Administration Record (MAR) for February 2025 and March 2025 revealed that staff administered as needed Ativan for agitation on February 1, 2025, at 4:05 a.m.; February 3, 2025, at 7:46 a.m.; February 6, 2025, at 11:23 p.m.; February 7, 2025, at 3:23 a.m. and 6:02 a.m.; February 9, 2025, at 5:47 p.m.; February 14, 2025, at 6:09 a.m. and 12:16 p.m.; February 15, 2025, at 7:46 a.m. and 3:00 p.m.; February 16, 2025, at 7:55 a.m. and 3:00 p.m.; February 19, 2025, at 4:00 p.m.; February 20, 2025, at 6:53 a.m. and 2:30 p.m.; February 21, 2025, at 6:33 a.m. and 6:23 p.m.; February 22, 2025, at 4:00 p.m.; February 23 2025, at 6:10 p.m.; February 24, 2025, at 6:14 a.m.; February 25, 2025, at 6:20 a.m.; February 26, 2025, at 5:00 p.m.; February 28, 2025, at 4:00 p.m.; March 1, 2025, at 7:37 a.m. and 5:30 p.m.; March 2, 2025, at 7:10 a.m. and 3:56 p.m.; and March 4, 2025, at 7:21 a.m. There was no documented evidence in Resident 46's clinical record to indicate that non-pharmalogical interventions were attempted prior to the Ativan being administered on the above dates and times. Interview with the Nursing Home Administrator on March 5, 2025, at 9:05 a.m. confirmed that there was no documented evidence to indicate that non-pharmacological interventions were attempted prior to the administration of Ativan for Resident 46. 28 Pa. Code 211.12(d)(3)(5) Nursing Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395569	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Hillsdale Park	383 Mountain View Drive Hillsdale, PA 15746

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)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 48941 Based on review of the facility's plans of correction and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of corrections for State Survey and Certification (Department of Health) survey ending April 11, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending March 6, 2025, identified repeated deficiencies related to abuse and neglect, updating/revising care plans, quality of care, and a safe environment that is free of accident hazards. The facility's plan of correction for a deficiency regarding failure to ensure residents were free from abuse and neglect, cited during the survey ending April 11, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F600, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding abuse and neglect. The facility's plan of correction for a deficiency regarding a failure to update/revise residents' care plans, cited during the survey ending April 11, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding updating/revising residents' care plans. The facility's plan of correction for a deficiency regarding quality of care, cited during the survey ending April 11, 2024, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding quality of care. The facility's plans of correction for deficiencies regarding a safe environment that is free of accident hazards, cited during the survey ending April 11, 2024, revealed that the facility developed plans of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F689, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding a safe environment that is free of accident hazards. Refer to F600, F657, F684, F689. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395569	A. Building B. Wing	03/06/2025

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.