STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395588	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Park Avenue	14714 Park Ave Extension Meadville, PA 16335

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 0580 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42655 Based on review of clinical records and facility policy and staff interviews, it was determined that the facility failed to notify the resident's representative of a change in condition and/or treatment for one of 24 residents reviewed (Resident R30). Findings include: The facility policy entitled Notification of responsible party and physician procedure dated 10/28/24, revealed Goal: The facility makes reasonable attempts to assure that responsible party and physician are notified and kept aware of a resident's condition, changes in orders, acute situations, lab/x-ray results, significant change in status, incidents that effect a resident's status or transfer from the facility to hospital, another agency or a change in residence. The responsible party will also be notified of incidents and accidents regarding the resident, medication error, change in medication/treatment, labs/x-rays/tests and results or transfer out of the facility. Documentation: Notification and attempts to notify the physician, responsible party and third party vendors should be documented. The DON/ADON [Director of Nursing/Assistant Director of Nursing] should be kept aware of unsuccessful notification attempts. Resident R30's clinical record revealed an admitted [DATE], with diagnoses that included unstageable pressure ulcer of right hip (a type of wound covered by slough or dead/blackened tissue), diabetes mellitus (a disease when the body has trouble controlling blood sugar and using it for energy), weakness, and chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe). Resident R30's clinical record revealed a physician's order dated 11/12/24, for Voltaren External Gel 1% (Diclofenac Sodium Topical), Apply to knees, elbows typically every 6 hours as needed for pain 2 grams. Resident R30's progress notes dated 11/12/24, indicated that x-ray (a type of radiation imaging that creates pictures of the inside of your body) results were reviewed with the Certified Registered Nurse Practitioner (CRNP) and an order was received for Voltaren gel 2 grams every six hours as needed for pain. The clinical record lacked evidence that Resident R30's representative was notified of CRNP's orders/treatment change and x-ray findings dated 11/12/24. (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident R30's representative on 11/19/24, at 1:00 p.m. revealed the facility does not always update him/her of new orders and/or test results. On 11/22/24, at 1:00 p.m. the DON confirmed the facility did not notify Resident R30's representative of the new orders/treatment change and x-ray findings dated 11/12/24. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12 (d)(1)(5) Nursing services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41309 Based on review of facility policy and clinical records, observations, and staff and resident representative interviews, it was determined the facility failed to ensure that residents with indwelling catheters (a tube inserted into the bladder to facilitate urine drainage) receive proper care and services to help prevent infections for two of nine residents reviewed with indwelling catheters (Residents R19 and R79). Findings include: A facility policy entitled, Catheter Care dated 10/28/24, revealed it is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Privacy bags will be available and catheter drainage bags will be covered at all times while in use. Resident R19's clinical record revealed an admitted [DATE], with diagnoses that included cerebral infarction (a condition where blood flow to the brain is blocked resulting in brain tissue death), aphasia (a language disorder that affects a person's ability to communicate), neuromuscular dysfunction of bladder (a condition that affects bladder control typically from a brain, spinal cord, or nerve problem), and urinary tract infection (UTI). Observation on 11/20/24, at 11:00 a.m., revealed Resident R19's catheter drainage bag uncovered and laying on the floor beside the bed. During an interview on 11/21/24, at approximately 1:00 p.m. Resident R19's resident representative revealed that Resident R19 recently was hospitalized for a UTI. Resident R79's clinical record revealed an admitted [DATE], with diagnoses that included encephalopathy (a term for any brain disease that alters brain function or structure caused by infection, tumor, or stroke), dementia, weakness, retention of urine, and history of UTI. Observation on 11/20/24, at 10:23 a.m., revealed Resident R79's catheter drainage bag uncovered and laying on the floor beside the bed. During an interview with Nursing Assistant Employee E1 on 11/20/24, at 10:25 a.m., it was confirmed that Resident R79's catheter bag was laying on the floor beside the bed without a catheter bag cover on it. During an interview on 11/21/24, at 2:14 p.m. the Director of Nursing confirmed that Resident R19 and R79's catheter bag should be covered and not lay on the floor and/or touch an unclean surface due to risk for infection. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0908 Level of Harm - Potential for minimal harm Residents Affected - Many	Keep all essential equipment working safely. 41309 Based on review of facility policy, observations, and staff interview, it was determined the facility failed to properly maintain safe operation of essential equipment in the main kitchen and prevent excessive build up of frost in the walk-in freezer. Findings include: Review of facility policy entitled, Cleaning Instructions: Freezer with a policy review date of 10/28/24, revealed that the freezer will be defrosted as needed (when the frost is greater than 1/4 inch thick and according to the cleaning schedule). Observations of the walk-in freezer in the Main Kitchen on 11/19/24, at 12:45 p.m. revealed areas with an accumulation of ice including on the ceiling that extended out from the condenser to the other side of the walk-in-freezer, as well as multiple areas on the floor by the entrance to the freezer. Water and ice was observed dripping and freezing on frozen food item boxes on the top of the shelves. Condenser coils were observed frozen in ice. During an interview on 11/20/24, at 12:00 p.m. the Dietary Manager confirmed that there was an accumulation of ice to include on the ceiling that extended out from the condenser to the other side of the walk-in-freezer, as well as multiple areas on the floor by the entrance to the freezer. Water and ice was observed dripping and freezing on frozen food item boxes on the top of the shelves. Condenser coils were observed frozen in ice. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3)(2.1) Management