STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Woodland Park	18889 Croghan Pike Orbisonia, PA 17243

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48941 Based on review of facility policies, clinical records, and investigation documents, as well as staff and resident interviews, it was determined that the facility failed to ensure that residents were free from abuse and neglect for one of five residents reviewed (Resident 4). Findings include: The facility's abuse policy, dated March 15, 2024, indicated that residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat resident's symptoms. Failure to report abuse, neglect, exploitation may result in civil monetary penalties. Administration will investigate and report any allegation of abuse within the timeframes as required by federal requirements. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs), dated, April 11, 2024, revealed that Resident 4 was cognitively intact, was clearly understood and able to clearly understand, required assistance with care needs, had weakness to one side, and had no fall history. A care plan addressing care needs for Resident 4, dated February 9, 2024, revealed that as of April 7, 2024, the resident required extensive assist of two staff with transfers. A facility investigation document, dated April 16, 2024, at 12:13 p.m. revealed that nursing was asked to assess Resident 4 due to therapy noting a large bruise to resident's middle lower back. Upon assessment, a dark purple bruise was noted to the resident's right lower back and buttocks measuring 18 centimeters (cm) x 7 cm. The resident stated that she may have bumped off the arm of her wheelchair when she got weak last Sunday when staff was assisting her to transfer from her wheelchair to her bed. She stated staff then used the hoyer lift to transfer her to bed. The areas of bruises were firm upon palpation (examination by touch), and the resident denied pain or discomfort. Facility investigation documents revealed that Resident 4 stated that she was transferred by one nurse aide on second shift on April 7, 2024, who had orange hair. It was reported that Nurse Aide 1 attempted to transfer Resident 4 by herself despite resident being care planned for a two-person transfer. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Woodland Park	18889 Croghan Pike Orbisonia, PA 17243

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview statement from Nurse Aide 1, dated April 16, 2024 at 12:30 p.m., revealed that she and Nurse Aide 2 tried to transfer Resident 4 into bed from her wheelchair and she got weak and started going backward. She stated that the resident may have hit her right buttock on the arm rest of the wheelchair. She stated they got Nurse Aide 3 to help but they could not get her up so they got the hoyer lift and used the lift to transfer the resident. She stated that they reported Resident 4's weakness to the licensed practical nurse. A written statement from Nurse Aide 2, dated April 16, 2024, revealed that on April 7, 2024, she was in room [ROOM NUMBER] when she noticed her watch ringing and saw that it was Nurse Aide 1 calling and she said she needed help in room [ROOM NUMBER] with Resident 4. She stated that Resident 4 was sitting on Nurse Aide 1's legs in between the bed and the chair. Nurse Aide 1 was the only person in the room with the resident. She stated that Nurse Aide 1 tried to get the resident in bed and could not find her because she was doing care in room [ROOM NUMBER]. She stated that Nurse Aide 1 had the call bell on, but she did not see it due to being in room [ROOM NUMBER]. A phone interview statement from Nurse Aide 3, dated April 16, 2024, revealed that on the evening of April 7, 2024, Nurse Aide 1 came to her because she needed help transferring Resident 4 because she could not stand. Nurse Aide 1 told her that herself and Nurse Aide 2 tried to stand Resident 4 and she was too weak. They stood her up a little bit to get the lift pad under her and used the hoyer lift. Nurse Aide 3 was asked if Nurse Aide 2 was in the room when she arrived and she stated that Nurse Aide 2 had entered the room after her. A phone interview statement from Licensed Practical Nurse 4, dated April 16, 2024, revealed that nobody had reported any bruises and that the nurse aides mentioned having a hard time transferring Resident 4 and they ended up transferring her with the hoyer lift. A nursing note, dated April 7, 2024, at 6:52 p.m., revealed that staff had to use the hoyer lift on Resident 4 that evening due to weakness. A facility disciplinary action form for Nurse Aide 1, dated April 16, 2024, revealed that she was suspended pending investigation for possible neglect of Resident 4 due to the belief that she transferred Resident 4 with by herself resulting in a bruise when the resident was care planned for a two-person assist. A facility disciplinary action form for Nurse Aide 1, dated April 22, 2024, revealed that she was terminated due to her inability to follow Resident 4's plan of care, despite being educated multiple times. An interview with Resident 4 on April 30, 2024, at 2:05 p.m. revealed that she recalled the incident on April 7, 2024, and she stated that the nurse aide was transferring her from her wheelchair to the bed by herself when her right leg gave out and she fell on to her arm rest no her wheelchair. An interview with the Director of Nursing and the Nursing Home Administrator on April 30, 2024, at 3:15 p.m. confirmed that Resident 4 was extensive assist of two staff for transfers at the time of the incident on April 7, 2024. The Nursing Home Administrator was able to display the resident history on the care plan and confirmed that the resident was care planned to be transferred with extensive assist of two staff at the time of the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395697	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Woodland Park	18889 Croghan Pike Orbisonia, PA 17243

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing on April 30, 2024, at 3:36 p.m. confirmed that Nurse Aide 1 did not follow Resident 4's plan of care related to transfer assist at the time of the incident on April 7, 2024. She confirmed that the nurse aide was suspended pending the investigation, that all required agencies were notified, and that they substantiated the neglect of Resident 4 and Nurse Aide 1 was terminated. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(b)(e)(1) Management. 28 Pa. Code 201.29(a)(j) Resident Rights. 28 Pa. Code 211.12(d)(5) Nursing Services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2024
NAME OF PROVIDER OR SUPPLIER Embassy of Woodland Park		STREET ADDRESS, CITY, STATE, ZIP CODE 18889 Croghan Pike Orbisonia, PA 17243	

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 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 policies, clinical records, and investigation documents, as well as staff and resident interviews, it was determined that the facility failed to ensure that staff implemented care-planned interventions for one of five residents reviewed, resulting in injury (Resident 4). The facility's comprehensive care plan policy, dated March 15, 2024, indicated that the facility is to develop and implement 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, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs), dated, April 11, 2024, revealed that Resident 4 was cognitively intact, was clearly understood and able to clearly understand, required assistance with care needs, had weakness to one side, and had no fall history. A care plan related to care needs for Resident 4, dated February 9, 2024, revealed that as of April 7, 2024, the resident required extensive assist of two staff with transfers. A facility investigation document, dated April 16, 2024, at 12:13 p.m., revealed that nursing was asked to assess Resident 4 due to therapy noting a large bruise to resident's middle lower back. The resident stated that she may have bumped off the arm of her wheelchair when she got weak last Sunday when staff was assisting her to transfer from her wheelchair to her bed. She stated staff then used the hoyer lift to transfers her to bed. The areas of bruises were firm upon palpation (examination by touch), and the resident denied pain or discomfort. A facility interview with Resident 4 revealed that she was transferred by one nurse aide on second shift on April 7, 2024, who had orange hair. It was reported that Nurse Aide 1 attempted to transfer Resident 4 by herself despite resident being care planned for a two-person transfer. A facility disciplinary action form for Nurse Aide 1, dated April 22, 2024, revealed that she was terminated due to her inability to follow Resident 4's plan of care, despite being educated multiple times. An interview with Resident 4 on April 30, 2024, at 2:05 p.m. revealed that she recalled the incident on April 7, 2024, and she stated that the nurse aide was transferring her from her wheelchair to the bed by herself when her right leg gave out and she fell on to her arm rest to her wheelchair. When asked if she was to have a two-person assist for her transfers at the time of this incident, she stated that they would transfer her with one assist at times and other times with two assist. She could not recall the names of the staff involved. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395697	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Woodland Park	18889 Croghan Pike Orbisonia, PA 17243

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing and the Nursing Home Administrator on April 30, 2024, at 3:15 p.m. confirmed that Resident 4 was extensive assist of two staff for transfers at the time of the incident on April 7, 2024. The Nursing Home Administrator was able to display the resident history on the care plan and confirmed that the resident was care planned to be transferred with extensive assist of two staff at the time of the incident. An interview with the Director of Nursing on April 30, 2024, at 3:36 p.m. confirmed that Nurse Aide 1 did not follow Resident 4's plan of care related to transfer assist at the time of the incident on April 7, 2024. 28 Pa. Code 211.12(d)(5) Nursing Services.