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	10/03/2024

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

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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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 38012 Based on clinical record reviews and staff interviews, it was determined that the facility failed to provide the required notice to the resident or the resident's representative following the end of their Medicare coverage for two of two residents reviewed (Residents 62, 95) who remained in the facility for long-term care. Findings include: A Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review form, completed by the facility and dated July 30, 2024, revealed that Medicare coverage for Resident 62 started on July 11, 2024, and that her last covered day was July 30, 2024. The form indicated that the facility initiated discontinuation from Medicare Part A coverage and that the resident's benefit days were not exhausted. The SNF Beneficiary Protection Notification Review form was not issued at least 48 hours in advance. The Advanced Beneficiary Notice of Non-coverage for Resident 62 was not issued. A SNF Beneficiary Protection Notification Review form, completed by the facility and dated July 8, 2024, revealed that Medicare coverage for Resident 95 started on June 19, 2024, and that her last covered day was July 10, 2024. The form indicated that the facility initiated discontinuation from Medicare Part A coverage and that the resident's benefit days were not exhausted. The Advanced Beneficiary Notice of Non-coverage for Resident 95 was not issued. Interview with the Admissions Director on October 1, 2024, at 10:55 a.m. revealed that Resident 62's SNF Beneficiary Protection Notice was not issued timely and that she was unaware that the ABN was required when the resident remained in the facility. 28 Pa. Code 201.18(e)(1) Management.

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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 41233 Based on review of policies, as well as observations and staff interviews, it was determined that the facility failed to maintain a clean and homelike environment for two of 38 residents reviewed (Residents 1, 39). Findings include: The facility's policy regarding cleaning and disinfecting, dated March 15, 2024, indicated that the facility was to provide a safe, comfortable, homelike environment. A quarterly Minimum data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated September 3, 2024, revealed that the resident was cognitively intact, required staff assistance for care needs, used a wheelchair, and had diagnoses that included cerebral palsy (CP - neurological disorder that affects a person's ability to move, balance, and maintain posture.) Observations on September 30, 2024, at 1:24 p.m. revealed that the resident was sitting in his electric wheelchair in his room. The carpet in his room was black and worn. An interview with the resident at the time revealed that he felt that the carpet was very dirty, and that the facility was planning on replacing the carpet with a different kind of flooring. Observations and interview with Resident 1 on October 1, 2024, at 3:30 p.m. revealed that the carpet in his room was still black and worn and that staff had attempted to clean the carpet but it had not changed the condition of it. Interview with the Director of Maintenance on October 2, 2024, at 9:01 a.m. revealed that the carpet in Resident 1's room was very dirty and had been shampooed multiple times, but due to the current condition of the carpet, the ground-in dirt could not be removed. The Director of Maintenance also stated that the facility has discussed replacing the floor with a vinyl type of flooring, but there was no discussed timeline, no estimates, or planned work schedules. An annual MDS assessment for Resident 39, dated September 24, 2024, revealed that the resident was cognitively intact and had diagnoses that included congestive obstructive pulmonary disease (a lung disease that makes it difficult to breath) and a history of congestive heart failure (a condition when the heart cannot pump enough blood to meet the body's needs). The resident was receiving continuous oxygen via nasal cannula (tubes that deliver oxygen into the nostrils). Observations on October 2, 2024, at 10:45 a.m., 11:50 a.m., and 2:30 p.m. revealed that Resident 39 was lying in her bed with a stand-up fan blowing directly on her. The fan was noted to have a moderate amount of visible dirt and debris accumulated on the blade cover. Interview with the Director of Maintenance on October 2, 2024, at 3:00 p.m. revealed that cleaning fans used by residents was not on their scheduled work list; however, if they are made aware of a dirty fan, they would then clean it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Housekeeping on October 2, 2024, at 3:25 p.m. revealed that the fan belonged to Resident 39. She remarked that cleaning resident fans is not on their list of duties; however, if they are made aware of a dirty fan, they would then clean it. She confirmed that the fan was blowing directly on the resident with a moderate amount of dirt and debris accumulated on the blade cover, and that it should have been clean and it was not. Interview with Director of Nursing on October 3, 2024, at 9:00 a.m. confirmed that Resident 39's fan cover should be clean, and it was not. 28 Pa. Code 201.29(j) Resident Rights. 28 Pa. Code 207.2(a) Administrator's Responsibility.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 43856 Based on review of policies and personnel files, as well as staff interviews, it was determined that the facility failed to ensure that the status of nursing licenses were checked with the State Board of Nursing for two of two nurses reviewed (Registered Nurse 1, Licensed Practical Nurse 2) and failed to complete a Nurse Aide Registry verification for one of three nurse aides reviewed (Nurse Aide 3). Findings include: The facility's policy regarding abuse prevention, dated March 15, 2024, indicated that the facility conducted background checks and will not knowingly employ or otherwise engage any individual who has disciplinary action in effect against his or her professional license by a state licensure board or registry as a result of a finding of abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property. The personnel file for Registered Nurse 1 revealed a start date of April 21, 2024. However, there was no documented evidence until October 2, 2024, that his license was verified with the State Board prior to him working. The personnel file for Licensed Practical Nurse 2 revealed a start date of July 14, 2024. However, there was no documented evidence until October 2, 2024, that her license was verified with the State Board prior to her working. The personnel file for Nurse Aide 3 revealed a start date of July 10, 2024. However, there was no documented evidence until October 2, 2024, that her standing on the Pennsylvania Nurse Aide Registry was verified. Interview with the Human Resources Director on October 2, 2024, at 2:20 p.m. confirmed that Registered Nurse 1 had a start date of April, 21, 2024, and Licensed Practical Nurse 2 had a start date of July 14, 2024, and there was no evidence that their licenses were verified with the State Board of Nursing until October 2, 2024. She also confirmed that Nurse Aide 3 had a start date of July 10, 2024, and there was no evidence that a registry verification was completed prior to her start date. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.

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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. 43856 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to develop care plans for one of 38 residents reviewed (Resident 61). Findings include: The facility's policy regarding the development of care plans, dated March 15, 2024, indicated that the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective person-centered care of the residents and meet professional standards of quality care. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 61, dated September 6, 2024, indicated that the resident was cognitively intact, required assistance from staff for her daily care needs, and was frequently incontinent (two or more episodes of bowel incontinence, but at least one continent bowel movement) of bowel. Task records for the month of September 2024 were reviewed and indicated that Resident 61 did have two or more bowel incontinence episode weekly. There was no documented evidence that a care plan was developed to address Resident 61's care needs related to bowel incontinence. Interview with the Director of Nursing on October 3, 2024, at 10:03 a.m. confirmed that Resident 61 should have had a care plan developed for bowel incontinence and she did not. 28 Pa. Code 201.24(e)(4) Admission Policy.

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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. 41233 Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to revise/update care plans for two of 38 residents reviewed (Residents 39, 61). Findings include: The facility's policy regarding care plans, dated March 15, 2024, indicated that nurses and interdisciplinary team members were responsible for updating the resident's care plan to reflect changes in the resident's status. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 39, dated September 24, 2024, indicated that the resident was cognitively intact, required assistance from staff for her daily care needs, and had diagnoses that included, heart failure, and chronic pain. Physician's orders for Resident 39, dated March 11, 2024, included an order for morphine sulfate solution (20 mg/ml), give one ml by mouth every eight hours for chronic pain. Physician's orders for Resident 39, dated May 1, 2024, included an order for morphine sulfate solution (20 mg/ml), give one ml by mouth every two hours as needed for pain. Physician's orders for Resident 39, dated June 12, 2024, included an order for a fentanyl transdermal (on the skin) pain patch 75 micrograms per hour, to be changed every three days, for chronic pain. There was no documented evidence in Resident 39's clinical record to indicate that the care plan was updated to include multiple medications for pain management. A significant change MDS assessment for Resident 61, dated September 6, 2024, indicated that the resident was cognitively intact, required assistance from staff for her daily care needs, and had diagnoses that included heart failure and non-traumatic brain dysfunction (a complex medical condition that impacts brain function and daily life). A physician's order for Resident 61, dated August 30, 2024, included an order for a urinary catheter related to urinary retention. However, the resident's current care plan, dated February 20, 2020, included a care plan for bladder incontinence and the use of pantiliners (a thin pad worn to protect undergarments from stains). Interview with the Director of Nursing on October 3, 2024, at 10:03 a.m. confirmed that Resident 39's care plan should have been updated to reflect that she was on multiple pain medications, and that Resident 61's care plan should have been updated to reflect that she did not have bladder incontinence and did not use pantiliners, and they were not. (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 201.24(e)(4) Admission Policy.

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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. 38012 Based on review of clinical records and facility investigation reports, as well as staff interviews, it was determined that the facility failed to ensure that the residents' environment remained free of accident hazards for residents for one of 38 residents reviewed (Resident 55). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 55, dated August 9, 2024, revealed that the resident was cognitively intact. An elopement risk for the resident, dated August 10, 2024, revealed that the resident was an elopement risk and that she required a Wanderguard bracelet (an electronic device that alarms when near the exit door). A nursing note for Resident 55, dated December 12, 2023, at 3:18 p.m. revealed that the resident was visualized exiting the building. She had a history of verbalizing her desire to go home. Wanderguards had been attempted in the past; however, she usually removes them. A nursing note for Resident 55, dated July 19, 2024, revealed that the resident was found outside the facility sitting on a bench. The resident's Wanderguard was not on her person and, therefore, did not sound to alert the staff that she was exiting the building. There was no documented evidence that the facility attempted to prevent Resident 55 from exiting the building in any way other than the Wanderguard, which they were aware she was removing herself. Interview with the Director of Nursing on October 3, 2024, at 12:54 p.m. confirmed that they were aware Resident 55 was removing her Wanderguard and that she was not happy residing at the facility; however, there were no further interventions in place to prevent her from leaving the building. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. 43856 Based on review of personnel files, as well as staff interviews, it was determined that the facility failed to verify registry verification prior to allowing individuals to work as a nurse aide for one of three newly hired nurse aides reviewed (Nurse Aide 3). Findings include: The personnel file for Nurse Aide 3 revealed that she was hired by the facility on July 10, 2024. However, there was no documented evidence that the facility verified the nurse aide's standing with the state nurse aide registry until October 2, 2024. Interview with the Human Resources Director October 2, 2024, at 2:20 p.m. confirmed that Nurse Aide 3 did not have a nurse aide registry check completed prior to her start date and that she should have. 28 Pa. Code 201.29 Personnel Policies and Procedures.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 42079 Based on clinical record reviews and staff interviews, it was determined that the facility failed to provide appropriate treatment and services for one of 38 residents reviewed (Resident 40) who had dementia. Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 40, dated July 16, 2024, revealed that the resident was understood, could understand others, had no behaviors, and had diagnosis that included cerebrovascular accident/stroke and anxiety. A care plan for the resident, dated June 17, 2022, revealed that the resident has behaviors including screaming, yelling, refusal of care, throwing items, and being demanding of staff. Observations of Resident 40 on September 30, 2024, at 11:48 a.m. during and after incontinence care provided by Nurse Aides 4 and 5 revealed that she saw snakes on her comforter and dinosaurs outside of her window. Both Nurse Aides 4 and 5 assured the resident that the snakes were not harmful and would be helpful during care and this was a good day for Resident 40 in regard to her behaviors as she was cooperative with care. Observations of Resident 40 on October 1, 2024, at 3:40 p.m. revealed that she was in her bed, calling out for a nurse, and crying. She said that her husband was outside stuck on the fence and he needed help inside. Interview with Licensed Practical Nurse 7 on October 1, 2024, at 3:44 p.m. indicated this was Resident 40's baseline, she frequently calls out, cries, and looks for her family. A care task record for Resident 40 from September 19, 2024 through October 2, 2024, was to be documented with any behavioral symptoms. There was no documented evidence that Resident 40's delusions or hallucinations were reported or any interventions were put in place. On October 1, 2024, at 4:31 p.m. it was documented that the resent was yelling. There was no documented evidence that any new interventions were attempted to address Resident 40's anxiety, anxiousness, confusion, and new hallucinations. Interview with the Nursing Home Administrator on October 2, 2024, at 11:53 a.m. revealed that she spoke to the physician, and the physician felt that the resident's behaviors were dementia related and does not need outside psychological services, as the behaviors are up and down. The Nursing Home Administrator confirmed that the facility staff were following the plan of care, but there was no documented interventions that staff attempted to assist the resident. 28 Pa. Code 211.12(d)(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. 42079 Based on facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for one of 38 residents reviewed (Resident 12). Findings include: The facility's policy for storage of controlled medications, dated March 15, 2024, revealed that when administering a controlled medication, the controlled drug record form must be signed when the medication is removed from the narcotic box, and the Medication Administration Record (MAR) must be signed after the medication is administered. Both documents must be signed. A significant change Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 12, dated July 26, 2024, revealed that the resident was understood and able to understand, was moderately cognitively impaired, had pain management, had a Stage IV pressure ulcer (wound caused by pressure with bone or tendon exposure), was receiving an opioid (controlled drug), and received hospice care (end of life comfort care). Interview with the Resident 12's spouse on September 30, 2024, at 1:01 p.m. revealed that he visits daily and that the resident has an open area on her buttocks and has received pain medication prior to dressing changes because she would cry and yell out during wound care. Physician's orders for Resident 12, dated September 9, 2024, included an order for the resident to receive 0.5 milliliter (20 mg/1 ml) of Morphine Sulfate solution (a narcotic pain medication) every two hours as needed for wound care, shortness of breath, pain, and discomfort. Review of Resident 12's controlled drug record (a form that accounts for each tablet/pill/dose of a controlled drug), dated August and September 2024, revealed that 0.5 ml of morphine (20 mg/1 ml) was signed out on the controlled drug record on September 6, 2024, at 1:30 p.m.; September 7, 2024, at 3:25 p.m.; and September 12, 2024, at 9:08 a.m.; however, they were not signed as administered on the MAR. Interview with the Director of Nursing on October 3, 2024, at 2:09 p.m. confirmed that there was no documented evidence in the clinical records to indicate that the signed-out doses of controlled medications mentioned above were administered to Resident 12. 28 Pa. Code 211.9(h) Pharmacy Services. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. 41233 Based on a review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to store medications properly for one of 38 residents (Resident 53) and failed to label multi-dose insulin pens with the date they were opened in one of one medication cart observed (300 Long). Findings include: The facility's policy regarding medication labeling and storage, dated March 15, 2024, revealed that multi-dose medications that have been opened or accessed are to be dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open medication. In addition staff are to prepare and observe the resident taking their medications. A diagnosis record for Resident 53 revealed diagnoses that included cancer of the prostate, high blood pressure, and heart disease. Observations on September 30, 2024, at 11:15 a.m. revealed that the resident was sleeping in his bed and he had a medicine cup full of pills on his bedside table. The medications included one large, white, round tablet; one small, cream, oval tablet; one large, brownish-tan, oval capsule; one red, oval tablet; three orange-colored, round tablets; one large, off-white capsule; and one small, white, round tablet; and one very small, round, white tablet. A review of Resident 53's clinical record did not reveal that he was cleared to administer his own medications. Interview with Licensed Practical Nurse 8 on September 30, 2024, at 11:15 a.m. revealed that she had poured them earlier in the shift and set them on his table because he likes to take them with his lunch. She stated she should not have left the medications at his bedside. Observations of the 300 Long medication cart on October 2, 2024, at 1:00 p.m. revealed that there was a glargine insulin pen, a Basaglar insulin pen, and a Toujeo SoloStar insulin pen that were opened and not dated with the date they were opened. The Basaglar and glargine insulins were to be discarded after 28 days, and the Toujeo SoloStar insulin pen was to be discarded after 56 days. Interview with Licensed Practical Nurse 9 on June 10, 2024, at 12:15 p.m. confirmed that the insulin pens should have been dated with the date they were opened. Interview with the Nursing Home Administrator on October 3, 2024, at 9:00 a.m. confirmed that Resident 53's medications should not have been poured and left at his bedside, and that the insulin pens should have been dated with the date they were opened. 28 Pa. Code 211.9(a)(1) Pharmacy Services. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(1) Nursing Services.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42079 Based on a review of facility policy and the facility's written menus, as well as observations and staff and resident interviews, it was determined that the facility failed to follow their planned menu. Findings include: A facility policy, dated March 15, 2024, indicated that menus shall be written in advance and followed. Any menu substitutions shall be made in an emergency situation only and recorded on the substitution log. An interview with a group of residents on October 1, 2024, indicated that the kitchen does not always serve what is on the menu. Observations of the kitchen on September 30, 2024, at 9:58 a.m. revealed that staff were preparing meatloaf, mashed potatoes, mixed vegetables (carrots, green beans, and wax beans), and vanilla cake for lunch. The facility's written and printed menu for the lunch meal on September 30, 2024, revealed that the residents were to receive meatloaf, mashed potatoes, Brussels sprouts, berry-topped yellow cake, coffee/tea, dinner roll, and margarine. Observations of the lunch meal in the dining room on September 30, 2024, at 12:14 p.m. revealed that the facility prepared and served Prince [NAME] veggie blend (green beans, wax beans, and carrots). Interview with [NAME] 6 on September 30, 2024, at 12:14 p.m. confirmed that she was unsure what was to be on the menu, but she did not have Brussels sprouts to serve for lunch. The only vegetable she had was a carrot, green bean, and wax bean mix. Interview with the Dietary Manager on September 30, 2024, at 12:17 p.m. confirmed that she forgot to order Brussels sprouts and substituted with the Prince [NAME] mix. She did not inform residents or the resident council president of the menu change. The facility's recipe for chicken breast citrus glazed (ground), undated, indicated that two fluid ounces of citrus wing sauce was to be served with one scoop of ground chicken. Observations of tray line on October 1, 2024, at 12:08 p.m., revealed that the regular texture trays had a chicken breast dipped in a liquid glaze, but the scoop of ground chicken breast had poultry gravy added on top of the serving and not the citrus glaze. A test tray on October 1, 2024, at 12:25 p.m. revealed that the chicken breast with citrus glaze of ground texture did not taste the same as the regular texture chicken breast. The ground chicken did not have a citrus glaze and had a poultry gravy flavor. (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	10/03/2024

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.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Dietary Director on October 1, 2024, at 12:32 p.m. confirmed that the ground chicken did not have the citrus glaze and should have.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42079 Based on review of facility policy, observations, and staff interviews, it was determined that the facility failed to prepare and store food in accordance with professional standards for food service safety. Findings include: A facility policy for food storage, dated March 15, 2024, revealed that all items being stored in the freezer must be labeled, dated, and sealed in the same manner and may be stored for the period of time per Hazardous Analysis Critical Control Point (HACCP - a systematic approach to the identification, evaluation, and control of food safety hazards) guidelines. Dry storage items must be six inches off the floor. Observations of the main kitchen during the initial tour on September 30, 2024, at 9:55 a.m. revealed that there were two cardboard boxes of coffee on the floor stacked one on top of the other. Observations in the three-door freezer on September 30, 2024, at 9:58 a.m. revealed a box with approximately two thirds of a chocolate cake that was not dated, labeled, or sealed. Interview with Dietary Director on September 30, 2024, at 10:08 a.m. confirmed that the coffee should not be stored directly on the floor and that the chocolate cake in the freezer should be dated, labeled, and sealed. 28 Pa. Code 211.6(f) Dietary Services.

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	395697	A. Building B. Wing	10/03/2024

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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 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. 42079 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) surveys ending November 30, 2023; January 29, 2024; April 30, 2024; and July 10, 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 October 3, 2024, identified repeated deficiencies related to failure to prove a safe, clean, homelike environment; failure to develop and implement abuse and neglect policies; failure to develop resident care plans; failure to be free from accident hazards; failure to maintain a complete and accurate account of controlled medications; failure to label and store drugs and biologicals; failure to provide menus prepared in advance and menus followed to meet residents' needs; and failure to store, prepare, and serve food in a sanitary manner. The facility's plan of correction for a deficiency regarding a safe, clean, comfortable, homelike environment, cited during the surveys ending November 30, 2023, and January 29, 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 F584, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding a safe, clean, comfortable, homelike environment. The facility's plan of correction for a deficiency regarding the developing and implementing abuse and neglect polices, cited during the survey ending November 30, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F607, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding the development and implementation abuse and neglect polices. The facility's plans of correction for deficiencies regarding developing and implementing comprehensive care plans, cited during the surveys ending November 30 2023, and April 30, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F656, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with the regulation regarding developing and implementing comprehensive care plans. (continued on next page)

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	395697	A. Building B. Wing	10/03/2024

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

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's plan of correction for a deficiency regarding being free of accident hazards, cited during the surveys ending November 30, 2023, and July 10, 2024, revealed that the facility would complete audits and report 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 was ineffective in maintaining compliance with the regulation regarding being free of accident hazards. The facility's plan of correction for a deficiency regarding failure to maintain a complete and accurate accounting of controlled medications, cited during the survey ending November 30, 2023, 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 F755, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding maintaining a complete and accurate accounting of controlled medications. The facility's plan of correction for a deficiency regarding the labeling and storage of drugs and biologicals, cited during the survey ending November 30, 2023, 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 F761, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding the labeling and storage of drugs ands biologicals. The facility's plan of correction for a deficiency regarding menus being prepared in advance and followed to meet residents' needs, cited during the survey ending November 30, 2023, 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 F803, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding menus being prepared in advance and followed to meet residents' needs. The facility's plan of correction for a deficiency regarding food storage, preparation, and serve in a sanitary manner, cited during the survey ending November 30, 2023, 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 F812, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding food storage, preparation, and serve in a sanitary manner. Refer to F584, F607, F656, F689, F755, F761, F803, F812. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18(e)(1) Management.