STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395588	A. BLDG: 00 B. WING:	12/11/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
EMBASSY OF PARK AVENUE STATE LICENSE NUMBER: **131702**	**14714 PARK AVENUE EXTENSION** **MEADVILLE, PA 16335**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance Survey and an Abbreviated Complaint Survey completed on December 11, 2025, it was determined that Embassy of Park Avenue was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations for the Health portion of the survey process.	F 0000		
F 0812 SS=D		F 0812		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0812 SS=D	Continued from page 1 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	Preparation and submission of this plan of correction is required by state and federal law. This plan of correction does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. The policy titled "Use and Storage of Food Brought in by Families or Visitors" was reviewed and remains appropriate. At the time of surveyor identification, the items identified in the resident refrigerators that were not labeled as required and/or expired were removed per policy. All staff will be re-educated on the "Use and Storage of Food Brought in by Families or Visitors" policy. This will be the responsibility of the Administrator and/or designee. To ensure ongoing compliance, a weekly audit of all resident refrigerators will be conducted to ensure that all items in the resident refrigerators are labeled as required and that all expired items were	Completion Date: **01/12/2026** Status: **APPROVED** Date: **12/23/2025**

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F 0812 SS=D	Continued from page 2	F 0812	removed per the " Use and Storage of Food Brought in by Families or Visitors " policy. This audit will be the responsibility of the Administrator and/or designee. This audit will occur weekly x 4 weeks, then every other week for a month, then monthly until practice is determined to be in compliance. Audits will be reviewed no less than quarterly by Quality Assurance Performance Improvement committee	

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F 0812 SS=D	Continued from page 3 Based on review of a facility policy, observations, and staff interview, it was determined that the facility failed to ensure that food was stored in accordance with standards for food safety in a resident pantry in two of four refrigerators reviewed (Rehab Unit and North Unit). Findings include: Review of facility policy entitled "Use and Storage of Food Brought in by Family or Visitors", dated 8/29/25, revealed that "The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator; The prepared food must be consumed by the resident within 3 days; If not consumed within 3 days, food will be thrown away by facility staff; All items not maintained are subjected to being thrown away if not removed by the resident and/or resident representative." Observations on 12/8/25, at 11:57 a.m. of a refrigerator in the Rehab Unit used for residents	F 0812		

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F 0812 SS=D	Continued from page 4 revealed three single serve containers of cottage cheese with a resident name and expiration date of 11/24/25, and one can of Celsius-Retro Vibe drink without a resident name or date. During an interview on 12/8/25, at the time of observation, Registered Nurse Employee E1 confirmed that food items in the resident refrigerator contained items that were not labeled as required, and/or items that were expired. Observations on 12/8/25, at 3:45 p.m. of a refrigerator in the North Unit used for residents revealed one bottle of orange juice with a resident name and expiration date of 6/15/25, and one bottle of Hazelnut coffee creamer with a resident name and expiration date of 11/15/25. During an interview on 12/8/25, at the time of observation, Nursing Assistant Employee E2 confirmed that food items in the resident refrigerator contained items that were expired.	F 0812		

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F 0812 SS=D	Continued from page 5 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1) Management	F 0812		

Pennsylvania Department of Health

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P 5520		P 5520		

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P 5520	Continued from page 1 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	No residents were found to be negatively affected by the deficient practice of regulation. In an effort to maintain compliance with the regulation the facility should utilize the following process: 1. In an attempt to achieve appropriate staffing ratios, the facility has created a daily assignment grid for the Scheduler to complete daily that designates the required amount of Certified Nurse Aides per shift that are required to meet the regulatory requirements. The assignment grids will be reviewed during Labor Meetings to be held no less than weekly. Additionally, the Scheduler will be re-educated on the required amount of Certified Nurse Aides per shift that are required to meet the regulatory requirements. This review will be the responsibility of the Director of Nursing or designee. 2. When a call-off is received, the Supervisor will make every effort to	Completion Date: **01/12/2026** Status: **APPROVED** Date: **12/29/2025**

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P 5520	Continued from page 2	P 5520	replace hours fully. In the event that the Supervisor is unable to fully cover the hours of a staff call-off and the loss of staff might impact the facility's compliance with the regulatory requirement, the RN Supervisor will notify the Director of Nursing and Assistant Director of Nursing so that all administrative clinical staff can be notified of the need so they can assist with coverage. 3. The facility will continue with recruitment efforts and will continue to enforce the attendance policy. 4. The facility shall complete a monitor of staffing ratios weekly utilizing the DOH staffing calculation tool for 1 month, then monthly for 2 months then quarterly until such time it is determined by the Quality Assurance Committee that the facility is maintaining compliance. This shall be the responsibility of the Director of Nursing or designee.	

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P 5520	Continued from page 3 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to meet the Nurse Aide (NA) ratios for one NA per 10 residents on day shift for three of 21 days reviewed (6/14/25, 6/15/25, and 6/17/25); failed to meet the NA ratio for one NA per 11 residents on the evening shift for two of 21 days reviewed (6/14/25 and 6/17/25); and failed to meet the NA ratio for one NA per 15 residents on the overnight shift for three of 21 days reviewed (6/12/25, 6/13/25, and 6/16/25). Findings include: Review of facility nursing staffing documents for the time periods from 6/11/25, through 6/17/25; 9/1/25, through 9/7/25; and 12/3/25, through 12/9/25, revealed the following NA staffing shortages for the day shift where the NA ratios were not met: 6/14/25 census of 116 residents 11.00 NAs worked and 11.60 were required 6/15/25 census of 114 residents 10.00 NAs	P 5520		

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P 5520	Continued from page 4 worked and 11.40 were required 6/17/25 census of 114 residents 10.47 NAs worked and 11.40 were required Review of facility nursing staffing documents for the time periods from 6/11/25, through 6/17/25; 9/1/25, through 9/7/25; and 12/3/25, through 12/9/25, revealed the following NA staffing shortages for the evening shift where the NA ratios were not met: 6/14/25 census of 116 residents 10.50 NAs worked and 10.55 were required 6/17/25 census of 114 residents 9.47 NAs worked and 10.36 were required Review of facility nursing staffing documents for the time periods from 6/11/25, through 6/17/25; 9/1/25, through 9/7/25; and 12/3/25, through 12/9/25, revealed the following NA staffing shortages for the overnight shift where the NA ratios were not met: 6/12/25 census of 115 residents 7.00 NAs worked and 7.67 were required	P 5520		

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P 5520	Continued from page 5 6/13/25 census of 117 residents 5.75 NAs worked and 7.80 were required 6/16/25 census of 114 residents 7.50 NAs worked and 7.60 were required During an interview on 12/11/25, at 9:10 a.m. the Nursing Home Administrator confirmed that the facility did not meet the minimum NA ratios for the above days and shifts.	P 5520		
P 5640		P 5640		

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P 5640	Continued from page 6 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	No residents were found to be negatively affected by the deficient practice of regulation. In an effort to maintain compliance with the regulation, the facility shall utilize the following process: 1. In an attempt to achieve general nursing care hours of at least a minimum of 3.2 hours of direct resident care hours per resident in a 24-hour period, the facility has created a daily assignment grid for the Scheduler to complete daily that designates the required amount of direct care staff in relation to Resident census. The assignment grids will be reviewed during Labor Meetings to be held no less than weekly. This review will be the responsibility of the Director of Nursing or designee. 2. When a call-off is received, the Supervisor will make every effort to replace hours fully. 3. The facility will continue with recruitment efforts and will continue to enforce the attendance policy. 4. The facility shall complete a	Completion Date: **01/12/2026** Status: **APPROVED** Date: **12/29/2025**

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P 5640	Continued from page 7	P 5640	monitor of staffing PPD's on a daily basis utilizing the DOH staffing calculation tool until such time it is determined by the Quality Assurance Committee that the facility is maintaining compliance. This shall be the responsibility of the Director of Nursing or designee. 5. The scheduler and RN Supervisors will be re-educated on the regulatory guidelines for the minimum number of general nursing care hours of 3.2 hours of direct resident care hours per resident in a 24-hour period. This will be the responsibility of the Director of Nursing.	

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P 5640	Continued from page 8 Based on review of facility nursing staffing documents and staff interview, it was determined that the facility failed to meet 3.20 minimum number of general nursing care hours for each 24-hour period for two of 21 days reviewed (6/13/25 and 6/17/25). Findings include: Review of facility nursing staffing documents for the time periods from 6/11/25, through 6/17/25; 9/1/25, through 9/7/25; and 12/3/25, through 12/9/25, revealed the following general nursing care hours was below the minimum 3.20 per patient day (PPD) on the following days: 6/13/25 3.16 PPD 6/17/25 3.14 PPD During an interview on 12/11/25, at 9:10 a.m. the Nursing Home Administrator confirmed that the facility did not meet the 3.20 PPD minimum nursing care hours on the above dates.	P 5640		

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P 5640	Continued from page 9	P 5640		

Certified End Page

EMBASSY OF PARK AVENUE

STATE LICENSE NUMBER: 131702

SURVEY EXIT DATE: 12/11/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY