STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395273	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Scranton	824 Adams Avenue Scranton, PA 18510

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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 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** 26142 Based on review of clinical records and staff interview, it was determined the facility failed to timely notify the resident's responsible representative of a change in condition for one resident out of 6 sampled (Resident 5). Findings include: A review of the clinical record revealed that Resident 5 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (commonly referred to as diabetes, is a group of metabolic diseases in which there are high blood sugar levels over a prolonged period) and dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems). A review of a nurses note dated June 24, 2024 at 1:08 P.M. revealed, Resident 5 was complaining of right upper extremity pain and edema (swelling) and the CRNP(certified registered nurse practioner) was made aware. A new order noted for Doppler study (Doppler ultrasound is a noninvasive test that can be used to measure the blood flow through the blood vessels. It works by bouncing high-frequency sound waves off red blood cells that are circulating in the bloodstream. A regular ultrasound uses sound waves to produce images, but can't show blood flow) of the resident's left upper extremity(LUE) A review of a nurses note dated June 24, 2024 at 8:36 P.M. revealed, Venous doppler results received for LUE due to edema and pain results showed no DVT (deep vein thrombosis, is a condition in which blood clots (or thrombi) form in deep veins in the legs or other areas of the body. Veins are the blood vessels that carry blood from the body's tissues to the heart. Deep veins are located deep in the body, away from the skin's surface) and a large hematoma (collection of blood) of the resident's left forearm. A nurses note dated June 25, 2024 at 12:44 P.M. revealed, Resident 5's LUE remains swollen, the resident denied pain at this time and was seen by CRNP. A nurses note dated June 27, 2024 at 06:32 A.M. revealed, Resident 5 woke up this morning crying and yelling at staff and complained of left arm pain. The resident refused any pain medications. (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	A review of a CRNP note dated June 27,2024 at 11:04 A.M. revealed, Resident 5 was seen for medical follow up re: left forearm edema/pain, panful but ice to arm helping. Resident does not want to keep taking Tylenol. States today that she is unable to use left hand due to pain, she will not perform active ROM (range of motion) or hand flexion/extension. According to this CRNP note te resident's left forearm is without bruising, redness, wounds. +1 non pitting edema (pitting edema is graded on a scale from 1 to 4, which is based on both the depth the pit leaves and how long the pit remains. A score of 1 has edema that is slight (roughly 2 mm in depth) and disappears rapidly present at forearm). Good radial pulse but the resident is unable to fully extend and contract her left hand. The CRNP was unable to assess the resident's strength due to this edema. The resident has bruising noted into her phalanges (fingers). Documentation dated June 27, 2024 at 2:06 P.M. revealed, new orders to obtain an X-Ray of the resident's left arm, forearm & wrist regarding swelling. A nurses note dated June 28, 2024 at 10:43 A.M. revealed the resident's left arm remains swollen and firm and she complained of numbness in her left hand, with no discoloration. A new order by CRNP, indicated send the resident to the emergency room for evaluation. The note indicated the resident and te responsible representative is aware. A nurses note dated June 29, 2024 at 12:50 A.M. revealed, the Resident was admitted to the hospital with compartment syndrome (a condition in which increased pressure within one of the body's anatomical compartments results in insufficient blood supply to tissue within that space. Compartments of the leg or arm are most commonly involved). There was no documented evidence that the resident's resident representative was informed of the changed in the residents condition until she was admitted to the hospital on June 28, 2024. The resident's responsible representative was not made aware of the resident's reports of pain and swelling when initially began on June 24, 2024 requiring assessment and testing. An interview with the director of nursing on August 9, 2024, at approximately 2:00 PM confirmed the facility failed to notify the resident's representative in a timely manner of the change in condition of the residents left arm, swelling and pain and numbness. 28 Pa Code 211.12 (c)(d)(3)(5) Nursing services

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records, select facility policy facility documentation, and staff interview, it was determined the facility failed to ensure that three residents out of 6 sampled were free from physical abuse (Residents 2, 3 and 4). Findings include: A review of facility policy entitled Abuse Reporting and Investigation (no revision date available) revealed, the facility will thoroughly investigate all reports of suspected or alleged abuse. Clinical record review revealed Resident 2 was admitted to the facility on [DATE] with diagnosis to include but not limited to, psychosis, mood disorder, intermittant explosive disorder and seizure disorder. An annual minimum data set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated May 3, 2024 indicated he was moderately, cognitively impaired with a BIMS score of 9 (Brief Interview for Mental Status. The BIMS test is used to get a quick snapshot of how well you are functioning cognitively at the moment 8 to 12 points suggests moderate cognitive impairment) and required assistance from staff for activities of daily living. A review of the resident's care plan dated January 22, 2024, indicated the resident has the potential to demonstrate physical/verbal abusive behaviors towards peers and staff, it is noted he has a history of kicking, punching and slapping peers, throwing things, kicking other residents wheelchairs, holding scissors and pointing them at staff with refusal of giving up the scissors all related to intermittent explosive disorder. The documented interventions for these behaviors include: When the resident becomes agitated: Intervene before agitation escalates; Guide the resident away from source of distress; Engage the resident in calm conversation; If the resident's response is aggressive, staff are to walk calmly away and approach the resident at a later time;. Assess the resident's coping skills and support system; Analyze the residents behaviors for key times, places, circumstances, triggers, and what de-escalates the resident's behavior and include documentation of the resident's behaviors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility investigation documentation dated May 9, 2024 at 11:00 A.M., revealed Resident 3(cognitively intact with a BIMS score of 15) was self propelling in the hallway on her way to the activity room. As she approached the end of the hallway, Resident 2 was sitting outside of his room and attempted to block Resident 3 from passing him (which she needed to do in order to get to the activity area). When Resident 3 asked Resident 2 to move, Resident 2 wiggled the handles of her wheelchair. Resident 2's physical touch to Resident 3's wheelchair was witnessed by the activity assistant. A housekeeper heard residents shouting and responded and witnessed Resident 2 kick the back of Resident 3's wheelchair as he began began cursing at her. The staff immediately separated the residents. Resident 3 reported to staff that Resident 2 hit me on my arms and kicked me. Resident 2 stated as documented indicated, I did it because I could. I did not kick her, I shook her chair. New interventions to prevent this behavior for Resident 2 include a psychiatric evaluation and a change of his room. A nurses note dated June 2, 2024 at 3:45 P.M. revealed, Resident 2 was angry with Resident 4 and almost went physical but was separated by the staff and sent to his room, Resident 2 issued threats to this Resident 4 by telling him it's not over, hence keeping an eye on him. On June 3, 2024 at 8:30 A.M., Resident 4 was seated in his wheelchair at the nurses station, taking his medication and accidently spilled his drink on the floor. Resident 2 came out of his room and started yelling at Resident 4 stating you are a scum bag and you pissed on the floor. Nursing staff separated the residents and redirected both to their rooms. At 9:00 A.M. both residents were in the hallway. Resident 2 stood up from his wheelchair and hit Resident 4 in the face with a closed fist. Resident 2 stated to Resident 4 that he is going to continue going after him because he can and no one is going to stop him!. The staff separated the residents. Resident 4 was noted with a nose bleed and received treatment and was sent to the hospital for an evaluation. A nurses note dated June 3, 2024 at 2:38 P.M., revealed due to te physical altercation between Resident 2 and Resident 4, Resident 2 was a 302 commitment (A 302 commitment in Pennsylvania is an involuntary commitment for psychiatric placement at an inpatient psychiatric unit) to a local hospital and then transferred to an out of area (Philadelphia PA) psychiatric hospital for treatment. A Nursing Note dated June 12, 2024 at 5:25 PM revealed, Resident 2 returned to facility around 2:55 PM from the hospital. Interventions dated June 14, 2024 to prevent re occurrence of Resident 2's behavior include, hospitalization for noted behaviors and redirection from any interaction with Resident 4. There was no evidence that effective interventions were put into place after the physical altercation initiated by Resident 2 on Resident 3 on May 9, 2024 in an attempt to prevent any future altercations initiated by Resident 2, resulting in an additional physical altercation between Resident 2 and Resident 4 and causing injury, a bloody nose. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on August 9, 2024, at approximately 11:00 AM, the DON (director of nursing) and NHA (nursing home administrator) confirmed the facility failed to protect the above residents from physical abuse perpetrated by Resident 2. The DON and NHA confirmed that residents have the right to be free from abuse, including physical abuse perpetrated by other residents. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident Rights 28 Pa. Code 211.12(d)(5) Nursing Services

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. 26142 Based on review of clinical records, facility policy provided to residents upon transfer from the facility, and interview with facility staff revealed the facility failed to demonstrate the implementation of specifically delineated procedures for Medicaid payor source bed holds and the provision of notices of the facility's bed hold policy in an understandable language that allow a resident to return to the facility after a transfer to the emergency room for one resident out of six reviewed. (Resident 5). Findings include: A review of a facility policy, Discharge/Transfer Letter Policy and Bed Hold Notices for bed-holds and returns, (policy review date unavailable at the time of the survey), revealed, prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. The policy revealed the residents may return to and resume residence in the facility after hospitalization or therapeutic leave as outlined in this policy. Prior to a transfer, written information will be given to the residents and the resident representatives that explain in detail: -the rights and limitations of the resident regarding bed-holds -the reserve bed payment policy as indicated by the state plan (Medicaid) -the facility per diem rate required to hold a bed(non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents) and -the details of the transfer (per the notice of transfer). If a Medicaid resident exceeds the state bed-hold limit and/or non-Medicaid residents who request a bed-hold are responsible for the facility's basic per diem rate while his or her bed is held. A review of Resident 5's clinical record revealed the resident was under managed care Medicaid insurance at the time of the transfer to the hospital on July 5, 2024, due to a change in clinical condition. A review of the copy of the facility's bed hold policy form prepared for Resident 5's transfer by the facility staff revealed that a vacant bed will be held while the resident is at the hospital or on therapeutic leave, Medicaid will pay the following: hospitalization 15 days and Therapeutic leave 30 days. During this time, the resident is permitted to return and resume residence in the facility. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If the hospitalization or therapeutic leave exceeds the number of days indicated above, the resident will be readmitted immediately upon the first availability of a vacant bed in a semi-private room if: the resident requires the services provided by the facility, and if the resident is eligible for Medicaid nursing facility services. If the resident is transferred with the expectation that he or she will return, but it is determined that the resident cannot return, that resident will be formally discharged . The resident will be permitted to return to an available bed in the location of the facility that he or she previously resided. If there is not an available bed in that part, the resident will be given the option to take an available bed in another distinct part of the facility and return to the previous part of the facility when a bed becomes available. A review of a facility form for Resident 5 entitled Notification of Transfer, Emergency dated July 5, 2024, as per the facility's admission agreement, the facility shall transfer/discharge a resident, when the facility determines that such action is appropriate to meet the resident's needs for health care or other services. This is to inform the resident that, (no resident name indicated on the form) will be transferred/discharged to the hospital on July 5,2024 for the following reasons, psychiatric behaviors. This form was not signed by a facility staff member and was noted to be mailed. There was no evidence at the time of the survey the resident or her responsible party received the bed hold/transfer form. A review of a care plan dated April 13, 2024 revealed, Resident 5 has exhibited increased behavioral symptoms-verbal/ physical abuse: racial slurs, yelling, hitting, throwing items at staff, cursing, shouting orders, talking down to her roommate, making discriminatory statements towards staff, accusatory statements towards staff, refusing to remove stored food from her room, and accusing others of stealing from her and placing calls to 911. Interventions implemented include Resident 5 prefers not to have African American staff provide care to her. A review of nursing documentation dated July 5, 2024 at 10:10AM revealed that Resident 5 was delusional, making racial slurs to African American staff, the resident kicked a nurse aide in the stomach, and continues to accuse room mate of stealing her belongings and money and threatens to hurt her. The resident spit on the nursing supervisor and stated I will kick you in the face. The Director of Nursing made the decision to send the resident to the hospital for an evaluation. A review of a nursing documentation dated July 5, 2024 at 10:40 AM revealed the resident agreed to go to the hospital for an evaluation, but she refused to go to a psychiatric facility. Resident 5 was then transferred to the emergency room of the hospital for an evaluation. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a nurses note written by the Director of Nursing, dated July 8, 2024 at 7:13 PM revealed, the facility received a call from the hospital on Sunday July 7, 2024 regarding the resident, inquiring if she is a bed hold or not. The hospital social worker stated that resident 5 was admitted to the hospital for a UTI(urinary tract infection). This nurse (DON) informed social worker that resident 5 was not sent to the hospital for a UTI, she was sent to the hospital for a psychiatric evaluation. She is know to have a bipolar (a serious mental illness characterized by extreme mood swings, a mood disorder that causes radical emotional changes and mood swings, from manic, restless highs to depressive, listless lows. Most bipolar individuals experience alternating episodes of mania and depression) diagnosis and the resident's daughter is refusing to put her on (psychoactive)medication. The condition for Resident 5's readmission to the facility, according to the DON, is for the resident and her daughter to agree to start treatment of behavior medication. At this time the facility is unable to meet the residents needs due to verbal abuse of staff and other residents. The DON will inform MD. There was no evidence at the time of the survey of any additional information regarding Resident 5's readmission to the facility. There was no discharge plan for this resident at the time of her admission to the hospital. There was no documented evidence at the time of the survey ending August 9, 2024, that Resident 5 was afforded the opportunity to return to the facility after a stay in the hospital for a UTI. During an interview August 9, 2024, the DON stated that Resident 5 and her daughter refused to accept psychoactive medications. She stated that Resident 5 did not want certain nursing staff members taking care of her. The DON stated that there were not enough staff that the resident would allow to care for her. The DON stated that because of this, the facility could not meet this residents needs. The facility had evaluated the resident's ability to return to the facility based on her past behavior, when originally transferred to the hospital and the resident's clinical record failed to show that the facility made efforts to work with the hospital to ensure the resident's condition and needs were able to be met by the facility. The facility was unable to provide documented evidence of the resident's or the resident's representative decision to decline or accept the bed hold. 28 Pa. Code 201.29 (a)(c) Resident rights

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of select facility policy, and clinical records, and staff interview, it was determined the facility failed to thoroughly assess and evaluate bowel function and implement individualized approaches to restore normal bowel function to the extent possible for one out of 6 sampled residents (Resident 1). Findings include: A review of the facility policy entitled Continence Status Guidelines (no date as reviewed provided at the time of the survey), revealed residents admitted to the facility will be assessed to determine their level of bowel and bladder continence and appropriate interventions put into place when indicated. Guidelines to include: Residents will be assessed within two weeks of admission, upon significant change in status on incontinence and routinely, to determine their continence status; After an assessment residents will be placed in one of the following categories for bowel and bladder: Continent-resident is continent of bowel and bladder. Residents will be provided products and assistance per request. Bowel and Bladder program-Resident is occasionally or frequently incontinent but is cognitively able to assume more responsibility for being continent over time with staff assistance and reminders. May involve being reminded to use bathroom at specific times, assistance to use the bathroom, etc. Resident will be placed on an individual program to be reminded to use the bathroom, bedside commode or bedpan with assistance as needed. Check and change-a resident that would not benefit from a bowel and bladder program due to a cognitive level (such as not recognizing why being placed on a commode, dementia, etc.), a physical condition that makes the use of the bathroom, bedside commode or bedpan difficult or painful, or the resident's unwillingness to participate in a program. Resident will wear the appropriate incontinence product, be checked by staff routinely about every 2 hours and prn and changed when needed. A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses to include, dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems), and atrial fibrillation (an abnormal heartbeat). A review of Resident 1's Minimum quarterly Data Set assessment (MDS- a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 5, 2024, revealed that the resident was continent of bowel. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A bladder/bowel assessment dated [DATE] indicated that Resident 1 was continent of bladder and bowel. A review of nursing documentation indicated the resident was hospitalized on [DATE] and was readmitted to the facility on [DATE]. A review of a quarterly MDS dated [DATE] indicated the resident was now frequently incontinent of bowel. A review of Resident 1's clinical record revealed the facility failed to initiate a bowel assessment after the residents decline in bowel function. A review of toileting records dated July 13, 2024 through August 9, 2024 (past 30 days) indicted the resident was noted to be continent on three of the days and incontinent of bowel on the remaining days. The facility failed to initiate a three day bowel activity assessment in order to determine the resident's pattern of incontinence in response to the documented resident's decline in bowel function. Further, the facility failed to identify the resident's habits or patterns of incontinence to develop an individualized toileting plan to restore bowel function to the extent possible for the resident. A review of the resident's current plan of care dated March 15, 2024 revealed that the resident is incontinent of bowel at times. Interventions to include, assist to toilet as needed and to identify incontinence pattern and establish a toileting plan accordingly. Interview with the Director of Nursing on August 9, 2024, at approximately 2:00 PM confirmed the facility failed to thoroughly assess the resident's bowel and bladder function to identify each resident's habits, patterns and plan to meet the residents' toileting needs and decrease incontinence. 28 Pa. Code 211.12 (d)(5) Nursing services

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 26142 Based on staff interviews and a review of employee personnel records it was determined that the facility failed to provide abuse prevention training to four employee out of four reviewed. (Employees 1,2,3, and 4). Findings include: During an interview with Employee 1 (agency Licensed Practical Nurse) on August 9, 2024 at 9:45 AM she stated that she worked at the facility on and off for the past four months. Employee 1 stated that she was never trained on the facility's abuse prohibition policy prior to assuming her duties today. During an interview with Employee 2 (agency registered nurse) on August 9, 2024 at 9:55 AM she stated this is the fourth shift she had worked at the facility and stated she was never trained on the facility's abuse prohibition policy prior to assuming her duties today. During an interview with Employee 3 (agency nurse aide) on August 9, 2024 at 10:00 AM she stated that she worked at the facility on and off for the past 6 months. Employee 3 stated she was never trained on the facility's abuse prohibition policy prior to assuming her duties today. During an interview with Employee 4 (agency nurse aide) on August 9, 2024 at 10:05 AM she stated that she worked at the facility on and off for the past 4 months. Employee 4 stated that she was never trained on the facility's abuse prohibition policy prior to assuming her duties today. There was no documentation that Employee 1 (agency licensed practical nurse), 2 (agency registered nurse), 3 (agency nurse aide) and 4 (agency nurse aide) was trained on the facility's abuse prohibition policies and procedures as part of staff orientation and training on the prohibition of all forms of abuse, neglect, and exploitation prohibition. Interview with the Director of Nursing (DON) on August 9, 2024 at 2:00 PM., confirmed the facility had no written records to show that Employee 1,2,3,and 4, all agency employees, were trained on the facility's policy and procedures on as part of staff orientation and training before assuming their job duties. The DON further stated that agency employees are not inserviced on the facility abuse policy prior to working at the facility. 28 Pa. Code 201.20 (a)(b) Staff development 28 Pa. Code 201.19 (6)(7) Personnel policies and procedures