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	01/28/2026

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, facility policies, facility investigative documentation, video surveillance, and resident and staff interviews, it was determined the facility failed to ensure that the environment remained as free of accident hazards as possible and failed to provide adequate supervision and environmental safety to prevent an avoidable accident. This failure placed one of eight residents reviewed (Resident 1) in Immediate Jeopardy to their health and safety due to the high likelihood of serious injury or death from falls or self-harm.Findings include: A clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses to include anxiety (a mental health condition characterized by excessive worry or fear) and major depressive disorder (a mental health disorder characterized by persistent low mood, loss of interest in activities, low energy, poor concentration, appetite changes, sleep disturbances, and suicidal thoughts). A review of an admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 24, 2025, revealed that Resident 1 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 to 15 indicates cognition is intact). A review of an admission MDS assessment dated [DATE], revealed that Resident 2 (Resident 1's wife, who also resided in the same room) was cognitively intact with a BIMS score of 15 A review of Resident 1's care plan initiated on November 19, 2025, identified depression and anxiety with goals to reduce symptoms through medication and non-pharmacological interventions (such as one-to-one interaction, change in position or scenery, redirection, and diversional activities). The care plan did not include Resident 1's documented history of suicide attempts until after the incident on January 25, 2026. Resident 1's care plan revealed they had been identified by the state PASRR (Preadmission Screening and Resident Review) process as a level II PASRR (screening used to identify serious mental illness or intellectual disability requiring specialized services). A review of outside hospital documentation provided by the facility of a discharge summary with instructions dated November 19, 2025, revealed that during the hospital admission Resident 1's medication regimen had changed and the Prozac (an antidepressant medication) had increased from 40 mg (milligrams) to 60 mg daily, trazodone (an antidepressant medication) 25 mg had been ordered three times a day for anxiety, continued Ativan (antianxiety medication) 0.5 mg twice daily, discontinued their sertraline 100 mg (generic for Zoloft, an antidepressant), and instructed to follow up with a psychiatrist and primary care physician. A review of physician's orders dated November 19, 2025, revealed orders for fluoxetine 20 mg (generic for Prozac, an antidepressant), one tablet daily in the morning for depression, and lorazepam (generic for Ativan). 0.5 mg, one tablet twice a day for anxiety, and trazodone 0.5 mg (antidepressant used to treat depression, anxiety and sleep problems) every eight hours as needed for depression. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of an elopement evaluation for Resident 1 dated November 19, 2025, revealed a score of 8, which indicated that a 5 or higher may be at risk for elopement from the facility. It was noted that Resident 1 stated he wanted to leave but made no attempt to leave, and he was documented as not currently being an elopement risk. A review of physician's orders dated November 24, 2025, revealed an order for hydroxyzine (an antihistamine, a medication used to treat allergies, that is also used to treat anxiety) 25 mg, one tablet every 8 hours as needed for anxiety, and an order for trazodone 50 mg, to give half a tablet at bedtime for depression. A review of Employee 8's, Certified Registered Nurse Practitioner (CRNP) progress notes dated December 2, 2025, revealed Resident 1 was admitted for therapy services with possible long-term placement due to being unable to care for himself at home, particularly with his wife. Resident 1 verbalized stress regarding his wife and seemed very depressed. It was noted that the resident reported that he was so stressed at home because of the issues with his wife that he overdosed at some point. A review of a psychology progress note from the Licensed Clinical Social Worker (LCSW) for Resident 1, dated December 5, 2025, revealed the resident was evaluated due to his history of depression and anxiety and was previously admitted to an inpatient psychiatric hospital in December 2024 and August 2025. It was noted that Resident 1 appeared guarded and withdrawn throughout the session. A review of Employee 10's, Licensed Practical Nurse (LPN), progress note dated December 9, 2025, at 1:37 PM revealed Resident 1 was continuously pacing in his room and hallways and repeatedly struck his head against the wall despite verbal redirection. The note indicated his behavior appeared to be escalating, with increased restlessness and rapid breathing. No visible injury was noted. Resident 1 did not respond to verbal reassurance or orientation attempts. A review of physician's orders dated December 13, 2025, for Resident 1 revealed an order for fluoxetine 20 mg, two tablets daily in the morning for depression; clonazepam (an antianxiety medication) 0.25 mg daily at bedtime for anxiety; and hydroxyzine 25 mg twice a day, every morning and at bedtime for anxiety, with an additional 25 mg every 24 hours as needed for insomnia if the resident wakes up in the middle of the night. The resident's lorazepam was discontinued on December 13, 2025. A review of Employee 9's psychiatric CRNP progress note for Resident 1 dated December 16, 2025, revealed diagnoses that included depression and anxiety. The resident was observed sitting in his room drowsy but arousable and admitted to continued depression and intermittent anxiety. A review of Employee 8's, CRNP progress note dated December 17, 2025, revealed the resident reported feeling anxious and appeared to be having a panic attack. He stated that his wife's repetitive speech and fixation on topics significantly contributed to his anxiety and made it difficult for him to relax. The resident expressed a desire to go home but acknowledged that his home was not in livable condition. He did not want to move to a separate room or place fault on his wife due to her Alzheimer's disease (a brain disorder that progressively impairs memory and thinking). He stated he would feel better at home but admitted to experiencing similar anxiety there. The CRNP noted that Resident 1's desire to return home suggested the need to assess the viability of that option and address home condition issues. A review of Employee 6's, LPN, progress note, dated December 20, 2025, at 1:20 PM revealed Resident 1 was noted with increased anxiety and agitation and was pacing back and forth in his room and hallways. The resident pulled the nurse to the side and stated he felt that he was struggling and continued to make mistake after mistake. After speaking with Employee 6, he agreed to speak to the psychiatrist. A review of psychology progress notes from the LCSW dated December 26, 2025, revealed that the Director of Nursing provided additional clinical insight stating Resident 1 and his wife (Resident 2), who resided in the same room, were known to have had numerous attempted joint suicides with psychiatric hospitalizations. Resident 1 continued to present with high anxiety and reported his nerves (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	were horrible and that he felt dizzy and trapped. Resident 1 repeatedly requested medication changes and stated, so there's really nothing you can do for me, and remained guarded. A review of Employee 7's, Registered Nurse (RN) progress notes dated December 26, 2025, at 11:47 PM revealed that while in session with psychology, Resident 1 sat in his wheelchair, leaning forward with his head on the bed, brought his knees to the floor, and then lay on his back in a manner described as purposeful. A review of Employee 8's, CRNP progress note dated December 26, 2025, revealed Resident 1 felt anxious and could not sleep. The plan was to continue current medications, follow psychology recommendations, and consider a room change to separate the resident from his wife to reduce nighttime triggers. A review of a physician's orders for Resident 1 dated December 29, 2025, revealed an order for fluoxetine 20 mg, two tablets daily in the evening for depression, and for hydroxyzine 25 mg every 12 hours as needed for anxiety for 14 days. A review of Employee 9's psychiatric CRNP progress note for Resident 1 dated December 30, 2025, revealed the resident was being seen for his history of anxiety and depression and was seen pacing in the hallways. It was noted Employee 9 redirected him to a chair, and it was difficult due to the resident's anxiety and restlessness. Resident 1 appeared disheveled (disordered and untidy). The resident admitted to continued depression and anxiety. Staff reported frequent falls, likely related to increased restlessness. A review of Employee 8's CRNP progress note dated January 2, 2026, revealed Resident 1 continued to report anxiety, wanted to go home, and worried about his wife. The resident was noted to have significant psychiatric issues and was being followed by in-house psychiatric services. A review of Employee 9's psychiatric CRNP progress note for Resident 1 dated January 13, 2026, revealed the resident was being seen for his depression and anxiety and was lying in bed wringing his wrists and appeared noticeably restless and disheveled. Employee 9 redirected him to a chair with difficulty due to anxiety and restlessness. The resident reported depressed mood and continued anxiety and described new onset visual hallucinations (seeing things that are not present) and stated it has happened before. Staff reported increased confusion and depression. Employee 9 assessed the resident continued with worsening mood disturbances and an increase in hallucinations with worsening depression. At that time, Resident 1 met criteria for MDD (major depressive disorder) with psychotic disturbance (severe form of depression with persistent sadness and loss of interest along with psychotic symptoms or fixed false beliefs which can increase the risk of unsafe behavior or self-harm). A review of physician's orders dated January 14, 2026, revealed an order for fluoxetine 20 mg three tablets daily in the evening for depression, and clonazepam 0.25 mg (antianxiety medication) two times a day for anxiety. A review of psychology progress notes dated January 16, 2026, revealed the Resident 1 appeared less restless and stated he had been alright, though he avoided eye contact. A Geriatric Depression Scale screening was performed, and the resident scored in the range indicating major depression. Employee 8 CRNP reported the resident had been extremely anxious and encouraged separation from his wife throughout the day due to her triggering his distress. A review of psychology progress notes from the LCSW for Resident 1, dated January 16, 2026, revealed he was being seen for his history of depression and anxiety, and the resident appeared less restless than in previous sessions and stated he has been alright and avoided eye contact. A GDS (Geriatric Depression Scale) depression screening was performed, and the resident scored significantly, indicating major depression. They noted from the medical CRNP that it was reported that the resident was seen to be extremely anxious and encouraged to find separate space away from his wife throughout the day, as it seems she may trigger his distress. A review of Employee 1's, RN supervisor progress notes at 4:05 PM on January 25, 2026, revealed the note summarized events that occurred earlier that day. According to the entry, at the beginning of the shift Resident 1 was observed lying in (continued on next page)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and staff interviews, it was determined the facility failed to implement procedures to ensure the accurate administration of prescribed medications for one of eight sampled residents (Resident 1).Findings include: A review of the facility policy titled Admission/ readmission Chart Review Process last reviewed January 22, 2026, revealed the facility will ensure there exist follow through of physician orders upon admission and / or readmission to the facility and a complete chart review will be conducted within 24 hours of the admission/ readmission. Review of the facility policy titled Use of Psychotropic Medication last reviewed January 22, 2026, revealed residents are not given psychotropic medications unless necessary to treat a specific condition and the medication is beneficial to the resident. The compliance guidelines in the policy indicated the attending physician will assume a leadership role in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents, their family / representatives, other professionals and the interdisciplinary team. A review of the clinical record revealed Resident 1 was admitted to the facility on [DATE], from an acute care hospital. admission diagnosis included but was not limited to cerebral palsy (a condition that permanently affects body movement and muscle coordination), anxiety (a feeling of worry, nervousness, or unease), and depression (mood disorder that causes a persistent feeling of sadness and loss of interest). A review of an admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 2, 2025, identified Resident 1 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A review of the facility document titled Discharge Summary, written by the hospital medical doctor and dated November 19, 2025, revealed Resident 1 was hospitalized from [DATE], through November 19, 2025. Upon discharge from the hospital, Resident 1 was admitted to the facility on [DATE]. The hospital medical doctor documented that Resident 1 had multiple hospital admissions over the previous two months, including an admission to an inpatient psychiatric facility for treatment of generalized anxiety disorder (a mental health condition characterized by excessive, uncontrollable worry) and major depressive disorder (a mental health disorder characterized by persistent low mood, low self-esteem, and loss of interest). The hospital discharge summary documented that while Resident 1 was in the inpatient psychiatric facility, the medication Fluoxetine was increased from 40 milligrams (mg) to 60 mg daily. Fluoxetine (also known as Prozac, a medication used to treat depression and anxiety by affecting chemical messengers in the brain). The discharge summary indicated that Resident 1 received Trazodone 25 mg three times daily as needed for anxiety. Trazodone (also known as Desyrel, a medication used to treat depression and anxiety). Further review of the hospital discharge summary revealed that Lorazepam 0.5 mg twice daily was to be continued. Lorazepam (also known as Ativan, a medication that works by enhancing the activity of chemical messengers in the brain and is used to treat anxiety and insomnia/difficulty sleeping). The discharge summary also indicated Resident 1 was to follow up with psychiatry as an outpatient and that the facility was encouraged to provide frequent and continued reassurance related to Resident 1's wife, Resident 2. Recommendations from the medical doctor in the department of psychiatry were included in the hospital discharge summary. The psychiatric provider recommended that Resident 1 continue Fluoxetine 60 mg daily for improved anxiety management and that Trazodone 25 mg three times daily be administered as needed for anxiety or sleep. The (continued on next page)

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	01/28/2026

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychiatric provider also recommended that Lorazepam be gradually decreased and eventually discontinued due to Resident 1's age and documented memory deficits. A review of facility medication orders revealed that upon admission to the facility on November 19, 2025, Employee 8, CRNP (certified registered nurse practitioner) ordered Fluoxetine HCl 20 mg once daily in the morning. Further review of facility records revealed that on December 13, 2025, the order was changed to Fluoxetine HCl 20 mg, two tablets once daily in the morning, for a total daily dose of 40 mg. On December 29, 2025, the administration time for Fluoxetine 40 mg was changed from morning to evening. On January 14, 2026, Fluoxetine 40 mg was discontinued and replaced with Fluoxetine 60 mg once daily in the evening. A review of facility records revealed Resident 1 did not receive the hospital-recommended dose of Fluoxetine 60 mg daily until January 14, 2026, despite documentation that the dose had been increased prior to admission to address symptoms of anxiety, panic, and depression. A review of medication orders further revealed Lorazepam 0.5 mg was administered twice daily from November 19, 2025, until December 13, 2025, when the medication was discontinued. No documentation was identified to show the dose was gradually reduced prior to discontinuation as recommended in the hospital discharge summary. During an interview with the Director of Nursing on January 28, 2026, at 11:30 AM, the above findings were reviewed, including that Resident 1 did not receive the hospital-recommended Fluoxetine 60 mg daily for several weeks after admission and that Lorazepam was discontinued without gradual dose reduction as recommended. The Director of Nursing was unable to provide a documented justification for why the recommended medication regimen was not implemented to meet the psychiatric needs of Resident 1. 28 Pa. Code 211.12 (d)(1)(5) Nursing services. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa Code 211.9 (c)(k) Pharmacy services. 28 Pa Code 211.5(f)(x) Clinical records.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on a review of clinical records, employee job descriptions, and staff interviews, the facility's administration, including the Nursing Home Administrator (NHA) and Director of Nursing (DON), failed to effectively manage facility operations to ensure resident safety and to maintain the highest practicable physical and mental well-being of residents. This failure occurred because the facility did not ensure the environment was maintained as free of accident hazards as possible, did not ensure adequate supervision and environmental safety, and did not ensure appropriate management of a resident's psychiatric care and medication regimen for one of eight residents sampled (Resident 1), who was able to exit the facility through a second-floor window and landed on a porch into the snow. This failure resulted in Immediate Jeopardy to resident health and safety.Findings included: A review of the job description for the Nursing Home Administrator (NHA) signed and dated September 16, 2024, revealed the administrator will direct day-to-day functions of the facility in accordance with current federal, state and local standards, guidelines, and regulations that govern long-term care facilities to ensure that the highest degree of quality care can be always provided to the residents. The job description for Director of Nursing (DON), signed and dated March 12, 2024, revealed the DON will organize and direct nursing administration, nursing services, and resident care, developing, organizing, implementing, evaluating, and directing day-to-day functions of the nursing service department and its programs and activities.The failure of the Administrator and Director of Nursing to carry out their respective administrative responsibilities demonstrated ineffective use of facility resources. This included failure to ensure appropriate supervision, failure to ensure consistent implementation of facility policies related to resident safety, failure to ensure that windows were secured to reduce environmental hazards and placed residents at risk for falls and self-harm, and failure to ensure appropriate oversight of psychiatric treatment and medication management (ensuring that prescribed drugs are given in the correct dose, at the correct time, and monitored for effectiveness and side effects). These failures showed a lack of coordinated administrative and clinical oversight. As a result of these administrative failures, the facility did not maintain an effective system to identify and mitigate risks for a resident with known psychiatric conditions, including suicidal ideation (thoughts of self-harm) and worsening depression. The combination of unsecured windows, lack of increased supervision, and ineffective management of the resident's psychiatric medications created a high likelihood of serious injury or death. The presence of additional unsecured windows created an ongoing risk to other residents. This deficient practice is related to the Immediate Jeopardy citation under F 689 (Accidents, 42 CFR S483.25(d)), which identified that the lack of effective administrative oversight, monitoring, and enforcement of policies by facility leadership contributed to the Immediate Jeopardy situation.Refer F 689 28 Pa. Code: 201.14 (a) Responsibility of licensee28 Pa. Code: 201.18 (e)(1) Management28 Pa. Code 211.12 (d)(3) Nursing services