

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395273	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2026
NAME OF PROVIDER OR SUPPLIER Embassy of Scranton		STREET ADDRESS, CITY, STATE, ZIP CODE 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0635</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide doctor's orders for the resident's immediate care at the time the resident was admitted.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, select facility policies, and staff interviews, it was determined the facility failed to complete a comprehensive admission and readmission evaluation and failed to ensure physician diet orders were accurate, verified, and consistent with the resident's assessed swallowing needs and interdisciplinary care planning process for one of three residents reviewed with swallowing deficits (Resident 8). Findings include: Review of the facility policy titled Resident admission Procedure last reviewed by the facility on January 22, 2026, indicated that upon a resident's admission to the facility nursing staff will complete the admission packet, assessments, education, consents and documentation per facility policies and procedures. The 24-Hour Admission/readmission chart review checklist directed nursing staff to transfer information from the hospital obtained upon admission to the facility, and to complete admission and readmission assessments. Clinical record review revealed Resident 8 was admitted to the facility on [DATE], with diagnoses including schizophrenia (a mental illness affecting how a person thinks, feels, and behaves), bipolar disorder (a mental health condition causing alternating periods of elevated mood and depression), and dysphagia (difficulty swallowing). Review of records indicated the resident previously resided in a group home. A review of Resident 8's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 23, 2026, revealed that Resident 8's BIMS score (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) was unable to be completed, indicating the resident was unable to provide responses or did not provide responses to complete this section. Review of the admission Evaluation dated March 5, 2026, indicated the resident's diet was mechanical soft texture (moist and tender-textured foods that require minimal chewing, such as ground meats, mashed vegetables, and soft fruits. It is designed for residents with chewing and/or swallowing difficulties) with nectar thick liquids (beverages modified to a slightly thicker consistency, similar to fruit nectar, to assist residents with swallowing difficulties in safely drinking fluids). Review of the physician's order dated March 5, 2026, also reflected a mechanical soft diet with nectar thick liquids. Review of hospital discharge documentation, nursing assessments, and progress notes failed to reveal documented evidence supporting the need for a mechanically altered diet upon admission. The facility failed to provide documented evidence that nursing staff contacted the transferring hospital or the resident's prior group home to verify the resident's previous diet consistency, swallowing history, or nutritional needs at the time of admission. Resident 8 was transferred to the hospital on March 6, 2026, for a change in mental status and readmitted to the facility on [DATE]. Review of the admission Evaluation dated March 12, 2026, indicated the resident's diet remained mechanical soft texture with nectar thick liquids. However, review of the physician's order dated March 12, 2026, indicated a mechanical soft diet with thin liquids. The physician's order was inconsistent with the admission Evaluation, and the facility failed to provide documented evidence that the diet order was verified, clarified, or supported by an assessment of the resident's swallowing status. Resident 8 was again transferred to the hospital on March 13, 2026, for psychiatric evaluation and readmitted to the facility (continued on next page)</p>

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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<p>F 0635</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>on [DATE]. The facility failed to provide documented evidence an admission Evaluation was completed on the March 16, 2026, readmission, as required by facility policy. Review of physician orders revealed the March 12, 2026, order for mechanical soft texture with thin liquids remained active following the March 16, 2026, readmission. The facility failed to document review, clarification, or reassessment of the diet order to ensure it reflected the resident's current swallowing needs, prior diet consistency, or clinical condition. Review of the facility document titled Medical Nutrition and Hydration Evaluation, dated March 17, 2026, completed by the Registered Dietitian, failed to include the resident's food and nutrition history. Specifically, the sections addressing therapeutic diet prior to admission and prior knowledge of mechanically altered diets were left blank. The evaluation identified the resident's current diet as mechanical soft texture with thin liquids without documented reconciliation of prior records, clinical history, or swallowing needs. Review of the interdisciplinary care conference summary dated March 18, 2026, indicated an interdisciplinary care conference (a meeting involving multiple disciplines responsible for coordinating and reviewing resident care) was attended by a Registered Nurse, Dietary staff, Therapy staff, Nursing Administration, Administration, and staff from the resident's group home. The summary documented the resident's diet as puree texture (food blended to a smooth consistency requiring no chewing) with nectar thick liquids. Following the March 18, 2026, care conference, the physician's order was updated to reflect a puree diet with nectar thick liquids. Review of the Speech Therapy evaluation dated March 20, 2026, indicated staff from the resident's prior group home reported the resident previously tolerated a puree diet with nectar thick liquids. Clinical impression indicated the resident presented with oral dysphagia (a swallowing disorder occurring in the mouth, characterized by difficulty controlling food or liquid, chewing, or moving it to the throat) requiring Speech Therapy to restore oral and pharyngeal function (rehabilitating the mouth and throat muscles to enable safe, efficient swallowing, preventing food or liquids from entering the airway). The Speech-Language Pathologist recommended a diet of puree texture with nectar thick liquids. During an interview conducted April 23, 2026, at 1:15 PM, the Speech-Language Pathologist confirmed she evaluated Resident 8 on March 20, 2026, following a therapy referral generated from the March 18, 2026, interdisciplinary care conference. The facility failed to ensure completion of the admission evaluation upon readmission and failed to obtain, verify, and document the resident's current dietary needs to ensure physician diet orders were accurate and consistent with the resident's known swallowing deficits and prior diet consistency. During an interview on April 23, 2026, at 2:00 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) confirmed the facility could not provide documented evidence that an admission Evaluation was completed for the March 16, 2026, readmission. Additionally, they were unable to provide evidence that staff obtained or verified the resident's diet status from the hospital or group home upon initial admission or subsequent readmissions to ensure accuracy of physician diet orders. 28 Pa. Code 211.5(f)(i)(iv)(v)(viii) Medical Records 28 Pa. Code 211.10 (c)(d) Resident Care Policies 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing Services</p>		