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	06/11/2026

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a clinical record review and staff interview, it was determined the facility failed to ensure that the required resident information was communicated to the receiving health care provider for two out of 10 residents reviewed (Residents 1 and 2).Findings include: A review of Resident 1's clinical record revealed the resident was admitted to the facility on [DATE], and transferred to a hospital emergency department on two separate dates May 13, 2026, and May 25, 2026.A review of Resident 1's transfer records for May 13, 2026, and May 25, 2026, revealed the facility failed to document that it communicated required transfer information to the receiving health care provider. The record lacked evidence that the facility provided the name and contact information of the physician responsible for the resident's care, resident representative contact information, advance directive information, special instructions or precautions for ongoing care, comprehensive care plan goals, and other information necessary to facilitate continuity of care during the transfer.Review of emergency department records dated May 13, 2026, revealed Resident 1 was returned to the facility with a diagnosis of urinary tract infection (an infection involving any part of the urinary system), despite documentation indicating the resident had originally been transferred for evaluation of a wound (an injury or break in the skin or underlying tissue). The clinical record lacked evidence that the facility communicated the resident's wound-related care needs and treatment information to the receiving provider at the time of transfer. Review revealed the clinical record for Resident 1 lacked evidence that wound treatment information accompanied the resident to the emergency department to assist the receiving provider in evaluating and treating the resident's condition.A review of Resident 2's clinical record revealed the resident was admitted to the facility on [DATE], and transferred to the emergency department on May 1, 2026. Resident 2 returned from the hospital on May 6. 2026.A review of Resident 2's clinical record revealed the facility failed to document that it communicated required transfer information to the receiving health care provider at the time of transfer. The record lacked evidence that the facility provided the name and contact information of the physician responsible for the resident's care, resident representative contact information, advance directive information, special instructions or precautions for ongoing care, comprehensive care plan goals, and other information necessary to ensure continuity of care.During an interview conducted on June 11, 2026, at 11:30 AM, the Director of Nursing was unable to provide documentation demonstrating the facility communicated the required transfer information to the receiving health care providers for Resident 1 on May 13, 2026, and May 25, 2026, or for Resident 2 on May 1, 2026. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.29 (a) Resident rights.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, documentation review, resident representative interview, and staff interview, , it was determined the facility failed to ensure that a resident who was dependent on staff for assistance with activities of daily living (ADLs) consistently received necessary care and services to maintain personal hygiene and dignity for one resident out of 10 sampled residents (Resident 1).Findings include: A review of Resident 1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included sepsis (the body's extreme, life-threatening response to an infection and bacteremia (the presence of viable bacteria in the bloodstream). Review of Resident 1's admission Minimum Data Set Assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 22, 2026, revealed that Resident 1 was severely cognitively impaired with a BIMS score of 0 (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 0 through 7 indicates severe cognitive impairment). A review of Resident 1's MDS revealed Resident 1 was completely dependent on staff for all showering and bathing needs. The MDS defines bathing as the ability to wash, rinse, and dry the body. An interview with Resident 1's emergency contact on June 11, 2026, at 11:30 AM revealed he had concerns regarding the resident's hygiene and cleanliness. The emergency contact stated he had requested staff clean the resident on multiple occasions because the resident had a noticeable odor and appeared soiled. The emergency contact further stated he marked the resident's brief to determine whether it had been changed and later observed the marked brief remained in place. The emergency contact stated he believed the resident was not consistently receiving scheduled showers. A review of Resident 1's Kardex (a quick-reference care guide used by staff to communicate resident care needs and assigned tasks) revealed Resident 1 was scheduled to receive showers every Monday and Thursday on the evening shift. A review of the Documentation Survey Report V2 for April 2026 and May 2026 revealed that on multiple scheduled shower dates, including April 17, 2026, April 20, 2026, April 23, 2026, April 27, 2026, April 30, 2026, May 4, 2026, May 7, 2026, May 11, 2026, May 14, 2026, May 18, 2026, and May 21, 2026, staff either failed to document that a shower was provided or documented that a bed bath was provided in place of the scheduled shower. The record contained no documented evidence explaining why a bed bath was substituted for a scheduled shower and contained no evidence of a change in the resident's condition that would have prevented showering. A review of the Documentation Survey Report Version 2 further revealed an area designated for documenting AM (morning care) and HS (care provided at bedtime or hour of sleep). This section required staff to document whether bathing and personal hygiene care were provided and whether the resident's bathing preference was followed by indicating a shower, bath, bed bath or partial bed bath. The April 2026 and May 2026 Documentation Survey Reports contained numerous entries in which AM care and/or HS care were left blank or documented as Not Applicable, despite the resident's complete dependence on staff for bathing and personal hygiene care. Examples include:April 18, 2026, AM care was left blankApril 18, 2026, HS care was left blankApril 21, 2026, HS care was left blankApril 22, 2026, HS care was left blankApril 23,2026, HS was documented as Not Applicable. April 26, 2026, HS care was documented as Not Applicable. April 28, 2026, HS care was documented as Not Applicable. April 29, 2026, HS care was documented as Not Applicable. April 30, 2026, HS care was left blank. May 1, 2026, AM care was left blank, and the HS care was documented as Not Applicable. May 2, 2026, AM care and HS care we documented as Not Applicable. May 3, 2025, AM care was documented as Not Applicable. May 4, 2026, AM care and HS care were both documented as Not Applicable. May 5, 2026, AM care was left blank, HS care was documented as Not Applicable. May 6, 2026, AM care was documented as Not provided and HS care was documented as Not Applicable. May 7, 2026, AM care was documented as Not Applicable, and HS care was (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented as Not Applicable. May 8, 2026, HS care was left blank. May 9, 2026, HS care was left blank. May 10, 2026, HS care documented as not applicable. May 14, 2026, HS care was left blank. May 15, 2026, AM care was left blank. May 16, 2026, HS care was left blank. During an interview with the Director of Nursing (DON) on June 11, 2026, at 11:00AM, the DON acknowledged that Resident 1 was scheduled to receive showers every Monday and Thursday and acknowledged showers should have been provided as scheduled. The DON was unable to explain why showers were not consistently provided or documented. The above findings were reviewed with the DON on June 11, 2026, at 2:00 PM. The facility was unable to provide documented evidence demonstrating Resident 1 received showers as scheduled or that bathing, and that personal hygiene was provided as directed by the Kardex. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, external wound care records, hospital records, and staff and family interviews, it was determined the facility failed to provide necessary treatment and services consistent with professional standards of practice to assess, monitor, and treat an existing pressure injury for one of 10 residents reviewed (Resident 1) resulting in actual harm.Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research & Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: Comprehensive skin assessment, standardized pressure ulcer risk assessment, care planning, and implementation to address the areas of risk. The American College of Physicians (ACP) is a national organization of internists, who specialize in the diagnosis, treatment, and care of adults. The largest medical-specialty organization and second-largest physician group in the United States, Clinical Practice Guidelines, indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e., support surfaces, repositioning, and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement, and wound cleansing; using adjunctive therapies; and considering possible surgical repair. A review of the facility policy titled Pressure Injury Prevention and Management, last reviewed by the facility on March 26, 2026, revealed the facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure injury, prevent infection, and prevent the development of additional pressure injuries. The facility defines avoidable as the resident developed a pressure injury and the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. Clinical record review revealed Resident 1 was admitted to the facility on [DATE], with diagnoses that included sepsis (the body's extreme and potentially life-threatening response to infection) and methicillin-resistant Staphylococcus aureus (MRSA, a type of bacteria resistant to many commonly used antibiotics making infections much harder to treat). A care plan initiated April 18, 2026, identified impaired skin integrity (damage to skin tissue) related to actual open skin areas involving the coccyx (tailbone area), left buttock, and right buttock. Interventions included use of a pressure-reduction mattress, pressure-reduction chair cushion, monitoring wounds for signs of infection or worsening, skin observations during bathing and showering, notification of the wound nurse, physician, and family regarding new or worsening areas, wound measurements, and treatment as ordered. An admission evaluation titled admission Evaluation- Area Skin, dated April 18, 2026, revealed Resident 1 was at risk for alteration in skin integrity related to open skin areas identified on admission. The assessment documented an open area to the coccyx measuring 1 centimeter (cm) by 2 cm by 0.1 cm. Review of the clinical record from April 18, 2026, through May 12, 2026, revealed no documented wound assessments, measurements, reassessments, or weekly skin assessments related to the coccyx wound during this 25-day period despite physician orders, care plan interventions, treatment orders, and the presence of an open wound identified upon admission. Review of a physician's order dated April 18, 2026, revealed an order to cleanse wounds located on the right buttock, left buttock, and coccyx with normal saline, pat dry, and apply Calmoseptine (an over-the-counter moisture barrier ointment used to protect skin from irritation and moisture) every shift and as needed. Review of the Treatment Administration Record (TAR) for April and May 2026 revealed staff documented completion of the ordered wound treatment from April 18, 2026, through May 25, 2026. However, despite documentation indicating treatment was provided, the clinical record contained no documented wound assessments, measurements, reassessments, or weekly skin (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	assessments between April 18, 2026, and May 12, 2026, to evaluate the effectiveness of the treatment or identify wound deterioration. Review of physician orders revealed Resident 1 had an order dated April 18, 2026, directing staff to complete weekly skin assessments every Thursday evening and document the assessment findings in the assessment section of the clinical record. Review of the Medication Administration Record/Treatment Administration Record revealed staff documented completion of the weekly skin assessments ordered. However, review of the assessment section of the clinical record revealed no corresponding skin assessments or assessment findings were documented between April 18, 2026, and May 12, 2026, despite staff documenting completion of the ordered weekly skin assessments. As a result, the clinical record contained no evidence the facility assessed or monitored the condition of the coccyx wound during this period. Review of the clinical record revealed staff were assigned a task to turn and reposition Resident 1 every shift to reduce prolonged pressure on vulnerable skin areas. Review of the April 2026 documentation report revealed staff failed to document completion of turning and repositioning on 13 of 42 reviewed shifts. Review of the May 2026 documentation report revealed staff failed to document completion of turning and repositioning on 26 of 72 reviewed shifts. A review of the clinical record revealed the consent for wound care services was signed on April 21, 2026, and uploaded to the resident's medical record. Despite the signed consent, Resident 1 was not evaluated by the wound care specialist until May 12, 2026, 21 days after the consent was obtained. During an interview on June 11, 2026, at 9:58 AM, the Director of Nursing was unable to provide documentation or communication from the wound care provider supporting the reason for the delay in wound care treatment. An external wound clinic report dated May 12, 2026, 25 days after admission, documented an unstageable pressure injury (a severe pressure injury in which the depth of tissue damage cannot be determined because dead tissue covers the wound) measuring 3.5 cm by 7.5 cm with the depth unable to be determined. The report documented 90 percent yellow fibrinous slough (dead tissue that can delay healing), 10 percent granulation tissue (new healing tissue), moderate bloody and purulent drainage (thick, milky, or cloudy fluid containing infection-related material), and a malodorous (foul-smelling) wound odor. The wound specialist recommended a low-air-loss mattress (a specialized support surface that redistributes pressure and manages moisture to help prevent and treat pressure injuries). Resident 1 was scheduled for a follow-up appointment in one week. The only documented wound measurements identified in the clinical record between admission and the wound clinic evaluation were the admission measurement obtained on April 18, 2026, and the wound clinic measurement obtained on May 12, 2026. Comparison of those assessments revealed the coccyx wound increased from 1 cm by 2 cm by 0.1 cm to an unstageable pressure injury measuring 3.5 cm by 7.5 cm with the depth unable to be determined. An external wound clinic report dated May 19, 2026, documented an unstageable pressure injury measuring 4.1 cm by 7.9 cm with the depth unable to be determined. The wound bed contained 70 percent slough (dead tissue that can delay healing) and 30 percent granulation tissue (new healthy tissue formed during healing). The wound status was documented as unchanged despite an increase in wound measurements since the previous assessment. During the visit, the wound care provider performed a sharp excisional debridement (the medical removal of dead, damaged, or infected tissue using surgical instruments to promote healing and prevent infection) involving 16.2 square centimeters of tissue. Following the procedure, the wound measured 4.1 cm by 7.9 cm with a depth of 0.8 cm. Review of laboratory records revealed a wound culture was obtained on May 12, 2026, at 8:32 AM. Laboratory results available in the clinical record on May 16, 2026, identified multiple organisms within the wound including methicillin-resistant Staphylococcus aureus (MRSA, a type of bacteria resistant to many commonly used antibiotics), Pseudomonas aeruginosa (a bacteria commonly associated with serious wound infections), gram-positive cocci (a category of bacteria), and gram-negative bacilli (a category of bacteria). Review of nursing documentation dated May 13, 2026, at 10:36 AM revealed a non-emergent hospital transfer was initiated due to an abnormal wound culture that had been reviewed by the nurse practitioner. A review of a physician progress note dated (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	May 13, 2026, at 3:29 PM documented that Resident 1 underwent a wound culture of the pressure injury that identified numerous bacteria. The physician documented Resident 1 was experiencing fatigue and weakness and noted concern regarding the severity of the wound infection and possible osteomyelitis (an infection of the bone). Based on these findings, the physician ordered transfer to the emergency department for further evaluation, including diagnostic imaging and consultation with an infectious disease specialist (a physician who specializes in the diagnosis and treatment of infections). A review of facility progress notes revealed Resident 1 returned from the emergency department on May 13, 2026, at 7:10 PM with a diagnosis of a urinary tract infection (an infection involving the urinary system). Review of the emergency department records from May 13, 2026, did not identify documentation that the pressure injury was evaluated during that visit. During an interview on June 11, 2026, at 11:00 AM the Director of Nursing stated the facility was unable to provide the transfer documentation that accompanied Resident 1 to the emergency department on May 13, 2026. As a result, the facility was unable to demonstrate that the physician's concerns regarding the wound infection, possible osteomyelitis, and need for wound evaluation were communicated to the hospital at the time of transfer. A review of a physician's progress note dated May 18, 2026, at 10:23 AM confirmed Resident 1 had been transferred to the emergency department on May 13, 2026, for evaluation of the infected wound but returned without the wound being examined. The physician documented that on May 17, 2026, six days after the wound culture was obtained, Resident 1 started on Clindamycin 300 milligrams (an antibiotic medication used to treat bacterial infections) every six hours for 10 days to treat the wound infection. A review of a progress note dated May 25, 2026, at 2:45 PM revealed Resident 1 was again transferred to the emergency department. The progress note did not document the reason for the transfer. A subsequent progress note dated May 25, 2026, at 4:00 PM revealed emergency department staff contacted the facility to determine the reason Resident 1 had been sent to the hospital. Facility documentation indicated the resident was transferred at the family's request and that the resident was asymptomatic (not showing outward signs or symptoms of illness) at the time of transfer despite the resident's ongoing wound infection. During a telephone interview conducted on June 11, 2026, at 1:00 PM Resident 1's emergency contact stated the family requested the May 25, 2026, hospital transfer after observing the wound for the first time since admission. The emergency contact stated the wound appeared significantly worse than expected and described it as very bad, prompting the family to request immediate evaluation at the hospital. A review of hospital records revealed Resident 1 was admitted to the hospital on [DATE], for treatment of the infected pressure injury and a urinary tract infection. Hospital records revealed Resident 1 required transfer on May 29, 2026, to another facility for a higher level of care, where the resident subsequently underwent surgical intervention for management of the wound. Hospital records revealed Resident 1 required surgical intervention on June 1, 2026, including sacral debridement and negative pressure wound therapy (NPWT- the process of applying sterile foam or gauze dressing to the wound bed, sealing it with airtight film, and connecting it to a portable vacuum pump to promote new tissue growth and healing) . The facility failed to assess and monitor Resident 1's existing pressure injury, failed to complete ordered skin assessments, failed to consistently implement and document pressure-relieving interventions, failed to identify and respond to wound deterioration, and failed to ensure timely wound care treatment. As a result, Resident 1's coccyx wound deteriorated from an open area measuring 1 cm by 2 cm by 0.1 cm upon admission to an infected unstageable pressure injury requiring hospitalization, intravenous antibiotic therapy, surgical debridement, and negative pressure wound therapy. This deficient practice resulted in actual harm. On June 11, 2026, at 2:35 PM these findings were reviewed with the Director of Nursing and Nursing Home Administrator. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on clinical record review and staff interview, it was determined the facility failed to develop, communicate, and implement an individualized toileting and bowel incontinence management program for one of 10 residents reviewed (Resident 1). The facility failed to establish interventions to ensure timely toileting assistance, routine monitoring for bowel incontinence, and prompt incontinence care for a resident assessed as completely dependent on staff for toileting and always incontinent of bowel.Findings include: A review of Resident 1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included sepsis (the body's extreme, life-threatening response to an infection and bacteremia (the presence of viable bacteria in the bloodstream). Review of Resident 1's admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 22, 2026, revealed that Resident 1 was severely cognitively impaired with a BIMS score of 0 (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 0 through 7 indicates severe cognitive impairment). The assessment revealed Resident 1 was completely dependent on staff for toileting hygiene and toileting transfers and was always incontinent of bowel. A review of the resident's person-centered care plan, initiated April 17, 2026, identified the resident was at risk for altered skin integrity related to bowel incontinence and decreased mobility and required preventive skin care measures. However, the care plan failed to include individualized interventions directing staff how to manage the resident's known bowel incontinence and promote timely care to prevent the potential of skin breakdown. The care plan did not include a scheduled toileting program, routine checks to determine whether the resident required changing after an incontinent episode, staff reminders and assistance with toileting, or specific instructions for monitoring and responding to the resident's bowel elimination needs. A review of the resident's Kardex (a nursing information system used to obtain specific care information for each resident), in effect from April 17, 2026, through May 25, 2026, failed to include instructions regarding bowel incontinence management. There was no documented evidence staff were directed to perform routine incontinence checks, provide scheduled toileting assistance, or implement any individualized bowel management program.A review of a three-day voiding diary (a record kept over a continuous 72 hour period that documents the times a resident urinates, amount, episodes of incontinence and related toileting patterns to evaluate bowel and bladder function to plan care) dated April 17, 2026, through April 20, 2026, revealed Resident 1 was incontinent during the majority of documented episodes, indicating an identifiable pattern of bowel and bladder incontinence requiring evaluation and care planning. A review of Documentation Survey Report v2 (general care nursing tasks completed for the resident) for April 2026 revealed Resident 1 was documented as incontinent of bowel during 100 percent of documented bowel elimination episodes. In addition, 28 percent of bowel elimination documentation was left blank on multiple shifts. A review of the Documentation Survey Report V2 for May 2026 revealed Resident 1 was documented as incontinent of bowel during 100 percent of documented bowel elimination episodes. In addition, 36 percent of bowel elimination documentation was left blank on multiple shifts. A review of Resident 1's progress notes revealed a progress note dated May 8, 2026, at 12:49PM documenting that Resident 1's visitor was concerned about Resident 1 experiencing loose stools and the hygienic cleanup of the bowel movements. The note documented Resident 1 had received incontinence care within the previous two hours and that any additional needs were delegated to a nursing assistant. During the survey, the facility administration was requested to provide a policy regarding the assessment, monitoring, and management of bowel incontinence. The facility was unable to provide such a policy.Despite the resident's assessed dependence for toileting, consistent (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bowel incontinence, identified risk for skin breakdown, documented pattern of incontinence, incomplete monitoring records, and visitor concerns regarding bowel hygiene, there was no documented evidence the facility evaluated the resident's bowel elimination patterns and developed, communicated, or implemented an individualized bowel incontinence management program to ensure timely toileting assistance, routine monitoring for incontinence, and prompt incontinence care. An interview with the Director of Nursing on June 11, 2026, at 11:15 AM, confirmed the facility was unable to provide a policy regarding bowel incontinence management for dependent residents and was unable to provide documentation demonstrating the facility had developed and implemented a planned bowel incontinence management program for Resident 1. 28 Pa. Code 211.10(a)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, observations, and staff interviews, it was determined the facility failed to implement individualized, person-centered interventions identified in the care plan to address dementia-related behaviors for one of seven sampled residents (Resident 3). Findings include: A review of the facility's Dementia Care Policy, reviewed July 2025, revealed the facility would provide appropriate treatment and services to residents diagnosed with dementia to attain or maintain their highest practicable physical, mental, and psychosocial well-being. The policy indicated that the facility would assess residents' needs and develop and implement care plans through an interdisciplinary team approach, including the resident and resident representative, and provide the resources necessary to achieve identified care plan goals. A review of the clinical record revealed Resident 3 was admitted to the facility on [DATE], with diagnoses including dementia (a condition involving the loss of memory, thinking, reasoning, and other cognitive abilities that interferes with daily functioning). A review of Resident 3's annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 14, 2026, revealed the resident was severely cognitively impaired and no BIMS sore (Brief interview for mental status, a tool within the cognitive section of the MDS that is used to access the resident's attention, orientation and ability to register and recall new information) was available at the time of the survey. A review of Resident 3's care plan initiated on June 4, 2026, and revised on June 8, 2026, revealed staff identified behavioral concerns related to dementia, including wandering into other residents' rooms, lying on the floor, refusing meals, and episodes of crying. The care plan goal indicated the resident would demonstrate a reduction in these behaviors. A review of care plan interventions revised on June 4, 2026, revealed staff were instructed to stop and talk with the resident when passing by and monitor for signs and symptoms of anxiety, including fidgeting and crying. A review of additional care plan interventions revised on June 4, 2026, revealed staff were instructed to intervene as necessary to protect the resident's rights and the rights and safety of others, approach and speak with the resident in a calm and reassuring manner, redirect and divert the resident's attention as appropriate, and remove the resident from situations to an alternate location when necessary. During an observation conducted on June 11, 2026, at 12:30 PM, Resident 3 was observed wandering into resident rooms on the second floor. The resident subsequently approached a medication cart located in the hallway while carrying a plastic component from a respiratory treatment device. Resident 3 did not receive respiratory treatments, and the source of the equipment could not be identified during the observation. During an interview at the time of the observation, Employee 1, Nurse Aide, stated Resident 3 wandered throughout the hallways and entered other residents' rooms on a regular basis despite staff attempts to redirect her. Employee 1 stated staff were unable to provide one-to-one supervision because of staffing limitations and could not identify where Resident 3 obtained the plastic respiratory equipment component. During an interview on June 11, 2026, at 11:30 AM, Resident 4, who was assessed as cognitively intact and able to provide reliable information, stated Resident 3 entered her room multiple times each shift on a daily basis. Resident 4 stated Resident 3 would remove a stop sign placed across the doorway, enter the room, touch personal belongings, and handle food items on meal trays. Resident 4 stated she routinely notified nursing staff and requested assistance removing Resident 3 from her room. Despite the facility identifying Resident 3's wandering behavior and revising the care plan with specific interventions intended to redirect, divert, monitor, and remove the resident from situations, when necessary, observations, interviews, and record review revealed the resident continued to wander into other residents' rooms and access items that did not belong to her. There was no evidence that the facility consistently implemented the identified care plan interventions or provided additional supervision or (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	06/11/2026

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diversional approaches to address the ongoing behaviors. During an interview conducted on June 11, 2026, at 1:00 PM, the Director of Nursing confirmed that the individualized dementia care plan interventions were not implemented for Resident 3. 28 Pa Code 211.12 (d)(5) Nursing services.

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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, hospital records, physician orders, and staff interviews, it was determined the facility failed to ensure physician-ordered laboratory services were obtained in a timely manner and failed to follow through on ordered laboratory testing for one of seven residents reviewed (Resident 4). Findings included: A review of the clinical record revealed Resident 4 was admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy (a condition caused by illness or abnormalities within the body that affect brain function and can result in confusion or altered mental status), dementia (a progressive decline in memory and thinking abilities that interferes with daily functioning), and Stage 3 chronic kidney disease (moderate loss of kidney function). A review of Resident 4's Quarterly Minimum Data Set (MDS, a federally required standardized assessment used to evaluate a resident's condition and care needs) dated May 9, 2026, revealed the resident was severely cognitively impaired. The Brief Interview for Mental Status (BIMS, a standardized assessment used to evaluate memory and cognitive function) was not completed. A review of a physician's order dated April 20, 2026, revealed an order to obtain a urinalysis (a laboratory test of urine used to identify infection or other abnormalities) and culture and sensitivity (a laboratory test used to identify bacteria and determine which antibiotics are effective for treatment) related to a suspected urinary tract infection. Nursing documentation dated April 20, 2026, at 6:58 AM revealed the resident refused to get out of bed to use the bathroom and the urine specimen was not obtained. Nursing documentation dated April 21, 2026, at 1:56 PM revealed the resident was taken to the bathroom; however, staff were unable to obtain a urine specimen and documented they would continue attempts to obtain a urine sample. Nursing documentation dated April 22, 2026, at 1:04 PM revealed the resident's temperature was 97.2 degrees Fahrenheit and the resident was incontinent of urine. Staff documented they were unable to obtain a urine specimen and had contacted the physician. There was no documented evidence that the facility obtained the physician-ordered urinalysis and culture and sensitivity or implemented alternative measures to ensure timely completion of the ordered laboratory testing between April 20, 2026, and April 30, 2026. Nursing documentation dated April 30, 2026, at 1:29 AM revealed the urinalysis and culture and sensitivity specimen was obtained and sent to the laboratory, ten days after the physician's order was issued. Nursing documentation dated May 1, 2026, at 8:17 AM revealed Resident 4 exhibited increased confusion and weakness, a temperature of 101 degrees Fahrenheit, and concentrated, foul-smelling urine. Staff notified the physician and received an order to transfer the resident to the hospital for evaluation. Hospital records dated May 1, 2026, revealed Resident 4 presented with fever, worsening confusion, foul-smelling urine, and vaginal discharge. A urinalysis and culture and sensitivity were obtained at the hospital. The resident was diagnosed with a urinary tract infection, received intravenous antibiotics (medication administered directly into a vein), and was admitted for treatment. Resident 4 returned to the facility on May 6, 2026. The facility did not obtain the physician-ordered urinalysis and culture and sensitivity until ten days after the order was issued. During that period, the resident experienced a decline in condition, including increased confusion, weakness, fever, and foul-smelling urine, and subsequently required hospitalization where a urinary tract infection was diagnosed and treated. During an interview conducted on June 11, 2026, at approximately 1:00 PM, the Director of Nursing confirmed there was a delay in obtaining the physician-ordered urine specimen. 28 Pa. Code 211.12 (3)(5) Nursing services.