STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395433	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Tunkhannock	30 Virginia Drive Tunkhannock, PA 18657

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident clinical records, facility policies, and staff interviews, it was determined the facility failed to ensure one of ten sampled residents (Resident 1) was free of a significant medication error resulting in the administration of incorrect doses on multiple occasions. Findings include:A review of facility policy titled Coumadin Monitoring Procedure revealed it is the responsibility of the nurse to update the MAR (Medication Administration Record) with the new Coumadin dose order, and the PT/INR (Prothrombin Time/International Normalized Ratio, blood tests used to measure how quickly blood clots) laboratory draw orders.A review of a facility policy titled Medication Administration revealed it is the responsibility of the nurse to compare the medication with the MAR to verify the right resident, medication name, form, dose, route and correct time of administration. A clinical record review revealed Resident 1 was admitted to the facility on [DATE], with diagnoses that included dementia (a group of conditions that cause a decline in cognitive abilities, such as memory, thinking, reasoning, and problem-solving, severe enough to interfere with daily life) and muscle weakness.A physician ' s order dated August 15, 2025, directed administration of Warfarin 2 mg by mouth (brand name Coumadin is a prescription anticoagulant medication/blood thinner used to prevent or treat blood clots by slowing the body ' s ability to form clots. It requires regular blood testing PT/INR to ensure the dose is safe and effective because too much can cause bleeding and too little can increase the risk of clotting) every Tuesday and Friday at 8:00 PM., which was discontinued on September 20, 2025. Another physician ' s order dated August 13, 2025, directed administration of Warfarin 3 mg by mouth every Monday, Wednesday, Thursday, Saturday, and Sunday at 8:00 PM, discontinued on September 20, 2025.A nursing progress note dated September 17, 2025, at 3:24 PM., documented a new order from the Coumadin clinic to administer Warfarin 5 mg by mouth once on September 17, 2025, and then to resume the prior alternating 2 mg and 3 mg schedule.A review of Resident 1 ' s September 2025 Medication Administration Record (MAR) showed that on September 17, 2025, the resident received two doses of Warfarin (Coumadin) 3 milligrams (mg) at 8:00 PM and 5 mg at 8:47 PM The total amount administered was 8 mg, even though the physician ' s order directed that only 5 mg be given that day.A review of Resident 1 ' s order summary for the same date revealed that when the nurse entered the new one-time order for Warfarin 5 mg on September 17, she also entered new standing orders for Warfarin 2 mg every Tuesday and Friday and Warfarin 3 mg every Monday, Wednesday, Thursday, Saturday, and Sunday at 9:00 p.m., but did not discontinue the older, duplicate Warfarin orders already in the system. Because the older and new orders were both active, the electronic medication record displayed multiple Warfarin doses, which led to additional doses being administered in error.As a result, Resident 1 received incorrect doses over several days:September 17, 2025: total of 8 mg instead of the ordered 5 mg.September 18, 2025: total of 6 mg instead of the ordered 3 mg.September 19, 2025: total of 4 mg instead of the ordered 2 mg.A review of the facility ' s medication-error investigation showed that these extra doses were discovered on September 20, 2025. The duplicate orders were then discontinued. The investigation confirmed that the resident had received 8 mg on September 17, 6 mg on September 18, and 4 mg on September 19, 2025, as a result of the active duplicate orders.Additionally, the clinical record revealed Resident 1 was hospitalized from [DATE] through October 14, 2025. The hospital discharge summary included a new physician ' s order for Warfarin (Coumadin) 3 milligrams (mg) by mouth every Tuesday and Friday only, with instructions to begin the medication on October 17, 2025.However, a review of Resident 1 ' s October 2025 Medication Administration Record (MAR) revealed that Warfarin 3 mg was administered on October 14, 2025, at 8:00 PM despite the physician ' s order to hold the medication until October 17, 2025. During an observation of the medication cart on October 15, 2025, a dose of Warfarin 3 mg was found prepared for administration that evening. This indicated that the system and medication record still showed Warfarin as an active order, creating the potential for the resident to continue receiving the medication in error.An interview conducted with the Assistant Director of Nursing (ADON) on October 15, 2025, at 8:30 AM, revealed the facility was aware Resident 1 had been given Warfarin before the appropriate restart date. The ADON stated that, upon receiving new or updated medication orders, nursing staff are responsible for reviewing the MAR and discontinuing any outdated or duplicate orders to prevent further errors.These findings were reviewed with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) on October 15, 2025, at 12:15 PM. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(5) Nursing services. 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services