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	03/24/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, the facility's abuse, neglect, and exploitation policy, information provided by the facility, and resident and staff interviews, it was determined the facility failed to report alleged violations of resident-to-resident abuse for two of 12 residents reviewed (Residents 1 and 2).Findings include: A review of the facility policy titled Abuse, Neglect, and Exploitation, last reviewed by the facility on January 23, 2026, revealed it is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, and exploitation. The policy indicates that an alleged violation is a situation or occurrence that is observed or reported by staff, a resident relative, or others but has not yet been investigated and, if verified, could be an indication of non-compliance with federal requirements related to mistreatment, exploitation, neglect, or abuse. The policy indicates reporting of all alleged violations to the administrator, state agency, adult protective services, and to all other required agencies within specified timeframes: immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. A clinical record review revealed Resident 1 was admitted to the facility on [DATE], with diagnoses that include spondylosis (arthritis of the spine). A review of Resident 1's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 17, 2026, 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 through 15 indicates cognition is intact). A clinical record review revealed Resident 2 was admitted to the facility on [DATE], with diagnoses that included diabetes (a condition resulting in high levels of sugar in the blood) and intellectual disabilities (a developmental condition involving limitations in reasoning, learning, and problem solving that affect daily functioning). A review of Resident 2's quarterly MDS dated [DATE], revealed the BIMS interview was not completed because the resident was rarely or never understood. Further review of MDS Section C1000 Cognitive Skills for Daily Decision Making revealed Resident 2 was moderately impaired in cognitive skills for daily decision making (difficulty making routine decisions). in the ability to make decisions regarding tasks of daily life. A review of Resident 1's care plan initiated August 7, 2018, revealed behavioral concerns that included verbal agitation and aggression towards staff and verbal aggression towards the roommate and roommate's family. Interventions included not positioning the resident near others who disturb the resident, attempt interventions before behaviors begin, and helping the resident avoid situations or people that are upsetting to him to prevent escalation of behaviors. A review of investigative documentation provided by the facility dated February 7, 2026, revealed Resident 1 wheeled Resident 2 in Resident 2's wheelchair into Resident 2's room and shut the door. Documentation indicated the nursing supervisor initiated safety monitoring checks every 30 minutes for two nursing shifts for Resident 2 (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and provided education to Resident 1 regarding not pushing other residents' wheelchairs. Investigative documentation dated February 7, 2026, revealed facility review of video footage confirmed Resident 1 wheeled Resident 2 into Resident 2's room and shut the door before returning to his own room. The documentation indicated staff entered Resident 2's room shortly after the event and remained with the resident for several minutes. Investigative documentation dated February 8, 2026, revealed Resident 1 was interviewed by the Nursing Home Administrator regarding the event. The document indicated Resident 1 pushed Resident 2 into her room because she was acting out and shut the door.An interview conducted March 24, 2026, at 11:45 AM with Employee 1, nurse aide (NA), revealed Employee 1 observed Resident 1 wheel Resident 2 approximately two feet into Resident 2's room and shut the door. Employee 1 recalled Resident 1 appeared annoyed and stated words to the effect that Resident 2 should remain in the room stating, If you act up, you are going to stay in the room. Employee 1 NA reported opening the door, checking on Resident 2, and bringing Resident 2 to the nursing station to ensure safety. Employee 1 NA indicated Resident 2 did not appear to understand that Resident 1 was upset or angry. Investigative documentation dated February 16, 2026, at 10:00 AM revealed Resident 1 was observed ramming/intentionally striking Resident 2's wheelchair multiple times with his own wheelchair. Resident 1 was provided with education that he cannot be running his wheelchair into others and needed to leave Resident 2 alone. Documentation indicated the residents were separated and Resident 2 was moved to a different nursing unit for safety. A progress note dated February 16, 2026, at 10:01 AM documented Resident 1 intentionally ran into Resident 2's wheelchair multiple times and was instructed to stop the behavior. During an interview on March 24, 2026, at 12:30 PM, Resident 1 indicated he did not believe he harmed Resident 2 and reported that he sometimes assisted Resident 2 to her room when she appeared upset. During an interview on March 24, 2026, at 1:46 PM, the nursing home administrator (NHA) confirmed that he investigated allegations of resident-to-resident abuse between Residents 1 and 2. The NHA confirmed that he did not report the allegations of resident-to-resident abuse involving incidents that occurred on February 7, 2026, and February 16, 2026, to the state agency or adult protective services. The facility failed to identify incidents as allegations of resident-to-resident abuse (actions by one resident that cause or could cause physical or emotional harm to another resident) that must be reported to the required external agencies within required timeframes, regardless of investigation outcome. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18 (b)(1)Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.10(d) Resident care policies.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **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 timely identify changes in nutritional parameters, implement appropriate nutritional interventions, and notify the attending physician and the resident's responsible party of a significant weight loss for one of 12 sampled residents (Resident 3).Findings included: A review of a facility policy entitled Weight Policy, last reviewed by the facility January 23, 2026, indicated resident weights would be obtained in a timely and accurate manner and documented and responded to appropriately. Upon admission or readmission, weights will be obtained and documented. The resident will be weighed every week for the following three (3) weeks, then monthly unless ordered otherwise by the medical doctor (MD) or nurse practitioner (NP) or the registered dietitian (RD). If a weight showed the same or greater variance, a nurse would verify the weight was obtained correctly. Significant weight losses of 5 percent in one month, 7.5 percent in three months, and/or 10 percent over six months will be tracked by the RD. The RD will work with the facility staff during the routine weight meeting to review resident weight changes and determine any additional interventions for the resident's weight change. The MD and responsible party (RP) will be made aware of significant changes in weight, and the RD or MD may order specific nutritional interventions, supplements, or other interventions if indicated. A review of Resident 3's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and major depressive disorder (a mental health condition characterized by persistent low mood and loss of interest in usual activities). A review of Resident 3's Quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment process conducted at specific intervals to plan resident care) dated March 5, 2026, revealed the resident was severely cognitively impaired with a BIMS score of 1 (Brief Interview for Mental Status, a tool to assess the residents' attention, orientation, and ability to register and recall new information; a score of 0 through 7 indicates severe cognitive impairment). A review of Resident 3's comprehensive care plan, initiated March 4, 2024, identified nutritional problems or potential nutritional problems related to advanced age, mechanically altered diet texture (food texture modified to reduce chewing or swallowing difficulty), and thickened liquids (liquids modified to reduce risk of choking). Goals included maintaining weight within 3 percent of 124 pounds and consuming 75 percent of at least two meals served daily. Planned interventions included providing the diet as ordered, fortified foods (foods with added calories or protein) with all meals, a 4 oz. nutritional shake with meals (a calorie and protein supplement), a 4 oz. magic cup/frozen nutritional supplement daily, obtaining weights as ordered, and RD (Registered Dietitian) evaluation with recommendations as needed. A review of Resident 3's weight record revealed the following documented weights: January 4, 2026: 124 pounds February 1, 2026: 120 pounds March 3, 2026: 117 pounds March 15, 2026: 118 pounds March 22, 2026: 114.5 pounds. The March 22, 2026, weight reflected a loss of 3.5 pounds, representing approximately 3 percent body weight loss in one week, and a 7.5 percent change since January 4, 2026. The clinical record failed to reveal documentation that a reweight was obtained to verify this significant change. A review of a weight change note completed by the facility's remote RD (a registered dietitian providing nutrition oversight through electronic clinical record review rather than on-site presence) dated February 21, 2026, at 11:48 PM, in response to a weight alert for the February 1, 2026, value, documented a weight loss of approximately 3 percent (4 pounds). The RD noted the resident received a 4 ounce nutritional shake twice daily and recommended a 4 ounce nutritional shake with meals (three times daily). A review of physician orders revealed an order dated March 4, 2026, at 11:02 AM, for a commercial nutritional shake 4 ounces with meals, eleven days after the RD recommendation. A review of a weight change note completed by the remote RD dated March (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9, 2026, at 9:12 PM, in response to a weight alert for the March 3, 2026, value, documented a weight loss of 10 percent (14 pounds) over 180 days and recommended a 4 ounce frozen nutritional supplement with dinner and weekly weights. A review of physician orders revealed an order dated March 9, 2026, at 9:36 PM, for weekly weights. A review of physician orders revealed an order dated March 17, 2026, at 10:47 AM, for a 4 ounce frozen nutritional supplement with dinner, eight days after the RD recommendation. The clinical record failed to reveal documented evidence that recommended nutritional interventions, including the 4 ounce nutritional shakes with meals and 4 ounce frozen nutritional supplements with dinner, were implemented in a timely manner following identification of weight loss. Additionally, the clinical record failed to reveal documented evidence that Resident 3's attending physician and responsible party were notified of the significant weight loss on March 22, 2026. During an interview with the Director of Nursing on March 24, 2026, at 2:00 PM, the above findings were reviewed. The Director of Nursing confirmed no additional documentation could be provided to demonstrate timely notification of the physician and responsible party or timely implementation of recommended nutritional interventions related to the identified weight changes. 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on a review of the statement of deficiencies from the survey ending January 30, 2026, it was determined the facility's Quality Assurance Performance Improvement (QAPI) committee failed to develop and implement corrective action plans to prevent continued quality deficiencies related to the facility's food and nutrition services department and implement effective plans to correct and prevent further quality deficiencies related to timely identification of changes in nutritional parameters, implementation of appropriate nutritional interventions, and notification of the attending physician and the resident's responsible party of a significant weight.Findings included: A review of a facility policy entitled Quality Assurance Performance Improvement, last reviewed by the facility January 23, 2026, indicated the facility developed and maintains an effective, comprehensive, data-driven quality assurance and performance improvement program that focuses on indicators of the outcomes of care and quality of life and will utilize the best available evidence to design and measure indicators of quality and have facility goals that reflect processes of care and facility operation that have been shown to be predictive of desired outcomes for residents. During a survey completed on January 30, 2026, deficient facility practice was identified under the requirement of food and nutrition services related to timely identification changes in nutritional parameters, implementation of appropriate nutritional interventions, and notification to the attending physician and the resident's responsible party of a significant weight loss. In response, the facility developed a plan of correction to include a quality assurance monitoring component to ensure that solutions were sustained. This plan was to be completed by February 28, 2026, and indicated that the following would be performed: Current residents will be reviewed to determine if a significant weight loss has occurred in the past month, and if so, a nutritional assessment will be completed, interventions will be implemented as appropriate, the resident's care plan will be adjusted as appropriate, and the resident's physician and responsible party will be notified. The regional dietician/designee will educate the registered dietician on identification of significant weight loss, initiation of nutritional assessment, implementation of interventions to prevent further weight loss, and adjustments to the resident's care plan. The ADON/designee will re-educate the licensed nursing staff on the identification of a significant weight loss and notification of the registered dietitian and the resident's physician and responsible party. Residents with identified significant weight loss will be audited weekly by the registered dietitian/designee to ensure that there is a new nutritional assessment completed, implementation of interventions to prevent further weight loss, and adjustments to the residents' care plan. These audits will be performed weekly for four weeks and monthly for 3 months, and the results of these audits will be brought to the facility QAPI meeting monthly for further review and recommendation. This corrective plan was to be in place by February 28, 2026. However, during the survey ending March 24, 2026, continuing deficient facility practice was identified with these same requirements. A review of Resident 3's weight record revealed the following documented weights: January 4, 2026: 124 pounds February 1, 2026: 120 pounds March 3, 2026: 117 pounds March 15, 2026: 118 pounds March 22, 2026: 114.5 pounds. The March 22, 2026, weight reflected a loss of 3.5 pounds, representing approximately 3 percent body weight loss in one week, and a 7.5 percent change since January 4, 2026. The clinical record failed to reveal documentation that a reweight was obtained to verify this significant change. A review of a weight change note completed by the facility's remote RD (the RD works offsite and is not routinely physically present in the facility and provides dietary oversight through electronic record review and communication with staff) dated February 21, 2026, at 11:48 PM, in response to a weight alert for the February 1, 2026, value. The RD documented a weight loss of 3 percent (4 pounds) and that the resident receives a 4 oz. nutritional shake twice a day and recommended a 4 oz. nutritional shake with meals (three times a day). A review of physician orders revealed an order dated March 4, 2026, at 11:02 AM, for a house commercial shake, 4 oz., with meals, eleven days after it was (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommended by the RD. A review of a weight change note completed by the facility's remote RD dated March 9, 2026, at 9:12 PM, in response to a weight alert for the March 3, 2026, value. The RD documented a weight loss of 10 percent (14 pounds) over 180 days and recommended a 4 oz. frozen nutritional treat with dinner and weekly weights for the resident. A review of physician orders revealed an order dated March 9, 2026, at 9:36 PM, for weekly weights. A review of physician orders revealed an order dated March 17, 2026, at 10:47 AM, for 4 oz. frozen nutritional treats with dinner, eight days after it was recommended by the RD. The clinical record failed to reveal documented evidence that the recommended nutritional interventions, including the 4 oz. nutritional shakes with meals and 4 oz. frozen nutritional treat with dinner, were implemented in a timely manner following the identification of weight loss. Additionally, the clinical record failed to reveal documented evidence that Resident 3's attending physician and responsible party were notified of the significant weight loss on March 22, 2026. During an interview on March 24, 2026, at 3:30 PM, the Director of Nursing confirmed that the facility failed to demonstrate timely notification of the physician and responsible party regarding the resident's significant weight loss and timely implementation of nutritional interventions. The facility's quality assurance monitoring plan failed to identify ongoing deficient practice with the facility's monitoring for Resident 3's nutritional status. Refer F692 28 Pa. Code 201.18(e)(4) Management.28 Pa Code 211.10 (c)(d) Resident care policies.