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	05/20/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records and staff interview, it was determined the facility failed to provide nursing services consistent with professional standards of practice by failing to ensure that a licensed nurse assessed, monitored, and documented a resident's condition following an unwitnessed incident for one of three residents reviewed (Resident 1).Findings include: According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of resident care regarding documenting assessments clinical problems, communications with other health care professionals regarding the resident communication with and education of the resident, family, and the resident's designated support person and other third parties. A review of Resident 1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include dementia (a group of symptoms affecting memory, thinking, judgment, and the ability to perform everyday activities) and depression. A review of Resident 1's annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 18, 2026, revealed that Resident 1 was severely cognitively impaired with a BIMS score of 3 (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 01 through 07 indicates cognition is severely impaired), was independent for ambulation, and also used a wheelchair. During an interview on May 20, 2026, at 9:45 AM, the Nursing Home Administrator confirmed that on May 16, 2026, prior to 6:00 PM, Resident 1 exited the facility without staff awareness and was subsequently located sitting on a sidewalk adjacent to the facility's main entrance approximately 25 feet from the building. During an observation of the area on May 20, 2026, at 10:00 AM, the Director of Nursing (DON) stated that a nurse aide announced that a resident was outside and requested supervisory assistance. The DON reported that she responded to the area and found Resident 1 sitting on the sidewalk. The DON stated she was the first licensed nurse to assess the resident. The DON reported that the resident was upset, stated she was leaving to look for her car, and was assisted into a wheelchair and returned to the nursing station. The DON stated she completed a brief visual assessment of the resident but did not document her assessment findings, resident status, or the care provided. The DON indicated that she did not document the incident in the clinical record. The DON stated that she did a quick head to toe assessment of the resident but did not document the brief assessment she completed or ensure that the resident was fully assessed and documented by the RN Supervisor. A review of the clinical record failed to reveal documented evidence of a nursing assessment following the incident. Further review failed to reveal documentation regarding the resident's physical condition, assessment findings, monitoring, resident response, nursing interventions, or communications regarding the resident's status following the incident. During an interview on May 20, 2026, at 10:00 AM, the DON confirmed there was no (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented evidence of a nursing assessment, resident monitoring, or nursing documentation following the May 16, 2026, incident when Resident 1 was found outside the facility after exiting without staff awareness. ReferF689 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services. 28 Pa. 211.5 (f)(ii)(iii)(ix) Medical records.

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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 - Minimal harm or potential for actual harm 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 observation, review of clinical records, review of a facility policy, information submitted by the facility to the state agency, and staff interview, it was determined that the facility failed to provide adequate supervision and ensure planned safety interventions were effectively implemented to prevent a resident exiting the facility without staff awareness.for one of three residents reviewed (Resident 1).Findings include: Review of the facility's Elopement and Wandering Resident Policy last reviewed January 26, 2026, indicated the facility ensures that residents who exhibit wandering behavior and, or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Elopement occurs when a resident leaves the premises or a safe area without authorization (an order for discharge or leave of absence) and, or any necessary supervision to do so. Guidelines include: The facility is equipped with door locks/alarms to help avoid elopements. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, monitoring for effectiveness and modifying interventions when necessary. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. Adequate supervision will be provided to prevent accidents or elopements. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly. The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff. Post elopement a nurse will perform a physical assessment, document, and report findings to the physician. Any new physician orders will be implemented and communicated to the resident representative. Staff may be educated on the reasons for the elopement and possible strategies for avoiding such behavior. Documentation in the medical record will include findings from nursing and social service assessments, physician and family notification, care plan discussions, and consultant notes as applicable. A review of Resident 1's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include dementia (a group of symptoms affecting memory, thinking, judgment, and the ability to perform everyday activities) and depression. A review of Resident 1's annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 18, 2026, revealed that Resident 1 was severely cognitively impaired with a BIMS score of 3 (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 01 through 07 indicates cognition is severely impaired), was independent for ambulation, and also used a wheelchair. A physician order, originally dated June 18, 2021, directed staff to check placement and function of the resident's Wander guard bracelet (a wearable alarm device designed to alert staff when a resident attempts to leave a secure area) every shift. A review of Resident 1's care plan, initiated June 18, 2021, revealed the resident was at risk for elopement and injury related to wandering behavior and attempts to leave the facility associated with dementia, anxiety, and agitation. Interventions included redirecting the resident away (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from exits as needed based on behaviors. A review of Resident 1's Wander and Elopement Evaluation dated December 12, 2025, revealed the resident scored an eight. The assessment indicated that a score of five or greater identified a resident as being at risk for elopement. The evaluation further directed staff to check placement and function of the resident's Wanderguard bracelet each shift. During an interview on May 20, 2026, at 9:45 AM, the Nursing Home Administrator confirmed that on May 16, 2026, prior to 6:00 PM, Resident 1 exited the facility and was later located on a sidewalk approximately 25 feet from the facility's main entrance. The Administrator stated the resident wore a Wanderguard bracelet and was identified as being at risk for elopement. The Administrator further stated the facility's investigation determined that a visitor entering a passcode at the front entrance temporarily disengaged the alarm function, allowing the resident to exit through the doorway while it remained open. During an interview on May 20, 2026, at 9:45 AM, the Nursing Home Administrator confirmed that on May 16, 2026, prior to 6:00 PM, Resident 1 exited the facility and was located on a sidewalk approximately 25 feet from the facility's main entrance. The Nursing Home Administrator confirmed that the director of nursing contacted him on May 16, 2026, about the incident and reported to him that the resident was outside for a short time. The Nursing Home Administrator stated the resident wore a Wander guard bracelet and was identified as being at risk for elopement. The Nursing Home Administrator stated the facility's investigation determined that a visitor entered a passcode at the front entrance, which temporarily disengaged the alarm function and allowed the resident to pass through the doorway while it remained open. Following the incident the main door passcodes were changed to prevent family members from entering a passcode which momentarily disengages the alarm to prevent resident elopements when visitors are entering or exiting the building. During observation on May 20, 2026, at 10:00 AM in the presence of the director of nursing (DON) of the sidewalk area where the resident was observed, the DON confirmed the resident was seated on the sidewalk adjacent to the facility entrance. The DON stated she responded and observed Resident 1 outside the facility. The resident was combative at the time and the resident stated that she was leaving and looking for her car. The DON stated that she did a quick head to toe assessment of the resident but did not document the brief assessment she completed or ensure that the resident was fully assessed by the RN Supervisor. Staff returned the resident to the facility and provided supervision at the nurses' station. Observation conducted on May 20, 2026, at 11:05 AM in the presence of the Maintenance Director, Nursing Home Administrator, and Chief Operating Officer revealed that the resident's alarm bracelet was functioning and activated an alarm when brought near the main entrance. During the observation the front doors could not be opened without entering a passcode. However, if the person with the alarmed bracelet exited through the door after the passcode was entered and the door was still ajar the person with the alarmed bracelet could also go through without it sounding an alarm. As a result, the facility decided to have the alarm bracelet company reassess the system. A sign was posted to alert staff and visitors to ensure no residents are allowed to exit the building without facility approval. The elopement book in the lobby area contained pictures of all residents at risk for elopement. The passcode was changed to limit the number of staff who have access to the passcodes until the system could be fully assessed. Visitors and staff are now required to ring the doorbell for entry and ask for staff assistance when exiting the facility. During an interview on May 20, 2026, at 1:00 PM, the Nursing Home Administrator confirmed Resident 1, who had been identified as being at risk for elopement, exited the facility without staff awareness. The Nursing Home Administrator acknowledged that the facility's elopement prevention interventions were not effective at the time of the incident. Refer F68428 Pa Code 201.14(a) Responsibility of Licensee.28 Pa Code 201.18(b)(1) (e)(1) Management.28 Pa. Code 211.10(a)(c) Resident care policies28 Pa. Code: 211.12 (c)(d)(1)(3)(5) Nursing Services