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	03/21/2025

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on observation, clinical record review and staff interview, it was determined the facility failed to provide meal service in an environment that maintains each resident's dignity for two residents of 20 sampled residents (Residents 52 and 6). Findings include: On March 18, 2025, at approximately 11:55 AM, in the [NAME] Unit dining/game room, Resident 31, who is independent with eating, was observed seated at a table with Residents 52 and Resident 6. At 11:56 AM, staff placed Resident 31's lunch tray in front of her, and she began eating. However, Residents 52 and 6, who require assistance with feeding, did not receive their trays or staff assistance until approximately 30 minutes later. On March 19, 2025, at approximately 12:10 PM, in the [NAME] Unit dining/game room, Resident 31 was again observed eating her lunch while seated at a table with Residents 52 and 6. However, staff did not provide Residents 52 and 6 with their lunch trays or initiate feeding assistance until approximately 20 minutes later. A review of Resident 52's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including unspecified dementia and has severe cognitive impairment. Review of Resident 6's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including unspecified dementia and has severe cognitive impairment. An interview with the Director of Nursing (DON), in the presence of the facility's nurse consultant, on March 20, 2025, at approximately 1:00 PM, confirmed that Residents 52 and 6 should have been served and assisted with their meals within the same timeframe as Resident 31. The Nursing Home Administrator (NHA) further confirmed the facility failed to ensure a dignified dining experience for Residents 52 and 6 and acknowledged that the meal service on the [NAME] Unit was not conducted in a manner that promotes each resident's dignity. 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 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. 26142 Based on a review of the facility's surety bond, resident fund accounts, and staff interviews, it was determined the facility failed to ensure the amount of the surety bond was sufficient to cover the total amount of resident funds held by the facility. Findings include: A review of the Resident Fund Trust bank account revealed average daily balances of: September 13, 2024, $155,582.09 September 18, 2024, $159,603.09 September 24, 2024, $155,907.09 September 25, 2024, $158,032.09 October 11, 2024, $149,969.76 October 15, 2024, $149,904.76 October 16, 2024, $153,880.76 October 17, 2024, $135,222.66 October 22, 2024, $133,642.76 October 28, 2024, $133,529.76 October 30, 2024, $133,487.42 November 1, 2024, $150,497.22 November 4, 2024, $133,493.62 November 5, 2024, $139,259.84 November 6, 2024, $140,624.84 November 7, 2024, $139,194.84 November 8, 2024, $140,194.84 November 12, 2024, $140,955.42 (continued on next page)

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	November 13, 2024, $143,050.22 December 12, 2024, $141,922.79 January 13, 2024, $130,801.51 A review of the facility's surety bond in place since June 11, 2024, revealed the coverage amount was $130, 000.00, which was not sufficient to cover the resident fund balances on multiple dates reviewed. During an interview with the Nursing Home Administrator (NHA) on March 24, 2025, at 9:30 AM via telephone, after review of the awaited submitted documents, the NHA confirmed that the surety bond coverage amount was inadequate to fully cover the resident funds held by the facility. 28 Pa. Code: 201.18(1)(2)(3) Management.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of the facility's abuse policy, investigative reports, clinical records, and staff interviews, it was determined that the facility failed to ensure that residents were free from misappropriation of property, specifically resident medications, for one of 20 sampled residents (Resident 28). Findings included: A review of the facility policy titled Abuse, Neglect, and Exploitation, last reviewed in January 2025, revealed that the facility is responsible for ensuring the health, welfare, and rights of each resident by implementing written policies and procedures prohibiting and preventing abuse, neglect, exploitation, and misappropriation of resident property. Misappropriation of property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. Review of clinical record revealed that Resident 28, was admitted to the facility on [DATE], with diagnoses to include to dementia and cerebral infarction (stroke) with hemiplegia (weakness on one side of the body). A review of an annual minimum data set assessment (Minimum Data Set - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated February 13, 2025, indicated that Resident 28 was moderately cognitively impaired and required staff assistance for activities of daily living. A physician's order dated October 18, 2024, prescribed Oxycodone 5 mg (an opioid narcotic medication) one tablet by mouth every six hours as needed for moderate to severe pain. A pharmacy record dated December 30, 2024, confirmed that a 30-count supply of Oxycodone 5 mg was dispensed to the facility for Resident 28. A review of the Medication Administration Record (MAR) revealed that Oxycodone was documented as administered on the following dates and times: January 7, 2025, at 7:41 AM January 8, 2025, at 7:54 AM January 11, 2025, at 8 AM January 12, 2025, at 8:24 AM January 15, 2025, at 8 AM January 16, 2025, at 8:10 AM (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	January 17, 2025, at 8 AM January 18, 2025, at 11:57 AM January 20, 2025, at 12:30 AM January 21, 2025, at 8:28 AM January 22, 2025, at 8:07 AM and 6:15 PM January 30, 2025, at 8:32 AM January 31, 2025, at 8:21 AM February 3, 2025, at 8:06 AM February 4, 2025, at 8:08 AM February 5, 2025, at 8:30 AM February 6, 2025, at 9:07 AM February 8, 2025, at 9:34 AM February 9, 2025, at 8:20 AM for a total of 20 doses of the Oxycodone. A review of the MAR for February 2025 revealed that 10 of the 30 dispensed doses of Oxycodone 5 mg were not accounted for. Additionally, the narcotic sign-out record associated with the Oxycodone 5 mg was not available at the time of the survey. A review of the facility's investigative report dated February 10, 2025, at 9:10 PM, indicated that on February 10, 2025 (no time documented), Employee 1 (LPN) reported to the Director of Nursing (DON) that while administering medications on the Blue Unit, she observed that Resident 28 no longer had any Oxycodone 5 mg in the medication cart. Employee 1 stated that she had worked on the Blue Unit the previous day (February 9, 2025, 7 AM to 3 PM shift) and at that time, Resident 28's Oxycodone was still in the medication cart. Employee 1 and the DON immediately checked the Blue Unit medication cart, but Resident 28's Oxycodone blister pack and the narcotic sign-out record were missing. On February 11, 2025, the Nursing Home Administrator (NHA) reviewed the facility ' s surveillance footage from February 9, 2025 (second shift). The video revealed that at 9:10 PM, Employee 2 (Agency LPN) was observed removing the narcotic blister pack from the locked narcotic drawer inside the medication cart, dispensing one pill into her hand, and placing it into a small medicine cup. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The video footage continued to reveal at 9:14 PM, Employee 2 was observed reopening the narcotics drawer, withdrawing the entire Oxycodone blister pack, dispensing the remaining pills into the same medicine cup, and placing the cup into a disposable glove box. Employee 2 was then observed placing the glove box (containing the narcotic medication) into her backpack along with the folded narcotic sign-out record. The facility attempted to obtain a statement from Employee 2 (Agency LPN) through the staffing agency, but no response was received. No further employee statements or investigative findings were available at the time of the survey. An interview with the NHA on March 19, 2025, at approximately 1:00 PM, confirmed that the facility failed to ensure that Resident 28 was free from misappropriation of property, specifically the misappropriation of prescribed pain medication. 28 Pa Code 211.12 (c)(d)(1)(5) Nursing services 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a)(c) Resident rights

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52053 Based on clinical record review and staff interview, it was determined the facility failed to ensure that a residents' comprehensive care plans were reviewed and revised as needed to accurately reflect their current needs and services required by three of 20 residents sampled (Residents 25, 49, and 64). Findings include: A clinical record review revealed Resident 25 was admitted to the facility on [DATE], with diagnoses to include acute and chronic respiratory failure with hypoxia (a condition where there is inadequate supply of oxygen to the body's tissues) and diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces). A physician's order dated February 10, 2025, at 8:19 PM, directed oxygen administration at 2 liters (L) via nasal cannula continuously. A review of Resident 25's comprehensive plan of care, last revised on January 6, 2025, failed to reflect these updated medical treatment goals and interventions for oxygen at 2L via nasal cannula continuously. A clinical record review revealed Resident 49 was admitted to the facility on [DATE], with diagnoses to include depression (a mental health condition characterized by low mood or loss of pleasure or interest in activities for long periods of time) and cognitive-communication deficit (difficulties in communication arising from impairments in cognitive processes such as attention, memory, or problem-solving) A physician's order dated January 15, 2025, at 1:57 PM, prescribed Trazodone 50 mg (antidepressant) daily for depression. An additional physician's order dated March 6, 2025, at 2:28 PM, prescribed Lexapro 20 mg (antidepressant) daily for depression. A review of Resident 49's comprehensive plan of care, last revised on January 28, 2025, failed to reflect these updated medical treatment goals and interventions for depression management, including the monitoring of potential side effects of antidepressant therapy. A clinical record review revealed Resident 64 was admitted to the facility on [DATE], with diagnoses that included atrial fibrillation (a condition that causes the heart to beat irregularly and sometimes much faster than normal) and chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's orders dated February 9, 2024, at 4:07 PM revealed prescribed oxygen therapy at 2L via nasal cannula continuously. Another physician's order dated February 15, 2024, at 10:20 AM, prescribed Eliquis 5 mg (blood thinner) twice daily for atrial fibrillation (an irregular heartbeat that reduces the heart's ability to pump blood through the body, which means the body does not get enough oxygen), with instructions to monitor for signs of bruising, dark urine, or black tarry stools and to notify the physician of any findings. A review of the comprehensive care plan, last revised on February 22, 2024, failed to include interventions for oxygen therapy and monitoring requirements for blood-thinning medication. An interview with the Director of Nursing on March 20, 2025, at approximately 10:15 AM, confirmed the facility failed to review and revise Residents 25, 49, and 64's care plan to accurately reflect their current medical status, risks, and required interventions. 28 Pa. Code 211.12(d)(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 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** 51726 Based on a review of clinical records and resident and staff interviews, it was determined the facility failed to ensure that residents dependent on staff for assistance with activities of daily living consistently received showers as planned to maintain good personal hygiene for two of 20 residents sampled (Residents 30 and 65). Findings include: During a resident group meeting conducted on March 19, 2025, at 10:15 AM, two out of six residents in attendance (Residents 30 and 65) stated they had not been showered as scheduled. Resident 65 stated I have not had a shower in a week because they do not have the help. Resident 30 stated she had not had her showers as scheduled. A review of Resident 30's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include intrahepatic bile duct carcinoma (a cancer that originates in the bile ducts within the liver) and vascular dementia (a type of dementia caused by reduced blood flow to the brain). A quarterly Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated February 7, 2025, indicated the resident required partial/moderate assistance for showering/bathing. The resident was severely cognitively impaired with a BIMS score of 07 (brief interview for mental status, a tool to assess the residents' attention, orientation, and ability to register and recall new information, a score of 0-7 indicates severe cognitive impairment). A review of the Documentation Survey Report v2 (care tasks completed for the resident) indicated that Resident 30 was scheduled to receive showers on Mondays, Thursdays, and Saturdays during the evening shift. A review of the Documentation Survey Report v2 from March 1, 2025, through March 19, 2025, revealed that Resident 30 did not receive a shower on: Thursday, March 6, 2025 Saturday, March 15, 2025 Monday, March 17, 2025 There was no documented evidence the facility provided showers as scheduled three times per week or that the resident refused showers on those dates. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 65's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include cerebral infarction (a condition that occurs when blood flow to part of the brain is suddenly blocked) and atherosclerotic heart disease (a condition characterized by fatty deposits in arteries which can narrow them and block blood flow). An annual MDS assessment of Resident 65 dated February 5, 2025, indicated the resident required substantial/maximal assistance for showering/bathing. The resident was moderately cognitively impaired with a BIMS score of 11. A review of the Documentation Survey Report v2 revealed the resident was scheduled to receive showers on Tuesdays and Fridays during the evening shift. A review of the Documentation Survey Report v2 from March 1, 2025, through March 20, 2025, revealed that Resident 65 did not receive a shower on: Tuesday, March 4, 2025 Friday, March 7, 2025 Tuesday, March 11, 2025 There was no documented evidence that the facility provided showers as scheduled twice per week or that the resident refused showers on those dates. An interview with the Director of Nursing (DON) on March 20, 2025, at approximately 1:00 PM, confirmed that the residents were not showered as scheduled. 28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 26142 Based on a review of the facility's activities programming, clinical records, staff and resident interviews, and observations, it was determined the facility failed to provide an ongoing program of activities designed to meet the needs, interests, preferences, and functional abilities of its residents, including those diagnosed with dementia for six of six residents sampled (Residents 26, 42, 30, 59, 15, and 65). Findings include: A review of the facility census at the time of the survey ending March 21, 2025, revealed that the facility had 71 residents, including 24 residents with a documented diagnosis of dementia residing across both open resident units. A review of the facility's March 2025 activity calendar revealed a lack of variety in scheduled activities. The only dementia-specific activity, labeled as a Sensory Group, was scheduled three times during the month. Additionally, evening activities were scheduled only once per week (Thursdays at 6:00 PM), and weekend activities remained unchanged week to week, lacking variety or engagement. During a resident group interview on March 19, 2025, at 10:00 AM, Residents 26, 42, 30, 59, 15, and 65 expressed dissatisfactions with the facility's activity programming. They reported a lack of variety in scheduled activities and stated that one evening activity per week was insufficient. On March 18, 2025, at 10:30 AM, 10 residents were observed seated in wheelchairs and Geri-chairs in the Blue Unit activity room. The television was turned on to a cartoon program; however, none of the residents appeared engaged or watching. A review of the March 2025 activity calendar indicated that at this time, the scheduled activity was Trivia and Word Games, but there was no evidence that this activity was conducted. At 1:00 PM on March 18, 2025, the same 10 residents remained seated in the Blue Unit activity room, again with the television on playing a cartoon program with inappropriate content, rather than participating in a scheduled activity. The posted calendar listed the 1:00 PM activity as 1 to 1 visits which were not observed taking place. The 10 residents observed in the activity room had poor cognitive ability and were unable to participate in interviews to express their engagement or interest in the activities provided. On March 19, 2025, at 10:00 AM, Employee 1 (LPN) stated that the residents in the small activity room all had dementia, and the television was turned on to keep them in one area for easier staff monitoring rather than to provide meaningful engagement. During an interview with the Activity Director on March 21, 2025, at approximately 11:00 AM, the Activity Director confirmed that the facility lacked adequate activity staff to provide specialized dementia care activities. The Activity Director further acknowledged that the facility's evening activity programming was minimal, with little to no structured activities offered during evening hours. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to develop and implement an activities program that provided meaningful engagement to all residents, including those with dementia. The facility did not offer individualized or customized activities based on residents' previous lifestyles, occupations, family involvement, hobbies, preferences, and comfort needs. The facility further failed to ensure that scheduled activities were carried out as planned. 28 Pa. Code 201.29 (a) Resident rights 28 Pa. Code 201.18 (e)(1)(2)(3)(6) Management

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52053 Based on a review of clinical records, select facility policy and staff interviews, it was determined the facility failed to provide nursing services consistent with professional standards of quality to ensure that licensed nurses properly evaluated and provided nursing care according to physician orders for 4 residents out of 20 residents sampled (Resident 12, 24, 42, 64). Findings include: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the Registered Nurse (RN) was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health care team by exercising sound judgment based on preparation, knowledge, skills, understandings, and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) document and maintain accurate records. A clinical record review revealed Resident 12 was admitted to the facility on [DATE], with diagnoses that included atrial fibrillation (a condition that causes the heart to beat irregularly and sometimes much faster than normal) and hypertension (blood pressure that is higher than normal). A review of facility policy titled Coumadin Monitoring Procedure, last reviewed by the facility on June 1, 2024, revealed it is the responsibility of the nurse to update the Medication Administration Record (MAR) with the new Coumadin (a blood thinner) dose order and the PT/INR (a blood test that tells you how long it takes for the blood to clot) that indicated orders for lab draws. The physician or Certified Nurse Practitioner (CRNP) must be notified of the results of every PT/INR drawn, directions obtained for the next time it is to be drawn, verification of the Coumadin dose to be given, and the notifications and directions documented. An interview with the Director of Nursing (DON) on March 19, 2025, at 1:30 PM confirmed that PT/INR levels were primarily obtained via the CoagChek XS point-of-care machine (fingerstick method), but occasionally through a laboratory draw. However, the DON could not specify when each method was used, and the facility's policy did not outline which method should be used in different circumstances. A review of clinical records revealed no evidence the physician or CRNP was made aware of the method used to obtain PT/INR of laboratory draw versus fingerstick draw at the time of the survey for Resident 12. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A clinical record review revealed Resident 24 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 congestive heart failure (a condition in which the heart doesn't pump blood as well as it should). A review of a physician's order dated February 23, 2025, noted an order for daily weights to monitor for fluid retention related to congestive heart failure. A review of weight logs and the Treatment Administration Record (TAR) dated from March 1, 2025, to March 21, 2025, revealed that Resident 24 did not receive daily weights on March 11, March 20, and March 21 as ordered by the physician. A clinical record review revealed Resident 42 was admitted to the facility on [DATE], with diagnoses that included diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces) and cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body). A physician order dated August 9, 2024, was noted for Metoprolol Tablet (used to treat high blood pressure and heart rate control) 25 milligrams and give one tablet by mouth two times a day related to cardiomyopathy. Hold this medication if the resident's systolic blood pressure is less than 100 millimeters of mercury (mm Hg) or heart rate is less than 60 beats per minute with required physician notification. Review of the resident's corresponding MARs for the months of September 2024, October 2024, November 2024, December 2024, January 2025, February 2025, and March 2025 revealed the medication was being administered with no documented evidence that blood pressure or heart rate measurements were obtained prior to medication administration in accordance with the physician's order. A clinical record review revealed Resident 64 was admitted to the facility on [DATE], with diagnoses that included morbid obesity (a chronic disease that's characterized by a body mass index of 40 or higher, or a body mass index of 35 or higher with obesity-related health issues) and chronic obstructive pulmonary disease (COPD is a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe). A review of clinical records for Resident 64 revealed a physician's order dated July 18, 2024, for monthly weights. A review of weight logs and the TAR dated from October 2024 to February 2025 revealed the facility failed to obtain and document monthly weights for Resident 64 in October 2024, November 2024, December 2024, January 2025, and February 2025. An interview with the DON on March 20, 2025, at approximately 1:15 PM confirmed that the facility did not consistently follow physician orders for Residents 12, 24, 42, and 64. The facility failed to provide nursing care in accordance with professional standards and physician orders. 28 Pa Code 211.12 (d)(1)(3)(5) Nursing Services (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.10 (c) Resident care policies

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record reviews, staff interviews, and facility policy reviews, it was determined that the facility failed to ensure the provision of pharmacy services necessary to assure the timely receipt and administration of physician-prescribed medications for two of twenty residents sampled (Residents 28 and 127). The facility also failed to maintain oversight of its medication dispensing system, including ensuring emergency medication availability and routine pharmacy audits. Findings include: Review of clinical record revealed that Resident 28, was admitted to the facility on [DATE], with diagnoses to include to dementia and cerebral infarction (stroke) with hemiplegia (weakness on one side of the body). A physician order dated October 18, 2024, prescribed Oxycodone 5 mg (an opioid narcotic medication), one tablet by mouth every six hours as needed for moderate to severe pain. A review of the November and December 2024 Medication Administration Records (MARs) revealed that Oxycodone was signed out on the controlled drug record form on: November 17, 2024, at 8:25 AM November 27, 2024, at 8:43 AM December 26, 2024, at 7:25 PM However, there was no documentation on the medication administration record (MAR) that the medication was administered to Resident 28 on these dates. At the time of the survey, there was no evidence that Resident 28 received the prescribed doses of the narcotic pain medication. Review of the clinical record revealed that Resident 127 was admitted to the facility on [DATE], at 3:45 PM following a hospital stay, with diagnoses including congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), and diabetes. A physician order dated March 6, 2025, at 9:00 PM, prescribed multiple essential medications, including: Loratadine 10 mg at 9 PM Simvastatin 20 mg at 9 PM Acetazolamide 500 mg at 9 PM Amiodarone HCL 400 mg at 9 PM (for atrial fibrillation) (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Apixaban 5 mg at 9 PM (anticoagulant for atrial fibrillation) Budesonide Inhalation Solution 0.5 mg/2ml at 9 PM Famotidine 20 mg at 9 PM Guaifenesin 1200 mg at 9 PM Metformin ER 500 mg at 8 PM (oral diabetic medication) Potassium chloride ER 20 meq at 5 PM A review of Resident 127's March 2025 MAR confirmed that the resident did not receive any of these prescribed medications on March 6, 2025, due to a delay in delivery from the pharmacy. An interview with the Director of Nursing (DON) on March 20, 2025, at 1:00 PM revealed that when new residents are admitted , physicians' orders are entered into the electronic ordering system. However, if orders are entered after 12:00 PM or after 6:00 PM, the facility does not receive a same-day medication delivery. The DON stated that licensed staff should check the emergency supply for necessary medications or contact the physician for alternative orders, but this was not done for Resident 127. A review of the facility's pharmacy policy, revised January 16, 2025, titled Emergency Medication System: Removal of Outdated Medications revealed that the contract pharmacy is required to perform routine audits of the emergency medication system to: Ensure expired medications are removed. Confirm medication stock aligns with the system's recorded inventory. However, a review of the facility's emergency medication supply and an observation of the automated medication dispensing system on March 19, 2025, at 12:00 PM, in the presence of the DON and a representative of the contract pharmacy, revealed: Discrepancies between the recorded medication inventory and actual stock. Expired medications still available in the system. Medications listed as available but not physically present (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The pharmacy representative stated that she is in the facility monthly to check expiration dates noted in the electronic medication dispensing system. She stated that she does not check individual (single prepackaged medications) medications in the emergency supply system. She stated that it was her responsibility to check the electronic data stored in the system for future discontinuation dates for the medications. If the individual medications discontinuation dates are within 60 days of her visit to the facility, she will remove the medications from the system at that time. She stated that at that time, she will inform licensed nursing staff of the medication removal from the system, and it is then the responsibility of the nursing staff to reorder and then fill the machine. She confirmed that she does not fill the emergency medication system. She could not confirm the time frame for this process and what staff are to do for an emergency stock of medications. There was no documentation of the monthly pharmacy oversight for the emergency medication system available at the time of the survey. The facility failed to provide documentation of pharmacy oversight, including routine monthly audits for expired medications and medication availability. A review of the facility's Medication Ordering and Receipt, After-Hours Pharmacy Service policy revealed that emergency pharmaceutical services are available 24 hours a day, 365 days a year. According to the policy, emergency medication needs should be met using onsite supplies provided by the pharmacy, including an emergency box, interim box, starter kit, controlled substance interim box, and an electronic cabinet, as permitted by regulations. The policy further states that STAT (immediate) medication requests can be made to the pharmacy and that a corporate pharmacist is available 24/7 to either dispense medications from the pharmacy or arrange for dispensing from a backup pharmacy to meet the facility's medication needs. During an interview on March 19, 2025, at 11:00 AM, the DON and the Nursing Home Administrator (NHA) confirmed that the facility did not have a backup emergency pharmacy, despite facility policy stating one should be available. They also acknowledged that facility nursing staff, rather than trained pharmacy personnel, were responsible for restocking the automated medication dispensing system. The DON stated that she was considered a pharmacy super user and provided training to licensed nursing staff, including agency nurses. However, a review of training documentation only included a user manual for the automated medication dispensing machine and did not contain specific pharmacy policies and procedures for restocking medications, including controlled substances and intravenous medications. The DON was unable to define the role of a pharmacy super user. There was no documented evidence that facility staff received formal training from a licensed pharmacist on proper restocking procedures. Additionally, no documentation of pharmacy oversight or routine audits was provided at the time of the survey. 28 Pa. Code 211.9 (a)(l)(d)(k) Pharmacy Services. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing Services.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 26142 Based on clinical record and staff interview, it was determined the facility failed to ensure documented evidence of clinical necessity for administration of an antibiotic drug for one resident (Resident CR1) out of 20 residents reviewed for unnecessary medications. Findings include: A review of the clinical record revealed that Resident CR1 had a physician's order dated January 27, 2025, for Ciprofloxacin HCL (an antibiotic medication) 500 mg, one tablet to be administered one tablet twice a day for seven days for the treatment of a urinary tract infection (UTI). A review of a urine and a culture and sensitivity (C & S a urine culture is a method to grow and identify bacteria that may be in the urine. The sensitivity test helps select the best medicine to treat the infection) report dated January 28, 2025, revealed that it was positive for Escherichia coli a type of bacteria commonly found in the intestines, some strains of which can cause infections. The C&S report indicated that E. coli was resistant to Ciprofloxacin HCL, making the prescribed medication ineffective against the infection. However, the clinical record revealed that Resident CR1 had already received two doses of Ciprofloxacin HCL before the resistance was identified. A new physician's order dated January 28, 2025, prescribed Cefdinir 300 mg twice daily for the treatment of the UTI, a different antibiotic selected after reviewing the culture and sensitivity results. During an interview conducted on March 21, 2025, at 11:00 AM, the facility's Infection Preventionist confirmed that several residents had received unnecessary antibiotic therapy before the facility reviewed the results of urine culture and sensitivity tests. The Infection Preventionist also stated that since assuming the role in December 2024, they had observed a pattern of antibiotic prescriptions being initiated before confirming bacterial susceptibility, leading to potential unnecessary medication use. 28 Pa Code 211.12(d)(3)(5) Nursing Services

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on staff interview, a review of personnel files, employee credentials, and facility documentation it was determined the facility failed to provide sufficient staff with the necessary skill set and competencies to ensure appropriate nutritional oversight for residents. The facility also failed to ensure that the full-time Director of Food and Nutrition Services, who was not a qualified dietitian or other clinically qualified nutrition professional, received frequent consultations from a qualified dietitian or other clinically qualified nutrition professional. Findings include: Federal regulations require the facility to employ sufficient staff with the appropriate competencies and skill sets to meet the nutritional needs of residents, considering resident assessments, individual plans of care, and the facility assessment. In the absence of a full-time qualified dietitian, the Director of Food and Nutrition Services must meet minimum qualifications and receive frequent consultations from a qualified dietitian or other clinically qualified nutrition professional The Pennsylvania Code, Title 49, Chapter 21, Professional and Vocational Standards: Responsibilities of the Licensed Dietitian/ Nutritionist Section 21.711 Professional Conduct indicated that the Licensed Dietitian/ Nutritionist shall provide information which will enable patients to make their own informed decisions regarding nutrition and dietetic therapy, including the reasonable expectations of the professional relationship. Review of the Facility assessment dated [DATE], failed to indicate the necessity of a qualified dietitian or clinically qualified nutrition professional to meet the nutritional needs of the residents. An interview with the Director of Nursing (DON) on March 20, 2025, at 9:00 AM, revealed the last documented on-site visit by the Registered Dietitian (RD) was October 8, 2024. The DON confirmed that since that date, the RD had been working remotely (off-site) and had not provided direct on-site oversight or consultation. An interview with the facility's Full-Time Food Service Director (FSD) on March 20, 2025, at 10:15 AM, confirmed that she is a Certified Dietary Manager (CDM) but does not meet the minimum qualifications to be considered a qualified dietitian or clinically qualified nutrition professional. The FSD reported that the facility employs a part-time RD who works remotely, primarily communicating via email and telephone to provide and receive updates on residents' nutritional needs. The FSD also stated that while she interacts with residents to obtain food preferences, which are added to meal tickets and documented in the clinical record, she does not provide clinical nutritional assessments or medically related dietary interventions. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Certifying Board for Dietary managers (the credentialing agency for the Association of Nutrition and Food Service professionals) scope of practice for certified dietary managers, these individuals were able to conduct routine nutritional screening including food/fluid intake information, calculate nutrient intake, implement diet plans and orders, utilize standard nutrition care procedures, document nutritional care screening data in the medical record and complete forms, review meal intakes, complete meal rounds, document food intake, participate in care conferences and review the effectiveness of nutritional care. Basic diet information could be provided using evidence-based education materials. Their scope of practice did not include the clinical assessment and evaluation of residents for medically related nutritional therapy or to make recommendations regarding medications or supplementation. The facility's FSD had limited scope of practice and lacked necessary credentials/qualifications to provide the operational and nutritional oversight of a RD or clinically qualified nutrition professional. A review of a facility provided job description for the RD indicated the primary purpose of the job description is to implement, coordinate, and evaluate the medical nutrition therapy for the residents, provide resident, and family education, provide nutritional assessment and consultation to assist planning, organizing, and directing the food and nutritional services of the facility. Functions of the RD included to perform administrative duties such as completing necessary forms, reports, evaluations, studies, etc., to assure control of the Food Service Department, inspect food storage rooms, utility/janitorial closets, etc., for upkeep and supply control, participate in facility surveys (inspections) made by authorized government agencies, assist in developing methods for determining quality and quantity of food served, and participate in Quality Assurance programs, and any facility committee or program, which seeks to improve the performance or accuracy of resident care. However, the RD's part time remote status limited her ability to fulfill these responsibilities effectively. Interview with the facility's consultant and DON on March 20, 2025, at 1:30 PM, failed to provide documentation confirming the RD's role included on site consultation or provided frequent, scheduled oversight of the Food and Nutrition Services Department. Additionally, they confirmed the remote RD accessed residents' clinical records remotely but did not observe residents eating, conduct resident interviews, or provide in-person nutritional consultations. The RD had not been on-site to assess residents for signs and symptoms of nutritional or hydration deficiencies. The facility failed to provide sufficient on-site nutritional oversight and ensure frequent consultation between the RD and the FSD. Refer F803 28 Pa Code 201.18(e)(1)(6) Management.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 43944 Based on observations, resident and staff interviews, a review of the facility's 4-week menu cycle, and Food Committee meeting minutes, it was determined that the facility failed to ensure the menu was periodically reviewed and updated to reflect reasonable consideration of resident food preferences, thereby failing to enhance meal variety for six out of 20 sampled residents (Residents 26, 42, 30, 59, 65, and 15). Findings include: During a group meeting conducted on March 19, 2025, at 10:15 AM, Residents 26, 42, 30, 59, 65, and 15 reported concerns regarding the repetitiveness of the facility's menu and snack options. They stated that meal variety was lacking, side dishes were often unfamiliar, and portion sizes, particularly for meat-based dishes such as casseroles and tacos, were insufficient. Additionally, they expressed frustration that condiments such as sour cream and salsa were inconsistently available due to the facility running out due to the food order not arriving yet. Resident 26, the elected Resident Council President, stated, You get a teaspoon of meat when casseroles and tacos are served. He further reported that resident concerns about the menu had been raised in multiple Food Committee meetings with the facility's Certified Dietary Manager (CDM), but no changes had been made. Resident 26 explained that the menu was developed by a corporate Registered Dietitian (RD), and the CDM lacked the authority to adjust it to better accommodate resident preferences. Resident 42 commented that poultry was served for multiple consecutive meals and often prepared the same way, despite being given different names. She also noted that fluffy rice was frequently on the menu but was too dry to eat. Residents 26, 30, 59, and 65 agreed with this assessment, stating they would prefer alternative side dishes that were not overly dry or sticky. A review of the minutes from Food Committee meetings held on October 21, 2024, November 25, 2024, January 9, 2025, and February 25, 2025, confirmed that the residents in attendance had consistently reported issues regarding the repetitiveness of the menu and the lack of meal variety. A review of the facility's adopted Diet Manual indicated that the menu was planned based on the Dietary Guidelines for American's (DGA's), 2020-2025 for Older Adulthood The Dietary Guidelines for Americans, 2020-2025 provides advice on what to eat and drink to meet nutrient needs, promote health, and help prevent chronic disease and this edition of the Dietary Guidelines provides guidance for healthy dietary patterns by life stage, from birth through older adulthood and indicated that older adults can improve their dietary patterns and better meet nutrient needs by choosing from a wider variety of protein sources. A review of the facility's 4-week Fall/Winter 2024-2025 menu cycle revealed that the last documented review and approval by the regional RD occurred on October 4, 2024. An analysis of the menu cycle confirmed a repetitive pattern in meal planning, with the same protein sources served consecutively over multiple meals. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Monday week one, the planned entree for dinner was a beef burrito (consists of a flour tortilla wrapped around a filling of meat, often beef, and combined with beans, rice, and salsa), lunch on Tuesday, the planned lunch was barbeque beef roast with beef served for consecutive meals. Week one Thursday the planned entree for lunch was chicken Hawaiian thighs. The planned entree for dinner was roasted turkey with pasta (poultry). Additionally, week one Friday the planned entree for dinner was a chicken sandwich. The planned entree for lunch on Saturday was chicken breast with rosemary. The planned entree for lunch on Sunday was turkey breast with apple cider sauce (poultry). Poultry was served for three consecutive meals. A review of Monday week two, the planned entree for Monday dinner was a turkey pot pie. The planned dinner on Tuesday was a chicken sandwich with cheese sauce. The planned lunch on Wednesday was chicken honey thigh. Poultry was served for three consecutive meals. Thursday week two, the planned entree for lunch was spaghetti with meatballs. The planned entree for dinner was chili with beans. Beef was served for two consecutive meals. Saturday week two, the planned entree for dinner was a beef sloppy joe. The planned entree for Sunday lunch was beef pot roast. Beef was served for two consecutive meals. A review of Saturday week three, the planned entree dinner was turkey tetrazzini. The planned entree for lunch on Sunday was a chicken garlic oregano thigh. Poultry was served for two consecutive meals. The planned dinner for Sunday week three was stuffed cabbage rolls (beef). The planned dinner for Monday week four was a meatball sandwich. The planned lunch for Tuesday week four was beef with broccoli. The planned dinner for Tuesday was a beef burger with cheese. The planned lunch for Wednesday was a beef hot dog on a bun. Beef was served for four consecutive meals. Additionally, a review of week four, Saturday the planned lunch entree was a steak sandwich. The planned entree for Sunday dinner was beef lasagna. Beef was served for two consecutive meals. An interview with the facility's nurse consultant and Director of Nursing (DON) on March 20, 2025, at 1:00 PM, confirmed that meal options were frequently repetitive and failed to provide adequate variety to mitigate menu fatigue. They acknowledged that resident concerns about limited variety had not been addressed and that adjustments to the menu had not been made despite repeated feedback from the Food Committee. Refer F801 28 Pa. Code 211.6 (a) Dietary services. 28 Pa. Code 201.18 (e)(2)(3) Management 28 Pa. Code 201.29(a) Resident rights.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 51726 Based on review of select facility policy, resident staff interviews and direct observations, it was determined that the facility failed to routinely offer snacks to six of six residents interviewed (Residents 15, 26, 30, 42, 59, and 65). Findings include: Review of the facility policy titled Snack Policy indicated that snacks will be provided between meals if ordered and in the evening for residents who desire them. Furthermore, the policy indicated HS snacks will be delivered to the nurse's station. Nursing staff will offer residents the snack and will be responsible for making sure the snack intakes are recorded. Resident Council minutes dated December 30, 2024, indicated Residents were not receiving snacks. A grievance was filed December 30, 2024, by Resident 26 which stated, No snacks readily available, or if snacks are available the bowl of snacks are on top of the fridge - unreachable. Resident Council minutes dated February 25, 2025, revealed that residents must ask for a snack or retrieve it themselves. On February 25, 2025, Resident Council members filed a second grievance regarding the same issue. On March 1, 2025, the Assistant Director of Nursing (ADON) documented a response indicating that a memorandum was posted on the units directing staff to offer snacks and drinks regularly and that staff had been educated, with signed education forms on file. On March 18, 2025, at 12:04 PM, observations of the blue and green unit resident pantry areas revealed small baskets of individually wrapped graham crackers placed on top of the unit refrigerators and pitchers of juice for medication pass inside the refrigerators. During a group meeting with residents conducted on March 19, 2025, at 10:15 a.m. six out of six residents (Residents 15, 26, 30, 42, 59, and 65) in attendance, stated that they are not offered snacks as desired. All residents in attendance confirmed that despite two grievances being filed, residents are still not being offered snacks. In an interview on March 20, 2025, at 1:00 PM, the Director of Nursing (DON) confirmed that the issue of snack distribution has been raised multiple times by residents. The DON acknowledged that each unit should have an ample supply of snacks to accommodate residents' preferences and dietary/texture requirements for bedtime snacks. 28 Pa. Code 211.12 (d)(3)(5) Nursing Services.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. 26142 Based on a review of facility documentation, it was determined the facility failed to comprehensively review and update its facility-wide assessment to ensure it accurately reflected the specific needs of its resident population and the personnel resources necessary to meet those needs for 24 of 71 residents. Findings Include: A review of the facility-wide assessment provided to the survey team on February 19, 2025, indicated that the facility had last reviewed its assessment on January 14, 2025. The document was intended to evaluate the specific and unique needs of the resident population, along with the available and accessible resources to meet those needs on a daily basis and during emergent situations. At the time of the survey ending March 21, 2025, the facility census was 71 residents, including 24 residents with a documented diagnosis of dementia. The facility-wide assessment stated that the facility provided a more structured environment with additional diversional activity hours on the secured Memory Care Unit (MCU), along with food-related activities and snacks as a diversion for behaviors. Additionally, the assessment noted that annual dementia and Alzheimer's care training was provided to staff to enhance their ability to care for residents. It further described the MCU as a secured unit where residents could move freely and gather safely in a large multi-purpose room. However, there was no locked Memory Care Unit in the facility at the time of the survey, and the assessment did not reflect the actual care environment for the 24 residents with dementia who resided throughout the facility. Furthermore, the assessment lacked specific details regarding the care needs, staffing requirements, and specialized activity programming necessary to meet the needs of residents with dementia or Alzheimer's disease. Additionally, there was no evidence the facility had updated its facility-wide assessment to address how available resources were being used to support staffing and operational decisions in a manner that ensured compliance with regulatory requirements. The assessment lacked comprehensive data regarding the current resident population and necessary resources to deliver safe and appropriate care. On March 18, 2025, at 10:30 AM, 10 residents were observed seated in wheelchairs and geri-chairs in the Blue Unit activity room. The television was on, playing a cartoon program; however, none of the residents appeared engaged or watching. A review of the March 2025 activity calendar indicated that Trivia and Word Games was the scheduled activity during that time, but there was no evidence the activity was conducted. At 1:00 PM on the same day, the same 10 residents remained in the activity room with the television still playing cartoons, despite a different activity being scheduled on the posted calendar as 1 to 1 visits. Again, the scheduled activity did not take place. (continued on next page)

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	395433	A. Building B. Wing	03/21/2025

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

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 10 residents observed in the activity room were noted to have advanced dementia and were unable to express their preferences or level of engagement due to cognitive impairment. On March 19, 2025, at 10:00 AM, Employee 1 (LPN) stated that the residents in the small activity room all had dementia, and the television was turned on to keep them in one area for easier staff monitoring rather than to provide meaningful engagement. During an interview with the Activity Director on March 21, 2025, at approximately 11:00 AM, the Activity Director confirmed that the facility lacked adequate activity staff to provide specialized dementia care activities. The Activity Director further acknowledged that the facility's evening activity programming was minimal, with little to no structured activities offered during evening hours. The facility-wide assessment presented during the survey ending March 21, 2025, did not include comprehensive, current data regarding the resident population or the necessary resources to provide competent and safe care. Refer F679 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(e)(1)(3) Management

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51726 Based on a review of clinical records and staff interview, it was determined the facility failed to ensure coordination of care and services between the facility and the Hospice agency for one resident (66) out of 20 sampled. Findings include: A review of facility policy titled Coordination of Hospice Services, last reviewed by the facility on June 1, 2024, revealed it is the facility policy to coordinate a plan of care and implement interventions in accordance with the resident's needs, goals, and recognized standards of practice in consultation with the resident's attending physician/practitioner and resident's representative, to the extent possible. The policy indicates the plan of care will identify the care and services that each entity will provide in order to meet the needs of the resident and his/her expressed desire for hospice care. A review of Resident 66's clinical record revealed she was admitted to the facility on [DATE], with diagnoses to include peripheral vascular disease (a condition that affects the blood vessels outside of the heart and brain) and type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). A review of physician's order dated October 23, 2024, revealed the resident was admitted into hospice services for a diagnosis of peripheral vascular disease. A review of the resident's care plan initially dated February 15, 2024, and last revised March 18, 2025, revealed that the resident's care plan failed to reflect coordination of services between the facility and the Hospice agency in meeting the resident's daily care needs and specific needs related to care and services provided for the resident's terminal diagnosis. An interview conducted with the DON on March 20,2025 at approximately 8:35 AM, indicated the resident's care plan did not reflect coordination of services between the facility and the hospice agency. There was no documented evidence of interdisciplinary communication or coordination ensuring that hospice and facility staff were aligned in their provision of care for Resident 66. 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services 28 Pa. Code 201.21(c) Use of outside resources

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52053 Based on a review of clinical records, select facility policy, observations, and resident and staff interviews, it was determined the facility failed to implement enhanced barrier infection control procedures for one resident out of the 20 residents sampled (Resident 12). Findings include: A review of facility policy titled Enhanced Barrier Precautions, last reviewed by the facility on June 1, 2024, revealed it is the facility policy to expand the use of personal protective equipment and refer to the use of gowns and gloves during high-contact resident care activities that provided opportunities for transfer of multi-drug-resistant organisms (MDROs) to staff hands and clothing. The policy indicates nursing home residents with wounds are especially high risk for both the acquisition of and colonization with MDROs. The policy indicates that the facility will make gowns and gloves available immediately outside of the resident's room for those who require enhanced barrier precautions, and that clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment, and the high-contact resident care activities that require the use of gowns and gloves. The policy indicates high-contact resident care activities include wound care of any skin opening requiring a dressing. A clinical record review revealed Resident 12 was admitted to the facility on [DATE], with diagnoses that included atrial fibrillation (a condition that causes the heart to beat irregularly and sometimes much faster than normal) and hypertension (blood pressure that is higher than normal). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 25, 2025, revealed that Resident 12 is cognitively intact with a BIMS score of 14 (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 13-15 indicates cognition is intact). A review of Resident 12's wound assessment report dated February 25, 2025, documented the presence of a left heel wound with serous drainage (clear to yellow fluid leaking from a wound). Treatment orders included the application of medical-grade honey and a bordered gauze dressing. However, a review of the clinical record revealed no physician orders for Enhanced Barrier Precautions (EBP) at the time of assessment. An observation of Resident 12's room on March 18, 2025, at 12:20 PM, revealed: No signage or postings indicating that Resident 12 required enhanced barrier precautions. No PPE (gowns or gloves) readily available outside the resident's room for staff use. In an interview with the Director of Nursing (DON) on March 20, 2025, at 11:50 AM, it was confirmed that Resident 12's physician orders for Enhanced Barrier Precautions were initiated on March 20, 2025, at 12:07 PM-two days after the observation and after surveyor inquiry. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow-up interview on March 20, 2025, at 1:15 PM, the DON confirmed that the facility is responsible for ensuring full implementation of infection control procedures, including enhanced barrier precautions, in accordance with facility policy and nationally recognized infection control guidelines. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa code 211.12 (d)(1)(5) Nursing services.

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture. 43944 Based on observations, staff interviews, and review of facility practices, it was determined that the facility failed to provide adequate dining space to accommodate the number of dependent residents requiring staff assistance during meals in one of two occupied resident units (Blue Unit). Findings include: An observation of the Blue Unit dining room on March 18, 2025, at 12:15 PM revealed that five dining tables were occupied by thirteen residents in wheelchairs, while two additional residents in Geri reclining chairs were seated with mobile bedside tables in front of them. The dining area was congested, making it difficult for staff to pass through, set up meal trays, and assist residents effectively. The limited space also restricted residents' ability to maneuver safely within the room. A subsequent observation of the same dining area on March 19, 2025, at 12:35 PM revealed fifteen residents in wheelchairs seated among the five dining tables, along with two residents in Geri reclining chairs using mobile bedside tables. Due to the number of residents requiring assistance and the presence of staff providing feeding support, the space remained congested, further restricting movement for both residents and staff. During an interview with the Director of Nursing (DON) and in the presence of the clinical nurse consultant on March 21, 2025, at 10:30 AM, the DON stated that due to staffing constraints, there was only one seating for each meal in the dependent resident dining rooms. The DON and the clinical nurse consultant acknowledged that the dining area was a tight fit during meals and confirmed that the current setup should be reassessed to ensure adequate space for residents, enhancing both safety and the overall dining experience. The failure to provide adequate dining space compromised the ability of staff to efficiently assist residents with meals and restricted residents' movement, creating an environment that did not support a dignified and comfortable dining experience. 28 Pa Code 201.18 (e) (2.1) Management