

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Embassy of Tunkhannock		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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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 dietitian. Based on staff interview and a review of employee credentials, it was determined the facility failed to ensure the registered dietitian (RD) provided the required on-site oversight of the food and nutrition services department. Findings include: A review of a facility provided job description for the Registered Dietitian (RD) indicated the position purpose includes planning, organizing, developing, and directing the nutritional care of the residents in accordance with current federal, state and local standards, guidelines, regulations and established facility policies and procedures. Major duties and responsibilities included the following: to provide registered dietitian services in one or more sites according to policies and procedures; plan, organize, develop, and direct the nutritional care of the residents in accordance with current federal, state and local standards, guidelines and regulations; assesses/monitors the residents' nutritional status and provides recommendations to clinical/medical staff; observes resident meal services to ensure diets are correct and modifications are followed; educates residents, families, and staff on nutrition concepts and diet modification; work with other members of the interdisciplinary team to ensure that modified texture or therapeutic diets are in compliance with the resident's medical condition; reviews menu changes to ensure compliance with the facility's policy and procedures and state and federal guidelines; updates diet orders and menu changes as required; conducts audits of relevant nutritional care on a routine basis; completes nutritional assessments on residents on admission, readmission, quarterly, annually, and with any changes in condition as per guidelines; performs inspections of food service areas for sanitation, order, safety, and proper performance of assigned duties; monitors residents for weight changes, nutrition support, and skin breakdown, and makes recommendations as needed; and participates in inspection surveys, ensuring compliance with nutritional and dietary policies and procedures as per state and federal guidelines. During an interview conducted on January 28, at 12:00 PM, the Nursing Home Administrator (NHA), reported the facility's RD worked 24-32 hours per pay period (two-week intervals) and most hours worked were remotely (off-site) with one day per pay period on-site on a Saturday or Sunday. The NHA confirmed the RD had a full-time job elsewhere and was not available to the facility during regular day shift hours of 8:00 AM to 4:00 PM. Additionally, the NHA reported that since the RD could not perform duties on-site, the facility's full-time certified dietary manager (CDM) reviews weights, performs admission interviews with residents or families and communicates the information to the RD for the assessment and documentation to be performed remotely. The NHA also confirmed the RD did not conduct on-site supervisory oversight of the food and nutrition services department, including staff training, direct observation of residents for nutritional assessments, or monitoring of meal services. The facility failed to ensure compliance with federal requirements by not providing the necessary on-site oversight and consultation by a qualified dietitian or clinically qualified nutrition professional. This failure created the potential for inadequate monitoring and coordination of food and nutrition services necessary to meet residents' clinical and nutritional needs. Refer F 69228 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa Code 201.18 (b)(1)(3)(e)(1)(6) Management.		

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on a review of the facility's abuse prohibition policy, employee personnel files and staff interviews, it was determined the facility failed to implement procedures to fully screen four employees out of five to ensure they were eligible for employment in a long term care nursing care facility. (Employees 1, 2, 3, and 4). Findings include: A review of the facility's Resident Abuse policy last reviewed by the facility on January 23, 2026, revealed the requirement for screening potential employees including obtaining references from the most recent or previous employer. Review of employee personnel files revealed the following: Employee 1 (Licensed Practical Nurse): Hired on September 30, 2025. The application listed previous employers, but there was no documentation showing the facility had contacted the most recent former employer to fully screen the individual to ensure the individual was eligible for employment in a long term care nursing facility. Employee 2 (Social Services): Hired on November 4, 2025. The application listed previous employers, but there was no documentation showing the facility had contacted the most recent former employer. Employee 3 (Dietary Aide): Hired on November 17, 2025. The application listed previous employers, but there was no documentation showing the facility had contacted the most recent former employer. Employee 4 (Nurse Aide): Hired on July 18, 2025. The application listed previous employers, but there was no documentation showing the facility had contacted the employees' most recent former employer. Interview with the Nursing Home Administrator (NHA) on January 29, 2026, at 1:15 PM confirmed there was no evidence that previous employers were contacted for information regarding the employees' past work history. The facility failed to follow its own abuse prohibition policy by not verifying previous employment for two out of five new hires. 28 Pa. Code 201.14(a) Responsibility of Licensee. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.19 (1) Personnel records.		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on review of facility documents and staff interview, it was determined the facility failed to ensure the Medical Director or designee participated in the facility's Quality Assurance and Performance Improvement (QAPI) Committee meetings on a quarterly basis for two of four quarters (Quarter 1 and Quarter 2 of 2025). Findings include:: A review of the facility policy titled Quality Assurance Performance Improvement (QAPI) last reviewed by the facility on January 23, 2026, revealed the would develop and maintain an effective, comprehensive, data-driven QAPI program. However, the policy did not clearly identify required QAPI committee membership, did not specify required participation of the Medical Director or a designated physician representative, and did not outline attendance expectations or accountability for participation in quarterly meetings. A review of QAPI committee meeting sign-in sheets for the period of March 2025 through January 2026 revealed that although QAPI meetings were conducted quarterly, the Medical Director or the Medical Director's designated physician representative was not in attendance at the meetings held on March 19, 2025; July 17, 2025; and September 22, 2025, representing two of four quarters reviewed in 2025. Interview with the Director of Nursing and the Nursing Home Administrator on January 30, 2026, at 11:00 AM confirmed review of the findings related to the absence of the Medical Director or designee from the identified QAPI committee meetings. 28 Pa. Code 211.2 (d)(3)(4)(5)(6) Medical director. 28 Pa. Code 201.18 (e)(1)(3) Management.		

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on staff interviews and review of facility training and orientation records, it was determined that the facility failed to ensure that all employees received required annual education on the facility's abuse prohibition policy and procedures. Findings include: A review of the facility's policy entitled Abuse, Neglect, Exploitation and Misappropriation of Resident Property last reviewed by the facility on January 23, 2026, indicated the facility would educate its staff upon hire and annually thereafter regarding the facility's policy concerning abuse, neglect, exploitation and misappropriation of resident property and how to handle resident-to-resident abuse and injuries of unknown sources. During an interview with the Nursing Home Administrator (NHA) on January 30, 2026, at 12:45 PM, the NHA reported that the Human Resources Director position was eliminated in mid-December 2025 due to budgetary reductions and that the responsibilities of the position were reassigned to administration. The NHA provided the educational content intended for the facility's annual abuse prevention training program. However, the facility was unable to provide documented evidence demonstrating that the annual abuse prevention education was completed for facility staff. The NHA provided the educational content intended for the facility's annual abuse prevention training program. However, the facility could not provide documented evidence demonstrating that the annual abuse prevention education was completed for facility staff. Additionally, the interview on January 30, 2026, at 12:55 PM, confirmed that documentation verifying completion of the facility's mandatory annual abuse prevention training could not be located. As a result, the facility was unable to demonstrate that its required annual abuse prevention training program was implemented to ensure that all facility staff received the facility's abuse prohibition policy and procedures to identify and report abuse, neglect, exploitation, or misappropriation of resident property or resident abuse prevention. 28 Pa. Code 201.20(a)(b) Staff development. 28 Pa Code 201.18 (e)(1) Management. 28 Pa Code 211.10 (c) Resident care policies.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on facility policy and clinical record review and staff interview, it was determined the facility failed to ensure that a resident's comprehensive care plan was reviewed and revised as needed to accurately reflect their current needs and services required for one of 23 residents sampled (Resident 45). Findings include: A review of the facility policy entitled Comprehensive Care Planning last reviewed on [DATE], revealed the facility will develop a comprehensive person-centered care plan for each resident that includes measurable goals and timetables to meet the resident's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment. A clinical record review revealed Resident 45 was admitted to the facility on [DATE], with diagnoses to include Diabetes Mellitus (a metabolic disorder in which the body has high sugar levels for a prolonged period.) and cerebral infarction (a type of stroke where the blood flow to the brain is blocked or reduced). A review of Resident 45's clinical record revealed a document labeled Advance Directive (a written or verbal instruction that states a person's wishes for health care treatment or names another person to make health care decisions if the person becomes unable to make those decisions) dated [DATE], that indicated Resident 45 did want Cardiopulmonary Resuscitation (CPR) (a lifesaving technique used in emergencies when the heart stops) . A review of Resident 45's comprehensive care plan, last revised on [DATE], failed to reflect Resident 45's Advanced Directive choice for CPR and indicated Resident 45's code status (a patient's preference regarding emergency treatment, particularly in situations when their heart or breathing stops) was Do Not Resuscitate (DNR). An interview with the Director of Nursing on [DATE], at 11:00 AM confirmed the facility failed to review and revise Resident's 45's care plan to accurately reflect their code status. 28 Pa. Code 211.12(d)(3)(5) Nursing services. 28 Pa Code 211.10 Resident care policies.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, facility policy review and staff interview, it was determined the facility failed to ensure that nursing services met professional standards of quality according to the Pennsylvania Code Title 49, Professional and Vocational Standards, by failing to ensure Licensed Practical Nurses (LPNs) were properly trained and validated as competent prior to administering intravenous (IV) medications through a central venous catheter for one of twenty-three residents reviewed (Resident 52). Findings include: According to the Pennsylvania Code Title 49, Professional and Vocational Standards Department of State, Chapter 21 State Board of Nursing, Chapter 21.145 Functions of the LPN (Licensed Practical Nurse) require the following: The LPN is prepared to function as a member of the health care team by exercising sound nursing judgement based on preparations, 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. (b) The LPN administers medication and carries out the therapeutic treatment ordered for the patient in accordance with the following: (d) The Board recognizes codes of behavior as developed by appropriate practical nursing associations as the criteria for assuring safe and effective practice. Chapter 21.145 b. IV therapy curriculum requirements: (f) An LPN may perform only the IV therapy functions for which the LPN possesses the knowledge, skill and ability to perform in a safe manner, except as limited under S 21.145 a (relating to prohibited acts), and only under supervision as required under paragraph (1). (1) An LPN may initiate and maintain IV therapy only under the direction and supervision of a licensed professional nurse or health care provider authorized to issue orders for medical therapeutic or corrective measures (such as a CRNP, physician, physician assistant, podiatrist or dentist). (g) An LPN who has met the education and training requirements of S 21.145 b (relating to IV therapy curriculum requirements) may perform the following IV therapy functions, except as limited under S 21.145 and only under supervision as required under subsection (f): (1) Adjustment of the flow rate on IV infusions. (2) Observation and reporting of subjective and objective signs of adverse reactions to any IV administration and initiation of appropriate interventions. (3) Administration of IV fluids and medications. (4) Observation of the IV insertion site and performance of insertion site care. (5) Performance of maintenance. Maintenance includes dressing changes, IV tubing changes, and saline or heparin flushes. (6) Discontinuance of medication or fluid infusion, including infusion devices. (7) Conversion of a continuous infusion to an intermittent infusion. (8) Insertion or removal of a peripheral short catheter. (9) Maintenance, monitoring and discontinuance of blood, blood components and plasma volume expanders. (10) Administration of solutions to maintain patency of an IV access device via direct push or bolus route. (11) Maintenance and discontinuance of IV medications and fluids given via a patient-controlled administration system. (12) Administration, maintenance and discontinuance of parenteral nutrition and fat emulsion solutions. (13) Collection of blood specimens from an IV access device. A review of a facility policy titled Catheter Insertion and Care-Flushing Central Vascular Access Devices (tube placed into a large vein near the heart to deliver medications or fluids) and Midline Catheters last reviewed by the facility on January 23, 2026, revealed the facility is to verify the scope of practice for Registered Nurses and Licensed Practical Nurses and competency requirements for this procedure with the State Nurse Practice Act. Clinical record review revealed that Resident 52 was admitted to the facility on [DATE], with diagnosis to include pneumonia (an infection that inflames the air sacs of the lungs) and septic arterial embolism (an infected blood clot that travels through the blood stream), and was admitted to the facility with a PICC line (a peripherally inserted central catheter, a long catheter introduced through a vein in the arm and passed through to the larger veins into the heart). A review of the clinical record revealed physician orders dated January 17, 2026, to administer the following medications through the intravenous (IV) catheter: Normal Saline Flush (Sodium Chloride Flush), 10 milliliters IV every eight (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hours to maintain patency (to keep the catheter open and prevent blockage). Ceftriaxone Sodium, 2 grams IV once daily until February 21, 2026. Ceftriaxone Sodium is an antibiotic medication used to treat bacterial infection and was ordered related to an intestinal abscess (a pocket of infection in the intestine). Vancomycin HCL, 1,000 milligrams IV twice daily until February 21, 2026. Vancomycin HCL is an antibiotic medication used to treat serious bacterial infections and was also ordered related to an intestinal abscess. During an observation of medication administration on [NAME] Hall on January 29, 2026, at 8:45 AM, Employee 5, a Licensed Practical Nurse (LPN), was observed washing her hands, putting on gloves, flushing the resident's peripherally inserted central catheter (PICC line) with normal saline, and administering Ceftriaxone Sodium through the PICC line. The facility was unable to produce any documentation verifying that Employee 5, LPN had current competency validation, supervision documentation, or internal training specific to PICC line administration. During an interview conducted on January 29, 2026, at 10:30 AM, the Director of Nursing (DON) confirmed that the facility did not provide education or training to LPNs for the administration of medications through PICC (central) lines. The DON further stated that it was the facility's policy that only Registered Nurses were permitted to administer medications via central lines. Despite this stated policy, an LPN was observed administering IV medication through a PICC line without documented training or competency validation, indicating the facility failed to ensure nursing services were provided in accordance with professional standards and failed to ensure staff were properly trained prior to performing high-risk nursing procedures. 28 Pa. Code 201.20(a) Staff Development. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa Code 211.12(c)(d)(1)(2)(3)(5) Nursing services.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, and resident and staff interviews, it was determined the facility failed to ensure that residents with limited mobility received the necessary services, equipment, and assistance to maintain or improve mobility for one of 18 residents reviewed (Resident 1). Findings Include: Review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses which include cerebral ischemia (a condition in which reduced blood flow to the brain limits oxygen and nutrients needed for brain function) and flaccid hemiplegia to the right dominant side (a condition where there is complete paralysis or weakness of the muscles on one side of the body). These conditions affected Resident 1's ability to move and use the right hand and arm. A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 22, 2025, revealed that Resident 1 was severely cognitively impaired with a BIMS score of 5 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 0-7 indicates cognition is severely impaired). Review of Resident 1's current physician orders revealed an order dated August 11, 2022, for a functional position hand splint to the right hand and wrist with instructions to wear it continuously, perform skin checks every shift, and remove it only for hygiene before reapplying it. Review of Resident 1's current care plan reflected the same intervention, which directed that the right hand splint always remain in place, be removed each shift for skin inspection, and that staff monitor for skin breakdown. The care plan was initiated July 20, 2022. During an observation conducted in the dining room on January 29, 2026, at 11:00 AM Resident 1 was observed without the ordered right hand splint in place. The splint was observed lying on the resident's bedside table rather than being applied as ordered. A review of Resident 1's Documentation Survey Report v2, which reflected care tasks completed for December 2025 and January 2026, revealed inconsistent, incomplete, and conflicting documentation related to restorative and functional nursing services intended to maintain mobility. Multiple entries were documented as not applicable or left blank. Documentation revealed the following: On December 8, 2025, evening shift was documented as not applicable. On December 9, 2025, evening shift was documented as not applicable. On December 13, 2025, evening shift was documented as not applicable. On December 18, 19, 20, 24, and 25, 2025, the day shift was documented as not applicable. On January 4 and January 18, 2026, the day shift was documented as not applicable. On January 27, 2026, the evening shift was documented as not applicable. On January 29, 2026, the same date the resident was observed without the splint at 11:00 AM., documentation indicated the splint had been applied at 7:04 AM, which conflicted with direct observation. During an interview with the Director of Nursing on January 29, 2026, at 1:30 PM, the Director of Nursing was unable to provide documented evidence that Resident 1's functional nursing program, including the ordered right-hand splint intended to maintain mobility and prevent loss of function, was consistently implemented according to the physician's order and care plan. 28 Pa. Code: 211.5(f)(i)(ii) Medical records. 28 Pa Code 211.12 (c)(d)(5) Nursing services.		

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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 18 sampled residents (Resident 5). 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 5's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included generalized muscle a reduction in muscle strength affecting multiple muscle groups) irritable bowel syndrome (IBS, a disorder affecting the stomach and intestines that may cause abdominal pain, bloating, diarrhea, or constipation), and major depressive disorder (a mental health condition characterized by persistent low mood and loss of interest in usual activities). A review of Resident 5's comprehensive care plan, initiated January 12, 2024, identified nutritional problems or potential nutritional problems related to advanced age, mechanically altered diet texture, and mild protein store depletion (a condition in which the body's protein reserves are reduced). Goals included maintaining weight, avoiding significant weight changes, and consuming 75 percent of meals served. Planned interventions included providing the diet as ordered, obtaining weekly weights, and RD evaluation with recommendations as needed. A review of physician orders revealed an order dated December 15, 2025, at 1:53 AM, for weekly weights. A review of Resident 5's weight record revealed the following documented weights: December 21, 2025, at 1:05 PM: 120.5 pounds December 28, 2025, at 10:03 AM: 121.5 pounds January 4, 2026: 121.5 pounds January 11, 2026, at 10:32 AM: 105 pounds The January 11, 2026, weight reflected a loss of 16.5 pounds, representing approximately 13.5 percent body weight loss in one week. The clinical record failed to reveal documentation that a reweight was obtained to verify this significant change. 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 though electronic record review and communication with staff) dated January 15, 2026, at 3:19 PM, in response to a weight warning for the January 11, 2026, value. The RD documented a weight loss of 13.2 percent (16 pounds) greater than one month and 9.1 percent (10.5 pounds) in three months and recommended that a reweight be obtained due to significant weight loss. Resident 5's weight had not been rechecked until January 16, 2026, at 1:43 PM, when the resident's weight was recorded as 106 pounds and continued to reflect a significant weight loss. A subsequent RD note dated January 16, 2026, at 4:39 PM, documented a significant weight loss of 12.4 percent (15 pounds) in less than 30 days and 8.2 percent (9.5 pounds) in three months. The note documented the resident's body mass index (BMI), which is a measure of weight relative to height used to screen nutritional risk, as 20.7 (within normal range). The RD recommended fortified foods with all meals and a 4 ounce nutritional shake (a high-calorie, high-protein supplement) with lunch and dinner. An RD progress note dated January 23, 2026, at 2:21 PM, documented the resident's weight from January 18, 2026, was 106.2 pounds and (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted the resident was tolerating a mechanical soft diet with thin liquids and consuming approximately 75 percent of meals served. The RD documented the resident was to receive 4-ounce nutritional shakes with lunch and dinner. However, the clinical record failed to reveal documented evidence that the recommended nutritional interventions, including the 4-ounce nutritional shakes with lunch and dinner, were implemented in a timely manner following the identification of the significant weight loss on January 11, 2026. Additionally, the clinical record failed to reveal documented evidence that Resident 5's attending physician and responsible party were notified of the significant weight loss. Further review of the weight record revealed a recorded weight of 104 pounds on January 25, 2026, representing an additional weight loss of 2.2 pounds from the previous recorded weight. During an interview with the Director of Nursing (DON) on January 29, 2026, at 2:13 PM, the above findings were reviewed. The Director of Nursing confirmed that no additional documentation could be provided to demonstrate timely notification of the MD and responsible party regarding the resident's significant weight loss or timely implementation of nutritional interventions. The Director of Nursing also confirmed that reweights were not completed in a timely manner. Cross Ref. F943 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395433	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Embassy of Tunkhannock		STREET ADDRESS, CITY, STATE, ZIP CODE 30 Virginia Drive Tunkhannock, PA 18657	
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on review of clinical records, select facility policy, observation, and staff interview, it was determined that the facility failed to implement procedures to maintain records of controlled drugs and ensure accurate drug administration for two out of the 23 residents sampled (Resident's 4 and 58). Findings include: A review of the facility policy titled Medication Administration, last reviewed by the facility on January 23, 2026, revealed that medications are to be administered by licensed nurses or other staff authorized to do so by the state, as ordered by the physician, and in accordance with professional standards of practice to prevent contamination, infection, and medication errors. The policy further requires that the licensed nurse administering a medication immediately document the resident's name, date and time of administration, dose, route of administration, and the signature of the nurse on the medication administration record. The policy also requires that medications classified as controlled substances (medications regulated by law due to their potential for misuse or dependence) be documented on a controlled substance record to ensure accurate tracking and accountability. A review of the clinical record revealed Resident 58 was admitted to the facility on [DATE], with diagnoses that included vascular dementia with behavioral disturbance (a condition caused by reduced blood flow to the brain that affects memory, thinking, and behavior) and generalized anxiety disorder (a condition characterized by persistent and excessive worry that interferes with daily functioning). A review of the clinical record revealed a physician's order dated August 21, 2025, for Lorazepam 0.5 milligrams (mg) by mouth three times daily related to generalized anxiety disorder. Lorazepam is a Schedule IV controlled substance, a medication with accepted medical use but regulated due to its potential for misuse or dependence. Review of facility records revealed the facility utilizes a Controlled Drug Receipt/Record/Disposition Form to track, monitor, and reconcile controlled substances and a Medication Administration Record (MAR) to document each administered dose, including the date, time, medication, and staff administering the medication. A comparison of Resident 58's Controlled Drug Receipt/Record/Disposition Form with the MAR for the period of August 1, 2025, through January 2026, revealed three entries on the controlled substance record indicating Lorazepam 0.5 mg was used; however, there was no corresponding documentation on the MAR to indicate that the medication was administered to the resident. The discrepancies occurred on the following dates and times: September 6, 2025, at 6:00 AM September 14, 2025, at 5:00 AM January 2, 2026, at 4:00 PM The absence of MAR documentation for doses recorded as used on the controlled substance record indicated a failure to ensure accurate medication administration documentation and reconciliation. A review of the clinical record revealed Resident 4 was admitted to the facility on [DATE], with diagnoses that included dysphagia (difficulty swallowing) and muscle weakness (reduced muscle strength that limits the ability to perform daily activities). The record further revealed Resident 4 was admitted to hospice care (specialized care focused on comfort and symptom management for individuals with a life expectancy of six months or less). Further review of the clinical record revealed a physician's order dated October 10, 2025, for Morphine Sulfate concentrated oral solution 20 mg per milliliter (ml), with instructions to administer 0.25 ml by mouth three times daily related to musculoskeletal symptoms. Morphine Sulfate is a Schedule II controlled substance, meaning it has a high potential for misuse and requires the highest level of monitoring, documentation, and accountability. A review of the clinical record revealed a physician's order dated October 10, 2025, for Morphine Sulfate concentrated oral solution 20 mg per milliliter (ml), with instructions to administer 0.25 ml by mouth three times daily related to musculoskeletal symptoms. Morphine Sulfate is a Schedule II controlled substance (high potential for misuse and requires the highest level of monitoring, documentation, and accountability). A comparison of Resident 4's Controlled Drug Receipt/Record/Disposition Form with the MAR from October 10, 2025, through (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	January 2026, revealed three entries on the MAR indicating that Morphine Sulfate was administered; however, there was no corresponding documentation on the controlled substance record to indicate that the medication was removed, administered, or otherwise accounted for. The discrepancies occurred on the following dates and times: October 19, 2025, at 11:30 AM November 15, 2025, at 5:00 PM November 16, 2025, at 12:53 AM The absence of controlled substance documentation for doses recorded as administered on the MAR indicated a failure to maintain accurate and complete controlled medication records. An interview was conducted on January 29, 2026, at 10:45 AM, with the Director of Nursing (DON) to review the above findings related to the facility's failure to implement effective procedures to reconcile Resident 4 and Resident 58's-controlled substance medications. 28 Pa Code 211.5(f)(xi) Medical records. 28 Pa Code 211.9(a)(1)(k) Pharmacy services. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa Code 211.12 (d)(1)(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 loss. 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.		