STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395456	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Wyoming Valley	50 N. Pennsylvania Ave. Wilkes Barre, PA 18701

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on review of clinical records, the facility's abuse prohibition policy, select investigative reports, and interviews with staff and residents, it was determined the facility failed to ensure that a resident was free from neglect by not providing care with assistance of two-persons as planned to ensure safety and prevent major injuries, fractures to the left distal femur and right distal tibial, for one resident, Resident 2, out of eight sampled residents for abuse prohibition. Findings include: Review of the facility's policy entitled Abuse, Neglect, and Exploitation that last revised by the facility on January 1, 2024, defined neglect as the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The facility would deploy trained and qualified registered, licensed, and certified staff on each shift and assure that the staff assigned have knowledge of the individual residents' care needs and behavior symptoms. Review of Resident 2's clinical record revealed the resident was initially admitted to the facility on [DATE], with diagnoses to include unspecified intellectual disabilities (neurodevelopmental condition that develops in childhood and affects one's capacity to learn and retain new information, and it also affects everyday behavior such as social skills and hygiene routines. Individuals with this condition experience significant limitations with intellectual functioning and developing adaptive skills like social and life skills) liver disease (is a broad term to describe damage to the liver), anxiety disorder, and abnormalities of gait (walking pattern) and mobility. Review of Resident 2's Quarterly MDS assessment (Minimum Data Set - a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 29, 2024, revealed the resident had a BIMS score of 3 (Brief Interview for Mental Status is a tool used to evaluate cognitive impairment and assist with dementia diagnosis. A score of 0-7 equates to severe cognitive impairment). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 2's current comprehensive person-centered care plan, initiated on July 1, 2022, indicated the resident had an ADL (activities of daily living) self-care performance deficit related to intellectual disabilities, history of falls, and a history of seizures. Planned resident centered interventions revealed he required two-staff participation with bed mobility to reposition and to turn in bed, and also required two-staff participation for bathing/showering and dressing, bed mobility, transfers, toileting and hygiene. Additionally, the resident's cognition and communication care plan indicated the resident had impaired cognition but is able to respond yes or no to simple questions when asked. A review of a nurses note completed by Employee 1, a Licensed Practical Nurse (LPN), dated September 7, 2024, at 7:05 PM, revealed Resident 2 was yelling out in pain when rolled to the left side on his hip area and when his left leg is lifted. On call CRNP (certified registered nurse practitioner) was made aware and new orders were obtained for a STAT x-ray (immediate) of the left hip and leg. The resident's responsible party (RP) was made aware. The X-ray was completed at 11:30 PM. A review of the x-ray results dated September 8, 2024, at 4:41 AM, revealed the resident had sustained an acute displaced comminuted fracture (fractures caused by severe trauma) to the distal femur (thighbone that occur just above the knee joint), and the on-call physician was notified, and the resident was transferred to the hospital. A review of an investigative report provided by the facility, completed by Employee 1, a Licensed Practical Nurse (LPN), dated September 8, 2024, at 4:41 AM, in response to the resident's pain and unknown injury indicated the x-ray results of Resident 2's left femur/knee were received, and impression read acute displaced comminuted (result of trauma or force to an area) distal femoral fractures with no witnessed to report. Immediate actions were to notify the on-call physician with new orders noted to send resident to the emergency room (ER) for evaluation and treatment. The responsible party (RP) was aware and in agreement with the treatment. A review of the facility's investigation revealed a witness statement completed by Employee 2, a Nurse Aide (NA), dated September 8, 2024, no time indicated, indicated Employee 2, last saw the resident during last rounds and was laying in bed around 6:00 PM on September 7, 2024. A co-worker, Employee 3, a NA and I changed the resident, and I didn't witness any fall or abuse. Additionally, during a staff interview conducted by the facility's Director of Nursing, on September 8, 2024, no time indicated, Employee 2 stated she provided care to Resident 2 at approximately 8:30 AM on September 7, 2024, with NA Employee 3 present to help her. Employee 3 noticed his leg was not right, so she got the nurse, Employee 1, LPN. (Employee 1 did not confirm she evaluated the resident at this time as per statements) Employee 2 stated the next time she provided care to the resident was at 2:00 PM, with Employee 3 on September 7, 2024. Employee 2 stated the resident seemed to be in pain when care was rendered. Employee 2 stated that at 4:00 PM, she and Employee 3 were providing care to the resident and they asked Employee 1, LPN to evaluate his leg, the nursing supervisor was also notified at this time. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of a witness statement completed by Employee 3, a NA, no date or time noted on the statement, revealed around 1:45 PM on September 7, 2024, her co-worker Employee 2 NA asked her to assist her to provide care to Resident 2, Employee 2 NA, informed her something seemed to be wrong with the resident's leg, when Employee 2 moved his leg he cried out in pain. Employee 3 followed Employee 2 into the room, and Employee 2 started to push him towards Employee 3 in order to change his brief and he cried out in pain. Employee 3 told Employee 2 to call the nurse and the nurse came into the room and she was informed of the resident's pain. A review of statements obtained during a verbal interview conducted by the DON and signed by Employee 3 on September 9, 2024, no time indicated, regarding September 7, 2024, revealed a statement that read The first time I assisted to help change Resident 2 was at approximately 2:00 PM, with Employee 2. Employee 2 came to me and said, can you come help me with Resident 2, I think there is something wrong with his leg. They did not see Employee 1 right away but did get her and Employee 1, LPN evaluated the resident, Employee 3 stated I did not care for or help care for him for the rest of the night. Further review of a witness statement completed by Employee 4, a LPN, in response to the concern for Resident 2 from September 7, 2024, (verbal statement obtained by telephone, not dated as to when obtained) revealed she was made aware by Employee 2, NA when the resident was moved to the left side he yelled out in pain. Employee 4 stated she went in to assess the resident and when she picked up his left leg by the calf area he yelled out in pain. Employee 4 made the on-call physician aware and a STAT (immediate) x-ray (are used to generate images of tissues and structures inside the body, an image will be formed that represents the shadows formed by the objects inside of the body) was ordered and awaiting results at this time 11:26 PM. Employee 4 indicated she was his nurse on 3-11 PM shift on September 6, 2024, and there were no signs or symptoms of pain or discomfort. A review of the emergency department nursing progress notes dated September 8, 2024, at 6:11 AM, indicated that Resident 2 was mostly non-verbal with minimal short verbal responses and the note indicated the resident was questioned regarding his leg injury. The resident was asked if he fell out of bed at the nursing facility and he responded yeah. The resident was asked a second time to confirm, and he once again stated yeah, when asked if he fell out of bed at the nursing facility. A review of the emergency department documentation dated September 8, 2024, at 11:30AM revealed the resident sustained a left distal femur fracture and a right distal tibial fracture. During on-site survey conducted on October 1, 2024, a phone call was placed at 1:30 PM, to Employee 3 to gather additional details related to the incident that occurred September 7, 2024. However, Employee 3 did not return the phone call. There was no documented evidence or confirmation that Employee 3, NA assisted Employee 2 NA with Resident 2's care at 8:30 AM on September 7, 2024 as indicated by Employee 2. There was also no documented evidence or confirmation that Employee 1 LPN was made aware of the concerns of Resident 2's leg not being right at 8:30 AM on September 7, 2024, as per statement from Employee 2, NA. There was no documented evidence to determine that Employee 2 utilized the proper assistance of two staff members to provide care to Resident 2 at 8:30 AM. Employee 2 indicated she cared for the resident at 8:30 AM assisted by Employee 3 however Employee 3 stated she only assisted Employee 2 to care for resident at 2:00PM. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview with the nursing home administrator (NHA) and DON on October 1, 2024, at 2:00 PM, it was reported the facility's investigation process revealed that Employee 2 failed to consistently provide assistance of two persons with bed mobility as planned for Resident 2 to maintain safety and deter injury. Additionally, it was confirmed that Employee 2 neglected to fulfill duties required to safely render care to Resident 2 that resulted in a left distal femur fracture and a right distal tibial fracture causing the resident pain and discomfort. The facility failed to ensure that Resident 2 was provided the services necessary to avoid serious physical harm by ensuring that Employee 2 consistently provided care to the resident with the assistance of another staff member as planned. 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.29 (a) Resident Rights 28 Pa. Code 211.12 (d)(5) Nursing Services.