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	07/08/2025

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** Based on a review of clinical records, select facility policy, investigative documentation provided by the facility, and interviews with facility staff, it was determined the facility failed to protect one of five sampled residents (Resident 3) from neglect by not implementing the individualized care plan intervention of a mechanical lift for all transfers, resulting in actual harm in the form of a spiral fracture of the left tibia. This deficiency is cited as past noncompliance Findings include: A review of a facility policy titled Abuse, Neglect, and Exploitation, last reviewed by the facility on February 19, 2025, revealed it is the facility's policy to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies that prohibit and prevent abuse and neglect. The policy defines 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. A clinical record review revealed Resident 3 was admitted to the facility on [DATE], with diagnoses that include dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities) and osteoarthritis (a degenerative joint disease that occurs when tissues that cushion the ends of bones within the joints break down). A review of Resident 3's individualized care plan revealed she has an activities of daily life (ADL) self-care performance deficit related to dementia initiated on June 6, 2025. Interventions implemented to assist Resident 3 with her goal to improve her level of functioning through the review period include transfers with the assistance of two staff with the Hoyer lift (a mechanical device used to safely transfer individuals with limited mobility between surfaces like beds, chairs, or wheelchairs) implemented on June 6, 2025. A review of an admission Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 12, 2025, documented that Resident 3 was severely cognitively impaired with a BIMS score of 02 (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 00-07 indicates 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	A review of a Task List Report (a report that indicates the date when interventions were added to the Kardex, a quick reference for staff that includes a summary of resident required care information) revealed Resident 3 was to be transferred with the assistance of two (employees) for all transfers and the Hoyer lift was initiated on June 5, 2025. A progress note dated June 24, 2025, at 3:32 PM indicated Employee 1, a licensed practical nurse (LPN), went into Resident 3's room to administer morning medications around 8:20 AM. Employee 1, LPN, indicated when the employee raised the head of the resident's bed, Resident 3 began yelling, My leg is hurting. Don't touch it!. Upon examination, red discoloration and swelling were noted on the inner lower left leg. An X-ray ordered by the Certified Registered Nurse Practitioner (CRNP) confirmed a nondisplaced spiral fracture across the distal left tibia (A twist type break in the lower part of the left shin bone near the ankle. The broken bone pieces are still lined up correctly and have not shifted out of position). A review of the documentation survey report dated June 2025 revealed Employee 2, agency nurse aide (NA), transferred the resident to bed on June 23, 2025, during the 3 to 11 nursing shift. A facility-provided investigative document dated June 25, 2025, revealed Employee 2, an agency nurse aide (NA), indicated that Resident 3 was in her chair at 4:00 PM when she arrived (on June 23, 2025). The document indicated Employee 2, Agency NA, was questioned about how she transferred Resident 3 into her bed that evening. Employee 2, Agency NA, stated, Nobody helped. I put her arms around me and put her back to bed myself. A review of the facility provided investigative witness statements that revealed no other employees were aware of any falls, improper transfers, injuries, or distress related to Resident 3 from June 23, 2025, through June 24, 2025, until 8:20 AM. A physician's order for acetaminophen oral tablet 500 mg with directions to give by mouth three times a day related to fracture was initiated on June 24, 2025. A review of Resident 3's Medication Administration Record dated June 2025 revealed the resident received Acetaminophen 325 mg at 8:30 AM for a pain level of three out of ten on June 24, 2025, and received Acetaminophen 500 mg three times a day from June 24, 2025, at 9:00 PM through July 8, 2025. A subsequent orthopedic consult report dated June 27, 2025, indicated Resident 3's left leg presented with redness and tenderness. The consultation indicated a diagnosis of a left tibial shaft fracture requiring non-weight bearing precautions, daily skin inspections to the left leg, a CAM boot (a device used to immobilize and protect the foot and ankle after an injury or surgery) for 6 to 12 weeks to the left leg, and a follow-up appointment in 4-6 weeks. During an interview conducted on July 8, 2025, at 9:55 AM, Employee 1 (Licensed Practical Nurse) confirmed that she first observed Resident 3 complaining of leg pain on June 24, 2025, at approximately 8:30 AM. Employee 1 stated that Resident 3's lower left leg appeared red and swollen. Employee 1 further explained that when she asked Resident 3 what had happened, the resident replied that the girl with the band on her head had hurt her. Employee 1 also reported that she had last provided care to Resident 3 the previous day, June 23, 2025, at approximately 3:15 PM, at which time the resident was seated in her chair in her room and showed no signs of pain or distress. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on July 8, 2025, at 12:07 PM, Employee 2 (Agency Nurse Aide) confirmed that she transferred Resident 3 by herself on June 23, 2025. Employee 2 stated that she was not familiar with Resident 3's specific care needs and was unaware that the resident's care plan required all transfers to be performed with two staff members and the use of a mechanical lift. Employee 2 also indicated that she did not know how to access resident care plan interventions in the facility's system and was unaware that Resident 3's leg had been injured. Employee 2 confirmed she was assigned to Resident 3's hallway from June 23, 2025, at approximately 4:00 PM until the end of her shift on June 24, 2025, at 7:00 AM. A review of Employee 2's personnel file showed that she had signed an attestation on April 27, 2025, acknowledging that she received the facility's orientation, which included training on the facility's abuse and neglect policy, safe transfer and lift procedures, and the use of the electronic health record system. During an interview on July 8, 2025, at approximately 12:45 PM, the Director of Nursing confirmed that the facility's investigation determined that Employee 2 failed to follow Resident 3's care plan, which required assistance from two staff and the use of a mechanical lift for all transfers. This failure resulted in serious physical injury in the form of a spiral fracture of the tibia. The Director of Nursing stated that Employee 2 was immediately removed from the staffing schedule and placed on the facility's do not return list for agency staff. This deficient practice resulted in actual harm and is cited as past noncompliance. Corrective actions implemented by the facility included: Per physician, the resident was ordered an X-ray of the left lower extremity. It was determined the resident has a spiral fracture of the left tibia. The resident's chart was reviewed for transfer status orders, transfer status in tasks, care plan, and the Kardex. No other residents were affected. All residents' charts were reviewed to confirm current transfer status orders matched care plan interventions and Kardex summaries All new admission charts will be audited for transfer status orders, transfer status on care plans, tasks, and Kardex. Education on abuse, neglect prevention, transfer procedures, and proper use of the Kardex was provided to all clinical staff, including agency staff. The Director of Nursing or designee performs random audits of caregivers once a week for four weeks, then every two weeks for two months, to ensure care provided matches each resident's individualized care plan. Audit results are reviewed during quality assurance and performance improvement meetings for further action as needed. The facility's compliance date for correction of this deficient practice was June 30, 2025. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(5) Nursing services.