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	12/03/2025

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 - Minimal harm or potential for 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility's abuse policy, clinical records, investigation reports, and interviews with residents and staff, it was determined that the facility failed to assure that one resident (Resident 1) out of six sampled residents was free from sexual abuse perpetrated by another resident (Resident 2).Findings included:A review of the current facility policy titled Abuse, Neglect and Exploitation, last reviewed by the facility on February 19, 2025, revealed it is the policy of the facility to provide protections for health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Sexual abuse is defined as non-consensual sexual contact of any type with a resident. A review of Resident 2's clinical record revealed admission to the facility May 20, 2025, with diagnoses to include dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), and high risk heterosexual behavior (multiple partners, unprotected sexual activity, and/or substance use during sexual activity).A quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated August 27, 2025, revealed that Resident 2 was severely cognitively impaired with a BIMS score of 6 (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 severe cognitive impairment), and was independently ambulatory.is able to ambulate independently. A review of nursing documentation dated August 22, 2025, at 2:44 PM revealed Resident 2 was observed wandering into peers' rooms and using other residents' bathrooms. Additional documentation dated September 6, 2025, at 9:24 PM revealed Resident 2 was found wandering the halls entering multiple female resident rooms and making sexual remarks toward staff members. The resident was redirected easily however, documentation indicated behaviors continued despite redirection. Documentation also indicated supervision was provided by staff. Nursing documentation dated September 8, 2025, at 3:00 PM revealed Resident 2 continued with frequent wandering into peer rooms. A review of Resident 2's care plan dated September 20, 2025, identified the resident exhibited inappropriate sexual behaviors, making sexual comments and touching. Interventions planned were to immediately respond to sexually inappropriate comments or behavior by telling him he is being inappropriate and it will not be tolerated, medicate as ordered with Depakote (divalproex sodium- a prescription medication used to treat seizure disorders and mood disorders such as bipolar disorder, and to help reduce aggressive or impulsive behaviors by stabilizing electrical activity in the brain), redirect if necessary from female staff and peers by offering diversional activity, snack, or conversation, redirect to room is visibly aroused to respect dignity and privacy, respect resident's privacy if he is found masturbating, ensure he is in his room and the curtain is closed to maintain dignity, and to seat the resident next to male peers at activities to decrease chances of sexual stimulation. Resident 2's care plan was revised on October 6, 2025, with an added intervention to redirect from the doorways of female peers as needed. Nursing documentation dated October 4, 2025, at 8:11 PM indicated Resident 2 was placed on one-to-one supervision (a level of supervision in which one staff member provides continuous direct observation to one resident) due to wandering into female residents' rooms.A review of Resident 1's clinical record revealed admission to the facility on August 27, 2025, with diagnoses to include dementia, anxiety, and depression. An admission Minimum Data Set assessment dated [DATE], revealed that Resident 1 was severely cognitively impaired with a BIMS score of 3.Nursing documentation dated October 4, 2025, at 9:00 PM revealed Resident 3's daughter called the facility stating that a male resident entered her mother's room and sat on her roommate's bed, staring at her and causing her to cry. She stated her mother said there was no contact made, he just stared at her. The facility was informed to maintain one-to-one supervision of the male resident (Resident 2) until further notice.A witness statement provided by Employee 4 (Registered Nurse) dated October 5, 2025, revealed that she initiated an investigation after being informed by Resident 3's daughter that Resident 2 had entered Resident 1 and 3's room on October 4, 2025, at approximately 8:00 PM and touched Resident 1's breasts. Resident 3 stated she yelled at him to leave; after several minutes he did. Resident 3 also reported that as Resident 2 exited, he said, You're next. Law enforcement and protective services were notified and responded. Resident 1's daughter confirmed that her mother stated a