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	06/23/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility policy, and staff interviews, it was determined that the facility failed to notify a resident's responsible party of a significant change in condition, specifically a fall with a head injury, and the resulting physician-ordered treatment, for one of 14 sampled residents (Resident 1). Findings include: A review of the facility policy titled Fall Prevention and Management Policy, dated January 24, 2026, revealed it is the facility's policy that following a resident fall, the resident's responsible party will be notified.Resident 1 was admitted to the facility on [DATE], with a diagnosis of late-onset Alzheimer's disease (a progressive disorder of the brain that causes memory loss, impaired thinking, and changes in behavior that begin later in life). A review of Resident 1's (quarterly) Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 11, 2026, revealed that Resident 1 was severely cognitively impaired with a BIMS score of 3 (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 3 reflects major difficulty in recalling recent information and indicates pronounced issues with orientation to time, such as remembering the year, month, or day of the week). A review of a late-entry nursing note dated June 2, 2026, revealed Resident 1 sustained a fall with a head injury on May 29, 2026, at 2:45 AM. The nursing note documented that the physician was notified and issued orders to cleanse the skin injury to the resident's right forehead, apply antibiotic ointment, and leave the area open to air. The physician also ordered Tetanus Immune Globulin administered by intramuscular injection (an injection given into a muscle that provides immediate antibodies to help protect against tetanus following certain high-risk wounds). Review of the clinical record failed to reveal documentation that the resident's responsible party was notified of the resident's fall with head injury or the physician's treatment orders following the change in the resident's condition. During an interview conducted on June 23, 2026, at 3:20 PM the Nursing Home Administrator and the Director of Nursing confirmed the resident's responsible party was not notified of Resident 1's fall with injury or of the physician-ordered treatment following the resident's change in condition. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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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	395456	A. Building B. Wing	06/23/2026

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Embassy of Wyoming Valley	50 N. Pennsylvania Ave. Wilkes Barre, PA 18701

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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 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 a review of clinical records, select facility policy, Treatment Administration Records and staff interviews, it was determined that the facility failed to provide nursing services in accordance with professional standards of practice by failing to ensure licensed nursing staff administered a physician-ordered wound treatment as prescribed for one of 14 residents reviewed (Resident 1).Findings include: A review of the facility policy titled Charting and Documentation last reviewed on January 24, 2026, revealed that all services provided (including medications and treatments) shall be documented in the medical record. The guidelines indicated that documentation of procedures and treatments will include the date and time the treatment was provided, the name and title of the individual providing the care and completing the documentation of care. Resident 1 was admitted to the facility on [DATE], with a diagnosis of Alzheimer's disease with late onset (a disease that causes progressive memory loss and decline in thinking abilities). A review of Resident 1's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 11, 2026, revealed that Resident 1 was severely cognitively impaired with a BIMS score of 3 (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 3 reflects major difficulty in recalling recent information and indicates pronounced issues with orientation to time, such as remembering the year, month, or day of the week). A review of the physician's order dated May 30, 2026, directed staff to clean a laceration (deep cut in the skin) on Resident 1's right forehead with normal saline solution (clean water with a small, balanced amount of salt mixed in), apply antibiotic ointment (germ fighting cream), and cover the area with a bandage. A review of the June 2026 Treatment Administration Records (TAR) (the legal documents used to record treatments), revealed nursing staff did not complete the prescribed treatment to the right forehead on June 1, 2026, or June 2, 2026. An interview with the Nursing Home Administrator and Director of Nursing on June 23, 2026, at 2:30 PM reviewed the above findings and acknowledged the facility failed to ensure the physician-ordered treatment was administered as prescribed. 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services. 28 Pa Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (c)(d)(1)(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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and staff interview, it was determined that the facility failed to maintain an accurate and complete clinical record for one of 14 sampled residents (Resident 1).Findings include: Review of the facility policy entitled, Fall Prevention and Management Policy, dated January 24, 2026, indicated in the event of a fall, details of the fall will be gathered and documentation completed as indicated. The procedure guidelines included: update the fall assessment, conduct neurological checks (evaluations to identify any hidden brain injuries or issues after someone hits their head) if the resident is observed to hit one's head, and complete post fall documentation for 72 hours. Resident 1 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease with late onset (a progressive condition that causes memory loss and impaired thinking). A review of Resident 1's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated March 11, 2026, revealed that Resident 1 was severely cognitively impaired with a BIMS score of 3 (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 3 reflects major difficulty in recalling recent information and indicates pronounced issues with orientation to time, such as remembering the year, month, or day of the week) Clinical record review revealed a late-entry nursing note dated June 2, 2026, documenting that Resident 1 sustained a fall with a head laceration (a tear in the skin) on May 29, 2026, at 2:45 AM. A review of the facility's investigative documentation completed at the time of the incident revealed Resident 1 had been sleeping in another resident's room and was being assisted back to her own room. During the transfer, Resident 1, who was able to ambulate without assistance, swung her arms and attempted to throw a photo album toward two staff members. During the incident, Resident 1 fell, struck her head, and sustained a 3-centimeter laceration to the right forehead with active bleeding. A review of the Neurological Evaluation Flow Record revealed neurological evaluations were initiated at 2:45 AM on May 29, 2026. Documentation included Resident 1's vital signs (blood pressure, heart rate, respirations, and temperature), level of alertness, pupil assessment, mobility, and pain. The flow record directed staff to complete neurological evaluations every 15 minutes for one hour, every 30 minutes for four hours, every hour for two hours, and every shift thereafter for 72 hours.Review of the clinical record revealed the last documented neurological evaluation was completed at 7:00 AM on May 29, 2026. The medical record contained no documentation that neurological evaluations were completed thereafter. Specifically, the clinical record did not contain documentation for the evaluations due at 7:30 AM, 8:30 AM, and 9:30 AM on May 29, 2026, or the required evaluations during the remaining evening and night shifts on May 29, 2026, and continuing through the day shift on May 30, 2026. Review of the narrative progress notes (written descriptions that explain what happened) revealed the May 29, 2026, fall was documented as a late-entry nursing note dated June 2, 2026. The next narrative entries were documented on June 2, 2026, at 10:39 AM and June 2, 2026, at 11:59 PM. The clinical record contained no follow-up narrative documentation related to Resident 1's condition on May 30, May 31, or June 1, 2026, despite the facility policy requiring post-fall documentation for 72 hours following the incident. During an interview on June 23, 2026, at 2:30 PM, the above information was reviewed with the Nursing Home Administrator and Director of Nursing who acknowledged the clinical record was incomplete and omitted required documentation related to the May 29, 2026, fall. 28 Pa Code 211.5(f)(xi) Medical records. 28 PA. Code 211.12 (c)(d)(1)(3) (5) Nursing services.