STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395706	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of East Mountain	101 East Mountain Drive Wilkes-Barre, PA 18702

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on a review of clinical records and the Resident Assessment Instrument (RAI) and staff interview, it was determined the facility failed to ensure the Minimum Data Set Assessment (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of one resident out of 21 sampled (Resident 25). Findings included: A review of Resident 25's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses which included dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and oropharyngeal dysphagia (difficulty swallowing). A current physician order initially dated April 30, 2024, noted an order for Nutren 1.5 (liquid nutritional supplement) 45 ml/hour via peg tube (percutaneous endoscopic gastrostomy tube- feeding tube surgically placed through the abdomen into the stomach, allowing direct delivery of nutrition, fluids, and medications) for enteral feeding (method of delivering nutrition directly into the gastrointestinal tract though a tube). A current physician order initially dated September 19, 2024, noted an order for a full liquid nectar/mildly thick consistency diet (consists of liquids that need to be thickened to a consistency similar to fruit nectar, using a thickener to prevent choking) for pleasure feeding only. A review of Resident 25's quarterly MDS assessment dated [DATE], revealed in Section K0520 Nutritional Approaches the resident did not have a feeding tube (flexible tube inserted into the stomach or small intestine to deliver fluids, medications, and liquid nutrition to individuals who cannot safely or adequately eat or drink by mouth). An interview with the director of nursing on March 7, 2025, at 9:00 AM, confirmed that Resident 25's MDS Assessment was inaccurate. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.12(c)(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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on a review of clinical records and staff interviews, it was determined the facility failed to refer residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for a Preadmission Screening and Resident Review (PASRR) level II resident review for one out of 21 residents (Resident 81). Findings include: Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing facilities for long-term care. The PASRR process requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have serious mental illness before admission. This is called a PASRR Level I screen. Those individuals who test positive for PASRR Level I are then evaluated in-depth; this is called PASRR Level II. The results of this evaluation result in a determination of need, a determination of an appropriate setting, and a set of recommendations for services for the individual's plan of care. A review of the Pennsylvania Department of Human Services Office of Long-Term Living Bulletin titled Revised Pennsylvania Preadmission Screening Resident Review (PASRR) Level 1 Identification Form (MA 376), effective July 1, 2024, revealed if the individual has a change in condition that affects the program office criteria as found on the PASRR Level I form, a PASRR Level II evaluation form will need to be completed. Nursing facilities will communicate the need to have a PASRR Level II form done by notifying the department's Office of Long-Term Living, Division of Nursing Facility Field Operations Team. A clinical record review revealed Resident 81 was admitted to the facility on [DATE], with diagnoses including anxiety and depression. A review of the Pennsylvania Preadmission Screening Resident Review (PASRR) Identification Level I form, dated February 1, 2023, indicated Resident 81 does not have a mental health condition or suspected mental health condition that may lead to a chronic disability (examples include schizophrenia, psychotic disorder, and personality disorder). The form indicated Resident 81 is a negative screen for serious mental illness and no further revaluation (Level II) is necessary. A nurses note dated September 26, 2024, at 3:00 PM noted that Resident 81 was having suicidal thoughts and when asked if he would act upon these the resident stated that it all depends. Resident offered emotional support and when asked if he would seek staff before acting upon suicidal thoughts and harming himself he stated that he could not make any promises. The Physician assistant was contacted with a new order to transfer the resident to the hospital for a psychiatric evaluation. Resident is own resident representative and is in agreement. Staff member sat with resident for safety in the room until the ambulance arrived and transported the resident to the hospital. A nurses note dated September 27, 2024, at 6:11 AM noted the resident was admitted to the hospital. (continued on next page)

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the clinical record revealed the resident was readmitted to the facility on [DATE]. A hospital discharge note dated October 1, 2024, indicated the resident had a diagnosis of suicidal ideation which was stable upon discharge. During an interview on March 7, 2025, at 12:20 PM the consultant social worker, confirmed that Resident 81's inpatient stay in a behavioral unit for evaluation of suicidal ideation was not reported to the state's mental health authority to determine if Resident 81 was appropriately placed in a nursing facility or required additional services to treat his mental health diagnoses. During an interview on March 7, 2025, at approximately 9:00 AM, the Nursing Home Administrator (NHA) confirmed it is the facility's responsibility to ensure all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition are referred for a Preadmission Screening and Resident Review (PASRR) level II. 28 Pa. Code 201.14(a) Responsibility of licensee.

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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 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** 21738 Based on clinical record review, information submitted by the facility, 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 the resident's current needs and services required by one of 21 residents reviewed (Resident 81). Findings include: Review of the clinical record of Resident 81 revealed the resident was admitted to the facility on [DATE], with diagnoses to include depression, and anxiety. On September 26, 2024, at 3:00 PM, nursing documentation indicated that Resident 81 expressed suicidal thoughts and, when asked if he would act upon them, responded, it all depends. The resident was offered emotional support and was asked if he would seek staff assistance before harming himself, to which he responded that he could not make any promises. The physician assistant was contacted, and an order was obtained to transfer the resident to the hospital for psychiatric evaluation. The resident, as his own representative, agreed to the transfer. Staff remained with the resident for safety until the ambulance transported him to the hospital. A nurses note dated September 27, 2024, at 6:11 AM noted the resident was admitted to the hospital. On October 1, 2024, the resident was readmitted to the facility following hospital discharge. The hospital discharge note indicated a diagnosis of suicidal ideation, which was stable upon discharge. An annual Minimum Data Set Assessment (MDS - federally mandated assessment of a resident's abilities and care needs) of Resident 81 dated November 5, 2024, indicated the resident was cognitively intact with a BIMS (brief interview for mental status) score of 15 (13-15 represents intact cognition) and had no mood or behavior issues during the assessment look back period. On January 5, 2025, at 3:18 PM, facility documentation indicated that staff found Resident 81 in his bed with several superficial lacerations on his anterior (front) left forearm. A dry, clean dressing was applied. When questioned, the resident stated, I did it because I want to see my psychiatrist. Initially, the resident claimed he inflicted the injuries using his hand, but later admitted , I used a knife. Staff discovered a pocketknife at the resident's bedside and secured it. The resident provided multiple conflicting explanations regarding how he obtained the knife, stating at different times that a friend brought it, that he had possessed it for [AGE] years, and that he used his nails. The resident admitted to self-inflicting injury due to feelings of hopelessness. Emotional support was provided, and the physician was notified. The resident was transferred to the emergency room for further evaluation, where hospital staff recommended a voluntary psychiatric admission (201 status). A nurses note dated January 6, 2025, at 1:30 PM documented the resident's return from the emergency room . Psychiatric evaluation determined that the resident was not a current threat to himself. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 81's care plan revealed that the resident had a focus area for a history of suicidal ideation with self-harm, initially dated January 19, 2024, and last revised on July 31, 2024. The care plan goal was to ensure the resident's safety in the facility, with interventions including: Contacting the local crisis office if the resident experienced a mental health breakdown, Ensuring psychiatric follow-ups as scheduled, and Providing supportive care services through psychiatry/psychology. However, despite the resident's hospitalization for suicidal ideation from September 29 to October 1, 2024, and his self-inflicted injury on January 5, 2025, a review of the care plan showed that it had not been revised since July 31, 2024. There was no documented evidence that the facility reviewed and revised the resident's care plan to evaluate and implement updated, individualized interventions to address his suicidal statements, self-harming behavior, and mood disturbances. An interview with the Director of Nursing on March 7, 2025, at approximately 11:00 AM, confirmed that the facility failed to review and revise Resident 81's care plan to accurately reflect his current status, risks, and needs. 28 Pa. Code 211.12(d)(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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21738 Based on a review of clinical records and resident and staff interviews it was determined the facility failed to develop and implement an individualized discharge plan for two of 21 residents reviewed (Residents 252 and 81) to reflect the residents' discharge goals. Findings Include: Clinical record review revealed that Resident 251 was admitted to the facility on [DATE], with diagnoses to include alcoholic cirrhosis of the liver (a degenerative disease of the liver resulting in scarring and liver failure). Review of an admission Minimum Data Set Assessment (MDS- a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated December 17, 2024, indicated the resident had a BIMS (brief interview mental screener that aids in detecting cognitive impairment) score of 15 indicating he was cognitively intact. A review of Resident 251's social service notes, revealed a note dated December 11, 2024, indicating the resident would like to be discharged home when able. This note further stated the resident's wife did not want him to be discharged home. There was no documented evidence the facility addressed the desire of the cognitively intact resident to go home and his wife's desire for him to stay in the facility. Further review of Resident 251's clinical record revealed there was no further documentation regarding discharge to home until the resident decided to discharge home AMA (Against Medical Advice) on February 1, 2025. A review of the resident's comprehensive care plan, reviewed during the survey ending March 7, 2025, revealed no documented evidence that an individualized discharge plan was revised, as needed to reflect the resident's current desire for discharge or long-term placement at the facility. During an interview with the Nursing Home Administrator on March 7, 2025, at 12:00 PM confirmed there was no documented evidence of a current discharge goal and plan for this resident. Clinical record review revealed that Resident 81 was admitted to the facility on [DATE], with diagnoses to include depression and anxiety. Review of a quarterly MDS assessment dated [DATE], indicated the resident was cognitively intact with a BIMS score of 15. Interview with Resident 81 on March 5, 2025, at 9:15 AM revealed the resident had a desire to return home with waiver services (an alternative to nursing home placement, allowing individuals to receive long-term care services in their home or community, including assistance with daily activities). The resident stated the facility was aware of his desire to return home. A review of the resident's comprehensive care plan initially dated November 15, 2023, and reviewed during the survey ending March 7, 2025, revealed the resident will remain at the facility for long-term placement with interventions to review and update the discharge plan quarterly and as needed. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence that Resident 81's discharge plan was updated at least quarterly, and the resident agreed with long-term placement in the facility. Interview with the director of nursing on March 5, 2025, at approximately 1:00 PM failed to provide documented evidence the facility implemented a discharge plan that focused on the resident's discharge goal. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 201.29 (a) Resident rights.

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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** 21738 Based on review of clinical records, select facility policy, and resident and staff interview, it was determined the facility failed to consistently provide restorative nursing services as planned to maintain mobility for one resident (Resident 85) out of 21 residents sampled. Findings include: Review of the facility Restorative Nursing Services Policy last reviewed January 16, 2025, indicated a Restorative Nursing Program is utilized to assist residents to achieve and/or maintain their optimal functional level consistent with their capabilities, goals, and preferences. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services (physical, occupational, or speech therapies). Residents may be started on a restorative nursing program upon admission, during the course of a stay or when discharge from rehabilitative care. Restorative goals and objectives are individualized and resident-centered and are outlined in the resident's plan of care. The resident or representative will be encouraged to participate in determining goals and the plan of care. A review of the clinical record revealed Resident 85 was admitted to the facility on [DATE], with diagnoses to include diabetes and congestive heart failure (chronic condition in which the heart does not pump blood as well as it should). A Quarterly Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated January 1, 2025, revealed the Brief Interview for Mental Status (BIMS section of the MDS which assesses cognition, a tool to assess the resident's attention, orientation, and ability to register and recall new information. A score of 8-12 equates to being moderately cognitively impaired) indicated the resident scored a 10, which indicated that she was moderately cognitively impaired, and the resident had the ability to walk at least 150 feet in the corridor or similar space with two staff members. During an interview with Resident 85 on March 4, 2025, at 11:30 AM the resident stated she would like to walk in the hall with nursing more than once per week. Resident 85 noted she needs assistance with ambulation. Resident 85 indicated when she is on therapy the therapist walks with her often but once therapy ends, she feels she gets weaker due to not walking. Resident 85 stated she would like to be on a walking program. Review of Resident 85's Physical Therapy Discharge Summary dated February 28, 2025, revealed the resident was provided gait training with a rolling walker (wheeled mobility aid designed to provide support and stability for individuals with difficulty walking, featuring wheels for easy movement without lifting). Resident 85 was referred for a restorative ambulation program to ambulate with a rolling walker and minimal assistance for 20 feet with a wheelchair following her. The resident's prognosis to maintain current level of functioning is excellent with participation in restorative nursing program. (continued on next page)

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	395706	A. Building B. Wing	03/07/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 85's care plan in effect at the time of the survey ending March 7, 2024, failed to indicate the resident was placed on a restorative ambulation program as recommended by therapy. There was no evidence in the clinical record the restorative ambulation program for Resident 85 was implemented to maintain the resident's current level of functioning upon discharge from therapy on February 28, 2025. Interview with the director of nursing on March 7, 2025, at approximately 11:30 AM failed to provide documented evidence that Resident 85 was placed on a restorative ambulation program as recommended by therapy to maintain the resident's mobility to the extent possible. 28 Pa. Code: 211.5(f)(viii) Medical records 28 Pa Code 211.12(c)(d)(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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on observations and interview, it was determined the facility failed to maintain an environment free of accident hazards to the extent possible in three of three resident hallways Findings include: During an observation conducted on March 4, 2025, at 10:00 AM, the following environmental hazards were identified: In the 200 hallway, three linen carts were positioned at the end of the hallway on the same side, obstructing access to the handrails. Additionally, four linen carts were lined up against the wall in the hallway connecting the 100 and 200 hallways, further occluding the handrails. A floor cleaning machine was also present in this hallway, on the same side, blocking access to the handrails. This hallway included access to the resident dining room, an area of frequent resident traffic. In the 100 resident hallway, plastic storage bins with three drawers, containing Personal Protective Equipment (PPE) such as face masks, gloves, and gowns, were observed in front of resident rooms [ROOM NUMBERS]. A mechanical lift was positioned between rooms [ROOM NUMBERS], all on the same side of the hallway, further restricting access to the handrails. In the 200 resident hallway, additional plastic storage bins containing PPE were observed in front of rooms 200, 207, 213, 215, 217, and 223. Additionally, two wheelchairs were placed outside of room [ROOM NUMBER], further obstructing the resident handrails. In the 300 resident hallway, a plastic storage bin with three drawers containing PPE was observed in front of room [ROOM NUMBER], as well as in front of the 300 hallway mechanical room, impeding access to handrails in these areas. During an interview on March 7, 2025, at 10:00 AM, the Nursing Home Administrator confirmed the above observations and acknowledged that the placement of these items created obstructions in the hallways. The facility failed to ensure that hallways were free from obstructions to allow safe passage for residents, staff, and visitors. 28 Pa. Code 211.12 (d)(4)(5)Nursing Services. 28 Pa Code 201.18 (b)(1) Management

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 26142 Based on observation, review of select facility policy and staff interview, the facility failed to store Oxygen in a safe and secure manner. Findings include: A review of a select facility policy for Oxygen safety, last reviewed January 1, 2025, revealed it is the policy of the facility to provide a safe environment for residents, staff and the public. This policy addresses the use and storage of oxygen equipment. Oxygen storage locations shall be in an enclosure or within an enclosed interior space of non-combustible or limited combustible construction, with doors or gates that can be secured against unauthorized entry. Precautionary signs readable from 5 feet shall be maintained on the door or gate where oxygen is used or stored. (Example: OXYGEN STORED WITHIN-NO SMOKING) On March 4, 2025, at 9:00 A.M., seven full oxygen cylinders were observed in a multi-tank rack on wheels (not secured to the wall or floor) positioned on the right side of the hallway. Five empty oxygen tanks were stored in a similar multi-tank rack on wheels (not secured to the wall or floor) on the left side of the hallway at the end of the west resident hallway near the exit door. Signs posted above the oxygen tanks designated areas for full and empty cylinders. The sign above the full tanks read: Full cylinders only. This area is designated for full O2 (oxygen) cylinders only. If cylinders are used, please place empty cylinders in the carrier to the far left. The sign above the empty tanks read: Empty cylinders only. This area is designated for empty O2 cylinders. If the cylinders are used, please place empty cylinders here. On March 4, 2025, at 2:26 P.M., Employee 1 (Maintenance Assistant) was observed refilling the oxygen storage rack with full tanks, resulting in a total of 12 full oxygen tanks stored in the unsecured hallway location. During an interview on March 4, 2025, at 2:30 P.M., Employee 1 (Maintenance Assistant) stated that an enclosed, locked oxygen storage area is located outside the west hallway exit door. He reported that he removes empty oxygen tanks and replaces them with full tanks inside the hallway every afternoon, stating he has been performing this task forever and that it is just easier for nursing staff to retrieve oxygen from inside rather than going outside to the designated storage area. During an interview March 5, 2025, at 1 P.M., the Nursing Home Administrator confirmed that Oxygen stored in the hallway is not in accordance with the facility policy. 28 Pa. Code 201.18 (b)(3)(e)(1)(2) Management. 28 Pa code 211.12 (d)(1)(2) 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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39929 Based on review of clinical records and staff interview, it was determined the facility failed to provide therapeutic social services to promote the mental and psychosocial well-being of two residents out of 21 sampled (Resident 251 and Resident 81). Findings include: A review of the clinical record revealed that Resident 251 was admitted to the facility on [DATE], with diagnoses to include alcoholism and a history of suicidal ideations. Review of a quarterly Minimum Data Set Assessment (MDS- a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated January 15, 2025, indicated the resident had a BIMS (brief interview mental screener that aids in detecting cognitive impairment) score of 15 indicating he was cognitively intact. Further review of the clinical record indicated the resident expressed a strong desire to be discharged home, but his wife opposed the discharge. The resident frequently voiced frustration and agitation about wanting to leave the facility, yet there was no documented evidence that social services addressed the conflict between the resident and his wife regarding discharge planning. A nursing note dated January 30, 2025, documented that the resident was agitated, restless, and expressed a desire to leave. The facility contacted the resident's wife, who refused to pick him up. On February 1, 2025, the resident signed out Against Medical Advice (AMA). A review of the resident's care plan, initiated December 11, 2024, failed to include interventions related to the resident's alcoholism, history of suicidal ideations, or concerns about discharge planning. The care plan did not address the resident's continued expressions of distress and desire to leave. Additionally, there was no documentation of therapeutic social services provided to support the resident. Interview with the Nursing Home Administrator (NHA) and Director of Nursing (DON), on March 6, 2025, at approximately 2:00 PM revealed the Social Service Director at the time of Resident 251's stay in facility was no longer employed in the facility and there were concerns with the provision of therapeutic social services provided to residents during her employment. A clinical record review revealed Resident 81 was admitted to the facility on [DATE], with diagnoses including anxiety and depression. The resident had a documented history of suicidal ideation and self-harming behaviors, which resulted in multiple hospitalization s for psychiatric evaluation on September 26, 2024, and January 5, 2025. Despite these ongoing concerns, there was no evidence that the facility's social services provided appropriate therapeutic interventions to address the resident's mental health needs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395706	A. Building B. Wing	03/07/2025

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Embassy of East Mountain	101 East Mountain Drive Wilkes-Barre, PA 18702

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A social services note dated January 6, 2025, documented the social worker discussed the possibility of transferring the resident to another facility. However, there was no documentation that social services made any inquiries or acted regarding alternate placement options. Further review of the clinical record revealed no documented evidence that the facility provided therapeutic social services to support Resident 81's mental health needs related to his history of suicidal ideation and self-harming behaviors. An interview with the Director of Nursing (DON) on March 7, 2025, at approximately 9:00 AM confirmed there was no documented evidence that social services interventions were provided to support Resident 81's psychosocial well-being. Refer F657 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.16 (a) Social Services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 26142 Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure the provision of pharmacy services to assure the timely receipt and administration of physician-prescribed medications for three (3) of twenty-one (21) residents reviewed (Residents 90, 64, and 201). The facility also failed to implement a process for providing pharmacy services, including access to emergency medications when not available onsite, and failed to maintain oversight of the facility's medication dispensing system. Findings include: Review of clinical record revealed that Resident 90, was admitted to the facility on [DATE], at 10:45 AM with diagnoses to include chronic obstructive pulmonary disease (COPD- group of lung diseases that block airflow and make it difficult to breathe), dysphagia (difficulty swallowing), depression, and anxiety. A physician order dated February 4, 2025, documented an order for Clonazepam (an antianxiety medication) 1 mg by mouth twice daily for a diagnosis of anxiety. A review of the February 2025 Medication Administration Record (MAR) revealed that Clonazepam was not administered to Resident 90 as prescribed on February 4, 2025, due to awaiting pharmacy delivery. An interview with the Director of Nursing (DON) on March 5, 2025, at approximately 11:00 AM confirmed that the medication was not available in the facility due to a delay in pharmacy delivery. Review of the clinical record revealed Resident 64 was admitted to the facility on [DATE] with diagnosis to include dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), and congestive heart failure (weakness of the heart that leads to build-up of fluid in the lungs and surrounding body tissues). The resident sustained a fall on February 23, 2025, at 9:30 PM and was hospitalized with fractures of the right hip and right pubic ramus. Upon readmission to the facility on [DATE], at 3:00 PM the resident had physician orders for Oxycodone HCL 5 mg every 4 hours (a narcotic opioid pain medication) for moderate pain as needed, hospital documentation, The resident received 2 doses of oxycodone in the hospital, one at 5:57 AM and another at 10:19 AM. A review of the facility physician orders dated February 24, 2025, at 9:00 PM revealed an order for Oxycodone HCL 5 mg by mouth every 4 hours as needed for pain rated 6-10 on the pain scale. However, this order was discontinued on February 25, 2025, at 7:00 AM. A new order for Oxycodone HCL 5 mg every 4 hours as needed for pain was re-entered on February 25, 2025, at 7:00 AM, with the addition of non-pharmacological interventions. A review of Resident 64's February 2025 Medication Administration Record (MAR) indicated that the resident did not receive Oxycodone on February 24, 2025, February 25, 2025, February 26, 2025, or February 27, 2025. The first recorded administration of Oxycodone was at 7:09 AM on February 27, 2025. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing documentation dated February 27, 2025, at 6:09 AM noted that the resident exhibited increased confusion throughout the night, reporting visual hallucinations of children in her room. She remained awake all night and was unable to be redirected or oriented to time and place. The documentation further stated that she complained of pain and was given Tylenol instead of Oxycodone. A note was placed on the provider's communication board requesting a signed prescription for Oxycodone HCL 5 mg. The documentation also indicated that the medication had not been available in the facility since the resident's hospital discharge. A review of the clinical record confirmed that the medication was not administered due to a delay in delivery from the pharmacy. An interview with the Director of Nursing (DON) on March 5, 2025, at 2:15 PM revealed that the facility's procedure when a medication is unavailable from the pharmacy is to check the emergency supply to determine if the medication is available. If the medication is not available, the physician should be consulted for further instruction. A review of the facility's emergency medication supply confirmed that Oxycodone HCL 5 mg was not available in the emergency cart. Clinical record review revealed that Resident 201 was admitted to the facility on [DATE], with diagnoses to include aftercare and therapy after hospitalization , muscle weakness and atrial fibrillation (an irregular heartbeat reducing the heart's ability to pump blood through the body reducing oxygen supply). Review of an admission Minimum Data Set Assessment (MDS- a federally mandated standardized assessment process completed at specific intervals to plan resident care) dated January 17, 2024, indicated the resident had a BIMS (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 13-15 equates to being cognitively intact) score of 15 indicating he was cognitively intact. Review of Resident 201's January 2025 Medication Administration Record revealed Physician orders to include: Diltiazem HCl ER 300 mg daily for hypertension Oxycodone-Acetaminophen 5-325 mg every 6 hours as needed for moderate pain Levothyroxine Sodium 88 mcg daily for thyroid management. A review of the January 2025 MAR (medication administration record) revealed that Diltiazem HCl ER, Oxycodone-Acetaminophen, and Levothyroxine Sodium were not administered on January 15, 2025, due to pharmacy delays, and were not available until January 16, 2025. The DON confirmed on March 5, 2025, that the medications were unavailable and not stocked in the emergency supply A review of facility pharmacy policy reviewed January 16, 2025, entitled, Emergency Medication System: Removal of Outdated Medications revealed, the contract pharmacy staff shall perform routine audits of the system to ensure the integrity of contents and outdated or soon to be outdated contents are removed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procedures to include, Audits shall be performed routinely to ensure the OOS (Pyxis like system, an automated, medication system, located in the facility) do not contain outdated medications. Medications should be removed at least 90 days prior to expiration. Non-controlled medications may be returned outdated/excess medications to the pharmacy. Non-controlled medications may be returned to the pharmacy by courier during the daily medication delivery return process. A list of medications removed shall be created and signed by both the pharmacy staff and the nursing staff. A list of each item and quantity shall be provided to the facility. A review of the facility's emergency medication supply and observation of the automated medication dispensing system on March 7, 2025, at 12:00 PM, revealed discrepancies between the recorded medication inventory and the actual stock. The noted medication's expiration dates in the system did not match the actual expiration dates on the unit dose packs of the meds contained in the machine and medications listed as available were not physically present. The facility failed to provide documentation of pharmacy oversight, including routine monthly audits for expired medications and medication availability. A review of the facility's Medication Ordering and Receipt, After-Hours Pharmacy Service policy revealed that emergency pharmaceutical services are available 24 hours a day, 365 days a year. According to the policy, emergency medication needs should be met using onsite supplies provided by the pharmacy, including an emergency box, interim box, starter kit, controlled substance interim box, and an electronic cabinet, as permitted by regulations. The policy further states that STAT (immediate) medication requests can be made to the pharmacy and that a corporate pharmacist is available 24/7 to either dispense medications from the pharmacy or arrange for dispensing from a backup pharmacy to meet the facility's medication needs. However, during an interview on March 7, 2025, at 11:00 AM the Director of Nursing (DON) and Nursing Home Administrator (NHA) confirmed the facility did not have a backup emergency pharmacy, despite the policy stating that one should be available. They stated the facility relied solely on an out of state-based pharmacy with daily courier deliveries. Additionally, they acknowledged that facility nursing staff, rather than trained pharmacy personnel, were responsible for restocking the automated medication dispensing system. The DON further confirmed that facility staff had not received training from a pharmacist on proper restocking procedures and that no documentation of pharmacy oversight or staff training was provided during the survey. The facility failed to provide timely access to physician-prescribed medications for multiple residents, resulting in delays in the administration of essential medications, including pain management and critical daily prescriptions. Additionally, the facility lacked a process to ensure emergency medication availability and failed to maintain proper oversight of the medication dispensing system. 28 Pa. Code 211.9 (a)(l)(d)(k) Pharmacy Services. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing Services.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on review of clinical records and resident payor source data, and staff interview, it was determined the facility failed to offer routine annual dental services for two private payor source residents (Residents 60 and 39) out of four residents sampled for dental services. Findings include: Review of Resident 60's clinical record revealed admission to the facility on [DATE], with diagnoses to include Alzheimer's disease (a progressive brain disease that destroys memory and other important mental functions) and COPD (chronic obstructive pulmonary disease-lung disease that blocks airflow and makes it difficult to breathe). The resident was identified as private payor source. Review of Resident 60's quarterly Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated February 9, 2025, indicated that the resident was severely cognitively impaired. There was no documented evidence in the clinical record at the time of the survey ending March 7, 2025, that Resident 60's responsible party was offered routine annual dental services for Resident 60 in the past year. Review of Resident 39's clinical record revealed admission to the facility on [DATE], with diagnosis to include Alzheimer's disease and muscle weakness. The resident was identified as private payor source. There was no documented evidence in the clinical record at the time of the survey ending March 7, 2025, that Resident 39's responsible party was offered routine annual dental services for Resident 60 in the past year. Interview with the Director of Nursing on March 6, 2025, at 9:15 AM confirmed that Resdient 60 and 39's resident's responsible party had not been consulted regarding offering of dental services in the past year. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48277 Based on review of clinical records and resident payor source data, and staff interview, it was determined the facility failed to offer routine annual dental services for one Medicaid payor source resident (Resident 64) out of four residents sampled for dental services. Findings include: Review of Resident 64's clinical record revealed admission to the facility on [DATE] with diagnosis to include dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), and congestive heart failure (weakness of the heart that leads to build-up of fluid in the lungs and surrounding body tissues). The resident was identified as Medicaid payor source. Review of Resident 64's Annual Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated November 18, 2024, indicated that the resident was moderately cognitively impaired. There was no documented evidence in the clinical record at the time of the survey ending March 7, 2025, that Resident 64's responsible party was offered routine annual dental services for Resident 64 in the past year. Interview with the Director of Nursing on March 6, 2025, at 9:15 AM confirmed that the resident's responsible party had not been consulted regarding the offering of dental services for Resident 64 in the past year. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 26142 Based on a review of the facility's automated emergency medication system, applicable state regulations, facility policies, and staff interviews, it was determined that the facility failed to comply with Federal, State, and Local laws and professional standards by not ensuring pharmacy services necessary for daily pharmacy operations according to state requirements of Pa. Code title 49. Findings include: A review of Pennsylvania Code title 49, part I, subpart A, chapter 27 - STATE BOARD OF PHARMACY, 49 Pa. Code S 27.204 - Automated medication systems revealed: (a) This section establishes standards applicable to licensed pharmacies that utilize automated medication systems which may be used to store, package, dispense or distribute prescriptions. (b) A pharmacy may use an automated medication system to fill prescriptions or medication orders provided that: (1) The pharmacist manager, or the pharmacist under contract with a long-term care facility responsible for the dispensing of medications if an automated medication system is utilized at a location which does not have a pharmacy onsite, is responsible for the supervision of the operation of the system. (4) The automated medication system must electronically record the activity of each pharmacist, technician or other authorized personnel with the time, date and initials or other identifier so that a clear, readily retrievable audit trail is established. A pharmacist will be held responsible for transactions performed by that pharmacist or under the supervision of that pharmacist. (c) The pharmacist manager or the pharmacist under contract with a long-term care facility responsible for the delivery of medications shall be responsible for the following (2) Ensuring that medications in the automated medication system are inspected, at least monthly, for expiration date, misbranding and physical integrity, and ensuring that the automated medication system is inspected, at least monthly, for security and accountability. (4) Ensuring that the automated medication system is stocked accurately, and an accountability record is maintained in accordance with the written policies and procedures of operation. (5) Ensuring compliance with the applicable provisions of State and Federal law. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(6) Set forth methods that ensure that access to the automated medication system for stocking and removal of medications is limited to licensed pharmacists or the pharmacist's designee acting under the supervision of a licensed pharmacist. An accountability record which documents all transactions relative to stocking and removing medications from the automated medication system must be maintained. (g) The pharmacist manager shall be responsible for ensuring that, prior to performing any services in connection with an automated medication system, all licensed practitioners and supportive personnel are trained in the pharmacy's standard operating procedures with regard to automated medication systems set forth in the written policies and procedures. The training shall be documented and available for inspection. Specifically, the facility failed to ensure: The oversight and management of the automated medication system as required by Pennsylvania Code Title 49, Chapter 27, which mandates pharmacist supervision, system inspections, and proper medication accountability. The timely delivery and availability of prescribed medications, leading to multiple instances of missed doses for residents, including Clonazepam for Resident 90, Oxycodone for Resident 64, and Diltiazem, Levothyroxine, and Oxycodone-Acetaminophen for Resident 201. The maintenance of a readily retrievable audit trail and documented oversight of the automated medication system. The Pennsylvania code Title 49 require that automated medication systems be managed under the supervision of a pharmacist and include documentation of oversight activities, system inspections, and accountability for stocking and removing medications. However, the facility failed to provide documentation verifying that the required oversight and management of the automated medication system were conducted. During an interview on March 7, 2025, at 11:00 AM, the Nursing Home Administrator confirmed the facility pharmacy did not adhere to the Pennsylvania code regarding pharmacy services. She further stated that documentation regarding oversight of the system was unavailable, and that pharmacy staff were not actively managing the system. This lack of oversight contributed to medication availability issues, delays in administration, and a failure to maintain regulatory compliance. Cross refer F755 28 Pa. Code 201.18 (b)(3)(e)(1)Management. 28 Pa. Code 211.9 (a)(l)(d)(k)(l)(1)(2)(3) Pharmacy Services. 28 Pa. Code 211.12 (d)(3)(5) Nursing Services.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on clinical record review, and staff interview, it was determined the facility failed to ensure coordination of Hospice services with facility services to meet each individual residents' needs daily for the management of a terminal illness of one of two residents reviewed receiving hospice services. (Resident 54 and 61). Findings include: A review of the clinical record revealed that Resident 54 was admitted to the facility on [DATE], with diagnoses of cerebral infarct (stroke). The resident was admitted to hospice services on February 5, 2025, for cerebral infarct. Review of Resident 54's plan of care, during the survey ending March 7, 2025, revealed no evidence the resident's plan of care was integrated with hospice services to demonstrate coordination of care and services to meet the resident's needs related to the care of the resident's terminal illness daily. A review of the clinical record revealed that Resident 61 was admitted to the facility on [DATE], with diagnoses of dementia, chronic obstructive pulmonary disease (a progressive lung disease) and anxiety. The resident was admitted to hospice services on October 10, 2024, for end stage chronic obstructive pulmonary disease. Review of Resident 61's plan of care, during the survey ending March 7, 2025, revealed the resident's care plan failed to reflect coordination of services between the facility and the Hospice agency in meeting the resident's daily care needs and specific needs related to care and services provided for the resident's terminal diagnosis. There was no evidence the hospice and the nursing home collaborated in the development of a coordinated plan of care for each resident receiving hospice services to identify the provider responsible for performing each or any specific services/functions that have been agreed upon and the location of the necessary plans. During interview with the Director of Nursing (DON) on March 6, 2025, at 2:00PM she confirmed the residents' care plans were not integrated/coordinated with hospice for Resident 54 and 61. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services