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	01/09/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** Based on observations, review of clinical records, review of select facility policies and information submitted by the facility, and staff interviews, it was determined that the facility failed to provide adequate staff supervision of a resident to monitor the resident's whereabouts and timely identify the resident's absence from the facility to assure prompt implementation of established procedures for a missing resident, which placed the resident in immediate jeopardy for one out of 19 residents sampled (Resident 26). Following this elopement the facility further failed to promptly identify the resident's absence as well as identify supervisory and safety needs to prevent unsupervised exits from the facility, which placed residents in immediate jeopardy of unsupervised exits from the facility and the potential for serious bodily injury or death. Findings include: A review of the facility policy entitled Elopement and Wandering Residents, last reviewed January 16, 2025, revealed it was the policy of the facility to ensure that residents who exhibit wandering behavior or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their plan of care. The policy further required residents to be assessed for risk of wandering and elopement upon admission and throughout their stay by the interdisciplinary team. Clinical record review revealed that Resident 26 was admitted to the facility on [DATE], with diagnosis to include Mild Intellectual Disability (a developmental condition characterized by below-average cognitive functioning and adaptive skills, allowing individuals to learn practical life skills with minimal support). The resident's functional status was independent with ambulation. Review of a quarterly Minimum Data Set assessment (MDS, federally mandated standardized assessment conducted at specific intervals to plan resident care) dated November 22, 2025, revealed the resident had a BIMS score of 11 (Brief Interview for Mental status, a tool to assess the resident's cognition, orientation, and ability to register and recall new information). A score of 8-12 indicates moderate cognitive impairment. Review of information provided by the facility revealed they eliminated the receptionist position, resulting in no staff assigned to monitor the front lobby or main entrance. The receptionist's last day was December 9, 2025. A request was made on January 6, 2026, at 10:30 AM for Resident 26's initial elopement risk assessment. The assessment was not provided to the surveyor and was not located in the electronic medical record. Concurrent interview with the Director of Nursing revealed that the resident was not considered an elopement risk. Review of the resident's care plan, initiated April 4, 2025, did not identify the resident as an elopement risk, despite documentation noting difficulty adjusting to placement in the facility. Review of facility investigative documentation dated December 22, 2025, at 12:35 PM revealed the facility was notified by Resident 26's legal guardian that she was at her private residence. Documentation indicated Resident 26 was last seen at 10:30 AM in the main lobby of the facility requesting staff assistance to make telephone calls to her guardian. Review of facility surveillance video revealed Resident 26 exited the facility through the lobby door at 11:03 AM without staff awareness. The resident returned to the facility at 1:06 PM via a neighbor's private vehicle. Upon return, nursing documentation indicated Resident 26 was wearing a coat, hoodie, pants, and sneakers. A body audit and temperature assessment were completed, revealing a temperature of (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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	97.2 degrees Fahrenheit. Resident 26 had an open area on her left great toe measuring 2 cm (centimeter) by 2 cm by 0.1 cm, with a small amount of serous (clear) drainage and an epithelialized base (new skin growth). Review of the investigative documentation and staff interviews revealed Resident 26 walked to her home, located two to three miles from the facility, during winter weather conditions (the temperature was 30 degrees Fahrenheit) in an area of heavy vehicular traffic, exposing her to environmental hazards and risk of serious injury. During a telephone interview conducted on January 6, 2026, at 12:27 PM, Resident 26's legal guardian stated she received a phone call from the resident at 10:32 AM on December 22, 2025. Resident 26 stated she wanted to leave the facility and go home. The guardian stated she sent a maintenance worker to check on the condition of the resident's home. At 12:35 PM, the guardian received a text message confirming Resident 26 was present at the home. The guardian contacted the facility and informed the Director of Nursing that Resident 26 was found at her home. At that time, licensed nursing staff were unaware the resident was not at the facility. Resident 26's absence from the facility was a little over two hours. Review of the Director of Social Service witness statement dated December 22, 2025, indicated Resident 26 was observed in the lobby at 10:30 AM talking on the telephone. Review of Employee 5's, Licensed Practical Nurse, witness statement dated December 22, 2025, indicated Resident 26 was last seen around 10:30 AM on the west wing walking toward the dining room with her father, who is also a resident of the facility. Licensed nursing staff failed to identify Resident 26's absence until notified by the legal guardian. The facility permitted access to an unlocked and unmonitored exit, lacked a system to account for resident whereabouts in common areas such as the lobby, and failed to ensure adequate staff supervision. These failures resulted in the resident leaving the facility unsupervised and placed her at Immediate Jeopardy, with ongoing risk to other residents for elopement, and serious bodily injury, or death. Following the incident, the facility relocated Resident 26 to a secure unit, despite the resident not having a diagnosis of dementia. The Nursing Home Administrator was notified of the Immediate Jeopardy (IJ) and provided the IJ Template on January 6, 2026, at 2:30 PM. In response, the facility submitted a written Immediate Jeopardy action plan at 5:15 PM on January 6, 2026. The plan included the following corrective actions: The resident is currently accounted for and had no ill effects from the incident. A skin assessment was initially completed on December 22, 2025, at 2:55 PM and another assessment on December 23, 2025, with no new findings. Elopement assessment completed on Resident 26, which indicated resident is at high risk for elopement and was moved to secure ACU (advanced cognitive unit) unit. Guardian and MD (physician) Notified. Care plan updated. Director of Nursing (DON) completed elopement assessments on all residents with a BIMS of 11 or less Residents identified as high risk had care plans updated, and appropriate intervention were reviewed and updated. Elopement binders updated in facility. Education was provided to all staff on the elopement policy. Policy reviewed and no changes noted. Random weekly audits to be completed by DON to identify any elopement concerns. Residents with wander guard were checked for function and placements on December 22, 2025. New elopement assessments were completed. Doors will be checked every shift by maintenance/designee daily for 4 weeks. Elopement drills will be completed on January 6, 2026, with day shift staff. Elopement drills will continue monthly. Audits weekly x 4 weeks, then monthly x 4 months. Results will be reviewed during QAPI meeting. On January 6, 2026, all doors will be locked at all times. New doorbell installed in foyer. Signage posted through facility, main lobby, reception and all nursing stations. All staff educated regarding all doors locked at all times on January 6, 2026. Date of compliance will be January 7, 2026. Verification of implementation of the Immediate Jeopardy action plan was completed, and the Immediate Jeopardy was determined to have been removed on January 7, 2026, at 10:15 AM after it was verified that the corrective actions had been fully implemented and were effective in removing the immediate threat to resident health and safety. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18 (e)(1) (2.1) (3) Management.28 Pa. Code 211.10 (d) Resident care policies.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on a review of facility policy, the minutes from facility Resident Council meetings, and grievances filed with the facility, and resident and staff interviews, it was determined the facility failed to put forth sufficient efforts to promptly resolve continued resident complaints and grievances expressed during Resident Council meetings and verbal grievances, including those voiced by five of five residents attending a resident group meeting (Residents 51, 58, 63, 73, and 99) and failed to keep the residents apprised of the status of the facility's decisions and efforts toward grievance resolution.Findings include: A review of the facility's Grievance Policy last reviewed on January 16, 2025, indicated the residents', families, and their representatives have the right to voice grievances concerning care and treatment, behavior of staff or other residents or any concerns regarding their stay. Further stating the grievance official will keep the resident apprised of progress of resolution of grievance. A review of the Minutes from a Resident Council meeting, which included a food committee review, dated June 4, 2025, revealed concerns from residents that snacks were not being provided in the evening. Review of grievances revealed no documented evidence of a grievance regarding this concern and no evidence of any corrective actions taken to address this issue. A review of the grievance list of any grievances for the month of December 2025, provided by the facility on January 7, 2026, showed only one grievance for the month of December regarding missing clothing. A group meeting conducted on January 7, 2026, at 10:00 a.m. with five residents (Residents 51, 58, 63, 73, and 99) revealed multiple concerns regarding potential new ownership and significant changes that the facility has been implementing since December 2025, including (of significant concern to all the residents in attendance) the lack of activities. All residents in attendance also had concerns regarding shower temperatures in both the east and west halls, lack of snacks and inability to get snacks after dinner. During this meeting surveyor asked residents if they were aware of the grievance process, all residents in attendance stated that they had filed grievances after the last resident council meeting on December 17, 2025. Further stating there had been no follow up in regard to these grievances. These grievances were not part of the grievance list from December provided to surveyors by the facility. Upon further inquiry after the resident council meeting on January 7. 2026, the Director of Social Services provided these grievances to surveyor. These grievances had been modified, the bottom part of the paper which would generally indicate resolution to grievance had been cut off, thus leaving only the concern with no documented resolution. These grievances all stated the same thing, that the residents were concerned and upset about the lack of services being provided by the facility specifically Activities. When the Director of Social Services was further interviewed on January 8, 2026, at 11:00 a.m., she indicated she had been advised by former Nursing Home Administrator to cut off the bottom of the grievance form which would document resolution and was unable to provide evidence that these grievances had been addressed. The facility was unable to provide documented evidence that efforts had been made to resolve resident complaints concerning activities as of the survey ending January 9, 2026, that had been brought up during resident council meeting. During an interview on January 8, 2026 at 11:10 a.m., the Director of Nursing (DON) confirmed the absence of documented actions addressing grievances raised during Resident Council meetings or verbal complaints. 28 Pa. Code 201.18 (e)(1)(4) Management.28 Pa. Code 201.29(a) Resident Rights.28 Pa. Code 211.10 (d) Resident care policies

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and resident and staff interviews, it was determined the facility failed to maintain a safe, sanitary, and homelike environment in two out of three resident shower rooms (East and West). Findings include: During a resident council meeting on January 7, 2026, at 10:10 AM, interviews with five cognitively intact residents, Residents 73, 51, 58, 63, and 99, it was reported during the month of December through present, the temperatures inside the East shower room was frequently cold and uncomfortable and the [NAME] shower room's hot water intermittently went cold during showers and was uncomfortable. All residents reported nursing staff were aware, but nothing was addressed. During an observation of the [NAME] shower room with facility's maintenance director on January 7, 2026, at 10:55 AM, observed contractors and the regional maintenance director investigating issues with the water heating system. An interview with Employee 2, a nurse aide, January 7, 2026, at 11:02 AM, revealed staff were able to complete some resident showers in the [NAME] shower room but the water temperature got colder with increased use. Additionally, it was reported that when the water temperature was not a comfortable temperature, nursing staff used the East shower room. A review of facility provided daily water temperature logs for East and [NAME] shower rooms dated December 2025, through survey ending January 9, 2026, revealed no recorded temperature monitoring on the following dates: December 1, 2025, through December 5, 2025, December 6, 2025, through December 7, 2025, December 13, 2025, through December 14, 2025, December 20, 2025, through December 21, 2025, December 27, 2025, through December 28, 2025, and January 3, 2026, through January 4, 2026, or forty-two (42) missed recordings/observations. Observations of the East resident shower room in the presence of the facility's maintenance director present on January 7, 2026, at 11:04 AM, revealed the environmental temperature was only 65 degrees Fahrenheit and felt uncomfortably cold. Additionally, inside the shower room observed a strong urine smell, missing/loose tiles along the baseboard, and a buildup of a black substance in the corners and crevices around drains and baseboard. A review of a work order (6693) submitted by nursing dated December 5, 2025, at 6:15 AM, indicated the East shower room's environmental temperature was 68 degrees Fahrenheit. During an interview with the facility's maintenance director on January 7, 2026, at 11:05 AM, it was reported that he worked at a sister facility and starting work at the building as the maintenance director on October 20, 2025, and identified some maintenance issues throughout the facility that included the heating system that heated the East shower room but didn't get to repair it yet. The above findings were reviewed with the facility's interim Nursing Home Administrator (NHA) on January 8, 2026, at 12:30 PM, and confirmed the resident's shower rooms should be maintained to assure comfortable temperatures and a clean area for a homelike environment. 28 Pa Code 207.2(a) Administrator's responsibility.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on a review of scheduled activities and resident and staff interviews, it was determined the facility failed to provide an ongoing program of activities to meet the interests of and support the physical, mental, and psychosocial well-being of residents including experiences expressed by five out of five residents during a resident group interview (Residents 51, 58, 63, 73, and 99).Findings include: During a resident group interview conducted on January 7, 2026, at 10:00 AM, five out of five residents interviewed (Residents 51, 58, 63, 73, and 99) expressed concerns regarding the lack of available activities within the facility. Residents stated there were no meaningful activities being offered that aligned with their interests. Resident 51, identified as the Resident Council President, reported that all activity staff had either resigned or were no longer employed by the facility. Resident 51 further stated that the most recent activity offered was BINGO on Monday, January 5, 2026, which was facilitated by a nurse aide due to the absence of activity department staff. All residents present verbalized frustration and disappointment regarding the lack of activities and expressed sadness over the departure of the former Activity Director, whom they described as kind and effective in providing enjoyable activities. The residents interviewed consistently reported no alternative or substitute activities were provided following the departure of activity staff. A review of the facility's January 2026 activity calendar revealed scheduled activities that did not occur. Specifically, the calendar listed a coffee social scheduled for January 6, 2026, at 10:00 AM and puzzles scheduled for January 6, 2026, at 2:00 PM. Documentation and resident interviews confirmed these activities did not take place. Additionally, the calendar listed a coffee social scheduled for January 7, 2026, at 10:00 AM, which also did not occur. No documentation was provided to indicate alternative activities were offered in place of those scheduled. During an interview conducted on January 7, 2026, at 11:00 AM, the Director of Nursing (DON) stated the facility previously employed four activity staff members, consisting of one Activity Director, two part-time activity aides, and one per diem (as needed) activity aide. The DON explained that a recent administrative decision resulted in the allocation of only one activity staff position for the facility. The DON confirmed the Activity Director resigned, with her last day of employment being December 31, 2025. The DON further stated the last remaining activity aide's final day of employment was January 2, 2026. According to the DON, a new Activity Director was expected to begin employment on or about January 8 or January 9, 2026. The DON confirmed that no activities had been conducted by activity staff from January 2, 2026, through the date of the interview. During a separate interview conducted on January 7, 2026, at 9:15 AM, the DON acknowledged the facility was not currently offering a structured activities program for residents. The DON confirmed there were no scheduled or implemented activities at that time, including the absence of evening activities. 28 Pa. Code 201.18 (b)(3)(e)(6) Management.201.14(a) Responsibility of licensee.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on review of facility documentation and staff interviews it was determined the facility failed to employ and maintain a qualified activities director.Findings include: Review of facility documentation: job description Activity Director: The primary purpose of the job position is to plan, organize, develop, direct and implement the overall operation of the Activity Department in accordance with current, federal, state, and local standards, guidelines and regulations, our established policies and procedures, and as may be directed by the Administrator, to assure that an on-going program of activities is designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. During an interview on January 7, 2026, at 1:00 PM with the Director of Nursing and Regional Nurse Consultant, it was reported the Activities Director left employment on December 31, 2025. The DON and Regional Nurse Consultant confirmed that since December 31, 2025, there has been no activities director. An individual has been hired as an activities director and is expected to begin employment on January 8, 2025. A review of the newly hired activities director's application for employment date August 13, 2025 reveled no experience or qualification as an activity director. Interview with the NHA on January 8, 2026, at 9:38 AM confirmed the newly hired activities director does not possess the minimal qualifications. The newly hired activities director is not licensed, registered or eligible for certification as a therapeutic recreation specialist, is not an activities professional recognized by an accrediting body, and does not possess two years of experience in a social or recreational program within the last five years. Since December 31, 2025, the facility does not have a qualified professional to direct the provision of activities to the residents. 28 Pa. Code 201.18 (e)(6) Management.28 Pa. Code 201.9(3) Personnel policies and procedures.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observations and resident and staff interviews, it was determined the facility failed to consistently provide snacks as desired by residents, including experiences reported by five out of five residents during a group interview (Residents 73, 51, 58, 63, and 99).Findings included: During a resident group interview with cognitively intact residents, Residents 73, 51, 58, 63, and 99, on January 7, 2026, at 10:10 AM, reported since a decrease in the facility's activity department staffing, no evening/bedtime snacks were being passed to residents and would like to receive an evening/bedtime snack. The residents reported after dinner activities staff would obtain snacks from the dietary department and come around to each unit to pass snacks as per resident preference. However, this process had not been occurring for about three weeks. Observations of the [NAME] resident pantry on January 7, 2026, at 11:15 AM, revealed inside the cupboards only two open boxes of oatmeal cream pies and cookies available for residents and not enough for all residing on the unit. The resident refrigerator/freezer contained items brought in from outside the facility for specific residents, pitchers of fruit punch and lemonade, and applesauce for medication passes. During an interview with the Direcor of Nursing (DON) on January 9, 2026, at 12:25 PM, the above was reviewed. The DON reported the activities staff were responsible for distributing evening/bedtime snacks to residents. However, since a decrease in the facility's activities department staff, a new process for the evening/bedtime snack pass had not been established or tasked to alternative staff/departments. Further interview with the DON confirmed that residents were not consistently receiving snacks as desired and confirmed residents should receive a nourishing snack in accordance with their needs, preferences, and requests at bedtime on a daily basis.28 Pa. Code 211.12 (d)(3)(5) Nursing Services

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observations, review of clinical records, review of select facility policies and job descriptions, information submitted by the facility, and staff interviews, it was determined that the facility failed to ensure effective administrative oversight to maintain systems necessary to provide a safe environment and adequate supervision to prevent resident elopement. This failure resulted in Immediate Jeopardy to the health and safety of one resident (Resident 26) out of 19 residents sampled and placed other residents at risk for serious bodily injury or death.Findings included: A review of the job description for the Nursing Home Administrator (NHA) signed and dated July 7, 2025 revealed the NHA must be knowledgeable of and demonstrate the ability to provide quality care by fostering a safe environment for residents and staff; provide emotional and psychological support for the residents within the facility, direct and oversee the day to day operation of the facility to ensure the highest degree of quality of care is maintained at all times in accordance with current state and federal standards, and implement and enforce company policies and procedures to that end. The job description further identified responsibilities that include planning, developing, organizing, implementing, and directing programs and activities; assisting departments in the use of departmental policies and procedures; fostering interdepartmental rapport and teamwork with an emphasis on safety; and assuring that all employees, residents, and visitors follow established policies and procedures. A review of the Director of Nursing Services (DON) job description, signed and dated June 1, 2024, outlined responsibilities that included planning, organizing, developing and directing the overall operation of the resident care department in accordance with all current regulatory standards to ensure the highest degree of quality care, knowledge of professional nursing theory and practice to provide first class resident care, expert knowledge of policies, regulations and procedures governing resident care, expert knowledge of medical equipment and instruments to administer resident care. The ability to apply the principles, methods, and techniques of professional nursing associated with long term resident care; preparing and maintaining detailed records, writing reports, and responding to correspondence; cultivate and manage effective working relationships with residents, medical staff, and the community; effectively manage regulatory and company compliant quality control standards and demonstrate effective verbal and written English communication. The position responsibilities included the DON would evaluate effects of care delivered and assign special treatments when indicated, assure resident safety through nursing staff, integrate and coordinate care with other disciplines, determine and schedule the staffing needs to meet the total care needs of the residents, develop, implement, and maintain an effective staff orientation plan, ensure that personnel follow established departmental policies and procedures and provide discipline as necessary. Despite these clearly defined administrative and nursing leadership responsibilities, the facility failed to ensure that effective systems were in place to monitor resident whereabouts, supervise common areas, and promptly identify and respond to a missing resident. As a result, Resident 26 exited the facility through an unlocked and unmonitored lobby door without staff awareness and remained absent from the facility for more than two hours. Licensed nursing staff were unaware the resident was missing until notified by the resident's legal guardian. The investigation further revealed that the facility had eliminated the receptionist position and failed to implement alternative systems to monitor the front lobby and main entrance. This administrative decision resulted in an unmonitored point of exit and directly contributed to the facility's inability to detect Resident 26's unsupervised exit and to promptly identify the resident's absence. The Administration failed to provide adequate monitoring and failed to implement effective nursing interventions to prevent Resident 26's elopement. In addition, there was insufficient coordination and direction of staff to ensure the safety of other residents identified as at risk for elopement. Following the elopement, the facility failed to demonstrate that effective supervisory systems had been implemented to identify and mitigate elopement risks for other residents. The facility's inability to implement and enforce policies and oversight systems to monitor (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents and address elopement risks resulted in Immediate Jeopardy to the health and safety of eight residents, reflecting a systemic failure in administrative oversight, leadership accountability, and resource allocation necessary to ensure a safe environment. Immediate Jeopardy was identified on January 6, 2026, at 2:30 PM, as the facility's actions and inactions caused, or were likely to cause, serious injury, harm, impairment, or death. Refer F689 28 Pa. Code: 201.14 (a) Responsibility of licensee 28 Pa. Code: 201.18 (e)(1) Management 28 Pa. Code 211.12 (c)(d)(1) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on a review of clinical records, select facility policy, observation, and resident and staff interviews, it was determined the facility failed to ensure oxygen therapy was administered per physician orders consistent with the professional standard of practice for one resident out of 18 sampled (Resident 40).Findings include: A review of the facility policy titled Oxygen Administration, last reviewed by the facility on January 16, 2025, revealed it is the facility's policy to provide oxygen therapy to residents who need it, consistent with professional standards of practice that are comprehensive person-centered care plans, and the resident's goals and preferences. The policy indicates oxygen is administered under orders of a physician, except in the case of an emergency. Personnel authorized to initiate oxygen therapy include physicians, RNs, LPNs, and respiratory therapists according to the policy. A clinical record review revealed Resident 40 was admitted to the facility April 15, 2024, with diagnoses that include peripheral vascular disease (a disorder of the blood vessels outside the heart that affects blood flow to the limbs). Further clinical record review revealed Resident 40 providers orders included administration of Oxygen at 2 liters per minute via nasal cannula (a medical device used to deliver supplemental oxygen to a patient through their nostrils) as needed for shortness of breath. The order was dated December 22, 2025, at 7:00 AM. An observation on January 6, 2025, at 11:24 AM, at 12:10 PM revealed Resident 40 was awake in bed, the head of bed was elevated, with supplemental oxygen in place via an oxygen concentrator with the liter flow set at 0.5 liters per minute. Tubing connected the oxygen concentrator to her via a nasal cannula. Resident 40 was in no distress, breathing easily and able to speak without demonstrating shortness of breath. During an interview on January 6, 2025, at 12:05 PM, Employee 1, Licensed Practical Nurse (LPN), confirmed Resident 40 should be receiving continuous oxygen via a nasal cannula at 2 liters per minute. During an interview on January 7, 2025, at 1:00 PM, the Director of Nursing (DON) and Regional Nurse Consultant confirmed it is the facility's responsibility to ensure oxygen therapy is administered by provider orders and consistent with professional standards of practice. 28 Pa. Code 211.10 (c) Resident care policies.28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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	01/09/2026

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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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documents, clinical records, and staff and resident interviews, it was determined that the facility failed to ensure physician review and oversight of recommendations provided by a consulting medical specialist for one of 19 residents reviewed (Resident 11).Findings include:Review of the policy titled 'Suprapubic Catheter Placement' last reviewed January 16, 2025, indicated it is the policy of the facility to reinsert a suprapubic catheter when there appears to be a drainage problem and or when directed by a physician.A clinical record review reveals Resident 11 was admitted to the facility on [DATE], with a diagnosis of permanent atrial fibrillation (irregular heart rhythm). From February 13, 2025, to February 22, 2025, Resident 11 was hospitalized for sepsis (a potentially life-threatening condition that occurs when the body's response to infection causes injury to its own tissues and organs).Review of a document from the acute care facility, titled Consult - Urology dated February 17, 2025, revealed a suprapubic catheter (a medical device that helps drain urine from the bladder and enters the body through a small incision in the abdomen) was recommended for Resident 11 due to urethral pathology (a condition affecting the tube that carries urine from the bladder to the outside of the body). The suprapubic tube was inserted while Resident 11 was hospitalized . Clinical record review revealed Resident 11 returned to the facility on February 22, 2025, with the suprapubic catheter in place. Review of the facility care plan initiated February 23, 2025, identified that Resident 11 had a suprapubic catheter with a goal for the resident to remain free from catheter-related trauma (injury or damage to tissue at or near the catheter site). Review of the clinical record revealed Resident 11 attended a urology (doctor who specializes in disorders of the urinary system) appointment on May 9, 2025. Documentation from that visit indicated the suprapubic catheter was replaced. The written urology consult from May 9, 2025, included the recommendation that the skilled nursing facility change the suprapubic catheter monthly. The consult further documented that the resident would require monthly clinic visits if the facility was unable to safely remove and reinsert the catheter.Review of the facility medical record failed to demonstrate that the recommendations contained in the May 9, 2025, urology consult were reviewed, acknowledged, or verified by the facility physician. The medical record lacked evidence of a physician progress note, order, or other documentation indicating provider review of the recommended suprapubic catheter change schedule. Further review of facility nursing documentation revealed Resident 11 experienced episodes of suprapubic catheter blockage on November 11, 2025; November 30, 2025; December 16, 2025; December 23, 2025; January 2, 2026; and January 6, 2026. On each of these dates, the suprapubic catheter was documented as not draining urine as intended. Nursing documentation indicated flushing attempts were unsuccessful, and the suprapubic catheter was removed and reinserted.During an interview conducted on January 9, 2026, at 8:10 AM, the Director of Nursing was unable to provide evidence that the facility medical provider reviewed or acted upon the urology consult dated May 9, 2025, including the recommendation for a scheduled suprapubic catheter change. 28 Pa. Code 211.2(d)(3)(9) Medical Director.28 Pa. Code: 211.5 (f)(vii) Medical records.28 Pa. Code; 211.10 (d) Resident care policies.28 Pa. Code; 211.12(a)(c)(d)(1)(3)(5) Nursing Services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, observations, and staff interviews, it was determined the facility failed to ensure medications and biologicals were stored and labeled in accordance with professional standards and manufacturer recommendations. Specifically, the facility failed to ensure that multi-dose medication vials were labeled with an open date on two of two nursing areas (East Hall Medication Room and [NAME] Hall Medication Room).Findings include:A review of the facility policy titled Medication Administration and Medication Storage, last reviewed [DATE], indicated that medications and biologicals (medications derived from living organisms) are to be stored safely, securely, and in accordance with manufacturer or supplier instructions. The policy further indicated that multi-dose vials (containers intended for multiple uses after initial entry) must be dated when first opened or accessed (for example, punctured by a needle) and discarded within 28 days unless the manufacturer specifies a shorter or longer time frame.During an observation of the medication refrigerator located at the [NAME] Hall Medication Room on [DATE], at 8:50 AM, in the presence of Employee 3, a Licensed Practical Nurse (LPN), one vial of Tuberculin Purified Protein Derivative (a solution used in the Mantoux skin test to detect exposure to tuberculosis) was observed stored in the refrigerator and available for resident use. The vial did not have a label indicating the date it was opened.At the time of the observation, an interview with Employee 3, LPN, confirmed that the Tuberculin Purified Protein Derivative vial had been opened and was in use but was not dated to identify when it was first accessed.A review of the manufacturer's storage instructions indicated that Tuberculin Purified Protein Derivative must be stored under refrigeration and discarded 30 days after opening, or sooner if the solution becomes expired, cloudy, or discolored. Without an open date, staff were unable to determine whether the vial remained safe and appropriate for use. A second observation was conducted in the East Hall Medication Room on [DATE], at 9:05 AM, in the presence of Employee 4, a Registered Nurse (RN). One vial of Lantus Insulin Glargine (a long-acting insulin used to control elevated blood glucose levels) was observed stored in the medication refrigerator and available for resident use. The vial was not labeled with an open date. At the time of the observation, an interview with Employee 4, RN, confirmed that the vial of Lantus Insulin Glargine had been opened and was in use but was not dated. An interview was conducted with the Director of Nursing on [DATE], at 12:00 PM, to review the above findings. The Director of Nursing confirmed the facility failed to ensure that multi-dose medication vials stored in both the East and [NAME] Hall Medication Rooms were labeled with the date opened, preventing staff from determining whether the medications were within the manufacturer's recommended time frame for safe use. 28 Pa. Code 211.9 (a)(1)(k) Pharmacy Services.28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services.28 Pa. Code 211.10 (c) Resident care policies.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, facility-initiated transfer notices, and staff interview, it was determined the facility failed to notify the resident and the resident's representative(s) of the transfer in writing and in a language and manner they understand and to provide copies of written notice of facility-initiated hospital transfers of residents to a representative of the Office of the State Ombudsman for two out of 19 residents reviewed (Resident 11 & Resident 41). Findings include: A clinical record review revealed Resident 11 was admitted to the facility on [DATE]. Further clinical record review revealed Resident 11 was transferred to a community hospital on August 29, 2025, and was readmitted to the facility on [DATE]. A clinical record review revealed Resident 41 was admitted to the facility on [DATE]. Further clinical record review revealed Resident 41 was transferred to a community hospital on December 16, 2026, and was readmitted to the facility on [DATE]. The facility was unable to provide documented evidence that the resident and resident representative were notified of the reasons for the transfer in writing or provide documented evidence the facility sent copies of written notices of these transfers to the representative of the Office of the State Long-Term Care Ombudsman. An interview with the Nursing Home Administrator (NHA) on January 8, 2026, at approximately 10:11 AM confirmed there was no documented evidence that copies of transfer notices for Resident 11 and Resident 41 were sent to a representative of the Office of the State Long-Term Care Ombudsman. 28 Pa. Code 201.14(a) Responsibility of licensee.