STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395273	A. BLDG: 00 B. WING:	04/01/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
EMBASSY OF SCRANTON STATE LICENSE NUMBER: **010102**	**824 ADAMS AVENUE** **SCRANTON, PA 18510**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a state revisit and abbreviated complaint survey completed on April 1, 2025, it was determined that Embassy of Scranton was not in compliance with the following requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0584 SS=D		F 0584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0584 SS=D	Continued from page 1 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	The replacement doors for the Kitchen and the Laundry Room entrances have been ordered and will take 6- 8 weeks to be manufactured. Once they are received, they will be replaced. The Maintenance Director/designee will conduct an initial audit of existing doors in the facility to ensure that they are in good working order. The Administrator/designee will ensure identified concerns are rectified in a timely manner. The Maintenance Director/designee will educate staff to notify the maintenance department of any safety concerns or repair needs. Any identified needs will be entered into the preventive maintenance program (TELS) by issuing a work order for repair. The Maintenance department will repair the identified concern and/or involve the Administrator to gain approval for purchase of a timely replacement if necessary. The Maintenance Director/designee	Completion Date: **04/29/2025** Status: **APPROVED** Date: **04/14/2025**

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F 0584 SS=D	Continued from page 2 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584	will audit existing doors in the facility on a weekly basis as part of the preventative maintenance program to ensure that they are in good repair. The Administrator/designee will ensure identified concerns are rectified in a timely manner. The results of these audits will be discussed at the facility QAPI meeting monthly for further review and recommendations.	

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F 0584 SS=D	Continued from page 3 Based on observation and staff interview, it was determined the facility failed to maintain a safe, clean, and homelike environment in two areas of the facility (the kitchen entrance door and the laundry room entrance door), affecting the safety and security of the environment for both staff and residents. Findings include: On April 1, 2025, at 10:00 A.M. in the presence of the of the Dietary Manager, an observation of the kitchen's dishwasher entrance revealed the double entrance doors were broken. The doors could not be properly closed or locked. When attempting to open the doors, they swung off the hinges, making it difficult to completely open them for tray carts to pass through. This entryway was used for transporting both clean and soiled food carts. The door locks were inoperable, and instead, two sliding locks located at the top inside of the doors were used at night to secure the area. Staff would exit the kitchen through alternate doors.	F 0584		

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F 0584 SS=D	Continued from page 4 During an interview at the time of the observation, the Dietary Manager stated she was hired in December 2024 and that the doors were already broken at that time. She was unable to confirm how long the doors had been in disrepair. On April 1, 2025, at 1:00 P.M., an observation revealed that the laundry room entrance door was also broken. The door would not fully close and could not be secured with a lock. A document review of a repair quote dated August 21, 2024, showed the facility had received pricing for replacement and installation of both the kitchen and laundry room doors. However, there was no evidence presented during the survey that the facility had acted on the quote or made repairs to either door. An interview April 1, 2025, at 2 P.M., the Nursing Home Administrator confirmed that both the kitchen and laundry room doors were broken.	F 0584		

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F 0584 SS=D	Continued from page 5 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(2) Management	F 0584		
F 0804 SS=E		F 0804		

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F 0804 SS=E	Continued from page 6 483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by:	F 0804	The facility cannot retroactively r the cited deficiency. Meals that are being served are palatable, attractive, and at a safe and appetizing temperature. The Dietary Manager/Designee will re-educate the dietary staff on the facility's Test Tray and Point of Service Food Temperatures policy. The ADON/designee will re-educate nursing staff on timely pass of resident meal trays to help to ensure safe temperature of meals. The Dietary Manager/designee will audit all three meals weekly x 4, then monthly x 3 to ensure acceptable temperatures are served and that they are palatable and attractive on the tray line. Any variations will be corrected immediately and/or offered as training to staff to ensure compliance. The Dietary Manager/designee will audit all three meals weekly x 4, then monthly x 3 on the units to ensure that trays are being served timely and what is	Completion Date: **04/29/2025** Status: **APPROVED** Date: **04/14/2025**

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F 0804 SS=E	Continued from page 7	F 0804	being served is palatable, attractive, and that the temperatures are in an acceptable range. Any variations will be corrected immediately and/or offered as training to staff to ensure compliance. The results of these audits will be discussed at the facility QAPI meeting monthly for further review and recommendations.	

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F 0804 SS=E	Continued from page 8 Based on observation, review of facility policy, test tray results, and interviews with staff and residents, the facility failed to serve meals that were palatable and maintained at a safe and appetizing temperature for 6 of 10 residents sampled (Residents 2, 3, 5, 6, 7, and 8). Findings include: According to the federal regulatory guidance at 483.60(i)-(2) Food safety requirements - the definition of "Danger Zone," found under the Definitions section, is food temperatures above 41 degrees Fahrenheit and below 135 degrees Fahrenheit that allow rapid growth of pathogenic microorganisms that can cause foodborne illness. On April 1, 2025, at 8:20 a.m., an observation was made of a breakfast cart on the second floor, positioned directly across from the elevator with no staff present to distribute trays. Upon re-observation at 8:45 a.m., the cart remained in the same location, and staff were just beginning to pass trays at that	F 0804		

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F 0804 SS=E	Continued from page 9 time. A test tray evaluation was conducted on the last tray from the same cart at 8:48 a.m. The regular diet meal included waffles, ham, hot cereal, and coffee. Food temperatures were as follows: Waffles: 100.3°F Ham: 89.2°F Hot cereal: 115.3°F Coffee: 156°F The waffles were soggy and mushy, the ham was cold, and the cereal was not palatable, all due to being served below the required 135°F minimum. These temperatures fall within the "Danger Zone," defined as above 41°F and below 135°F, which allows the rapid growth of harmful bacteria. An interview with Resident 2, a cognitively intact resident, on April 1, 2025, at 9:30 a.m., revealed the facility's food was served cold most times and that the food was not palatable.	F 0804		

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F 0804 SS=E	Continued from page 10 An interview with Resident 3, a cognitively intact resident, on April 1, 2025, at 9:40 a.m., revealed the facility's food was often served cold and the food was not palatable. An interview with Resident 5, a cognitively intact resident, on April 1, 2025, at 9:50 a.m., revealed the facility's food was often served cold. An interview with Resident 6, a cognitively intact resident, on April 1, 2025, at 10:00 a.m., revealed the facility's food was often served cold and not palatable. An interview with Resident 7, a cognitively intact resident, on April 1, 2025, at 10:40 a.m., reported food was cold due to delays in tray passing, as carts often remained in hallways. An interview with Resident 8, a cognitively intact resident, on April 1, 2025, at 10:45 a.m., revealed the facility's food was often served cold and she stated, " it has been getting worse lately".	F 0804		

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F 0804 SS=E	Continued from page 11 An interview with the Nursing Home Administrator on April 1, 2025, at approximately 12:20 p.m. confirmed that food must be palatable and served at safe and appetizing temperatures. The dietary manager acknowledged the test tray results did not meet regulatory or facility standards. The facility failed to maintain appropriate food temperatures which resulted in meals that were not safe, appetizing, or palatable, affecting resident satisfaction and increasing the risk of foodborne illness. 28 Pa. Code 201.18 (e)(3) Management	F 0804		

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P 5520		P 5520		

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P 5520	Continued from page 1 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	The facility will provide a staffing ratio based on July 1, 2024, regulations of one nurse aide per 10 residents on the day shift, one nurse aide per 11 residents during the evening shift, and one nurse aide per 15 residents during the night shift. All facility residents have the potential to be affected by this practice. The facility has implemented staff incentives for current and new staff as well as reinforcing the facility call off policy to deter unnecessary call offs. We are also hiring PRN CNAs to assist in covering shifts with call offs or openings in the schedule. We will be using Indeed for advertisements of open positions, participating in career fairs as they are available, and giving sign on bonuses and/or referral bonuses to new hires and our staff. NHA or designee will educate staff on incentives and call off policy. Administrator/designee during	Completion Date: **04/29/2025** Status: **APPROVED** Date: **04/14/2025**

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P 5520	Continued from page 2	P 5520	weekday daily review of nursing schedules will audit to ensure Certified Nurse Aide ratios are maintained. The results of these audits will be discussed at the facility QAPI meeting monthly for further review and recommendations	

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P 5520	Continued from page 3 Based on a review of nurse staffing and staff interview, it was determined the facility failed to ensure the minimum nurse aide staff to resident ratio was provided on each shift for 5 shifts out of 21 reviewed. Findings include: A review of the facility's weekly staffing records revealed that on the following dates the facility failed to provide minimum nurse aide staff of 1:10 on the day shift, 1:11 on the evening shift, and 1:15 on the night shift based on the facility's census. March 27, 2025 - 8.2 nurse aides on the day shift, versus the required 8.5 for a census of 85. March 28, 2025 - 5.5 nurse aides on the night shift, versus the required 5.6 for a census of 84. March 30, 2025 - 4.75 nurse aides on the night shift, versus the required 5.67 for a census of 85. March 31, 2025 - 7.7 nurse aides on the day shift, versus the required 8.6 for a census of 86. March 31, 2025 - 7.36 nurse aides on the evening	P 5520		

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P 5520	Continued from page 4 shift, versus the required 7.82 for a census of 86. On the above dates mentioned no additional excess higher-level staff were available to compensate this deficiency. An interview with the Nursing Home Administrator on April 1, 2025, at approximately 3:30 p.m., confirmed the facility had not met the required nurse aide to resident ratios on the above dates.	P 5520		
P 5530		P 5530		

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P 5530	Continued from page 5 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	The facility will provide a staffing ratio of one Licensed Practical Nurse per 25 residents on day shift, one Licensed Practical Nurse to 30 residents on evening shift, and one Licensed Practical Nurse per 40residents on overnight shift. All facility residents have the potential to be affected by this practice. The facility has implemented staff incentives for current and new staff as well as reinforcing the facility call off policy to deter unnecessary call offs. We are also hiring additional PRN LPNs to help cover shifts when there are call offs or openings in the schedule. We will be using Indeed for advertisements of open positions, participating in career fairs as they are available, and giving sign on bonuses and/or referral bonuses to new hires and our staff. NHA or designee will educate staff on incentives and call off policy. Administrator/designee during	Completion Date: **04/29/2025** Status: **APPROVED** Date: **04/14/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395273	A. BLDG: __00_____ B. WING: _____	04/01/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
EMBASSY OF SCRANTON STATE LICENSE NUMBER: **010102**	**824 ADAMS AVENUE SCRANTON, PA 18510**

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P 5530	Continued from page 6	P 5530	weekday daily review of nursing schedules will audit to ensure License Practical Nurse ratios are maintained. The results of these audits will be discussed at the facility QAPI meeting monthly for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395273	A. BLDG: 00 B. WING:	04/01/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
EMBASSY OF SCRANTON STATE LICENSE NUMBER: **010102**	**824 ADAMS AVENUE** **SCRANTON, PA 18510**

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P 5530	Continued from page 7 Based on a review of nurse staffing and staff interview, it was determined that the facility failed to ensure the minimum licensed practical nurse staff to resident ratio was provided on each shift for two shifts out of 21 reviewed. Findings include: A review of the facility's weekly staffing records revealed that on the following dates the facility failed to provide minimum licensed practical nurse (LPN) staff of 1:25 on the day shift, 1:30 on the evening shift, and 1:40 on the night shift based on the facility's census. March 26, 2025 - 2.0 LPNs on the night shift, versus the required 2.10 for a census of 84. March 29, 2025 - 2.0 LPNs on the night shift, versus the required 2.13 for a census of 85. On the above dates mentioned no additional excess higher-level staff were available to compensate this deficiency.	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395273	A. BLDG: __00_____ B. WING: _____	04/01/2025

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P 5530	Continued from page 8 An interview with the Nursing Home Administrator on April 1, 2025, approximately 9:15 AM, confirmed the facility had not met the required LPN to resident ratios on the above dates.	P 5530		

Certified End Page

EMBASSY OF SCRANTON

STATE LICENSE NUMBER: 010102

SURVEY EXIT DATE: 04/01/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY