

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395433	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/09/2026
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NAME OF PROVIDER OR SUPPLIER: EMBASSY OF TUNKHANNOCK	STREET ADDRESS, CITY, STATE, ZIP CODE: 30 VIRGINIA DRIVE TUNKHANNOCK, PA 18657
STATE LICENSE NUMBER: 551002	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	F 0000		
F 0628 SS=D	Based on an abbreviated complaint survey completed on April 9, 2026, it was determined that Embassy of Tunkhannock, 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 0628		

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 0628 SS=D	Continued from page 1 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) Discharge Process §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i) (A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-	F 0628	1. Facility cannot retroactively correct deficiency as it relates to resident 51 on 4/6/2026. 2. Facility audit of last 10 resident transfers to hospital to ensure that e-interact UA (utilization assessment) and corresponding information on code status, MAR, face sheet and baseline condition were sent to hospital to ensure a safe and effective transition of care. 10/10 residents had corresponding documentation. 3. Licensed nursing staff educated on procedures for resident hospital transfers to include specific documentation to send with EMS to ensure an effective transition of care to include the PCC utilization assessment, baseline condition, code status, MAR, face sheet and reason for transfer. RN supervisor to verify proper information is collected and sent. 4. Audit of each hospital transfer will be completed by DON/designee X 2 months to ensure compliance with education. Results will be provided to the QA committee each	Completion Date: 04/25/2026 Status: APPROVED Date: 04/21/2026

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F 0628 SS=D	Continued from page 2 (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c) (2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c) (1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i) (A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 0628	month to verify compliance with regulatory requirements for hospital transfers. 5. April 25, 2026	

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F 0628 SS=D	Continued from page 3 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy	F 0628		

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F 0628 SS=D	Continued from page 4 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 0628		

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F 0628 SS=D	Continued from page 5 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).	F 0628		

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F 0628 SS=D	Continued from page 6 This REQUIREMENT is not met as evidenced by:	F 0628		
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F 0628 SS=D	Continued from page 7 Based on review of clinical records and staff interview, it was determined the facility failed to ensure necessary resident-specific clinical information was communicated to the receiving health care provider at the time of an emergent transfer to the hospital for one of 19 residents reviewed (Resident 51). Findings include: A review of Resident 51's clinical record revealed the resident was admitted to the facility on July 6, 2022, and transferred to the emergency department on April 6, 2026. The resident had an advance directive indicating a no code status (no code means that in the event the resident's heart or breathing stops, cardiopulmonary resuscitation (CPR) is not to be initiated). A progress note dated April 6, 2026, at 6:30 AM revealed that at 5:30 AM Resident 51 was administered another resident's medication. Specifically, Resident 51 accidentally received	F 0628		

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F 0628 SS=D	Continued from page 8 morphine sulfate 0.5 ml (morphine sulfate is a potent opioid medication used to treat moderate to severe pain; opioid medications can slow breathing and heart rate and may cause life-threatening complications when given inappropriately). Emergency Medical Services (EMS) were contacted, and the resident was transferred to the emergency department for evaluation and treatment related to the medication error. Clinical record review revealed no documented evidence that the facility communicated necessary clinical information to the receiving health care provider at the time of transfer. Specifically, there was no documentation indicating the facility provided information regarding the medication error, including the name of the medication, dosage, time administered, or the clinical circumstances related to the accidental opioid exposure. Additionally, there was no documented evidence that the facility communicated other essential information necessary for continuity of care,	F 0628		

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F 0628 SS=D	Continued from page 9 including the resident's advance directive status, special instructions, precautions for ongoing care, baseline condition, or comprehensive care plan goals, as appropriate, to ensure a safe and effective transition of care. During an interview conducted on April 9, 2026, at 3:45 PM, the Director of Nursing (DON) and Nursing Home Administrator (NHA) were unable to provide documented evidence that the facility communicated Resident 51's necessary clinical information to the receiving health care provider at the time of the emergent transfer on April 6, 2026. Refer F760 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.12 (d)(3) Nursing services.	F 0628		

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F 0658 SS=G		F 0658		

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F 0658 SS=G	Continued from page 11 483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 0658	1. Facility cannot retroactively correct deficiency as it relates to resident 51 on 4/6/2026 and a medication error. 2. Audited medication errors from 1/1/2026 to current to review root cause of errors. Results have been added to our education component for licensed nurses. 3. As outlined by the self-directed letter, AAE Consulting Services, approved by the Department of Health, will provide facility-wide education on the program called "Professional Standards and Significant medication error standards as well as federal regulations and accompanying guidelines. Education will be provided by AAE Consulting Services to conduct the directed in-service sessions on 4/23/26. Anyone that is unable to attend the 4/23/26 sessions will be required to attend a makeup session and be completed prior to their next scheduled working shift. A copy of the in-service will also be added to agency orientation documents for	Completion Date: 04/25/2026 Status: APPROVED Date: 04/21/2026

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F 0658 SS=G	Continued from page 12	F 0658	<p>review prior to working a shift within the facility. All residents who did not refuse have been issued wrist bands for a secondary identification. Wrist band checks added to residents' TAR per shift to check for placement. All resident pictures for primary identification have been uploaded in their respective EMR's on 4/9/2026.</p> <p>4. Facility education will be completed biannually with licensed nursing staff for the 5 rights of medication verification. Education will be included in all new licensed nursing staff education during the initial orientation process upon hire. Educations will be audited monthly by the DON/designee and forwarded to the QA committee to ensure compliance with resident identification during medication passes.</p> <p>5. April 25, 2025</p>	

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F 0658 SS=G	Continued from page 13 Based on review of clinical records, facility provided investigative documentation, select facility policies, applicable state professional nursing standards, and staff interviews, it was determined the facility failed to provide nursing services in accordance with professional standards of practice, resulting in actual harm. The facility failed to ensure a licensed nurse correctly identified a resident prior to medication administration for one of 11 residents reviewed (Resident 51). The failure resulted in the resident receiving another resident's prescribed opioid medication, causing adverse clinical effects requiring emergency medical treatment. Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing 21.11 (a)(1)(2)(4) indicates the registered nurse is responsible for assessing human responses and plans, implementing nursing care, analyzing/comparing data with the norm in determining care needs, and carrying out nursing	F 0658		

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F 0658 SS=G	Continued from page 14 care actions that promote, maintain and restore the well-being of individuals. According to the Pennsylvania Code Title 49, Professional and Vocational Standards Department of State, Chapter 21 State Board of Nursing, Chapter 21.14 Functions of the RN (Registered Nurse) requires the following: The RN is prepared to function as a member of the health care team by exercising sound nursing judgement based on preparations, knowledge, skills, understandings, and past experiences in nursing situations. The RN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. (a) A licensed RN may administer a drug ordered for a patient in the dosage and manner prescribed in accordance with the following: (d) The Board recognizes codes of behavior as developed by appropriate practical nursing associations as the criteria for assuring safe and effective practice.	F 0658		

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F 0658 SS=G	Continued from page 15 A review of the facility policy titled "Medication Administration," last reviewed by the facility on January 23, 2026, indicated medications are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice. The policy indicated that staff are to verify resident identity prior to medication administration, including use of the resident's photograph in the medication administration record. Resident 50 and Resident 51 are roommates. Clinical record review revealed Resident 50 was admitted to the facility February 14, 2024, with diagnoses including senile degeneration of the brain (a condition involving progressive decline in memory, thinking, and reasoning abilities). Review of the quarterly Minimum Data Set (MDS, a federally required standardized assessment used to evaluate resident status and guide care planning) dated February 10, 2026, revealed that Resident 50 was severely cognitively impaired with a BIMS score of 5 (Brief Interview for Mental Status, a tool	F 0658		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 0658 SS=G	Continued from page 16 within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 01 through 07 indicates cognition is severely impaired). Clinical record review revealed Resident 51 was admitted July 6, 2022, with diagnoses including dementia (a disorder characterized by decline in memory, thinking, and reasoning that interferes with daily functioning). Review of the annual Minimum Data Set dated February 11, 2026, revealed a BIMS score of 3, indicating severe cognitive impairment. Resident 50's clinical record revealed physician orders for Morphine Sulfate oral concentrate 20 milligrams per milliliter (mg/ml), a potent opioid pain medication used to treat moderate to severe pain. The medication is classified as a Schedule II controlled substance; it has a high potential for abuse, addiction, and dependency, give 0.5 milliliters (ml) by mouth one time daily, initiated	F 0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395433	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/09/2026
NAME OF PROVIDER OR SUPPLIER: EMBASSY OF TUNKHANNOCK STATE LICENSE NUMBER: 551002		STREET ADDRESS, CITY, STATE, ZIP CODE: 30 VIRGINIA DRIVE TUNKHANNOCK, PA 18657		
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F 0658 SS=G	Continued from page 17 February 21, 2026. Opioids may slow breathing and heart rate and can cause serious adverse effects when taken inappropriately. Resident 50 also had an order for Levothyroxine sodium 25 micrograms (mcg) by mouth daily, initiated July 19, 2024. Levothyroxine is a medication used to treat a thyroid hormone deficiency. A nursing progress note dated April 6, 2026, at 6:30 AM documented that at 5:30 AM Employee 1, RN agency, (agency staff are employees of an external company that fill the facility's vacancies as needed) entered the room shared by Residents 50 and 51 and called out Resident 50's name. According to the progress note, Resident 51 responded, "huh." The progress note documented that Employee 1 approached Resident 51 and identified the medications prepared for administration, specifically morphine sulfate 0.5 ml and levothyroxine sodium 25 mcg. The progress note indicated Resident 51 responded, "okay," and Employee 1 administered Resident 50's medications to Resident 51. The nurse documented that after	F 0658		

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F 0658 SS=G	Continued from page 18 leaving the room and returning to the computer to document medication administration, she realized the medications had been administered to the wrong resident. The documentation indicated Employee 1 immediately obtained Resident 51's vital signs and requested Employee 2, nurse aide, remain with the resident while emergency services were contacted. Documentation revealed Resident 51's blood pressure was 90/50 millimeters of mercury (mm Hg) (blood pressure measures the force of blood pushing through arteries; normal adult blood pressure is approximately 120/80 mm Hg), heart rate was 38 beats per minute (normal adult resting heart rate typically ranges from 60 to 100 beats per minute), respirations were 12 breaths per minute, and oxygen saturation was 98 percent (oxygen saturation measures the percentage of oxygen carried in the blood; normal levels typically range from 95% to 100%). Hospital records revealed Resident 51 arrived at the	F 0658		

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F 0658 SS=G	Continued from page 19 emergency department at 6:42 AM with abnormal vital signs including heart rate of 29 beats per minute and low blood pressure. Documentation indicated the resident was alert but disoriented. Hospital documentation indicated Resident 51 received two doses of Narcan (naloxone, a medication used to reverse the effects of opioid medications during overdose) to treat opioid poisoning (a condition that occurs when an opioid medication, such as morphine, causes harmful effects on the body including slowed breathing, decreased heart rate, decreased level of consciousness, or risk of death) and profound bradycardia (an abnormally slow heart rate, generally fewer than 60 beats per minute). resulting in bradycardia (dangerously slow heart rate). The resident was monitored and discharged back to the facility with a diagnosis of accidental opioid poisoning. During a phone interview on April 9, 2026, at 1:00 PM, Employee 1, RN, stated she administered medication to the wrong resident and confirmed she did not follow accepted medication administration	F 0658		

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F 0658 SS=G	Continued from page 20 practices to verify the correct resident prior to administering medications. The employee confirmed that she did not follow the 5 rights of verifying medication and that she was apologetic for the error. Accepted standards of nursing practice require licensed nurses to follow the 5 Rights of Medication Administration (right resident, right medication, right dose, right route, and right time), a safety process used to ensure medications are administered accurately and safely. During an interview on April 9, 2026, at 2:00 PM the Director of Nursing indicated facility policy requires staff to verify resident identity prior to medication administration. The facility failed to ensure nursing services were provided in accordance with accepted standards of nursing practice, including verification of the correct resident prior to medication administration. Failure to follow the 5 Rights of Medication Administration resulted in Resident 51 receiving another resident's opioid medication and experiencing adverse clinical effects requiring emergency medical treatment, constituting	F 0658		

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F 0658 SS=G	Continued from page 21 actual harm. 28 Pa. Code 211.12 (b)(1) Management. 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.	F 0658		
F 0677 SS=D		F 0677		

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F 0677 SS=D	Continued from page 22 483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 0677	Facility cannot retroactively correct deficiency as it relates to 51 on 4/6/2026 regarding ADL care. 2. Facility residents were reviewed by nursing and provided nail care on 4/13/26 and 4/14/26. 3. Facility personnel care procedures reviewed and updated. Education provided to facility nursing staff on the facility Personnel Care Procedure of nail care completion after showers and as needed during ADLs. 4. LPN charge nurse to complete random nail audits daily X 2 weeks, then weekly X 2 months with results sent to the QA committee to ensure compliance with resident grooming and personnel hygiene. 5. April 25, 2026	Completion Date: 04/25/2026 Status: APPROVED Date: 04/21/2026

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F 0677 SS=D	Continued from page 23 Based on a review of clinical records, resident and staff interviews, and facility provided documentation, it was determined the facility failed to ensure that residents who were dependent on staff for assistance with activities of daily living (ADLs) consistently received necessary care and services to maintain personal hygiene and dignity for one resident out of 11 sampled residents (Residents 51). Findings include: A review of a facility policy titled "Personal Care Procedure", last reviewed by the facility on January 23, 2026, revealed it is the policy of the facility to provide and assist resident care and hygiene to each resident based on their individual status and needs. The policy defined personal care to include bathing, showers, oral care, and grooming. The policy further detailed that for residents who need assistance, it is the responsibility of the staff to provide as much help as needed, which may include total assistance for residents who are confused, or physically unable to do it themselves. The policy revealed that nail care is	F 0677		

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F 0677 SS=D	Continued from page 24 to be completed during showers with cleaning and trimming as needed. After the procedure is completed, the care is to be documented in the nurse's notes or point of care area, if the resident refuses, the staff is to document the refusal. A review of Resident 51's clinical record revealed the resident was admitted to the facility on July 6, 2022, with diagnoses to include chronic atrial fibrillation (a common, often chronic arrhythmia characterized by rapid, disorganized electrical activity in the heart's upper chambers causing a fast, irregular heartbeat), and dementia (a progressive syndrome characterized by a decline in memory, language, and thinking severe enough to disrupt daily life). Review of Resident 51's Annual Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 11, 2026, revealed that Resident 51 was cognitively impaired with a BIMS score of 3 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the	F 0677		

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F 0677 SS=D	Continued from page 25 resident's attention, orientation, and ability to register and recall new information; a score of 0-7 indicates severe cognitive impairment). The MDS further detailed that Resident 51 was totally dependent on staff for assistance with bathing and personal hygiene. A review of Resident 51's Kardex (a quick-reference summary for staff to guide delivery of care) documented that Resident 51 was scheduled to receive showers on Wednesday and Saturday during the evening shift, the Kardex documented Resident 51 preferred taking showers over bed baths, or baths. A review of the Documentation Survey Report v2 for March 2026 and April 2026 revealed that showers were completed as scheduled, including the most recent shower documented on April 8, 2026, at 9:59 PM. Observation conducted on April 9, 2026, at 12:00 PM revealed Resident 51 to have visible buildup	F 0677		

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F 0677 SS=D	Continued from page 26 and grime under five out of five fingernails on both hands. The nails were observed to have debris trapped under the nails, with grayish black residue under the fingernail tips. The facility was unable to provide any documentation to support Resident 51 had refused nail care, despite receiving a shower 1 day prior to the observation of her nails. The facility was unable to provide any documentation that Resident 51's fingernails had been cleaned, as defined in the facility policy. The above findings were reviewed with the Director of Nursing on April 9, 2026, at 3:30 PM. The facility could not provide documented evidence of staff following facility policy to ensure residents received appropriate personal care. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa. Code 211.12 (c)(d)(5) Nursing services.	F 0677		

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F 0760 SS=K		F 0760		

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F 0760 SS=K	Continued from page 28 483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 0760	Facility completed resident identification pictures in the electronic medical records for residents 48, 53, 65, 6, 7, 12, 59, 34, 23 on 4/9/2026. All resident photos uploaded and audited on same date 2. Audit of all residents completed on 4/9/2026 to ensure photos of all residents were present in their medical chart for identification purposes. 3. Facility procedures for Medication Administration, Resident Admission Procedure and Orientation checklist for LPN/RN were reviewed and updated to reflect the taking of photographs of new residents upon admission and place in the electronic medical record for resident identification, completed on 4/9/2026. Residents received wrist bands on 4/13/2026 with exception of 5 residents who refused to have a wrist band as a secondary method of identification. Agency RN marked as a "do not return" to facility and agency was updated to mediation error on 4/7/2026. Education completed with facility licensed	Completion Date: 04/25/2026 Status: APPROVED Date: 04/21/2026

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F 0760 SS=K	Continued from page 29	F 0760	nurses on 4/9/2026 and ongoing on policies and procedures, resident identification, secondary identifications with use of wrist band, and 5 rights of medication administration. 4. New admission audits will be completed by the NHA/designee to ensure photo identification is uploaded to the EMR. QA committee notified of the IJ and abatement plan of correction. New admission audits for picture identification will continue daily X 2 months with results of audits to QA committee for review and alternative actions as required. DON/designee will audit nurses administering medications to ensure the 5 rights of medication pass are followed and all residents have accurate resident identification prior to medications administration is identified in 3 resident med passes, 3 X week for 4 weeks. 5. April 25, 2026	

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F 0760 SS=K	Continued from page 30 Based on a review of clinical records, select facility policies, documentation provided by the facility, observations, and staff interviews, it was determined the facility failed to ensure residents were free of significant medication errors and failed to implement effective procedures to accurately identify residents prior to medication administration. This failure resulted in an Immediate Jeopardy situation when a nurse administered a narcotic medication (morphine sulfate) prescribed for Resident 50 to Resident 51, causing profound bradycardia (abnormally slow heart rate) requiring emergency transfer to the hospital and administration of naloxone (a medication that reverses the effects of opioid overdose) on two occasions. Additionally, the facility failed to ensure an effective system for resident identification, placing 9 of 65 residents reviewed (Residents 6, 7, 12, 23, 34, 48, 53, 59, and 65) at risk for serious injury, harm, impairment, or death. Findings include:	F 0760		

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F 0760 SS=K	<p>Continued from page 31</p> <p>A review of the facility policy titled "Medication Administration," last reviewed by the facility on January 23, 2026, indicated medications are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice. The policy indicated residents are to be identified by photograph in the electronic health record prior to medication administration.</p> <p>A review of the facility policy titled "Resident Admission Procedure," last updated April 9, 2026, indicated a photograph of the resident will be obtained and uploaded to the electronic health record to ensure accurate identification of residents.</p> <p>Clinical record review revealed Resident 50 was admitted February 14, 2024, with diagnoses that included senile degeneration of the brain (a condition characterized by loss of cognitive functioning such as memory, thinking, and reasoning sufficient to interfere with daily life).</p> <p>A review of Resident 50's quarterly Minimum Data</p>	F 0760		

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F 0760 SS=K	<p>Continued from page 32</p> <p>Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated February 10, 2026, revealed that Resident 50 was severely cognitively impaired with a BIMS score of 5 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 01 through 07 indicates cognition is severely impaired).</p> <p>A clinical record review revealed that Resident 51 was admitted to the facility on July 6, 2022, with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities).</p> <p>A review of Resident 51's annual MDS assessment dated February 11, 2026, revealed that Resident 51 was severely cognitively impaired with a BIMS score of 3 (a score of 01 through 07 indicates</p>	F 0760		

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F 0760 SS=K	Continued from page 33 cognition is severely impaired). Review of Resident 50's clinical record revealed a physician order dated February 21, 2026, for Morphine Sulfate concentrate solution 20 mg/ml, give 0.5 ml by mouth one time daily. Morphine sulfate is a Schedule II controlled substance (a drug with accepted medical use but high potential for abuse, addiction, and serious adverse effects). Resident 50 also had an order dated July 19, 2024, for Levothyroxine sodium 25 mcg (a medication used to treat thyroid hormone deficiency) to be administered daily in the morning. A progress note dated April 6, 2026, at 6:30 AM revealed that at 5:30 AM, Employee 1, an agency (agency staff are employees of an external company that fill the facility's vacancies as needed) registered nurse (RN), entered the shared room of Residents 50 and 51 to administer medications. Employee 1, RN, called out Resident 50's name. Resident 51 responded with "huh". Employee 1 administered morphine sulfate 0.5 ml and levothyroxine sodium	F 0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395433	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 04/09/2026
NAME OF PROVIDER OR SUPPLIER: EMBASSY OF TUNKHANNOCK		STREET ADDRESS, CITY, STATE, ZIP CODE: 30 VIRGINIA DRIVE TUNKHANNOCK, PA 18657		
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F 0760 SS=K	Continued from page 34 25 mcg intended for Resident 50 to Resident 51 without verifying the resident's identity using a photograph or another reliable identification method. A progress note dated April 6, 2026, at 6:30 AM documented by Employee 1, agency RN, revealed that at 5:30 AM, Employee 1 was administering medications. The progress note indicated Employee 1 entered the room shared by Residents 50 and 51 and called out Resident 50's name. According to the progress note, Resident 51 responded, "huh." The progress note documented that Employee 1 approached Resident 51 and identified the medications prepared for administration, specifically morphine sulfate 0.5 ml and levothyroxine sodium 25 mcg. The progress note indicated Resident 51 responded, "okay," and Employee 1 administered Resident 50's medications to Resident 51. The progress note further indicated that after leaving the room and returning to the computer to document, Employee 1 realized the medications had been administered to the wrong resident. According to the progress note, Employee 1 immediately obtained	F 0760		

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F 0760 SS=K	Continued from page 35 Resident 51's vital signs and requested Employee 2, Nurse Aide, remain with the resident while Employee 1 made the required notifications. The progress note documented Employee 1 contacted 911, the physician, and the resident representative. The progress note indicated Resident 51's blood pressure was 90/50 mm Hg (millimeters of mercury, a measurement of the force of blood moving through the arteries; a typical adult blood pressure is approximately 120/80 mm Hg), heart rate was 38 beats per minute (normal adult heart rate is typically 60 to 100 beats per minute), respirations were 12 breaths per minute (breathing rate), and oxygen saturation was 98% (oxygen saturation measures the percentage of oxygen carried in the blood; normal levels typically range from 95% to 100%). Emergency medical services were contacted and Resident 51 was transferred to the hospital. Community hospital emergency department documentation dated April 6, 2026, revealed	F 0760		

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F 0760 SS=K	Continued from page 36 Resident 51 arrived at the emergency department at 6:42 AM with accidental opiate poisoning (a condition that occurs when an opioid medication, such as morphine, causes harmful effects on the body including slowed breathing, decreased heart rate, decreased level of consciousness, or risk of death) and profound bradycardia (an abnormally slow heart rate, generally fewer than 60 beats per minute). The documentation indicated Resident 51 was administered the incorrect medication at the nursing facility and presented with bradycardia (a condition characterized by an abnormally slow resting heart rate, typically fewer than 60 beats per minute). The documentation indicated emergency medical services reported the resident's heart rate was as low as 29 beats per minute with systolic blood pressure 100 mmHg. Additional documentation revealed blood pressure of 86/64 mm Hg, respirations of 20 breaths per minute and continued clinical instability. The resident was in acute distress (a serious medical condition requiring immediate attention).	F 0760		

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F 0760 SS=K	Continued from page 37 Continued review of community emergency department documentation dated April 6, 2026, revealed Resident 51 experienced profound bradycardia (an abnormally slow heart rate, generally fewer than 60 beats per minute) likely related to an accidental administration of morphine at the nursing facility. The emergency department documentation indicated Resident 51 required two administrations of naloxone hydrochloride (naloxone HCl) 0.2 mg (a life-saving medication designed to rapidly reverse an opioid overdose by restoring normal breathing). The documentation indicated that following the second administration of naloxone 0.2 mg, Resident 51's heart rate increased to the mid-50 beats per minute range, and blood pressure improved. Continued monitoring documented a systolic blood pressure of 134 mmHg and heart rate ranging from the low 50s to 65 beats per minute. Emergency department documentation indicated Resident 51 was discharged from the hospital on April 6, 2026, at 6:41 PM after stabilization of vital signs.	F 0760		

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F 0760 SS=K	Continued from page 38 A facility progress note dated April 6, 2026, at 8:00 PM documented that upon Resident 51's return to the facility from the emergency department, the physician issued new orders to monitor vital signs every shift for three days and to conduct safety checks every 30 minutes for 24 hours. A review of documentation provided by the facility revealed that following the medication error incident on April 6, 2026, the facility provided education to licensed nursing staff regarding medication administration. A review of training materials titled "Medication Administration and Documentation -Education" revealed staff were instructed to identify residents prior to and during medication administration. However, review of the education materials failed to reveal specific procedures staff must follow to accurately identify residents, particularly residents who are cognitively impaired (have difficulty understanding or communicating information) or	F 0760		

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F 0760 SS=K	Continued from page 39 residents without photographs available in the electronic health record. Observation conducted on April 9, 2026, at 8:25 AM revealed Employee 3, Licensed Practical Nurse (LPN), administering medications to Resident 53 while referencing the electronic health record. The electronic health record included a designated location for a resident identification photograph; however, no photograph was present for Resident 53 at the time of medication administration. During interview on April 9, 2026, at 8:35 AM Employee 3, LPN, stated staff use photographs in the electronic health record to identify residents prior to medication administration. Employee 3 confirmed Resident 53 did not have a photograph available for identification and was unable to explain why the photograph was not present. Employee 3, LPN, indicated that she is familiar with the residents at the facility and is able to identify the residents; however, she was unsure how staff unfamiliar with residents would accurately identify residents without	F 0760		

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F 0760 SS=K	Continued from page 40 photographs. During interview on April 9, 2026, at 8:55 AM Employee 4, Registered Nurse (RN), confirmed staff rely on resident photographs in the electronic health record to identify residents prior to medication administration. Employee 4 confirmed that there are a few residents at the facility that do not have photographs uploaded to the electronic health record for identification. Employee 4 stated staff may ask residents to state their name when the resident is cognitively intact. Employee 4 was unable to describe a consistent method used to identify residents who are cognitively impaired. During interview on April 9, 2026, at 9:00 AM Employee 5, LPN, confirmed facility policy requires staff to identify residents prior to medication administration. Employee 5 stated photographs in the electronic health record are used for resident identification; however, some residents do not have photographs available. Employee 5 indicated staff may rely on familiarity with residents or nameplates	F 0760		

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F 0760 SS=K	Continued from page 41 located on resident room doors to identify residents. Employee 5 acknowledged agency staff unfamiliar with residents may have difficulty accurately identifying residents when photographs are not available. A review of clinical records revealed Residents 48, 53, 65, 6, 7, 12, 59, 34, and 23 did not have photographs uploaded to the electronic health record for resident identification until surveyor inquiry was made on April 9, 2026. Fourteen percent of residents reviewed did not have photographs available to assist staff in accurately identifying residents prior to medication administration. The facility failed to implement its internal policy requiring resident photographs to be uploaded to the electronic health record. The facility did not establish an alternative reliable identification process for residents without photographs. Clinical record review revealed: Resident 7 admitted January 14, 2026, BIMS score	F 0760		

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F 0760 SS=K	Continued from page 42 12, indicating moderate cognitive impairment (reduced ability to reliably recall or communicate information). Resident 12 admitted February 12, 2026, BIMS score 12, indicating moderate cognitive impairment. Resident 53 admitted February 6, 2026, BIMS score 15, indicating cognition intact (able to reliably communicate information). Resident 6 admitted March 3, 2026, BIMS score 15, indicating cognition intact. Resident 48 admitted March 4, 2026, BIMS score 13, indicating cognition intact. Resident 65 admitted March 10, 2026, BIMS score 13, indicating cognition intact. Resident 59 admitted April 1, 2026, BIMS score 13, indicating cognition intact.	F 0760		

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F 0760 SS=K	Continued from page 43 Resident 23 admitted April 2, 2026, BIMS score 15, indicating cognition intact. Resident 34 admitted April 7, 2026, BIMS score 15, indicating cognition intact. The facility identified photographs in the electronic health record as the primary method used by staff to verify resident identity prior to medication administration. In the absence of photographs, staff reported relying on familiarity with residents, resident statements of identity, or room nameplates. These methods are not reliable for residents with cognitive impairment and are not reliable for staff unfamiliar with residents, including agency nurses (nurses employed by an external staffing company who may not routinely work in the facility). Without a consistent and reliable identification process, agency staff or newly assigned staff may not be able to accurately identify residents prior to medication administration. The facility did not implement an alternative identification method to ensure accurate resident identification when photographs were not	F 0760		

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F 0760 SS=K	Continued from page 44 available. A review of nurse staffing schedules dated April 2, 2026, through April 9, 2026, revealed agency nurses accounted for 5.97% of the licensed nursing staff during that time period, increasing the likelihood that staff unfamiliar with residents may rely on photographs or other identification methods to ensure accurate medication administration. During an interview on April 9, 2026, at 9:30 AM the Director of Nursing (DON) confirmed Employee 1 administered morphine sulfate 0.5 ml and levothyroxine sodium 25 mcg intended for Resident 50 to Resident 51, resulting in transferring to the emergency department for treatment of opiate poisoning. The DON confirmed facility policy requires photographs to be available in the electronic health record to assist staff in identifying residents prior to medication administration. The DON stated that previously admissions staff were responsible for uploading resident photographs; however, that position had been eliminated due to	F 0760		

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F 0760 SS=K	<p>Continued from page 45</p> <p>staffing changes. The DON was unable to provide documentation of competency validation, orientation records, or training specific to resident identification procedures for Employee 1.</p> <p>During a phone interview on April 9, 2026, at 2:53 PM, Employee 1 confirmed she administered morphine sulfate 0.5 ml and levothyroxine sodium 25 mcg intended for Resident 50 to Resident 51 on April 6, 2026. Employee 1 stated she was an agency nurse, and this was her second shift in the facility. Employee 1 stated she was unfamiliar with the residents and did not know Resident 51 was severely cognitively impaired. Employee 1 indicated she reviewed an orientation packet prior to her first shift but could not recall receiving instruction regarding a specific procedure to accurately identify residents prior to medication administration.</p> <p>During phone interview on April 9, 2026, at 3:08 PM, Employee 2, Nurse Aide (NA), stated that on April 6, 2026, at 5:45 AM, Employee 1 "was frantic and in tears" and requested Employee 2 remain with</p>	F 0760		

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F 0760 SS=K	<p>Continued from page 46</p> <p>Resident 51 until emergency medical services arrived to transport the resident to the hospital.</p> <p>Immediate Jeopardy was identified on April 9, 2026, at 11:15 AM due to the facility's failure to implement procedures to ensure residents are free from significant medication errors. The facility failed to ensure staff accurately identified residents prior to medication administration, resulting in administration of a narcotic opioid medication to the wrong resident and requiring emergency transfer for life-saving medical treatment. Additionally, the facility demonstrated a systemic failure to implement an effective resident identification process, placing residents, at risk for serious injury, harm, impairment, or death.</p> <p>The facility was notified of the Immediate Jeopardy on April 9, 2026, at 11:19 AM and the IJ template was provided to the facility.</p> <p>The facility's Immediate Jeopardy removal plan was provided to the survey team on April 9, 2026, at</p>	F 0760		

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F 0760 SS=K	Continued from page 47 3:45 PM and included the following: 1. The facility identified nine residents who do not have photographs in the electronic health record. 2. Photographs of seven of the nine residents were taken between 10:12 AM and 10:25 AM on April 9, 2026. At 10:30 AM on April 9, 2026, photographs for all seven residents were uploaded to the electronic health record. Two residents were not in the facility at the time and photographs will be completed immediately upon their return. At 12:20 PM on April 9, 2026, one resident returned to the facility, and the resident's photograph was taken and immediately uploaded to the electronic health record. 3. An audit of all residents' electronic health records was completed. Facility staff determined that eight of nine residents had photographs taken and uploaded to the electronic health record for identification purposes. The system process for resident identification was reviewed. The facility	F 0760		

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F 0760 SS=K	Continued from page 48 policy states that photographs of residents for identification purposes will be added to the electronic health record upon admission. 4. The facility ordered wristbands for all residents containing the residents' name and date of birth as a secondary identification method. The wristbands are expected to arrive at the facility on April 13, 2026. 5. Resident photographs will be updated in the electronic health record as necessary and will be reviewed annually during resident care planning meetings by the Social Services Director or designee. 6. The Nursing Home Administrator (NHA), Registered Nurse Supervisor, or designee will ensure resident photographs are taken on the day of admission and uploaded to the electronic health record for identification purposes during medication administration. A medical wristband containing the resident's name and date of birth will also be applied in accordance with the resident admission	F 0760		

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F 0760 SS=K	Continued from page 49 procedure. 7. Education for Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) began at 10:30 AM on April 9, 2026, and remains ongoing to ensure nursing staff follow the policy regarding the five rights of medication administration (right resident, right medication, right dose, right route, and right time). Education emphasizes use of photographs in the electronic health record to identify residents and prevent administration of medication to the wrong residents. Employees working the second shift will receive education prior to accepting resident assignments. Education regarding procedures for obtaining resident photographs and uploading images into the electronic health record is available in the RN Supervisor's office. The facility utilizes one agency for nursing staff. The agency received a copy of the education materials, which must be completed by agency staff prior to accepting shifts in the facility. No agency staff are currently scheduled. The orientation packet for agency staff will be updated to include the revised admission procedure and	F 0760		

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F 0760 SS=K	Continued from page 50 updated medication administration policy. 8. Audits of new admissions will be conducted by the NHA or designee to ensure photographs are uploaded appropriately into the electronic health record. The Quality Assurance Committee was notified of the Immediate Jeopardy and plan of correction. Audits of photograph identification for new admissions will be conducted daily for two months, with results reported to the Quality Assurance Committee for review and alternative actions as required. The facility implemented corrective actions on April 9, 2026, including obtaining resident photographs, uploading photographs to the electronic health record, initiating staff education regarding the five rights of medication administration (right resident, right medication, right dose, right route, right time), and implementing a secondary resident identification method utilizing wristbands containing resident name and date of birth.	F 0760		

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NAME OF PROVIDER OR SUPPLIER: EMBASSY OF TUNKHANNOCK		STREET ADDRESS, CITY, STATE, ZIP CODE: 30 VIRGINIA DRIVE TUNKHANNOCK, PA 18657		
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F 0760 SS=K	Continued from page 51 Verification of implementation of corrective actions was completed onsite April 9, 2026. The Immediate Jeopardy was lifted April 9, 2026, at 3:45 PM. Refer F627 Refer F658 Refer F835 28 Pa. Code 211.12 (b)(1) Management. 28 Pa. Code 211.9 (a)(1)(d) Pharmacy services. 28 Pa. Code 211.10 (c)(d) Resident care policies. 28 Pa. Code 211.12 (d)(1)(2)(3)(5) Nursing services.	F 0760		
F 0835 SS=E		F 0835		

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F 0835 SS=E	Continued from page 52 483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 0835	Facility cannot retroactively correct the deficient practice identified by the complaint survey on 4/9/2026 2. Administrator and Director of Nursing audited all charts for resident identification and provided education to licensed nurses as part of the IJ abatement plan and continue to follow approved abatement plan enforcement actions. 3. Administrator and Director of Nursing will be educated by the Chief Nursing Officer, Corporate Operations Officer and Regional Director of Operations on job descriptions, expectations, and implementation of enforcement of effective systems to support accurate resident identification prior to medication administration. Corporate leadership will review current policies for resident identification and compliance monitoring. 4. DON/designee will audit nurses administering medications to ensure the 5 rights of medication pass are followed and all residents have accurate resident identification prior	Completion Date: 04/25/2026 Status: APPROVED Date: 04/21/2026

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F 0835 SS=E	Continued from page 53	F 0835	to medications administration is identified in 3 resident med passes, 3 X week for 4 weeks. Results from audits will be sent to the QA committee as part of the compliance program to ensure 100% correct resident identification for medication passes. 5. April 25, 2026	

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F 0835 SS=E	Continued from page 54 Based on a review of clinical records, facility policies and procedures, job descriptions, facility investigative documentation, and staff interviews, it was determined the facility failed to administer the facility in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The Nursing Home Administrator and Director of Nursing failed to ensure implementation, oversight, and enforcement of effective systems to support accurate resident identification prior to medication administration and resulted in Immediate Jeopardy when an opioid medication was administered to the wrong resident (Resident 51), requiring emergency medical intervention. Findings included: A review of the facility's Nursing Home Administrator's (NHA) job description signed June 1, 2024 revealed that the NHA is responsible for directing the day-to-day functions of the facility in	F 0835		

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F 0835 SS=E	Continued from page 55 accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality care can be provided to residents at all times The job description indicated the NHA is responsible for developing and maintaining written policies and procedures that govern the operation of the facility. The NHA is responsible for interpreting the facility's policies and procedures to employees, residents, and government agencies. The NHA is responsible to consult with department directors concerning the operation of their departments to assist in eliminating or correcting problem areas, ensure that all facility personnel follow established safety regulations, and ensure that residents receive care in a manner and in an environment that maintains or enhances their quality of life without affecting the safety and rights of other residents. The NHA is also responsible to ensure that each resident receives the necessary nursing, medical, and psychosocial services to attain and maintain the highest possible mental and physician functional status.	F 0835		

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F 0835 SS=E	Continued from page 56 A review of the Director of Nursing (DON) job description, signed and dated January 26, 2026, revealed that under the supervision of the NHA and Medical Director, the DON is responsible for planning, organizing, developing, implementing, evaluating, and directing the overall operation of the Nursing Services Department in accordance with current federal, state, and local laws, regulations, and professional standards. The job description identified the DON as responsible for ensuring the highest practicable level of quality nursing care is always provided. The DON is further responsible for developing, maintaining, and periodically updating nursing policies and procedures that govern day-to-day nursing operations, as well as ensuring staff are educated on and compliant with those policies. The job description also identified responsibility for coordinating nursing services with other departments to ensure continuity of care and the resident's total plan of care is consistently implemented.	F 0835		

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F 0835 SS=E	Continued from page 57 A review of the facility policy titled "Medication Administration," last reviewed January 23, 2026, required licensed nurses to follow professional standards of practice and the five rights of medication administration, including verification of the right resident prior to administering medication. The policy required staff to utilize the resident's photograph in the Medication Administration Record (MAR, a clinical record used to document medications administered) as part of the identification process. A review of the facility policy titled "Medication Administration," last reviewed January 23, 2026, revealed medications are to be administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice to ensure safe and accurate medication administration. The policy requires nurses to follow the five rights of medication administration, which include confirming the right resident (verifying the correct individual),	F 0835		

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F 0835 SS=E	Continued from page 58 right drug (verifying the correct medication), right dose (verifying the correct amount), right route (verifying the method of administration, such as by mouth), right time (verifying the correct scheduled time), and right documentation (recording the medication in the Medication Administration Record (MAR), a clinical record used to document medications administered). The policy also requires the nurse to remain with the resident until medications are taken. The policy further requires staff to verify the resident's identity by reviewing the resident's photograph in the MAR prior to and during administering medications. A review of the facility policy titled "Resident Admission Procedure," last updated April 9, 2026, required staff to obtain and upload resident photographs to the electronic health record to support accurate identification of residents. As cited under the Code of Federal Regulatory	F 0835		

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F 0835 SS=E	Continued from page 59 Groups for Long Term Care, Quality of Care (F 760) 483.45(f)(2) Pharmacy Services, Employee 1 agency Registered Nurse (RN) administered morphine sulfate (a potent opioid pain medication that can slow breathing and heart rate) and levothyroxine (a medication used to treat thyroid deficiency) intended for Resident 50 to Resident 51. Although Resident 51 had a photograph available in the electronic health record, Employee 1 did not utilize the photograph or another reliable identifier to confirm the resident's identity prior to medication administration. Employee 1 called out Resident 50's name, and Resident 51 responded verbally. Employee 1 proceeded with medication administration without further verification of identity. Resident 51 experienced adverse effects including bradycardia (an abnormally slow heart rate) and required transfer to the emergency department where naloxone (a medication used to reverse opioid effects) was administered to prevent further clinical decline.	F 0835		

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F 0835 SS=E	<p>Continued from page 60</p> <p>In addition, record review revealed multiple residents did not have photographs available in the electronic health record until surveyor inquiry on April 9, 2026, indicating the facility did not consistently implement its identification process and did not ensure an alternative reliable method for resident identification was consistently used by staff.</p> <p>The NHA and DON failed to ensure effective systems were implemented, monitored, and enforced to support staff compliance with facility policy and professional standards for resident identification prior to medication administration. The facility failed to ensure staff consistently follow established identification protocols designed to prevent medication errors.</p> <p>The facility's failure to effectively manage and oversee operations resulted in a breakdown of medication administration safeguards and placed residents at risk for serious harm or death.</p> <p>Immediate Jeopardy was identified on April 9,</p>	F 0835		

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F 0835 SS=E	Continued from page 61 2026, at 11:15 AM, as the facility's noncompliance caused or was likely to cause serious injury, harm, impairment, or death to residents. Immediate Jeopardy was removed on April 9, 2026, at 3:45 PM, following implementation of corrective actions. Refer F760 28 Pa Code 211.10 (c) Resident care policies. 28 Pa. Code: 201.12 (a) Responsibility of licensee 28 Pa. Code: 201.18 (b)(1)(e)(1) Management 28 Pa. Code:211.12(c) Nursing Services	F 0835		



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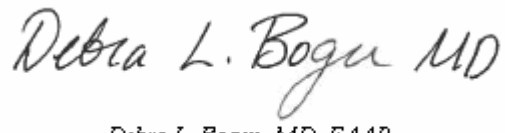
EMBASSY OF TUNKHANNOCK

STATE LICENSE NUMBER: 551002

SURVEY EXIT DATE: 04/09/2026

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, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

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