| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395456 | A. BLDG: 00<br>B. WING: | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
|---|---|
| **EMBASSY OF WYOMING VALLEY**<br>STATE LICENSE NUMBER: **971402** | **50 NORTH PENNSYLVANIA AVE**<br>**WILKES BARRE, PA 18701** |

| (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 |
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| F 0000 | INITIAL COMMENT<br><br>Based on an Abbreviated Complaint Survey completed on January 30, 2025, it was determined that Embassy of Wyoming Valley 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 0803<br><br>SS=F | | F 0803 | | |

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 0803<br><br>SS=F | Continued from page 1<br><br>483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed<br><br>§483.60(c) Menus and nutritional adequacy.<br>Menus must-<br><br>§483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;<br><br>§483.60(c)(2) Be prepared in advance;<br><br>§483.60(c)(3) Be followed;<br><br>§483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;<br><br>§483.60(c)(5) Be updated periodically;<br><br>§483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and<br><br>§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.<br><br>This REQUIREMENT is not met as evidenced by: | F 0803 | F 803<br>The facility follows the written planned menus.<br>Residents 14,55,27 and 56 were not harmed from the deficient practice, nor were the remaining residents.<br>On 1/30/2025 a substitution was made as the food items on the menu did not arrive with the weekly order nor the makeup order the following day. All substitutions are approved by the dietician; all will be audited for appropriate ness.<br>'The dietary department may 'run out of an item', or an item may not have come in.' The dietary department is in weekly contact with the vendor regarding missed items and will purchase locally any items that we do not have available for the next meal. Audits will be conducted weekly x 6 weeks of items needed to be purchased locally. Menu changes will be posted next to all menus, as soon as a change needed is known.<br>The Food service director has in-serviced staff on food substitutions, accurate ordering and inventory | Completion Date: **02/28/2025** Status: **APPROVED** Date: **02/18/2025** |

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| F 0803<br><br>SS=F | Continued from page 2 | F 0803 | Surveys will be conducted with Residents weekly x 8 weeks to assure they are getting the food items as per menus<br>Audits will be conducted weekly 6 weeks, by dietician/FSS on any changes on the menu as well as shopping needs.<br>Eight residents attended the recent food committee on 2/10/2025, with little concerns<br>Results of audits will be reviewed monthly at the Facility's QAPI meeting x 3 months | |
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| F 0803<br><br>SS=F | Continued from page 3<br><br>Based on observations, a review of the facility's planned cycle menus, and resident and staff interview it was determined that the facility failed follow written planned menus for four of seven residents sampled. (Resident 14, 55, 87, and 56).<br><br>Findings included:<br><br>Review of the facility policy titled "Menu Substitutions" last reviewed by the facility January 2024, revealed that menu substitutions/changes shall be made to the planned menu in an emergency situation only and not for the convenience of the facility.<br><br>At the time of the survey ending on January 30, 2025, the facility census was 86 residents.<br><br>On January 30, 2025, at 9:50 AM resident 14 reported the menu changes occurred frequently, and staff only notified him when they are picking up his breakfast tray. He stated that they run out of food and blame the truck for not supplying food to the | F 0803 | | |

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| F 0803<br><br>SS=F | Continued from page 4<br><br>facility.<br><br>Interview with Resident 14 on January 30, 2025, at 10:00 AM revealed that the "always available menu is not consistently available- it's now changed to "IF available" (always available menu is called the alternate entrée menu which includes egg salad sandwich, turkey sandwich, hamburger, grilled cheese sandwich and meatball hoagie). He reported that the facility is consistently running out of the "always available" food items.<br><br>He stated that when ordering from the '"always available" menu, if the kitchen runs out of an item, they will serve him whatever they have left. He provided an example of ordering a hamburger and was served a tuna fish sandwich instead, without any explanation or confirmation that he was agreeable to the substitution. He continued "they run out of food, and they blame the truck for not supplying".<br><br>Interview with Resident 55 on January 30, 2025, at 11:00 AM reported residents do not receive weekly | F 0803 | | |

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| F 0803<br><br>SS=F | Continued from page 5<br><br>menus in their rooms. She stated she would like to have a copy of the menu so she could decide based on the options presented in front of her. She reported that she frequently orders a toasted cheese sandwich and "sometimes they just give you whatever is available, not what I ordered. It happens at least once a week".<br><br>Interview with Resident 87 on January 30, 2025, at 11:15 AM stated that "the kitchen gives me the wrong order when they run out of stuff".<br><br>Interview with Resident 56 on January 30, 2025, at 11:35 AM stated that her food orders were frequently incorrect. She provided an example of ordering a grilled cheese sandwich but receiving a hamburger stating, "That's all they have cause the truck never came". She continued, "I don't get my coffee. They say the ran out of coffee cause the truck didn't come"<br><br>Review of Resident Council Meeting Minutes (January 14, 2025): | F 0803 | | |

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| F 0803<br><br>SS=F | Continued from page 6<br><br>The minutes documented the alternate menu was not always available, and basic food supplies such as sugar, butter, milk, tea, ketchup, and coffee were frequently out of stock. It was noted that the facility was experiencing food supply shortages, but there was no documented evidence that these concerns were addressed by the facility. The facility frequently runs out of bread<br><br>At the time of the survey ending January 30, 2025, there was no documented evidence that the facility addressed the concerns voiced during the food committee meeting regarding food supply shortages.<br><br>Review of the facility's Week 3 lunch menu for Thursday January 30, 2025, revealed that the planned menu included maple glazed ham, macaroni and cheese, Prince Edward vegetable blend, wheat dinner roll and choice of dessert.<br><br>However, an observation of the lunch meal on Thursday January 30, 2025, at 12:34 PM revealed chicken and dumplings were severed in place of the | F 0803 | | |

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| F 0803<br><br>SS=F | Continued from page 7<br><br>ham and macaroni and cheese, and mixed vegetables was served in place of the planned Prince Edward vegetable blend.<br><br>Interview with the dietary manager at this time confirmed substitutions for the lunch meal were made. The dietary manager noted the facility maintains a substitution log and frequently substitutions are made due to not having the food items needed based on the planned menu.<br><br>Review of the facility's meal substitution records revealed multiple instances due to unavailable ingredients affecting a variety of planned menu items.<br><br>Review of the facility's Substitution Record for November 2024 revealed that planned menu items such as baked potatoes, BBQ beef, spinach, mixed vegetables, California blend vegetables, coleslaw, rice, and potato chips all required substitutions due to the items/ingredients to prepare the food items not being available in the facility. | F 0803 | | |

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| F 0803<br><br>SS=F | Continued from page 8<br><br>Review of the facility's Substitution Record for December 2024 revealed that planned menu items such as taco coup, stuffed shells, chicken casserole, tossed salad, hot dogs, and Prince Edward vegetable blend all required substitutions due to the items/ingredients to prepare the food items not being available in the facility.<br><br>Review of the facility's Substitution Record for January 2025 revealed that planned menu items such as ham salad, peaches, pears, hot dogs, French toast, bacon, fruit cocktail, egg salad, taco soup, fish, maple ham, Prince Edward vegetable blend, and macaroni and cheese all required substitutions due to the items/ingredients to prepare the food items not being available in the facility.<br><br>An interview with the Nursing Home Administrator (NHA) and the Dietary Manager on January 30, 2025, at approximately 1:20 PM confirmed that the facility was unable to consistently follow the written planned menus due to supply shortages. The Dietary Manager stated that menu items were ordered | F 0803 | | |

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| F 0803<br><br>SS=F | Continued from page 9<br><br>timely, but the food service supplier was not delivering the food order in its entirety. The NHA confirmed that the facility's food service supplier is not providing the facility with their full order upon delivery.<br><br>The facility to follow written planned menus as required which resulted in unapproved meal substitutions, lack of access to resident-preferred menu options, and inconsistent meal service.<br><br>28 Pa. Code 211.6(a) Dietary Services | F 0803 | | |
| F 0804<br><br>SS=E | | F 0804 | | |

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| F 0804<br><br>SS=E | Continued from page 10<br><br>483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br><br>This REQUIREMENT is not met as evidenced by: | F 0804 | F804<br>The facility will provide meals that are palatable and at a safe and appetizing temperature. Residents 1, 5, 6, 14 and 87 had no ill effect from deficient practices. Residents were asked at Monthly Food services meeting on 2/10/2025 about palatability and temperature concerns, none voiced.<br>Food items are tasted and temped prior to starting the tray line as well as during try line. The trays are then immediately taken upstairs in an enclosed cart. Staff qre being notified as soon as cart arrives for best temperatures and palatability.<br>The Food service director has in-serviced staff on food palatability, how to keep temps at required levels.<br>f804<br>A QA project will be completed on temperatures and the time it takes to serve the resident, and what the temperature is at service time.<br>Findings will be reviewed monthly at the building's QAPI meeting.<br>Changes will be made when deemed appropriately. | Completion Date:<br>**02/28/2025**<br>Status:<br>**APPROVED**<br>Date:<br>**02/18/2025** |

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| F 0804<br><br>SS=E | Continued from page 11 | F 0804 | Staff will be in serviced on palatability | |

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| F 0804<br><br>SS=E | Continued from page 12<br><br>Based on observation, review of food committee minutes, resident and staff interviews, and test tray results, it was determined the facility failed to serve meals that were palatable and at a safe and appetizing temperature for four of the 7 residents sampled (Residents 1, 56, 14, and 87)<br><br>Findings include:<br><br>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.<br><br>Review of the Resident Food Committee Meeting minutes dated December 11, 2024, revealed the residents were asked if the temperature of the hot/cold foods were appropriate. The response indicated was no, with the added comment: cold meals at dinner. | F 0804 | | |

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| F 0804<br><br>SS=E | Continued from page 13<br><br>Review of the Resident Food Committee Meeting minutes dated January 15, 2025, revealed the residents were asked if the temperature of the hot/cold foods were appropriate. The response indicated was "no" with the comment not always and specifically noting French fries.<br><br>During an interview with Resident 14 on January 30, 2025, at 10:00 AM, reported were served at best, lukewarm and that French fries were never hot. He stated he had voiced concerns in Food Committee Meetings, but the facility failed to address the issue.<br><br>During an interview with Resident 1 on January 30, 2025, at 10:47 AM, she reported that the hot food was frequently cold, sometimes warm on the outside but cold in the middle. She reported sending food back to the kitchen out of concern for food safety.<br><br>During an interview with Resident 87 on January 30, 2025, at 11:00 AM, reported the hot food was never hot, just warm. | F 0804 | | |

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| F 0804<br><br>SS=E | Continued from page 14<br><br>During an interview with Resident 56 on January 30, 2025, at 11:10 AM, she reported that hot food was cold sometimes, but she has gotten used to the food not being served hot, so she eats it anyway.<br><br>A test tray performed on the 2nd floor Nursing Unit on January 30, 2025, revealed the test tray arrived on the Nursing Unit at 12:17 PM. The hot meal was chicken and dumplings, mixed vegetables, a butterscotch bar, and a beverage of choice.<br><br>At 12:34 PM, upon serving the last resident, a test tray evaluation was conducted with the Dietary Manager present. The food temperatures were recorded as follows:<br><br>Chicken and dumplings: 125.5 degrees Fahrenheit below the 135 degrees Fahrenheit minimum for hot foods<br>Mixed vegetables: 104.8 degrees Fahrenheit significantly below the required temperature | F 0804 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395456 | A. BLDG: 00<br>B. WING: | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
|---|---|
| **EMBASSY OF WYOMING VALLEY**<br>STATE LICENSE NUMBER: **971402** | **50 NORTH PENNSYLVANIA AVE**<br>**WILKES BARRE, PA 18701** |

| (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 0804<br><br>SS=E | Continued from page 15<br><br>The hot food tasted cold and was not palatable at the time it was served.<br><br>An interview with the Dietary Manager on January 30, 2025, at 12:36 PM confirmed that food must be palatable and served at safe and appetizing temperatures.<br><br>During an interview on January 30, 2025, at approximately 1:10 PM, the Nursing Home Administrator verified the facility is responsible for ensuring that all residents receive meals that are palatable and at a safe and appetizing temperature.<br><br>The facility failed to serve food at proper temperatures and resulted in the lack of palatable and appetizing meals with the potential of food safety risks and unaddressed resident concerns, which compromised the quality of the dining services provided by the facility.<br><br>28 Pa. Code 201.18 (e)(3)(4) Management | F 0804 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | **395456** | A. BLDG: __00_____ B. WING: _____ | **01/30/2025** |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
|---|---|
| **EMBASSY OF WYOMING VALLEY**<br>STATE LICENSE NUMBER: **971402** | **50 NORTH PENNSYLVANIA AVE**<br>**WILKES BARRE, PA 18701** |

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|---|---|---|---|---|
| F 0804<br><br>SS=E | Continued from page 16 | F 0804 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395456 | A. BLDG: __00_____ B. WING: _____ | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
|---|---|
| **EMBASSY OF WYOMING VALLEY** STATE LICENSE NUMBER: **971402** | **50 NORTH PENNSYLVANIA AVE WILKES BARRE, PA 18701** |

| (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 |
|---|---|---|---|---|
| P 5520 | | P 5520 | | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395456 | A. BLDG: 00<br>B. WING: | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
|---|---|
| **EMBASSY OF WYOMING VALLEY**<br>STATE LICENSE NUMBER: **971402** | **50 NORTH PENNSYLVANIA AVE**<br>**WILKES BARRE, PA 18701** |

| (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 |
|---|---|---|---|---|
| P 5520 | Continued from page 1<br><br>Nursing services.<br><br>(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.<br><br>This REGULATION is not met as evidenced by: | P 5520 | P 5520<br>Facility cannot retroactively correct this deficiency.<br>Recruitment of nursing staff will continue via facility websites, Indeed, social media websites, job fairs, off site recruiters and instant interviews from walk-in candidates. Agency staff may be utilized for open shifts if available. The Valentine Open Hiring Event was conducted with interest expressed Retention efforts will be made in earnest. Referral bonuses are offered to current employees. The facility is currently offering a significant sign-on bonus for all new nursing staff.<br>The Director of Nursing/designee will review the ratio daily for compliance.<br>All efforts will be made to meet certified aide staffing ratios. If a call off occurs all efforts will be made to fill that position.<br>The Director of Nursing/designee will audit the certified aide ratio 1x/week for 4 weeks then monthly for | Completion Date: **02/28/2025**<br>Status: **APPROVED**<br>Date: **02/18/2025** |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395456 | A. BLDG: __00_____ B. WING: _____ | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
|---|---|
| **EMBASSY OF WYOMING VALLEY** STATE LICENSE NUMBER: **971402** | **50 NORTH PENNSYLVANIA AVE WILKES BARRE, PA 18701** |

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|---|---|---|---|---|
| P 5520 | Continued from page 2 | P 5520 | 2 months.<br>Results of the audits will be presented to the QA committee for review and recommendation. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395456 | A. BLDG: 00<br>B. WING: | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
|---|---|
| **EMBASSY OF WYOMING VALLEY**<br>STATE LICENSE NUMBER: **971402** | **50 NORTH PENNSYLVANIA AVE**<br>**WILKES BARRE, PA 18701** |

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|---|---|---|---|---|
| P 5520 | Continued from page 3<br><br>Based on a review of nurse staffing and staff interview, it was determined that the facility failed to ensure the minimum nurse aide staff to resident ratio was provided on each shift for 8 shifts out of 21 reviewed.<br><br>Findings include:<br><br>Review of the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations, §211.12 Nursing Services, dated July 1, 2023, indicated the following subsections.<br>(f.1) In addition to the director of nursing services, a facility shall provide all of the following:<br>(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.<br><br>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 | P 5520 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395456 | A. BLDG: 00<br>B. WING: | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
|---|---|
| **EMBASSY OF WYOMING VALLEY**<br>STATE LICENSE NUMBER: **971402** | **50 NORTH PENNSYLVANIA AVE**<br>**WILKES BARRE, PA 18701** |

| (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 |
|---|---|---|---|---|
| P 5520 | Continued from page 4<br><br>night shift based on the facility's census per the regulation that was effective July 1, 2024.<br><br>January 24, 2025 - 5.17 nurse aides on the night shift, versus the required 5.93 for a census of 89.<br>January 26, 2025 - 7.93 nurse aides on the day shift, versus the required 8.90 for a census of 89.<br>January 26, 2025 - 7.17 nurse aides on the evening shift, versus the required 8.09 for a census of 89.<br>January 26, 2025 - 5.77 nurse aides on the night shift, versus the required 5.93 for a census of 89.<br>January 27, 2025 - 6.47 nurse aides on the day shift, versus the required 8.90 for a census of 89.<br>January 27, 2025 - 5.83 nurse aides on the evening shift, versus the required 7.91 for a census of 87.<br>January 28, 2025 - 8.37 nurse aides on the day shift, versus the required 8.70 for a census of 87.<br>January 29, 2025 - 7.87 nurse aides on the day shift, versus the required 8.60 for a census of 86.<br><br>On the above dates mentioned no additional excess higher-level staff were available to compensate this deficiency. | P 5520 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395456 | A. BLDG: __00_____ B. WING: _____ | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
|---|---|
| **EMBASSY OF WYOMING VALLEY** STATE LICENSE NUMBER: **971402** | **50 NORTH PENNSYLVANIA AVE WILKES BARRE, PA 18701** |

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|---|---|---|---|---|
| P 5520 | Continued from page 5<br><br>An interview with the Nursing Home Administrator on January 30, 2025, at approximately 2:30 PM, confirmed the facility had not met the required nurse aide to resident ratios on the above dates. | P 5520 | | |
| P 5530 | | P 5530 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395456 | A. BLDG: 00<br>B. WING: | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
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|---|---|---|---|---|
| P 5530 | Continued from page 6<br><br>Nursing services.<br><br>(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.<br><br>This REGULATION is not met as evidenced by: | P 5530 | p 5530<br>Facility cannot retroactively correct this deficiency.<br>Recruitment of nursing staff will continue via facility websites, Indeed, social media websites, job fairs, off site recruiters and instant interviews from walk-in candidates. Agency staff may be utilized for open shifts if available. The Valentine Open Hiring Event was conducted with interest expressed Retention efforts will be made in earnest. Referral bonuses are offered to current employees. The facility is currently offering a significant sign-on bonus for all new nursing staff.<br>The Director of Nursing/designee will review the ratio daily for compliance.<br>All efforts will be made to meet LPN's ratios. If a call off occurs all efforts will be made to fill that position.<br>The Director of Nursing/designee will audit the LPN ratio 1x/week for 4 weeks then monthly for 2 months. Results of the audits will be | Completion Date: **02/28/2025**<br>Status: **APPROVED**<br>Date: **02/18/2025** |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395456 | A. BLDG: __00_____ B. WING: _____ | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
|---|---|
| **EMBASSY OF WYOMING VALLEY** STATE LICENSE NUMBER: **971402** | **50 NORTH PENNSYLVANIA AVE WILKES BARRE, PA 18701** |

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|---|---|---|---|---|
| P 5530 | Continued from page 7 | P 5530 | presented to the QA committee for review and recommendation. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395456 | A. BLDG: 00<br>B. WING: | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
|---|---|
| **EMBASSY OF WYOMING VALLEY**<br>STATE LICENSE NUMBER: **971402** | **50 NORTH PENNSYLVANIA AVE**<br>**WILKES BARRE, PA 18701** |

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|---|---|---|---|---|
| P 5530 | Continued from page 8<br><br>Based on a review of nurse staffing, resident census, and staff interview, it was determined the facility failed to provide a minimum of one LPN (licensed practical nurse) per 30 residents on the evening shift and one LPN per 40 residents on the night shift on 7 shifts out of 21 reviewed.<br><br>Findings include:<br><br>The minimum required ratio on the evening shift is one LPN for every 30 residents and the minimum required ratio on the night shift is one LPN for every 40 residents. A review of the facility's daily staffing records revealed that the facility did not meet the required minimum LPN-to-resident ratios on the following dates:<br><br>January 24, 2025 - 1.84 LPNs on the evening shift, versus the required 2.97 for a census of 89.<br>January 26, 2025 - 2.22 LPNs on the evening shift, versus the required 2.97 for a census of 89.<br>January 26, 2025 - 1.97 LPNs on the night shift, versus the required 2.23 for a census of 89. | P 5530 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395456 | A. BLDG: __00_____ B. WING: _____ | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
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|---|---|---|---|---|
| P 5530 | Continued from page 9<br><br>January 27, 2025 - 1.91 LPNs on the evening shift, versus the required 2.90 for a census of 87.<br>January 28, 2025 - 1.69 LPNs on the evening shift, versus the required 2.87 for a census of 86.<br>January 29, 2025 - 1.84 LPNs on the evening shift, versus the required 2.87 for a census of 86.<br>January 29, 2025 - 2.06 LPNs on the night shift, versus the required 2.15 for a census of 86.<br><br>An interview with the Nursing Home Administrator on January 30, 2025, at approximately 2:30 PM, confirmed the facility had not met the required LPN-to-resident ratios on the above shifts. | P 5530 | | |
| P 5640 | | P 5640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
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|---|---|---|---|---|
| P 5640 | Continued from page 10<br><br>Nursing services.<br><br>(2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident.<br><br>This REGULATION is not met as evidenced by: | P 5640 | P5640<br><br>P5640The Facility cannot retroactively correct this deficiency. Recruitment of nursing staff will continue via facility websites, Indeed, social media websites, job fairs, off site recruiters and instant interviews from walk-in candidates. Agency staff may be utilized for open shifts if available. The Valentine Open Hiring Event was conducted with interest expressed<br><br>Retention efforts will be made in earnest. Referral bonuses are offered to current employees. The facility is currently offering a significant sign-on bonus for all nursing staff. The Director of Nursing/designee will review the PPD daily for compliance. All efforts will be made to meet the required PPD of 3.2. If a call off occurs all efforts will be made to achieve the PPD.<br>The Director of Nursing/designee will audit the PPD 1x/week for 4 weeks then monthly for 2 months. | Completion Date: **02/28/2025**<br>Status: **APPROVED**<br>Date: **02/18/2025** |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
|---|---|---|---|
| | 395456 | A. BLDG: __00_____ B. WING: _____ | 01/30/2025 |

| NAME OF PROVIDER OR SUPPLIER: | STREET ADDRESS, CITY, STATE, ZIP CODE: |
|---|---|
| **EMBASSY OF WYOMING VALLEY** STATE LICENSE NUMBER: **971402** | **50 NORTH PENNSYLVANIA AVE WILKES BARRE, PA 18701** |

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|---|---|---|---|---|
| P 5640 | Continued from page 11 | P 5640 | Results of the audit will be presented to the QA committee for review and recommendation | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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|---|---|---|---|---|
| P 5640 | Continued from page 12<br><br>Based on a review of nurse staffing and resident census and staff interview, it was determined that the facility failed to consistently provide minimum general nursing care hours to each resident daily.<br><br>Findings include:<br><br>Review of the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations, §211.12 Nursing Services, dated July 1, 2023, indicated the following subsections.<br>(i) A minimum number of general nursing care hours shall be provided for each 24-hour period as follows:<br>(2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident.<br><br>A review of the facility's staffing levels revealed that on the following dates the facility failed to provide minimum nurse staffing of 3.2 hours of general | P 5640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC) | (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION: | (X3) DATE SURVEY COMPLETED: |
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| | 395456 | A. BLDG: 00<br>B. WING: | 01/30/2025 |

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|---|---|---|---|---|
| P 5640 | Continued from page 13<br><br>nursing care to each resident per the regulation effective July 1, 2024:<br><br>January 24, 2025 - 3.09 direct care nursing hours per resident.<br>January 26, 2025 - 2.81 direct care nursing hours per resident.<br>January 27, 2025 - 2.65 direct care nursing hours per resident.<br>January 28, 2025 - 3.13 direct care nursing hours per resident.<br>January 29, 2025 - 3.08 direct care nursing hours per resident.<br><br>The facility's general nursing hours were below minimum required levels on the dates noted above.<br><br>An interview with the Director of Nursing on January 30, 2025, at approximately 2:30 PM confirmed the facility failed to consistently provide minimum general nursing care hours to each resident daily. | P 5640 | | |

# Certified End Page

**EMBASSY OF WYOMING VALLEY**

**STATE LICENSE NUMBER: 971402**

**SURVEY EXIT DATE: 01/30/2025**

**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