STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395273	A. Building B. Wing	01/07/2022

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Embassy of Scranton	824 Adams Avenue Scranton, PA 18510

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on observation and staff interview, it was determined that the facility failed to maintain a clean and orderly environment in resident areas and in resident rooms on two of three units (Unit 2 and Unit 3). Findings include: Observations on January 5, 2022, at 12:20 PM, on Unit 3, revealed two dirty resident breakfast trays that was left on a cart with a clean ice chest that was used for resident beverages in the resident pantry area. There was another dirty breakfast tray observed on top of the microwave in the resident pantry. Dried spills and food debris were observed to be stuck on the interior surfaces of the microwave in the pantry. Observations made January 5, 2022, at 12:30 PM, on Unit 3 inside resident room [ROOM NUMBER] - A and 321 - B, revealed dirt and debris scattered on the floor. Observation in resident room [ROOM NUMBER] - A and 320 - B revealed dirt and debris scattered on the floor around the room. A pair of pants were observed on the floor of the bathroom, which was also soiled. An accumulation of dirt and debris was observed around the perimeter of the unit and in the corners of the hallway. Observations on January 6, 2022, at 12:45 PM, on Unit 2 inside resident room [ROOM NUMBER]-A, revealed that dirt and debris accumulated behind the bed and in the corners of the room and black scuff marks and shoe prints on the floor throughout the room. Resident 20's tube feeding pole was observed with an accumulation of splattered feeding formula at the base of the pole. Interview with the Nursing Home Administrator (NHA) on January 6, 2022, at 1:00 PM, confirmed the above observations and confirmed that the residents' environment and care equipment should be maintained in a clean and orderly manner. 28 Pa Code 207.2(a) Administrators responsibility

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 26228 Based on a review of the facility's abuse policy and employee personnel files and staff interviews, it was determined that the facility failed to implement their established procedures for training and screening of five of five employees (Employee 1, 2, 3, 4 and 5). Findings include: A review of the facility's current Abuse Protection policy last reviewed January 2021 revealed procedures for screening potential employees that included protocols for conducting background checks including State criminal and Federal criminal (if applicable). It also indicated that mandated staff training/orientation programs that include such topics as abuse prevention and training is provided at the time of hire, annually and as needed. In accordance with Act 13 Elder Abuse Mandatory Reporting and Act 169 Criminal Background Checks, nursing facilities are required to obtain a criminal background check on all newly hired employees. Facilities are required to obtain the Pennsylvania State Police background check within 30 days of hire on all prospective employees. If the prospective employee does not have continuous residency in Pennsylvania for two years prior to employment then the facility is required to obtain a Federal Bureau of Investigation (FBI) check within 90 days. Employee 2 (Nurse Aide) was hired on October 1, 2021, the Pennsylvania State Police background check in the employee's file was dated May 1, 2020, more than a year prior to her hire date. There was no indication the facility obtained a current Pennsylvania State Police background check upon hire. Employee 1 (Activity Director) was hired on December 7, 2021, Employee 2 (Nurse Aide) was hired on October 1, 2021, Employee 3 (Temporary Nurse Aide) was hired on December 14, 2021, Employee 4 (Maintenance Assistant) was hired on December 15, 2021, and Employee 5 (Cook) was hired on November 10, 2021. The facility was unable to provide evidence that any of the 5 newly hired employees received abuse prevention training on orientation as indicated in facility policy. Interview with the Human Resources Director on January 6, 2022 at 12:15 p.m., confirmed Employee 2, did not have a current Pennsylvania State Police background check in the last year and a half, and that there was no evidence that Employee 1, 2, 3, 4 and 5 were inserviced at the time of orientation on the facility's abuse prohibition policy and procedures 28 Pa. Code 201.20(b) Staff development 28 Pa. Code 201.19 Personnel policies and procedures 28 Pa. Code 201.29(a)(c) Resident rights

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of the facility's abuse prohibition policy and procedures, information submitted by the facility and select facility investigative reports and staff interviews it was determined that the facility failed to timely report alleged sexual abuse of one resident (Resident 2) out of 17 residents sampled. Findings include: Review of facility's policy entitled Abuse Policy last reviewed by the facility January 2022, indicated all reports of resident abuse shall be promptly reported to local, state, and federal agencies and thoroughly investigated by the administrator or designee. Reporting to the state agency (Pennsylvania Department of Health) is required within two hours if the alleged violation involves abuse or 24 hours if the alleged violation does not involve abuse. In response to an allegation of abuse, the facility will analyze and implement necessary changes to prevent future occurrences of abuse. A review of the clinical record of Resident 2 revealed admission to the facility on [DATE], with diagnoses which included chronic respiratory failure with hypoxia (oxygen deficiency). A review of Annual Minimum Data Set assessment dated [DATE], (MDS - a federally mandated standardized assessment process completed periodically to plan resident care) revealed that the resident was moderately cognitively impaired. A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses that included unspecified mood disorder A review of Admission Minimum Data Set assessment dated [DATE], revealed that Resident 1 was moderately cognitively impaired. A review of progress notes in Resident 1's clinical record dated from February 2022 through March 2022, revealed the resident displayed inappropriate behaviors of propositioning female staff and residents, being flirtatious with female staff and residents, trying to get female residents to come into his room, and increased sexual verbalizations. A review of a facility incident report dated March 7, 2022, at 1:30 PM, indicated that staff were made aware of an incident that occurred on March 5, 2022, between Resident 1 and Resident 2. A review of an Employee 1's , TNA (temporary nurse aide), witness statement dated March 5, 2022, revealed that Employee 1 was walking by Resident 2's bedroom and saw Resident 1 standing over Resident 2 kissing her, while Resident 2 remained in bed. Employee 1 stated that Resident 1's pants were halfway down and Resident 2's brief was unfastened. The employee stated that she notified Employee 2 LPN (license practical nurse) of the incident. According to information submitted by the facility dated March 7, 2022, the facility reported the alleged sexual abuse of Resident 2, two days after the occurrence on March 5, 2022. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Employee 2, LPN, on March 10, 2022, at 10:50 AM revealed that Employee 2 verified that after the incident between Resident 1 and Resident 2, she did not assess Resident 2 or call the nursing supervisor to assess Resident 2 for sexual activity or injury. Employee 2 stated that she instructed the nurse aide staff to get Resident 2 out of bed and seat her in the dining room. Employee 2 stated that she did not report the incident of alleged sexual abuse of Resident 2 because she did not believe it was abuse. When asked if she was aware the facility's procedures in response to potential sexual abuse, including any resident assessment and measures for preservation of the scene and potential evidence, Employee 2 was unaware of what to do with a situation of potential sexual abuse of a resident. An interview with the Nursing Home Administrator on March 10, 2022, at 11:33 AM revealed she was not aware of the alleged sexual abuse until March 7, 2022, two days after the incident occurred. She confirmed that the potential sexual abuse of Resident 2 by Resident 1 was not reported to the State Survey Agency in a timely manner and in accordance with facility policy. 28 Pa. Code 201.14 (a) Responsibility of licensee 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a)(c)(d) Resident Rights 28 Pa. Code 211.12(a)(c)(d)(5) Nursing Services

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on a review of clinical records, facility submitted documentation, select incident/accident reports, and staff interviews it was determined that the facility failed to timely investigate the alleged sexual abuse of a resident and failed to promptly implement measures to protect this resident and other female residents from the potential for further abuse while the investigation was in progress for one resident out of 16 sampled (Resident 1). Findings included: A review of facility policy entitled Abuse Policy last revised January 2022, revealed that the facility will complete a timely and thorough investigation of all allegations of abuse. A review of the clinical record of Resident 2 revealed admission to the facility on [DATE], with diagnoses which included chronic respiratory failure with hypoxia (oxygen deficiency). A review of Annual Minimum Data Set assessment dated [DATE], (MDS - a federally mandated standardized assessment process completed periodically to plan resident care) revealed that the resident moderately cognitively impaired. A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses that included unspecified mood disordered. A review of Admission Minimum Data Set assessment dated [DATE], revealed that the resident moderately cognitively impaired. A review of progress notes in Resident 1's clinical record dated from February 2022 through March 2022, revealed that Resident 1 exhibited inappropriate behaviors of propositioning female staff and residents, being flirtatious with female staff and residents, trying to get female residents to come into his room, and increased sexual verbalizations. A review of a facility incident report dated March 7, 2022, at 1:30 PM, indicated staff was made aware of an incident that occurred on March 5, 2022, between Resident 1 and Resident 2. A review of an Employee 1's TNA (temporary nurse aide) witness statement dated March 5, 2022, revealed that Employee 1 was walking by Resident 2's room and saw Resident 1 standing over Resident 2 kissing her as Resident 2 was in bed. Resident 1's pants were halfway down and Resident 2's brief was unfastened. Employee 1 stated that she informed Employee 2 LPN (license practical nurse) of the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Employee 2 LPN on March 10, 2022, at 10:50 AM revealed that Employee 2 verified that the incident between Resident 1 and Resident 2, she did not assess Resident 2 for signs of potential sexual abuse or injury or call the nursing supervisor to assess Resident 2. Employee 2 stated that she instructed the nursing staff to get Resident 2 out of bed and seat her in the dining room. The employee stated Resident 1 and Resident 2 remained on the same unit and were not separated until March 7, 2022. Employee 2 also confirmed that an investigation was not initiated at the time of the incident. Employee 2 stated that she not believe the incident was abuse despite Resident 2's cognitive impairment and inability to consent to sexual activity. An interview with the Nursing Home Administrator on March 10, 2022, at 11:33 AM revealed she was not aware of the alleged sexual abuse until March 7, 2022. Further she confirmed that an investigation into the alleged abuse was not initiated timely and did not begin until March 7, 2022, two days after the incident occurred and the immediate measures were not taken to protect Resident 2 from the potential for further abuse. 28 Pa. Code 201.18 (e)(1) Management 28 Pa. Code 201.18 (e)(2) Management 28 Pa. Code 201.29 (a) Resident rights 28 Pa. Code 201.29 (c) Resident rights 28 Pa. Code 201.29 (d) Resident rights 28 Pa. Code 211.12 (c) Nursing services

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13456 Based on clinical record review and staff interview, it was determined the facility failed to ensure that the necessary resident information was communicated to the receiving health care provider for three out of 18 sampled residents (Resident 16, Resident 57, and Resident 58) transferred and failed to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility and ensure the presence of required documentation demonstrating the necessity for the resident's discharge one resident out of 18 sampled (Resident 120). The findings include: Review of Resident 57's clinical record revealed that he was initially admitted to the facility on [DATE], with diagnoses that included sepsis [an infection of the blood stream resulting in a cluster of symptoms such as drop in a blood pressure, increase in heart rate and fever], cognitive communication deficit, and unspecified dementia without behavioral disturbances [a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems]. Further review of the resident's clinical record revealed that the resident was admitted to the hospital on October 30, 2021 and returned to the facility on [DATE]. A review of the clinical record revealed that Resident 58 was most recently admitted to the facility on [DATE], with diagnoses to include metabolic encephalopathy [is a broad category that describes abnormalities of the water, electrolytes, vitamins, and other chemicals that adversely affect brain function], dysphagia (difficulty swallowing), diabetes, and major depressive disorder [is caused by genetic, environmental and psychological factors with symptoms that include feelings of sadness, low esteem, hopelessness]. Further review of the resident's clinical record revealed that the resident was admitted to the hospital on September 7, 2021 and returned to the facility on [DATE]. A review of Resident 16's clinical record revealed on October 24, 2021 he was admitted to the hospital after sustaining a fall. Progress notes indicated he had a large hematoma (a localized swelling that is filled with blood caused by a break in the wall of a blood vessel) to his left forehead and his left eye was noted to be red and blue in color. Resident 16 was admitted to the hospital and returned to the facility on [DATE]. Interview conducted on with the Nursing Home Administrator (NHA) on January 6, 2022, at 10:15 AM, revealed that that nursing staff should communicate with the receiving health care facility upon transfer or discharge from the facility by providing the receiving facility a copy of the resident's Profile Face Sheet, the current Medication Administration Record, comprehensive person-centered care plan, and their POLST (Provider Orders for Life Sustaining Treatment) form. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	However, the facility was unable to demonstrate that Resident 57's, Resident 59's and Resident 16 that the necessary information, including the resident's care plan goals, was included with the transfer information communicated to the receiving health care facilities. A review of the clinical record revealed that Resident 120 was admitted to the facility on [DATE] with diagnoses including unspecified dementia with behavioral disturbance and anxiety. The most recent quarterly Minimum Data Set assessment (a federally mandated standardized assessment completed periodically to plan resident care) dated, August 7, 2021, indicated that the resident had a BIMS (brief interview mental screening) score of 6 indicating severe cognitive impairment. A review of the resident's clinical record and information submitted by the facility revealed that following the resident's admission the resident had been involved involved in incidents with with other residents, including altercations during which the resident smacked another resident with a newspaper and also episodes of intrusive wandering, into other resident rooms and rummaging through other residents' personal belongings. Progress notes dated September 21, 2021, revealed that the facility contacted the resident's daughter informing her of the resident's increased behaviors. It was noted that facility explained to the resident's daughter that due to the facility being unable to appropriately meet her needs they recommended that the resident be transferred to a facility with a locked unit. The resident's daughter agreed to the transfer. The facility informed the resident's daughter that a sister facility had an available bed for the resident. The resident was transferred out of the facility on this same date. A review of the resident's discharge summary written by the CRNP (certified nurse practitioner) on September 30, 2021, revealed that the reason for discharge was related to advancing dementia. The summary of the resident's care revealed that the resident required 24 hour supervision, medication management for bipolar disorder, insomnia and heart failure. The resident required frequent redirection related to cognitive deficits during her course of stay at the facility. The facility failed to demonstrate that any of the circumstances permissible for a facility to initiate a transfer or discharge had occurred. The resident's clinical record did not show the basis for the resident's transfer or discharge. This documentation must be made before, or as close as possible to the actual time of transfer or discharge. The resident's physician had not documented information about the basis for the transfer or discharge including te specific resident needs the facility could not meet; the facility efforts to meet those needs; and the specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility Interview with the social worker on January 7, 2022 at 2:30 PM indicated that the resident was transferred to another facility because the facility was unable to properly supervise the resident. 28 Pa. Code 201.25 Discharge policy

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13456 Based on clinical record review and staff interview, it was determined the facility failed to ensure that a written notice of transfer to the hospital was provided to the resident and the residents' representative in a language and manner that could be understood for three out of 18 residents reviewed (Resident 57, 58 and 16). Findings include: Review of Resident 58's clinical record revealed that the resident admitted to the hospital on September 7, 2021. Review of the facility provided Notification of Transfer (Emergency) form that was dated September 8, 2021, revealed that the resident was transferred /discharged to an acute care facility on September 7, 2021 for the reason of Sepsis which was not noted in a language and manner that could be understood to the resident or resident representative. Review of Resident 57's clinical record revealed that the resident was admitted to the hospital on October 30, 2021. Review of the facility provided Notification of Transfer (Emergency) form that was dated November 1, 2021, revealed that the resident was transferred /discharged to an acute care facility on October 30, 2021 for the reason of GI Bleeding (Gastrointestinal (GI) bleeding is a symptom of a disorder in your digestive tract). Interview with the Nursing Home Administrator (NHA) on January 6, 2022, at approximately 10:20 AM, confirmed that the written notices provided to both the resident and resident' representative did not include the reason for the facility-initiated transfer in a language and manner that could be understood. Review of Resident 16's clinical record revealed that the resident was admitted to the hospital on October 24, 2021 and returned to the facility on [DATE]. The facility was unable to provide a Notification of Transfer (Emergency) form which indicated the reason for transfer to the hospital provided to the resident and representative, which was confirmed by the NHA during interview on January 7, 2022. 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge 28 Pa. Code 201.29(h) Resident rights 28 Pa. Code 201.14(a) Responsibility of Licensee

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 13456 Based on a review of clinical records and staff interview it was determined that the facility failed to provide evidence of written information of the facility's bed hold policy provided upon transfer to the hospital for one of three residents reviewed for hospital transfers. (Resident 16). Findings include: A review of the clinical record revealed that Resident 16 was transferred to the hospital on October 24, 2021, and returned to the facility October 27, 2021. Interview with the Nursing Home Administrator on January 7, 2022 at 1:00 PM, confirmed that the facility did not provide the resident or resident representative with a written notice, which specifies the duration of the bed hold upon the residents' transfer to the hospital. 28 Pa Code 201.18 (e)(1) Management 28 Pa Code 201.29 (b)(d)(f) Resident rights

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 26228 Based on a review of clinical records and the Resident Assessment Instrument (RAI) and staff interviews, it was determined that the facility failed to conduct a significant change Minimum Data Set Assessments (MDS - a federally mandated standardized assessment process conducted at specific intervals to plan resident care) for one of 18 residents reviewed (Resident 63). Findings include: The RAI Manual Version 3.0 Coding Instructions for A0310A indicates that If a nursing home resident elects the hospice benefit, the nursing home is required to complete an MDS Significant Change in Status Assessment (SCSA). A review of the clinical record of Resident 63 revealed that the resident had experienced a significant decline in condition and was placed on Hospice Care (a type of care and philosophy of care that focuses on the palliation of a chronically ill, terminally ill or seriously ill patient's pain and symptoms, attending to their emotional and spiritual needs) on December 19, 2021. According to the RAI User's Manual a significant change MDS assessment is to be completed within 14 calendar days of the determination of a significant change. The facility failed to complete a significant change MDS Assessment of Resident 63 to reflect the resident elected the hospice benefit on December 19, 2021. An interview with the Administrator on January 6, 2021, at 9:00 a.m. verified that a significant change MDS Assessment was not completed to reflect Resident 63's election of the hospice benefit on December 19, 2021. 28 Pa. Code 211.5(g)(h) Clinical records 28 Pa. Code 211.12(c)(d)(3)(5) Nursing services

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13456 Based on a review of clinical records and the Resident Assessment Instrument and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set Assessments (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) accurately reflected the status of seven residents out of 18 sampled (Residents 30, 48, 61, 63, 67, 31 and 56). Findings include: A review of Resident 30's quarterly MDS Assessments dated July 1, 2021, and November 4, 2021, both revealed in Section N0410 Medications Received that Resident 30 received an antianxiety medication during the entire 7 days of the look back period. Review of the Medication Administration Records (MAR) for June 2021, July 2021, October 2021 and November 2021, revealed no indication that Resident 30 received an antianxiety medication during these 4 months reviewed. A review of Resident 48's quarterly MDS Assessments dated November 16, 2021, revealed in Section N0410 Medications Received that Resident 48 did not receive an Opioid medication during the entire 7 days of the look back period. Review of the resident's MAR for November 2021, revealed that Resident 48 received Tramadol (a drug that belongs to the group of medicines called opioid analgesics used to treat moderate to severe pain) 50 milligrams (mg) three times a day during the entire 7 days of the look back period. A review of Resident 61's quarterly MDS Assessments dated December 10, 2021, and annual MDS assessment dated [DATE], both revealed in Section N0410 Medications Received that Resident 61 received an antianxiety and hypnotic medication. Review of the MARs for July 2021 and November 2021, revealed no indication that Resident 61 received an antianxiety or hypnotic medication. A review of Resident 63's significant change MDS assessment dated [DATE] revealed in Section H0100 Appliances, indicated that Resident 63 had an indwelling catheter. Review of Resident 63's clinical record revealed no indication that the resident had an indwelling catheter. A review of Resident 67's quarterly MDS assessment dated [DATE], revealed in Section N0410 Medications Received that Resident 67 received an antipsychotic medication during the entire 7 days of the look back period. Review of the Medication Administration Record for May 2021, confirmed that the resident received an antipsychotic drug. However, in section N0450 Antipsychotic Medication Review it was noted that no antipsychotic medications were received making the May 7, 2021, quarterly MDS inaccurate. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395273	A. Building B. Wing	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 67's quarterly MDS assessment dated [DATE], Section N0410 Medications Received indicated that Resident 67 did not receive an anticoagulant medication during the entire 7 days of the look back period. Review of the MAR for December 2021, indicated that Resident 67 received Xarelto (an anticoagulant medication) 2.5 mg two times a day during the entire 7 days of the look back period. According to the RAI User's Manual, Section A 1500 Preadmission Screening and Resident Review (PASRR) is to be completed if the type of assessment is an admission assessment, significant change or annual assessment. An Annual MDS' Assessments of Resident 31 dated November 6, 2021, revealed Section A 1500 was coded as 0 indicating that the resident was not considered by the State to require a Level II PASRR process, to have serious mental illness, and/or intellectual disability or mental retardation or a related condition. However, a review of Resident 31's clinical record revealed a Level I PASRR was completed on July 18, 2016, which indicated that the resident met the criteria for a Level II PASRR. Interview with the Social Worker on January 7, 2021 at 1:00 pm. confirmed that the resident's annual MDS assessment dated [DATE] was inaccurate, with respect to completion of Section A 1500 related to the PASRR. A Significant Change MDS Assessment of Resident 56 dated November 5, 2021, revealed Section A 1500 was coded as 0 indicating that the resident was not considered by the State to require a Level II PASRR process, to have serious mental illness, and/or intellectual disability or mental retardation or a related condition. However, a review of Resident 56's clinical record revealed a Level I PASRR was completed on November 24, 2014, which indicated that the resident met the criteria for a Level II PASRR that was completed on November 19, 2014. Interview with the Social Worker on January 7, 2021 at 1:00 pm. confirmed that the resident's annual MDS Assessments dated November 5, 2021 was inaccurate, with respect to completion of Section A 1500 related to the PASRR. Interview with the Administrator on January 7, 2022 at 10:30 p.m. confirmed the MDS errors for Residents 30, 48, 61, 63, 31. 56 and 67. 28 Pa. Code 211.5(g)(h) Clinical records 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on review of clinical records and staff interview it was determined that the facility failed to implement a resident's person-centered comprehensive care plan to meet the individualized needs of one resident (Residents 66) out of 18 sampled. Findings included: Review of Resident 66's clinical record revealed that he was admitted to the facility on [DATE], with diagnoses including epilepsy (seizure disorder), Cerebral Palsy [(CP) is a group of movement disorders that appear in early childhood], depressive disorder, and anxiety. A review of a Resident 66's quarterly-Day MDS (Minimum Data Set - a federally mandated standardized assessment process conducted periodically to plan resident care) dated December 15, 2021, revealed that resident was cognitively impaired. Review of Resident 66's care plan and Kardex (summary of resident care for staff to follow for rendering care) revealed an intervention dated January 20, 2021, for staff to remain in shower with resident and if the resident becomes agitated remain within visual field. An incident report completed by Employee 6, an LPN (licensed practical nurse), dated December 31, 2021, at 6:15 AM, revealed that Resident 66's was upset due to his morning routine being disrupted and was waiting for his shower. Employee 6 noted that she heard a loud bang and when she entered the shower room, she saw Resident 66 on the floor having a seizure. A Progress Note - Incident Note completed by Employee 7, a RN, dated December 31, 2021, at 8:36 AM, revealed that the resident was conscious and appeared to be in a daze as if to have had a recent seizure. Employee 7 noted that Resident 66 had no injuries post fall and placed a therapy referral. No other witness statements were provided with incident report. Interview with the Nursing Home Administrator, NHA, conducted on January 6, 2022, at 9:55 AM, confirmed that Resident 66's fall was unwitnessed fall in the shower room and that staff should not have left him alone in the shower room and out of vision as noted on the resident's care plan and Kardex. 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing Services. 28 Pa. Code 211.11(d) Resident care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on clinical record review, select incident reports, and staff interview, it was determined that the facility failed to review and revise the comprehensive care plan to address the current needs of a resident displaying inappropriate sexual behavior for one resident out of 17 sampled (Resident 1). Findings included: A review of the clinical record revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses that included unspecified mood disorder. The resident's clinical record revealed that the resident was moderately cognitively impaired and displayed behaviors of increased sexual verbalizations. A review of an incident report dated March 7, 2022, at 1:30 PM, indicated that staff was made aware of an incident that occurred on March 5, 2022, with Resident 1 and Resident 2. A review of an Employee 1's TNA (temporary nurse aide) witness statement dated March 5, 2022, revealed that Employee 1 was walking by Resident 2's room and witnessed Resident 1 standing over Resident 2 kissing her. Resident 1's pants were halfway down and Resident 2's brief was unfastened. A review of Resident 1's current plan of care conducted during the survey of March 10, 2022, revealed the problem that the resident exhibits inappropriate sexual behaviors initially dated February 6, 2022. The resident's plan of care was not revised following the incident with Resident 2 to assure effective measures were developed and implemented protect Resident 2 and other female residents in the facility from incidents of a similar nature and unwanted sexual contact by Resident 1. Interview with the Nursing Home Administrator on March 10, 2022, at approximately 2:30 PM confirmed the facility's failure to revise the resident's care plan with new interventions to protect other residents in response to a sexual incident that occurred with Resident 2. 28 Pa. Code 211.11 (d)(e) Resident care plan 28 Pa. Code 211.12 (d)(3)(5) Nursing services

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	395273	A. Building B. Wing	01/07/2022

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41581 Based on review of clinical records, facility incident report, and staff interviews it was determined that the facility failed to provide nursing services consistent with professional standards of practice to ensure that licensed nurses properly evaluated and provided nursing care for one resident (Resident 2) and conducted tuberculin skin testing for one resident (Resident 3) out of 17 sampled residents. Findings included: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the registered nurse was to collect complete ongoing data to determine nursing care needs, analyze the health status of individuals and compare the data with the norm when determining nursing care needs, and carry out nursing care actions that promote, maintain, and restore the well-being of individuals. The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound judgement based on preparation, knowledge, skills, understandings and past experiences in nursing situations. The LPN participates in the planning, implementation and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records. A review of the clinical record of Resident 2 revealed admission to the facility on [DATE], with diagnoses which included chronic respiratory failure with hypoxia (oxygen deficiency). A review of Annual Minimum Data Set assessment dated [DATE], (MDS - a federally mandated standardized assessment process completed periodically to plan resident care) revealed that the resident moderately cognitively impaired. A review of an incident report dated March 7, 2022, at 1:30 PM, indicated staff was made aware of an incident that occurred on March 5, 2022, with Resident 1 and Resident 2. A review of an Employee 1 TNA (temporary nurse aide) witness statement dated March 5, 2022, revealed that Employee 1 was walking by Resident 2's room and saw Resident 1 standing over Resident 2 kissing her in bed. Resident 1's pants were halfway down and Resident 2's brief was unfastened. A review of Resident 2's clinical record revealed no documented evidence that licensed professional nursing staff had Resident 2 for signs of potential sexual abuse or injury after an alleged sexual abuse incident. An interview with Employee 2, LPN, on March 10, 2022, at 10:50 AM revealed that Employee 2 verified that after the incident between Resident 1 and Resident 2, she did not assess Resident 2 for signs of sexual abuse or injury or request that the nursing supervisor assess Resident 2. Employee 2 stated that instructed the staff to get Resident 2 out of bed and seat her in the dining room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Nursing Home Administrator on March 10, 2022, at approximately 2:30 PM confirmed there was no documented evidence in the resident's clinical record that the facility's professional nursing staff had timely and properly assessed a resident who was involved in an alleged sexual incident. According to the Pennsylvania Code Title 49, Professional and Vocational Standards Department of State, Chapter 21 State Board of Nursing, Chapter 21.145 Functions of the LPN (Licensed Practical Nurse) requires the following: 21.145(e) The LPN may administer immunizing agents and do skin testing only if the following conditions are met: (3) Written policies and procedures under which the LPN may administer immunizing agents do skin testing have been established by a committee representing the nurses, the physicians and the administration of the agency or institution employing or having jurisdiction over the LPN. A current copy of the policies and procedures shall be provided to the LPN at least once every 12 months. The policies and procedures shall provide for: (i) Identification of the immunizing and skin testing agents which the LPN may administer; (ii) Determination of contradictions for the administration of specific immunizing and skin testing agents; (iii) The listing, identification, description, and explanation of principles, including technical and clinical indications, necessary for the identification and treatment of possible adverse reactions; (iv) Instruction and supervised practice required to insure competency in administering immunizing and skin testing agents. A review of education provided to facility staff in response to deficiencies cited from the survey of January 7, 2022, indicated that residents must be given Tuberculin injection (TB test) upon admission as per facility protocol. Same must be documented in the clinical record. Orders are to be placed correctly under the MAR (mediation administration record) and TAR (treatment administration record) to reflect ate of application and results. The education was provided to RNs (registered nurse) and LPNs (licensed practical nurse). Of the 24 licensed staff that were inserviced 16 were LPNs. However, there was no documented evidence that these LPN had been trained to administer or read the PPD skin tests as per their scope of practice. A review of the facility policy entitled, Administration and Interpretation of PPD Test, dated as reviewed by the facility August 2017, indicated PPD skin testing will be administered and results interpreted by a licensed nurse. Further review of the facility's TB policy, failed to reflect the requirements of the Pennsylvania Code Title 49, Professional and Vocational Standards Department of State, Chapter 21 State Board of Nursing, Chapter 21. 145 Functions of the LPN (Licensed Practical Nurse) that the policies and procedures shall provide for: (i) Identification of the immunizing and skin testing agents which the LPN may administer; (ii) Determination of contradictions for the administration of specific immunizing and skin testing agents; (iii) The listing, identification, description, and explanation of principles, including technical and clinical indications, necessary for the identification and treatment of possible adverse reactions. The facility policy did not include contraindications and possible adverse reactions to the two-step tuberculin skin testing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 3's clinical record revealed that she was admitted to the facility on [DATE], and received step two of the two step PPD skin test (PPD -Purified Protein Derivative - a solution used to test for Tuberculosis, a potentially serious infectious bacterial disease that mainly affects the lungs) on February 26, 2022 . The test was administered by Employee 3 (LPN- Licensed Practical Nurse). An interview with the Director of Nursing (DON) on March 10, 2022, at 11:30 AM verified that LPNs do administer PPD skin testing to both staff and residents. The DON also was unable to provide any documented evidence of LPN competencies regarding immunizations. The DON further stated she was unaware that LPNs had to be specifically trained to administer or interpret the results of a PPD. Facility LPNs administered and read TB skin tests for residents and staff, but the facility failed to provide documentation to demonstrate that staff LPNs were provided with the current policies and procedures related to skin testing, which included the above professional requirements (contradictions and adverse reactions). The facility was unable to provide policies and procedures regarding TB skin testing competency testing of the facility LPNs or other information required by the State Board of Nursing. 28 Pa. Code 201.19 Personnel policies and procedures 28 Pa. Code 201.20(a) Staff development 28 Pa. Code 201.22(a) Prevention, control, and surveillance of tuberculosis (TB) 28 Pa. Code 211.12 (a)(c)(d)(1)(5) Nursing services 28 Pa. Code 211.5 (f)(g)(h) Clinical Records

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	395273	A. Building B. Wing	01/07/2022

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26228 Based on clinical record review, and staff interview, it was determined that the facility failed to provide nursing services to maintain range of motion, mobility, and current level of functioning for two of 18 sampled residents (Resident 20 and 61). Findings include: A review of Resident 20's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses that included right shoulder pain, lower back pain, and peripheral vascular disease [(PVD) - is a circulatory system disorder that causes blood vessels to become narrow, blocked, and spasm that may result in pain]. Resident 20 was discharged from Physical Therapy on June 23, 2021, with recommendations for a restorative nursing program for active range of motion (ROM) to bilateral lower extremities (BLE) while in bed or seated, 10 repetitions each of both hips, knees and ankles daily to maintain mobility. Review of Resident 20's Survey Documentation Report for Restorative Nursing Tracking dated September 2021, revealed that there was no documented evidence that the program was completed 20 times during that month. Survey Documentation Report for the Restorative Nursing Tracking dated October 2021, revealed that there was no documented evidence that the program was completed 28 times during that month. Survey Documentation Report for the Restorative Nursing Tracking dated November 2021, revealed that there was no documented evidence that the program was completed 21 times during that month. Further review of the Survey Documentation Report for the Restorative Nursing Tracking dated December 2021, revealed that there was no documented evidence that the program was completed 23 times during that month. Interview with the Nursing Home Administrator (NHA) on January 5, 2022, at 10:25 AM, confirmed that Resident 20 had not consistentky received the planned restorative nursing program for the above months. A review of the clinical record revealed that Resident 61 was admitted to the facility on [DATE], with diagnoses of osteoarthritis (A type of arthritis that occurs when flexible tissue at the ends of bones wears down), and depression. According to the clinical record, the resident was on a Nursing Rehab Program since April 23, 2021, for Passive ROM to bilateral upper extremities (BUE), while in bed, provide PROM to elbows, and shoulders 10 repetitions times three sets. Review of Tracking of the Nursing Rehab Program for the Passive ROM to bilateral upper extremities from October 1, 2021 to December 31, 2021, revealed that during October 2021, there was no documented evidence that the program was completed on 11 days duing October, 19 times during the month of November 2021, and on 19 occassions during the month of December 2021. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator on January 5, 2022, at 2:15 p.m. confirmed the lack of documented evidence that the planned restorative nursing program was consistently completed during the above months. 28 Pa. Code: 211.5(f) Clinical records 28 Pa Code 211.12 (a)(c)(d)(5) Nursing services

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	395273	A. Building B. Wing	01/07/2022

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on observations, a review of clinical records and select facility investigation reports and staff interviews, it was determined that the facility failed to provide necessary staff supervision for a resident with a history of falls and unsafe behaviors that increased the resident's risk for falls and injuries to prevent falls with serious head injuries, a subarachnoid hemorrhage and an intercranial hemorrhage, for one resident out of 8 residents reviewed (Resident 1). Findings include: A review of the clinical record of Resident 1 revealed admission to the facility on [DATE], with diagnoses that included cerebral infarction(stroke), toxic encephalopathy, (occurs when toxic chemicals, or a chemical imbalance caused by an infection, affects brain function), anxiety, lack of coordination, was non-verbal and had a history of falls. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 10, 2021, revealed that the resident was severely cognitively impaired, required staff assistance with activities of daily living, including requiring the assistance of one staff for ambulation in hallways, was at risk for falls and has had 2 falls since admission to the facility. A review of nursing documentation dated October 9, 2021, at 9:32 p.m. revealed nursing noted Patient restless and pacing up and down halls; increasing over the course of the past few days. Patient requiring frequent redirection with poor effectiveness to sit for meals, rest periods. A review of nurse's notes dated November 22, 2021 at 10 p.m. revealed that a nurse aide came to charge nurse stating that Resident 1 had blood coming from her mouth. Upon nursing assessment, at first, {Resident 1} would not open her mouth and was noted to have blood all over her mouth and down her gown. The nurse and two nurse aides were able to convince her to open her mouth and a lot of blood came pouring from her mouth. We were able to convince her to open her mouth again, because as we were rubbing her cheeks, we could tell that there was a foreign body in her mouth. It took a couple of minutes, but when she did open her mouth, a big red bingo chip fell out of her mouth and to the floor. We cleaned out her mouth to the best that she would allow at that time. Nurse practioner called, new orders noted to call the dentist and also for nursing to place Resident on every 15 minute checks for 72 hours. Facility documentation indicated the every 15 minute checks were conducted from November 22, 2021, and then discontinued on November 24, 2021. A review of nurse's notes dated November 24, 2021, at 2:11 p.m. revealed that Resident 1's daughter was contacted concerning a room change from the third floor (where several residents run a small store from the resident lounge at the end of the hallway. Items for sale include packaged candy, chips and many other snack items. All of these items are displayed on several long tables, were open and available for resident choice) to the second floor due to Resident 1 touching items at the resident snack shop with redirection being unsuccessful. (continued on next page)

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	395273	A. Building B. Wing	01/07/2022

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 1 was transferred on November 24, 2021, to a room on the second floor at that time but returned to her original room on the third floor on that same day after a male resident was paying inordinate attention to her and sitting very close, making Resident 1 very uncomfortable according to the resident's clinical record documentation. A review of nurses notes dated January 10, 2022 at 1:24 p.m. revealed Resident 1 continuously pacing back and forth, going in and out of other resident rooms, taking drinks, straws and tissues from the medication cart (stored next to the nurses desk in the hallway) and other resident rooms despite redirection, food/fluid, toileting and diversional activities. Nursing noted will continue to monitor and redirect. A review of a social services note dated January 11, 2022, at 2:40 p.m. revealed worker visited with {Resident 1}, approaching her in a calm, unhurried manner. She continuously walked back and forth on the unit throughout the interaction. The social worker reviewed the importance of respecting other peers belongings and not going into resident rooms that were not hers. Her comprehension was questionable as {Resident 1} remains verbally unresponsive to staff. She appeared to be calm and content at this time as evidenced by facial expression. A review of a nurses noted dated January 21, 2022, at 9:49 a.m. revealed, this nurse witnessed {Resident 1} walking very fast up and down the hallways. I approached resident and encouraged her to slow down and take her time walking. {Resident 1} then sat down in a chair in the resident dining room for a moment. She then stood up and began walking very fast again. She immediately fell , hitting the left side of her head on the dining room floor. She was alert and basic first aide applied, the physician was contacted and {Resident 1} was sent to the hospital. A review facility investigation report dated January 21, 2022 at 9:31 a.m. revealed, the nurse witnessed Resident 1 walking very fast up and down the hallways. The nurse encouraged her to slow down and take her time walking. The resident sat down in a chair in the dining room for a moment. Resident 1 then stood up and began walking very fast and immediately fell hitting the left side of her face on the dining room floor. The physician was called and the resident was transferred to the hospital for evaluation and treatment. The report identified the predisposing factors for this incident were that the the resident was incontinent, impulsive and had impaired safety awareness. Upon return to the facility, interventions to prevent future falls were noted as the use of a chair and bed alarm. Additional notes included in the investigation report dated January 21, 2022 (no time indicated) revealed Call placed to local hospital for an update on {Resident 1}. Spoke to the resident's emergency room nurse. {Resident 1} was currently having stitches placed to the left side of her forehead. {Resident 1} will be transferred to another hospital to be treated for brain bleed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of hospital documentation dated January 21, 2022, at 2:47 p.m. revealed that Resident 1 had a witnessed fall at the skilled nursing facility and was transported to the emergancy room for evaluation and treatment. A CT (CT scan: A computerized tomography (CT) scan combines a series of X-ray images taken from different angles and uses computer processing to create cross-sectional images) of the head was preformed and revealed a subarachnoid hemorrhage (bleeding in the space that surrounds the brain.) in the area of the right temporal lobe. She was transferred to the receiving hospital for a higher level of care to be evaluated by neurosurgical service. {Resident 1} was admitted to the intensive care unit (ICU) for this head bleed for closer monitoring. She will be seen by neurosurgery as well. The physician assessment included, traumatic brain injury, admit the resident to the ICU, scalp laceration, continue with wound care. Resident 1 was readmitted to the facility on [DATE] at 3:20 p.m. A review of a care plan for at risk for falls, initiated August 6, 2021 revealed new interventions, dated January 28, 2022, after the resident's fall with head injury, were to add a chair and bed alarm. A review of the resident's care plan for wandering behavior, initiated August 12, 2021, revealed the care plan was last reviewed September 8, 2021, but had not been reviewed or updated with any additional interventions since the August 2021 date. There was no documented evidence that the resident's need for staff supervision was identified as a planned intervention to promote this resident's safety and incorporated into the resident's plan of care and implemented by staff. Continued review of the clinical record from the time of the resident's return to the facility on [DATE], through the time of the survey April 6, 2022, the nursing continued to document the resident's unsafe and wandering behaviors. A review of nurses notes dated April 2, 2022 at 7:48 a.m. revealed an RN assessment was completed. {Resident 1} remains alert. No change in level of consciousness (LOC). Makes eye contact. Neurological signs within normal limits. Hematoma (a collection of blood under the skin) left forehead. Scant amount of bleeding from the left forehead. Laceration measuring 0.5 cm x 0.1 cm. Ice applied . Resident remains nonverbal, at baseline with poor safety awareness. A review of a nurses note dated April 2, 2022 at 8:37 a.m. revealed that the resident was transferred via ambulance to the local hospital. There was no documentation in Resident 1's clinical record of the circumstances surrounding the resident's fall with a second head injury. However, review of a facility investigation report dated April 2, 2022, at 8:09 a.m. revealed that Resident 1 fell while in the resident dining area at 7:45 a.m. and found with her arm resting behind and beneath her. Active bleeding to the left side of her forehead was present. Non-skid socks were on both feet and the resident was continent at the time of the fall. Chair alarm in use according to the report. There were no staff witness statements included with the investigation report available at the time of the survey of the April 6, 2022, which identified the location of staff at the time of the resident's fall, which had occurred during the breakfast meal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395273	A. Building B. Wing	01/07/2022

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of hospital documentation dated April 2, 2022, at 11:30 a.m. revealed that {Resident 1} presents to the hospital after fall from a chair with a head strike. The patient was sitting at breakfast and fell forward out of her chair. She did strike her head. LOC (level of consciousness) is unknown. Patient is non verbal and non- interactive at her baseline. A review of a CT scan report dated April 2, 2022, revealed, acute, small subdural hematoma along the midline falx that measures 4 mm in thickness. Neurosurgery was consulted. The resident was admitted to the PCU, (A PCU is a Progressive Care Unit. PCUs, sometimes referred to as intermediate care or step-down units, provide an intermediate level of patient care that bridges the gap between intensive care units and medical-surgical units) for observation and treatment. A review of a nurses note dated April 2, 2022 2:34 p.m. revealed call placed to the hospital for an update. {Resident 1} is admitted to the hospital with intercranial hemorrhage (bleeding inside the skull {cranium})at this time. Resident 1 was readmitted to the facility on [DATE], at 8:28 p.m. A body audit was completed by nursing noting a 1.5 cm, healing laceration with steri-strips intact, and 1.5 cm x 1.5 cm bruise, left forehead above healed laceration. Observations made during the survey of April 6, 2022 at 10:50 a.m revealed that Resident 1 was seated in a geri chair in the third floor resident dining room. The surveyor observed Resident 1 stand up from her chair and begin to pace around the perimeter of the room. She continued to wander, pace the hallways, unmonitored by staff, often increasing her speed. The chair alarm was in place, but not sounding to alert staff of the resident's self-rising and unassisted ambulation. The facility failed to demonstrate that the resident was consistently provided with necessary staff supervision due to the resident's known unsafe behaviors to prevent repeated falls and serious head injuries. The resident fell and sustained a serious head injury on January 21, 2022, which required hospitalization and again incurred a second fall with head injury requiring hospitalization on [DATE]. During an interview April 6, 2022 at approximately 2 p.m., the Nursing Home Administrator (NHA) confirmed that the facility was unable to provide evidence that the facility had consistently provided sufficient staff supervision of this resident at risk for falls and injuries and unsafe behaviors that was known to facility staff and had implemented effective safety interventions to prevent falls and multiple head injuries. 28 Pa. Code 211.12(a)(c)(d)(3)(5) Nursing Services 28 Pa. Code 211.11(d) Resident care plan

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 13456 Based on clinical record review and staff interview, it was determined the facility failed to attempt non-pharmacological interventions to alleviate pain prior to the administration of an opioid pain medication prescribed on an as needed basis for one resident (Resident 59) of 18 residents reviewed. Findings include: A review of Resident 59's clinical record revealed a current physician order, initially dated December 8, 2021, for Oxycodone HCL 10 mg (opioid pain medication) one tablet by mouth every 12 hours for severe pain and Oxycodone HCL 5 mg one tablet by mouth every six hours as needed for breakthrough pain for a 4-10 pain level. A review of the resident's December 2021 Medication Administration Record (MAR) revealed that staff administered the opioid pain medication thirteen times during the month of December 2021. Of the thirteen doses given, all were administered without evidence that non-pharmacological interventions attempted to reduce pain prior to administering the pain medication. A review of the resident's January 2022 MAR revealed that staff administered the pain medication six times during the month of January 2022, as of the time of the survey ending January 7, 2022. Of the six doses given, all were administered without non-pharmacological interventions attempted to reduce pain prior to giving the pain medication. Interview with the Nursing Home Corporate Registered Nurse on January 7, 2022 at approximately 1:00 PM confirmed there was no evidence that non-pharmacological interventions were consistently attempted, and proved ineffective, prior to administration of prn opioid pain medication. 28 Pa. Code 211.5(f)(g) Clinical records 28 Pa. Code 211.12(a)(c)(d)(1)(5) Nursing Services.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 13456 Based on clinical record and select policy review and resident and staff interview it was determined the facility failed to consistently monitor a resident's prescribed fluid intake related to kidney disease and dialysis treatment for one resident receiving dialysis out of two residents receiving dialysis sampled (Resident 59). Findings include: Review of the facility policy entitled Encouraging and Restricting Fluids reviewed by the facility January 2021, indicated that the facility will follow specific instructions/MD orders concerning fluid intake or restrictions. Review of Resident 59's clinical record revealed admission to the facility December 28, 2021, with diagnoses of chronic kidney disease with hemodialysis [process of removing waste products and excess fluid from the body when the kidneys are not able to adequately filter the blood]. A physician order was noted December 28, 2021, for a 960 milliliter (ml) fluid restriction daily. Review of Resident 59's current care plan indicated that the distribution of fluids was noted as: 120cc with 7 AM to 3 PM med pass, 240 cc with breakfast, 240 cc with lunch, 120 cc with 3 PM to 11 PM med pass, 180 cc with dinner, and 60 cc for 11 PM to 7 AM. Resident 15's September 2021 MAR revealed that the resident exceeded the 960 ml physician prescribed fluid restriction on 25 days out of 30 days during the month. On 5 days, Resident 15's fluid intake was not monitored by staff. A review of the resident's December 2021 and January 2022 MAR (medication administration record) revealed that the facility staff only sporadically documented the amount of fluids the resident consumed with the resident's medication administration. The faciity was unable to provide documentation of the resident's fluid intake during his meals and daily activities. The facility was unable to demonstrate that staff accurately monitored the resident's daily fluid intake or maintenance of the resident's fluid restriction. Interview with the Nusing Home Administrator (NHA) on January 20, 2022, confirmed that the facility failed to accurately monitor and record fluid intakes for a resident ordered on a fluid restriction. 28 Pa. Code 211.12 (a)(c)(d)(3)(5) Nursing Services

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13456 Based on review of nurse staffing and staff interview, it was determined the facility failed to provide a Director of Nursing working full-time, 35 hours per week, in the facility. Findings include: Review of the facility staffing and deployment sheets revealed that the facility failed to have a Director of Nursing working on a full time basis from December 22, 2021 through January 7, 2022. This lack of a full time DON was confirmed by interview with the nursing home administrator on January 4, 2022. The NHA stated that the previous DON left the faciity on [DATE], due to conflicts with the work schedule. The NHA stated that they hired an interim DON, Employee 8, who currently worked as a supervisor at a sister facility. However, a review of an Employee Action form dated December 24, 2021, indicated that Employee 8 was hired by the facility as DON for only three days per week. The NHA stated the DON only planned to work onsite in the facility on Mondays, Wednesdays and Fridays and not full-time, a minimum of 35 hours. During the week of January 3, 2022 through January 7, 2022 Employee 8 worked only January 3, 2022 and January 5, 2022. The facility did not have a full time director of nursing, working at least 35 hours a week, from December 22, 2021, through the time of the survey ending January 7, 2022. 28 Pa. Code 201.18(e)(6) Management 28 Pa. Code: 211.12(b)(c)(f)(1) Nursing services.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on observations, a review of clinical records and select facility investigation reports and staff interviews, it was determined that the facility failed to provide necessary behavioral health care and services to maintain the highest practicable mental and psychosocial well-being for one of 8 sampled residents (Resident 1) with unsafe behavioral symptoms. Findings include: A review of the clinical record of Resident 1 revealed admission to the facility on [DATE], with diagnoses that included cerebral infarction(stroke), toxic encephalopathy, (occurs when toxic chemicals, or a chemical imbalance caused by an infection, affects brain function), anxiety, lack of coordination, was non-verbal and had a history of falls. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 10, 2021, revealed that the resident was severely cognitively impaired, required staff assistance with activities of daily living, including requiring the assistance of one staff for ambulation in hallways, was at risk for falls and has had two falls since admission to the facility. A physician order dated April 6, 2022, was noted for a regular diet, puree texture and nectar thick consistency for liquids. A review of nursing documentation dated October 9, 2021, at 9:32 p.m. revealed Patient restless and pacing up and down halls; increasing over the course of the past few days. Patient requiring frequent redirection with poor effectiveness to sit for meals, rest periods. A review of nurse's notes dated November 22, 2021, at 10 p.m. revealed, nurse aide came to charge nurse stating that Resident 1 had blood coming from her mouth. Upon assessment, at first, Resident would not open her mouth and was noted to heave blood all over her mouth and down her gown. Nurse and 2 nurse aides were able to convince her to open her mouth and a lot of blood came pouring from her mouth. We were able to convince her to open her mouth again, because as we were rubbing her cheeks, we could tell that there was a foreign body in her mouth. It took a couple of minutes, but when she did open her mouth, a big red bingo chip fell out of her mouth and to the floor. We cleaned out her mouth to the best that she would allow at that time. Nurse practioner called, new orders noted to call the dentist and also for nursing to place Resident on every 15 minute checks. A review of nurses notes dated November 24, 2021 at 2:11 p.m. revealed that Resident 1's daughter was contacted concerning a room change from the third floor (where several residents run a small store from the resident lounge at the end of the hallway. Items for sale include packaged candy, chips and many other snack items. All of these items are displayed on several long tables, open for resident choice) to the second floor due to Resident 1 touching items at the resident snack shop with redirection being unsuccessful. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 1 was transferred to a room on the second floor at that time, but subsequently returned to her original room on the third floor after a male resident was paying inordinate attention to her and sitting very close, making Resident 1 very uncomfortable according to the clinical record. A review of nurses notes dated January 10, 2022, at 1:24 p.m. revealed Resident 1 was continuously pacing back and forth, going in and out of other resident rooms, taking drinks, straws and tissues from the medication cart (stored next to the nurses desk in the hallway) and other resident rooms despite redirection, food/fluid, toileting and diversional activities will continue to monitor and redirect. A review of a nurse's noted dated January 21, 2022 at 9:49 a.m. revealed, this nurse witnessed Resident 1 walking very fast up and down the hallways. I approached resident and encouraged her to slow down and take her time walking. Resident 1 then sat down in a chair in the resident dining room for a moment. She then stood up and began walking very fast again. She immediately fell , hitting the left side of her head on the dining room floor. She was alert and Basic first aide applied, the physician was contacted and Resident 1 was sent to the hospital. Resident 1 was admitted to the intensive care unit (ICU) for this head bleed for closer monitoring. Resident 1 was readmitted to the facility on [DATE] at 3:20 p.m. A review of the resident's care plan for wandering behavior, initiated August 12, 2021, and reviewed September 8, 2021, however had not been reviewed or updated with any additional interventions since the August 2021 date. Staff supervision for safety or resident specific behavioral modification or management techniques to be employed by staff were not noted as care planned interventions for this resident. From January 2022, through the time of the survey April 6, 2022, nursing continued to document the resident's unsafe wandering behavior. A review of a nurses note dated April 2, 2022 at 8:37 a.m. revealed Resident 1 transferred via ambulance to the local hospital. A review of a facility investigation report dated April 2, 2022 at 8:09 a.m. revealed Resident 1 fell while in the resident dining area at 7:45 a.m. Active bleeding to the left side of her forehead. A review of a nurses note dated April 2, 2022 2:34 p.m. revealed that Resident 1 was admitted to the hospital with intercranial hemorrhage at this time. Resident 1 was readmitted to the facility on [DATE], at 8:28 p.m. Observations on April 6, 2022 at 10:50 a.m revealed Resident 1 was seated in a geri chair in the third floor resident dining room. Resident 1 stood up from her chair and started to pace around the perimeter of the room. She continued to wander, pace the hallways, unmonitored by staff, often increasing her speed during the observations. The surveyor observed the resident to continuously and randomly touch objects in the room, including a breakfast tray on another table (that was in front of another resident). (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Continued observation revealed that Resident 1 then left the dining room and walked into the resident shower/bathroom. Employee 1 (LPN) attempted to redirect the resident with little success. Employee 1 then redirected Resident 1 back into the resident dining room where Resident 1 continued to ambulate around the perimeter of the room, increasing her speed during ambulation. Continued observation revealed that Resident 1 again left the dining room, ambulated to the unattended medication cart and removed a styrofoam, covered bowl of applesauce (used in medication administration to some residents) and carried it to the opposite end of the hallway, into the resident lounge/snack shop area. She placed the container of applesauce on a couch and ambulated over to the 2 tables of candy/snacks, that were being sold by Resident 2. Continued observation revealed that Resident 2 made multiple trips to the open boxes of candy/snacks and helped herself to several candy bars. She handled these candy bars with her hands then placed them on the couch with the container of applesauce. This observation lasted approximately 10 minutes. After which a facility staff member removed the candy from Resident 1 and returned the open boxes on the table. The resident was escorted back to the residents' dining room and seated in her gerichair. An additional observation on April 6, 2022, at approximately 11:30 a.m., revealed Resident 1 was again ambulating from the residents' dining room down the short hallway. She was increasing her speed as she walked down the hall. She then walked down the long hallway to the resident lounge area/snack shop area. Resident 1, again picked up multiple candy bars, handling them as she walked, eventually placing them on the couch. The facility failed to demonstrate that the resident was provided with necessary behavioral health care services in response to her unsafe behaviors and her placing objects into her mouth causing bleeding to her oral cavity. The facility to identify and obtain necessary services for the behavioral health care needs of Resident 1 and develop and implement a person-centered care plan that included and supported the behavioral health care needs of this resident. The facility failed to review and revise the resident's care plan that have not been effective in promoting the resident's safety and psychosocial well-being. During an interview April 6, 2022 at approximately 2 p.m., the Nursing Home Administrator (NHA) confirmed that the facility failed to provide this resident with necessary behavioral health care and services and plan individualized approaches to care, including direct care and activities, to meet the resident's behavioral health needs. 28 Pa. Code 211.12(a)(c)(d)(3)(5) Nursing Services 28 Pa. Code 211.11 (d) Resident care plan 28 Pa. Code 201.21 (b) Use of outside resources

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	395273	A. Building B. Wing	01/07/2022

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43944 Based on clinical record review and staff interview it was determined the facility failed to demonstrate the clinical necessity for an antipsychotic medication for two residents out of 18 sampled residents (Resident 20 and 51). Findings included: A review of Resident 20's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses to have included unspecified dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems), and cognitive communication deficit. Review of Resident 20's Physician's Orders dated February 22, 2021, revealed that the resident had an initial physician order for the antipsychotic drug, Zyprexa 10 mg daily via peg tube. Review of the clinical record Progress Notes - Nursing Note dated February 22, 2021, at 9:21 PM, indicated that the resident was transferred from the facility's sister facility and was noted to yell out at times and difficult to redirect. Review of Consultant Pharmacist Communication to Physician dated September 9, 2021, revealed that the pharmacist recommended for the attending physician to attempt a GDR (gradual dose reduction) for Zyprexa 10 mg daily or if the GDR was not able to be reduced due to being contraindicated for the physician to provide a rationale. Review of the physician response to the pharmacist's recommendation/finding that was completed by the Certified Registered Nurse Practitioner (CRNP) on September 30, 2021, responded that no GDR was indicated and that a reduction would be expected to exacerbate targeted symptoms. Additionally, noted that the medication had good effect. Further review of Resident 20'a clinical record revealed that target behaviors were not identified, monitored, and documented, from admission on February 22, 2021 through survey ending January 7, 2022, to justify the use of an antipsychotic drug. Additionally, the clinical record failed to reveal that the resident had displayed behaviors to justify use of the antipsychotic medication. Interview with the Nursing Home Administrator (NHA) on January 5, 2022, at 10:25 AM, confirmed that the facility failed to identify Resident 20's target behaviors, and monitor behaviors, and document the resident's behaviors to justify the use of an antipsychotic medication. A review of Resident 51's clinical record revealed that the resident was initially admitted to the facility on [DATE], with diagnoses to have included psychosis, major depressive disorder, and peripheral vascular disease [(PVD) is the narrowing of arteries that results in reduced blood flow to head, arms, stomach and legs and causes leg pain]. (continued on next page)

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	395273	A. Building B. Wing	01/07/2022

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 51's Physician's Orders revealed that the resident had a physician order for the antidepressant drug, Cymbalta 30 mg by mouth daily related to other symptoms and signs involving the musculoskeletal system. Review of Consultant Pharmacist Communication to Physician dated September June 14, 2021, revealed that the pharmacist recommended for the attending physician to attempt a GDR (gradual dose reduction) of Cymbalta 30 mg daily or if the GDR was not able to be reduced due to being contraindicated for the physician to provide a rationale. Review of the physician response to the pharmacist's recommendation/finding that was completed by the Certified Registered Nurse Practitioner (CRNP) on June 17, 2021, responded that a GDR was not possible clinically without a negative effect on the underlying psychiatric illness. Additionally, the CRNP indicated that the Cymbalta was being utilized for musculoskeletal pain and there were no adverse side effects note from the medication. Review of Resident 51's attending physician's Progress Note dated November 5, 2021 and December 7, 2021 revealed that the resident's depression was stable with Cymbalta. Review of Physician's Orders dated December 22, 2021, at 9:30 PM, revealed that Cymbalta was increased to 60 mg by mouth daily related to other symptoms and signs involving the musculoskeletal system. Further review of Resident 51's clinical record revealed that there was no documented evidence to justify the increase of the antidepressant, Cymbalta. Additionally, there was no evidence that attending physician was aware of the CRNP's adjustments to the resident's medication treatment plan and rationale for the use of the medication. Interview with the Nursing Home Administrator (NHA) on January 5, 2022, at 10:30 AM, confirmed that facility failed to provide documented evidence to justify the increase in Resident 50's antidepressant and that the physician and CRNP coordinated the resident's medication treatment plan. 28 Pa. Code 211.2(a) Physician services 28 Pa. Code 211.5(f)(g)(h) Clinical records 28 Pa. Code 211.9(k) Pharmacy services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26142 Based on a review of clinical records and select facility investigation reports and staff interviews, it was determined that the facility failed to ensure complete and accurate clinical records for one resident out of 8 residents reviewed (Resident 1). Findings include: According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care: Assessments Clinical problems Communications with other health care professionals regarding the patient Communication with and education of the patient, family, and the patient ' s designated support person and other third parties. A review of the clinical record of Resident 1 revealed admission to the facility on [DATE], with diagnoses that included cerebral infarction(stroke), toxic encephalopathy (occurs when toxic chemicals, or a chemical imbalance caused by an infection, affects brain function), anxiety, lack of coordination, was non-verbal and had a history of falls. A review of a quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated November 10, 2021, revealed that the resident was severely cognitively impaired, required staff assistance with activities of daily living, including requiring the assistance of one staff for ambulation in hallways, was at risk for falls and has had 2 falls since admission to the facility. A review of nurses notes dated April 2, 2022 at 7:48 a.m. revealed that an RN assessment was completed. Nursing noted that {Resident 1} remains alert. No change in level of consciousness (LOC). Makes eye contact. Neurological signs within normal limits. Hematoma (a collection of blood under the skin) left forehead. Scant amount of bleeding from the left forehead. Laceration measuring 0.5 cm x 0.1 cm. Ice applied. Resident remains nonverbal, at baseline with poor safety awareness. There was no documentation in Resident 1's clinical record as to how the resident had sustained the above injuries requiring RN assessment. There was no documented evidence in the resident's clinical record that the resident had been involved in an incident or accident resulting in these injuries. (continued on next page)

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	395273	A. Building B. Wing	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Scranton	824 Adams Avenue Scranton, PA 18510

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, review of a facility investigation report dated April 2, 2022, at 8:09 a.m., which is not part of the resident's clinical record, revealed that Resident 1 fell while in the resident dining area at 7:45 a.m. and found with her arm resting behind and beneath her. Active bleeding to the left side of her forehead was present. Non-skid socks were on both feet and the resident was continent at the time of the fall. Chair alarm in use according to the report. The facility failed to document the circumstances surrounding Resident 1's fall with injury in the clinical record. During an interview April 6, 2022 at approximately 2 p.m., the Nursing Home Administrator (NHA) confirmed that Resident 1's clinical record was not accurately and completely documented and there was no reference to Resident 1's fall with injuries on April 2, 2022. 28 Pa Code 211.5 (f)(g)(h) Clinical records 28 Pa. Code 211.12 (a)(c)(d)(1)(5) Nursing Services

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 13456 Based on review of attendance records for the facility's Quality Assurance Committee, as well as staff interviews, it was determined that the facility failed to ensure that all required members of the Quality Assurance Committee attended quarterly meetings. Findings include: Review of the attendance records for the facility's Quality Assurance Committee meetings revealed that the Medical Director did not attend, in person or virtually, any meetings that were held during the third and fourth quarters of 2021. Interview with the Nursing Home Administrator on January 7, 2022 at 11:30 A confirmed that neither the Medical Director nor a designee attended meetings of the Quality Assurance Committee that were held during the third and fourth quarters of 2021. The NHA stated that the Medical Director last attended a QA meeting on June 9, 2021. 28 Pa. Code 211.2(d)(2) Physician Services 28 Pa. Code 201.18(e)(1)(2)(3) Management

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 13456 Based on a review of the facility's antibiotic use and staff interview, it was determined the facility failed to establish an antibiotic stewardship program including protocols for antibiotic use and monitoring to optimize the use of antibiotics in the facility. Findings include: During interview with the facility's Nursing Home Administrator (NHA) on January 7, 2022, the NHA was unable to provide evidence of the facility's current functioning antibiotic stewardship program that promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance. The NHA stated that the Director of Nursing (DON) was the employee who maintained that information, but since the DON had resigned as of December 22, 2021, the NHA was unable to provide any information from the past year regarding the facility's antibiotic stewardship program. There was no documented evidence that the facility had implemented protocols and a system to monitor antibiotic use. There was no evidence that any staff, i.e., Infection Preventionist had reviewed antibiotic use, monitor prescriptions and physician orders to ensure they were in accordance with any faciity antibiotic use and practices. There was no evidence that antibiotic use was tracked for patterns of use and adherence to determine if new stewardship interventions are effective An attempt to review of the facility's Antibiotic Stewardship surveillance, tracking and trending for the past year was conducted during the survey ending January 7, 2022, but there was no data available for review at the time of the survey. During an interview on January 7 2022. the NHA, confirmed that the facility was unable to provide evidence of surveillance, tracking and trending of antibiotic use in the facility at the time of the survey ending January 7, 2022. Refer F 727 28 Pa. Code: 211.10 (a)(d) Resident care policies. 28 Pa. Code: 211.12 (c)(d)(1)(2)(3)(5) Nursing services.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 13456 Based on observations, staff interviews and a review of the facility's infection control program it was determined that the facility failed to have a designated Infection Preventionist responsible for the facility's infection prevention and control program. Findings include: During an interview with the NHA (nursing home administrator) during the survey of January 7, 2022, the NHA stated that the facility's infection control surveillance program was the responsibility of the DON (director of nursing) who was also the Infection Preventionist. However, the DON was no longer employed by the facility and the December 2021 infection control tracking was nit available at the time of the survey ending January 7, 2021. The NHA stated that at the time of the survey ending January 7, 2022, facility had no one designated as the infection Preventionist (IP) who was responsible for the facility's IPCP and due to the lack of an IP the facility was unable to demonstrate a functioning system for surveillance for routine, ongoing, and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections (i.e., HAI and community-acquired), infection risks, communicable disease outbreaks, and to maintain or improve resident health status. The facility was unable to demonstrate how it tracks infections and addresses any areas needing corrective action. The facility was unable to to provide evidence of the development and implementation of an ongoing infection prevention and control program (IPCP) to prevent, recognize, and control the onset and spread of infection to the extent possible. Refer F 727 28 Pa. Code 211.12 (c)(d)(4)(5) Nursing Services. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 201.18 (e)(6) Management

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13456 Based on review of clinical records and select facility policy, and staff interview, it was determined that the facility failed to offer and/or provide the influenza and/or pneumococcal immunizations, unless the immunization was medically contraindicated or the resident had already been immunized for one of nine residents reviewed (Resident 70). Findings include: Review of the facility's Influenza/Pneumococcal Immunization policy last reviewed, January 2021, indicated all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Upon admission to the Living Center the resident and/or responsible party will be given education regarding the risks and benefits of receiving the Influenza and Pneumococcal immunization vaccines. Previous immunization history can be obtained from resident interview, responsible party interview, center admission paperwork, hospital discharge/transfer paperwork. Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccination. Provision of such education shall be documented in the resident's medical record. Additionally, if the resident is admitted to the facility after influenza season and has not already received the immunization, the vaccine will be offered, and verify that consent was given for the resident to receive the vaccine and that education of the risks and benefits were provided. This information will be documented in the resident's electronic health record Immunization portal. Review of the Resident 70's clinical record revealed the resident was admitted on [DATE]. Review of the resident's immunization record indicated that there was no documented evidence that the resident was offered the influenza and pneumococcal vaccines, that the resident was provided with education on the risk and benefits of these vaccines, or that the influenza and/or pneumococcal vaccines were administered to the resident. Interview with the Nursing Home Administrator on January 6, 2022, at approximately 1:30 PM, indicated that all immunization records should be recorded in the resident's electronic health record under the Immunization portal upon completion of the admission assessment. The NHA confirmed that there was no documented evidence in Resident 70's Immunization portal that the resident was offered the vaccines, educated on the vaccines, or administered the influenza and/or pneumococcal vaccines. 28 Pa Code 211.5 (f)(h) Clinical records 28 Pa Code 211.10 (c)(d) Resident care policies 28 Pa code 211.12 (a)(c)(d)(1)(5) Nursing Services 28 Pa code 201.29 (a) Resident rights