STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395868	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Embassy of Hearthside	450 Waupelani Drive State College, PA 16801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 18229 Based on clinical record review, and staff interview, it was determined that the facility failed to ensure complete and accurate clinical documentation for one of one resident reviewed (Resident 1). Findings include: Clinical record review revealed the facility admitted Resident 1 on June 12, 2024. Nursing documentation dated on November 12, 2024, at 12:27 PM revealed the licensed practical nurse noted after Resident 1 began eating his meal tray, he began to have a mild coughing episode and indicated he was not feeling well. The licensed practical nurse documented the registered nurse was aware. Nursing documentation dated November 12, 2024, at 1:13 PM indicated that the licensed practical nurse documented Resident 1's oxygen saturation was at 75% on room air and the registered nurse was aware. Nursing documentation dated November 12, 2024, at 4:35 PM indicated the licensed practical nurse noted while Resident 1 was eating dinner he began coughing and spitting up large amounts of mucus with particles of food. The licensed practical nurse noted the registered nurse was aware. Nursing documentation dated November 12, 2024, at 5:00 PM revealed that the licensed practical nurse noted Resident 1 was unresponsive, sternal rub was done with no success, and color was very gray. The registered nurse was called to the unit immediately. Resident 1 remained unresponsive, with large amounts of mucus and food running out of his mouth. Nursing documentation noted Resident 1 ceased to breath at 6:06 PM. Review of the current facility policy entitled Change in Condition Notification Protocol, revealed as soon as the nurse has been made aware of a change in condition by an employee, and once the nurse has been able to assess the resident, the nurse will initiate a Change in Condition Tool (SBAR). The nurse will gather pertinent information as directed by the SBAR prior to making a phone call to the physician. The facility will inform the resident, consult the resident's physician, and notify the resident's representative. They will complete notification to the resident's physician and/or nurse practitioner, or physician's assistant to discuss the resident status and the care for the resident. (continued on next page)

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

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 1's clinical record revealed the nurse did not complete the Change in Condition Tool. There was no documentation in Resident 1's closed clinical record that the nurse notified Resident 1's physician; however, the CRNP (certified registered nurse practitioner) sent an email to the facility dated November 22, 2044, that indicated the registered nurse notified her at the time of the first coughing episode and kept her apprised of the situation. The CRNP indicated that nursing was monitoring the oxygen saturation rates, downgraded Resident 1's diet, sent a request to speech therapy for an evaluation, and ordered a chest x-ray for the morning. Further review of Resident 1's clinical record revealed Employee 1 (registered nurse) did not document in Resident 1's clinical record until November 13, 2024. Resident 1's clinical record contained documentation created on November 13, 2024, at 7:17 AM noting on November 12, 2024, at 1:30 PM she received a call from the unit charge nurse that during lunch Resident 1 had a coughing episode and was complaining of not feeling well. Employee 1 noted she instructed the licensed practical nurse to apply oxygen until Resident 1 is assessed. Employee 1 documented on November 13, 2024, at 7:27 AM noting on November 12, 2024, at 1:40 PM Resident 1 was in no acute distress, he was alert per his baseline. A small amount of mucus was noted on his sweatshirt. Employee 1 documented on November 13, 2024, at 7:58 AM that she received a call on November 12, 2024, at 5:30 PM that Resident 1 was not responding. Employee 1 noted she arrived on the unit to observe Resident 1 sitting in the hall near the nurses' station with oxygen on, his head tilted forward with his chin on his chest. She noted a call was placed to 911 to transfer Resident 1 to the emergency department due to his sudden altered mental status change. Resident 1 was noted to be nonresponsive to sternal rub. Employee 1 noted Resident 1's skin color was pale, with a faint radial pulse. Review of Employee 1's personnel file revealed a Coaching/Counseling Form dated May 29, 2024, noting Employee 1 failed to complete registered nurse duties of documentation and communication as expected. The solution indicated that Employee 1 signed and agreed to complete documentation at the time of the occurrence, including registered nurse assessments completed prior to leaving her shift. Interview with the Nursing Home Administrator, Director of Nursing, and Employee 2 (regional nurse) on November 22, 2024, at 3:02 PM confirmed these findings and revealed that it is expected that Employee 1 complete her documentation so that the information is available to oncoming staff prior to her leaving her shift. The facility failed to ensure Resident 1's complete and accurate documentation. 28 Pa. Code 211.12(d)(1)(5) Nursing services