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	08/25/2025

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 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. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policies and procedures, clinical record review, observation, and staff interview, it was determined that the facility failed to provide the highest practicable care regarding elopements for one of five residents reviewed (Resident 4) and medication errors for one of five residents reviewed (Resident CR1). Findings include: The current facility policy entitled Elopements and Wandering Residents, revealed the facility ensures that residents who exhibit wandering behavior and/or are at risk of elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The facility will establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's plan of care and communicated to the appropriate staff. Adequate supervision will be provided to help prevent accidents or elopements. Clinical record review revealed the facility admitted Resident 4 on August 4, 2025. Nursing documentation dated August 4, 2025, at 11:48 PM revealed Resident 4 arrived at the facility via hospital transport and a nurse. Documentation revealed Resident 4 fled on foot and the police were notified by hospital staff. The police returned Resident 4 to the facility unharmed. Resident 4 was escorted into the facility with the assistance of the police, and one to one supervision was started with Resident 4 due to being an elopement risk. Resident 4's son was notified of his arrival and fleeing incident. Resident 4's son was notified his father was currently under one-to-one supervision. Review of Resident 4's elopement evaluation dated August 4, 2025, at 11:00 PM revealed Resident 4 had a history of elopement while at home. Nursing staff assessed Resident 4, scoring him as a 7 (high risk), noting Resident 4 eloped from the facility shortly after arrival and was found and taken to the hospital for evaluation. Resident 4 returned to the facility by the police and is currently under one-to-one supervision. An admission interdisciplinary note dated August 5, 2025, at 9:47 AM revealed Resident 4 initially arrived at 2:00 PM. Resident 4 was escorted to his room and within minutes he pushed the window open and fled the building. Documentation revealed the window was secured to open six inches, but Resident 4 was able to remove the bracket and screen. Staff immediately called the physician, alerting him of Resident 4's elopement. Several staff members exited the building and began the search. The facility contacted 911. Resident 4 was located approximately 15 minutes later and returned to the facility safely. Resident 4 was again escorted to his room. Physician and Psych certified nurse practitioner (CRNP) were onsite and agreed that Resident 4 be sent to the hospital. At approximately 8:00 PM the hospital emergency room called the facility and stated they were sending Resident 4 back to the facility. Documentation revealed the facility attempted to refuse Resident 4's admission but the transport van arrived with a driver, nurse from the local hospital, and Resident 4. Resident 4 got out of the van and again took off running. The facility called 911 again and the police located Resident 4 and returned him to the facility. There were no injuries noted. One on one care is continuing at this time. A picture of the resident was obtained and placed in the elopement book located at the front desk. A follow up elopement evaluation was completed August 5, 2025, and nursing staff assessed Resident 4, as a nine (high risk). Nursing documentation dated August 5, 2025, at 2:26 PM revealed Resident 4 was still pacing the halls trying to open windows. Documentation noted one to one remains in place. Nursing documentation dated August 13, 2025, at 9:39 AM revealed Resident 4 continued to exhibit exit seeking behaviors by going to the door and pushing numbers on the keypad. Staff was to maintain visual supervision when Resident 4 is having an acute episode. Nursing documentation dated August 14, 2025, at 3:25 PM revealed Resident 4 was walking throughout the halls, actively exit seeking, and clicking buttons at exit doors. Nursing documentation dated August 16, 2025, at 10:58 AM revealed Resident 4 was walking throughout the nursing unit, often going up to the keypads by the exit doors and typing in numbers. Nursing documentation dated August 22, 2025, at 9:56 AM revealed Resident 4 continued to seek exit doors and attempted to type in codes. Resident 4 was found pushing and pounding on

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined the facility failed to store food in accordance with professional standards for food service in the facility's main kitchen. Findings include: An observation in the facility's main kitchen on August 25, 2025, at 11:30 AM with Employee 1 (dietary manager) revealed the following: In the dry storage area, there was a bag of elbow macaroni, and a bag of opened egg noodles, with no open or use by dates. On the bread racks, there were six packs of English muffins, three loaves of bread, two packs of sandwich rolls, and one pack of hotdog rolls with no received or use by dates. In the walk-in Freezer, there was a box of mixed vegetables with no open or use by dates. The vegetables were not covered or sealed. In the walk-in refrigerator, there were boxes of mushrooms, lemons, and oranges with no open or use by dates. The items were not covered or sealed. In the reach-in cooler, there was an opened container of grape jelly and strawberry juice with no open or use by dates. In the production area, there was an opened box of thick and easy, bag of flour, container of peanut butter, container of quick oats, box of cream of rice, box of potato pearls, and a container identified by Employee 1 as Cream of Wheat. All of these items were opened with no open date or use by dates. The above findings in the main kitchen were reviewed with the Nursing Home Administrator and Director of Nursing on August 25, 2025, at 3:04 PM. 483.60(i)(2) Store, prepare, food safe and sanitaryPreviously cited 3/14/25 28 Pa. Code 201.14 (a) Responsibility of Licensee