

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2025
NAME OF PROVIDER OR SUPPLIER Embassy of Hearthside		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/07/2025
NAME OF PROVIDER OR SUPPLIER Embassy of Hearthside		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, clinical record review, and staff and resident interview, it was determined that the facility failed to protect a resident's right to be free from physical abuse by staff that resulted in bruises to the resident's left arm, and medications administered against the resident's will, for one of five residents reviewed resulting in actual harm (Resident 1) Findings include: Observation and interview with Resident 1 on October 7, 2025, at 11:30 AM revealed she was in bed in her room. The surveyor asked Resident 1 if something happened to her arm and she immediately told the surveyor to leave the room, not to worry about it, and to shut the door. Clinical record review for Resident 1 revealed a nursing progress note dated October 3, 2025, at 4:20 PM that indicated Resident 1's son reported to Employee 1, Licensed Practical Nurse (LPN), that Resident 1 had multiple bruises on her left arm. The note indicated that Employee 1 was able to observe the bruises on Resident 1's left arm but the resident would not allow her to measure them. The note indicated that there were three oddly shaped bruises noted on Resident 1's outer and inner left arm. Employee 1 asked Resident 1 what happened to her arm, she made an arm movement to her own arm as if to twist it. Employee 1 contacted the Nursing Home Administrator (NHA), Director of Nursing (DON), and Certified Registered Nurse Practitioner (CRNP) at this time regarding the bruises, and an investigation was initiated. Review of the facility's investigation into the bruises on Resident 1's left upper arm determined that the incident occurred on October 1, 2025, between 6:00 PM and 7:00 PM. Further review of the facility's investigation into the bruises on Resident 1's left upper arm revealed that she had multiple bruises on her left upper arm. The facility investigation notes dated October 3, 2025, indicated that Employee 2, registered nurse (RN), was interviewed by the NHA and DON by telephone on October 3, 2025. Employee 2 revealed that she went into administer medication to Resident 1, but the resident struck her hand and the medication (Ativan, a medication used to treat anxiety, 0.5 mgs two tablets) fell from her hand. She indicated the medications were found in Resident 1's bed. Employee 2 then indicated that Employee 3, nurse aide (NA), placed the pills in Resident 1's mouth. Employee 2 said that Employee 3 held the resident's legs down and was rubbing them to calm the resident down and Employee 4, NA, was holding the resident's left hand during the medication administration. She said that Resident 1 was wild during the medication administration and kept saying you are going to jail. Employee 2 also indicated that she directed Employee 3 to stop when she was being aggressive with Resident 1, but she did not respond to her direction. The facility investigation notes dated October 3, 2025, for Employee 4, NA, revealed that she was interviewed by the NHA and DON on October 3, 2025, in person. Employee 4 indicated that Employee 2 attempted to administer Resident 1's medication when the resident knocked them out of her hand. Employee 4 indicated that she witnessed Employee 3 put two Ativan in Resident 1's mouth and hold her mouth closed so the medication would dissolve. Employee 4 said that Resident 1 was initially very aggressive and yelled at Employee 3. Employee 4 said that Resident 1 told Employee 3, I will get you, you will get yours and then winked at Employee 4. Employee 4 also indicated that after Resident 1 calmed down Employee 3 asked her to assist with trimming the resident's nails. She said Employee 3 held Resident 1's wrist while she trimmed her nails. Employee 4 also said that she heard Employee 3 at the nurse's station verbalizing that she made Resident 1 take the pills and held her mouth shut. The facility investigation notes revealed that they interviewed Employee 5, NA, in person on October 3, 2025, and by telephone on October 5, 2025. Employee 5 indicated that Resident 1 struck her on the shoulder with a Swiffer broom. She indicated that Employee 3 entered the room after hearing the resident yelling. Employee 5 said that they were all looking for the Ativan tablets that Resident 1 hit out of Employee 2's hand. Employee 5 said the Ativan pills were found, one was in bed, and the other was on the floor. Employee 5 then said that she witnessed Employee 3, wrestle Resident 1 onto the bed, place the pills in the resident's mouth, and hold the resident's mouth closed until the pills dissolved. Employee 5 said that Resident 1 looked at Employee 3 and said that she would get hers and that she would get her. Employee 5 also indicated that she heard Employee 3 at the nurse's station saying, I made the resident take the pills because she scratched the shit out of me. The facility investigative notes revealed that they interviewed Employee 3 via text messages on October 5, 2025, regarding the incident that occurred on October 1, 2025. Employee 3 indicated that she heard yelling twice. When she heard it the second time she went into the hallway and noted Employee 5 backing out of Resident 1's room with a Swiffer broom. She said Employee 5 claimed that Resident 1 hit her with the Swiffer. Employee 3 said that Resident 1 was holding her door closed and Employee 2 told Employee 3 that she needed her to get into the room because the</p>		