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	05/06/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on staff and resident interviews, the facility failed to inform residents, in advance, of the care to be furnished for one of six residents reviewed (Resident 3).Findings include: Clinical record review for Resident 3 revealed a care plan (an outline of an individual's health needs, specific care requirements, and the actions necessary to achieve desired health outcomes, represented as the focus, goal, and interventions) initiated on December 14, 2023, with a focus that they have impaired communication related to hearing loss. Resident 3 has an intervention to utilize a dry erase board for communication, initiated on December 30, 2023. During an interview with Resident 3 on May 6, 2026, at 12:45 PM, it was observed that even with a hearing aide in place, the resident had difficulty hearing the surveyor, and questions needed to be repeated slowly and loudly for the resident to understand fully. The resident stated they were very upset about what the DON (Director of Nursing) did to them. The resident stated that a few weeks ago, the DON told them that the staff would take them to the shower room (also a bathroom area) to use the bathroom. Resident 3 stated that they understood this to mean that they would be taken to the bathroom to use the toilet. Instead, the resident was placed in a shower chair with a bucket underneath them and wheeled to the shower room in a chair to try and have a bowel movement into the bucket. The resident stated that they protested this multiple times and stated they did not want to be in a chair with a bucket underneath them. The resident indicated that they did not understand what was going to happen, and the DON did not write anything down during their conversation. The resident also stated that they wanted to speak with the DON regarding this event, but that the DON never came to speak with them. Interview with Employee 1, nurse aide, on May 6, 2025, at 12:50PM, revealed that she was directed by the DON to transfer Resident 3 to the bathroom in the shower chair because the resident needed to have a bowel movement. Employee 1 stated that the resident usually gets transported in a trolly (a shower cart where the resident is laying down) when they have a shower, and that they usually use a bedpan when they need to have a bowel movement. Employee 1 stated that the resident was very upset when she realized what was happening. Employee 1 stated they informed the DON that the resident wished to speak with them. Interview with Employee 2, nurse aide, on May 6, 2026, at 12:57 PM, stated that the DON came down to the unit and stated that Resident 3 needed to have a bowel movement, and that she should be placed into the shower chair. Employee 2 stated that the when the resident was returned to her room, she was very angry and was yelling and crying. The above information was reviewed with the Nursing Home Administrator and the Director of nursing on May 6, 2026, at 3:00 PM. The DON indicated they recalled the event. 201.14.(a) Responsibility of licensee 201.18.(b)(1) Management

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** Based on observation and staff interview, it was determined that the facility failed to maintain adequate housekeeping and maintenance services to ensure a clean, comfortable, orderly, and homelike environment on three of four nursing units, (Heirloom, [NAME] & University) and in an outdoor access area (breezeway) that leads to the central supply room. Findings Include:Observations of the Heirloom nursing unit main shower room on May 6, 2026, at 12:20 PM revealed that the bathroom has a strong, musty smelling odor. A dark, black substance was observed lining the white wall grout where the floor meets the wall under the shower head. The black buildup extended five feet from under the showerhead, to the corner, and three feet along the adjoining wall of the shower area, spreading into the grout of the floor tiles of the corner. Concurrent interview with Employee 3, nurse aide, revealed that the bathroom always had this odor, and the black substance had been present for a long time. Observation on May 6, 2026, at 12:35 PM of the outdoor breezeway that connects the main building to the laundry and central supply room revealed a drainage pipe on the ground measuring eight inches round with a metal cover that was broken in three pieces and resting inside the hole of the drain. Observation of the University nursing unit main shower room on May 6, 2026, at 11:51 AM revealed a bathtub located in the room. The white tub contained black dirt/debris throughout the interior of the tub. In a concurrent interview with Employee 4, nurse aide, Employee 4 indicated staff did not utilize the tub to bath residents but confirmed it was not in clean condition for resident use if they wished to do so. Continued observation of the University nursing unit main shower room revealed the following: A privacy curtain hanging in the shower room was stained and contained spots of a brown substance on the curtain. A plastic shower curtain on the shower stall was dirty and ripped/cracked in multiple places. The shower room was unkempt with pieces of equipment/bins staggered throughout the room, multiple bottles of shampoo, conditioner, creams, and used hairbrushes were scattered around unlabeled, on shelves, shower litter (bed for transport), and on stands and bins throughout the room. The toilet and flooring surrounding the toilet area was blackened and dirty. Multiple open cracks were observed in the seat cushion of a shower chair sitting beside the shower. Observation of the [NAME] nursing unit main shower room on May 6, 2026, at 11:56 AM revealed the shower stall was surrounded in a black substance covering the white grout where the flooring meets the wall. This extended in some areas up the wall and onto the flooring area. Further observation of the [NAME] unit main shower room revealed the following: A bathtub in the room contained a large yellow caution - wet floor sign, two disposable briefs, a stack of pink plastic basins, an electric razor, a piece of plastic piping, and an empty shampoo bottle in the interior of the tub. A toilet riser sitting directly on the floor unbagged under a bedside commode beside the bathtub. A small stand containing a used hairbrush covered in hair with shampoo and conditioner bottles unlabeled in the shower stall. Blackened floor tiles surrounding the toilet area and black buildup along the wall edges in the toilet/sink area. The exit doors to the hallway were significantly marred. A roof access door (piece of hard ceiling) located directly over the toilet was dirty and significantly marred. The above environment concerns related to the shower rooms and the outdoor breezeway were reviewed during a meeting with the Nursing Home Administrator and Director of Nursing on May 6, 2026, at 3:00 PM. 483.10(i)(1)-(7) Safe/clean/comfortable/homelike EnvironmentPreviously cited deficiency 2/20/2026 28 Pa. Code 201.18(b)(3)(e)(2.1) Management

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on staff interview, it was determined the facility failed to employee a full-time qualified director of food and nutrition services in the absence of a full-time qualified dietitian. Findings include: In an interview with Employee 6, certified dietary manager, on May 6, 2026, at 12:17 PM, Employee 6 indicated they were only working at the facility one day a week over the past one to two months to help out until the facility obtained a new food and nutrition services director, and that they were employed by another facility owned by the same company. Interview with the Nursing Home Administrator on May 6, 2026, at 1:19 PM indicated the facility's registered dietitian was only employed on an as needed basis and the facility did not employe a full-time registered dietitian. The facility did not employee a full-time registered dietitian or a full-time qualified director of nutrition services. Cross Refer 805, 810, and 812 483.60(a)(1) Qualified Dietary StaffPreviously cited 2/20/26 28 Pa. Code 201.18(b)(1)(3) Management

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on clinical record review, observation, and staff interview, it was determined that the facility failed to prepare food in a form to meet physician ordered diets for one of one resident reviewed (Resident 5).Findings include: Clinical record review for Resident 5 revealed an active physician's order dated November 5, 2025, to provide a pureed texture diet with nectar thick liquids. Observation of the lunch meal on May 6, 2026, at 12:40 PM revealed Resident 5's meal tray included an entree that presented as ground up meat, large pieces of sweet potatoes, and peas and diced carrots in their regular form, as well as a container of strawberry ice cream. Review of Resident 5's meal tray ticket on the tray confirmed the resident was to receive a puree texture diet with nectar thick consistency liquids. Employee 5, nurse aide, confirmed the meat was ground in texture as she observed on other resident trays with a ground consistency and not pureed, and the potatoes and peas and carrots were not pureed. Employee 5 also confirmed due to the resident being ordered nectar thick consistency liquids that the resident should not have received regular ice cream. The surveyor reviewed the above dietary concerns for Resident 5 during an interview with the Nursing Home Administrator and the Director of Nursing on May 6, 2026, at 3:00 PM. Cross Refer 801 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, clinical record review, and staff interview, it was determined that the facility failed to provide an assistive device for one of one resident reviewed (Resident 5).Findings Include: Review of Resident 5's care plan (an outline of an individual's health needs, specific care requirements, and the actions necessary to achieve desired health outcomes, represented as the focus, goal, and interventions), revealed the resident required assistance with activities of daily living (ADLs - things such as eating, drinking, dressing, bathing, hygiene). A spouted sippy cup (adaptive feeding cup with a lid and spout to assist in drinking) and red foam built up handles on spoons were listed as an intervention to aid the resident in eating/drinking. Observation of Resident 5 on May 6, 2026, at 12:40 PM revealed the resident in bed with a lunch meal tray in front of her. There was no sippy cup observed for the resident's liquid which was served in a regular cup on the meal tray. Further review of Resident 5's meal ticket on the tray revealed the resident was also to receive the food in separate bowls and the entree (protein and sides) were all served on one plate. Concurrent interview with Employee 5, nurse aide, confirmed the resident did not receive the appropriate adaptive feeding cup or food served in separate bowls as indicated on the resident's plan of care and meal tray ticket. The above information regarding Resident 5 was reviewed with the Nursing Home Administrator and Director of Nursing on May 6, 2026, at 3:00 PM. Cross Refer 801 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18 (b)(1) Management 28 Pa Code 211.10 (d) Resident care policies 28 Pa Code 211.12(d)(1)(5) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 that the facility failed to store food and maintain food service equipment in accordance with professional standards for food service safety in the facility's main kitchen.Findings include: An observation in the facility's main kitchen on May 6, 2026, at 12:17 PM revealed the following: A foot pedal garbage can was overflowing with trash to the point where the lid was completely held open vertically by empty food cans and trash. The flooring in the food delivery receiving area was covered in debris, dirt, and black marks. Employee 6, certified dietary manager, indicated the mess was from a delivery early in the day due to rain outside, although, much of the dirt/debris was collected up along the wall edges and dried throughout the flooring. The flooring in the dry storage area was significantly dirty upon observation with black dirt as well as debris including lids, wrappers, packs of crackers, and other debris throughout the flooring and under food storage shelving units. The flooring throughout was sticky to walk on. A commercial ice dispenser was observed in the dry storage room with dust/debris, and parts to the machine lying on top of it. The machine bin did not contain any ice. Employee 6 indicated she was not aware when the machine was last in use, or if it was under repair, and that the facility purchased ice from the store if needed. Multiple open wire rack shelving units were observed with various food items stored on them in the dry storage room. The lower shelves of the unit were observed with food stored on them six to eight inches from the floor. There was no solid barrier observed between the floor and the food items stored on the lower shelves to prevent the potential contamination from mop water splash or sweeping debris. The interior compartments of the steam table (areas of a steam table that holds water that is heated to maintain hot serving temperatures of pans of food that sit in the wells), observed as staff were removing pans of food upon completion of the lunch service line revealed the compartments were coated in thick brown buildup and multiple particles of food were floating in the water. The above findings were reviewed with the Nursing Home Administrator and Director of Nursing on May 6, 2026, at 3:00 PM. Cross Refer 801 483.60(i)(2) Store, prepare, food safe and sanitaryPreviously cited 2/20/26 28 Pa. Code 201.14 (a) Responsibility of Licensee