

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/23/2026
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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed clinical record review and staff interview, it was determined that the facility failed to develop a baseline care plan within 48 hours of admission for one of two residents reviewed (Residents CR2). Findings include: Closed clinical record review for Resident CR2 revealed the resident was admitted to the facility on [DATE], with a diagnosis list which included, UTI (urinary tract infection), dysphagia (difficulty swallowing), communication deficit, muscle weakness, difficulty walking, diabetes (blood glucose problem), sleep apnea (loss of breath), depression, back pain, anxiety disorder, absence of right toes, heart failure, reflux disease, elevated lipids, hypertension (high blood pressure), osteoarthritis (joint disease), chronic kidney disease, and muscle spasms. Resident CR1 was transferred to the hospital at the family's request on July 13, 2026, and did not return to the facility. Further record review for Resident CR2 revealed a nursing admission Evaluation with Baseline Care Plan was created in the electronic record on July 8, 2026, the date the resident was admitted. The sections of the evaluation consisting of the assessment of demographics (social history)/orientation to the facility, skin integrity, oral/nutritional, neurological, respiratory, cardiovascular (heart/lungs), gastrointestinal, bladder/bowel, pain, mobility/safety, sensory, discharge planning/psychosocial wellbeing, and medications/physician's orders and specialized services assessment did not show any entries were completed until July 13, 2026, five days after the resident's admission. At the time of the onsite survey on July 23, 2026, the same evaluation still showed in progress in the resident's closed clinical record. Review of Resident CR1's plan of care revealed no evidence any baseline care plan was created for the resident until July 13, 2026, five days after admission, and the day the resident was transferred to the hospital and subsequently discharged from the facility. There was no evidence the resident/responsible party were provided with a copy of a baseline care plan within 48 hours of admission. The facility failed to implement a baseline care plan within 48 hours of admission for Resident CR1 and provided a written copy to the resident/responsible party. The above information was reviewed with the Nursing Home Administrator and Director of Nursing on July 23, 2026, at 4:00 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. Based on clinical record review and resident and staff interview, it was determined that the facility failed to obtain diagnostic services to meet the needs of its residents and ensure those services are obtained promptly for one of one resident reviewed for a change in condition (Resident 4). Findings Include: Clinical record review for Resident 4 revealed a nursing progress note dated May 26, 2026, at 9:34 PM which noted the facility staff were alerted to the resident complaining of a swollen middle finger on the left hand. The note indicated upon assessment the finger was purple in color, swollen, and bruised. The note also indicated the resident had stated a family member took her out front outside the building and while opening the door her wheelchair had started to roll downhill and the resident tried to stop her wheelchair with her left hand and got her finger stuck and that is how it got swollen/bruised. The note further noted vital signs were obtained and medication was provided for pain management, and ice was offered for the middle finger, but the resident refused. The resident's medical provided was notified and verbally ordered and Xray. An order administration note dated May 27, 2026, at 7:17 AM noted the resident was administered hydrocodone-acetaminophen (pain reliever) for pain at a level of nine out of ten, for the left middle finger, bruising/swollen. Further review of Resident 4's clinical record revealed the following: A nursing note dated May 27, 2026, at 8:10 AM noted the resident's left third finger was assessed, and it is swollen and bruised. The note stated yesterday when doing wound rounding with the wound care provider the resident mentioned her toe was bleeding and stated she had bumped it and it was assessed and noted for wound care and being treated. Resident at that time did not mention her finger being injured. Will be ordering an Xray for the finger if it has not been ordered yet. A late entry provider note documented on May 30, 2026, for May 27, 2026, at 11:13 AM noted the resident was presenting with left middle finger swelling and bruising after her wheelchair rolled forward and her finger was caught on May 26, 2026. The provider noted that the resident reports pain at a level of nine out of ten with limited range of motion of the finger with no other complaints. The plan was noted as Xray of the left middle finger ordered to evaluate for fracture. Buddy tape applied to left index and middle fingers for stabilization PRN (as needed) pain management continued. Will follow up on imaging results and adjust plan accordingly. A nursing note May 28, 2026, at 1:41 AM noting left middle finger continues with swelling/bruising. A nursing note dated May 28, 2026, at 4:36 AM noted new orders from the doctor on rounds, ordered to buddy tape left pointer finger to middle finger, and Xray to be scheduled. A nursing note dated May 28, 2026, at 2:08 PM noted left index finger taped to left middle finger post injury, Xray scheduled. Review of physician orders for the resident revealed an order dated May 28, 2026 (two days after the injury was identified), for an Xray of the left hand, finger series re: left middle finger bruised and swollen. A nursing note dated June 9, 2026 (14 days after the first assessment of the resident's finger), at 1:10 PM which noted a left hand/finger Xray was ordered through Trident care with the claim number noted. A nursing note dated June 10, 2026, at 1:28 PM the noted the Xray was obtained on that shift. (15 days after the injury was identified). Review of an Xray report for Resident 4 dated with a service date of June 10, 2026, revealed an Xray was completed of the resident's left hand and fingers on that date. The results noted degenerative (gradual decline) changes to the resident's hand and fingers with no fracture or dislocation identified. In an interview with Resident 4 on July 23, 2026, at 1:31 PM the resident stated she got her finger stuck in the spoke of her wheelchair. The resident stated she still could not bend it all the way as she could her other fingers. Concurrent observation revealed the left middle finger did not bend as far as the other fingers on the hand but was free of (continued on next page)		

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	swelling and bruising. The resident stated she had an Xray of the finger about three weeks after it happened, they taped it for little while, she stated. The resident stated she was not aware of the Xray results. The resident stated that the finger is still sore from the top knuckle to the tip of the finger. Resident 4 did not receive an Xray of the finger as noted to be completed beginning on May 26, 2026, until June 10, 2026, 15 days after the resident sustained the injury, and it was indicated an Xray would be ordered and completed. There was no evidence the Xray results were reviewed with the resident. The above information was reviewed with the NHA and Director of Nursing on July 23, 2026, at 4:00 PM. 28 Pa. Code 211.12 (d) (5) Nursing services		