

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  03/14/2025
NAME OF PROVIDER OR SUPPLIER  Embassy of Hearthsides		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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>44738</p> <p>Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to ensure that the facility determined a resident's ability to self-administer medications for one of one resident reviewed (Resident 72).</p> <p>Findings include:</p> <p>Observation of Resident 72 on March 11, 2025, at 12:25 PM revealed the resident was in bed. An adjacent bedside table had Fluticasone nasal spray (a steroid medication used to treat various signs and symptoms that could be caused by allergies). A concurrent interview revealed the resident utilized the medication to treat allergies.</p> <p>A current physician's order dated February 22, 2025, for Resident 72 revealed an order for Fluticasone Propionate Nasal Suspension 50 micrograms per actuation (mcg/act)c, use two sprays in both nostrils one time daily related to allergic rhinitis (an allergic reaction to allergens in the air that may cause nasal congestion, sneezing, and watery eyes).</p> <p>Further clinical record review for Resident 72 revealed no physician's order that the resident may self-administer the medication, or that the facility determined the resident was able to safely self-administer the medication.</p> <p>The above information was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on March 13, 2025, at 2:40 PM.</p> <p>28 Pa. Code 201.18(b)(1) Management</p> <p>28 Pa. Code 211.9 (a)(1)(b) Pharmacy services</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>		

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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44738</b></p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to establish clear advance directives for one of four residents reviewed (Resident 323).</p> <p>Findings include:</p> <p>A review of the census for Resident 323 revealed that the resident was admitted to the facility on [DATE].</p> <p>Current physician orders for Resident 323 revealed no orders related to the code status (instructions for health care personnel if the resident's heart stopped beating or the resident stopped breathing; does the resident want cardiopulmonary resuscitation) for the resident.</p> <p>Review of the current care plan for Resident 323 revealed no care plan related to code status.</p> <p>Review of the POLST (Pennsylvania Orders for Life-Sustaining Treatment, a form directing medical staff to complete life-sustaining treatment or allow a natural death) documentation for Resident 323 on March 12, 2025, at 2:18 PM revealed a form located in the POLST binder on the Nittany Nursing Unit for Resident 323 that was signed by the resident's responsible party, but not the medical provider that indicated the resident was a DNR/Do Not Attempt Resuscitation (Allow Natural Death). This information was confirmed by Employee 8, licensed practical nurse, at the time of the findings.</p> <p>The above information for Resident 323 was reviewed with the Nursing Home Administrator and Director of Nursing on March 13, 2025, at 2:40 PM.</p> <p>The facility provided a second POLST form for Resident 323 on March 14, 2025, signed by the medical provider, however, not the resident or resident's responsible party. The facility reported there must have been two POLST forms filled out for the resident.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38839</p> <p>Based on observation and staff interview, it was determined that the facility failed to provide adequate housekeeping and maintenance services to ensure a clean, safe, and orderly environment on three of four nursing units ([NAME], Nittany, University and Residents 8, 15, 43, 54, 64, 81, 82, 91, 100).</p> <p>Findings include:</p> <p>Observation of Resident 64's room on March 11, 2025, at 12:59 PM revealed an electrical outlet box lying on the floor connected to wires, which extended into a long piece of conduit that was hanging off the wall behind the resident's bed. An unpainted area with empty screw holes was observed on the wall above where the outlet box was laying. Some dry wall debris and wire clippings were observed along the wall. An oxygen concentrator was plugged into the outlet box on the floor.</p> <p>A follow up observation of Resident 64's room on March 12, 2025, at 10:07 AM also revealed significant brown/black buildup along the baseboard heater under the window of the room where the floor meets the wall.</p> <p>An observation of Resident 8's room on March 12, 2025, at 10:19 AM revealed significant marring of the wall behind the resident's bed.</p> <p>An observation of Resident 81's bathroom (shared between Resident 81 and 64's rooms) on March 11, 2025, at 1:20 PM revealed staining throughout the floor, the caulking around the toilet base was orange and dirty, dust was observed hanging from the water connection from the wall to the toilet, and the interior of the toilet bowl was covered in black streaks. A screw was observed hanging out of the top corner of the right-side cabinet door under the vanity sink in the bathroom (appearing to be in place to prevent the door from opening). The left side cabinet door under the vanity opened. The interior of the cabinet under the vanity was dirty, and contained a piece of toilet paper, a plastic bag, and two large brass-colored bolts lying in the cabinet. A wall tile was missing by the soap dispenser in the bathroom. A garbage can in the bathroom was overflowing with the lid lying on the floor beside the can. The lid was soiled with a dried brown substance.</p> <p>An observation of Resident 15's room on March 12, 2025, at 10:29 AM revealed the privacy curtain along the wall and between the resident's bed and the roommate's bed were both significantly stained and contained brown smears on the curtains.</p> <p>An observation on March 13, 2025, at 1:05 PM of the [NAME] unit hallway extending from the shower room door to the double exterior doors at the end of the hall beside a staff office revealed the lower portion of the hallway wall was significantly marred.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An observation of the [NAME] nursing unit nourishment room on March 13, 2025, at 1:09 PM revealed a significant buildup of dirt at the door transition strip from the nursing unit to the nourishment room. The flooring of the nourishment room was dirty with dirt and debris throughout the flooring and where the floor meets the cabinets. The white metal cabinets in the room where food and resident supplies were stored contained visible rust on the doors, door frames, drawers, and shelves. The cabinets and drawers also had chipped paint, missing handles, and were in dilapidated condition. A lower cabinet door would not open without holding a drawer up, and the drawer could not open without moving the cabinet door. A large sink in the area contained stained caulking around the sink and a buildup of a thick yellow, cracked substance along the back edge of the sink where it meets the wall. Large pieces of the countertop covering were observed broken off. The countertop was stained and contained dried spills. A back room located within the nourishment room was observed with a large round light hanging upside down from the ceiling with the electric components and wires hanging down. A garbage can in the room was observed to have dried liquid spills on the exterior and the interior of the can. The lid was soiled with dried food and dried liquids.</p> <p>The above findings for Resident 8, 15, 64, 81, and the [NAME] nursing unit hallway and nourishment room were reviewed with the Nursing Home Administrator and Director of Nursing on March 13, 2025, at 3:09 PM.</p> <p>Observation of the Nittany Nursing Unit nutritional closet on March 13, 2025, at 1:56 PM revealed an extensive build-up of dust on an air vent located in the ceiling.</p> <p>Observation of the Nittany Nursing Unit activity/dining room on March 13, 2025, at 1:59 PM revealed a vent in the ceiling above the ice machine. The ceiling area surrounding the vent appeared to be previously repaired and was damaged and flaking pain in multiple areas. The corner of the ceiling vent appeared to be coming off the ceiling. There was a golf-ball sized hole in the ceiling adjacent to the vent.</p> <p>Further observation revealed the top of the ice machine was covered with a cloth pad that was stained with brown stains. Under the pad appeared to be a significant accumulation of dust and debris from the damaged area of the ceiling. A lidded garbage can next to the ice machine did not have a garbage bag in it and contained multiple paper products, two empty soda cans, and used medical gloves.</p> <p>The above information for the Nittany Nursing Unit was reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on March 13, 2025, at 2:40 PM.</p> <p>Observation of Resident 100's room on March 12, 2025, at 10:34 AM revealed there was dirt behind the door to the room and the bathroom door had peeling paint. The bathroom door frame was all marred. The bathroom mirror was dirty, the floor behind the toilet was dirty, the cove base all was dirty, there was a wall tile next to the soap dispenser with a piece broken off it, and the toilet was dirty.</p> <p>Observation of Resident 43's room on March 12, 2025, at 12:33 PM revealed dirt in the corner behind the door to his room, the curtain between the beds had two areas of something red smeared on it, and the window in the room appeared dirty and was hard to see out of.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of Resident 54's room on March 12, 2025, at 12:43 PM revealed dirt in the corner behind the door. The bathroom floor had loose dirt all over it, and there was a tissue with something brown on it on the floor in front of the garbage can.</p> <p>The Nursing Home Administrator and Director of Nursing were made aware of the concerns related to Residents 54, 43, and 100's environment on March 13, 2025, at 2:25 PM.</p> <p>Observation of Resident 82's room on March 11, 2025, at 2:34 PM revealed the privacy curtain was noted with dark brown soiled spots and pink opaque smears. The wall and the floor under the window and the floor behind the door were coated with black buildup and dirt.</p> <p>Observation of Resident 91's room on March 12, 2025, at 10:42 AM revealed the privacy curtain had multiple discolored areas. The filter on the AC unit under the window was coated in dust. The tray table veneer coating was removed around the corners, exposing particle board underneath.</p> <p>The Nursing Home Administrator and Director of Nursing were made aware of the concerns related to Residents 82 and 91's environment on March 13, 2025, at 2:44 PM.</p> <p>28 Pa. Code 201.18(b)(3) Management</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38839</p> <p>Based on observation, clinical record review, review of facility documents, and resident and staff interview, it was determined that the facility failed to protect the rights of a resident to be free from neglect by not providing the services necessary to avoid physical harm related to a fracture of her right leg on one of two residents reviewed for abuse/neglect (Resident 9).</p> <p>This deficiency is cited as past noncompliance</p> <p>Findings include:</p> <p>Observation and interview with Resident 9 on March 12, 2025, at 10:48 AM revealed the resident was in bed. She stated she was sore on both of her knees and had an injury in her thigh area from an incident with her wheelchair.</p> <p>Clinical record review for Resident 9 revealed a medical provider note dated January 21, 2025, at 9:49 PM that the resident was seen for an acute visit for right knee pain and the knee area was mildly swollen. An x-ray was ordered for the resident due to hitting her knee. There were no further details of any accident/injury.</p> <p>Review of x-ray results for Resident 9 dated January 23, 2025, revealed the resident was positive for a fracture of the right femur (thighbone).</p> <p>Review of a staff interview with Resident 9 dated January 23, 2025, revealed Resident 9 indicated Employee 18, licensed practical nurse, was pushing her in her wheelchair and her leg went under the wheelchair. She stated Employee 18 told her it would be okay.</p> <p>Resident 9 was transferred to the hospital on January 23, 2025, and was admitted for surgical intervention for the fracture.</p> <p>The facility investigation into Resident 9's injury revealed the resident was self-propelling to the dining room area on January 19, 2025, when Employee 18, licensed practical nurse, approached the resident from behind and began pushing her to the dining room and the resident's leg got caught under the wheelchair.</p> <p>Per Employee 18's statement of the incident dated January 23, 2025, Employee 18 indicated he was pushing the resident to lunch on January 19, 2025, when the resident's right foot fell to the ground (there were no leg rests to have caused her leg to fall to the ground) and went slightly back under the wheelchair, noting the resident yelled in pain. Employee 18 noted on the statement that he immediately stopped and carefully moved the resident to a comfortable position and indicated no injury, bruising, or swelling was noted. Employee 18 indicated on the statement the resident complained of pain of 4 on a scale of one to 10, and pain medication was administered. It was noted on the statement the resident ate lunch and did not mention any discomfort until shortly after the evening meal noting he made a follow up assessment and observed mild swelling, but no redness, bruising, or other signs of injury.</p> <p>(continued on next page)</p>		

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F 0600  Level of Harm - Actual harm  Residents Affected - Few	<p>There was no evidence Employee 18 reported the incident when it occurred on January 19, 2025, to any other staff. Per staff statements, the resident refused to get out of bed on January 20, 2025, due to pain, and did the same on January 21, 2025, when the medical provider was contacted.</p> <p>Resident 9 returned to the facility on [DATE].</p> <p>Employee 18 pushed Resident 9 in the wheelchair on January 19, 2025, to the dining room without leg rests on the chair causing Resident 9's right foot to get caught under the wheelchair resulting in a fracture. Employee 18 did not report the incident or the resident's change in condition due to the incident until the investigation revealed Employee 18's involvement in the injury on January 23, 2025.</p> <p>Employee 18 was terminated from the facility on January 27, 2025.</p> <p>All staff education was completed January 24-29, 2025, on abuse/neglect, proper notification of a resident change in condition, and utilizing leg rests when a resident requires being pushed in a wheelchair.</p> <p>The above information was reviewed with the Nursing Home Administrator and Director of Nursing on March 14, 2025, at 10:30 AM.</p> <p>28 Pa. Code 201.18(e)(1) Management</p> <p>28 Pa. Code 201.29(a) Resident rights</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide care and services to maintain or improve the ability to perform activities of daily living for one of three residents reviewed for eating concerns (Resident 105).</p> <p>Findings include:</p> <p>Clinical record review for Resident 105 revealed an MDS (Minimum Data Set, assessment completed at specific intervals to determine care needs) assessment dated [DATE], that staff assessed Resident 105 as requiring the supervision with set up help only for eating. Resident 105's next MDS assessment dated [DATE], revealed staff assessed Resident 105 as now requiring extensive assistance of one staff for eating.</p> <p>There was no documented evidence in Resident 105's clinical record to indicate that the facility identified or assessed Resident 105's decline in her ability to perform this activity of daily living.</p> <p>Speech Therapy did not assess Resident 105 until January 19, 2025. Further review of Resident 105's clinical record revealed from October 1, 2024, to January 13, 2025, he lost 27.10 pounds, a 15.65 percent severe weight loss in three months.</p> <p>The surveyor reviewed the above findings for Residents 105 with the Director of Nursing and the Nursing Home Administrator on March 13, 2025, at 1:45 PM. The facility was unable to provide any further documentation that the facility assessed Resident 105's decline in eating ability or implemented any measures to mitigate the decline.</p> <p>Cross refer F692.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>38839</p> <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on clinical record review and resident and staff interview, it was determined that the facility failed to implement physician orders for two of 24 residents reviewed (Residents 104 and 115).</p> <p>Findings include:</p> <p>In an interview with Resident 115 on March 12, 2025, at 9:44 AM the resident indicated she was recently admitted to the facility about a month prior and had a feeding tube in place when she arrived but was no longer receiving feedings through the tube because she was eating. Resident 115 then indicated the tube had not been flushed since the feedings through the tube had stopped. Resident 115 stated she asked a nurse about the tube not being flushed and was told everything had been discontinued. Resident 15 stated she was concerned because the tube had an odor.</p> <p>No odor was observed near Resident 115, although the resident lifted her shirt to expose a feeding tube coming from her abdomen area and the tubing had particles and a red substance observed inside the exposed area of the tubing.</p> <p>Clinical record review for Resident 115 revealed the resident did have a G-tube (gastrostomy tube, a flexible tube inserted through an incision into the abdomen and into the stomach which is used to provide supplemental nutrition and hydration) and had been receiving feedings of a nutritional supplement through the tube which were discontinued on February 26, 2025.</p> <p>Further review revealed Resident 115 had several water flush orders for her G-tube. A physician's order dated February 3, 2025, indicated the resident was to have a flush of 100 ml (milliliters) of water via the G-tube every four hours. This was an active order at the time of review, although no evidence of the order appeared on the resident's medication or treatment administration records.</p> <p>Resident 115 also had an order for a water flush of 100 ml's every four hours for a total of 2400 ml's every 24 hours to be infused via a feeding pump ordered on February 14, 2025, and discontinued on March 5, 2025.</p> <p>A new order dated March 6, 2025, was identified for Resident 115 to receive a 150 ml water flush of the tube three times a day. This was documented as administered one time on March 6, 2025, at 7:00 AM, but then was discontinued. Another new physician's order dated March 6, 2025, indicated to flush the G-tube with 150 ml of water three times a day. This was documented as completed twice on March 6, 2025, and on the day and evening shift of March 7, 2025, but was then discontinued on March 7, 2025.</p> <p>There was no evidence Resident 115 received any water flushes via the G-tube to maintain patency since March 7, 2025, even though an active order remained for flushes that were ordered on February 3, 2025.</p> <p>The above findings for Resident 115 were reviewed with the Nursing Home Administrator and Director of Nursing on March 12, 2025, at 2:30 PM.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a follow up interview with the Nursing Home Administrator and Director of Nursing on March 13, 2025, at 2:30 PM it was determined that Resident's 115's G-tube water flush order was entered incorrectly and did not appear on the resident's administration record. A new water flush order was placed for the resident on March 12, 2025. It was confirmed Resident 115 had not received any water flushes via the G-tube from March 7, 2025, as indicated until the new order was placed on March 12, 2025.</p> <p>Clinical record review for Resident 104 revealed an order dated March 1, 2025, at 2:00 PM that noted the resident was to have an arm sling on for four hours daily on bilateral arms for edema (swelling) every evening shift for four hours only.</p> <p>Review of Resident 104's current care plan revealed intervention dated March 4, 2025, that noted an arm sling for four hours daily on evening shift to bilateral arms due to edema.</p> <p>An interview with Resident 104 on March 14, 2025, at 10:08 AM revealed the resident was sitting in a chair with both arms hanging down towards the floor. The resident reported that he does not wear a sling or have one in the room that he is aware of.</p> <p>Nursing documentation for Resident 104 dated February 27, 2025, at 4:07 AM revealed that Both hands appear swollen with fluid and non-pitting edema (swelling that is not affected by pressure). Further review of the documentation revealed that both hands were propped on the resident's thighs and slightly elevated and staff will pass along in morning report to have the resident evaluated by the medical provider.</p> <p>Medical provider documentation for Resident 104 dated February 28, 2025, at 6:16 AM revealed that it was decided to use arm slings to help prop up the resident's arms. Documentation noted that it was decided on four hours on for each arm as a start, which gave the resident a free arm to do daily tasks. Further review of the medical provider's documentation noted that for the edema (swelling caused by fluid), we will try an arm sling to keep the resident's hands up because now they are resting on the resident's legs or pointing straight down.</p> <p>An interview with Employee 10, licensed practical nurse, on March 14, 2025, at 10:10 AM revealed after speaking with Resident 104 and checking the resident's room that there was not a sling present for the resident to wear. Employee 10 further stated that she believed that another shift utilized pillows to prop up the resident's arms because they hang down and swell due to his clinical history.</p> <p>A review of Resident 104's Treatment Administration Record (TAR where staff document the administration of treatments) for March 2025, revealed that staff documented the sling as being applied as ordered for the following dates on the evening shift: March 1, 3, 4, 6, 7, 8, 11, 2025. There was no documentation for March 2, 2025.</p> <p>A review of the March 2025, TAR notes entered by staff for Resident 104 revealed the following:</p> <p>March 5, 2025, at 10:34 PM awaiting on sling</p> <p>March 9, 2025, awaiting sling</p> <p>March 10, 2025, awaiting sling</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on March 14, 2025, at 11:30 AM with the Nursing Home Administrator revealed that there was a probable miscommunication between nursing staff and the physician and the sling for Resident 104 was not being applied as ordered by the physician or available for use.</p> <p>483.25 Quality of Care</p> <p>Previously cited deficiency 4/26/24</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>

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  03/14/2025
NAME OF PROVIDER OR SUPPLIER  Embassy of Hearthside		STREET ADDRESS, CITY, STATE, ZIP CODE  450 Waupelani Drive State College, PA 16801	

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>38839</p> <p>Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to offer a resident to receive proper treatment and care to maintain good foot health in accordance with professional standards of practice for one of 24 residents reviewed (Resident 81).</p> <p>Findings include:</p> <p>An observation of Resident 81's left foot during a pressure ulcer dressing change to the same foot, on March 14, 2025, at 10:26 AM revealed the resident's toenails on the left foot were yellow and extremely thick, one-half inch in depth raised up on top of the center surface of the toenails. A closer look revealed the toenails had extended from each toe and curled upward and had attached to the top flat surface portion of the nail with a fungal looking appearance. The skin on the toes was scaled and peeling.</p> <p>Upon concurrent interview with the resident regarding his toenails, the resident stated he has asked three times to see a podiatrist since he has been there and hasn't seen one yet.</p> <p>In an interview with the Director of Nursing on March 14, 2025, at 10:35 AM it was reported the resident was not scheduled for routine podiatry services through the facility's provider as the resident was considered short term and only long term residents are added for routine services such as podiatry. Since the resident had just changed to long term, the resident would now be able to be added for the routine services.</p> <p>A nursing note date March 13, 2025, at 3:29 PM indicated that facility staff spoke with the resident's family member regarding the resident wanting to see a podiatrist, but the family member would like to schedule the appointment so they could assure transportation was set up.</p> <p>There was no evidence any podiatry services were offered, or the resident/responsible party were assisted/offered coordination with outside services if the services could not be provided in the facility prior to March 13, 2025.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 18229</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to provide services to maintain a resident's range of motion for two of three residents reviewed for ROM concerns (Residents 101 and 25).</p> <p>Findings include:</p> <p>Clinical record review revealed the facility admitted Resident 101 on November 9, 2023. Review of Resident 101's most recent quarterly MDS (Minimum Data Set, an assessment completed at specific intervals to determine care needs) dated February 7, 2025, noted staff assessed Resident 101 as having impairment to his range of motion (ROM, movement of the body to maintain a resident's ability) of his bilateral lower extremities.</p> <p>Nursing documentation dated January 24, 2025, at 3:07 PM revealed Resident 101's daughter was made aware of his fall and that therapy was being discontinued.</p> <p>Review of Resident 101's physical therapy discharge summary dated January 16, 2025, noted he exhausted his benefits. Therapy documentation revealed Resident 101 was provided education for proper execution with exercises, benefits of range of motion and stretching, proper sequence and safety with bed mobility, and sit to stand transfers.</p> <p>Review of Resident 101's MDS assessment dated [DATE], revealed staff assessed Resident 101's cognition as severely impaired. Attempts to interview Resident 101 on March 12 and 13, 2025, were unsuccessful.</p> <p>Further review of Resident 101's therapy discharge summary dated January 16, 2025, revealed he responded positively to passive techniques to stimulate functional performance and enhance safety to prevent further decline. Therapy noted Resident 101 made improvements with the ROM of his knee and ankle. Therapy further documented Resident 101 did not meet all his goals, but he was safe in long term care facility with assistance from staff. Therapy noted Resident 101's prognosis to maintain his current level of function was good, with consistent staff follow through.</p> <p>There was no documentation that Resident 101 received care from staff to maintain his current level of function upon discharge from therapy.</p> <p>Interview with Employee 9 (physical therapist) on March 13, 2025, at 10:57 AM revealed that she was told the facility does not have enough staff; therefore, Employee 9 did not recommend a restorative nursing program upon Resident 101's discharge from therapy.</p> <p>The facility failed to ensure Resident 101 received appropriate treatment and services to maintain or prevent further decrease in his range of motion.</p> <p>Interview with the Director of Nursing and the Nursing Home Administrator on March 13, 2025, at 1:45 PM confirmed these findings.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Clinical record review for Resident 25 revealed that the facility admitted her on March 8, 2019. Review of her most recent quarterly MDS dated [DATE], revealed that she had an impairment of her bilateral lower extremities.</p> <p>Review of Resident 25's most recent physical therapy discharge summary dated September 20, 2024, revealed that Resident 25 was provided with home exercise programs to complete. Her prognosis was documented as excellent with the home exercise program and consistent staff support. There was no restorative program established and the discharge summary indicated it was not indicated at this time.</p> <p>Interview with Employee 9 (physical therapist) on March 13, 2025, at 10:57 AM revealed that she was told the facility does not have enough staff; therefore, Employee 9 did not recommend a restorative nursing program upon Resident 25's discharge from therapy.</p> <p>Interview with Resident 25 on March 13, 2025, at 1:06 PM revealed that she was given exercises to do but she does not remember to do them. She also indicated that her left knee is worse since she has not been receiving therapy and it does not straighten the same.</p> <p>Interview with the Director of Nursing and the Nursing Home Administrator on March 13, 2025, at 1:45 PM confirmed the above noted findings that Resident 25 does not have a program to prevent a decline in her ROM to her lower extremities.</p> <p>483.25(c) Mobility</p> <p>Previously cited 4/26/24</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38839</p> <p>Based on clinical record review, review of select facility policies and procedures, and resident and staff interview, it was determined the facility failed to ensure acceptable parameters of nutrition status were maintained for four of 15 residents reviewed for nutrition concerns (Residents 49, 81, 105, and 108) and provide timely assessments and interventions from a qualified nutrition professional to promote acceptable parameters of nutrition status resulting in severe weight loss resulting in harm for one of 15 residents reviewed for nutrition concerns (Resident 81).</p> <p>Findings include:</p> <p>Review of facility policy entitled Nutrition Management, last reviewed on January 1, 2025, revealed the facility is to provide care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. Compliance guidelines of the policy indicate a systemic approach is used to optimize each resident's nutritional status including monitoring the effective ness of interventions and revising them as necessary. The policy states a nutritional assessment will be completed by a dietitian within 72 hours of admission , annually, and upon significant change in condition. Monitoring will occur to determine if current interventions are being implemented and effective, and the physician will be notified of any significant weight changes, intake changes, or changes in nutritional status.</p> <p>In an interview with Resident 81 on March 11, 2025, at 1:11 PM the resident stated he has lost weight since his admission to the facility and that he was down to about 180 pounds from 210 pounds.</p> <p>Clinical record review for Resident 81 revealed the resident was admitted to the facility on [DATE]. The resident's weight upon admission was 210 pounds.</p> <p>Review of a nutrition assessment completed by a registered dietitian dated December 29, 2024, greater than 72 hours after the resident's admission, indicated the resident was receiving a mechanical soft diet due to difficulty chewing. It was noted the resident had increased needs due to alcohol abuse and that the resident was asking for shakes as he had been trying to eat better at home with the support of his family. Resident 81 reported he was drinking two to three shakes a day to get better. The dietitian noted the resident's appetite and intakes were good and the resident is above an ideal body weight, although it was noted the resident had indicators of mild protein calorie malnutrition. The dietitian indicated one shake would be added to the resident's lunch meal and noted the resident was identified at nutritional risk.</p> <p>A review of Resident 81's physician orders revealed the resident was ordered a four-ounce shake on December 29, 2024.</p> <p>A review of Resident 81's plan of care revealed a nutrition care plan was added on December 29, 2024, that indicated the resident was at risk for alteration in nutrition and/or hydration status and interventions included monitoring weight on admission, per facility policy, every month and as needed, to notify the physician of any significant weight change, and to monitor acceptance, effectiveness, and ongoing needs. There were no new interventions added since December 29, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 81's weight on January 6, 2025, 13 days after his admission, was 200.6 pounds indicating a 9.4-pound (4.4 percent) weight loss in just under two weeks. There was no evidence the dietitian addressed the weight loss.</p> <p>Resident 81 was weighed again on January 13, 2025, at 198.8 pounds reflecting another 1.8-pound loss and a total of 11.2 pounds since admission, now a significant weight loss at 5.3 percent. There was no evidence the resident was reassessed by the dietitian.</p> <p>The resident then was documented as weighing 189.2 on January 20, 2025, a further decline of 9.6 pounds in a week, and now a 20.8 pound loss since admission, which was a 9.9 percent severe weight loss in less than a month. There was no evidence the resident was reassessed by the dietitian.</p> <p>Resident 81 was weighed again on January 28, 2025, remaining at 189 pounds On February 3, 2025, Resident 81 weighed 180 pounds, reflecting a 30-pound weight loss since admission, which was a 14 percent severe weight loss. There was no evidence that Resident 81 was weighed after February 3, 2025, no evidence of the resident refusing to be weighed, and no further assessments by the dietitian despite the severe weight loss and minimal food intakes.</p> <p>Review of Resident 81's meal intake records for December 2024, January, February, and March 2025, revealed the resident ate well for two meals on the day of admission December 24, 2024, and one meal on December 25, 2024. All other meals for the remainder of the month were only documented as intakes of zero to 50 percent, with an occasional meal that was greater.</p> <p>Review of Resident 81's medication administration record (where staff document acceptance of nutrition supplements) revealed the resident was receptive and accepting the nutritional shake that was ordered on December 24, 2024, one time a day. There was no evidence the resident was offered or had the shakes increased as he had indicated he was drinking two to three a day at home prior to admission.</p> <p>As of March 13, 2025, there was no evidence Resident 81 was seen or further assessed by the dietitian since the resident presented with significant and severe weight loss from week to week from December 24, 2024, to February 3, 2025.</p> <p>There was no evidence Resident 81's physician was aware of the resident's significant weight changes as noted above.</p> <p>The above information was reviewed with the Nursing Home Administrator and Director of Nursing on March 14, 2025, at 9:30 AM and a current weight was requested if Resident 81 would allow. Resident 81's current weight was 178.4 pounds, an additional 1.6-pound loss since the last weight on February 3, 2025, for a total loss of 31.6 pounds (15 percent severe weight loss) since admission on December 24, 2024.</p> <p>At 10:35 AM on March 14, 2025, the Nursing Home Administrator confirmed there was no evidence the dietitian had reviewed or assessed Resident 81 since the initial nutrition assessment was completed on December 29, 2024, or that the resident's medical provider was made aware of the resident's significant weight changes.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Clinical record review for Resident 49 revealed the resident experienced a weight loss from September 2, 2024, to October 1, 2024, from 121 pounds to 118.6 pounds. The resident was weighed again on November 1, 2024, at a weight of 107.8 pounds, a significant loss of 10.8 pounds (9.1 percent) in one month, and a severe 13.2-pound (10.9 percent) loss over the prior two months.</p> <p>There was no evidence Resident 49's severe weight loss on November 1, 2024, was addressed by a nutrition professional until February 14, 2025, three months later. There was no evidence Resident 49 had been seen by a nutrition professional since August 2024.</p> <p>There was no evidence Resident 49's provider or responsible party was made aware of Resident 49's significant change in nutrition status in November 2024.</p> <p>Clinical record review for Resident 105 revealed the resident experienced a severe weight loss from October 1, 2024, of 173 pounds to November 1, 2024, weighing 146 pounds, a loss of 26.7 pounds (15.4 percent). A re-weight was completed on November 28, 2024, of 144.2 pounds, a 2.2-pound additional loss.</p> <p>There was no evidence Resident 105 was assessed by the dietitian after the severe weight loss was identified on November 1, 2024, until November 26, 2024.</p> <p>Review of a dietary progress note date November 26, 2024, at 2:11 PM for Resident 105 revealed the dietitian assessed the resident as eating well and weight loss at the rate indicated would not be likely and noted in addition to a nutrition supplement being added to the resident's meals, the resident would be placed on weekly weight monitoring.</p> <p>Further review of Resident 105's weights after the resident was seen by the dietitian on November 26, 2024, revealed the resident was weighed on December 1, 2024, at 130.8 pounds, a further loss of 13.8 pounds from November 18, 2024, and no weekly weights were documented as completed between December 1, and the next weight on December 20, 2024, which did indicate a slight increase.</p> <p>There was no evidence Resident 105 was followed by the dietitian after the November 26, 2024, visit until December 27, 2024.</p> <p>Clinical record review for Resident 108 revealed the resident was documented at a weight of 140 pounds on October 2, 2024. The resident's next weight on November 1, 2024, was 126.8 pounds, a severe weight loss of 13.2 pounds (9.4 percent). A re-weight was not completed until November 18, 2024, at 127.2 pounds.</p> <p>There was no evidence Resident 108's severe weight loss indicated on November 1, 2024, was addressed by a registered dietitian or medical provider until November 26, 2024.</p> <p>Review of a dietary progress note dated November 26, 2024, at 3:36 PM for Resident 108, indicated the resident had been experiencing trending weight loss since June of 2024, and had not been on any nutritional support. The dietitian noted the resident presented with signs of moderate protein calorie malnutrition and was unable to identify factors of weight loss other than the resident's dementia. It was noted the resident would be started on nutrition supplementation of a fortified pudding three meals a day, a nutrition supplement at evening medication pass, and add the resident to the weekly weight list.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>There was no evidenced Resident 108 received any weekly weights for monitoring as recommended on November 26, 2024, the next weight was documented on December 1, 2024, and then December 23, 2024. Resident 108 did stabilize in weight although there was no further dietary assessment for Resident 108 until January 9, 2025.</p> <p>There was no evidence Resident 108's physician or responsible party was notified of Resident 108's significant change in weight that occurred on November 1, 2024.</p> <p>The above information regarding Residents 49, 105, and 108, was reviewed with the Nursing Home Administrator and Director of Nursing on March 13, 2025, at 10:30 AM.</p> <p>Cross Refer F801</p> <p>28 Pa. Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>38839</p> <p>Based on clinical record review, observation, and staff and resident interview, it was determined that the facility failed to ensure the availability of necessary emergency supplies for one of one resident reviewed receiving hemodialysis (Resident 15).</p> <p>Findings include:</p> <p>In an interview and observation of Resident 15 on March 11, 2025, at 1:39 PM revealed she was lying in bed eating lunch. The resident indicated she attended dialysis outside the facility three days a week. Resident 15 pointed to her dialysis access site on her left chest area and indicated she used to have it on the right side, but they had to change it.</p> <p>Concurrent observation of Resident 15's room did not reveal any emergency supplies in the resident 's room for the central line to include sterile gauze, hemostat (a tool used to control bleeding), needleless connector, or tape. With the resident's permission to look in her bed side drawers, closet, and wheelchair bag, there was also no evidence of any emergency supplies in those areas belonging to Resident 15.</p> <p>Clinical record review for Resident 15 revealed the resident was receiving hemodialysis (a machine that performs a basic function of the kidney by cleansing the blood of impurities) three days a week outside the facility and the resident had a left chest tunnel catheter (a central line placed under the skin allowing long term access to a vein) for dialysis.</p> <p>A review of Resident 15's plan of care revealed a care plan focus last revised on January 11, 2025, that indicated the resident had a potential for bleeding or hemorrhage related to the use of anticoagulant (blood thinning) medication. An intervention last revised on January 15, 2025, indicated in the event of bleeding from the catheter site to hold pressure and apply a pressure dressing, if bleeding is uncontrollable to call 911 and notify the physician. An additional focus last revised on March 10, 2025, indicated the resident was at risk for potential complications related to requiring dialysis and the resident had a new left chest catheter.</p> <p>In the same interview noted above with Resident 15, the resident indicated she had an emergency kit when she was at home but had not had one at the facility since her admission on January 7, 2025.</p> <p>A follow up observation of Resident 15's room on March 12, 2025, at 10:28 AM revealed an emergency kit was now hanging on the wall above the resident's bed. Resident 15 was out of the facility at dialysis.</p> <p>The above information was reviewed with the Nursing Home Administrator and Director of Nursing on March 12, 2025, at 2:30 PM.</p> <p>28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>18229</p> <p>Based on review of facility documentation and staff interview, it was determined that the facility failed to ensure that nursing staff possessed the appropriate competencies and skill sets related to the care and assessment of residents with enteral tube feeding, catheter care, medication administration, and dressing changes for four of four employees reviewed for competencies (Employees 11, 12, 13, and 14).</p> <p>Findings include:</p> <p>A review of the facility documentation revealed that the facility had a total of 118 residents receiving medications, eight residents with indwelling catheters (insertion of a tube into the bladder to remove urine), seven residents with pressure ulcers, and three residents with enteral tube feedings (device that allows liquid food to enter your stomach or intestine through a tube).</p> <p>A request for nursing staff competencies for enteral tube feeding, catheter care, medication administration, and dressing changes revealed the facility was unable to provide any competencies for Employees 11 and 12 (registered nurse), and Employees 13 and 14 (licensed practical nurse).</p> <p>The findings were reviewed with the Nursing Home Administrator and Director of Nursing on March 14, 2025, at 10:33 AM. Further interview with the Director of Nursing at this time confirmed the facility could provide no documentation that ensured Employees 11, 12, 13, and 14 had specific competencies and skill sets to care for the residents needs listed above.</p> <p>28 Pa Code 201.20(a) Staff development</p>

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>36798</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to develop and implement an individualized person-centered care plan to address dementia and cognitive loss displayed by one of two residents reviewed (Resident 25).</p> <p>Findings include:</p> <p>Clinical record review for Resident 25 revealed the facility admitted her on March 8, 2019, with diagnosis including Dementia (loss of memory, language, problem-solving, and other thinking abilities that interfere with daily life). A review of Resident 25's significant change Minimum Data Set Assessment (MDS, a form completed at specific intervals to determine care needs) dated May 28, 2024, indicated that the facility assessed Resident 25 as having a diagnosis of dementia. The facility determined that a care plan for dementia and cognitive loss would be developed.</p> <p>A review of Resident 25's care plan entitled Cognitive Status: has an impaired cognitive function r/t (related to) dx (diagnosis) vascular Dementia revealed that there was no indication that the facility had implemented an individualized person-centered care plan to address the resident's dementia and cognitive loss needs.</p> <p>The findings were reviewed with the Nursing Home Administrator and Director of Nursing on March 14, 2025, at 12:30 PM.</p> <p>The facility failed to develop and implement an individualized person-centered care plan to address dementia and cognitive loss for Resident 25.</p> <p>483.40(b)(3) Dementia Treatment and Services</p> <p>Previously cited 04/26/24</p> <p>28 Pa Code 211.12 (d)(1)(3)(5) Nursing services</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36798</p> <p>Based on clinical record review and resident and staff interview, it was determined that the facility failed to ensure that medically related social services were provided to one of one resident reviewed (Resident 100).</p> <p>Findings include:</p> <p>Clinical record review revealed a nursing progress note date [DATE], at 4:19 PM that indicated Resident 100's family was in and notified her that her husband had passed away. The progress note indicated that Resident 100 cried for a while with family present and was doing well while they were visiting.</p> <p>Further clinical record review for Resident 100 revealed a progress note dated [DATE], at 1:58 PM that indicated she was mildly depressed today due to the passing of her spouse and family was in to visit.</p> <p>A social service progress note dated [DATE], at 11:16 AM revealed that the social service worker met with Resident 100 regarding her depression after her husband passed away. The note indicated that Resident 100 stated that she is doing okay and is still feeling sad. She also indicated that she was trying to keep her mind busy with leisure activities. The note indicated that she presented well and was at her baseline. No new concerns were presented.</p> <p>A dietary progress note dated [DATE], at 10:41 PM revealed that the dietician visited with Resident 100 and her son at lunch, and the son reported that Resident 100 does not have an appetite since her spouse passed away. Resident 100 reported that she has had no appetite stating that she is eating less and less. The dietician indicated that she would notify the physician of Resident 100's significant decreased appetite in the past three months.</p> <p>A social service progress note dated [DATE], at 12:09 PM revealed that social services met with Resident 100 because she had stated she wanted to die. The note indicated that Resident 100 appeared to not feel well when the social worker entered her room, and that the resident did have some liquid in her basin. The note indicated that Resident 100 stated she did not want to die but that she is just not feeling well and hoping once she is no longer sick, she will feel better overall.</p> <p>A nursing progress note dated February 1, 2025, at 11:20 AM revealed that Resident 100's son and daughter-in-law were at her bedside. The nurse spoke to them at length regarding Resident 100's decline in condition. They indicated that they felt like she was giving up due to wanting to be with her husband in heaven.</p> <p>An interview with Resident 100 on [DATE], at 9:47 AM revealed that she has not had an appetite since her husband died and she knows she is losing weight. She was unable to state when he died but stated that she believed it was just recently. She indicated her family visits sometimes and that she is ok but sad.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 100 was notified of the death of her spouse on [DATE]. There was no follow-up documentation indicating medically related social service interventions were provided to Resident 100 related to the loss of her spouse and her depression until social service documented on [DATE], at 11:16 AM, 11 days later, indicating that she met with Resident 100 regarding her depression related to her spouse passing away.</p> <p>Interview with the Nursing Home Administrator on [DATE], at 9:32 AM revealed that there was no evidence that the facility provided Resident 100 with medically related social services to include interventions to provide support during the grieving process and the offer of psych services related to her depressive symptoms.</p> <p>The facility failed to meet the needs of a Resident 100 who was grieving the loss of her spouse.</p> <p>28 Pa. Code 201.29 (a) Resident rights</p> <p>28 Pa. Code 211.12 (d)(5) Nursing services</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>38839</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to maintain pharmacy recommendations or evidence pharmacy recommendations were addressed by the physician for five of five residents reviewed (Residents 8, 16, 101, 108).</p> <p>Findings include:</p> <p>Clinical record review for Resident 8 revealed pharmacy notes dated July 22, August 22, September 11, December 15, 2024, and January 16, 2025, which indicated a pharmacy review was completed for the resident and pharmacy recommendations were made to the physician. There was no evidence of the pharmacist report of recommendations or a physician's response to the pharmacy recommendations for the dates indicated.</p> <p>Clinical record review for Resident 101 revealed pharmacy notes dated August 20, 2024, and January 17, 2025, which indicated a pharmacy review was completed and pharmacy recommendations were made. There was no evidence of the pharmacist report of recommendations or a physician's response to the pharmacy recommendations for the dates indicated.</p> <p>Clinical record review for Resident 108 revealed pharmacy notes dated September 11, December 29, 2024, and January 18, and February 12, 2025, which indicated a pharmacy review was completed and pharmacy recommendations were made for the resident. There was no evidence of the pharmacist report of recommendations or a physician's response to the pharmacy recommendations for the dates indicated.</p> <p>Clinical record review for Resident 16 revealed pharmacy notes dated September 12, December 20, 2024, and January 16, and February 13, 2025, which indicated a pharmacy review was completed for the resident and recommendations were made to the physician. There was no evidence of the pharmacist report of recommendations or a physician's response to the pharmacy recommendations for the dates indicated.</p> <p>Interview with the Nursing Home Administrator and Director of Nursing on March 14, 2025, at 12:45 PM confirmed they could not locate the pharmacy recommendations noted for the resident and dates above or a physicians response to the recommendations.</p> <p>483.45(c)(4) Pharmacy review</p> <p>Previously cited 4/26/24</p> <p>28 Pa. Code 211.9 (d)(k) Pharmacy services</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>38839</p> <p>Based on staff interview, it was determined that the facility failed to employ a full-time qualified director of food and nutrition services in the absence of a full-time qualified dietician.</p> <p>Findings include:</p> <p>During an interview on March 12, 2025, at 1:45 PM the Administrator stated the facility was utilizing a registered dietitian on a part time basis who was primarily working remotely with some onsite visits, and the facility did employ a full-time dietary manager (Employee 1). The Administrator was not sure of Employee 1's qualifications.</p> <p>In a follow up interview on March 13, 2025, at 10:00 AM, the Administrator confirmed Employee 1 was not a certified dietary manager, certified food service manager, did not have a national certification for food service management and safety, and did not hold a degree in food service management. The Administrator also indicated the registered dietitian onsite visits to the facility occurred over the night shift hours when no food service operations were taking place, and residents were likely sleeping.</p> <p>The facility did not employ a full-time qualified dietitian or qualified director of food and nutrition services.</p> <p>Cross Refer F692, F812</p> <p>28 Pa. Code 201.18(b)(1)(3) Management</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38839</p> <p>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, and one of four nursing units ([NAME]).</p> <p>Findings include:</p> <p>An observation in the facility's main kitchen on [DATE], at 10:26 AM with Employee 1, dietary manager revealed the following:</p> <p>A large hole in the left lower wall inside the entrance doors to the kitchen.</p> <p>Dried food splatter and staining were observed on the ceiling tiles and light covers in the dish room area.</p> <p>The top of the dishwasher was covered in debris and dust.</p> <p>The tile flooring in the dish room contained multiple cracks and broken tiles. Water and food particles were observed pooling in the areas where the tiles were broken off.</p> <p>Two stacks of dish washing racks were observed on carts in the center of the dish machine room. The gray colored plastic wash racks were worn, with multiple broken plastic pieces at the base of the rack. A large ball of what appeared to be hair was attached to one of the broken sections.</p> <p>A three-tiered cart parked in the clean end of the dish machine, which Employee 1 indicated staff use to sit clean items on as they come out of the machine was dirty, dusty, and covered in lime scale buildup.</p> <p>A large meal tray storage rack was observed sitting along the wall in the dish room. The flooring under and behind the rack contained a buildup of dirt and debris, a pitcher and lid were also observed under the rack.</p> <p>A portable air conditioner sitting in the dish room was dirty and the filter on the back was coated in thick brown dust/debris.</p> <p>Lids observed over empty steam table wells contained brown buildup. The lower shelf of the steam table where pans and supplies were stored were observed with dried spills and food debris.</p> <p>A steamer was located on a metal table/stand across from the steam table area. Water coming from the steamer was observed to be dripping down from the steamer onto multiple adaptive feeding dishes (lip plates and divided dishes) located on a lower shelf of the table. Employee 1 indicated the dishes were clean in use for serving meals from the tray line.</p> <p>A red knob on the stove/oven was blackened and sticky.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A plate warming unit contained brown buildup surrounding the plate hole openings and black support brackets around the openings.</p> <p>The tilt kettle had a buildup of dark brown matter on the interior lids, and exterior front of the kettle. Dried food splatter/runs were observed down the side of the kettle towards the stove.</p> <p>Employee 2, cook, was observed transferring hot pans on the production area wearing a large white oven mitt on each hand. Both oven mitts were significantly blackened and stained.</p> <p>A utensil rack was observed hanging from the ceiling above the cooks table with multiple serving utensils hanging from the rack such as ladles, spoons, spatulas, and many other utensils exposing food contact surfaces to airborne particles, and potential for food splatter from the work area. Six white spatulas observed hanging from the rack were significantly stained orange/brown.</p> <p>Three cake pans were observed on the lower shelf of the production table. The pans were covered in brown/black burnt on buildup.</p> <p>A large round garbage can by the preparation table was observed filled with trash and did not have a lid.</p> <p>Two knife racks mounted on the wall in the food preparation area with knives in them, contained dust/debris on the top of the racks where the knives are inserted.</p> <p>A shelf extending from the wall where spices, peanut butter, chocolate chips, and marshmallow were stored was dirty with dust and food debris.</p> <p>A large portable air conditioning unit located in the corner of the kitchen beside a two-door cooler was observed not in operation, but the front vent and filter of the unit was covered with thick orange/brown debris.</p> <p>Inside a two-door cooler in the production area was a clear plastic bin with diced carrots in a liquid. The container was dated [DATE]. On the same shelf was another clear plastic container with several hot dogs, some partially cut, floating in a chunky liquid. The container was dated [DATE]. It was unclear if the items expired on the date indicated or when they were placed there. Employee 2, was asked what the hot dogs were floating in, and Employee 2 indicated grease and probably water, whatever they were cooked in. Employee 2 indicated she was not sure how long the products were good for after the date, as she had not worked at the facility very long but thought three to four days. The carrots had been there seven days from the date indicated, and the hot dogs six days from the date on the container.</p> <p>A lower shelf of an additional production table where the food processor was located was observed with a piece of equipment on the shelf covered in plastic bags. The bags were covered in white food particles and dried food. Under the bag was a food slicer. The slicer was dirty with a white substance in several spots on the slicer that could be wiped away.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A stack of resident meal service trays was observed by the tray line serving area, the trays were cracked, worn, and contained broken edges exposing the metal edges from under the plastic coating. A plastic bin filled with plastic adaptive feeding cups was observed sitting in the same area. The cups were significantly stained brown, and some had spots of black debris.</p> <p>Multiple dish machine wash racks were stacked on dollies along the wall across from the tray line serving station. The racks were significantly worn, some with broken pieces, and many contained black buildup, appearing soiled. The racks were filled with clear plastic beverage cups. The cups were significantly stained brown and contained white limescale buildup. The clear plastic cups were completely opaque (could not be seen through).</p> <p>Two beverage pitchers in a nearby upright cooler were observed with iced tea in them. The pitchers and lids were significantly stained brown.</p> <p>The outside delivery entrance to the kitchen located off a small hallway area outside the dry storage room was observed piled with leaves, with a significant number of cobwebs and bugs hanging from the lights over the area.</p> <p>An ice machine located in the dry storage room was observed with the cover over the top of the machine hanging off with screws hanging out. The flooring near the drain located behind the machine was wet with a wet towel observed on the floor around the drain. Water splatter was also observed on the wall by the drain.</p> <p>Two unplugged floor standing fans were observed in the dry storage area. The metal fan blade covers for both fans were covered in dust.</p> <p>Lower shelves of the walk-in cooler were observed with dried food hanging from the rack on the right side of the cooler.</p> <p>A piece of cove base molding was observed missing by the floor of the kitchen exposing a hole in the dry wall.</p> <p>A foot pedal trash receptacle located by the three-compartment sink was observed with dried liquid runs and dried food on the exterior of the can.</p> <p>Observation of a nourishment room located on the [NAME] nursing unit on [DATE], at 1:19 PM revealed the following:</p> <p>Multiple beverage cups on the counter in the resident nourishment room included an open bottle of Gatorade, an open bottle of soda, a plastic cup with ice/liquid from an outside restaurant, and metal water mugs with straws.</p> <p>Five plastic bowls of various types of dry cereal were stored in a corner cabinet. The metal cabinet was blackened and rusty. The bowls did not have any labels to indicate the contents, or date to indicate when they were placed there, or when the needed used by.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Three condiment storage trays were observed on the countertop containing ketchup, mustard, syrup, sugar, sweetener, salt, pepper, and various other packets of condiments. The bins of the container contained debris such as loose salt, pepper, sugar, etc. and the bins were dated with a use by date of [DATE].</p> <p>The interior of the microwave contained rusted spots on the base of the interior door, along the back edge of the interior base, and on the left interior side where a vent area was also observed broken. Dried food splatter was observed on the interior top of the microwave.</p> <p>The countertop contained dried spills and staining and broken pieces off the surface of the countertop.</p> <p>A refrigerator located in a back area of the nourishment room was observed packed with food items, with cups tipped over, and multiple items piled on top of one another. The shelves were soiled. The drawers were soiled and the area under the bottom right drawer of the refrigerator was completely covered in a dried brown substance. Bags of fast food were observed in a drawer with a resident name and no date. Several facility plastic bowls were inside the refrigerator with no label to identify the contents and no date. The freezer of the unit contained a frozen liquid in a plastic cup from an outside source with an open lid and straw sticking out of it with no label or date. A large cup of an ice cream product was observed also sitting on the shelf with a spoon sticking out of it, uncovered, with no label or date. The ice cream appeared to have thawed partially and refroze.</p> <p>The above items in the [NAME] unit nourishment room were concurrently reviewed with the Nursing Home Administrator.</p> <p>The above findings in the main kitchen were reviewed with the Nursing Home Administrator and Director of Nursing on [DATE], at 2:45 PM.</p> <p>483.60(i)(2) Store, prepare, food safe and sanitary</p> <p>Previously cited [DATE]</p> <p>28 Pa. Code 201.14 (a) Responsibility of Licensee</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38839</p> <p>Based on observation and staff interview, it was determined that the facility failed to implement appropriate enhanced barrier precautions for three of 24 residents reviewed (Residents 40, 72, and 325) and ensure an environment free from the potential spread of infection with the storage of resident equipment and supplies for one of four nursing units ([NAME]; Residents 8, 54, 64, and 81), and the facility laundry area.</p> <p>Findings include:</p> <p>An observation of Resident 81's bathroom, which is shared with an adjoining room with Resident 64 on March 11, 2025, at 1:20 PM revealed a raised toilet seat sitting beside the toilet directly on the floor.</p> <p>An observation of Resident 8's bathroom on March 12, 2025, at 10:19 AM revealed a raised toilet seat sitting directly on the floor beside the toilet in the bathroom.</p> <p>An observation of the [NAME] unit nourishment room, located behind the nursing station on March 13, 2025, at 1:09 PM revealed a rusted white metal cabinet in the room labeled personal hygiene. The cabinet contained three packages of protective gowns. A drawer above the cabinet labeled thermometers was observed with chipped paint, blackened, and rusty. In the drawer were several items including gait belts (supported belt used in resident ambulation), a pancake syrup packet, three empty boxes labeled electric shaver manual, an electric razor, loose disposable razors, a brush wrapped in plastic, slipper socks, and two urinary leg bags.</p> <p>A cabinet under a sink located in the same area with rusted and dilapidated doors revealed a cardboard case of vinyl exam gloves, a roll of toilet paper, and two basins stored under the sink.</p> <p>An observation of Resident 54's room on March 12, 2025, at 12:43 PM revealed a raised toilet seat and two bath basins directly on the floor under the sink in his bathroom.</p> <p>The infection control concerns related to Resident 54's were reviewed with the Nursing Home Administrator and Director of Nursing on March 13, 2025, at 2:20 PM.</p> <p>The findings noted above for Resident 8, 64, and 81, and the [NAME] nourishment room were reviewed with the Nursing Home Administrator on March 13, 2025, at 3:09 PM.</p> <p>Review of the memo entitled Enhanced Barrier Precautions (EBP, gown and glove use) in Nursing Homes to Prevent the Spread of Multi-drug Resistant Organisms released by the Center for Medicaid and Medicare Services (CMS) on March 20, 2024, with an implementation date of April 1, 2024, revealed that nursing care facilities are to use EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. High-contact activity would include dressing, transferring, changing linens, providing hygiene, changing briefs, wound care, device care, etc.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation of Resident 72 on March 11, 2025, at 12:25 PM revealed the resident had wounds to the lower extremities that the resident stated are being treated by the facility.</p> <p>Further observation of Resident 72's room revealed no evidence that the resident was on EBP (no sign indicating EBP precautions, no personal protective equipment (PPE) in the room or at the doorway to don, or any sign placed that instructed to see the nurse prior to care).</p> <p>Clinical record review for Resident 72 revealed a diagnoses list that included ulcers of the bilateral lower extremities, local infection of the skin and subcutaneous tissue, and a history of methicillin resistant staphylococcus aureus infection (MRSA, bacteria that is resistant to certain antibiotics).</p> <p>Review of Resident 72's care plan revealed that the resident has an area of skin impairment due to venous ulcers of the right and left lower legs. An intervention dated March 1, 2025, included enhanced barrier precautions.</p> <p>Clinical record review for Resident 40 revealed the resident had a nephrostomy tube (a medical tube that drains urine from the kidney).</p> <p>Further review of Resident 40's clinical record revealed the resident had physician orders dated January 22, 2025, for nephrostomy care.</p> <p>Resident 40's care plan related to potential complications due to a right nephrostomy tube revealed an intervention that included EBP that was dated as initiated March 12, 2025.</p> <p>There was no evidence in Resident 40's clinical record that they were on enhanced barrier precautions or any type of isolation.</p> <p>Observation of Resident 40 on March 11, 2025, at 9:46 AM revealed no evidence that the resident was on EBP (no sign indicating EBP precautions, no PPE in the room or at the doorway to don, or any sign placed that instructed to see the nurse prior to care).</p> <p>Observation of Resident 325 on March 11, 2025, at 1:18 PM revealed they had a foley catheter (medical tubing that drains urine from the bladder) that was hanging from the resident's left side of the bed.</p> <p>There was no evidence that Resident 325 was on EBP (no sign indicating EBP precautions, no PPE in the room or at the doorway to don, or any sign placed that instructed to see the nurse prior to care).</p> <p>Further observation of Residents 40, 72, and 325's rooms on March 12, 2025, at 11:05 AM now revealed signs on each of the doors that indicated Contact Precautions (a type of isolation measure that is intended to prevent transmission of infectious agents, which are spread by direct or indirect contact with the resident or the resident's environment).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A concurrent interview with Employee 8, licensed practical nurse, on March 12, 2025, at 11:07 AM about the Contact Isolation sign on Resident 325's door revealed the sign was placed because the resident had a foley catheter and the employee proceeded to enter the room and confirm the presence of a foley catheter. Employee 8 further revealed that staff refer to either the orders or care plan to confirm the resident is on EBP or isolation.</p> <p>The above information for Residents 40, 72, and 325 were reviewed in a meeting with the Nursing Home Administrator and Director of Nursing on March 12, 2025, at 2:15 PM.</p> <p>Further review of Resident 325's clinical record revealed that their foley catheter was removed on March 13, 2025, at 1:00 AM.</p> <p>Further observation of Resident 40 and 72's rooms on March 13, 2025, at 1:56 PM revealed signs on the door were again changed by the facility to now indicate, Enhanced Barrier Precautions.</p> <p>Observation of the facility's main laundry area on March 14, 2025, at 2:02 PM with Employee 15, Director of Maintenance, revealed the following:</p> <p>Four rows of facility linens that included blankets and various other linen were stacked four feet high directly on the ground behind the egress door to the folding room. The linens were uncovered and unprotected from the ambient environment.</p> <p>A glass window in the folding room was broken. The air conditioning unit in the window had a significant accumulation of dust build-up on it.</p> <p>The dirty linen sorting room had two damaged panels on the ceiling.</p> <p>The cooling/heating unit on the wall adjacent to the washing machines had a significant build-up of dust and debris accumulating on it and the surrounding area.</p> <p>There was a significant accumulation of dust and debris behind the washing units.</p> <p>There was a blue colored liquid chemical leaking onto the ground behind the washing machines from an unknown source. A blanket was located on the floor in the area and was absorbing some of the blue colored liquid.</p> <p>There was a build-up of what Employee 15 referred to as calcium on top of each washing machine.</p> <p>The dryers had an accumulation of dust and lint located behind them.</p> <p>There was an extensive build-up of lint on the floor and on the vent in the dryer service room.</p> <p>The above information for the facility's laundry area was reviewed in a meeting with the Nursing Home Administrator on March 14, 2025, at 2:07 PM.</p> <p>483.80(a)(1)(2)(4)(e)(f) Infection Prevention &amp; Control</p> <p>Previously cited deficiency 4/26/24</p> <p>(continued on next page)</p>		

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  03/14/2025
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.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>28 Pa. Code 211.10(d) Resident care policies</p> <p>28 Pa. Code 211.12(d)(1) Nursing services</p>		

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  03/14/2025
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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>18229</p> <p>Based on review of employee education records and staff interview, it was determined that the facility failed to ensure that nurse aides received 12 hours of in-service training annually for two of two nurse aides reviewed (Employees 16 and 17).</p> <p>Findings include:</p> <p>During a meeting with the Nursing Home Administrator and Director of Nursing on March 13, 2025, at 1:45 PM the surveyor asked for training records to indicate that nurse aides had received at least 12 hours of in-service training in the last year for Employees 16 and 17 (nurse aides).</p> <p>Interview with the Director of Nursing on March 14, 2025, at 10:41 AM confirmed there was no documented evidence that Employee 16 received the required 12 hours of annual in-service training in the last year.</p> <p>Review of Employee 17's Employee Annual Education Tracking Sheet, revealed that the Director of Nursing documented Employee 17 completed 27.5 hours of training on February 11, 2025.</p> <p>Interview with the Director of Nursing on March 14, 2025, at 10:40 AM revealed the facility gave Employee 17 a packet of information to review and the Director of Nursing and Employee 17 signed that she received the packet and would review. There was no further documentation to ensure that Employee 17 had at least 12 hours of in-service training in the last year.</p> <p>28 Pa. Code 201.19 (7) Personnel policies and procedures</p>		