

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

Printed: 07/18/2026
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 02/20/2026
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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on staff interview, it was determined that the facility failed to employ a full-time qualified director of food and nutrition services in the absence of a full-time qualified dietitian. Findings include: During an Interview with Employee 9, dietary aide, on February 17, 2026, at 9:25 AM, she revealed that the facility currently did not have a dietary supervisor or a certified dietary manager (CDM) employed. Interview with the Nursing Home Administrator on February 18, 2026, at 2:15 PM confirmed the facility did not employ a full-time registered dietitian or qualified director of food and nutrition services. Cross Refer 801 and 804 S483.60(a)(1) Qualified dietary staff Previously cited 3/14/25 28 Pa. Code 201.18(b)(1)(3) Management		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined 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 two of four nursing units (Nittany and University). Findings include: An observation in the facility's main kitchen on February 17, 2026, at 9:25 AM with Employee 9, dietary aide, revealed the following: The dishwasher room ceiling tiles above the clean dish line have yellow water damage and are buckled, broken, and hanging down revealing broken drywall beneath the ceiling tiles. A dirty vent in the same area is uncovered and dust and cobwebs are visible inside. The drain in the center of the dishwasher room has water pooling around it and white 2 half inch sized pieces of grout from the floor are in the water around the drain. The three-compartment sink has a continual drip of water from the handle of the hot water faucet. The knobs of the stove have large amounts of dust and debris collected behind and between the knobs. Both ovens are noted to have brown residue built up inside the glass doors and inside the ovens. Expired apple cider vinegar on the spice shelf was noted to have a best before date of August 5, 2025. The refrigerator was noted to have multiple containers of food dated February 16, 2026, that were leftovers from the previous day, however no cool down temperature logs were available. Employee 9 confirmed that there was no binder that contained any cool down log information in the kitchen. A storage shelving unit of clean kitchen equipment had a plastic cover on the shelf that was broken and left a two-inch exposed area in the middle of the bottom shelf. There is a half inch deep triangular shaped hole in the floor in front of the tray line caused by a broken floor tile. The refrigerator was noted to have four quarts of expired Lactaid milk, dated February 15, 2026. Observation of the nourishment room on Nittany unit revealed a zip lock bag filled with condiments including mayonnaise, ketchup, and mustard. There was no date on the bag to indicate when the bag was delivered or a best before date, and no items within the bag were noted with any expiration or best before dates. Employee 11, licensed practical nurse, confirmed that these items are delivered from dietary. The above information was reviewed with the Nursing Home Administrator and the Director of Nursing on February 19, 2026, at 2:45 PM. Chapter 8 of the 2018 International Plumbing Code, 802.3.1 Air gap, stipulates that the air gap between the indirect waste pipe and the flood level rim of the waste receptor shall not be less than twice the effective opening of the indirect waste pipe. Chapter 8 of the 2018 International Plumbing Code, 802.3.2 Air break, stipulates that an air break shall be provided between the indirect waste pipe and the trap seal of the waste receptor. Observation of the University nursing unit ice machine, with Employee 6 (licensed practical nurse), on February 18, 2026, at 10:56 AM revealed that the white drainage pipe from the back of the machine had no visible air gap between the indirect waste pipe and the floor drain. Employee 6 stated that this ice machine is the only ice supply for all residents on the second floor of the facility. The surveyor reviewed the above ice machine concerns during an interview with the Nursing Home Administrator and the Director of Nursing on February 18, 2026, at 2:00 PM. Cross Refer 801.483.60(i)(2) Store, prepare, food safe and sanitary Previously cited 3/14/25, 5/6/25, and 8/25/25 28 Pa. Code 201.14 (a) Responsibility of Licensee		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and resident and staff interview it was determined that the facility failed to provide adequate housekeeping and maintenance services to maintain a clean, safe, and functional environment for three of four nursing units (University, Heirloom, and Nittany; Residents 7, 49, 53, 84, 109, and 121) and the facility's laundry department. Findings include: Observation of the University nursing unit nurses' station on February 18, 2026, from 9:05 AM to 9:15 AM revealed an intermittent audible sound that resonated from a wall-mounted call bell device. Interview with Employee 6 (licensed practical nurse) on the date and time of the observation confirmed that there were no resident room call bell lights visible on the University nursing unit hallways. There was no room number indicated on the screen of the wall-mounted call bell device. Employee 6 described the ongoing intermittent noise as, a phantom call bell. Employee 6 indicated that the malfunctioning device has been an issue for approximately a year, that maintenance staff were aware through the facility's system of reporting building maintenance needs, and that staff were told by the maintenance representative that, the wiring is old. Observation of the University nursing unit nurses' station on February 18, 2026, from 9:41 AM to 10:15 AM revealed the intermittent audible sound continued from the wall-mounted call bell device without a resident room identification. Observation of the University nursing unit nurses' station on February 19, 2026, at 12:09 PM revealed the intermittent audible sound continued from the wall-mounted call bell device without a resident room identification. Interview with Employee 6, on February 19, 2026, at 12:10 PM indicated that, it's that phantom one again. Interview with Employee 7 (nurse aide) on February 19, 2026, at 12:30 PM indicated that the audible signal (not indicative of a resident room call bell activation) signals throughout the night. The audible noise does not stop at any time. The surveyor reviewed the above concern regarding the continuous audible noise on the University nursing unit during an interview with the Director of Nursing and the Nursing Home Administrator on February 18, 2026, at 2:00 PM. Observation of Resident 7's room on the University nursing unit on February 18, 2026, at 10:30 AM revealed a gray floor fall mat on the left side of his bed with a large amount of various colored debris and spillage. Observation of Resident 7's room on February 19, 2026, at 12:15 PM revealed his floor fall mat continued to be soiled with various colored debris and spillage. The surveyor confirmed the observation with Employee 8 (registered nurse) on February 19, 2026, at 12:17 PM. Observation on February 17, 2026, at 12:16 PM of the hallway on the Nittany unit outside the main kitchen revealed the flooring to be in disrepair. A missing floor tile was observed adjacent to a carpeted area with two chairs and a table near the exterior exit. Further review reveals multiple tiles running the entire length of the hallway are raised and peeling away from the floor. A four-foot span of tiles are noted to be held down around the edges with duct tape and masking tape, which has peeled away in places and left behind an adhesive residue. Interview with Employee 11, licensed practical nurse, on February 17, 2026, at 12:38, revealed that the facility often runs out of washcloths and instead towels, which have been cut to the size of a washcloth, are utilized. Concurrent observation of the laundry room on the Nittany nursing unit revealed a stack of 25 washcloths, more than two thirds of which were noted to have fraying edged as though they were cut up towels. Observation of the facility laundry room on February 19, 2026, at 1:02 PM with Employee 14 (laundry supervisor) revealed there was a stack of cut of towels in the area of clean linen to be folded. Employee 14 stated the staff frequently run out of washcloths and cut up towels to use as a washcloth. Observation of Resident 84's bathroom on February 17, 2026, at 12:19 PM revealed drywall damage to the right of the mirror. Two inches of brown drywall paper is visible on either side of a soap dispenser mount. Observation of Resident 109's bedroom on February 17, 2026, at 1:10 PM revealed a heating and cooling unit was installed inside the metal casing of the previous unit. There are sharp metal edges noted to be protruding from around this casing. The new unit was smaller than the previous unit, and there were four towels rolled up filling the gap inside the unit. Additionally, (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	multiple towels were noted to be lying across the top of the old unit casing and along the windowsill above the unit. A cold draft could be felt when standing near the window. Concurrent observations of resident 109's bedroom revealed the bedside stand had a large area of peeling varnish to the front locking drawer, measuring four by six inches. Observation of Resident 49's bathroom on February 18, 2026, at 9:56 AM revealed drywall damage to the right of the mirror. The area behind the soap dispenser was noted with brown drywall paper on either side and the damage measured two and three inches wide to the right and left sides respectively. The right corner of the bathroom above the soap dispenser was noted to have an eight-inch squared area of repaired drywall with brown water spots around the corners of the repair. The corner below the repair is noted to have paint on wall that has bubbled. The paint damage at the ceiling is six inches across, gradually narrowing to one inch and extending down three feet of the wall. Concurrent observations of Resident 49's room revealed a heating and cooling unit was installed inside the metal casing of the previous unit. There are sharp metal edges noted to be protruding from around this casing. There are multiple towels lying across the windowsill above the heating and cooling unit and around the old metal casing. Concurrent interview with Resident 49 revealed the towels are there because of a draft. The above noted concerns related the Nittany unit and Residents 84, 49, and 109, were reviewed with the Nursing Home Administrator and the Director of Nursing on February 19, 2026, at 2:45 PM. Observation of the Heirloom unit on February 17, 2026, at 12:49 PM revealed there was a large sticky spot on the floor in the hallway upon entering the unit from the facility's main dining room. Observations made on February 18, 2026, at 10:41 AM and February 19, 2026, at 12:26 PM revealed the same sticky spot remained in the hallway on the floor. Observation of the Heirloom unit on February 18, 2026, at 10:28 AM revealed Resident 53's wall was marred next to the doorframe, and the wallpaper was peeling off the wall. Observation of the Heirloom unit on February 18, 2026, at 10:28 AM revealed Resident 121's wall was marred next to the doorframe, and the wallpaper was peeling off the wall. The above noted concerns related to Heirloom unit and Residents 53 and 121 were reviewed with the Nursing Home Administrator and Director of Nursing on February 19, 2026, at 2:12 PM 483.10(i)(1)-(7) Safe/clean/comfortable/homelike Environment Previously cited 5/6/25 and 3/14/25 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(e)(2.1) Management 28 Pa. Code 211.12(d)(3) Nursing services		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on a review of select facility policies and procedures, clinical record review, observation, and resident and staff interview, it was determined that the facility failed to obtain informed consent prior to the installation of bedrails for two of eight residents reviewed (Residents 8 and 11), and failed to assess all potential risks for entrapment for five of eight residents reviewed for bedrail use (Residents 4, 8, 9, 11, and 93). Findings include: The facility policy entitled, Bed Rail Procedure, last reviewed without changes on January 21, 2026, revealed that if a resident is appropriate for a bed rail, nursing and/or designee will complete a Bed Rail Education/Consent with the resident and/or responsible party. Note, consent must be completed prior to bed rail(s) being placed on the resident's bed. Nursing will place a request for bed rails in TELS (maintenance communication system). Maintenance will confirm that consent/education was completed before placing bed rails to the bed, will install bed rails as requested, will ensure that manufacturer's recommendations and specifications are followed for bed rails being placed, and will conduct quarterly inspection of all beds with bed rails as part of a regular maintenance program to identify areas of possible entrapment. Housekeeping will notify maintenance of the discharge or transfer of a resident to remove bed rails. Ambassadors are to look for empty beds with bed rails to request removal via TELS. The Maintenance Bed Rail Evaluation noted seven zones evaluated for entrapment risk; and noted to refer to facility policy. A diagram identified seven potential entrapment zone locations on a bed equipped with bed rails. Zone six was defined as between the end of the rail and the side of the head or foot board. The Dimensional Guidelines for Entrapment Zones noted specific measurements for zones one through five; however, had no measurements noted for zones six or seven. Observation of Resident 11's room on February 18, 2026, at 11:17 AM revealed that her bed was equipped with a headboard, footboard, and bilateral assist bed rail devices. Interview with Resident 11 on the date and time of the observation revealed that she recently moved rooms although she was unsure of the exact date or reason for the move. Clinical record review for Resident 11 revealed no documented assessment for the need for, consent for the use of, or entrapment risk assessment regarding the bed rails. Interview with the Nursing Home Administrator and the Director of Nursing on February 19, 2026, at 2:00 PM revealed that staff who facilitated Resident 11's room change (on February 8, 2026) did not exchange Resident 11's bed; and allowed her to use the bed that was in the room she transferred to. Staff submitted a maintenance request to have enabler bars removed on February 11, 2026 (three days after Resident 11 moved to a new room), however, this was not done as of the time of the onsite survey. The facility failed to assess Resident 11 for the risk of entrapment from bed rails prior to her use of her bed, failed to review the risks and benefits of bed rails to obtain informed consent prior to her use of her bed, and failed to assess that her new bed's dimensions were appropriate for her size and weight. Observation of Resident 8's room on February 18, 2026, at 10:52 AM revealed him in his bed that was equipped with bed rail assist devices bilaterally at the head of his bed, a headboard, and a footboard. Clinical record review for Resident 8 revealed an active physician's order dated January 5, 2026, for bilateral enabler bars on his bed for bed positioning and bed mobility. A Bed Rails Informed Consent for Use was not dated; and did not include an acknowledgement or signature to attest that Resident 11 and/or his responsible party consented to the use of the devices. A Maintenance Bed Rail Evaluation dated January 5, 2026, noted that maintenance staff checked the boxes that seven zones were evaluated for entrapment risk. Interview with the Nursing Home Administrator and the Director of Nursing on February 19, 2026, at 2:00 PM confirmed that the facility had no signed consent for Resident 8's use of bed rails. Observation of Resident 4's room on February 18, 2026, at 11:10 AM revealed her to be in her bed that was equipped with bed rail assist devices bilaterally at the head of her bed, a headboard, and a footboard. Clinical record review for Resident 4 revealed an active (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician order dated June 14, 2024, for bilateral enabler bars to aide with turning and repositioning. A Maintenance Bed Rail Evaluation dated January 5, 2026, noted that maintenance staff checked the boxes that seven zones were evaluated for entrapment risk. Observation of Resident 9's room on February 18, 2026, at 11:20 AM revealed her sitting in a chair beside her bed. Her bed was noted to be equipped with bedrail assist devices bilaterally. Concurrent interview with Resident 9 revealed that she utilized the bedrail assist devices to help her move in bed. Clinical record review for Resident 9 revealed an active physician's order dated February 11, 2026, for bilateral enabler bars to aid with turning and repositioning. A Maintenance Bed Rail Evaluation dated February 11, 2026, noted that maintenance staff checked the boxes that seven zones were evaluated for entrapment risk. Observation of Resident 93's room on February 17, 2026, at 3:12 PM revealed her in her bed with bedrail assist devices bilaterally. Concurrent interview with Resident 93 revealed that she used the bedrails to help move herself in bed. Clinical record review for Resident 93 revealed that there was no current physician's order for her bilateral bedrail assist devices until February 19, 2026, after the surveyor discussed Resident 93's bilateral assist devices with the facility during a meeting on February 18, 2026, at 2:45 PM. A Maintenance Bed Rail Evaluation for Resident 93 dated January 10, 2026, noted that maintenance staff checked the boxes that seven zones were evaluated for entrapment risk. Interview with Employee 10 (maintenance director) on February 20, 2026, at 11:26 AM confirmed that although he was documenting that zones six and seven posed no entrapment risk, he had no parameter or expectation of a measurement or finding that would meet a criterion to determine that there was no entrapment risk (e.g., a range of measurements or angle degrees) for zones six or seven. Employee 10 confirmed that neither zone had an established range or measurement within the facility policies or procedures. Employee 10 stated that he would expect no gaps (e.g., measurement of zero) when he assessed zone seven, however, he had no parameter for zone six. The surveyor reviewed the above concerns regarding the facility's policy and procedure for bed rail/assist bar assessments during an interview with the Nursing Home Administrator and the Director of Nursing on February 20, 2026, at 11:45 AM. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to ensure a medication error rate less than five percent (Residents 17 and 100). Findings include: The facility's medication error rate was eight percent based on 25 medication opportunities with two medication errors. Observation of a medication administration pass on February 18, 2026, at 12:36 PM revealed Employee 4 (licensed practical nurse) administer Carafate (anti-ulcer medication, adheres to the stomach lining to protect it from acids and enzymes) 1 gm (gram) to Resident 17. The packaging of the Carafate medication included instructions to administer the medication on an empty stomach. Resident 17 had her lunch tray in front of her on her overbed table and was beginning to eat her lunch at the time of the medication administration. Employee 4 stated, normally trays are not this early, as she administered the medication to Resident 17, to which Resident 17 responded, I didn't eat a lot. Interview with Employee 4 on February 18, 2026, at 12:54 PM verified that the labeling on the Carafate medication noted to give the medication on an empty stomach, however, Resident 17 was in the process of eating her lunch at the time she took the medication. The medication reference Drugs.com instructions regarding the administration of Carafate noted, The usual dosage for ulcer treatment is four times daily on an empty stomach (at least an hour before food and at bedtime). Continued observation of a medication administration pass on February 18, 2026, at 12:32 PM revealed Employee 4 administered Diclofenac Sodium external gel (a nonsteroidal anti-inflammatory topical medication, works by reducing substances in the body that cause pain and inflammation) to Resident 100's bilateral knees. Employee 4 dispensed a small dollop of the gel on her gloved fingers before massaging the gel over Resident 100's knees. Clinical record review for Resident 100 revealed an active physician's order for staff to apply four grams of Diclofenac Sodium external gel topically to Resident 100's bilateral knees three times a day, not to exceed 32 grams in 24 hours. The medication reference Drugs.com instructions regarding the administration of Diclofenac Sodium gel noted that this medicine comes with a dosing card. Be sure you know how to use it. Interview with Employee 4 on February 18, 2026, at 12:54 PM indicated that she was not aware of the process of utilizing a dosing card to measure the amount of Diclofenac Sodium gel for an accurate dose of four grams. Observation of the medication packing revealed a plastic dosing card that permitted the user to dispense different amounts for either a two-gram or a four-gram dose. Observation of the medication's box also included a diagram of the approximate length of gel used to administer a two-gram dose or a four-gram dose. The surveyor reviewed the above two medication error concerns during an interview with the Nursing Home Administrator and the Director of Nursing on February 19, 2026, at 2:00 PM. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility documents, and resident and staff interview, it was determined that the facility failed to provide menu items as indicated for the dining room and two of four nursing units (Heirloom and Nittany, Residents 51 and 89). Findings include: In an interview with Resident 51 on February 17, 2026, at 1:05 PM they stated that they often do not receive what they are supposed to on their meal tray. Review of the menu for lunch on February 19, 2026, included maple glazed ham, macaroni and cheese, Prince [NAME] vegetable blend, wheat dinner roll, and rainbow sherbet. During an observation of the tray line service on February 19, 2026, at 11:40 AM the plating of the meals for the dining room and Heirloom unit were observed. No wheat dinner rolls or bread was plated with the meal. Observation on February 19, 2026, at 12:18 PM on the Nittany unit of Resident 89's tray revealed that no bread was present. Observation of lunch meal service on the Heirloom unit on February 19, 2026, from 12:29 to 12:58 PM revealed there were no dinner rolls, or bread present on any of the meal trays. Observation of the kitchen supply room on February 19, 2026, at 1:30 PM, revealed three and a half racks of sliced bread, one rack of bread buns, and one rack of hoagie buns. Concurrent interview with Employee 13, dietary aide, revealed that bread was not served with the lunch meal today. Employee 13 also stated that no dietary supervisor was present today, and the bread item was not seen when checking the menu for the day. The above information was reviewed with the Nursing Home Administrator and the Director of Nursing on February 19, 2026, at 2:45 PM. Cross Refer 801 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, and resident and staff interview, it was determined that the facility failed to serve food at palatable temperatures on three of four nursing units (Heirloom, University, and Nittany; Residents 3, 13, 17, 89, and 93). Findings: Review of the mealtime documentation provided by the facility revealed the Heirloom food carts are scheduled to arrive on the nursing unit at 12:00 PM. Observation of the Heirloom nursing unit meal cart revealed it was observed outside the kitchen on February 19, 2026, at 11:55 AM. Observation of the lunch meal service on February 19, 2026, on the Heirloom nursing unit revealed that food trays arrived on the meal cart at 12:29 PM. Staff immediately began passing the food trays until the last tray was passed at 12:42 PM. The surveyor began testing the food temperatures of Resident 3's tray at this time with the following results: Puree ham was cold at 90.4 degrees Fahrenheit Puree mixed vegetables were cold at 92.2 degrees Fahrenheit Puree mac and cheese was cold at 91.4 degrees Fahrenheit Container of sherbert was melted Interview with Resident 17 on February 18, 2026, at 8:53 AM revealed that her food is delivered cold. Observation of the lunch meal on the University nursing unit on February 18, 2026, at 12:15 PM revealed that food trays arrived via the meal cart. Staff immediately began passing the food trays, and the surveyor began testing the food temperature of Resident 17's tray on February 18, 2026, at 12:18 PM with Employee 6 (licensed practical nurse). The chicken served on Resident 17's meal tray was cold at 107.2 degrees Fahrenheit. The surveyor reviewed the above dietary concerns on the Heirloom and University nursing units in a meeting with the Nursing Home Administrator and Director of Nursing on February 19, 2026, at 2:04 PM. Interview with Resident 93 on February 17, 2026, at 3:00 PM revealed that her food is always cold. She said it happens every day at every meal. Observation of the lunch meal on February 20, 2026, on the Nittany unit revealed the lunch trays were delivered at 12:30 PM on the food carts. The staff immediately began passing the trays and the surveyor began testing the temperature of the food on Resident 93's food tray at 12:35 PM with Employee 12 (nursing aide). The ham served on Resident 93's meal tray was cold at 94.5 degrees Fahrenheit. The surveyor discussed the dietary concerns noted on Nittany unit related to Resident 93's tray with the Nursing Home Administrator and Director of Nursing on February 19, 2026, at 3:00 PM. During an interview with Employee 11, licensed practical nurse, on February 17, 2026, at 12:38 PM, they stated that the food often arrives cold. During an interview with Resident 13 on February 17, 2026, at 1:15 PM they stated that the food temperatures are not good. Interview with Resident 89 on February 17, 2026, at 2:05 PM revealed that food often comes cold and when she asks for a substitution, such as grilled cheese, it often comes cold or very hard and difficult to eat. The concerns regarding food temperatures for Residents 13 and 89 were discussed with the Nursing Home Administrator and the Director of Nursing on February 19, 2026, at 2:45 PM. Cross Refer 801 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 211.6(a) Dietary services		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on review of the facility's arbitration agreements and resident and staff interview, it was determined that the facility's arbitration agreements failed to ensure the selection of a neutral arbitrator for two of three residents reviewed with a signed arbitration agreement (Residents 93 and 118); and failed to include required regulatory language for one of three residents reviewed with a signed arbitration agreement (Resident 49). Findings include: Review of an Arbitration Agreement (an agreement that the resident/resident's responsible party and the facility will resolve legal disputes through binding arbitration, waiving their right to a trial) signed by Resident 93 on December 13, 2023, revealed that the document stipulated that, The arbitration shall be conducted by the National Arbitration Forum (NAF). If the NAF process is no longer in existence at the time of dispute, or NAF is unwilling or unable to conduct the arbitration, a mutually acceptable neutral third-party alternative will be agreed to by the parties. The agreement afforded the facility the initial selection of the arbitrator (third-party decision-maker contracted to resolve a dispute). Review of an Arbitration Agreement signed by Resident 118's responsible party (daughter) on November 22, 2023, revealed that the document stipulated that, The arbitration shall be conducted by the National Arbitration Forum (NAF). If the NAF process is no longer in existence at the time of dispute, or NAF is unwilling or unable to conduct the arbitration, a mutually acceptable neutral third-party alternative will be agreed to by the parties. The agreement afforded the facility the initial selection of the arbitrator. Interview with Resident 49 on February 19, 2026, at 11:40 AM revealed that he did not remember signing an arbitration agreement. Review of Voluntary Arbitration Agreement, signed by Resident 49 on April 12, 2025, revealed that Resident 49 electronically initialed all paragraphs of the provided document, however, the document did not contain an acknowledgement to stipulate that Resident 49 understood the agreement. The document did not explicitly grant Resident 49 the right to rescind the agreement within 30 calendar days of signing it. The document did not explicitly inform Resident 49 of his right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(2)(e)(1) Management 28 Pa. Code 201.29(a) Resident rights		

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on clinical record review and resident and staff interviews, it was determined that the facility failed to ensure that written notice, including the reason for a room change, was provided to a resident prior to a facility-initiated room change for one of one resident reviewed for concerns related to resident choice (Resident 11). Findings include: Interview with Resident 11 on February 18, 2026, at 11:15 AM revealed that she, .got room moved and do not know why, staff just came in and started taking stuff out of closets and drawers and was moved that day. Resident 11 further stated, I'm not cattle, they could have talked to me about it. I speak English and understand what they say. Clinical record review for Resident 11 revealed census information that she did reside in the same room from November 18, 2024, to February 8, 2026, when she moved to her current room. Nursing documentation by the registered nurse dated February 8, 2026, at 12:17 PM noted, We spoke with resident about moving rooms and she agreed she is okay with moving rooms, I also called and left a message for her daughter so she would know we moved her room. Resident 11's clinical record contained no evidence that written documentation was given to Resident 11 and/or her responsible party of why the room move was required. The facility also could provide no documentation to evidence that Resident 11 was given the opportunity to see the new location or meet her new roommate. The surveyor reviewed the above concerns regarding Resident 11's room and roommate change during an interview with the Nursing Home Administrator and the Director of Nursing on February 19, 2026, at 2:00 PM. The interview confirmed that there was no written documentation given to Resident 11 and/or her responsible party of why the room move was required. The facility also could provide no documentation to evidence that Resident 11 was given the opportunity to see the new location or meet her new roommate. 28 Pa. Code 201.14(a) Responsibility of licensee 29 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.12(d)(3) Nursing services		

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on clinical record review, facility documentation review, and resident and staff interview, it was determined that the facility failed to obtain written authorization to manage personal funds for one of two residents reviewed for personal funds concerns (Resident 12). Findings include: Interview with Resident 12 on February 18, 2026, at 9:23 AM revealed that the business office in the facility held money for him, that a cousin deposited a check in that account for him, but that he did not receive a statement or had knowledge of how much money was in the account. Clinical record review for Resident 12 revealed a Resident Personal Funds agreement dated November 7, 2022, that Resident 12 signed to elect to manage his own funds (declined to have the facility manage his funds). A Resident Fund Management Service (RFMS) Authorization and Agreement to Handle Resident Funds form signed by Resident 12 on November 8, 2022, declined an RFMS account. A Resident Personal Funds agreement dated November 5, 2024, signed by Resident 12, again documented his election to manage his own funds (declined to have the facility manage his funds). An RFMS Authorization and Agreement to Handle Resident Funds form signed by Resident 12 on November 5, 2024, again documented his declination to establish an RFMS account. An Authorization Agreement for pre-authorized payments signed by Resident 12 on January 22, 2025, permitted the facility to automatically withdraw a monthly amount not to exceed \$2000.00 from his bank's checking account. Review of an RFMS statement dated from December 15, 2025, to February 17, 2026, indicated that Resident 12's monthly payments, care cost debits, interest payment, and a credit adjustment resulted in a \$191.88 credit balance in the account. The surveyor requested the written authorization completed by Resident 12 to establish a personal fund during an interview with the Nursing Home Administrator and the Director of Nursing on February 18, 2026, at 2:00 PM. An interview with Employee 2 (business office manager), the Director of Nursing, and the Nursing Home Administrator, on February 20, 2026, at 11:45 AM confirmed that Resident 12 authorized the facility to withdraw his personal liability payment from his personal checking account monthly, however, there was no evidence that he provided written authorization to establish an RFMS account. 28 Pa. Code 201.18(b)(2)(e)(1) Management 28 Pa. Code 201.29(a) Resident rights		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to establish clear end of life directives for one of six residents reviewed (Resident 13). Findings include: A review of Resident 13's clinical record revealed an active physician's order dated [DATE], that indicated the resident was a DNR (do not resuscitate, do not attempt CPR (cardiopulmonary resuscitation) when the person has no pulse and is not breathing) and stated, DNR (Do Not Resuscitate)-LIMITED: NO INTUBATION, use medical treatment, IVF, ABX Discussed with daughter, new POLST completed. Resident 13's POLST (Pennsylvania Orders for Life-Sustaining Treatment, a form directing medical staff to complete life-sustaining treatment or allow a natural death) dated on [DATE], was noted to be signed by the resident's daughter due to confusion at that time. Clinical record review for Resident 13 revealed a quarterly MDS (Minimum Data Set, an assessment completed at periodic intervals of time to assess resident care needs), dated [DATE], in which facility staff assessed the resident as having a BIMS (Brief Interview for Mental Status, used to evaluate aspects of cognition such as attention, orientation, and memory recall) score of 15, the highest possible score, indicating a normal level of cognition. The resident was noted to have a previous POLST dated [DATE], signed by the resident which indicated a desire for CPR and full medical treatment. No evidence was found that the facility discussed the change of code status with Resident 13 to confirm the resident's wishes for the change in end-of-life care. This was confirmed with the Nursing Home Administrator and the Director of Nursing during a meeting on February 20, 2026, at 11:20 AM. Resident was unavailable for further interview due to a medical procedure. 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Discontinue Treatment; Formulate Adv Dir Previously cited deficiency [DATE] 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services 28 Pa. Code 201.29(a) Resident rights		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of select facility policies and procedures, clinical record review, and staff interview, it was determined that the facility failed to thoroughly investigate and report to the appropriate agencies a potential allegation of misappropriation of resident property for one of 24 records reviewed (Resident 30). Findings include: The facility policy entitled Abuse, Neglect, and Exploitation, last reviewed without changes on January 21, 2026, revealed an immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect, or exploitation occur. The facility will report all alleged violations to the Administrator, state agency, adult protective services, and all other required agencies (i.e. law enforcement, when applicable) within specified timeframes, not later than 24 hours if the events that cause the allegation do not involve abuse, and do not result in serious bodily injury. Nursing documentation dated January 23, 2026, at 2:25 PM revealed Resident 30 put her husband on the phone with Employee 5 (licensed practical nurse). Resident 30's husband told Employee 5 when Resident 30 was on the Heirloom nursing unit she had a wallet with cards and \$128.00 in it and the staff on the Heirloom nursing unit took Resident 30's wallet and locked it up. Employee 5 did not know anything about a wallet but told Resident 30's husband that she would talk to the Heirloom staff and see if they had Resident 30's wallet. Employee 3 (social worker) revealed she spoke with the Heirloom nurse, and the nurse stated they did not take anything from Resident 30 and lock it up, indicating she checked all areas and there was no wallet in any of those areas. Employee 3 notified Employee 1 (assistant director of nursing) and let her know what Resident 30's husband and Heirloom staff stated. Further review of Resident 30's clinical record revealed no investigation into Resident 30's allegation of the potential misappropriation of Resident 30's wallet and contents. During a meeting with the Nursing Home Administrator and Director of Nursing on February 18, 2026, at 2:11 PM they stated Resident 30 did not have a wallet. Nursing documentation dated February 18, 2026, at 5:49 PM, noted Resident 30's purse with money and belongings had been located, and the purse, money, and belongings were returned to Resident 30's husband. Interview with the Nursing Home Administrator and Director of Nursing on February 19, 2026, at 2:08 PM confirmed the above findings for Resident 30. The facility failed to complete an investigation, obtain witness statements, notify law enforcement, or notify Department of Health related to Resident 30's husband allegation of a potential misappropriation of resident property. 483.12 (b) Development and Implementation of Abuse Policy Previously cited June 11, 2025 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1)(3)(e)(1) Management 28 Pa Code 201.19(8) Personnel policies and procedures		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review and staff interview, it was determined that the facility failed to implement a comprehensive, person-centered care plan for suicidal ideations one of 24 residents reviewed (Resident 101). Findings include: Clinical record review revealed the facility admitted Resident 101 on September 22, 2025. Nursing documentation dated January 30, 2026, at 2:55 PM noted Resident 101 was very tearful, stating she was scared and wanted to go home. Documentation revealed Resident 101 stated she wanted a straight razor because if she does not do it to herself, this place will, stating she would be better off dead. Documentation revealed the facility contacted Resident 101's daughter and she was unable to calm Resident 101. The facility placed Resident 101 on every 15-minute checks. Review of Resident 101's care plan on February 20, 2026, revealed no comprehensive, person-centered care plan that addressed Resident 101's suicidal ideation. Interview with Employee 3 (social worker) on February 20, 2026, at 1:11 PM confirmed the above findings for Resident 101 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident and staff interview, it was determined that the facility failed to assist dependent residents with activities of daily living for two of two residents reviewed for activities of daily living concerns (Residents 11 and 8). Findings include: Clinical record review for Resident 11 revealed a quarterly MDS (Minimum Data Set, an assessment tool completed at specific intervals to determine resident care needs) assessment dated [DATE], that staff determined Resident 11 needed partial/moderate staff assistance for showering/bathing. Review of a plan of care initiated by the facility on November 20, 2024, to address Resident 11's care preferences, revealed interventions that included that staff honor that Resident 11 stated that she preferred a shower in the morning. Resident 11 is scheduled for a shower on day shift. Review of a plan of care initiated by the facility on November 19, 2024, to address assistance Resident 11 needed for activities of daily living (ADLs), revealed that Resident 11 needed staff supervision for bathing and personal hygiene. During an interview with Resident 11 on February 18, 2026, at 11:16 AM she stated, I haven't had a shower in quite a while. I think it is twice a week I'm supposed to get a shower. I think because the move (room assignment moved). Review of Resident 11's Documentation Survey Report (electronic documentation completed by nurse aide staff for the completion of ADL care) dated January and February 2026 revealed that staff failed to document the completion of morning care, evening care, and bathing/showering on the following occasions: Morning (AM shift) care was not applicable/not done on January 6, 10, 11, 2026 Evening (evening shift) care was not applicable/not done on January 2, 5, 9, 10, 11, 12, 14, 16, and 22, 2026; and February 9, 13, 16, and 17, 2026 Resident 11 did not receive a shower on January 8 and 15, 2026 (staff documented the completion of only a partial bath) Interview with Employee 1 (assistant director of nursing) and the Director of Nursing on February 20, 2026, at 11:25 AM confirmed that Resident 11's assessed need and preferences for ADL care were not followed by staff as documented on the above occasions. Clinical record review for Resident 8 revealed an admission MDS assessment dated [DATE], that staff determined Resident 8 needed substantial/maximal staff assistance for showering/bathing and that he was dependent on staff for personal hygiene. Review of a plan of care initiated by the facility on December 31, 2025, to address Resident 8's care preferences, revealed interventions that included staff honor that Resident 8 stated he preferred a shower in the morning. Resident 8 was scheduled for a shower on day shift. Review of a plan of care initiated by the facility on December 30, 2025, to address assistance Resident 8 needed for ADLs, revealed that Resident 8 needed extensive staff assistance for bathing and limited staff assistance for personal hygiene. Review of Resident 8's Documentation Survey Report dated January and February 2026 revealed that staff failed to document the completion of morning care, evening care, and bathing/showering on the following occasions: Morning (AM shift) care was not applicable/not done on January 7 and 29, 2026; and February 8, 2026 Evening (evening shift) care was not applicable/not done on January 3 and 23, 2026 Resident 8 did not receive a shower on January 7, 11, 14, 21, and 25, 2026 (staff either omitted documentation, documented as not applicable, or documented the completion of only a partial bath). Resident 8 received only one shower from February 1 through 18, 2026, as staff documented a bed bath on February 4, 2026, not applicable on February 7, 2026, and a partial bath on February 11, 2026. Interview with Employee 1 and the Director of Nursing on February 20, 2026, at 11:25 AM confirmed that Resident 8's assessed need and preferences for ADL care were not followed by staff as documented on the above occasions. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and resident and staff interview, it was determined that the facility failed to provide services to maintain a resident's range of motion (ROM) for two of six residents reviewed for ROM concerns (Residents 59 and 118). Findings include: Clinical record review revealed the facility admitted Resident 59 on August 8, 2025. Review of Resident 59's most recent quarterly MDS (Minimum Data Set, an assessment completed at specific intervals to determine care needs) dated January 20, 2026, noted staff assessed Resident 59 as having impairment to his range of motion (ROM, movement of the body to maintain a resident's ability) of one side of his upper extremities. Review of Resident 59's discharge progress note from occupational therapy dated September 30, 2025, indicated discharge recommendations for a restorative nursing program. There was no evidence in Resident 59's clinical record that Resident 59 received a passive range of motion program. Review of Resident 59's therapy discharge recommendation sheet dated and signed by therapy on January 5, 2026, indicated that he was to have an exercise program that consisted of bilateral upper extremity passive range of motion. There was no evidence in Resident 59's clinical record that he was provided the passive range of motion program as recommended by therapy on January 5, 2026. Clinical record review for Resident 118 revealed that the facility admitted her on November 22, 2023. Review of Resident 118's most recent quarterly MDS dated [DATE], revealed that she had and impairment of her bilateral lower extremities. Interview of Resident 118 on February 18, 2026, at 12:04 PM revealed that she was on physical therapy, but it was discontinued a couple of weeks ago. She indicated that she was to have exercises completed by nursing staff to both her legs, but they did not start them yet. Review of Resident 118's physical therapy Discharge summary dated [DATE], revealed discharge recommendations for lower extremity exercises. The discharge summary indicated that a restorative program was not established at this time, but a functional maintenance program was established and trained for range of motion. The discharge summary also indicated that the program was established and trained and that Resident 118's prognosis to maintain current level of functioning was good with consistent staff follow-through. Interview with the Director of Nursing and Nursing Home Administrator on February 19, 2026, at 2:48 PM revealed that the functional maintenance program is completed by the nursing staff and would be considered a range of motion program. Interview with the Director of Nursing on February 20, 2026, at 11:12 AM revealed that the facility had no evidence that Resident 118's ROM program was being completed as recommended. The facility failed to ensure Residents 59 and 118 received appropriate treatment and services to maintain or prevent further decrease in their range of motion. 483.25(c) MobilityPreviously cited 3/14/25 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on clinical record review, observation, and resident and staff interviews, it was determined that the facility failed to implement a CPAP (continuous positive airway pressure) machine as recommended by a physician for one of one resident reviewed for oxygen concerns (Resident 93). Findings include: Interview with Resident 93 on February 17, 2026, at 3:13 PM revealed that her cardiologist was upset that she still does not have a CPAP machine (a device used to treat sleep apnea by delivering a steady gentle stream of pressurized air through a mask to keep the airway open during sleep). She indicated that her cardiologist had asked for her to have a CPAP machine three times now. She also indicated that the staff have never discussed the CPAP machine with her. Review of a cardiology consult visit form dated September 26, 2024, indicated that the cardiologist wanted the facility to get Resident 93's CPAP as she was on it at home. Further clinical record review for Resident 93 revealed cardiologist visit note dated March 18, 2025, that indicated he strongly recommends Resident 93 receives CPAP therapy for her obstructive sleep apnea. Clinical record review for Resident 93 revealed a progress note dated April 14, 2025, at 1:22 AM that indicated resident had a cardiology appointment on March 18, 2025, and recommendations for Resident 93 to receive CPAP therapy for her obstructive sleep apnea were sent to the nurse practitioner who indicated that Resident 93 had refused a CPAP machine in the past when suggested to her. The note indicated that the nurse went to the room to speak with Resident 93 but that she was asleep and she would attempt again in the morning. There was no further documentation noted related to Resident 93 and CPAP therapy. Interview with the Director of Nursing on February 19, 2026, at 2:44 PM revealed that the nurse practitioner revealed to her that she did have the discussion with Resident 93 regarding the CPAP machine and she refused it. There was no documentation to confirm that the nurse practitioner had a discussion with Resident 93 related to the CPAP machine. The facility failed to offer or provide Resident 93 with a CPAP machine as recommended by her cardiologist. The Nursing Home Administrator and Director of Nursing were made aware of the above noted concerns related to Resident 93's CPAP therapy on February 20, 2026, at 11:30 AM. 28 Pa. Code 211.12(d)(1)(5) Nursing services		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, clinical record review, and resident and staff interview, it was determined that the facility failed to secure medications on one of four nursing units (Nittany, Residents 13 and 51). Findings include: Observation of Resident 51's room on February 17, 2026, at 1:05 PM revealed an eye dropper container of Refresh Tears (artificial tears designed to provide temporary relief from dry eyes, irritation, and discomfort caused by insufficient tear production) on their bedside table. During a concurrent interview with Resident 51, they stated that the facility was aware they had the eye drops in their room. Observation of Resident 13's room February 17, 2026, at 1:15 PM revealed an eye dropper container of Genteal Tears (eye drops used to relieve dry, irritated eyes) on their bedside table. There was no evidence Resident 51 or Resident 13 was evaluated or ordered to self-administer the eye drops as indicated above and the eye drops were stored in the resident's room. The Nursing Home Administrator and the Director of Nursing were made aware of the above findings on February 19, 2026, at 2:15 PM. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services		

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

Printed: 07/18/2026
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 02/20/2026
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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, it was determined that the facility failed to provide routine dental services for two of four residents reviewed for dental concerns (Residents 2 and 30). Findings include: Clinical record review revealed the facility admitted Resident 30 on March 18, 2025. Observation of Resident 30 on February 17, 2026, at 11:08 AM revealed Resident 30 was in the dining room. Observation of Resident 30's mouth revealed several broken teeth. Review of Resident 30's admission MDS (Minimum Data Set, an assessment completed by the facility, at intervals to determine the care needs of the resident) dated March 24, 2025, revealed that she had some of her own natural teeth and that she had obvious or was likely to have cavities or broken teeth Review of Resident 30's care plan-initiated April 6, 2025, revealed Resident 30 is at risk for dental or chewing problems related to missing and broken teeth. Further review of Resident 30's clinical record revealed Resident 30 was not seen by the facility's consultant dentist since admission and was not seen by a dental hygienist until February 3, 2026. There was no documentation that indicated Resident 30 was offered routine dental services every six months as the State Plan allows. The above findings for Resident 30 were reviewed with the Nursing Home Administrator and Director of Nursing on February 20, 2026, at 11:55 AM. Interview with Employee 3 (social worker) confirmed Resident 30 did not receive dental care according to the State Plan. Clinical record review for Resident 2 revealed that the facility admitted her on March 23, 2023. Observation of Resident 2 on February 19, 2026, at 11:30 AM revealed her to have some broken teeth. Review of Resident 2's annual MDS dated [DATE], revealed that she had some of her own natural teeth and that she had obvious or was likely to have cavities or broken teeth. Review of Resident 2's care plan that was initiated June 25, 2023, revealed that Resident 2 is at risk for dental or chewing problems related to broken teeth. Review of Resident 2's clinical record revealed that she was seen by the dental hygiene practitioner on November 14, 2025, but the facility was unable to provide information regarding the last time Resident 2 was seen by the facility's consulting dentist. There was no documentation that indicated Resident 2 was offered routine dental services every six month as allowed by the State Plan. The above noted findings for Resident 2 were reviewed with the Nursing Home Administrator and Director of Nursing on February 20, 2026, at 11:45 PM. 28 Pa. Code 201.18(d) Management 28 Pa. Code 211.10(a) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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 02/20/2026
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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, review of facility documents, and resident and staff interview, it was determined that the facility failed to provide food and drink to accommodate individualized preferences for one of 24 sampled residents. (Resident 89). Findings include: Interview with Resident 89 on February 17, 2026, at 2:05 PM revealed that despite explaining to the facility that she is vegetarian, eating only occasionally some chicken or turkey, she is continually served meat. Resident 89 stated she was served ham for breakfast this morning and received the meat at lunch (menu reveals that the meat was Salisbury steak). Resident 89 also stated that she only receives water to drink and she does not receive ice. Evidence the facility obtained food preferences/choices for Resident 89 was requested from facility staff on February 18, 2026, at 2:30 PM but was not provided during the survey. Interview with Resident 89 on February 19, 2026, at 9:36 AM revealed that she received bacon for breakfast that morning and only received water as her beverage without ice. Review of Resident 89's dietary meal ticket revealed that pork and pork products and beef products were listed on the ticket as dislikes for the resident, and no beverages were listed. During an interview with the Nursing Home Administrator on February 19, 2026, at 2:40 PM, she stated that if the resident's dislikes listed all pork products and beef products, it would likely indicate the resident may be vegetarian. Resident 89's food and beverage preferences were not honored as noted above. The above information was reviewed with the Nursing Home Administrator and the Director of Nursing on February 19, 2026, at 2:45 PM. 201.14(a) Responsibility of licensee		