

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395868	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 02/05/2025
NAME OF PROVIDER OR SUPPLIER: EMBASSY OF HEARTHESIDE		STREET ADDRESS, CITY, STATE, ZIP CODE: 450 WAUPELANI DRIVE STATE COLLEGE, PA 16801		
STATE LICENSE NUMBER: 940502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
K 0000	INITIAL COMMENT Facility ID #940502 Component 01 Main Building 01 Based on an Abbreviated survey, as part of a complaint investigation completed on February 5, 2025, it was determined that Embassy of Hearthside was not in compliance with the following requirements of Title 42, Code of Federal Regulations; the Pennsylvania Code; and the Life Safety Code NFPA 101 for an existing health care occupancy. This is a two story, Type III (211) protected, ordinary building, that is fully sprinklered.	K 0000		
K 0100 SS=C		K 0100		

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

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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K 0100 SS=C	Continued from page 1 NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:	K 0100	-The facility had identified an issue with the dry system prior to this event. -Staff have been educated on events that need to be reported to the department of health and will do so in a timely manner. -Two vendor quotes were obtained for the repairs. -The dry system was functioning fully until the permanent repairs can be completed.	Completion Date: 03/05/2025 Status: APPROVED Date: 02/27/2025

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K 0100 SS=C	Continued from page 2 Based on observation and interview, it was determined the facility failed to notify the Department of Health of an event at the facility that compromised quality assurance or patient safety, affecting the entire facility. Findings include: 1. Observation on February 5, 2025, revealed the dry sprinkler system which serves the entire facility, had a known issue within the system prior to receiving a repair quote on December 24, 2024. The facility failed to address the issue identified on the quote leading to the dry sprinkler system failure on January 27, 2025. This failure was the cause of a fire alarm activation on January 27, 2025. These events have not been reported to the Department of Health (DOH) as of February 6, 2025. Interview at the exit conference with the Maintenance Manager on February 5, 2025, at 11:15 am, confirmed the cause of the dry sprinkler system failure had not been repaired at the time of	K 0100		

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K 0100 SS=C	Continued from page 3 survey. The dry system is however fully functional with the use of a temporary air compressor. Refer to Title 28, Health and Safety, Part IV. Health Facilities § 51.3. Notification. (e)(f).	K 0100			



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EMBASSY OF HEARTHSIDE

STATE LICENSE NUMBER: 940502

SURVEY EXIT DATE: 02/05/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

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K 0000	INITIAL COMMENT Facility ID #940502 Component 02 Main Building 02 Based on an Abbreviated survey, as part of a complaint investigation completed on February 5, 2025, it was determined that Embassy of Hearthsides was not in compliance with the following requirements of Title 42, Code of Federal Regulations; the Pennsylvania Code; and the Life Safety Code NFPA 101 for an existing health care occupancy. This is a two story, Type II (222), fire resistive building, that is fully sprinklered.	K 0000		
K 0100 SS=C		K 0100		

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