STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395250	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holy Family Manor	1200 Spring Street Bethlehem, PA 18018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of facility documentation, clinical record review, and staff interview, it was determined that the facility failed to inform a resident and/or responsible party, in advance, of a treatment and treatment options prior to receiving psychotropic medication for one of 19 sampled residents. (Resident 67)Findings include: Review of facility documentation entitled, Informed Consent for Psychotropic Medication Use, revealed that before receiving any psychotropic medication, an informed consent must be obtained. The resident or responsible party was to receive information and education regarding the benefits and potential side effects of the psychotropic medication. Clinical record review revealed that Resident 67 was admitted to the facility on [DATE], and had diagnoses that included metabolic encephalopathy (brain dysfunction), dementia, and anxiety. The Minimum Data Set assessment dated [DATE], indicated that the resident had cognitive impairment and displayed symptoms of feeling depressed and hopeless. Physician's orders dated April 22, 2026, and May 5, 2026, directed staff to administer an anti-anxiety medication, lorazepam, every six hours as needed. In addition, a physician's order dated May 7, 2026, directed staff to administer an antidepressant medication, sertraline, once a day. There was no documentation to support that the resident and resident's responsible party were provided with information and education regarding the benefits and potential side effects of the psychotropic medications or that consent was obtained prior to the administration of the psychotropic medications. In an interview on June 2, 2026, at 2:20 p.m., the Director of Nursing confirmed that an informed consent was not obtained and that the resident and resident's responsible party were not educated on the risks and benefits of the psychotropic medications. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.12(d)(1) Nursing services.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to assess a resident's capability to self-administer medications for one of 19 sampled residents. (Resident 60)Findings include: Review of facility policy entitled, Self-Administration of Medications/Bedside Medication Storage, last reviewed April 28, 2026, revealed that a resident may exercise the right to self-administer medications when determined that this practice is safe. It was the responsibility of the Interdisciplinary Team to determine the following issues with regards to resident self-administration of medications: resident safety to self-administer medications, location of medication administration, determine who will be responsible for storage, and documentation of medication administration. If the resident indicated a desire to self-administer his or her medications, the Interdisciplinary Team would complete the Self-Administration of Medications UDA (User Defined Assessment) to determine the resident's ability to safely self-administer medications. The Care Plan will document interventions to support self-administration of medications by the residents. Clinical record review revealed that Resident 60 was admitted to the facility on [DATE], and had diagnoses that included heart failure, diabetes, depression, and high blood pressure. Review of the Minimum Data Set (MDS) assessment, dated April 21, 2026, revealed that Resident 60 was alert and oriented. Observation of the scheduled medication administration on May 31, 2026, at 10:06 a.m., revealed the licensed practical nurse (LPN 1) placed a medication cup with five pills on Resident 60's bedside table and left the room. LPN 1 confirmed that she left the medications on the resident's bedside table for her to take later. There was no documentation to support that the resident had a physician's order to self-administer medications or that the interdisciplinary team had assessed the resident to self-administer medications. In an interview on June 1, 2026, at 1:00 p.m., the Nursing Home Administrator and Director of Nursing confirmed that Resident 60 did not have a physician's order to self-administer medications and the resident was not assessed to self-administer the medications. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to ensure that the responsible party was notified of a change in condition for one of 19 sampled residents. (Resident 67)Findings include: Review of the facility policy entitled, Change in Condition- Notification of Change, dated April 28, 2026, revealed the resident and the resident's legal representative/family, would be notified of any change in condition which included a change in behavior, medications, activities of daily living, a new onset of pain, and a change in treatment. Clinical record review revealed that Resident 67 had diagnoses that included metabolic encephalopathy (brain dysfunction), dementia, and muscle weakness. Review of a nurse's note dated May 13, 2025, revealed the physician was notified and made aware that the resident was incontinent, had a change in behavior, and complained of pain when urinating. The nurse further noted that the physician directed staff to obtain a stat (immediate) urine sample for urinalysis to rule out an infection. In addition, a physician's order dated May 14, 2026, directed staff to administer an increased dosage of an anti-depressant medication (sertraline) from 25 milligrams (mg) to 50 mg. There was no documentation to support that the resident's responsible party was notified of the physician's order for a urinalysis and increased dose of medication. In an interview on June 2, 2026, at 2:20 p.m., the Director of Nursing confirmed that the responsible party was not notified of the resident's changes in condition, including prescribed treatments. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on clinical record review and staff interview, it was determined that the facility failed to offer non-pharmacological interventions prior to the administration of as needed anti-anxiety medications for one of 19 sampled residents. (Resident 67)Findings include: Review of the facility policy entitled, Change in Condition- Notification of Change, dated April 28, 2026, revealed the resident and the resident's legal representative/family, would be notified of any change in condition which included a change in behavior, medications, activities of daily living, a new onset of pain, and a change in treatment. Clinical record review revealed that Resident 67 had diagnoses that included metabolic encephalopathy (brain dysfunction), dementia, and muscle weakness. Review of a nurse's note dated May 13, 2025, revealed the physician was notified and made aware that the resident was incontinent, had a change in behavior, and complained of pain when urinating. The nurse further noted that the physician directed staff to obtain a stat (immediate) urine sample for urinalysis to rule out an infection. In addition, a physician's order dated May 14, 2026, directed staff to administer an increased dosage of an anti-depressant medication (sertraline) from 25 milligrams (mg) to 50 mg. There was no documentation to support that the resident's responsible party was notified of the physician's order for a urinalysis and increased dose of medication. In an interview on June 2, 2026, at 2:20 p.m., the Director of Nursing confirmed that the responsible party was not notified of the resident's changes in condition, including prescribed treatments. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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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 facility policy review, personnel file review, and staff interview, it was determined that the facility failed to complete a reference check and verify a professional license/registration status prior to the start of employment for three of five newly hired employees. (Employees 3, 4, 5)Findings include:A review of the facility policy entitled, Resident Abuse Prevention and Reporting Reasonable Suspicion of a Crime, dated April 28, 2026, revealed that the facility was to conduct screenings for potential hires for a history of abuse, neglect, or mistreatment of residents, which included checking the appropriate licensing boards and registries for verification of license/certification to ensure the license was in good standing. Employee 3 (E3) had been working in the facility as a license practical nurse since April 15, 2026. There was no evidence that the facility submitted an inquiry to the state licensure board prior to E3 working among residents in the facility. Employee 4 (E4) had been working in the facility as a license practical nurse since April 6, 2026. There was no evidence that the facility submitted an inquiry to the state licensure board prior to E4 working among residents in the facility. Employee 5 (E5) had been working in the facility as the Administrator since April 27, 2026. There was no evidence that the facility submitted an inquiry to the state licensure board prior to E5 working among residents in the facility. In an interview on June 3, 2026, at 9:28 a.m., the Administrator confirmed there was no documented evidence that the license verifications were done prior to start of employment for E3, E4, and E5.28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(3) Management.28 Pa. Code 201.19(3) Personnel policies and procedures.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to provide ongoing assessment and monitoring for one of one sampled residents receiving dialysis (process of removing excess toxins and water from the blood). (Resident 24)Findings include:A review of the facility policy entitled, Dialysis, last reviewed April 28, 2026, revealed that staff were to complete the pre-dialysis portion of the dialysis communication form that provided information regarding the resident's ongoing status to send with the resident to dialysis, including the resident's pre-dialysis weight and vital signs. Clinical record review revealed that Resident 24 had diagnoses that included end-stage renal (kidney) disease and dependence on renal dialysis and had a physician's order for the facility to provide dialysis three days per week. There was a lack of evidence to support that Resident 24's pre-dialysis weight was obtained and documented on the dialysis communication forms that were to be completed before leaving for dialysis on 24 of 36 occasions from March 2, 2026, through June 1, 2026. Additionally, there was no documented evidence that the facility obtained Resident 24's vital signs on May 20, 2026.During an interview on June 3, 2026, at 1:48 p.m., the Administrator confirmed that the pre-dialysis weight and vital signs were to be obtained prior to leaving for dialysis and documented on the dialysis communication form and that there was no evidence that this was done on the previously mentioned days. 28 Pa. Code 211.12(1)(3)(5) Nursing services.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 in a sanitary manner in one of three resident dining rooms. (Second floor)Findings include: Observation in the Second Floor resident dining room on May 31, 2026, at 1:30 p.m., revealed areas of dark red discoloration along the length of the bottom shelf of the reach-in refrigerator, in addition to a puddle of water and soaked dish cloth. There was a carafe with water that was not dated. There was a carton of chocolate milk with a use by date of May 30, 2026. There was a plastic container with tartar sauce packets in it that had a thick layer of a dried white substance on the outside of the container. There was a bread knife directly touching a shelf in the cooler. In an interview on May 31, 2026, at 1:30 p.m., the Food Operations Manager confirmed that the water should have been dated, the expired milk removed, and that the knife was used to cut sandwiches and left in the reach-in cooler and should have been sent to the for washing and sanitizing. 28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201.18(b)(3)(e)(2.1) Management.