

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2025
NAME OF PROVIDER OR SUPPLIER  Bethlehem South Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  2021 Westgate Drive Bethlehem, PA 18017	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on clinical record review, it was determined that the facility failed to ensure that the physician and responsible party was notified in a timely manner of a change in the residents condition for one of five residents sampled. (Resident CR1)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident CR1 was admitted to the facility with diagnoses that included diabetes mellitus, dementia and mood disorder. A note by a nurse on June 21, 2025, at 2:45 p.m., noted that the resident had an increase in tiredness, wanted to sleep and had poor meal intake. The resident was observed to have had loose stools on three occasions on the afternoon shift. At 6:29 p.m. the nurse noted that the resident while being fed supper had vomited. The resident's blood pressure was noted to be low. There was no assessment by the nurse following the episode of vomiting.</p> <p>There was no documentation that the physician or responsible party was notified about the changes in Resident CR1's condition. The resident was transferred to the emergency room on June 22, 2025, at 7:30 a. m. due to an acute change in condition</p> <p>28 Pa. Code 211.12(d)(1)(5) 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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