STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395429	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethlehem South Skilled Nursing and Rehabilitation	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, facility documentation review, and staff interview, it was determined that the facility failed to ensure that residents were free from abuse that resulted in actual physical harm for one of seven sampled residents (Resident 2) This failure resulted in an Immediate Jeopardy situation. The incident has been identified as past non-compliance.Findings include: Review of the facility policy entitled, Abuse Prohibition, last reviewed on November 14, 2025, revealed that Center staff were to do all that was within their control to prevent occurrences of abuse for all patients. Actions to prevent abuse would include identifying, correcting, and intervening in situations in which abuse was more likely to occur. The Center was responsible for identifying patients who had a history of disruptive or intrusive interactions or who exhibited other behaviors that made them more likely to be involved in an altercation. Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], and had diagnoses that included dementia and major depressive disorder. According to the Minimum Data Set assessment (MDS, a periodic evaluation of resident care needs) dated March 3, 2026, the resident had moderate cognitive impairment and used a walker for ambulation. It did not indicate that the resident used a cane for walking. Review of the care plan revealed that the resident had the potential to exhibit physical aggression, such as throwing objects, hitting other residents, verbal aggression, and threatening behaviors and that the resident could walk with a roller walker and contact guard assistance (staff place one or two hands on the resident's body to help with balance) from one staff member. Review of the hospital Discharge summary dated [DATE], revealed the provider documented that Resident 1's family reported worsening behaviors (including aggressive behavior in which Resident 1 would repeatedly hit family members with his cane), calling the police claiming to be kidnapped, and eloping (unauthorized departure). On September 17, 2025, a nurse documented that Resident 1 banged his cane on his table and threw his urinal containing urine. On September 18, 2025, a nurse noted that Resident 1's family stated that he had a history of hitting people with his cane, throwing his walker, and urinating all over. On January 24, 2026, staff documented that Resident 1 hit his roommate, Resident 2, in the chest with his cane. In a written statement dated, January 24, 2026, at 7:00 p.m., Nurse Aide (NA) 1 stated that Resident 1 was observed continuously hitting Resident 2, thrusting his cane into Resident 2's chest. NA 1 stated that Resident 2 didn't want to leave (change) his room, and he wanted Resident 1 to leave the room. The provider and family were made aware of the incident. At the time of notification, Resident 1's family stated, He was getting like that before he left. In an interview on June 8, 2026, at 11:30 a.m., Resident 2 stated, I was hit in the chest a couple times with the cane. Why was he still allowed to have his cane? Clinical record review revealed that Resident 2 had diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the left side (weakness and loss of the ability to move one or more muscles voluntarily on the left side of body caused by a stroke), major depressive disorder, hoarding disorder (difficulty throwing away or parting with possessions), and obsessive-compulsive disorder (mental health condition with a pattern of unwanted thoughts and fears and repetitive behaviors or compulsions). Review of the care plan (continued on next page)

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	revealed that the resident was at risk for changes in mood and behavior due to major depressive disorder, obsessions, and compulsions and had a self-care deficit due to physical limitations. Review of facility documentation dated May 19, 2026, at 1:00 a.m. revealed that staff heard Resident 2 yelling for help at the end of the hall. Resident 1 was observed striking Resident 2, who was seated in his wheelchair, forcefully on the back, right side of the head with a cane. Registered Nurse (RN) 1 intervened by blocking the cane and removing it from Resident 1. When questioned by law enforcement, Resident 1 was unable to describe what happened. Resident 2 was transferred to the hospital with injuries requiring treatment. Review of the hospital Discharge summary dated [DATE], revealed that Resident 2 was assessed due to being the victim of an assault with multiple lacerations on the back of the head and a swollen right wrist. Resident 2 required six sutures and 15 staples to close the wounds on the back of his head. Resident 2 also sustained a right wrist fracture requiring a splint as a result of the incident. In an interview on June 8, 2026, at 11:30 a.m., Resident 2 stated that at the time of the incident, he was scared, shocked at what was happening, and in pain. There was no documented evidence that the cane was Resident 1's preferred assistive device. There was no documented evidence that Resident 1 was ever assessed to use the cane. There was no documented evidence that the cane was taken away from Resident 1 until May 19, 2026, at 1:00 a.m. On June 9, 2026, at 12:30 p.m., the Administrator was notified that the failure to keep a resident free from abuse, which resulted in actual harm to Resident 2, constituted an Immediate Jeopardy situation at F600-J, and the Immediate Jeopardy template was provided. The facility was informed that a corrective action plan was required. The facility identified the jeopardy at the time of the incident, May 19, 2026, at 1:00 a.m., and implemented the following corrective action plan: 1. Resident 1 was immediately placed on one-to-one supervision and removed from his shared room to another room on the opposite side of the unit. 2. At the time of the incident, Resident 1's cane was confiscated by local law enforcement. A thorough room search was conducted to ensure no additional potential weapons or unsafe items were present. 3. On May 19, 2026, Resident 1's medications were reviewed and an emergency psychiatric consultation (a comprehensive evaluation by a medical doctor to assess, diagnose, and treat mental, emotional, or behavioral disorders) was completed. Resident 1's care plan was updated to address refusing medications and psychiatric services. 4. On May 19, 2026, Resident 1 was transferred to the hospital for a comprehensive medical and psychiatric evaluation. Resident 1 returned to the facility on May 26, 2026, was placed on another unit, and continued on one-to-one supervision until a private room was available later that same day. 5. Upon return from the hospital, Resident 1 was re-evaluated by Physical Therapy. Resident 1 was instructed to utilize a walker and wheelchair for increased safety. Resident 1's care plan was updated to include one-to-one supervision during activities to ensure his safety and the safety of other residents. 6. The facility's admission process includes a comprehensive inventory of resident belongings upon admission. Whenever there is a concern regarding contraband (drugs, alcohol, weapons, etc.), paraphernalia (any equipment, product, or material used to produce, conceal, or consume illegal drugs), or safety risks, a room search is conducted in accordance with facility policy. 7. The facility's admission process for residents with behavioral health concerns includes a thorough interdisciplinary review prior to admission. The facility's admission process changed in September 2025, requiring the Clinical Admissions Director to send detailed emails to clinical staff, including all department heads and unit managers, to evaluate prior to admission. With this process, behavior and safety criteria are also evaluated. Residents must be free of significant behavioral incidents for at least 24 hours before admission whenever possible. The interdisciplinary team (IDT) evaluates each resident's medical condition, behavioral history, room placement needs, roommate compatibility, and appropriate unit assignment to ensure the safest and most therapeutic environment possible. 8. A house-wide behavioral audit was conducted on May 20, 2026. The behavioral audit is defined as medications, non-pharmacological interventions (methods used to prevent, manage, or treat health conditions without medication such as distraction, music, repositioning, snacks, etc.) mental and behavioral (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	health services, and whether medications have the correct diagnoses. Similar audits are conducted after significant behavioral incidents. The audit process includes IDT review of the event, staff education on abuse and prevention with questionnaires across all departments, and resident and family abuse and prevention education and questionnaire, initiated on May 20, 2026, and completed on May 22, 2026. 9. The Director of Nursing or designee initiated weekly audits and reports the results to the QAPI (Quality Assurance, Performance Improvement) committee. The first audit was done on May 20, 2026. The most recent weekly audit was completed on June 8, 2026. On June 9, 2026, a review was conducted to verify the complete implementation of the facility's corrective action plan. All staff interviewed confirmed that they received the training described in the facility's action plan. All nursing staff were aware of abuse prevention and behavior monitoring. During Interviews, administrative staff verbalized the procedure for potential admissions and the intake process. Behavioral audits were reviewed. All sampled residents were reviewed, and mood and behavior care plans were in place, behaviors were monitored, and residents were receiving behavioral health services. All staff training was completed by May 22, 2026. Resident 1 was observed in a private room on a different nursing unit from Resident 2. The Immediate Jeopardy existed from January 24, 2026, until May 22, 2026, at 5:00 p.m. Verification of all elements of the action plan was completed on June 9, 2026, at 3:00 p.m., and the Immediate Jeopardy was officially lifted effective May 22, 2026. The Nursing Home Administrator and the Director of Nursing were informed that residents were no longer considered to be in immediate jeopardy. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.29(a) Resident rights. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.