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	06/30/2026

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 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. **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 attempt non-pharmacological interventions prior to administering an anti-anxiety medication for one of six sampled residents. (Resident 1)Findings include: Clinical record review revealed that Resident 1 had diagnoses that included neurocognitive disorder with Lewy bodies (progressive brain disease caused by abnormal protein deposits), cerebral infarction (stroke), and insomnia (sleep disorder). Review of the Minimum Data Set assessment dated [DATE], revealed that the resident was cognitively impaired. A review of the care plan revealed that the resident exhibited physical and/or sexual behaviors related to poor impulse control. On May 22, 2026, a physician ordered staff to administer an anti-anxiety medication (lorazepam) every six hours as needed for agitation. Review of Resident 1's Medication Administration Record revealed that staff had administered the lorazepam seven times in May 2026 and 11 times in June 2026. There was no documented evidence that the staff attempted non-pharmacological interventions prior to administering the lorazepam. In an interview on June 30, 2026, at 1:00 p.m., the Assistant Director of Nursing confirmed that the staff had not attempted non-pharmacological interventions prior to administering the as needed lorazepam. 28 Pa. Code 211.12(d)(1)(5) 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **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 develop a comprehensive care plan to meet each resident's needs for one of six sampled residents. (Resident 1)Findings include:Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses that included neurocognitive disorder with Lewy Bodies (a disorder that affects brain function) and insomnia (inability to sleep). Review of nursing notes dated June 2, 3, 4, 11, 15, and 26, 2026, revealed that Resident 1 had increased behaviors of wandering into other resident rooms and taking their items. There were no care plan interventions to address Resident 1 wandering into other resident rooms or taking their items.In an interview on June 30, 2026, at 12:25 p.m., the Assistant Director of Nursing confirmed there was no documented evidence that the care plan addressed wandering into other resident rooms or taking their items. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethlehem South Skilled Nursing and Rehabilitation	2021 Westgate Drive Bethlehem, PA 18017

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, and resident interview, it was determined that the facility failed to ensure that staff provided adequate supervision in order to prevent wandering and accidents for one of six sampled residents. (Resident 1)Findings include:Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], with diagnoses that included neurocognitive disorder with Lewy Bodies (a disorder that affects brain function) and insomnia (inability to sleep). The Minimum Data Set assessment dated [DATE], indicated that the resident was cognitively impaired and was independent for transfers and ambulation (walking). A review of the care plan identified that the resident was at risk for falls. Review of nursing documentation revealed that on May 6, 2026, Resident 1 was wandering throughout the shift. On May 7, 2026, Resident 1 was documented as wandering down the hall all shift, opening doors, and entering resident rooms. On May 9, 2026, a nurse documented that Resident 1 was wandering the hall and attempting to take drinks from the medication cart. On May 21, 2026, Resident 1 was documented as being very invasive to other residents, being in their rooms, taking their belongings, and attempting to get in other residents' beds. On June 2, 2026, Resident 1 was documented as wandering the hall and entering other resident rooms, and taking items, including food and drinks, from other residents. It was noted that on June 3, 2026, Resident 1 was taking items off the medication cart and food delivery carts. On June 4, 2026, Resident 1 was documented as entering other rooms and trying to get into residents' beds. On June 10, 2026, psychiatry documented that Resident 1 continued to pace the hallways and enter other residents' rooms which upset multiple residents. On June 11, 2026, a nurse documented that Resident 1 had intrusive behaviors throughout the shift, going into other rooms uninvited and taking food from carts. On June 15, 2026, it was documented that Resident 1 had repeated incidents of entering other resident rooms and taking items from rooms and carts. Review of facility documentation dated June 23, 2026, revealed that Resident 1 was observed to have a laceration under his eye following wandering the halls. In an interview on June 30, 2026, at 11:25 a.m., Resident 2 stated that Resident 1 frequently came into her room, took and ate her food, and laid in her bed and that she found it disgusting.The facility failed to provide adequate supervision to prevent a resident from wandering into other resident rooms and failed to prevent accidents. CFR: 483.25(d) Accidents. Previously cited 07/25/25.28 Pa. Code 211.12(d)(1)(5) Nursing services.