STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395527	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethlehem North Skilled Nursing and Rehabilitation	2029 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 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 clinical record review and staff interview, it was determined that the facility failed to notify the responsible party of a change in the resident's medical condition for one of one resident receiving hospice services. (Resident R1) Findings include:Clinical record review revealed that Resident R 1 was admitted to the facility with diagnoses that included liver cancer. The resident was placed on hospice services on March 2, 2026, with a physician's order for a narcotic pain medication (morphine sulfate) to be administered orally every two hours as needed for pain. Review of the Medication Administration Record (MAR) for April 2026, revealed that the medication was administered to the resident on April 10, 2025, at 2:40 a.m. There was a lack of documentation to support that the resident's responsible party was made aware of the resident's change in medical status and medication.In an interview on April 10, 2026, at 11:45 a.m., the Nursing Home Administrator confirmed that the responsible party was not made aware of the change in medical condition and the administration of the pain medication. 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