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	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethlehem North Skilled Nursing and Rehabilitation	2029 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 48578 Based on clinical record review and observation, it was determined that the facility failed to ensure that a call bell was accessible for one of 39 sampled residents. (Resident 104) Findings include: Clinical record review revealed that Resident 104 had diagnoses that included polyneuropathy (a condition where peripheral nerves are damaged) and dementia. Review of the Minimum Data Set assessment, dated December 15, 2024, revealed Resident 104 was dependent on staff for activities of daily living, including toileting, dressing, and personal hygiene. Review of the care plan revealed that Resident 104 was at risk for falls with an intervention for staff to keep commonly used articles within easy reach and reinforce the need to call for assistance. On March 5, 2025, at 11:16 a.m., Resident 104 was observed in bed with the call bell on the floor next to the bed. Resident 104 was observed again at 12:19 p.m. and 2:40 p.m., in bed with the call bell on the floor and out of reach. In an interview on March 6, 2024, at 1:45 p.m., the Assistant Director of Nursing confirmed that the resident's call bell should have been placed within the resident's reach. 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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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43883 Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to notify a resident's responsible party of a change in condition for three of four sampled residents who experienced significant weight loss. (Residents 44, 46, and 164) Findings include: Review of the facility policy entitled, Weights and Heights, last reviewed, November 18, 2024, revealed that staff would notify a resident's representative of a significant weight change. Review of the facility policy entitled, Change in Condition: Notification of, last reviewed November 18, 2024, revealed that the facility must immediately notify the resident's representative when there is a significant change in a resident's condition. Clinical record review revealed that Resident 44 had sarcopenia and dementia. On November 16, 2024, the resident weighed 235 pounds (lbs.). On December 17, 2024, the resident weighed 209.5 lbs., which reflected a 25.5 lb. (10.8%) weight loss. On January 6, 2025, the resident weighed 208.5 lbs., which confirmed a significant weight loss. There was no evidence that the facility notified the residents representative of the significant weight loss. Clinical record review revealed that Resident 46 was admitted to the facility on [DATE], and had diagnoses that included anemia and anxiety. On December 3, 2024, the resident weighed 204.2 lbs. On January 3, 2025, the resident weighed 180.4 lbs., which reflected a significant weight loss of 24.2 lb. (11.8%). On January 6, 2025, the resident weighed 180.0 lbs., which verified the weight loss. There was a lack of evidence to support that the resident's representative was notified of the significant weight loss. Clinical record review revealed that Resident 164 had diagnoses that included traumatic brain injury and dysphagia. On December 19, 2024, the resident weighed 229 lbs. On December 23, 2024, the resident weighed 217.4 lbs., which reflected a weight loss of 11.6 lbs., (5.0%). On December 24, 2024, the resident weighed 217.0 lbs., which confirmed a significant weight loss. There was a lack of evidence to support that the resident's representative was notified of the significant weight loss. In an interview on March 6, 2025, at 10:31 a.m., the Administrator confirmed there was no evidence that the residents' representatives were notified of the significant weight loss. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 14599 Based on clinical record review, it was determined that the facility failed to notify the residents and/or the residents' representative(s) of their appeal rights and Ombudsman information in writing upon transfer from the facility for five of five sampled residents who were transferred to the hospital. (Residents 14, 57, 101, 133, and 164) Findings include: Clinical record review revealed that Resident 14 was transferred to the hospital on February 5, 2025, after a change in condition. There was no documented evidence that the resident, the resident's responsible party, or legal representative was provided information regarding appeal rights and the Ombudsman upon transfer to the hospital. Clinical record review revealed that Resident 57 was transferred to the hospital on December 4, 2025, after a change in condition. There was no documented evidence that the resident, the resident's responsible party, or legal representative was provided information regarding appeal rights and the Ombudsman upon transfer to the hospital. Clinical record review revealed that Resident 101 was transferred to the hospital on January 9, 2025, after a change in condition. There was no documented evidence that the resident, the resident's responsible party, or legal representative was provided information regarding appeal rights and the Ombudsman upon transfer to the hospital. Clinical record review revealed that Resident 133 was transferred to the hospital on January 31, 2025, after a change in condition. There was no documented evidence that the resident, the resident's responsible party, or legal representative was provided information regarding appeal rights and the Ombudsman upon transfer to the hospital. Clinical record review revealed that Resident 164 was transferred to the hospital on January 2, 2025, after a change in condition. There was no documented evidence that the resident, the resident's responsible party, or legal representative was provided information regarding appeal rights and the Ombudsman upon transfer to the hospital.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48578 Based on observation, clinical record review, and staff and resident interviews, it was determined that the facility failed to provide services to maintain adequate grooming and hygiene for three of 39 sampled residents. (Residents 1, 99, 183) Findings include: Clinical record review revealed that Resident 1 had diagnoses that included muscle weakness. Review of the care plan revealed that the resident required assistance from staff for activities of daily living (ADLs). On March 4, 2025, the resident was observed in her room. Her nails were long and dirty. She stated she preferred her nails to be kept short, staff had not offered assistance with nail care, and she had not refused. On March 5, 2025, at 12:04 p.m., the resident was again observed in her room. Her nails remained long and dirty. She stated that staff had not offered assistance with nail care. There was no evidence of refusals. Clinical record review revealed that Resident 99 had diagnoses that included dementia and dermatitis (inflammation of the skin). Review of the Minimum Data Set (MDS) assessment, dated February 7, 2025, revealed Resident 99 was confused and dependent on staff for ADLs, including toileting, dressing, and personal hygiene. Review of the care plan revealed that the resident was dependent for all ADLs. On March 4, 2024, at 12:02 p.m., the resident was observed sitting in a chair. Her fingernails were long, jagged, and yellow. There was a dark colored substance underneath the nails. The resident nodded no, that did not like her nails like this, and yes, she would like them cut. On March 5, 2024, at 11:25 a.m., the resident was observed in bed. Her fingernails remained long, sharp, and dirty. Clinical record review revealed that Resident 183 had diagnoses that included unspecified dementia and anxiety. Review of the MDS assessment, dated February 26, 2025, revealed Resident 183 was confused and dependent on staff for ADLs, including toileting, dressing, and personal hygiene. Review of the care plan revealed that the resident was at risk for decreased ability to perform ADLs due to impaired balance and limited mobility, and that staff was to anticipate the residents ADL needs. On March 4, 2025, at 10:32 a.m., the resident was observed in her chair. Her nails were long, jagged, and yellow. There was a dark colored substance underneath some of the nails. The resident stated that she did not like her fingernails long. On March 5, 2025, at 12:04 p.m., the resident was observed in her chair. Her fingernails remained long and dirty. In an interview on March 6, 2024, at 11:46 a.m., the Assistant Director of Nursing confirmed that the residents' fingernails should have been trimmed and cleaned with bathing and as needed. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43883 Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to implement interventions to prevent a decline in range of motion for one of 39 sampled residents. (Resident 159) Findings include: Clinical record review revealed that Resident 159 had diagnoses that included stroke and depression. Review of the care plan revealed that the resident had self-care deficits and required assistance from staff for activities of daily living. A physician's order dated December 27, 2024, directed staff to apply a soft hand splint to the right hand once per day, during the day (7:00 a.m. through 3:00 p.m.) shift. Review of an occupational therapy discharge assessment dated [DATE], revealed that the resident was to wear a right palm grip which was to be placed on her hand with morning care. There was no evidence that staff updated the resident's clinical record to include the correct orthotic device, per the therapy discharge summary. On March 4, 2025, at 12:33 p.m., Resident 159 was observed in bed. Her right hand was contracted and there was no orthotic device (a splint or a grip) in place. The resident reported that staff often did not offer to assist with placement of an orthotic device, she had not refused, and it was difficult for her to place it by herself. The resident was observed again at 1:17 p.m., and 2:40 p.m., and there was no splint in place. The resident was observed on March 5, 2025, at 8:16 a.m., and 12:20 p.m. She stated that staff did not offer to place an orthotic device at any point during the prior day, March 4, 2025, and that staff have not offered to assist with placement of an orthotic device on March 5, 2025. There were no documented refusals. In an interview on March 6, 2025, the Assistant Director of Nursing confirmed that the resident required an orthotic device and the order for the new hand grip was not put in place, per the therapy discharge summary. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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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. 43883 Based on facility policy review, clinical record review, observation, and resident and staff interview, it was determined that the facility failed to implement safety measures related to smoking for one of one sampled residents who smoke. (Resident 171) Findings include: Review of the facility policy entitled, Smoking, last reviewed November 18, 2024, revealed that resident smoking supplies, which included cigarettes and lighters, would be labeled with the resident's name, room number, and bed number, maintained by staff, and stored in a suitable cabinet at the nurses' station. Clinical record review revealed that Resident 171 had diagnoses that included depression and anxiety. Review of the care plan revealed that the resident was independent for smoking and the interventions were for staff to educate the resident on the smoking policy and monitor for compliance with the policy. On March 4, 2025, at 12:15 p.m., Resident 171 was observed in his room. He stated that he smoked cigarettes and that his smoking supplies, which included cigarettes and a lighter, were kept in his personal bag and not held by nursing staff when not in use. The bag that the resident reported contained his smoking supplies was observed on his bed. In an interview on March 5, 2025, at 2:45 p.m., the Director of Nursing stated that smoking supplies should be kept behind the nurses station. In an interview on March 6, 2025, at 1:45 p.m., the Assistant Director of Nursing confirmed that the resident did have his smoking supplies in his possession and they needed to be removed and placed at the nurses station. CFR 483.25(1)(2) Free of Accident Hazards/Supervision/Devices Previously cited 2/16/24 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43883 Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to adequately monitor and assess weight loss for two of four sampled residents at risk for weight loss. (Residents 164 and 46). Findings include: Review of the facility policy entitled, Weights and Heights, last reviewed November 18, 2024, revealed that a licensed nurse would notify the registered dietitian (RD) of any significant weight changes and the notification would be documented in a progress note. Clinical record review revealed that Resident 164 had diagnoses that included traumatic brain injury and dysphagia. Review of the care plan revealed that the resident was at risk for nutritional problems and the intervention was for staff to monitor for changes in nutritional status. On December 19, 2024, the resident weighed 229 pounds (lbs.). On December 23, 2024, the resident weighed 217.4 lbs. On December 24, 2024, the resident weighed 217.0 lbs., which confirmed a significant weight loss of 12 lbs., 5.2 percent (%). There was a lack of evidence to support that the RD was notified of the significant weight loss. The RD did not address the weight loss until January 30, 2025. On January 31, 2025, the resident weighed 195 lbs. On February 6, 2025, the resident weighed 223.5 lbs. On February 8, 2025, the RD noted that the resident's weight gain needed to be confirmed, and the resident's nutritional supplements were discontinued. On February 13 and 27, 2025, the resident weighed 187.0 lbs., which verified that the resident continued to experience weight loss. There was a lack of evidence to support that the RD was notified of the confirmed, continued, weight loss, or that the RD reassessed the resident. The nutritional supplements were no longer provided to the resident. Clinical record review revealed that Resident 46 was admitted to the facility on [DATE], and had diagnoses that included anemia and anxiety. Review of the care plan revealed that the resident was at risk for nutrition problems and had a history of significant weight loss. The intervention was for staff to monitor for changes in nutritional status. On December 3, 2024, the resident weighed 204.2 lbs. On January 3, 2025, the resident weighed 180.4 lbs., which reflected a significant weight loss of 24.2 lb. (11.8%). On January 6, 2025, the resident weighed 180.0 lbs., which verified the weight loss. There was a lack of evidence to support that the RD was notified of the significant weight loss, or that the weight loss was addressed until February 10, 2025. In an interview on March 6, 2025, at 10:31 a.m., the Administrator confirmed that there was no evidence that the RD was notified of the residents' weight loss or that the weight loss was addressed timely. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 43883 Based on clinical record review, observation, and resident interview, it was determined that the facility failed to ensure that adaptive equipment was provided to one of 39 sampled residents. (Resident 159) Findings include: Clinical record review revealed that Resident 159 had diagnoses that included stroke and depression. Review of the care plan revealed that the resident was at risk for nutrition problems and required adaptive equipment. The intervention was for staff to provide a curved right spoon. On March 4, 2025, at 12:33 p.m., the resident was observed in bed with her lunch tray on the table. The tray ticket indicated that the resident was to have a curved spoon. Observation of the resident's meal tray revealed that she had only a regular spoon. The resident stated the she was to have a curved spoon and she often does not receive it on her meal trays. The resident was observed on March 5, 2025, at 8:16 a.m., with her breakfast tray and at 12:20 p. m., with her lunch tray. At both observations, the resident received a regular spoon, the curved spoon was not in place. 28 Pa. Code 211.12(d)(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. 43883 Based on observation, it was determined that the facility failed to serve food under sanitary conditions in the kitchen. Findings include: During observation of the tray line service on March 5, 2025, at 11:18 a.m., dietary employee (DE) 1 was wearing gloves and assembling resident meals on the tray line. DE 1 proceeded to leave the tray line while pushing a rolling cart to obtain plates; she did not change her gloves or perform hand hygiene before she returned to the tray line. DE 1 continued to assemble resident meals wearing the same gloves. DE 1 was then observed wiping the gloves on her clothing on two different occasions; she did not change her gloves or perform hand hygiene. DE 1 then picked up cooked chicken from the steam table pan with her hands, while wearing the same gloves, and placed it onto resident meal trays six different times. DE 1 did not change her gloves or perform hand hygiene during the observation period. 28 Pa. Code 201.18(b)(3) Management.