

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395540	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Easton Skilled Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 Northampton Street Easton, PA 18045	
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 - Minimal harm or potential for actual harm 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 for one of seven sampled residents. (Resident 1) Findings include: Review of the facility policy entitled, Abuse Prohibition, last reviewed September 2025, revealed that the center prohibited abuse, mistreatment, and exploitation for all residents. The center implemented an abuse prohibition program for prevention of occurrences. Abuse was defined as willful infliction of injury, intimidation, and mental anguish. An alleged violation situation or occurrence that was observed or reported by staff, but has not yet been investigated and if verified, was an indication of non-compliance with Federal regulations related mistreatment or abuse. The purpose was to ensure that the center staff were doing all that was within their control to prevent occurrences of abuse for all residents. Clinical record review revealed that Resident 1 had diagnoses that included Alzheimer's disease, anxiety, insomnia, and dementia with psychotic disturbance. The Minimum Data Set assessment dated [DATE], indicated that the resident had memory impairment and was always incontinent of urine. A review of the care plan revealed that the resident required assistance with toileting and was resistive to care as demonstrated by physical aggression with spitting and yelling, related to cognitive loss and dementia. There was an intervention that if the resident became resistive or combative with care, staff was to postpone care and allow time for her to regain her composure. Review of facility documentation dated June 25, 2026, at 10:40 p.m., revealed that a staff to resident abuse incident had occurred when the nurse aide (NA) 1 had attempted to provide incontinence care to Resident 1. NA 1 attempted to check Resident 1's brief and Resident 1 spit in NA 1's face. NA1 then slapped the resident in the face. NA 2 provided a statement that she witnessed the event that occurred at the nurse's station. Review of NA 1's statement dated June 26, 2026, revealed that Resident 1 had been sitting at the nursing station at about 10:40 p.m. NA 1 stated that the resident did not look sleepy and that she was acting up. NA 1 then checked her brief and the resident spit in her face. Review of NA 2's statement revealed that on June 25, 2026, at 10:40 p.m., NA 2 had been sitting at the nursing station. NA 1 checked on the resident and Resident 1 spit in NA 1's face followed by NA hitting the resident on the face. NA 2 stated that she observed the entire incident. Further review of facility documentation revealed that the incident of abuse was substantiated based on NA 1's further statement that she admitted to slapping the resident in the face. In an interview on July 17, 2026, at 10:30 a.m., the Administrator stated that NA 1 had admitted to slapping the resident in the face after she had attempted to provide her with incontinence care. 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)(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 implement care planned interventions for one of seven sampled residents. (Resident 1) Findings include: Clinical record review revealed that Resident 1 had diagnoses that included Alzheimer's disease, anxiety, insomnia, and dementia with psychotic disturbance. The Minimum Data Set assessment dated [DATE], indicated that the resident had memory impairment and was always incontinent of urine. A review of the care plan revealed that the resident was resistive to care as demonstrated by physical aggression that included spitting and yelling related to cognitive loss and dementia. There was an intervention that if the resident became resistive or combative during care, staff was to postpone care and allow time for the resident to regain her composure. A review of the care plan revealed a problem area of incontinence of urine due to cognitive loss. There was an intervention for the resident to wear disposable briefs at all times. Review of facility documentation dated June 25, 2026, revealed that on that date at 10:40 p.m., the nurse aide (NA) 1 attempted to check Resident 1's brief at the nursing station. NA 1 stated that the resident did not look sleepy and that she was acting up. Rather than postponing care, NA 1 proceeded to check the resident for incontinence and the resident spit in NA 1's face. NA 1 then slapped the resident in the face. The facility failed to ensure that staff implemented care planned interventions to postpone care when the resident was resistive or combative with care. In an interview on July 17, 2026, at 1:25 p.m., the Administrator confirmed that NA 1 failed to follow and implement the resident's care plan. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		