

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

Printed: 07/18/2026
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 12/09/2025
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 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 facility policy review, 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 five sampled residents. (Resident 17) Findings include: A review of the facility policy entitled, Behaviors: Management of Symptoms, last reviewed on September 22, 2025, revealed that staff was to use approaches to care that did not involve medications (non-pharmacological interventions) as the first line of approach to manage challenging behaviors. Clinical record review revealed that Resident 17 had diagnoses that included psychotic disorder and anxiety. Review of the Minimum Data Set assessment dated [DATE], revealed that the resident was cognitively impaired and had been administered an anti-anxiety medication. On August 15, 2025, a physician ordered staff to administer an anti-anxiety medication (lorazepam) every eight hours as needed for agitation. Review of Resident 17's Medication Administration Record revealed that staff had administered the lorazepam two times in August, 13 times in September, seven times in October, five times in November, and two times in December 2025. There was no documented evidence that the staff attempted non-pharmacological interventions prior to administering the lorazepam. In an interview on December 9, 2025, at 1:25 p.m., the Director of Nursing confirmed that the staff had not attempted non-pharmacological interventions prior to administering 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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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, resident and staff interview, it was determined that the facility failed to ensure that appropriate assistance with grooming and personal hygiene was provided to two of four sampled residents who required assistance from staff to complete activities of daily living (ADLs). (Residents 51, 144) Findings include: Clinical record review revealed that Resident 51 had diagnoses that included other specified disorders of muscle and acute osteomyelitis (infection in the bone) of the right ankle and foot, and polyneuropathy (malfunction of the peripheral nerves affecting the skin, muscles, and organs). The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident had no cognitive impairment and required assistance with activities of daily living (ADLs). Review of the care plan revealed that the resident required assistance with ADLs, including bathing, dressing, hygiene, and grooming. On December 7, 2025, at 12:06 p.m., the resident was observed in bed. His fingernails were long and dirty. On December 8, 2025, at 1:19 p.m., the resident was observed with his nails in the same condition. In an interview at that time, Resident 51 stated he would like his nails to be trimmed and cleaned, and staff had not offered to do them. There was no documented evidence that staff offered to assist Resident 51 with trimming and cleaning his nails. Clinical record review revealed that Resident 144 had diagnoses that included chronic myeloproliferative disease (a group of blood cancers where the bone marrow overproduces too many red blood cells, platelets, or white blood cells) and chronic obstructive pulmonary disease. The MDS assessment dated [DATE], indicated that the resident had no cognitive impairment and required assistance with ADLs. Review of the care plan revealed that the resident required assistance with ADLs, including bathing, dressing, hygiene, and grooming. On December 7, 2025, at 11:41 a.m., the resident was observed in bed. His fingernails were long and dirty. On December 8, 2025, at 12:08 p.m., the resident was observed with his nails in the same condition. In an interview at that time, Resident 144 stated he would like his nails to be trimmed and cleaned, and staff had not offered to do them. There was no documented evidence that staff offered to assist Resident 144 with trimming and cleaning his nails. In an interview on December 9, 2025, at 11:30 a.m., the Director of Nursing confirmed that nail care was to be done when nursing staff was providing routine care and as needed. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, resident interview, and staff interview, it was determined that the facility failed to ensure that adequate catheter care was provided for one of four sampled residents with an indwelling urinary catheter. (Resident 3) Findings include: Review of the facility policy entitled, Catheter: Indwelling Urinary-Care of, last revised September 22, 2025, revealed that staff was to provide catheter care twice per day and as needed. Catheter care included performing inspection, assessment for signs or symptoms of infection or trauma, and providing routine hygiene of cleansing the site where the catheter enters the body and the length of the catheter tubing. Clinical record review revealed that Resident 3 had diagnoses that included a blockage in his bladder, chronic kidney disease, and diabetes. Review of the Minimum Data Set assessment dated [DATE], revealed that the resident was alert and oriented and required the use of an indwelling suprapubic urinary catheter. On November 24, 2025, a nurse noted that the resident was transferred to the hospital for a change in condition. At that time, physician's orders that staff change the catheter monthly and as needed for blockages, cleanse the catheter daily and every eight hours as needed, flush the catheter daily, empty and maintain the catheter each shift were discontinued. On November 26, 2025, the resident returned to the facility. A nursing note dated November 28, 2025, indicated Resident 3's urinary catheter was intact. No new orders for catheter care were obtained and the resident continued with a suprapubic catheter in place. There was a lack of documented evidence that catheter care was provided to the resident since November 26, 2025. In an interview on December 8, 2025, at 2:30 p.m., Resident 3 stated that suprapubic catheter care was not adequately and consistently provided by staff. In an interview on December 9, 2025, at 2:15 p.m., the Director of Nursing confirmed that there was no documented evidence that Resident 3's catheter care was provided as it should have been based on the facility policy. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, it was determined the facility failed to provide appropriate treatment and services to prevent complications of enteral feeding for one of two residents receiving nutrition via a feeding tube. (Resident 98) Findings include: Review of the facility policy entitled, Enteral Management, last revised September 22, 2025, revealed that the care plan would address the use of enteral feeding strategies that included strategies to prevent complications, and that feeding tube care would consist of securing the enteral feeding tube externally. Clinical record review revealed that Resident 98 had diagnoses that included cerebral palsy, dysphagia (difficulty swallowing), and intermittent explosive disorder (sudden bouts of impulsive, aggressive, violent behaviors or verbal outbursts). Review of the Minimum Data Set assessment dated [DATE], revealed that the resident was cognitively and visually impaired, was dependent on staff for activities of daily living, was unable to express his needs and understand others, and had an enteral feeding tube inserted into his stomach for receiving nutrition and medication. A physician's order dated July 12, 2024, directed staff to check that a StatLock (a clip that sticks to the skin designed to hold the tube in place) and an abdominal binder (a piece of fitted elastic material designed to go around the abdomen) were in place at all times, every shift, for feeding tube function. Review of the care plan revealed that the resident had potential for complications from the feeding tube due to potential for dislodgement and a history of multiple dislodgments. Interventions included use of the abdominal binder and a StatLock device for feeding tube securement. Observation on December 8, 2025, at 1:30 p.m., revealed that Resident 98 was in his wheelchair at the nurses' station with the feeding tube hanging out of the bottom of his shirt and in his lap. The feeding tube was not secured by an abdominal binder. Observation on December 9, 2025, at 11:15 a.m., revealed that Resident 98 was in bed receiving feeding through his feeding tube; his abdomen did not have a StatLock device securing the tubing to the stomach, and there was no abdominal binder in place. In an interview on December 9, 2025, at 2:16 p.m., the Director of Nursing confirmed that the StatLock and abdominal binder should have been in place. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on facility policy review, observation, and staff interview, it was determined that the facility failed to discard expired medications and properly label medications on one of four sampled medication carts. (Unit 1 East cart) Findings include: Review of the facility policy entitled, Storage of Medication, and the Appendix of Resources entitled, Medications with Shortened Expiration Dates, last reviewed on September 22, 2025, revealed that insulin glargine expires 28 days after first use and that outdated medications were to be immediately removed from stock. Further review of the policy revealed that the provider pharmacy was to dispense medications in containers that met state and federal labeling requirements that included the name of the resident and that medications were to remain in these containers and stored in a controlled environment such as a medication cart. Observation on December 9, 2025, at 8:46 a.m., revealed a vial of medication used to treat diabetes (insulin glargine 100 units/milliliter) that was opened on September 12, 2025. Licensed Practical Nurse (LPN 1) confirmed that the medication was expired. Further observation revealed a medication used to treat chronic obstructive respiratory disease (fluticasone propionate and salmeterol 250 micrograms/50 micrograms) was not in a box and did not have a prescription label on it. LPN 1 confirmed that she did not know which resident was to receive the medication. In an interview on December 9, 2025, at 1:25 p.m., the Director of Nursing confirmed that the insulin glargine had expired and should have been removed from the cart and the fluticasone propionate and salmeterol should have been in a box with a prescription label on it. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review and staff interview, it was determined that the facility failed to notify the resident and the resident's representative(s) or legal representative of all required information, including the date of transfer, the reason for transfer, the location to which the resident was transferred, their appeal rights, and the State Long-Term Care Ombudsman's information in writing upon transfer from the facility for three of four sampled residents who were transferred to the hospital. (Residents 1, 5, 8) Findings include: Clinical record review revealed that Resident 1 was transferred to the hospital on October 18, 2025, after a change in condition. There was no documented evidence that the resident, the resident's responsible party, or the legal representative was provided information regarding the location to which the resident was transferred, appeal rights, State Long-Term Care Ombudsman information, and agency information pertaining to protection of individuals with a mental disorder, and that the facility provided copies of the written transfer notices to a representative of the Office of the State Long-Term Care Ombudsman. Clinical record review revealed that Resident 5 was transferred to the hospital eight times on September 3 and 13, 2025, October 10, 12, and 24, 2025, November 20 and 30, 2025, and December 12, 2025, after changes in condition. There was no documented evidence that the resident, the resident's responsible party, or the legal representative was provided information regarding appeal rights, State Long-Term Care Ombudsman information, and agency information pertaining to protection of individuals with developmental disabilities, and that the facility provided copies of the written transfer notices to a representative of the Office of the State Long-Term Care Ombudsman for all transfers. Additionally, six of the eight transfer notices for Resident 5 did not include the date, the reason for transfer, and the location to which the resident was transferred. Clinical record review revealed that Resident 8 was transferred to the hospital on June 13 and 25, 2025, August 25, 2025, and October 8, 2025, after changes in condition. There was no documented evidence that the resident, the resident's responsible party, or the legal representative was provided information regarding appeal rights, State Long-Term Care Ombudsman information, and agency information pertaining to protection of individuals with developmental disabilities, and that the facility provided copies of the written transfer notices to a representative of the Office of the State Long-Term Care Ombudsman for all transfers. Additionally, two of the four transfer notices for Resident 8 did not include the date, the reason for transfer, and the location to which the resident was transferred. In an interview on December 9, 2025, at 12:55 p.m., the Administrator confirmed that the notifications of transfer were incomplete. 28 Pa. Code 201.14(a) Responsibility of licensee.		