STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395916	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kirkland Village	One Kirkland Village Circle 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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 facility policy review, clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to provide the necessary supervision to monitor a resident's location and prevent an elopement (unauthorized departure from the facility) for one of five sampled residents (Resident 1), This failure resulted in an Immediate Jeopardy situation. The incident has been identified as past non-compliance. Findings include: Review of the facility policy entitled, Elopement, last reviewed on December 29, 2025, revealed that staff were to monitor residents to prevent elopement. Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], and had diagnoses that included infection and inflammatory reaction due to an indwelling catheter (a tube inserted into the bladder to drain urine), abnormalities of gait and mobility, and muscle weakness. According to the Minimum Data Set assessment (MDS, a periodic evaluation of resident care needs) dated January 28, 2026, the resident had memory impairment and required partial assistance to walk. According to the current care plan, the facility identified that the resident could walk with a front wheeled walker and assistance from one staff member. Nursing documentation indicated that on February 14, 2026, a nurse noted that Resident 1's family informed the facility that they could not locate Resident 1 when they came for a visit at 11:44 a.m. Review of facility documentation, dated February 14, 2026, revealed that the resident was located at 12:30 p.m. in the parking garage of the [NAME] Independent Living Apartments, which is not part of the skilled nursing units. It is located at the opposite end of a connected building. Emergency 911 was called and Resident 1 was taken to the hospital for evaluation. Review of the facility investigation revealed that Resident 1 was last seen by staff at 10:00 a.m. walking in the hall of the skilled nursing facility. The investigation revealed that Resident 1 was found lying on the concrete garage floor, stating he was cold, with skin tears on his left foot/toes, left leg, and both elbows and dried blood on the back of his head. The resident also had a scalp laceration (cut) that required two staples. The facility was not aware of Resident 1's location or that he had left the facility for one hour and 45 minutes. In an interview on February 18, 2026, at 10:30 a.m., the Administrator stated that they believed Resident 1 exited through the unmonitored, unlocked doors to the Independent Living section of the building and made his way down the hall to the elevator that led to the parking garage. There was no evidence that the doors to exit the skilled nursing facility were alarmed, locked, or monitored, and residents at risk for elopement had access to this area. On February 18, 2026, at 12:27 p.m., the Administrator was notified that the failure to provide adequate supervision to prevent elopements constituted an Immediate Jeopardy situation at F689-J, and the Immediate Jeopardy template was provided. The facility was informed that a corrective action plan was required. The facility identified the jeopardy at the time of the incident, February 14, 2026, at 11:44 a.m., and implemented the following corrective action plan: 1. Resident 1 was assessed by a licensed nurse and sent to the hospital for (continued on next page)

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	evaluation.2. All facility residents had a new elopement assessment completed on February 14, 2026. All residents at risk for elopement were communicated to staff and had their care plans/interventions updated on February 14, 2026.3. All safety devices were checked to ensure they were in place, including electronic devices applied to at risk residents to prevent doors from opening (Wander Guard system). 4. An audit was conducted on February 14, 2026, of all skilled nursing community exits.5. On February 14, 2026, a staff member was placed to observe any exits that are not locked at all times until the facility's vendor completes the installation of new locking mechanisms.6. All staff were re-educated on February 14 and 15, 2026 on the elopement policy and that staff must monitor the exit doors at all times until the locking mechanisms are installed.7. The Director of Nursing or designee was to initiate weekly audits and report results to the QAPI (Quality Assurance, Performance Improvement) committee. The first audit was done on February 15, 2026.On February 18, 2026, a review was conducted to verify the complete implementation of the facility's corrective action plan. All staff interviewed confirmed that they received the training described in the facility's action plan. All nursing staff were aware of the requirements for supervising residents who were at risk for elopement. All facility doors and safety devices (Wander Guards) were checked and were functioning properly. Staff was observed monitoring exit doorways. All sampled residents were being supervised by staff when needed. All training was completed by February 15, 2026. The Immediate Jeopardy existed on February 14, 2026, from 11:44 a.m. until February 15, 2026, at 6:30 p.m. Verification of all elements of the action plan was completed on February 18, 2026, at 1:00 p.m., and the Immediate Jeopardy was officially lifted effective February 15, 2026. The Nursing Home Administrator and the Director of Nursing were informed that residents were no longer considered to be in immediate jeopardy. 28 Pa. Code 201.18(b)(1)(3) Management.28 Pa. Code 211.10(d) Resident care policies.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.