

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395916	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER Kirkland Village		STREET ADDRESS, CITY, STATE, ZIP CODE 2335 Madison Avenue 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45125</p> <p>Based on policy review, clinical record review, and staff interview, it was determined that the facility failed to notify a resident's responsible party of a significant weight loss for one of 12 sampled residents. (Resident 11)</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Change in Medical Condition, dated August 29, 2024, revealed that staff were to provide timely notification to the resident's representative of significant changes to the resident's physical status.</p> <p>Clinical record review revealed that Resident 11 had diagnoses that included dementia, adult failure to thrive, and dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had severe cognitive impairment. Review of the resident's weights revealed that on July 4, 2024, the resident weighed 146 pounds (lbs). On August 13, 2024, Resident 11 weighed 124.6 lbs, which was confirmed with a reweigh. On August 19, 2024, Resident 11 weighed 125 lbs. This reflected a 14 percent weight loss in one month. There was no documented evidence that Resident 11's responsible party was notified of the significant weight loss.</p> <p>In an interview on September 12, 2024, at 12:07 p.m., the Administrator confirmed that there was no documented evidence that Resident 11's responsible party was notified of the significant weight loss.</p> <p>Pa. Code 201.29(c) Resident rights.</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>45125</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that physician's orders were implemented for one of 12 sampled residents. (Resident 20)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 20 had diagnoses that included chronic kidney disease and heart failure. On June 14, 2024, a physician ordered that staff obtain a daily weight for the resident. A review of Resident 20's weights revealed that there was no documented evidence to support a weight was obtained on September 5, 6, 7, and 8, 2024.</p> <p>In an interview on September 12, 2024, at 11:10 a.m., the Administrator confirmed there was no documentation to support that weights were obtained by staff or refused by Resident 20 on the previously mentioned dates.</p> <p>CFR 483.25 Quality of Care</p> <p>Previously cited 10/26/23</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45125</p> <p>Based on facility policy review, staff interview, and clinical record review, it was determined that the facility failed to adequately monitor and assess a significant weight change for one of 12 sampled residents. (Resident 11)</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Nutrition Risk Identification, last reviewed August 29, 2024, revealed that the nursing or dietary department would identify residents with a weight loss of five percent total body weight in a 30 day period and a dietician would complete a nutritional evaluation and recommend any changes needed to aid the resident's return to optimal nutritional status. In an interview on September 12, 2024, at 12:10 p.m., the Administrator stated that nursing staff were to obtain a resident's weight and relay any changes to the dietitian.</p> <p>Clinical record review revealed that Resident 11 had diagnoses that included dementia, adult failure to thrive, and dysphagia (difficulty swallowing). Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had severe cognitive impairment. Review of the current care plan revealed that Resident 11 was at nutritional risk with an intervention for staff to monitor weights. Review of the resident's weights revealed that on July 4, 2024, the resident weighed 146 pounds (lbs). On August 13, 2024, Resident 11 weighed 124.6 lbs, which was confirmed with a reweigh. On August 19, 2024, Resident 11 weighed 125 lbs. There was no documented evidence that the dietitian addressed the significant weight loss.</p> <p>In an interview on September 12, 2024, at 12:07 p.m., the Administrator confirmed that there was no documented evidence that the dietitian addressed the significant weight loss.</p> <p>28 Pa. Code 211.10(a)Resident care policies.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5)Nursing services.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48578</p> <p>Based on facility policy review, clinical record review, observation, and staff interview, it was determined that the facility failed to implement transmission based droplet precautions and use of personal protective equipment (PPE) to prevent the spread of infection for two of 12 sampled residents. (Residents 15, 23)</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Covid-19 PPE Policy, last reviewed on August 29, 2024, revealed that staff was to wear cleanable or disposable eye wear, non-sterile, disposable isolation gowns, respirator type face masks, and gloves, which were donned and doffed when entering and exiting patients' room and were not to be reused. Review of the facility policy entitled, Droplet Precautions, last reviewed on August 29, 2024, revealed that staff were to clean their hands before entering and when exiting the room, to make sure eyes, nose, and mouth were fully covered before room entry, and to remove face protection before exiting the room.</p> <p>Clinical record review revealed that Resident 15 tested positive for Coronavirus disease 2019 (COVID-19) on September 1, 2024. Review of the care plan revealed that Resident 15 had a recently confirmed case of COVID-19, and that staff were to follow droplet isolation precautions that included gown, gloves, eye protection and an N95 grade respirator. Observation on September 11, 2024, at 10:01 a.m., revealed a food server (S1) entered Resident 15's room while wearing a surgical face mask. S1 did not have on the required PPE and did not remove her face mask when she exited the room at 10:06 a.m. . On September 11, 2024, at 10:08 a.m., Registered Nurse (RN1) was observed entering Resident 15's room for six minutes wearing a surgical face mask. RN1 did not have on the required PPE. RN1 was observed giving the resident her medications and exiting the room at 10:14 a.m RN1 did not remove her face mask when she exited the room.</p> <p>Clinical record review revealed that Resident 23 had tested positive for COVID-19 on September 10, 2024, and was on droplet precautions. Review of the care plan revealed that Resident 23 had a recently confirmed case of COVID-19, and staff were to follow droplet isolation precautions. On September 11, 2024, at 9:58 a. m., RN1 was observed entering Resident 15's room while wearing a surgical face mask. RN1 did not have on the required PPE. RN1 was observed giving the resident her medication and exiting the room at 10:03 a. m . RN1 did not remove her face mask when she exited the room.</p> <p>In an interview on September 11, 2024, at 2:47 p.m., the Administrator confirmed that droplet and COVID-19 PPE precautions should have been implemented and the policies were not being followed by staff.</p> <p>28 Pa. Code 211.10(d) Resident care policies.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		