STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396053	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Meadows Nursing Center of Bethlehem	4025 Green Pond Road Bethlehem, PA 18020

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, staff and resident interviews, clinical record review, and review of electronic call bell logs, it was determined that the facility failed to answer call bells in a timely manner to provide care and services respectful of each resident's dignity and preferences to promote the quality of life for three of 17 sampled residents. (Residents 1, 25, and 28)Findings include: Review of the facility's policy entitled Call Lights: Accessibility and Timely Response,” dated April 29, 2025, revealed that staff were responsible for responding to a call light in a reasonable amount of time. In an interview on July 31, 2025, at 8:45 a.m., the Nursing Center Operations Manager confirmed the expected call bell response time was within 15 minutes. Clinical record review revealed that Resident 1 had diagnoses that included pneumonia, muscle weakness, and difficulty walking. The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident was able to communicate his needs to staff and required assistance from staff for activities of daily living, such as toileting and dressing. Review of the care plan revealed that Resident 1 had physical limitations and was at risk for falls. The interventions included that staff ensure the call bell was within reach and encourage use of the call bell for assistance. In an interview on July 29, 2025, at 1:05 p.m., Resident 1 stated that staff took a long time to answer call bells which had affected his ability to receive care and services in a timely manner. Clinical record review revealed that Resident 25 had diagnoses that included cerebral infarction (stroke), hemiplegia and hemiparesis affecting left non-dominant side, and urinary tract infection. The MDS assessment dated [DATE], indicated that the resident was able to communicate his needs to staff and required assistance from staff for activities of daily living, such as toileting and dressing. Review of the care plan revealed that Resident 25 had physical limitations and was at risk for falls. The interventions included that staff encourage the use of the call bell for assistance. In an interview with Resident 25 on July 29, 2025, at 10:00 a.m., Resident 25 stated that he sometimes had to wait over an hour for staff to answer his call bells which had affected his ability to receive care and services in a timely manner. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clinical record review revealed that Resident 28 had diagnoses that included congestive heart failure, muscle weakness, and chronic kidney disease. The MDS assessment dated [DATE], indicated that the resident was able to communicate her needs to staff and was dependent on staff assistance for all activities of daily living such as toileting and dressing. Review of the care plan revealed that Resident 28 had physical limitations and was at risk for falls. The intervention included that staff ensure the call bell was within reach and encourage use of the call bell for assistance. In an interview on July 20, 2025, at 11:24 a.m., Resident 28 stated that staff took a long time to answer call bells which had affected her ability to receive care and services in a timely manner. Review of the facility form entitled, [NAME]-CARE Report, for Residents 1, 25, and 28, revealed that from July 15 through July 21, 2025, and July 24 through July 29, 2025, there were 16 occurrences when the call bell response time exceeded 15 minutes, and the call bell response time was between 19 to 91 minutes. During an interview on July 31, 2025, at 10:45 a.m., the Nursing Center Operations Manager confirmed the previously mentioned residents waited more than the expected response time of 15 minutes. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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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, review of facility documentation, and staff interview, it was determined that the facility failed to develop and implement a comprehensive care plan that addressed each resident's needs as identified in the comprehensive assessment for two of 17 sampled residents. (Residents 5, 25) Findings include: Clinical record review revealed that Resident 5 had diagnoses that included dementia, major depression disorder, and chronic kidney disease. The Minimum Data Set (MDS) assessment dated [DATE], noted that the resident had severely impaired cognition, had impaired communication abilities, was frequently incontinent of urine and required substantial assistance with toileting hygiene. The MDS Care Area Assessment (CAA) summary dated June 28, 2025, noted that the resident’s communication and urinary incontinence were to be addressed in the care plan. There was no documented evidence that interventions to address Resident 5’s communication or urinary incontinence were addressed in the current care plan. Clinical record review revealed that Resident 25 had diagnoses that included cerebral infarction (stroke), hemiplegia and hemiparesis affecting left non-dominant side, and urinary tract infection. The MDS assessment dated [DATE], noted that the resident had urinary incontinence. The MDS CAA summary dated May 23, 2025, noted that the resident’s urinary incontinence was to be addressed in the care plan. There was no documented evidence that interventions to address Resident 25’s urinary incontinence were included in the current care plan. In an interview on July 31, 2025, at 8:43 a.m., the Nursing Center Operations Manager confirmed the identified care areas were not addressed in the care plans. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on facility policy review, clinical record review, and staff interview, it was determined that the facility failed to implement physician's orders for two of 17 sampled residents. (Residents 7 and 25)Findings include: Review of the policy entitled Elimination Bowel Protocol, last reviewed April 29, 2025, revealed that the day shift (7:00 a.m. to 3:00 p.m.) and evening shift (3:00 p.m. to 11:00 p.m.) and medication nurses will check the bowel movement documentation in the electronic medical record (EMR). If no bowel movement had occurred in the past three days, the day shift medication nurse was to administer prune juice to the resident. If no bowel movement had occurred by the evening shift after administration of the prune juice, the evening shift medication nurse was to administer 30 milliliters (ml) of Milk of Magnesia as ordered by the physician. If no bowel movement had occurred by the next day on the evening shift, then the medication nurse was to administer a Dulcolax suppository as ordered by the physician. If the resident had no bowel movement by the next morning, the medication nurse would contact the physician for further orders. Clinical record review revealed that Resident 7 had diagnoses that included Parkinson's disease and age-related osteoporosis (weak bones). The physician's orders dated February 8, 2025, directed the staff to administer Milk of Magnesia and a suppository for constipation as needed. Review of the care plan revealed Resident 7 had the potential for constipation and instructed the facility to follow bowel protocol for bowel management. Review of facility documentation revealed that Resident 7 did not have a bowel movement (BM) July 3 through 7, 2025. There was no documented evidence that staff administered Milk of Magnesia on the third day without a BM, July 6, 2025, per the facility policy. Resident 7 did not have a BM July 13 through July 15, 2025. Resident 7 received Milk of Magnesia on July 16, 2025, which was ineffective. On July 17, 2025, Resident 7 received another dose of Milk of Magnesia and no suppository. In an interview on July 31, 2025, at 1:40 p.m., the Director of Nursing confirmed that Milk of Magnesia should have been given on July 6, 2025, per the bowel protocol and a suppository should have been given on July 17, 2025.Review of the facility policy entitled Medication Ordering and Receiving from Pharmacy, last reviewed on April 29, 2025, revealed that the nurse was not to take a medication from the emergency box (e-box) without checking allergies on the medical record and possible drug interactions with the pharmacist.Clinical record review revealed that Resident 25 had diagnoses that included cerebral infarction (stroke), essential hypertension, and heart disease. On May 19, 2025, the physician noted that Resident 25 had an allergy to metoprolol (a medication for high blood pressure). Review of the resident's medication administration records for May and July of 2025, revealed an allergy to metoprolol. Review of care plan revealed an allergy to Metoprolol. On June 30, 2025, staff noted that Resident 25 was experiencing tachycardia (rapid heart rate). The physician ordered staff to administer metoprolol which was to be obtained from the e-box. Clinical record review revealed that Registered Nurse (RN) 1 administered metoprolol. There was no evidence that RN 1 verified the resident's allergies upon pulling the medication from the e-box or prior to administration. After the medication was administered, RN 1 noted Resident 25's allergy to metoprolol and the resident was sent to the hospital for evaluation.In an interview on July 30, 2025, at 1:05 p.m., the DON confirmed that the nurse did not contact the pharmacy prior to retrieving the Metoprolol from the e-box and failed to determine if Resident 25 had an allergy to Metoprolol by checking the medical record as directed by facility policy.28 Pa. Code Resident Care Policies (a)(d)28 Pa. Code 211.12(d)(1)(5) Nursing services.