

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396077	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2025
NAME OF PROVIDER OR SUPPLIER Northampton Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 4100 Freemansburg Avenue 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>45840</p> <p>Based on observation and resident and staff interview, it was determined that the facility failed to ensure that meals were served in a manner that maintained each resident's dignity for one of 34 sampled residents. (Resident 138)</p> <p>Findings include:</p> <p>Observations of the lunch meal on the 2nd floor nursing unit on April 23, 2025, at 12:30 p.m., revealed Residents 32, 96, 99, 102, 138, and 143 were seated in the dining room. At 12:32 p.m., Residents 32, 96, 99, 102, and 143 were served and were eating their meals. Resident 138 was observed without a meal, throwing his hands in the air, and making comments including, What do you have to do to get food around here? Resident 138 was not served his lunch tray until 12:55 p.m.</p> <p>In an interview on April 25, 2025, at 9:18 a.m., the Director of Nursing confirmed that all residents in the dining room should be served a meal at the same time.</p> <p>28 Pa. Code 201.29(a) 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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45840</p> <p>Based on clinical record review, observation, resident interview, and staff interview, it was determined that the facility failed to ensure that a call bell was accessible for one of 34 sampled residents. (Resident 471)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 471 was admitted on [DATE], with a diagnosis of a recent stroke. A nursing note from the date of admission indicated that Resident 471 was alert, oriented, was able to make his needs known, had very little control of his left leg, and had no control of his left arm. Review of the care plan indicated Resident 471 was at risk for falls related to an acute stroke. There was an intervention for staff to be sure the call bell was within reach and provide reminders to use the call bell for assistance.</p> <p>On April 22, 2025, at 12:15 p.m., April 23, 2025, at 8:50 a.m. and 12:10 p.m., the resident was observed sleeping in his bed. The call bell was on the nightstand to the right side of the bed and was out of the resident's reach.</p> <p>On Thursday, April 24, 2025, at 10:45 a.m., the call bell was on the floor on the right side of the bed and the resident was sleeping. Later that same day, at 2:30 p.m., the call bell was on floor on the right side of the bed, and the resident was awake and talking with a visitor.</p> <p>In an interview on April 24, 2025, at 2:31 p.m., Resident 471 stated he could not find the call bell, that he could not use it because it kept falling off of the bed, and that he was relying on his roommate to ring for him whenever he needed help.</p> <p>In an interview on April 24, 2025, at 2:35 p.m., the Unit Manager stated the call bell should be clipped to the Resident's bed at all times.</p> <p>In an interview on April 25, 2025, at 9:28 a.m., the Director of Nursing confirmed the call bell should have been accessible and clipped to the bed.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45840</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment was completed to accurately reflect the resident's current status for one of 34 sampled residents. (Resident 147)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 147 had diagnoses that included non-traumatic subarachnoid hemorrhage (bleeding in the space around the brain), torticollis (a condition in which the muscles of the neck contract causing the head to twist and tilt to one side), and left hemiplegia (weakness on one side of the body). Review of the occupational therapy evaluation dated December 19, 2024, revealed that the resident had impairments with strength and range of motion in the left upper extremity. The MDS assessment dated [DATE], did not identify the resident as having an upper extremity impairment in functional limitation in range of motion on one side under section GG, Functional Status.</p> <p>In an interview on April 25, 2025, at 9:37 a.m., the Administrator stated that the assessment did not identify the upper extremity impairment and that the MDS was not coded to accurately reflect the resident's current status.</p>		

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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>45840</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to implement physician's orders for one of 34 sampled residents. (Residents 19)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 19 had diagnoses that included end stage renal disease and heart failure. A physician's order dated April 15, 2025, directed staff to administer a medication (midodrine) three times a day for hypotension (low blood pressure). Staff was not to administer the medication if the resident's systolic blood pressure (SBP, the first measurement of blood pressure when the heart beats and the pressure is at its highest) was greater than 130 millimeters of mercury (mm/Hg). Review of Resident 9's medication administration record revealed that staff administered the medication on April 16, 18, and 21, 2025, when the resident's SBP was greater than 130 mm/Hg.</p> <p>In an interview on April 25, 2025, at 10:05 a.m., the Director of Nursing confirmed that the medication was documented as administered outside of the established parameters for Resident 19.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45840</p> <p>Based on clinical record review, observation, and resident and staff interview, it was determined that the facility failed to implement interventions to prevent further decline and/or improve range of motion for one of nine sampled residents with limited range of motion. (Resident 147)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 147 had diagnoses that included non-traumatic subarachnoid hemorrhage (bleeding in the space around the brain), torticollis (a condition in which the muscles of the neck contract causing the head to twist and tilt to one side), and left hemiplegia (weakness on one side of the body). The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident had no cognitive impairment and was dependent on staff for personal hygiene and dressing. Review of the occupational therapy evaluation dated December 19, 2024, indicated that the resident had no functional limitations present due to contracture. Review of the occupational therapy discharge summary from January 27, 2025, revealed no discharge recommendations or restorative nursing program. The occupational therapy evaluation dated March 25, 2025, indicated that the resident had a functional limitation present due to contracture. Observations on April 22, 2025, at 11:31 a.m., April 23, 2025, at 9:15 a.m., and April 24, 2025, at 12:40 p.m., revealed that the resident was in a reclining chair with her left hand and wrist slightly contracted. In an interview at that time, the resident stated that her hand had gotten worse and she had difficulty moving her hand.</p> <p>In an interview on April 25, 2025, at 11:06 a.m., Occupational Therapist 1 confirmed that the resident had a decline in range of motion in the left upper extremity since the last assessment with no interventions put in place.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>48578</p> <p>Based on facility policy review, clinical record review, observations, and staff interview, it was determined that the facility failed to ensure that adequate catheter care was provided for one of three sampled residents with an indwelling urinary catheter. (Resident 106)</p> <p>Findings included:</p> <p>Review of the facility policy entitled, Catheter Care, Urinary, last reviewed November 1, 2024, revealed that a urinary drainage bag was to be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.</p> <p>Clinical record review revealed that Resident 106 had diagnoses that included urinary obstruction and enlarged prostate. On April 2, 2025, the physician ordered for the resident to have a foley catheter every shift. The care plan directed staff to keep the catheter below the level of the bladder. On April 22, 2024, from 12:45 p.m. to 2:00 p.m., Resident 106 was observed sitting in his recliner in the dining room and then across from the nurses' station with the catheter drainage bag hanging on the armrest of his recliner chair, which was above the level of his bladder. Urine was observed in the catheter tubing that hung over the arm rest. On April 23, 2025, from 9:00 a.m. to 10:15 a.m., Resident 106 was observed sitting in a recliner chair at the nurses' station with the catheter drainage bag hanging on the armrest of the recliner chair, which was above the level of the resident's bladder.</p> <p>In an interview on April 25, 2025, at 9:33 a.m., the Director of Nursing confirmed that the catheter drainage bag should have been maintained below the bladder at all times.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45840</p> <p>Based on clinical record review, observation, and staff interview, it was determined that the facility failed to provide enteral nutrition (delivery of nutrition by a feeding tube) in accordance with the physician's order for one of two sampled residents receiving nutrition by a feeding tube. (Resident 58)</p> <p>Findings include:</p> <p>Clinical record review revealed that Resident 58 had diagnoses that included history of a brain injury, a seizure disorder, and was a quadriplegic. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed that the resident was dependent on staff for activities of daily living and was unable to express needs or understand others. Further review of the MDS assessment revealed that the resident received more than 51 percent of nutrition through an enteral feeding tube. A physician's order dated May 28, 2024, directed staff to administer Jevity 1.2 (a tube feeding formula) at a rate of 55 milliliters (ml) per hour starting at 8:00 p.m., and to continue until a total volume of 935 ml was infused. On April 24, 2025, at 10:19 a.m., the resident was observed in bed. A bottle of tube feed formula was on the pole and its label indicated it was started on April 23, 2025, at 9:35 p.m. The tube feeding was not connected to the resident and the tube feeding pump was turned off. Only 300 ml was infused when observed. In an interview on April 24, 2025, at 10:25 a.m., Licensed Practical Nurse 1 (LPN 1), stated that the tube feed was typically started on night shift as ordered and was infused until 1:00 p.m. LPN 1 had not disconnected the tube feed during her shift which had begun that day at 7:00 a.m.</p> <p>In an interview on April 25, 2025, at 9:40 a.m., the Director of Nursing confirmed the tube feeding had been stopped for care and had not been resumed as ordered.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing services.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>48108</p> <p>Based on facility policy review, resident interviews, observation, and results of a test tray evaluation, it was determined that the facility failed to provide food that was palatable and at an appetizing temperature on one of three nursing units. (Second floor)</p> <p>Findings include:</p> <p>Review of the facility's Policy Manual Chapter 3: Food Production and Food Safety, dated November 1, 2024, revealed that fish, poultry, meat, pork and unpasteurized shell eggs should be cooked to a minimum temperature of 165 degrees Fahrenheit (F) for a minimum of 15 seconds and served at a temperature between 145 and 165 degrees F.</p> <p>In interviews on April 22, 2025 at 09:50 a.m. through 11:00 a.m., Residents 29, 70 116, and 117 stated that food was often served undercooked and cold.</p> <p>A test tray conducted on April 22, 2025, at 1:21 p.m., on the Second floor nursing unit after the last resident meal tray was served from the dining cart, revealed the baked breaded fish was 140 degrees F. The center of the fillet was liquid, cold to touch, and unpalatable.</p> <p>In an interview on April 22, 2025, at 1:21 p.m., the Dietary Manager confirmed the item did not meet the policy guidelines for the preparation and serving of hot foods.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p>		