STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396077	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton Post Acute	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, observation, and resident interview, it was determined that the facility failed to provide a safe, sanitary, and comfortable environment for residents and staff on one of three nursing units. (Unit 1) Findings include: Review of the facility policy entitled, Oxygen Storage, last reviewed on January 16, 2026, revealed that oxygen cylinders were to be stored in racks with chains, sturdy portable carts, or approved stands, were never to be left free-standing, and were not to be stored in any resident room or living area. Observations in resident room [ROOM NUMBER] on May 7, 2026, at 8:30 a.m., 10:30 a.m., and 1:05 p.m., revealed an unsecured oxygen tank standing in the corner of the room. Observations on May 5, 2026, between 1:55 p.m. and 2:10 p.m. and May 6, 2026, between 9:30 a.m. and 10:05 a.m. revealed the following: In the shower room on unit one, there were broken tiles on the walls of two shower stalls. In resident room [ROOM NUMBER]-B, an oxygen concentrator had dust and black hair on the top front cover, the concentrator filter was coated with a white substance, and the wallpaper behind the concentrator was torn. In resident room [ROOM NUMBER], the floor had a sticky substance with dust, paper and food debris. In an interview on May 7, 2026, at 8:30 a.m., the Nursing Home Administrator (NHA) confirmed that the identified environmental issues should have been addressed. In an interview on May 7, 2026, at 2:45 p.m., the NHA confirmed that the oxygen tank should not have been stored in the resident's room. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(e)(2.1) Management.

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 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 observation, clinical record review, and staff interview, it was determined that the facility failed to implement interventions to meet a resident's medical and physical needs for one of 35 sampled residents. (Residents 18)Findings include: Clinical record review revealed that Resident 18 was admitted to the facility on [DATE], and had diagnoses that included Alzheimer's disease with late onset, dementia, type two diabetes mellitus, peripheral vascular disease, and a history of falls. Review of the Minimum Data Set assessment dated [DATE], revealed Resident 18 required substantial to maximal assistance from staff for upper body dressing and was at risk for developing pressure ulcers. Review of Resident 18's care plan revealed he had skin breakdown related to impaired mobility, was at risk for spills and burns from hot liquids, and was dependent on staff for dressing, personal hygiene, and bathing. The care plan goal was to reduce the risk for skin breakdown with interventions that included for staff to apply Geri-Sleeves (cotton-blend Lycra arm sleeves that provide skin protection) with morning care and to remove them at bedtime. Observations on May 7, 2026, at 11:50 a.m. and 1:51 p.m., and May 8, 2026, at 11:35 a.m., revealed Resident 18 was wearing short-sleeved shirts without the Geri-Sleeves. There was no documentation that the resident refused wearing the Geri-Sleeves. During an interview on May 7, 2026, at 2:10 p.m., the nurse unit manager, RN 2, confirmed that Resident 18 should have had the Geri-Sleeves applied. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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, observation, and staff interview, it was determined that the facility failed to follow procedures to prevent accident hazards for one of 35 sampled residents. (Resident 162)Findings include: Review of the facility policy on Sharps Disposal, dated January 16, 2026, revealed that contaminated sharps will be discarded immediately and into closable, puncture resistant containers. Clinical record review revealed that Resident 162 had diagnoses that included cognitive communication deficit, acute embolism (when a blood clot travels and settles in another location) and thrombosis of unspecified vein (the formation of a blood clot in blood vessels, partially or completely blocking blood flow), anemia (a deficiency of healthy red blood cells), hypokalemia (low potassium levels, and other symptoms and signs involving cognitive functions and awareness. A Social Services assessment dated [DATE], revealed that Resident 162 had impaired cognition. Clinical record review revealed that Resident 162 was receiving an anticoagulant medication (a medication to prevent blood clots). Observation on May 5, 2026, at 11:00 a.m., revealed an uncapped disposable razor on the bedside table. Observation on May 5, 2026, at 12:50 p.m., revealed the razor in the waste basket beside the resident's bed. At 12:55 p.m., the unit manager, Registered Nurse 1, stated that it was not disposed of properly. In an interview on May 5, 2026, at 1:00 p.m., the Nursing Home Administrator confirmed that the facility policy was not followed and the razor should have been disposed of in a puncture resistant container. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, clinical record review, and staff interview, it was determined that the facility failed to maintain a medication error rate of less than five percent (%) for one of two nursing units observed during medication administration. (Unit 1)Findings include: Observations of medication administration on May 6, 2026, from 8:05 a.m. to 8:20 a.m., revealed 27 medication opportunities with two medication errors that resulted in a medication administration error rate of 7.41%. Clinical record review revealed that Resident 53 had diagnoses that included heart disease, high blood pressure, and thrombosis in a deep vein of the lower extremity (the formation of a dangerous blood clot in a vein of the leg). A review of the physician's orders dated December 24, 2025, revealed that staff was to administer an enteric coated (a polymer barrier coating on an oral tablet or capsule that prevents it from dissolving in the stomach's acidic environment) medication used to prevent blood clot formation (aspirin) and a combination medication used to treat constipation (senna-docusate sodium oral tablet 8.6 milligrams (mg)-50 mg). Observation revealed that Licensed Practical Nurse 1 administered a chewable aspirin (a form that did not have an enteric coating) and a senna 8.6 mg tablet, which should have been senna 8.6 mg-docusate sodium 50 mg tablet. In an interview on May 7, 2026, at 8:30 a.m., the Nursing Home Administrator confirmed that the two medication administration errors occurred. 28 Pa. Code 211.12(d)(1)(5) Nursing services.