

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395476	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER Northampton County-Gracedale		STREET ADDRESS, CITY, STATE, ZIP CODE Gracedale Avenue Nazareth, PA 18064	

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 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, review of facility documentation, and resident interview, it was determined that the facility failed to ensure that residents were free from physical and/or mental abuse for three of 10 sampled residents. (Residents 1, 2, 3)</p> <p>Findings include:</p> <p>Review of the facility policy entitled, Abuse Prevention Program/Abuse Free Environment, last reviewed March 24, 2025, revealed that residents had the right to be free from abuse.</p> <p>Clinical record review revealed that Resident 1 had diagnoses that included anxiety, depression, and mild intellectual disabilities. Review of the Minimum Data Set (MDS) assessment (a periodic assessment of resident care needs) dated May 28, 2025, revealed that the resident had cognitive impairment.</p> <p>Clinical record review revealed that Resident 2 had diagnoses that included diabetes (disease that affects the way the body uses blood sugar) and chronic obstructive pulmonary disease (lung condition). Review of the MDS assessment dated [DATE], revealed that the resident had no cognitive impairment.</p> <p>Clinical record review revealed that Resident 3 had diagnoses that included hemiplegia and hemiparesis (paralysis), insomnia (difficulty sleeping) and palpitations (irregular heart beats). Review of the MDS assessment dated [DATE], revealed that the resident had no cognitive impairment.</p> <p>Review of facility documentation dated June 23, 2025, revealed that the facility received a phone call from 911 (emergency call center designed to provide immediate assistance in emergencies) around 3:00 a.m. and alerted staff to go to room A3 on the Tower 7 nursing unit. In written statements dated June 23, 2025, Registered Nurses 1, 2, and 3 noted that upon opening the door to the room, License Practical Nurse (LPN) 1 was observed in full personal protective equipment (PPE) standing near Resident 1, tapping the resident on the chest and back, and sticking her fingers in the resident's mouth. There were blood stained wash cloths on the floor. Residents 2 and 3 were present in the room and shouting for help.</p> <p>(continued on next page)</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In a written statement dated June 23, 2025, Nurse Aide (NA) 2 stated that LPN 1 entered Resident 1's room (A3, Tower 7) at approximately 1:00 a.m. to provide care to Resident 1 while NA 2 was attending to other residents in the room. LPN 1 remained in the room after NA 2 left. NA 2 also stated that around 2:45 a.m., the call bell to the room was activated and when she went to respond, LPN 1 slammed the door in her face and told her to get out. There was no evidence that NA 2 reported the incident or that staff intervened until approximately 15 minutes later when a call was received from the 911 call center.</p> <p>In a verbal statement dated June 23, 2025, Resident 2 stated that LPN 1 woke her and told her to put on a PPE gown to protect her from the demons. Resident 2 stated that LPN 1 would not allow her to leave the room or go to the bathroom. She then watched LPN 1 hit Resident 1 on the chest and back and shove wash cloths and towels down her throat. Resident 2 called 911 from her personal cell phone at that time.</p> <p>In a verbal statement dated June 23, 2025, Resident 3 stated that LPN 1 gave her a PPE gown to put on and a wet wash cloth to clean her hands. Resident 3 could see LPN 1 hitting Resident 1 on the chest and back and sticking her fingers into Resident 1's mouth. Resident 3 also stated that LPN 1 sprinkled water on her numerous times.</p> <p>Resident 1 was transferred to the emergency room (ER) for evaluation and found to have had petechial hemorrhages (tiny spots of bleeding) to the hard palate (roof of the mouth) and periorbital (around the eyes) edema (swelling). Her upper and lower lip were noted to have been swollen and a slit was noted to her lower lip. She was observed having some difficulty closing her mouth. Nursing documentation dated June 24, 2025, at 12:00 a.m., upon the resident's return from the ER, noted that Resident 1 stated, I was so scared. I thought I was going to die.</p> <p>In an interview on June 25, 2025, at 10:30 a.m., Resident 3 stated that the incident was horrific and that she had been scared.</p> <p>Based on the findings, the facility failed to ensure that Residents 1, 2, and 3 were free from physical and/or mental abuse, resulting in actual physical harm to Resident 1.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee.</p> <p>28 Pa. Code 201.18(b)(1) Management.</p> <p>28 Pa. Code 201.29(a) Resident rights.</p>		