STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395476	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton County-Gracedale	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 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 and staff interview it was determined that the facility failed to develop and/or implement a comprehensive care plan that addressed individual resident needs as identified in the comprehensive assessment for two of ten sampled residents. (Residents 1, 2)Findings include: Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], and had diagnoses that included vascular dementia, syncope and collapse (fainting), and cerebral infarction (stroke). According to the Minimum Data Set (MDS) assessment, dated August 27, 2025, the resident had memory impairment and could walk without assistance. Review of the elopement assessment dated [DATE], revealed that the resident wandered and was at risk for elopement. On August 20, 2025, a nurse noted that an alert bracelet was applied to the resident's leg. There was no documented evidence that the facility included interventions on the care plan to monitor the resident's risk for elopement, wandering behavior and the use of this device. Clinical record review revealed that Resident 2 was admitted to the facility on [DATE], and had diagnoses that included dementia, insomnia (difficulty falling or staying asleep), wandering, restlessness, and agitation. According to the MDS assessment, dated September 5, 2025, the resident was Spanish speaking and rarely understood others when spoken to in English. The MDS Care Area Assessment summary noted that the resident's communication was to be addressed in the care plan. There was no documented evidence that interventions to address Resident 2's communication barrier were included in the care plan. 28 Pa. Code 211. 12(d)(1)(3)(5) Nursing services.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395476	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton County-Gracedale	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395476	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton County-Gracedale	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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, review of facility documentation, and staff interview, it was determined that the facility failed to provide adequate supervision to monitor a resident's whereabouts and prevent an elopement (unauthorized departure from the facility) for one of ten sampled residents at risk for elopement. (Resident 2) In addition, the facility failed to provide required education to staff related to elopement prevention on nursing unit Tower 3, affecting 29 residents assessed as at risk for elopement. This failure resulted in an Immediate Jeopardy situation. Findings include: Review of the facility policy entitled, Elopements/Elopement Policy, last reviewed September 19, 2025, revealed that staff were to assure the safety and security of all residents. Review of the facility policy entitled, One to one (1:1), Behavioral Intervention, last reviewed September 19, 2025, revealed that staff would remain within arm's length or within visual sight of the resident at all times when receiving 1:1 intervention. Clinical record review revealed that Resident 2 was admitted to the facility on [DATE], and had diagnoses that included dementia, insomnia (difficulty falling or staying asleep), wandering, restlessness, and agitation. According to the Minimum Data Set assessment (a periodic evaluation of resident care needs), dated September 5, 2025, the resident had memory impairment and could walk without assistance. An elopement assessment dated [DATE], revealed Resident 2 was at risk for elopement. Review of Resident 2's care plan revealed he was at risk for elopement with interventions for 1:1 observation and a roam alert bracelet (an electronic device that prevents doors from opening and/or sounds an alarm). On September 17, 2025, the physician ordered for staff to provide 1:1 supervision due to the resident being an elopement risk. On September 2, 2025, social services documented that the resident spends his day wandering around the unit and that his family stated he had a history of elopement and eloped via the window from his previous facility. On September 9, 2025, the physician documented that he discussed his concerns with risk management regarding the resident's high risk for elopement and to consider 1:1 if his behaviors persisted. On September 12, 2025, at 1:49 p.m., a nurse documented that Resident 2 was actively exit seeking, attempting to get on the elevators, and that he was on every 15 minute checks. At 2:49 p.m., it was documented that the resident was able to get on the elevator. On September 13, 2025, staff documented that Resident 2 was continuously standing by the elevator. On September 14, 2025 at 4:15 p.m., the resident was again on the elevator and when staff removed him he punched a window multiple times. At 10:16 p.m., the resident expressed that he needed to leave. On September 15, 2025, the psychology consultant recommended 1:1 supervision instead of every 15 minute checks. On September 16, 2025, Resident 2 was again noted to be hovering around the elevator and needed to be removed from the elevator multiple times by staff. On September 17, 2025, the resident was found with the elevator/door codes written on a piece of paper in his sock. He was then placed on 1:1 observation. On September 19 2025, staff documented that the resident was pacing between stairwells and elevators with the assigned 1:1 staff member following. On September 20, 2025, at 11:21 p.m., the nursing supervisor (RN 4) observed from her office on a different floor that the resident's alert bracelet was alarming and contacted the unit to locate the resident. He could not be located on the unit or on the facility grounds. Resident 2 was located by police on September 21, 2025 at 6:52 a.m., at a convenience store approximately two miles from the facility, and was taken to the emergency room for evaluation. He was returned to the facility at 9:30 a.m. Review of facility documentation, dated September 21, 2025, revealed that the resident's assigned 1:1 staff member left the assignment at 8:00 p.m. on September 20, 2025, and was not replaced. The resident was left unsupervised and did not have 1:1 observation, per his physician's order and care plan, and eloped from nursing unit Tower 3 and the building unwitnessed. Further review of facility documentation revealed that Resident 2 was later observed on camera footage exiting through a stairwell door on Tower 3 after using the code to open the door. There was no documented evidence that the nurse aide (NA 1) and nurse (LPN 1) assigned to Resident 2 on Tower 3 on September 20, 2025, at the time of the elopement, had received the required training prior to the start of their shifts as indicated in the facility's Immediate Jeopardy action plan dated September 19, 2025. Review of additional facility documentation revealed that 29 residents on Tower 3 were assessed to have been at risk for elopement on September 20, 2025. There was no documented evidence that the facility implemented or evaluated the psychology consultant's recommendation for 1:1 supervision until September 17, 2025. There was no documented evidence that the door codes where changed on September 17, 2025, after the resident was found with the codes, or on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395476	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton County-Gracedale	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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and a review of facility documentation, it was determined that the facility failed to provide sufficient and competent staff needed to implement a resident's care plan interventions. (Resident 2)Findings include:Clinical record review revealed that Resident 2 was admitted to the facility on [DATE], and had diagnoses that included dementia, insomnia, wandering, restlessness, and agitation. According to the Minimum Data Set assessment dated [DATE], the resident had memory impairment and could walk without assistance. Review of Resident 2's care plan revealed that he was at risk for elopement with interventions for one to one (1:1) observation. On September 17, 2025, the physician ordered for staff to provide 1:1 supervision due to the resident being an elopement risk. Review of facility documentation dated September 21, 2025, revealed that the staff member assigned to provide 1:1 supervision for Resident 2 left the assignment at 8:00 p.m. on September 20, 2025, and was not replaced by another staff member. Resident 2 was then left without 1:1 supervision which resulted in him eloping from the facility on September 20, 2025, at 11:21 p.m.Review of the facility staffing documentation for Saturday, September 20, 2025, revealed that the facility failed to meet the state required Nurse Aide ratios and minimum direct care hours per resident.28 Pa. Code 201.18(b)(1) Management.28 Pa. Code 211.12(d)(4)(5) Nursing services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395476	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northampton County-Gracedale	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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on review of facility job descriptions, clinical record review, and review of facility documentation, it was determined that the Nursing Home Administrator (NHA) and Director of Nursing (DON) did not effectively manage the facility to ensure that adequate interventions and supervision were provided to prevent the elopement of two of 10 sampled residents. (Residents 1 and 2) In addition, the NHA and DON failed to ensure staff education was completed as indicated in their Immediate Jeopardy Action Plan on nursing unit Tower 3, affecting 29 residents at risk for elopement. Findings include:Review of the NHA's job description revealed that the Administrator was responsible to plan, direct, and control the organization and management of administrative, patient care, ancillary, and service functions, and was to ensure the facility's compliance with State, Federal, and other regulations governing facility licensing. Review of the DON's job description revealed that the Director of Nursing was responsible for the planning, coordination, and control of all services provided through the Nursing department. Work included the development and implementation of nursing services, standards, staffing, and provision of overall administrative management functions. Clinical record review revealed that Resident 1 eloped from the facility on September 17, 2025, after self-removing his roam alert bracelet (an electronic device that prevents doors from opening and/or sounds an alarm). This resulted in an Immediate Jeopardy Situation. The facility's action plan, dated September 19, 2025, indicated that each nurse would receive education related to elopement prevention prior to the start of their next scheduled work shift and that all staff would receive the education by September 22, 2025.Clinical record review revealed that Resident 2 had a physician's order for staff to provide one to one supervision due to exit seeking behavior . Further review of the clinical record revealed that the resident had eloped from the facility on September 20, 2025, after being left unsupervised by the staff assigned to provide 1:1 supervision. This resulted in a second Immediate Jeopardy situation. There was no documented evidence that the nurse aide (NA 1) assigned to provide the 1:1 supervision had received elopement training before September 22, 2025, and that the nurse (LPN 1) assigned to oversee the nurse aide and the resident on September 20, 2025, at the time of the elopement, had received the required training prior to the start of the shift as indicated in the facility's Immediate Jeopardy action plan dated September 19, 2025. Review of additional facility documentation revealed that 29 residents on Tower 3 were assessed to have been at risk for elopement on September 20, 2025.The NHA and DON failed to fulfill essential duties and responsibilities of their position to ensure that the Federal and State guidelines and Regulations were followed, contributing to the two Immediate Jeopardy situations.28 Pa. Code 201.14(a) Responsibility of licensee.28 Pa. Code 201. 18(b)(1)(3)(e)(1) Management.28 Pa. Code 211.12(d)(1)(2)(3)(5) Nursing services.