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	10/02/2025

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 0628 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**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 ensure that a provider (physician or designee) was notified in a timely manner of a resident who left the facility against medical advice (AMA). In addition, the facility failed to ensure that a resident was capable of safely making the decision to independently discharge from the facility without interventions or services for one of six sampled residents (Resident 1). This failure resulted in an Immediate Jeopardy situation. Findings include: Review of the facility policy entitled, Discharging a Resident without a Physician's Approval, last reviewed March 2025, revealed that if a resident or representative requested a discharge earlier than outlined in the plan of care and without approval from the physician or provider (against medical advice), the resident's physician or provider was to be notified promptly. Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], and had diagnoses that included problems related to living alone, altered mental status, history of cerebral vascular accident (a stroke, a medical condition involving the interruption of blood flow to a part of the brain resulting in brain damage), muscle weakness, cognitive communication deficit (difficulty with communication from impaired cognitive function), metabolic encephalopathy (brain dysfunction from metabolic disturbances), and below the knee amputation. Review of the care plan revealed that the resident had a performance deficit with activities of daily living, limited physical mobility, impaired cognitive function, and short-term memory loss, and his discharge plan was uncertain. Review of Resident 1's history and physical, dated September 22, 2025, revealed that the resident's physician documented that the resident had hospital induced delirium, his decision-making capacity was to be re-evaluated before discharge, and that he seemed to lack the ability to understand potential problems after leaving the facility, which included not having a home and not being able to drive. On September 22, 2025, a nurse documented that the resident required assistance with opening and closing medication bottles, was not able to state what time medications were to be taken, was not able to state the proper doses of medications and was not able to dispense the proper number of medications. A social services note dated September 22, 2025, revealed that the discharge plan was uncertain, and indicated that the resident's family members did not wish to be involved in his care and he no longer had a home or a vehicle. A social worker's note dated September 25, 2025, indicated that the resident was in the facility lobby and expressed a desire to call a taxi to leave the facility and that Physician Assistant (PA) 1 assessed the resident and stated that he had capacity to make his own decisions and the discharge would be against medical advice (AMA). There was a lack of evidence to indicate that PA 1 performed a capacity evaluation at any point while Resident 1 was in the facility. In an interview on October 2, 2025, at 12:54 p.m., PA 1 stated that he did not perform a capacity evaluation on Resident 1 and that assessment was to be done by a resident's physician. PA 1 also confirmed that there was no evidence that the resident was re-evaluated to determine capacity to make his own decisions, he was not notified about Resident 1's AMA discharge until September 29, 2025, and notification should be at the time of the discharge. PA 1 confirmed that he did not perform an assessment to determine Resident 1's decision-making capacity, despite the social worker's note dated September 25, 2025, which indicated he had made that determination. On September 25, 2025, a nurse noted that the resident did not seem to have the insight regarding the level of care required for him at home, how he would perform aspects of care, or how he would get to any follow-up appointments. A nursing note dated September 25, 2025, revealed that Resident 1 required assistance from two staff members for transfers, continued to attempt to transfer himself independently, and was not compliant with using the safe level of assistance to transfer. On September 27, 2025, at 2:30 p.m., a nurse documented that the resident stated that he wanted to sign himself out of the facility and signed the paperwork to leave AMA. At 2:45 p.m., staff documented that the resident left the facility AMA with his belongings, no medications, no confirmed or safe destination, and had only a wheelchair for transportation. In an interview on October 2, 2025, at 11:25 a.m., Registered Nurse (RN) 1, stated that the resident signed his own AMA paperwork. RN 1 also stated that staff outside of the building had contacted the nursing supervisor's office to inform them that the resident had left the building in the wheelchair. There was no further instruction provided or intervention implemented at that time. RN 1 stated that approximately 10 minutes later, the police contacted the nursing supervisors' office to inquire if the facility was familiar with Resident 1. RN 1 was unaware of Resident 1's location at the time of that phone call. Review of facility documentation entitled, Discharge Against Medical Advice, revealed