| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395476 | A. Building<br>B. Wing | 10/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Northampton County-Gracedale | Gracedale Avenue<br>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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(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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|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, clinical record review, facility documentation review, and staff interview, it was determined that the facility failed to ensure that residents were free from abuse for two of ten sampled residents (Residents 2 and 4), resulting in physical harm for one resident. (Resident 2)Findings include: Review of the facility policy entitled, Abuse Prevention, last reviewed March 24, 2025, revealed that residents had the right to be free from abuse. Review of the facility policy entitled, Resident to Resident Altercations, last reviewed March 24, 2025, revealed that facility staff would monitor residents for aggressive behavior towards other residents or staff. The events would be reviewed for possible measures to prevent additional incidents and necessary changes to the care plan would be made. Clinical record review revealed that Resident 1 was admitted to the facility on [DATE], and had diagnoses that included mood affective disorder (condition that affects a person's emotional state), anxiety, non-compliance with medical treatment, alcohol-induced dementia, psychosis (difficulty telling the difference between what is real and what is not), and alcohol induced psychotic disorder. Review of the care plan revealed that the resident had a behavior problem and was verbally and physically aggressive towards staff and peers and refused medication, assistance, and care. Review of the Minimum Data Set assessment (a periodic assessment of resident care needs) dated August 19, 2025, revealed that his cognitive status was a 99 meaning the interview was not successful and the assessment could not be completed. On August 12, 2025, nursing staff noted that Resident 1 was upset with his admission to the facility, was verbally abusive with staff, and refused care. The nurse practitioner was made aware of the behaviors. On August 13, 2025, a nurse practitioner noted that the resident had a history of uncooperative, non-compliant, and verbally and physically abusive behaviors and hospitalizations for psychiatric services. The nurse practitioner noted that prior to admission to the facility, the resident continued to be anxious, hallucinated, and responded to internal stimuli. It was noted that upon admission, he was verbally abusive to staff and attempted to swing at them. Review of the clinical record revealed that throughout the resident's admission to the facility, nursing, social services, and therapy staff documented that he continued to display behavioral disturbances and verbal aggression towards staff. Redirection was often unsuccessful, and he would not permit staff to enter his room. Resident 1 raised a fist at staff when obtaining his meal tray and yelled at staff to get out of his room. Clinical record review revealed that Resident 2 had diagnoses that included cognitive communication deficit, dementia, and insomnia. Review of the care plan revealed that the resident had a language barrier, was an elopement risk due to disorientation, and exhibited behaviors such as wandering and rummaging. Interventions included that staff distract the resident from wandering by offering diversions, structured activities, food conversation, television, or a book. A care plan note dated September 30, 2025, revealed that the resident spent the majority of his time ambulating on the unit and wandering in and out of rooms. Review of facility documentation dated October 6, 2025, revealed that Resident 2 was observed in Resident 1's room and was noted to be naked with skin tears to the top of his head, right side of the forehead, and left elbow, and ecchymosis (bruising) to the left eye. There was also blood noted coming from his right elbow and top of his buttocks. Resident 1 was observed with blood on the front of his shirt and bruising to the knuckles of his left hand. No injuries to cause bleeding were observed on Resident 1. There was also blood observed on the bed sheets, floor, and wall of Resident 1's room. When questioned about the incident by law enforcement, Resident 1 stated that someone was in his room. Resident 2 was transferred to the hospital with injuries that required treatment. Review of the hospital Discharge summary dated [DATE], revealed that the resident was assessed due to being the victim of an assault with head injury and required wound care for soft tissue injuries. Clinical record review revealed that on October 14, 2025, Resident 2 was observed with altered mental status, increased confusion, was unable to feed himself, and was stumbling during ambulation. The resident was sent to the hospital for evaluation and found to have a hematoma (collection of blood outside of the blood vessels) to the left gluteal (buttocks) region and an acute fracture of the coccyx (bone of the pelvis). Review of facility documentation dated October 15, 2025, confirmed that the resident sustained a fracture of the coccyx, which was documented as believed to be from the assault from Resident 1 on October 6, 2025. There was a lack of evidence to support that the facility provided adequate interventions for Resident 1, who had known and continuing aggressive behaviors, and did not wish for others to enter his room, resulting in physical abuse with actual harm to a cognitively impaired resident (Resident 2) who wandered into Resident 1's room. In an |