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	05/14/2026

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 implement and develop a comprehensive care plan to meet the current needs for one of six sampled residents. (Resident 2)Findings include: Clinical record review revealed that Resident 2 was admitted to the facility on [DATE], and had diagnoses that included chronic obstructive pulmonary disease (a long-term lung disease that makes it hard to breathe), chronic pain syndrome (pain that lasts longer than three months in one or more parts of the body), and a history of alcohol and opioid (used to relieve pain) abuse (chronic use that causes clinically significant distress, harm, or impairment). Review of the care plan revealed that Resident 2 had a behavior problem with taking medications related to pocketing narcotics with an intervention for staff to monitor the resident for swallowing medications. On March 28, 2026, a nurse noted that that the resident had an unopened can of alcoholic beverage in his room during a room clean-up and it was removed. On March 31, 2026, a nurse noted that the resident smelled of alcohol, his face was red, flushed, and sweaty, stating that Resident 2 reported it was his cologne then came back to the nurses' station with a bottle with no label and some clear liquid stating it was mouthwash. On April 1, 2026, a nurse noted that while speaking to Resident 2 about alcohol consumption, he stated I am a biker, that's what we do; we drink, smoke, play pool, and party. The nurse also noted that the resident had some bottles with unidentified liquid, amber in color, in the same bottle from March 31, 2026, and in an apple juice bottle. On May 5, 2026, at 1:40 p.m., a nurse noted that Resident 2 returned from an independent leave of absence with an ataxic gait (unsteady, uncoordinated walking pattern with irregular foot placement and body swaying), sweating profusely, and slurred speech, and was verbally aggressive and causing a disturbance on the nursing unit. On May 5, 2026, a nurse noted that after transferring Resident 2 to the stretcher, in a wrapped up blanket on the floor, were: 12 to 15 marijuana vape cartridges, one bottle of [NAME] vodka, two 12 ounce (oz) empty bottles of Fireball, one 12 oz empty bottle of Southern Comfort whiskey, a large hunting knife, and a container of Resident 2's untaken prescribed medications, which were identified by the pharmacist as six allopurinol 100 mg tablets (prevents and lowers uric acid levels), one atorvastatin 20 mg tablet (used to lower cholesterol), two duloxetine 60mg capsules (antidepressant), eight gabapentin 400 mg capsules (pain medication), two loratadine 10 mg tablets (allergy medication), 36 melatonin 5 mg tablets (natural sleep aid), one multivitamin tablet, 27 oxycodone 10 mg tablets (opioid), 11 of which were partially dissolved, two ropinirole 1mg tablets (used to treat restless leg syndrome) , 1/2 tablet of trazadone 150 mg (antidepressant), two vitamin D3 capsules, one Tylenol 325 mg tablet, and two Tessalon Perles (cough medication). On May 7, 2026, the nurse noted Resident 2 was observed with a tiny straw held to his nostril, inhaling a white powdery substance while on 1:1 observation. The care plan failed to address Resident 2's alcohol and opioid abuse and failed to include interventions to safely manage the resident's independent leaves of absence or develop interventions specific for those behaviors. Additionally, the facility failed to implement interventions to monitor Resident 2 for medication pocketing during administration. In an interview on May 14, 2026, at 12:10 p.m., the Director of Nursing confirmed that the intervention for (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff to ensure that Resident 2 swallowed all his medications was not implemented and that there was no care plan developed to address Resident 2's history of alcohol and opioid abuse, including the associated safety risks after returning from independent leaves of absence. CFR 483.21(b)(1) Comprehensive Care PlansPreviously cited 9/23/25 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on clinical record review, policy review, facility documentation review, and staff interview, it was determined that the facility failed to ensure that a licensed practical nurse (LPN) maintained professional standards of quality care in following the established policies and procedures of the facility set forth in the Pennsylvania Code Title 49 Professional and Vocational standards for one of six residents sampled for medication administration. (Resident 1)Findings include: Review of Pennsylvania Code Title 49, Chapter 21, Subchapter B. Practical Nurses, revealed guidelines which included that an LPN shall follow the written, established policies and procedures of the facility. A licensed practical nurse shall document and maintain accurate records. A licensed practical nurse may not falsify or knowingly make incorrect entries into the patient's record or other related documents. Review of the facility policy entitled, Medication Administration Schedule, last reviewed December 18, 2025, revealed that the exact time of medication administration was to be documented in the medication administration record (MAR). If medication was administered early, late, or was omitted, the reason was also documented. Medications scheduled for evening shift are administered between 4:00 p.m. and 7:45 p.m. and medications scheduled for bedtime are administered between 8:00 p.m. and 11:00 p.m. Review of the facility policy entitled, Medication Administration Policy, last reviewed December 18, 2025, revealed that staff were to identify the resident before administering any medication. Staff were to check the arm band or photograph, ask the resident their name, or check with other staff members if necessary. The resident has the right to refuse medication. The nurse was to document accordingly. Review of Resident 1's medication administration record (MAR) revealed that on May 13, 2026, LPN 1 documented that Resident 1 was administered risperidone 4 milligram (mg) tablet (atypical antipsychotic) on evening shift and perphenazine 16 mg tablet (antipsychotic) at bedtime. LPN 1 indicated on the MAR to see the progress note for the following physician orders: benztropine mesylate 2 mg tablet (anticholinergic), divalproex sodium 500 mg tablet (used to manage manic phases of bipolar disorder), hydralazine 50 mg tablet (antihypertensive), and blood glucose (sugar) checks before meals and at bedtime. On May 13, 2026, at 10:39 p.m., LPN 1 noted medications were never given, Resident 1 was off the unit. A review of Resident 1's blood glucose summary indicated that LPN 1 documented results for the resident's blood glucose on May 13, 2026, at 8:34 p.m. twice, with results of 152 milligrams per deciliter (mg/dL) and 156 mg/dL. LPN 1 then struck out the results at 10:34 p.m. and 10:39 p.m. and documented that Resident 1 declined. On May 14, 2026, a nurse noted that Resident 1 had eloped (unauthorized departure from the facility) and returned to the facility at 1:00 a.m. Review of facility documentation revealed that Resident 1 was observed on camera footage leaving the facility on May 13, 2026, at 5:08 p.m. In a written statement dated May 14, 2026, Nurse Aide (NA)1 stated that she last saw Resident 1 at 4:00 p.m. and never saw him again for the rest of her shift. In an interview on May 14, 2026, at 9:45 a.m., the Director of Nursing confirmed that LPN 1 falsely documented in Resident 1's clinical record that medications were administered and blood glucose was checked when the resident was not in the building and altered the MAR after receiving a phone call from the police regarding the resident's elopement. 28 Pa. Code 211.10(c) Resident Care Policies. 28 Pa. Code 211.12(d)(1)(5) Nursing Services.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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, review of facility documentation, and staff interview, it was determined that the facility failed to provide adequate supervision to monitor a resident's whereabouts, prevent an elopement (unauthorized departure from the facility), and ensure that medications were administered as documented for one of six sampled residents. (Resident 1) In addition, the facility failed to provide adequate supervision to a resident with known behaviors and a history of substance abuse (Resident 2). This failure resulted in an Immediate Jeopardy situation.Findings include: Review of the facility policy entitled, Elopements/Elopement Policy, last reviewed December 18, 2025, revealed 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 December 18, 2025, revealed staff would remain within arm's length or within visual sight of the resident at all times when providing 1:1 intervention. Review of facility policy entitled, Medication Administration Policy, last reviewed December 18, 2025, revealed staff were to remain with the resident while medication was swallowed. Staff were to never leave medication in a resident's room without orders to do so. Clinical record review revealed Resident 1 was admitted to the facility on [DATE], and diagnosed with including: Schizoaffective Disorder, Bipolar type (chronic mental health condition that combines delusions and hallucinations with severe mood swings), Diabetes (a chronic condition where the body either cannot produce insulin or cannot effectively use the insulin it makes), and Chronic Kidney Disease (kidneys are damaged and cannot filter blood as they should, causing waste and fluid to build up in the body). According to Resident 1's Minimum Data Set (MDS) assessment (periodic evaluation of resident care needs) dated March 19, 2026, the resident had no memory impairment and could walk independently. Review of Resident 1's care plan revealed Resident 1 had impaired cognitive function and thought processes related to diagnoses of schizoaffective disorder, recall difficulty, and instances of delusional thinking. On January 1, 2026, the physician ordered Resident 1, based on a smoking assessment, was able to leave the nursing unit and smoke independently. Review of Resident 1's medication administration record (MAR) revealed on May 13, 2026, LPN 1 (Licensed Practical Nurse) documented Resident 1 was administered Risperidone 4 milligram (mg) tablet (atypical antipsychotic) on evening shift and Perphenazine 16 mg tablet (antipsychotic) at bedtime. Employee (LPN 1) indicated on the MAR to see the progress note for the following physician orders: Benztropine mesylate 2 mg tablet (anticholinergic), Divalproex sodium 500 mg tablet (used to manage manic phases of bipolar disorder), Hydralazine 50 mg tablet (antihypertensive), and blood glucose (sugar) checks before meals and at bedtime. Further review of May 13, 2026, at 10:39 p.m., revealed Employee (LPN 1) documented medications were never given as Resident 1 was off the unit. Review of Resident 1's blood glucose summary revealed LPN 1 documented results for the resident's blood glucose on May 13, 2026, at 8:34 p.m. twice, with results of 152 milligrams per deciliter (mg/dL) and 156 mg/dL. Employee (LPN 1) then struck out the results at 10:34 p.m. and 10:39 p.m. and documented Resident 1 declined. Additional review of clinical record revealed on May 14, 2026, a nurse noted Resident 1 had eloped (unauthorized departure from the facility) and returned to the facility at 1:00 a.m. Review of facility documentation revealed Resident 1 was observed on camera footage leaving the facility on May 13, 2026, at 5:08 p.m. Review of written statement dated May 14, 2026, Nurse Aide (NA) 1 stated she last saw Resident 1 at 4:00 p.m. on May 13, 2026, and never saw him again for the rest of her shift. Review of written statement dated May 14, 2026, NA 2 reported not seeing Resident 1 on May 13, 2026, at 5:00 p.m. and then again at 7:00 p.m. when passing water. NA 2 spoke with NA 1 and reported the resident missing to the nurse, LPN 1, at 9:00 p.m., at which time no action was taken, including reporting to the Nursing Supervisor. Review of the local police department's report, Resident 1 was standing outside the police station at 10:11 p.m. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The officer called the facility to see if Resident 1 was missing; the Nursing Supervisor was unaware at that time of Resident 1 missing from facility. In an interview on May 14, 2026, at 9:45 a.m., the Director of Nursing confirmed on May 13, 2026, LPN 1 falsely documented Resident 1's medications administered as ordered and resident's blood sugar was checked but altered the clinical record after the facility received the phone call from the police. The facility failed to monitor a resident's whereabouts, prevent elopement from the facility, and ensure that medications were administered as documented. Clinical record review revealed Resident 2 was admitted to the facility on [DATE], with diagnoses including; Chronic Obstructive Pulmonary Disease (long-term lung disease that makes it hard to breathe), chronic pain syndrome (pain that lasts longer than three months in one or more parts of the body), and a history of alcohol and opioid (type of pain medication) abuse (chronic use that causes clinically significant distress, harm, or impairment). According to Resident 2's MDS assessment, dated April 23, 2026, the resident had no memory impairment and could walk independently. Review of Resident 2's care plan revealed Resident 2 had a behavior problem with taking medications related to pocketing narcotics (pain medication) in his mouth. Interventions included for staff to monitor the resident for swallowing medications by asking the resident to open his mouth, stick out his tongue, and pull his cheeks out to verify that medications were swallowed and to report to the provider if the resident were to refuse to cooperate. On October 27, 2025, the physician ordered that Resident 2 was allowed to go on independent leaves of absence (LOA). The resident was not to leave the facility with scheduled or as needed medication. Review of Resident 2's clinical record revealed on March 28, 2026, a nurse noted Resident 2 had an unopened can of an alcoholic beverage in his room during a room clean-up and was removed. Further review of the clinical record revealed on March 31, 2026, a nurse noted the resident smelled of alcohol, his face was red, flushed, and sweaty, yet the resident reported it was his cologne. He then came back to the nurses' station with a bottle with no label and containing clear liquid stating it was mouthwash. Resident 2 left the unit and returned 90 minutes later with the same noted condition. Additional review of Resident 2's clinical record revealed on April 1, 2026, a nurse noted while speaking to Resident 2 about alcohol consumption when taking scheduled narcotics and possible adverse effects, Resident 2 stated, I am a biker, that's what we do; we drink, smoke, play pool, and party. The nurse noted her observation of the resident had bottles with unidentified amber colored liquid in the same bottle from March 31, 2026, and in an apple juice bottle. Resident 2 was questioned about what was in the bottles. Resident 2 stated he was not drunk and told the nurse to leave the room. Continued review of Resident 2's clinical record revealed on April 2, 2026, the physician noted he spoke with Resident 2 about his alcohol misuse then discontinued alprazolam (classified as a benzodiazepine - medication used to treat anxiety) for safety, and the resident's oxycodone, an opioid (pain medication), would be continued with close monitoring. On April 2, 2026, the physician ordered 1:1 supervision due to the resident's inappropriate behavior. Review of Resident 2's clinical record revealed on May 5, 2026, at 1:40 p.m., a nurse noted Resident 2 returned from an independent leave of absence with an ataxic gait (unsteady, uncoordinated walking pattern with irregular foot placement and body swaying), profuse sweating, slurred speech, and verbal aggression, and was causing a disturbance on the nursing unit. Resident 2 was taken outside to the smoking area to diffuse the situation while on 1:1 observation. The 1:1 staff reported Resident 2 was verbally aggressive and causing a disturbance in the smoking area where other residents were frightened, causing the other residents to leave. On May 5, 2026, at 3:13 p.m., the physician noted; he told the nurse to send Resident 2 to the emergency room and to call the police. On May 5, 2026, at 3:28 p.m., a nurse noted that Resident 2 was exhibiting violent behavior and slurred speech. During this episode, Resident 2 had a witnessed fall and hit his head. Resident 2 had increased agitation and combative behavior, posing a safety risk to himself and others. At 4:45 p.m. emergency services responded to the unit. Resident 2 left the facility at 4:59 p.m. The nurse noted that while attempting to transfer Resident 2 to the stretcher, and while cleaning up the area, found on the floor in a wrapped up blanket were: 12 to 15 marijuana vape cartridges, one bottle of (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[NAME] vodka, two 12 ounce (oz) empty bottles of Fireball, one 12 oz empty bottle of Southern Comfort whiskey, a large hunting knife, a wallet with $43.00 and cards, and a container of Resident 2's untaken prescribed medications, which were identified by the pharmacist as six allopurinol 100 mg tablets (prevents and lowers uric acid levels), one atorvastatin 20 mg tablet (used to lower cholesterol), two duloxetine 60 mg capsules (antidepressant), eight gabapentin 400 mg capsules (pain medication), two loratadine 10 mg tablets (allergy medication), 36 melatonin 5 mg tablets (natural sleep aid), one multivitamin tablet, 27 oxycodone 10 mg tablets (opioid), 11 of which were partially dissolved, two ropinirole 1 mg tablets (used to treat restless leg syndrome) , 1/2 tablet of trazadone 150 mg (antidepressant), two vitamin D3 capsules, one Tylenol 325 mg tablet, and two Tessalon Perles (cough medication). The police confiscated the vape, cartridges, and knife. Review of Resident 2's clinical record revealed on May 6, 2026, at 2:12 a.m., a nurse noted that Resident 2 returned to the facility upset, yelling at staff, and waking up his roommates regarding his wallet. On May 7, 2026, the nurse noted, that while the 1:1 staff left to get their coat and to ensure 1:1 monitoring was ongoing, the nurse entered the room and observed Resident 2 with his back turned and head lowered with a tiny straw held to his nostril, inhaling, moving right to left, then left to right, with a white powdery substance that disappeared from the table. The resident quickly grabbed antifungal powder and poured it over the substance and stated it was now antifungal powder. The facility failed to provide adequate supervision and interventions to prevent Resident 2 from pocketing medications that were administered, returning to the facility intoxicated more than once, and having narcotic medications, illegal marijuana vape cartridges, alcohol, and a weapon in a room shared with other residents. The facility failed to provide adequate supervision to monitor a resident's whereabouts and prevent elopement (Resident 1). Additionally, the facility failed to provide adequate supervision to monitor a resident with a known history of substance abuse during medication administration, resulting in diversion and stockpiling of prescribed medication, returning to the facility from a leave of absence intoxicated more than once, and possession of illegal marijuana vape cartridges, alcohol, and a weapon (Resident 2) constituted an Immediate Jeopardy situation at F689-J, and the Immediate Jeopardy template was provided. The facility was informed that a corrective action plan was required. The facility implemented the following corrective action plan: 1. Resident 1 was placed on 1:1 observation on May 14, 2026. 2. Resident 1 was moved to a secure unit on May 14, 2026. 3. Resident 1 had a wander guard placed on May 14, 2026, and will be checked every shift beginning May 14, 2026. 4. Speech therapy was requested to do a more detailed cognitive evaluation of Resident 1's abilities. 5. Residents without elopement risk and/or independent smokers will be allowed to move throughout the facility without restriction, but staff will account for residents as specified beginning May 14, 2026: during a.m. care, meals, medication administration times, during p.m. care, and an hour before the end of each shift. 6. Beginning May 14, 2026, the night shift nurse on each unit will run the census for the upcoming day. Each nursing unit will use their census to account for each resident during a.m. care, meals, medication administration times, during p.m. care, and an hour before the end of each shift. If resident is not visibly present on the unit at any of the above times, staff will immediately page for the resident to return to their unit. If the resident does not answer the page within 10 minutes, the nurse on the unit will instruct the staff on the unit to check the unit and will call the supervisor to check the outdoor smoking area. If the resident is not found, elopement code will be called by the supervisor and elopement procedures will commence. 7. Supervisors will collect the census sheets daily and review to ensure completion. ADONs will review census sheets weekly x 4 weeks, then biweekly for 2 months, then monthly. Results will be reported to QAPI (Quality Assurance, Performance Improvement) committee. 8. Supervised smokers will continue to be supervised while outside smoking. 9. The facility educated all staff in the facility on the facility's procedure regarding census and accountability during specified times, elopement procedures, reeducation about not signing off on any care, treatment or medications until after performance of the task. All staff that were available on May 14, 2026, were immediately educated. All staff were (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	educated via e-mail on May 14, 2026. Staff must sign and acknowledge the trainings on their next scheduled workday. 10. The facility policy, Resident Leave of Absence, was updated on May 14, 2026, and compliance with the updated policy will be implemented. The updates included if a resident returns and appears intoxicated, the resident will be searched for contraband (drugs, alcohol, weapons, etc.) upon returning from leave of absence. If the resident refuses the search, the resident will no longer be permitted to go on a leave of absence, resident room will be searched, and resident will be placed on 1:1 supervision until further review by interdisciplinary team which will include staff as well as the resident's primary care physician. Compliance with the policy will be audited through High-Risk Event and Quality Assurance and Performance Improvement (QAPI) meetings. 11. Process that requires residents leaving on Leave of Absence (LOA) to sign out of the building before leaving and to sign back in will continue. The Nursing Home Administrator (NHA) will remind responsible parties (RP), including residents that are their own RP's, of the process through the automatic messaging feature in the facility's electronic health record completed on May 14, 2026. 12. The NHA will remind RP's not to take any person off the nursing units, out of the building or off the property. Message to include they cannot assume a person is not a resident just by appearance. This was completed through the automatic messaging feature in the facility's electronic health record on May 14, 2026. 13. Knife and contraband were removed by staff and locked in secure area. Hoarded medications were checked by the pharmacist, and all the medications were the resident's prescribed medications. All items were turned over to the police when they arrived on May 6, 2026. 14. Resident's order for oxycodone was discontinued and suboxone sublingual was ordered. 15. An audit will be completed weekly by nursing administration of leave of absences of identified risk residents to ensure search was complete. Results to be reported to QAPI. 16. Residents who come under suspicion for not swallowing their medications shall have orders for mouth checks after medication administration added to their order list by May 15, 2026. Refusals to be reported to the physician. The physician will be consulted for discontinuing narcotics for residents who are non-compliant. 17. ADONs to complete observations of medication administration for five residents with a mouth check order per week for four weeks, then three residents for four weeks, and random sampling afterwards. Results will be reported to QAPI committee. 18. Education was provided to staff on changes to LOA policies, signs and symptoms of intoxication, process to follow if intoxication is suspected, and following the current policy for medication administration ensuring residents swallow their medication. All staff that were available on May 14, 2026, were immediately educated. All staff were educated via e-mail on May 14, 2026. Staff must sign and acknowledge the trainings on their next scheduled workday. The survey team validated that the Immediate Jeopardy was removed on May 14, 2026, at 10:12 p.m., through verification of facility training and review of facility procedures following the facility's implementation of the corrective action plan for removal of the Immediate Jeopardy. CFR 483.25(d)(2) Free of Accident/Hazards/SupervisionPreviously cited 9/19/25, 9/23/25 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services.