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	05/02/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 45244 Based on clinical record review and observation, it was determined that the facility failed to ensure that physician's orders were implemented for one of 37 sampled residents. (Resident 5) Findings include: Clinical record review revealed that Resident 5 had diagnoses that included acute cystitis without hematuria (bladder infection without bleeding), Alzheimer's disease, and chronic kidney disease. On April 23, 2024, the physician ordered for staff to apply a Darco Flat (specialty shoe) to Resident 5's right leg, a roam alert bracelet to Resident 5's right ankle, and a chair alarm. Observations on April 30, 2024, from 12:59 p.m. through 2:00 p.m., and again on May 1, 2024, from 11:58 a.m. through 1:10 p.m., revealed Resident 5 in his wheel chair in the dining room area without a Darco Flat, roam alert bracelet, or chair alarm in place. 28 Pa. Code 211.12(d)(1)(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
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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 45244 Based on facility policy review, clinical record review, and observation, it was determined that the facility failed to ensure that adequate catheter care was provided for one of four sampled residents with an indwelling urinary catheter. (Resident 5) Findings included: Review of the facility policy entitled, Urinary Catheter Care, last reviewed April 11, 2024, revealed that a urinary drainage bag was to be positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the bladder. Staff was also to ensure the catheter tubing and drainage bag was kept off the floor. Clinical record review revealed that Resident 5 had diagnoses that included acute cystitis without hematuria (bladder infection without bleeding), Alzheimer's disease, chronic kidney disease, and urine retention. On April 23, 2024, the physician ordered for the resident to have a foley catheter every shift. On April 30, 2024, from 1:04 p.m. to 2:00 p.m., Resident 5 was observed in his wheelchair with his catheter drainage bag hanging on the armrest of his wheel chair, which was above the level of his bladder. On May 1, 2023, from 8:52 a.m. to 10:06 a.m., Resident 5 was observed in bed with his catheter on the mattress, which was not below the level of his bladder. Observation on the same day, from 11:58 a.m. to 12:10 p.m., revealed Resident 5 in his wheel chair with his catheter bag directly on the floor. At 12:10 p.m., a registered nurse (RN1) put Resident 5's catheter bag on his lap, above the level of his bladder. Resident 5's catheter bag remained on his lap until 12:30 p.m., when he placed it on the dining room table. At 12:44 p.m., Resident 5 removed his catheter from the table and held it in his hands, which was above the level of his bladder. Resident 5 continued to hold his catheter in his hands until 12:54 p.m., when a nurse aide (NA1) placed it on his wheel chair armrest, which was above the level of his bladder. 28 Pa. Code 211.12(d)(1)(5) Nursing services.