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	05/01/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **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 ensure that residents were free from potential chemical restraints for two of five sampled residents who were ordered psychotropic medications. (Residents 18 and 361)Findings include: Clinical record review revealed that Resident 18 had diagnoses that included schizoaffective disorder bi-polar type, dementia, and anxiety disorder. The Minimum Data Set (MDS) assessment dated [DATE], indicated that the resident had cognitive impairment. A review of the care plan revealed that the resident had mood problems related to the disease process of schizoaffective disorder, exhibited behaviors of yelling out, and presented as anxious and restless. On August 7, 2025, a physician ordered for staff to administer an anti-anxiety medication (Ativan) as needed for anxiety. The order did not include a date to indicate when staff was to stop administering the as needed medication. Review of the Medication Administration Records (MAR) revealed that the as needed Ativan was administered two times in January 2026, five times in March 2026, and one time in April 2026. In an interview on May 1, 2026, at 9:27 a.m., the Director of Nursing stated that the as needed order was to have a stop date of 14 days. Clinical record review revealed that Resident 361 had diagnoses that included metabolic encephalopathy, heart failure, and peripheral vascular disease. On March 31, 2026, a physician ordered staff to administer an anti-anxiety medication (lorazepam) every four hours as needed for anxiety. The order did not include a date to indicate when staff were to stop administering the as needed medication. Review of Resident 361's MAR revealed that staff had administered the lorazepam on April 26, 2026. There was no documented evidence that the physician had re-evaluated continued use of the as needed anti-anxiety medication beyond 14 days. In an interview on April 30, 2026, at 2:21 p.m., the Director of Nursing confirmed that there had been no date added to the order to indicate when staff were to stop administering the anti-anxiety medication. 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

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **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 complete an accurate Minimum Data Set (MDS) assessment for two of 37 sampled residents. (Resident 24 and 377)Findings include: Clinical record review revealed that Resident 24 had diagnoses that included dementia (a progressive decline in thinking, memory, and judgment) and a history of falls. Review of Resident 24's MDS assessment dated [DATE], indicated that the resident did not have any falls since the prior assessment which was dated November 3, 2025. A nurse's note dated November 24, 2025, stated that the resident had a fall on that date. In an interview on April 30, 2026, at 2:36 p.m., the Director of Nursing (DON) confirmed that Resident 24's MDS assessment dated [DATE], was inaccurate and should have captured the fall that occurred on November 24, 2025. Clinical record review revealed that Resident 377 had diagnoses that included Alzheimer's disease (a progressive disease that affects memory, language problems, and body function) and chronic kidney disease. Review of Resident 377's MDS assessment dated [DATE], indicated that the resident was receiving dialysis while a resident. There was no documentation in the clinical record that indicated the resident was receiving dialysis. In an interview on April 29, 2026, at 12:45 p.m., the DON confirmed that the MDS was inaccurate and that Resident 377 was not on dialysis at that time. CFR 483.20 (g) Accuracy of AssessmentsPreviously cited 4/16/25

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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 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. Based on clinical record review and staff interview, it was determined that the facility failed to ensure physicians' orders were implemented for four of 37 sampled residents. (Residents 9, 10, 171, 234)Findings include: Clinical record review revealed that Resident 9 had diagnoses that included end stage renal disease and dialysis. On March 27, 2026, a physician ordered that staff obtain an occult blood stool test for three days. A review of Resident 9's clinical record revealed there was no documented evidence to support that the occult blood test was obtained as ordered. Clinical record review revealed that Resident 10 had diagnoses that included type 2 diabetes mellitus with diabetic kidney complications and acute respiratory failure. A physician's order dated August 29, 2025, directed staff to measure the resident's blood sugar before meals and at bedtime every day, and to notify the physician if the resident's blood sugar was below 70 milligrams per deciliter (mg/dL) or above 300 mg/dL. Review of Resident 10's Medication Administration Records (MAR) revealed that Resident 10's blood sugar was above 300 mg/dL once in January 2026, seven times in February 2026, and seven times in March 2026. There was no documented evidence that the physician was notified of those incidents. Clinical record review revealed that Resident 171 had diagnoses that included hypertension (high blood pressure) and dementia (a progressive decline in thinking, memory, and judgment). A physician's order dated March 24, 2026, directed staff to administer a blood pressure medication (carvedilol) two times a day. The physician ordered that staff were not to administer the medication if the resident's heart rate (the number of times a person's heart beats per minute) was less than 60 beats per minute. Review of Resident 171's MAR, revealed that staff administered carvedilol two times in March 2026 and six times in April 2026, when Resident 171's heart rate was less than 60 beats per minute. In interviews on April 30, 2026, at 1:54 p.m., and 2:36 p.m., the Director of Nursing confirmed that that the ordered occult blood stool test for Resident 9 was not done, there was no evidence that the physician was notified when Resident 10's blood sugar was higher than 300 mg/dL, and that Resident 171's medication was administered outside the ordered parameters as identified. Clinical record review revealed that Resident 234 had diagnoses that included cerebral infarction, vascular dementia, and muscle weakness. A physician's order dated June 24, 2025, directed staff to apply Prevalon boots (devices to prevent heel pressure injuries) while in bed. Review of the comprehensive care plan revealed that the resident was at risk for skin breakdown. Multiple observations on April 28 and 29, 2026, between 8:20 a.m., and 2:25 p.m., revealed Resident 234 in bed and the Prevalon boots were not applied. 28 Pa. Code 211.12(d)(1)(5) Nursing services.