

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395476</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>05/01/2026</b>
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NAME OF PROVIDER OR SUPPLIER: <b>NORTHAMPTON COUNTY HOME- GRACEDALE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2 GRACEDALE AVENUE NAZARETH, PA 18064</b>
STATE LICENSE NUMBER: <b>072802</b>	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0000	Continued from page 1  Based on a Medicare/Medicaid Recertification survey, State Licensure survey, Civil Rights Compliance survey and an Abbreviated survey in response to one complaint completed May 1, 2026, it was determined that Northampton County Home-Gracedale, was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 Pa. Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as they relate to the Health portion of the survey.	F 0000		

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F 0605 SS=D	<p>483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) Right to be Free from Chemical Restraints</p> <p>§483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:</p> <p>§483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).</p> <p>§483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must-. . .</p> <p>§483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that</p>	F 0605	<p>Pharmacist will send out a re-education to all the providers regarding PRN psychotropics and end dates by May 4, 2026.</p> <p>Resident records for all residents receiving psychotropics were checked on April 30, 2026- no other orders were missing stop dates.</p> <p>New psychotropic orders added to Point Click Care dashboard on May 1, 2026- listing shows new orders and stop dates. Interdisciplinary team will review dashboard during clinical meeting for stop dates- any missing stop dates will be added.</p> <p>Charge nurses will audit order listing report for new psychotropic orders- 5 residents will be audited x 4 weeks, then 2 residents per week for 4 weeks, then random residents monthly. Audits will be added to quality indicators and reviewed at QAPI.</p>	<p>Completion Date: <b>05/31/2026</b> Status: <b>APPROVED</b> Date: <b>05/15/2026</b></p>

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F 0605  SS=D	Continued from page 3  are not required to treat the resident's medical symptoms. ..... §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.  §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.  §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--  §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 0605		

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F 0605  SS=D	Continued from page 4  §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;  §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and  §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.  §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.  This REQUIREMENT is not met as evidenced by:	F 0605		

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F 0605  SS=D	Continued from page 5  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 February 17, 2026, 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	F 0605		

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F 0605  SS=D	Continued from page 6  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	F 0605		

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F 0605  SS=D	Continued from page 7  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.	F 0605		
F 0641  SS=D		F 0641		

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F 0641  SS=D	Continued from page 8  483.20(g)(h)(i)(j) Accuracy of Assessments  §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.  §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement.	F 0641	Lead RNAC will pull list of residents who have had any falls in last quarter and ensure falls are listed on the MDS. RNAC secretary will check list of residents with MDSs due and weekly and will check each name to see if any of the residents had a fall and will communicate that to the RNAC/LNAC. RNACs/LNACs will audit the nursing sections of two MDSs done by another team member weekly x 4 weeks, then two MDSs biweekly x 1 months, two monthly. Two monthly will continue as a routine quality indicator. Schedule will be adjusted based on results. (I.e. increase if errors are found or continue with two monthly as routine quality indicator if no errors are found.) Lead RNAC will report results of audits to QAPI.	Completion Date: <b>05/31/2026</b> Status: <b>APPROVED</b> Date: <b>05/15/2026</b>

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F 0641  SS=D	Continued from page 9  This REQUIREMENT is not met as evidenced by:	F 0641		

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F 0641  SS=D	Continued from page 10  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 February 2, 2026, 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 February 2, 2026, was inaccurate and should have captured the fall that occurred on November 24, 2025.	F 0641		

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F 0641  SS=D	Continued from page 11  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 February 10, 2026, 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 Assessments Previously cited 4/16/25	F 0641		
F 0684  SS=D		F 0684		

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F 0684  SS=D	Continued from page 12  483.25 Quality of Care  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.  This REQUIREMENT is not met as evidenced by:	F 0684	Infection Control Nurse will educate providers on how to enter hemocult order into treatment instead of into lab orders by 5/16/26. Infection Control Nurse will educate charge nurses to move hemocult order from lab order into treatment order if it has been mistakenly entered into lab order by 5/16/26. Charge nurses will run order listing report daily and check for incorrect lab orders.  Staff Development will educate nurses re: physician notifications by . ADONs will audit random events that required notification weekly x 4 weeks, biweekly for 4 weeks, then monthly.  ADON completed audit on 5/7/26 regarding all Prevalon boot orders - all care plans and tasks updated. Charge nurses will audit that boots are in place for all residents with order for boots- weekly x 4 weeks, then randomly monthly.  Root cause analysis revealed that	Completion Date: <b>05/31/2026</b> Status: <b>APPROVED</b> Date: <b>05/15/2026</b>

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F 0684  SS=D	Continued from page 13	F 0684	<p>nurse did not understand greater than and less than symbols. ADON completed audit of all meds with parameters utilizing greater than or less than symbols. Wording was corrected / symbols were removed to ensure clarity. Order template was update to include words, not symbols. Charge nurses will audit medication parameters weekly x 4 weeks, biweekly for 4 weeks, then monthly.</p> <p>Staff development will educate charge nurses will on the importance of running their order listing report and reviewing all new/updated orders for follow up.</p> <p>All audits will be reviewed monthly at QAPI.</p>	

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F 0684  SS=D	Continued from page 14  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	F 0684		

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NAME OF PROVIDER OR SUPPLIER: <b>NORTHAMPTON COUNTY HOME- GRACEDALE</b>  STATE LICENSE NUMBER: <b>072802</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2 GRACEDALE AVENUE NAZARETH, PA 18064</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0684  SS=D	Continued from page 15  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.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395476</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>05/01/2026</b>	
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F 0684  SS=D	Continued from page 16  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.	F 0684		

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NAME OF PROVIDER OR SUPPLIER: <b>NORTHAMPTON COUNTY HOME- GRACEDALE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2 GRACEDALE AVENUE NAZARETH, PA 18064</b>		
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F 0684  SS=D	Continued from page 17	F 0684			

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395476</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>05/01/2026</b>
NAME OF PROVIDER OR SUPPLIER: <b>NORTHAMPTON COUNTY HOME- GRACEDALE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2 GRACEDALE AVENUE NAZARETH, PA 18064</b>		
STATE LICENSE NUMBER: <b>072802</b>				
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P 5520	<p>Nursing services.</p> <p>(3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight.</p> <p>This REGULATION is not met as evidenced by:</p>	P 5520	<p>Sufficient staff was originally scheduled but dropped due to call outs. DON will educate schedulers and supervisors to add open shift to staff and agency requests when staff call out.</p> <p>Supervisors and / or schedulers round the units and ask additional staff to work as needed as call outs occur. Schedulers will monitor staffing numbers and report to DON daily.</p>	<p>Completion Date: <b>05/31/2026</b></p> <p>Status: <b>APPROVED</b></p> <p>Date: <b>05/15/2026</b></p>
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE:		(X6) DATE:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395476</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>05/01/2026</b>
NAME OF PROVIDER OR SUPPLIER: <b>NORTHAMPTON COUNTY HOME- GRACEDALE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>2 GRACEDALE AVENUE NAZARETH, PA 18064</b>		
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P 5520	Continued from page 1  Based on a review of nursing time schedules, it was determined that the facility failed to meet the minimum nurse aide (NA) to resident ratios for one of 22 days reviewed.  Findings include:  Review of nursing schedules for 22 days from March 1 to 17, 2026, and April 26 to 30, 2026, revealed the following:  The facility failed to meet the minimum NA to resident ratio of one NA for ten residents on day shift (7:00 a.m. to 3:00 p.m.) on March 8, 2026.  In an interview on May 1, 2026, at 9:25 a.m., the Director of Nursing stated that the facility failed to meet the NA ratio on the date listed above.	P 5520		



# Certified End Page

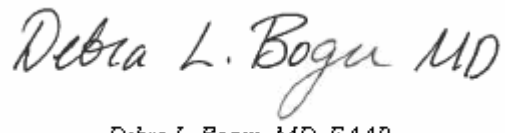
**NORTHAMPTON COUNTY HOME- GRACEDALE**

**STATE LICENSE NUMBER: 072802**

**SURVEY EXIT DATE: 05/01/2026**

**I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey**

  
Jeanne Parisi  
Deputy Secretary for Quality Assurance

  
Debra L. Bogen, MD, FAAP  
Secretary of Health



**Pennsylvania  
Department of Health**

THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY