IN THE COURT OF COMMON PLEAS OF NORTHAMPTON COUNTY
PENNSYLVANIA
CRIMINAL DIVISION

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| IN RE: | : | MISC. NO. 406-2024 |
| NORTHAMPTON COUNTY | : | |
| INVESTIGATING GRAND JURY OF 2024 | : | GJ CASE NO. C-9 |



NORTHAMPTON COUNTY INVESTIGATING GRAND JURY

REPORT NO. 1

**INTRODUCTION**

On or about March 14, 2024, pursuant to and based upon the application of the District Attorney of Northampton County, an Order of Court was entered by The Honorable Craig A. Dally, President Judge of the Northampton County Court of Common Pleas, summoning a County Investigating Grand Jury for the purpose of investigating matters including, but not limited to, unsolved homicides in and about the County of Northampton, Commonwealth of Pennsylvania.

The Honorable Craig A. Dally designated himself as Supervising Judge of the Grand Jury. The members of the Northampton County Investigating Grand Jury of 2024 were selected and seated on May 30, 2024, and charged by the Court with respect to duties and responsibilities. The aforesaid proceedings were conducted pursuant to 42 Pa. C.S.A. § 4541, *et seq.*, known as the Investigating Grand Jury Act.

In July of 2025, the District Attorney became aware of a series of concerning events related to an alleged serious assault of a disabled resident of Northampton County's Gracedale Nursing Home by a member of the nursing staff. The allegations included an assertion that the response to the assault by Gracedale's staff was

unreasonably delayed. A Notice of Submission for a Grand Jury investigation was filed by the District Attorney of Northampton County on or about July 29, 2025.

## HISTORICAL BACKGROUND

The facility known as the Gracedale Nursing Home, now located at 2 Gracedale Avenue, Nazareth, Pennsylvania, was originally part of a 600-acre farm, settled by the Moravian Church in 1745. The Moravians named the farm Gnadenthal (translation - Dale of Grace or Kindness).

In 1837, the Moravians sold 235 acres to Northampton County for the purpose of establishing an "Almshouse." Almshouses were precursors to non-profits, with their mission to employ and support the poor and the mentally ill. At the Northampton County Almshouse, the poor were "employed" to do farming on the property in return for housing and food. The property included a large dwelling house, with barns and other related buildings. By 1838, Northampton County had constructed an additional three-story stone building for housing large numbers of residents. The stone structure remains on the property to this day. Apparently, the total capacity of the Northampton Almshouse was 117 residents. Throughout the early 20th century, the Northampton County's Almshouse was primarily providing services to an older, indigent population.

In 1951, Northampton County constructed a two-story brick building on the Almshouse property, described as a dormitory style retirement home. The facility was named "Gracedale" and had the capacity to house approximately 500 residents. As of 1951, the property was no longer used as a farming operation, instead Gracedale operated solely as a fulltime care center for the elderly.

In 1975 the current ten-story tower was constructed and merged with part of the 1951 structure. At that time, Gracedale was designed to house almost 900 residents. The 1951 and 1975 structures were the last additions and now constitute the entirety of the Gracedale Nursing Home facility.

Currently, the Gracedale facility has an official (licensed) capacity of 688 beds and remains under the ownership of Northampton County. Measured by capacity, Gracedale is the second largest governmentally owned nursing home in Pennsylvania.

Gracedale accepts a wide range of residents, including those on Medicaid, Medicare, and with complex care needs. However, Gracedale does not accept every applicant, as admissions are based on medical necessity – people who require nursing home level of care. The term nursing home level of care generally refers to those who require a high level of care, supervision, and medical assistance required by individuals who cannot safely live alone due to severe physical, cognitive, or behavioral limitations who need assistance with daily living activities, medication management, and skilled nursing care. This level of care is required to qualify for Medicaid-funded nursing home stays.

Besides its general care units, Gracedale has two specialized memory care units which provide secure housing and intensive supervision for residents with Alzheimer's disease and forms of dementia; a rehabilitation unit that offers physical, occupational, and speech therapists; and a short-term respite care unit providing support for families who need assistance in managing health care needs on a temporary basis.

## REFERRAL TO THE GRAND JURY

In July of 2025, the District Attorney's Office first became aware of a series of concerning events related to patient safety issues at Gracedale.

The first matter involved an assault on an elderly patient named E.B. E.B. was diagnosed with an intellectual disability and related cognitive impairment; and, she was receiving hospice services. E.B. was a resident in Room A3 on Tower 7 at Gracedale. E.B. also had two roommates assigned to her, L.K. and M.B. E.B.'s roommates were also elderly.

In the early morning hours of June 23, 2025, Octavia Robinson, a Gracedale agency nurse, came into E.B.'s room and began assaulting E.B. by sticking her fingers down her mouth and then stuffing clothes and towels into her throat. In addition, Robinson was seen pounding on E.B.'s back and chest with her fist screaming that there was a demon inside E.B. that nurse Robinson was attempting to exorcise.

The roommates were horrified and L.K. made repeated calls to 911. Despite the repeated calls, the emergency response was confused and significantly delayed, exposing E.B. to an extended assault at the hands of nurse Robinson. Eventually, officers from the Upper Nazareth Police Department were dispatched to E.B.'s room. When the officers responded they observed nurse Robinson assaulting E.B. The police were required to forcibly interrupt the assault, as Robinson resisted her arrest.

The first call to the 911 center came in at 2:53 a.m. Apparently, a total of four calls were made to the 911 center reporting the assault; however, the police did not respond to E.B.'s room until 3:27 a.m.

Once the District Attorney's Office learned of the delay in processing the emergency 911 calls, the office commenced its investigation. Upon our initial inquiry, we learned that the Upper Nazareth Police Department had other concerns related to patient safety issues at Gracedale.

As a result, The District Attorney submitted a request to President Judge, Craig A. Dally, to allow its Grand Jury to begin an investigation into safety concerns related to the Gracedale residents. The President Judge authorized this Grand Jury investigation on July 29, 2025.

## 2025 MEDICARE INSPECTION DEFICIENCIES FOR GRACEDALE

As part of its investigation, the District Attorney's office accessed the United States Department of Health and Human Services website (Medicare.gov) for the recent inspection reports for Gracedale.

In 2023, Medicare issued 3 "Inspection Deficiencies", related to minor quality of care deficiencies. In 2024 there were 2 such reports. However, in 2025, there were 14, deficiency reports, several of which involved serious failures by Gracedale, including physical assaults of patients, patient elopements, and the failure to provide prescribed medical care. Our period of review involved the calendar year of 2025. We also note that there are strict legal protections for patient confidentiality and patient medical records, for this reason the District Attorney did not have access to individual patient medical records. Most of the reports reviewed were generated by Medicare inspections, resulting from several specific complaints, by a random review of selected medical records during the inspection process, and from some limited observerable

violations occurring on the few dates that Medicare inspectors were present on scene. Further, because Gracedale was under the scrutiny of Medicare inspectors on a very limited basis, it is impossible to render an opinion as to the extent of the patient safety issues over the period of our review.

The first set of deficiency reports were issued on April 16, 2025. The deficiency reports are summarized as follows:

1. On April 16, 2025, the Department of Health and Human Services (DHHS) issued a citation (F 0641) against Gracedale after a health inspection and review of medical records for Resident 322. In this citation, Gracedale was cited for the failure to provide anti-psychotic medication to a resident diagnosed with bi-polar disorder and dementia. Specifically, the medical records for the patient indicated that there were no orders from the staff to obtain psychotropic medicine for the resident that was prescribed by her physician, nor was there any reference in the patient's medical records that the resident was receiving the psychotropic medication prescribed for the resident.

2. On April 16, 2025, DHHS issued citation (F 0686) after a review of medical records for Resident 308. Resident 308 was diagnosed with diabetes melitus and had developed chronic skin lesions requiring specialized wound care. On February 21, 2026, the treating physician ordered daily cleansing of the wound and changing dressing every shift. The medical records contained no confirmation that treatment had been provided on March 1st, March 3rd, March 4th, March 7th, March 10th and March 11th of 2025 (6 out of 11 care days).

3. On April 16, 2025, DHHS issued a citation (F 0687) after a review of medical records for Resident 397. Resident 397 was suffering from brain injury, cognitive impairment, and was dependent on staff for care. On March 15, 2025, the treating physician directed specialized podiatry care for a fungal infection of toenails. On April 13th the resident was found in bed with toenails that were discolored, thick, long and jagged, upon review of the medical record, there was no documentation that the resident was provided prescribed podiatry/foot care. In an interview with the Director of Nursing, it was learned that the podiatrist was at the facility every week, but the resident had not been scheduled for a podiatry clinic visit.

4. On April 16, 2025, DHHS issued a citation (F 0688) after a review of medical records for Residents 21 and 380. Resident 21 was cognitively impaired and diagnosed with monoplegia (paralysis of one limb, muscle weakness and lack of coordination) and dependent on staff for activities related to daily living, including limitation in range of motion on one side of the body. On April 4, 2025 the occupational therapist recommended a restorative nursing program for range of motion activities, including directing staff to provide range of motion activities 5 to 7 times a week for 15 minutes as tolerated. As of April 16, 2025, the restorative nursing program prescribed by the occupational therapist had been provided to resident 21. Resident 380 was diagnosed with atrial fibrillation and a spinal cord injury. The care plan prescribed passive range of motion exercises daily. According to the medical records between March 15 and April 13, 2025, the resident missed 19 days of exercise.

5. On April 16, 2025, the Department of Health and Human Services (DHHS) issued a citation against Gracedale after a health inspection and review of medical

records for Resident 380. Resident 380 had a diagnosis for spinal chord damage and required staff assistance for daily living. Resident 380 had limited physical mobility and muscle weakness. However, Resident 380 was not cognitively impaired. Resident 380 was prescribed for passive restorative program for range of motion exercises for 15 minutes per day. In an interview with resident 380 and a confirming review of the medical records it revealed that resident 380 was not provided range of motion exercises on 19 of 30 days.

6. On April 16, 2025, DHHS issued a citation (F 0761) against Gracedale for the failure to securely store medication. The citation alleged that on April 14, 2025, the medication cart in Tower 5 was observed to have been left unlocked, unattended and was accessible to anyone from 11:20 AM through 11:36 AM and then again from 11:55 AM through 12:26 PM.

7. On April 16, 2025, the DHHS issued a citation (F 0812) against Gracedale for several observed failures to comply with basic food sanitary and safety protocols: (1) the refrigerator in the Northwest 1 Unit had 2 containers of soup with an expiration date of March 22nd and 24th, a container of black bean salad with an expiration date of March 20, 2025, and there were undated and unlabeled open packages of strawberries, blueberries, two packages of shrimp, a package of crawfish meat, pepperoni and chili sauce; (2) the refrigerator on the Northwest 2 Unit on April 14, 2025 had packages of blueberries, strawberries, meat sauce, peaches, and orange soda opened, undated and unlabeled. Additionally, there was a salad package with an expiration date of April 7th and, (3) a Licensed Practical Nurse was observed leaving the tray line while wearing her gloves to open doors and access the medication room and storage rooms, and then

return to the tray line to continue touching food and serving residents without changing her gloves.

8. On June 25, 2025, DHHS issued a citation (F 0600) for violations related to the assault occurring on June 23, 2025 to E.B. where nurse Octavia Robinson assaulted E.B. by stuffing rags and other material into her mouth in an effort to remove demons that were allegedly plaguing her.

9. On September 19. 2025, DHHS issued a citation (F 0689) for the failure to supervise (a complaint of elopement). The resident at issue was diagnosed with vascular dementia, syncope and collapse (fainting), cerebral infarction (stroke) and memory impairment but was able to walk without assistance. On August 20, 2025, an alert bracelet was applied to the resident's leg. The medical records noted that on September 13th a nurse noted that the resident had self-removed his alert bracelet and the nurse questioned if the unlocked unit was appropriate for the resident. On September 17th the resident was observed on the first floor and returned to his second-floor unit and a new alert bracelet was applied at 2:20 p.m. At 2:54 p.m. the resident had again removed bracelet, so another bracelet was attached. At 4:11 p.m., apparently based on the serial removal of his bracelets, a physician ordered that the Resident was to be placed on 15-minute check status. By 4:30 p.m. the Resident was missing and a search was conducted, but the resident could not be located at the facility. At 8:10 p.m. the Police located the Resident walking on a roadway one mile from the facility. The police returned the resident. Gracedale was cited for the lack of documentation addressing the escalating elopement behavior of the resident after each incident, as required by Gracedale's elopement policy.

10. On September 23, 2025, the Department of Health and Human Services again cited Gracedale (F 0689) for a second elopement violation with regard to the resident identified in the above Paragraph (No. 9). Due to the elopement on September 17, 2025 (resulting in the September 19th citation), the resident's supervision was increased to 1 to 1 (constant supervision by a staff member). However, on September 20, 2025 at 11:21 p.m., the Resident's alert bracelet was alarming and staff were unable to locate the resident at the facility. The resident was not found until the next day, September 21st, at 6:52 a.m. when the police discovered the resident at a convenience store approximately two miles from the facility. The second citation again noted that the resident was ordered to be placed on the 1 to 1 supervision after his first elopement occurring on September 17, 2025. However, according to the medical records, the assigned 1 to 1 staff member left his shift at 8 p.m. on September 20th and no replacement was available, resulting in the second elopement at 11:21 p.m.

11. Also, on September 23, 2025, a separate second elopement citation (F 0656) was issued against Gracedale for another Resident who also suffered from dementia. This second resident was Spanish speaking and a risk for elopement. The medical plan was deficient because there was not compliance with the care plan to (1) use an alert bracelet, and (2) address the communication barrier which existed due to the inability of the resident to speak English.

12. On October 2, 2025 the DHHS conducted an inspection with regard to a resident who was allowed to leave the facility against medical advice resulting in another citation (F 0628). The resident had cognitive problems related to stroke, he had muscle weakness, communication deficit, brain dysfunction, and a below knee

amputation. The resident had limited mobility and was wheelchair bound. On September 22, 2025, the medical record noted that the resident's physician indicated that the resident had hospital induced delirium and his decision-making capacity was to be reevaluated before discharge because he seemed to lack the ability to understand his medical situation including not having a home and not being able to drive. Further, the records indicated that the resident had difficulty accessing his medication by opening and closing his medication bottles. However, on September 25, 2025, the resident appeared in his wheelchair in the lobby of Gracedale and expressed a desire to call a taxi to leave. The medical report noted that a physician assistant assessed the resident, made his own determination on the spot that the resident had the capacity to make his own decisions and he allowed the resident to be discharged against medical advice (AMA), with his belongings, no medication, no confirmed or safe destination, and with only his wheelchair for transportation. A short time after leaving, the Resident was returned to Gracedale after the police found him traveling on a roadway near Gracedale in his wheelchair.

13. On October 17, 2025 the Department of Health and Human Services issued a citation regarding two separate assaults involving elderly residents (F 0600). The first listed citation involved an assault on October 6, 2025, in the room of Resident 1, who was noted in the medical records as being diagnosed with alcohol induced dementia with psychotic disorder. He was also upset with his admission to the facility, was verbally abusive to staff, uncooperative, refused medication, physically aggressive with staff and peers, and did not like others (including staff) to enter his room. Resident 2 was diagnosed with communication deficits, dementia, an elopement risk due to

disorientation, and he was frequently wandering and rummaging. Both had care plans to address their respective behaviors. On October 6, 2025, Resident 2 wandered into the room of Resident 1. Resident 1 violently assaulted Resident 2 causing severe injury. Resident 2 was found to be naked in the room of Resident 1, with blood strewn about the walls, the floor and bed sheets. Resident 1 had no injuries, but had blood on the front of his shirt and his knuckles were also bloody. Resident 2 had serious lacerations and contusions to his head, the right side of his face, his left eye, his left elbow, bleeding from the top of his buttocks, blood and a broken pelvis. Resident 2 was confused and disoriented and required hospitalization. The second incident involved Residents 3 and 4, and occurred on August 16, 2025. Resident 4 was noted as having anxiety and depression, but no reported cognitive impairment. However, the records noted that Resident 4 had a history of "shadowing caregivers" and engaging in "occasional inappropriate behaviors." On August 16th Resident 3 reported that Resident 4 entered his bathroom and touched his penis and she had to be told repeatedly to leave by Resident 3. As a result of the sexual abuse, Resident 3 required anti-anxiety medication. Gracedale was cited for the failure to implement the required interventions prescribed for the residents and for the failure to protect Residents from physical and sexual abuse.

## TESTIMONY OF DETECTIVE BRAD JONES

Brad Jones, a county detective employed by the Northampton County District Attorney's Office, testified before the Grand Jury on August 19, 2025, and again on November 4, 2025. Prior to his employment in the Office of the District Attorney,

Detective Jones was employed as an officer and a detective with the City of Bethlehem Police Department. He was also previously employed as a dispatcher for the Northampton County 911 Emergency Dispatch Center. He was assigned by District Attorney Stephen G. Baratta to oversee the investigation into alleged issues regarding Gracedale nursing home and its response to emergency situations.

Detective Jones laid the ground work regarding the investigation into the delayed response to the assault that occurred at Gracedale on June 23, 2025. According to Detective Jones, Octavia Robinson was employed as an Agency LPN on June 23, 2025, and was working the overnight shift on the 7th floor of the senior care center. At approximately 2:53 a.m., a resident named L.K. called 911 from her cell phone and reported that a nurse was trying to kill people on the 7th floor of the Gracedale facility. In response, a dispatcher from the 911 center contacted supervisors at Gracedale in order to advise them of the call. It was communicated to the dispatcher that someone would go check on L.K. Officer Zachary Dugan from the Upper Nazareth Police Department was notified of the call at 2:56 a.m. According to records received by Detective Jones, Officer Dugan closed the call at 3:00 a.m., and did not respond to Gracedale.

A second call from L.K. was received by the 911 center at 3:05 a.m. L.K. stated that there is a nurse trying to kill someone, and noted that the nurse was talking about "getting the demons out" of the victim. L.K. also related that the nurse would not let anyone else out of the room. At 3:08 a.m., Officer Dugan was dispatched by the 911 center, and a call was made by the 911 center to the supervisors at Gracedale in order to alert them to the second call from L.K. The answering supervisor stated that they had

already checked on the situation. Once again, the call was closed and Officer Dugan did not respond to Gracedale.

At approximately 3:18 a.m. on June 23, 2025, L.K. called the 911 center a third time. She stated that there was a nurse trying to kill someone, and expressed her frustration at the fact that no one had responded to her earlier calls. A dispatcher from the 911 center made contact with a supervisor at Gracedale at 3:20 a.m. The supervisor stated that they would make contact with L.K. and "take her phone away or something." Officer Zachary Dugan was dispatched a third time, but as before, closed the case without making contact with representatives at Gracedale.

A fourth and final call was received by the 911 center at 3:22 a.m. The call was placed by Nursing Supervisor Krishna Sreekumar who stated that LPN Octavia Robinson was acting strange and was unwilling to exit L.K.'s room. According to Sreekumar, there were a total of three (3) residents in the room at the time, and that, while she did not observe Robinson acting in a violent manner, Sreekumar indicated that Robinson was acting strange, and would not let anyone in or out of the room. Multiple officers from the Upper Nazareth Police Department were dispatched by the 911 center at 3:25 a.m. Officer Dugan was on-scene at Gracedale at approximately 3:27 a.m. Robinson was subsequently taken into custody at 3:32 a.m.

Detective Jones testified that he was in receipt of, and had reviewed, Officer Dugan's body camera footage from the arrest of Robinson. The body camera footage was received into evidence and viewed by the grand jury. The video showed several officers from Upper Nazareth Police Department arriving in room A3 on the 7th floor/Tower 7 at Gracedale. Robinson was visible standing over resident E.B. while

dressed in full personal protective equipment (PPE) gear. As the officers made entry into the room, they observed Robinson with her fingers pressed into E.B.'s mouth. There was blood on the bedding and on E.B.'s clothing. In addition, towels and other items, some with blood on them, were strewn about the room on the floor. The officers quickly intervened, and Robinson was taken into custody.

While Robinson was being processed, she was ranting about demonic possession, and stating that she was fulfilling her duty to protect people by removing the demon from E.B. She was transported to Lehigh Valley Hospital where she was ultimately held for a 302 psychiatric evaluation. Criminal charges were filed upon her release.

Detective Jones testified that he executed a search warrant to obtain Robinson's medical records from the hospital. According to Detective Jones, the medical records indicated an "unspecified psychosis," which was accompanied by delusions, aggression, assaultive behavior and verbal abuse of staff. The records also indicated that Octavia Robinson had to be restrained in four-point restraints to keep her from harming herself or others. Detective Jones also noted that, based upon his previous experiences as a 911 dispatcher and as a police officer in the City of Bethlehem, it was his professional opinion that there were multiple errors on the part of 911 Center employees, Gracedale employees, and Upper Nazareth Police Officers on the morning of June 23, 2025, all of which prolonged the assault on E.B. by Octavia Robinson.

On or about the date of December 16, 2025, Detective Jones updated the grand jury by testifying to the fact that he had spoken with Northampton County Coroner, Zachary Lysek. According to Coroner Lysek, E.B. was deceased. An autopsy with

toxicology was ordered, but the results were not immediately available at the time of the testimony.

## TESTIMONY OF OFFICER ZACHARY DUGAN

Officer Zachary Dugan of the Upper Nazareth Police Department testified before the Northampton County Investigating Grand Jury on October 21, 2025. Officer Dugan has been employed as a police officer since 2021, having started his career working for the City of Reading Police Department. He transferred to Upper Nazareth in 2023. He works for Upper Nazareth as a uniformed patrol officer assigned to the 5 p.m. to 5 a.m. shift.

During his testimony, Officer Dugan stated that he is very familiar with the Gracedale facility due to the fact that it is located in the jurisdiction of the Upper Nazareth Police Department. According to Officer Dugan, the department gets flooded with calls on a regular basis. Many of them are reports that a resident is being transported to a local hospital. Other times, dementia patients call and report imaginary incidents. As a result, the "standard practice" for many officers in the department is to have the 911 center reach out to the supervisors at Gracedale in order to determine whether or not an officer is actually needed. Officer Dugan acknowledged that he would make the decision on his own as to whether or not to respond to the Gracedale facility if the situation does not appear to be emergent, and that he does not respond to most calls. Since the Robinson incident, he has begun traveling to Gracedale more frequently than he did in the past.

Officer Dugan watched the footage from his body camera on June 23, 2025, and narrated his observations for the grand jury. He noted that it was pandemonium in room A3 when he arrived. Supervising Nurse Sandra Gerard-Amazan was yelling at Robinson, who had her hand and fingers in E.B.'s mouth. Robinson was dressed in full PPE gear and was sweating profusely. Officer Dugan ordered her to remove her hand and to step away from E.B. When Robinson did not initially comply, Officer Dugan removed his Taser from his belt and aimed it at her. While Robinson continued to act abnormally, Officer Dugan was able to take her into custody without further incident. As Robinson was being placed into a patrol car, and while she was being transported to the hospital, she continually repeated that E.B. had demons inside of her and that they needed to come out. She also pointed at some of Officer Dugan's tattoos and noted that they were coming for him as well.

While Robinson was secured in Officer Dugan's police vehicle, Officer Dugan went back into the building in order to speak with some of the personnel. He noted that the supervisors didn't seem to know Robinson's last name. They all only knew her as Octavia, and that she was an agency nurse. However, no one knew which agency she was employed with. Officer Dugan did not accompany Robinson to the hospital. That responsibility was handled by Officer Clinton Wambold.

Officer Dugan additionally provided testimony regarding elopements from Gracedale, and provided details regarding one specific recent episode. While he was on patrol, he observed a man hitchhiking on Bath Pike in Upper Nazareth Township. The man told Officer Dugan that he was trying to get to Bath Borough. Officer Dugan agreed to give him a ride. While the man did not have identification on him, he did provide

information to Officer Dugan, who was then able to run a check on him. After determining that the man did not have any active warrants, and after notifying the 911 dispatch center of the situation, Officer Dugan dropped the man off in Bath Borough.

Approximately forty-five minutes later, a dispatcher from the 911 center contacted Officer Dugan and advised him that Gracedale called and reported the man as missing from their facility. In response, Officer Dugan contacted a supervisor at Gracedale who in turn was able to reach out to the man's sister. The sister related that the man used to date a dancer at the Fox Gentleman's Club, which is located in Bath Borough. Officer Dugan immediately travelled to that location but did not locate the missing individual. It was ultimately discovered through the man's sister that the man ended up at an address in Moore Township where his girlfriend resided. He was located at the specified address and told that he needed to be returned to Gracedale.

Officer Dugan testified that the man who had eloped was fitted with a tracking bracelet as a resident at Gracedale. He had apparently cut the bracelet off, and threw it into a garbage can before walking out of the facility. Officer Dugan did not understand how it had taken so long for employees at Gracedale to report the man missing in light of the fact that he had cut off the bracelet prior to his elopement.

Officer Dugan testified that the number of assault calls from Gracedale had risen heavily since the Robinson incident. The calls included assaults between staff and patients as well as assaults between different patients.

## TESTIMONY OF OFFICER CLINTON WAMBOLD

Officer Clinton Wambold of the Upper Nazareth Police Department testified before the Northampton County Investigating Grand Jury on October 21, 2025. Prior to becoming employed as a uniformed officer in Upper Nazareth, he was employed as a Northampton County Deputy Sheriff for approximately three years. Officer Wambold has been employed with the Upper Nazareth Police Department for a little more than six (6) months.

Officer Wambold responded to Gracedale as part of the Octavia Robinson investigation on June 23, 2025. While Robinson was taken into custody by Officer Zachary Dugan, Officer Wambold interviewed L.K. as well as various members of the staff at Gracedale. Written statements were obtained from supervisors Michael Muia, Krishna Sreekumar, and Sandra Gerard-Amazan, all of which were submitted into evidence and presented to the grand jury for review.

According to Officer Wambold, after he spoke with L.K. and the Gracedale supervisors he returned to room A3 in Tower 7. Upon his return to the room, he noted that the room had been cleaned and that all of the clothing and gowns involved in the incident between E.B. and Octavia Robinson had been disposed of or cleaned. As a result, Officer Wambold was unable to collect any physical evidence related to the assault. Officer Dugan testified that in his estimation little or no effort was made by the Gracedale staff to intervene in the ongoing assault of E.B.

Officer Wambold accompanied Robinson as she was transported to Lehigh Valley Hospital for observation. He observed her erratic and irrational behavior at that time. After arriving at the hospital, and after consultation with the medical staff, Officer

Wambold completed documentation for a 302 involuntary psychiatric commitment for Robinson. Robinson was thereafter held for observation and Officer Wambold returned to the Upper Nazareth Police Station.

## TESTIMONY OF OFFICER DANIELLE PETRUCCI

Officer Danielle Petrucci of the Upper Nazareth Township Police Department testified before the Northampton County Investigating Grand Jury on the morning of November 4, 2025. Officer Petrucci has been employed as a police officer for almost eleven years, with all of her professional time spent with the Upper Nazareth Township Police Department. She worked the night shift as a uniformed patrol officer for the first seven years of her employment, before then switching to day shift as a uniformed police officer.

Officer Petrucci testified regarding several incidents that her department investigated over the course of the past year involving residents and staff at the Gracedale facility. The first incident she testified to was an altercation between two residents on the dementia unit, a co-ed, secured unit where many of the patients have cognitive impairments. Resident L.R. wandered into a room occupied by M.E. M.E. was unhappy and followed L.R. back out of the room and into a common area where he pushed L.R. into a wall. L.R. fell as a result of the assault, ending up with a head laceration and a broken hip. Neither patient was being monitored by staff at the time. Due to the injuries, L.R. suffered a cognitive and a physical decline. He is now bedridden and unable to interact with others. At the time of the assault, M.E. was

supposed to have a one-to-one staff assignment due to prior temperament issues. However, the closest staff member did not arrive until the assault had concluded.

Officer Petrucci noted that there have been several elopements from Gracedale during 2025. In one instance, a wheel-chair bound resident, who was a double amputee with a catheter, signed himself out AMA and was found wheeling his way down Gracedale Avenue. The police were forced to respond in order to handle the dangerous situation. Another resident named L.M. escaped from Gracedale several times requiring police action. L.M. has significant dementia and is confined to a secure floor at Gracedale which requires the entry of a passcode to exit. Nevertheless, on a number of occasions, L.M. found a way to exit the secure floor. Each time, emergency personnel were required to respond in order to search for and locate the resident. In addition to L.M. having significant dementia, L.M. is also combative and doesn't speak English.

According to Officer Petrucci, after reviewing internal reports with the Upper Nazareth Police Department, she determined that over a two-year period, the police were dispatched to Gracedale 1600 times. Many of the calls do not actually require police presence, especially for medical issues. In 2024, seventy-seven (77) police reports were generated by UNPD for incidents at Gracedale that required police intervention or investigation. Through October of 2025, there were an additional sixty-eight (68) police-related incidents.

Officer Petrucci noted that the nursing home does not have any independent full-time security on site. As with all county owned buildings, there is a Northampton County Deputy Sheriff stationed in the main lobby. That position is occupied Monday through Friday from 7 a.m. to 11 p.m. and sometimes on the weekend. The station is vacant

from 11 p.m. until 7 a.m. In addition, it is understood that the deputy sheriff is only on site for building security, and is directed not to intervene or investigate matters involving patients. By way of example, Officer Petrucci testified that the L.R. incident did not conclude until 11:14 p.m., noting that no deputy was on station at that time. She also testified that members of the nursing staff were found sleeping at their desks when the police were present. The grand jury did not solicit any direct testimony from the Northampton County Sheriff's Office on this issue.

## TESTIMONY OF CONFIDENTIAL GRACEDALE EMPLOYEE

On November 4, 2025, the Northampton County Investigating Grand Jury also heard testimony from a nurse employed at Gracedale regarding perceived problems at the facility. The nurse, who wished to remain anonymous, confirmed much of the information provided to the Grand Jury by Upper Nazareth Police Officers. She testified that the victim of the assault committed by Octavia Robinson, E.B., had expressed to her that she thought that Robinson was going to kill her by stuffing a washcloth down her throat.

Additionally, the nurse stated that all contracted agency nurses were forced to switch to one contract company, namely Tallavera Medical Staffing, in the Fall of 2025. Agency nurses were told that if they did not terminate their existing agency contracts and immediately sign with Tallavera, they would not be permitted to remain employed at Gracedale. According to the confidential employee, she was previously contracted through GHR Healthcare like Octavia Robinson. She testified that neither GHR nor Tallavera vetted their agency employees with mandated drug testing during the hiring

process. This was a concern for her based upon the fact that medication carts are not secured and can be accessed by any nurse on the floor.

The confidential nurse further indicated that the span of care (span of control) caused by staffing shortages is unacceptable at Gracedale, with as many as fifty (50) patients being cared for by as few as two to three nurses per shift. Finally, she indicated that there are a lot of turnovers in staff at Gracedale, including in top positions such as Administrator/Director and Director of Nursing. According to the nurse, she really cares for the residents at the facility and that is the motivating force that keeps her at Gracedale despite all of the staffing and security concerns.

## TESTIMONY OF MICHELLE MORTON

Four witnesses were subpoenaed to testify before the Northampton County Investigating Grand Jury on December 30, 2025. The witnesses were Gracedale Administrator Michelle Morton, Risk Manager/Investigative Nurse Monica Bierman, Nurse Supervisor Sandra Gerard-Amazan, and Nurse Supervisor Krishna Sreekumar. Due to the fact that all four individuals were employed directly by Northampton County, the County Executive appointed the Northampton County Solicitor's Office to provide legal representation for the employees before the grand jury. County Solicitor Melissa Rudas appeared before Supervising Judge Craig Dally, at which time she was informed of a probable conflict of interest in representing more than one witness before the grand jury pursuant to 42 Pa.C.S.A. §4549 of the Grand Jury Act.[1] Attorney Rudas indicated

[1] 42 Pa.C.S.A. §4549(c)(4) states "An attorney, or attorneys who are associated in practice, shall not continue multiple representation of clients in a grand jury proceeding if the exercise of the independent professional judgment of an attorney on behalf of one of the clients will or is likely to be adversely affected by his representation of another client. If the supervising judge determines that the interest of an individual will or is likely to be adversely affected,

that she would continue to represent Director Morton, and that the administration would endeavor to solicit outside counsel for the remaining three witness for a future date.

Director Michelle Morton graduated from Norristown Area High School before attending Temple University where she obtained a Bachelor of Science degree in Therapeutic Recreation. She completed an internship with Moss Hospital and then began working at the Doylestown Hospital Rehabilitation Center where she remained for four years. Thereafter, she began working in the field of long-term care. She obtained a personal care home license and was eventually offered the position as an assistant living administrator at a long-term care facility. While employed as an assistant living manager, her employer sent her to get a nursing home license.

After obtaining her nursing home license, Morton began working at a number of facilities as a nursing home administrator. She was employed as the administrator of Phoenix Center in Phoenixville, a 100-bed long-term care facility, when she learned of the job opening at Gracedale. She went through a number of interviews with different panels before being offered the position as Administrator of Gracedale by former County Executive Lamont McClure. Morton acknowledged that Gracedale is significantly larger than Phoenix Center, with an operating budget of over $100 million. During the interview process Morton was told about various issues at Gracedale, including problems with overtime, staffing shortages, and the need for retaining existing staff. She was also told that the administrative staff was in place and set for the facility by the county administration. Morton was hired as the Administrator of Gracedale in

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he may order separate representation of witnesses, giving appropriate weight to the right of an individual to counsel of his own choosing."

March of 2025. However, she was not given the authority to bring in any of her own choices for key administrative positions.

When questioned about the administrative staff listed on the county website, Morton acknowledged that the Risk Manager was not listed as a key administrative individual. She acknowledged that a risk manager is required by the Pennsylvania Code, and that a risk manager is tasked with addressing patient safety, making certain that the medical issues of the residents are properly managed, and that procedures are in place for the management of the facility in terms of being compliant with government mandated regulations. However, Morton denied that the Risk Manager should be classified as her "right-hand person." Morton identified Monica Bierman as the Risk Manager at Gracedale. According to Morton, Bierman's primary responsibility is to investigate incidents at the facility, and to make certain that all incidents are documented according to federal and state guidelines.

In 2023, Affinity Health Services, Inc., was retained by the county for $40,000 in public funds to complete an analysis of issues that existed at Gracedale, including problems with pay rates, problems with excessive reliance on agency nursing, a lack of employee retention programs, etc. A thorough report was generated by Affinity that was presented to County Council and to the existing county administration under former County Executive Lamont McClure. Morton commenced employment as administrator of Gracedale on March 17, 2025. When she began, she had a list of issues that she wanted to address with regard to running the Gracedale facility. However, she conceded that she never read the Affinity report, and that it was never presented to her by the county until the issue was raised at a county council meeting on November 6,

2025. As of the time of her testimony before the grand jury, Morton still had not read the report.

Contained within the Affinity report was the conclusion that Gracedale was relying too heavily on agency staffing, and that the county was spending too much money because of its dependence on non-county employees. As of the time of the report, Gracedale was staffed with 58% agency registered nurses, 43% agency employed LPNs, and 56% total agency direct care nursing staffing. Despite those conclusions, agency dependence rose to 75% during Morton's first eight months as administrator. Morton testified that dealing with all of the Department of Aging infractions at Gracedale took precedence over any other issues.

In response to questioning from District Attorney Stephen G. Baratta, Morton reviewed several Commonwealth reports detailing deficiencies at Gracedale. According to inspection reports that were submitted to the grand jury as Commonwealth Exhibit 13, there were three (3) deficiencies in 2023, two (2) deficiencies in 2024, and thirteen (13) for the first ten months of 2025. Included among the list of deficiencies for 2025[2] were claims that: (1) a resident who was supposed to be on anti-psychotic medicine hadn't been given his medicine for almost a month; (2) a resident who needed daily wound care only received such care on six out of eleven (11) days; (3) foot care was ordered by a medical doctor for one of the residents, but after nearly a month, no such care was administered by staff resulting in a fungal infection; (4) there were two residents that were supposed to receive restorative nursing care but did not; (5) the medication cart was left unattended twice on April 14, 2025; (6) expired soups and other

[2] Refer to 2025 Medicare Inspection Deficiencies for Gracedale, *supra*, in addition to Commonwealth's Exhibit Number 1, which is attached hereto.

perishable items were discovered in two separate refrigerators available to residents; (7) On May 2, 2025 and May 3, 2025, a resident diagnosed with bladder cancer and equipped with a catheter was observed for extended periods of time with the drainage bag situated above the level of his bladder, including having it placed on the dining room table where he was eating; (8) the assault by LPN Octavia Robinson on resident E.B.; and (9) resident elopements are detailed herein. Morton's response to the claims was that an inspection is only a moment in time and not a reflection that overall, things were poor. She appeared to minimize the documented infractions, as well as her role in the prevention of those matters. She also denied that staffing shortages contributed to the documented deficiencies.

When questioned about staffing shortages, Morton testified that she was unsure of how many nursing positions were open at Gracedale. While acknowledging that she is responsible for submitting the budget for all employees at Gracedale, she was uncertain how many vacancies existed at the time of her testimony. Her primary concern is with looking at the hours per resident and the ratio in comparison to the census, and to the total number of occupied beds. Morton conceded that the county was forced to rely on agency staffing in order to meet the level of care required by state and federal guidelines.

Morton stated to the grand jury that her strategic plan is to increase the number of county-employed nurses at Gracedale, especially in light of the fact that 75% to 80% of the nursing staff is agency employed, and that they continue to hire agency nurses because they have been unable to otherwise fill the positions. When questioned about the fact that in 2022, the county allocated $5 million from the American Rescue Plan for

use in annual employee retention bonuses and for attracting new hires, she admitted that she was questioned by county council in the summer of 2025 to account for the fact the bonuses were no longer being issued, and that nearly half of the allocated money was diverted to cover overtime payments and into the general revenue fund to pay expenses.

Morton testified that resident elopements have been an issue, and continue to be an issue at Gracedale. She stated that the facility is in the process of getting rid of the former entry code system, and switching over to a badge swipe system. All visiting family members for residents will have to be granted access to the building by staff so that unauthorized residents will no longer be able to acquire the code and walk away from secured areas. Morton also stated that she is looking at the resident admissions process to help screen out problematic residents before they are accepted at the facility.

During her testimony, Morton acknowledged that there have been a number of recent incidents involving assaults committed by one resident upon another at Gracedale. She confirmed the assault described by Officer Petrucci involving resident L.R. wandering into a room occupied by M.E., and his subsequent hospitalization after M.E. attacked him. On October 6, 2025, dementia patient R.W. went into a resident's room and severely assaulted him causing a gash on the resident's head and several facial injuries. In a third incident, C.S. threw a soda can at a blind resident who was confined to a wheelchair. The assault caused a significant laceration on the victim's face. According to Morton, problematic residents cannot simply be removed from the facility unless there is a safe location to which they can be discharged. She denied that the increase in assaults was due to understaffing problems.

When asked directly what the plan was for recruiting new county employees, Morton focused on staff development and training initiatives. She believes that increasing internal job satisfaction will be beneficial in bringing in new employees and with the on-boarding process. Her practice appears to involve the creation of internal committees in order to address staff concerns. However, it is interesting to note that her attitude towards the nursing profession overall was somewhat negative. Specifically, she stated to the grand jury that, "There is a saying in nursing that nurses eat their young. It's a common saying. I've always said that I don't know why they say that and why some nurses seem to say that with a sense of pride.... [I]t's a common saying in healthcare that nurses eat their young, [m]eaning ... that the employees that have been there aren't as nice as they should be to current employees." Morton was unaware of any allegations regarding supervisors sleeping at their desks during the night shift.

## TESTIMONY OF SUPERVISING NURSE SANDRA GERARD-AMAZAN

Sandra Gerard-Amazan testified before the grand jury on the morning of March 10, 2026. Gerard-Amazan was hired as a night-shift nursing supervisor in August of 2023. She was hired directly by Northampton County and has not been employed with an outside agency. She normally works three 12-hour shifts during a standard work week. The supervising nurse's office is located on the second floor of the Gracedale building. The job of the night shift supervising nurse is to oversee the nurses and the CNAs during that shift, and to make rounds on all of the units throughout the night. According to Gerard-Amazan, there are three supervisors working together on the night

shift. One oversees the men's dementia building, one oversees the towers, and one takes care of administrative duties in the supervisor's office.

Gerard-Amazan testified regarding the events on the night of June 22, 2025 into the morning of June 23, 2025 when Octavia Robinson was arrested for assaulting E.B. She stated that the initial 911 call came from L.K., and that she took the call from the dispatch center. Gerard-Amazan alleged that she contacted the CNA assigned to the unit who advised her that the nurse was already in the room with the caller. Clearly there was a breakdown in communication as the nurse was the individual identified as being responsible for the assault. 911 records indicate that in L.K.'s first call to the 911 center, she stated that a nurse was trying to kill someone. Gerard-Amazan advised the 911 Center that someone would check on L.K. However, after being advised by the CNA that a nurse was in the room, Gerard-Amazan "finished with what she was doing."

Supervising Nurse Krishna Sreekumar received the next call from the 911 center after L.K. called a second time and reported that a nurse was trying to kill someone, and stated that the nurse was talking about "getting the demons out" of the victim. L.K. also related that the nurse would not let anyone else out of the room. Sreekumar went up to the 7th floor, but then returned to the supervisor's station asking Gerard-Amazan to come view the situation herself. According to Gerard-Amazan, all three supervisors then went to the 7th floor together at which time they saw Octavia Robinson dressed in full PPE gear making physical contact with E.B.

It is significant to note that Gerard-Amazan was unable to provide information about the third call placed by L.K. to the 911 center when she expressed frustration that no one had come to assist. The first call was received by the 911 Center at 2:53 a.m.

The second call, allegedly answered by Sreekumar, was received at 3:05 a.m. According to Gerard-Amazan, Sreekumar went up to the 7th floor after the second call. However, as of 3:18 a.m., L.K. reported that no one from Gracedale had come to assist her. According to the 911 records, the supervising nurse who answered the 3:18 a.m. call told the dispatcher that they would make contact with L.K. and "take her phone away or something." It wasn't until 3:22 a.m. that Sreekumar contacted the 911 Center herself and requested police assistance. This summary of facts raises more questions than it answers.

After the three supervising nurses made entry into the room, they verbally confronted Robinson about her activities. She yelled at them all to get out, then told Gerard-Amazan that she was "going down too," and that "the Devil will take you down." Gerard-Amazan directed Sreekumar to call 911. Robinson started to push her hand into E.B.'s throat. When Gerard-Amazan yelled at her to stop, Robinson began throwing things at her. According to Gerard-Amazan, the supervisors continued to intervene and monitor the situation until the police arrived and took Robinson into custody.

Gerard-Amazan noted that there was a policy change that was adopted at Gracedale after the Robinson incident. In the past, when supervising nurses completed their rounds, they would simply check to make certain that everything appeared to be fine on each floor. However, supervisors are now required to locate the nurses during rounds, and have them sign the report sheet. The grand jury did not subpoena any records from Gracedale specifically relating to rounds completed by the supervising nurses on the night of the Robinson incident. Given the amount of time that Robinson appears to have been in the room occupied by E.B. and L.K., questions are raised

regarding why a supervisor did not discover what was going on during the rounds completed prior to L.K. calling 911.

Gerard-Amazan acknowledged during her testimony that during the overnight shift at Gracedale, the supervising nurses are in charge of the facility. While there is a chain of authority that includes the Administrator, the Assistant Administrator, the Director of Nursing and two Assistant Directors of Nursing, senior personnel do not work overnight. Therefore, the supervising nurses are responsible for making administrative decisions from 7 p.m. to 7 a.m.

Gerard-Amazan would like to see more county-employed nurses at Gracedale, rather than agency employed nurses because they are better invested in the residents, and in contributing to the work environment. She testified that Gracedale has lost quite a few county-employed nurses to agencies due to the discrepancies in pay. It is interesting to note however, that according to public records that were presented to the Grand Jury, in 2024 Gerard-Amazan was the 4th highest paid employee in Northampton County, having earned approximately $142,100 for the year.

## TESTIMONY OF SUPERVISING NURSE KRISHNA SREEKUMAR

Supervising Nurse Krishna Sreekumar appeared before the Northampton County Investigating Grand Jury on the morning of March 10, 2026. Sreekumar has been employed at Gracedale since August of 2022. She initially came on board as an international nurse through a staffing agency. However, when her agency contract expired, she was hired as a county-employed nurse in either April or May of 2025. She has worked the overnight shift since her first day of employment at Gracedale.

Sreekumar was working as one of the supervising nurses on the night of the Robinson incident. According to Sreekumar, she had been on vacation prior to that night, and met Robinson for the first time during her return shift on June 22, 2025. Sreekumar testified that she was in the supervisor's office when the first 911 call came in around 3:00 a.m. She noted that Gerard-Amazan answered the call and indicated that she would call up to the 7th floor. Sreekumar assumed that the situation had been taken care of until the second 911 call came in, which she answered. Based upon her conversation with the 911 dispatcher, Sreekumar told Gerard-Amazan that she would go up to the unit personally in order to determine what was transpiring.

When Sreekumar arrived on the 7th floor, she went immediately to L.K.'s room. As she opened the door, she saw blood-stained clothes on the floor along with wash cloths and bed sheets, and observed Robinson in full PPE gear. Sreekumar also saw Robinson tapping E.B. on the back and chest repeatedly, while also attempting to put her fingers down her throat. She verbally attempted to stop her, but Robinson neither responded nor even acknowledged her presence in the room. Sreekumar hurried back to the supervisor's office and asked the other supervisors to come with her back to the 7th floor. After they all returned to E.B.'s room, she contacted 911 and asked them to send the police.

Sreekumar had no knowledge of the third call placed to the 911 center, and stated that she did not tell the 911 dispatcher that someone would take away L.K.'s phone. According to Sreekumar, she answered the second dispatch call, and then called 911 after returning to E.B.'s room.

## TESTIMONY OF RISK MANAGER MONICA BIERMAN

Monica Bierman testified before the Northampton County Investigating Grand Jury on March 24, 2026. She is currently employed as the Risk Manager/Investigative Nurse at Gracedale. Bierman has worked for the county for approximately thirty-two (32) years, having started as a nurse's aide at the Gracedale facility. She eventually put herself through nursing school while still working part-time there. Bierman became an RN in 2000 and started working full-time on the 3 p.m. to 11 p.m. shift. Two years later, she was promoted to the position of supervising nurse where she remained for fifteen years. In 2017 she left employment as a supervising nurse on the middle shift in order to care for her daughter. Instead, she worked as a registered nurse assessment coordinator during the day shift. However, in 2022 she was given the position of risk manager/investigative nurse.

As the risk manager, Bierman stated that her primary responsibility is to review every resident incident report, investigate the underlying incident, and submit required documentation to the state. She noted that at the time of the Robinson incident, there were a group of seven individuals, including herself, who the nursing supervisors could contact for guidance with any questions or concerns that arose during the night shift. The group would take a turn being "on-call" every week. According to Bierman, Elizabeth Brinker was the on-call person during the night of the Robinson assault. Brinker came to Bierman's office at 7 a.m. on the morning that Robinson was arrested to inform her about the incident. However, it was clear that Brinker did not grasp exactly

what had happened during the night and thus could not adequately describe it to Bierman.

Bierman went on to state that her normal routine when she comes into work is to open the state reporting electronic system to check and see whether any reports were submitted by supervisors while she wasn't there. Whoever is in charge at the time of an incident is required to enter the incident into the reporting system. According to Bierman, reports of serious bodily injury and reports of sexual abuse have to be reported within two hours. Everything else must typically be reported within 24 hours. At the time of her testimony, Bierman could not recall whether anyone had submitted an electronic report for the assault on E.B., and conceded that most things do not get reported in a two-hour time frame at Gracedale.

To the best of her recollection, Bierman reviewed the nurse's notes from the previous night as well as the resident's charts. She went up to the 7th floor unit and spoke with L.K. as well as the supervising nurses. She was aware that the Department of Health had been notified, and was under the belief that the Area Agency on Aging was also given notice. Bierman also notified the Pennsylvania Department of State, which oversees nurse licensing, as well as the New Jersey Department of State. Bierman cited a severe lack of communication as being one of the main issues amongst staff and administrators at Gracedale. She didn't have any real suggestions on how to improve Gracedale other than to improve communication.

In her responses to questioning before the Grand Jury, Bierman appeared very unsure of herself and often could not recall significant facts that were placed before her. It was difficult to determine whether she was being evasive, defensive or uncertain as to

the significance of the matter at issue. However, her responses were at odds with her thirty-two (32) years of experience working in nursing at Gracedale.

**TESTIMONY OF FORMER ADMINSTRATOR JENNIFER STEWART**

Jennifer Stewart testified before the Northampton County Investigating Grand Jury on the morning of March 24, 2026. She worked at Gracedale from 2005 until she resigned in January of 2026, having begun her career as a night shift CNA. In 2009 she earned her bachelor's degree in psychology from ESU. After graduation, Stewart continued to work as a CNA while also working as a social services coordinator at Manor Care. The following year she began work as a social services coordinator at Gracedale at a time when admissions and social services were combined into one department.

In 2011, County Executive John Stoffa was working to sell Gracedale. However, pursuant to a referendum, the people of Northampton County voted to keep Gracedale under county ownership. Thereafter, in 2012, the county administration hired Premier Healthcare to manage Gracedale on behalf of the County. A decision was made at that time by the Premier Management Group to separate admissions from social services. David Holland from Premier was named as interim Administrator of Gracedale, and he began to work with Stewart. Together they completely revised the admissions process in order to better address the needs of the residents, the families, and the administration. In 2013, Stewart was named as the Director of Admissions for Gracedale.

Stewart remained as the Director of Admissions for approximately five years before being named as Assistant Administrator of Gracedale in 2018. D. Millard

Freeman was named as the Administrator of Gracedale during that time. Freeman left in 2016 and David Holland returned to the position until Ray Soto was appointed as Administrator. Stewart served as Assistant Administrator under Soto until she was named as Interim Administrator of Gracedale in January 2019, and thereafter as full Administrator on June of 2019.

In 2023 Stewart began contemplating her retirement from the County in the near future once she turned 55 years old, and after being employed for 20 years. She began meeting with Susan Wandalowski about her plans. In 2024 the position of Director of Admissions became vacant, and Stewart applied for the position in the hopes of stepping back while having time to help guide her replacement as Administrator. She was offered the job as Director of Admissions, but continued to serve as Interim Director as well until her replacement was hired.

While serving as the interim Administrator and the Director of Admission, Stewart was instructed to get the census up. At the time, the census was around 485. She was told by County Executive Lamont McClure to bring the census up to around 525 or 530 for budgetary reasons. According to Stewart, Gracedale did not have the staffing for a census of 525 or 530, so they were forced to turn to outside staffing agencies in order to meet that level.

Larry Erickson, an accountant at Gracedale, succeeded Stewart as interim Administrator until Michelle Morton was named the Administrator in March of 2025. Stewart testified that, while she attempted to assist Morton in transitioning into the role as Administrator at Gracedale, Morton didn't receive Stewart's mentorship in a positive manner. She indicated that until March of 2025 she had never been reprimanded or

found in violation of any rules or procedures at Gracedale. However, she was given a Program Improvement Plan (PIP) shortly after Morton came on board, and was mandated by Morton to increase resident numbers to 525-530, as requested by McClure, in order to make Gracedale fiscally solvent. Morton essentially told her that they should not be denying admissions to anyone in order to boost their admission numbers. At the same time, Morton informed Stewart that Gracedale would be severing ties with the outside agencies that Stewart had worked closely with over the years, and would be replacing them with a new agency in order to cut costs. Morton also usurped Stewart's authority as Director of Admissions by reviewing, and in many cases, overriding admissions denials in cases where Stewart believed that the resident was not an appropriate candidate for Gracedale.

Stewart felt like she was being micromanaged, and was concerned about being replaced before her pension fully matured. By November of 2025, on the advice of her medical doctor, Stewart was granted FMLA leave from the county. She remained on FMLA leave until January 9, 2026 when she formally retired. After retiring from Northampton County, Stewart was hired as the Nursing Administrator at Bethlehem North for the Genesis Corporation where she remains employed.

Stewart is extremely knowledgeable in the field of nursing home administration, and it is clear that Gracedale benefitted from her knowledge and leadership. She believes that Gracedale was thriving under the management of Premiere Healthcare, although she feels that it took a step back under the administration of Ray Soto. Stewart strongly believes that the prior county administration failed the residents at Gracedale by canceling the partnership with Premiere Healthcare, by forcing an increase in the

census at the expense of resident safety, and by forcing reliance on outside nursing agencies. It is clear to the Grand Jury that Stewart truly cares for the wellbeing of the residents at Gracedale and served the county effectively when she was Gracedale's Administrator.

## TESTIMONY OF COUNTY EXECUTIVE TARA ZRINSKI

Tara Zrinski was elected to serve as the County Executive in November 2025, and was sworn in as the County Executive in January 2026. Zrinski became aware of the Grand Jury investigation regarding Gracedale and asked District Attorney Stephen G. Baratta if she could be permitted to address the Grand Jury.

County Executive Tara Zrinski appeared before the Northampton County Investigating Grand Jury on April 21, 2026, and laid out her plans for Gracedale moving forward, including potential plans for the construction of a new facility. She indicated that her administration may be partnering with St. Luke's Hospital and other entities to fund the new facility. She also indicated that the current facility will be renovated and turned into an assisted living/independent living facility. She didn't have a timeframe or overall cost analysis for this proposed project.

Executive Zrinski also advised that she will be adding two administrative positions to help oversee operations at Gracedale. She added that she kept Michelle Morton on as Director of Gracedale and believes that Michelle Morton has the credentials and background to effectively run Gracedale. She indicated that since she took over as County Executive the staffing ratio of Gracedale employees and agency employees is 50/50, which is an improvement from under the prior administration. She

also indicated that they have met per patient day (PPD) requirements almost every day since her administration took over and they have received no citations from the Department of Health in 2026.

Executive Zrinski advised that she visits Gracedale quite frequently and monitors operations. She indicated that she has met with Sheriff Christopher Zieger, and suggested to him that the Deputy Sheriff assigned to Gracedale be more active in assisting with emergencies as well as being more active in vetting persons entering the facility. Executive Zrinski took numerous questions from the Grand Jurors and appeared to answer to the best of her ability, recognizing that she has only been in office for approximately four months.

## GRAND JURY FINDINGS

1. Critical Staffing Shortages with Severe Vacancies: As of mid-2025, Gracedale reported that only 25% of its nurse and nurse aide positions were filled by County employees. The facility's overall staffing vacancy rate stood at roughly 59%, with many employees leaving due to burnout or mistreatment from coworkers.

2. Expensive Agency Reliance: To meet mandatory staffing ratios, Gracedale relies heavily on external staffing agencies, which charge significantly higher rates than direct hires. This "bleeding" of funds has been a primary driver of the facility's budget shortfalls. Under Administrator Michelle Morton, agency staffing rose to an all-time high of 75%.

3. Staff Morale: The Gracedale "County" employees report low staff morale, related to the inequity in pay between where the outside agency nurses are

compensated at higher rates than the County employees. Also, there have been considerable complaints related to bullying within the employee ranks.

4. Failure to meet appropriate staffing levels: Federal (DHHS) and Pennsylvania (DHS) regulations require Gracedale to maintain specific levels of Care Hours Per Resident Day, which Gracedale has had consistent difficulty meeting due to its staffing difficulties. The failure to meet staffing levels was a contributor to Gracedale's low quality ratings.

5. Admissions Freeze: Due to these shortages, the facility has been forced to limit its resident population to between 400 - 450 residents, despite having a maximum capacity of 688.

6. Low Quality Ratings: Currently, Gracedale has the lowest quality rating for nursing home facilities - a 1 star out of a possible 5 stars. Medicare describes the one-star rating as "much below average." Both the low-quality rating and the 2025 negative Medicare inspections citing deficiencies in critical areas related to medical care and patient safety make it difficult to recruit new patients and/or receive referrals from health care professionals.

7. Financial Instability and Operational Deficits: According to media coverage of Northampton County Government, in mid-2025, the nursing home again required a $10 million transfer from the county's general fund to remain solvent. This cash infusion was in addition to approximately $15 million in American Rescue Plan Act funding dedicated to Gracedale in 2022 earmarked to address both staffing shortages and facility needs. Finally, In February 2026, the County Council approved another $7 million budget amendment to cover the facility's 2025 operating obligations and revenue

shortfalls. Council noted that the continuing financial gap was driven by lower census numbers and heavy reliance on expensive temporary agency nurses. The persistent financial struggles have renewed debates among some Council members regarding the long-term feasibility of keeping Gracedale under County ownership rather than privatizing it.

8. Lack of Adequate Risk Management: Under federal and Pennsylvania regulations, nursing homes are required to implement comprehensive patient safety, quality assurance, and compliance programs, which address risk management concerns.

## GRAND JURY RECOMMENDATIONS

The Northampton County Investigating Grand Jury of 2024 is authorized by law to issue an Investigating Grand Jury report to the Supervising Judge at any time during its term. By definition, an Investigating Grand Jury report is "a report submitted by the investigating Grand Jury to the supervising judge regarding conditions relating to organized crime or public corruption or both; or proposing recommendations for legislative, executive, or administrative action in the public interest based upon stated findings." 42 Pa.C.S.A. §4542. This Grand Jury believes that issuing a report outlining perceived deficiencies regarding the administration of Gracedale, a County owned elder care facility, falls well within the public interest of the citizens of Northampton County.

In light of the findings contained herein, it is evident that changes need to be implemented by Northampton County in order to better ensure the safety and well-being of both current and future residents at Gracedale. This Grand Jury believes that the current county administration, including Northampton County Executive Tara Zrinski, as

well as the elected officials comprising Northampton County Council, bear the responsibility of determining the specifics of what those changes should entail. To that end, it is the intention of this Grand Jury to present these findings, with the expectation that Northampton County Officials will work diligently to implement those changes deemed necessary. This Grand Jury has found that there is a lack of leadership with regard to the administration at Gracedale, and it is imperative that Northampton County officials take immediate steps to rectify the issues identified in this report. Suggested points to consider are as follows:

1. We recommend that plans be adopted to move away from agency staffing at Gracedale in favor of county-employed personnel. Past efforts to implement such a change have been futile, resulting in the proliferation of dangerous conditions and fiscal irresponsibility;

2. Gracedale should revise its policies with regard to the proper administration of the facility. Aside from an apparent lack of communication amongst staff, the administration should be working towards better documentation and follow up on all matters involving resident care and staff training;

3. Security is a major issue and should be addressed. The County should consider either retaining a private security agency to assist in preventing unauthorized access to the facility as well as to assist in preventing elopements, or it should work with the Northampton County Sheriff's Office to revise the duties and responsibilities of the deputy assigned to Gracedale;

4. A separate position should be created at Northampton County within the Department of Human Services to act as a liaison with the Gracedale Administrator.

That cabinet position should be held by an individual with specialized training in the proper administration of a long-term care facility;

5. Gracedale supervisors should be required to physically check on residents after every call made by residents to the 911 emergency communications center, and to document specific findings subsequent to each incident;

6. Policies should be put into place at Gracedale to establish in-house training for certified nurse assistants working at that facility; and

7. There should be an additional investigation into the policies and procedures of the Upper Nazareth Police Department with regard to how calls originating from Gracedale are handled and investigated by the department, with specific emphasis placed on the scope and/or limitations of officer discretion.

## CONCLUSION

This Report represents a summary of the pertinent evidence presented to the Northampton County Investigating Grand Jury of 2024 relating to the facts and circumstances surrounding any actions or inactions of any person or entity responsible for the safety and protection of Gracedale Nursing Home residents, and any policies, procedures, and practices for the safety and protection of Gracedale Nursing Home residents, Northampton County, Pennsylvania. Although this Report does not recite all of the testimony placed before the Grand Jury, this Report does contain sufficient cause upon which to conclude that a Report detailing our findings and recommendations was necessary and in the public interest.

# COUNTY OF NORTHAMPTON

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**TARA ZRINSKI**
NORTHAMPTON COUNTY EXECUTIVE


June 30, 2026

[redacted]

RE: The Grand Jury Report Regarding Gracedale, MISC. NO. 406-2024, GJ CASE NO. C-9, IN RE: NORTHAMPTON COUNTY, INVESTIGATING GRAND JURY OF 2024

Your Honor:

The following is the response of County Executive Tara Zrinski to the Grand Jury Report regarding Gracedale.

First, in July, 2017, the Pennsylvania Supreme Court formed a Task Force to review the investigative grand jury system in Pennsylvania. At the end of its work, the Task Force submitted a Report which included the following statements:

> "The investigating grand jury has dual goals: investigating crime and protecting citizenry from unfounded criminal charges," (page 6 of the Report).
>
> "County grand juries are impaneled... to investigate suspected criminal activity within that county," (page 6 of the Report).

Most importantly, a majority of the Task Force recommended abolishing grand jury reports, finding that the "reporting process is in tension with the Grand Jury's role as the protector of individual rights, as there are considerable due process concerns with the creation and release of a report." (page 12 of the Report). The Task Force Report also recommended that a grand jury report be precluded from "critically commenting on a named or otherwise identified individual unless the comment relates to charges filed against the individual or charges recommended

against the individual in an accepted presentment," (page 12 of the Report).

While these recommendations are yet to be adopted into law, they do reflect the problematic nature of investigative grand jury reports, and the importance of following the procedural protections that do exist currently.

**Second,** the Grand Jury was initially convened "for the purpose of investigating matters including, but not limited to, unsolved homicides in and about the County of Northampton, Commonwealth of Pennsylvania;" (page 1 of the Report). This appears to have been consistent with 42 Section 4543(b) which authorizes the convening of an investigative grand jury "because of the existence of criminal activity within the county which can best be fully investigated using the investigative resources of the grand jury."

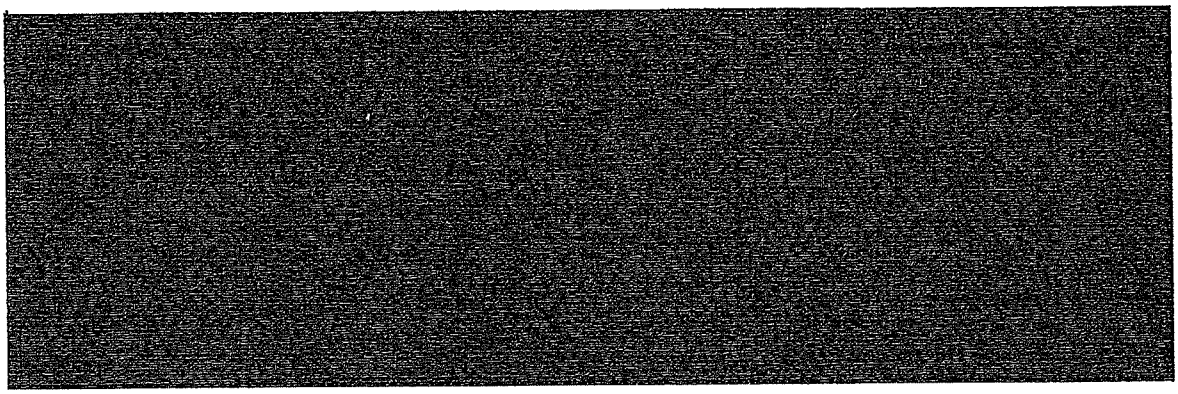
In addition, this purpose for the Grand Jury appears to be consistent with 42 Section 4548(a), which provides that an investigating grand jury "shall have the power to inquire into offenses against the criminal laws of the Commonwealth alleged to have been committed within the county or counties in which it is summoned."

When the District Attorney submitted a request to the presiding Judge to expand the scope of the Grand Jury, it was for the purpose of authorizing the Grand Jury "to begin an investigation into **safety** concerns related to the Gracedale residents." Further, the District Attorney reported that "the Upper Nazareth Police Department had other concerns related to patient **safety** issues." [bold added]. It is notable that there is no mention of potential criminal activities.

Further, a review of the Report discloses that the only potentially criminal activity identified in the course of this part of the Grand Jury's investigation related to the incident involving Agency Nurse Octavia Robinson that occurred on June 23, 2025, which was already being investigated and prosecuted by the Upper Nazareth Township Police Department. Apart from the conduct of Ms. Robinson during the June 23, 2025 incident, there is no suggestion in the Report that anyone else identified in the Report was engaged in, or may have been engaged in, criminal conduct. In fact, there is no mention of any criminal laws that might be applicable or analysis of culpability under any such laws. The Grand Jury Report makes no mention of any criminal violations, but instead focuses on staffing, admissions, ratings, financial challenges and risk management procedures. The Grand Jury Recommendations also do not address potential criminal activity in any meaningful way, but instead focus on staffing, administration, security, and policies. No criminal presentments were issued by the Grand Jury.

Criminal matters are within the authority of the District Attorney and any properly impaneled grand jury. The matters set forth in the Grand Jury Report are within the authority of the County Executive as the elected, top executive official for the County under the Home Rule Charter. Under the law, investigative grand juries may be convened "solely for the purpose of investigating criminal activity," not for the purpose of establishing policy and procedures under the authority of the County Executive (see also the statements from the Task Force Report above describing the purpose of an investigative grand jury to be on "suspected criminal activity"). Thus, the scope of this Grand Jury Report goes well beyond the authority granted to investigative

grand juries under the statute to investigate criminal matters and should be quashed/sealed for that reason.



For all of the reasons and procedural defects described above, I respectively request that the Grand Jury Report be quashed and/or sealed, and not issued publicly.

Further, I respectfully request that if not withstanding this response, you determine the Grand Jury Report should be released with or without redactions, you stay the release of the Report so that I may file a Petition for Review with the Supreme Court of Pennsylvania, and that the stay remain in place during the pendency of the Petition.

In addition, if you decline to grant such a stay of your own accord, I intend to include a request for a stay with our Petition, and I respectfully request that you hold the release of the Report until the request for a stay is resolved by the Supreme Court.

I also have the following additional concerns about the Report that should be addressed before the Report is released, if it is to be released:

A. **The Report contains details of a sensitive nature regarding residents of Gracedale, concerning events that have happened to such residents and conduct of such residents. All names of individual residents should be redacted from the Report and replaced with identifiers that will not lead to the identity of the residents** (for an example, see the testimony of Officer Petrucci and Michelle Morton).

B. **The following conclusions in the Report are not supported by the record as described in the Report and in some instances, display subjective conclusions of the writer of the Report and/or an attempt to skew the evidence in a particular direction:**

1. On page 19, Office Dugan is reported as testifying that "the number of assault calls from Gracedale had risen heavily since the Robinson incident. The calls included assaults between staff and patients as well as assaults between different patients." No data is provided in the Report to support this assertion, though such data could have been obtained. Also, the ambiguity of the final sentence leaves the impression that staff may have assaulted patients after

the incident, which there is no record of occurring. Staff of Gracedale could have testified to this issue if given the opportunity, but they were not asked.

2. On page 20, within the testimony of Office Wambold, it is noted that Officer Dugan testified that "in his estimation little or no effort was made by the Gracedale staff to intervene in the ongoing assault..." It is unclear exactly which officer made this statement, which creates some doubt over the credibility of the statement, including whether the officer who made the statement had sufficient knowledge regarding the conduct of Gracedale staff to support that conclusion. In addition, Officer Dugan, in his own testimony, summarized on page 17 of the Report, stated that it was pandemonium in room A3 when he arrived, and that one of the Supervising Nurses was yelling at Nurse Robinson. This is corroborated by the testimony of Supervisor Sreekumar, (on pages 31 and 32 of the Report. Efforts were made to halt Nurse Robinson's assaultive conduct.

3. On page 5 of the Grand Jury Report, it is stated that the period of review is calendar year 2025. And yet, on pages 21 and 22, testimony regarding police response in 2024 was apparently solicited, and included in the report. On page 26 of the Report, the Report recites conclusions from an internal quality audit of Gracedale conducted by Affinity in 2023. In addition to this being outside the 2025 scope, it is unclear how or if this information was presented to the Grand Jury since it does not appear to have been included in Michelle Morton's testimony. There is no indication in the Report that the Affinity study was made a Commonwealth Exhibit.

4. Page 33 of the Report includes the following editorial statement: "It is interesting to note however, that according to public records that were presented to the Grand Jury, in 2024 Gerard-Amazan was the 4th highest paid employee in Northampton County, having earned approximately $142,100 for the year." This comment appears to have been inserted in the Report in an effort to undercut the witness and does not appear to be relevant to the subject matter of the Report.

5. On page 39, several gratuitous statements are made about the witness Jennifer Stewart, praising her knowledge, concluding that Gracedale benefitted from her knowledge and leadership and opining that she truly cared for the wellbeing of the residents and served the County effectively. These are subjective and conclusory statements that seem to represent the opinions of the writer of the Report, and that are not really evidenced based – for example, the testimony described in the Report is not even close to being sufficiently broad or scrutinized to justify these conclusions.

6. This fawning over Ms. Stewart is particularly apparent when compared to the summary of Michelle Morton's testimony, including on page 29, where the writer seems to be trying to paint Ms. Morton in a negative light by including a quotation that does not appear to substantially contribute to the Report's narrative. Another example in the Morton narrative is the following insertion on page 27: "especially in light of the fact that 75% to 80% of the nursing staff is agency employed." Given the way this is stated, it is unclear whether that was part of Ms. Morton's testimony or added in as an editorial comment. In any case, reliance on agency nurses was at its highest around the time Ms. Morton was brought on staff early in 2025, and

consequently, should not be attributed to her management. By August, 2025, 25 of 89 full-time nursing positions were held by County employed Gracedale staff (approximately 28%), and 59 of 198 CNA positions were held by County employed Gracedale staff (approximately 30%). During 2026, Gracedale switched to measuring this ratio by hours worked as a more accurate way of measurement: as of February, 2026, of total hours worked by nurses and CNAs, 43% were worked by County employed Gracedale staff and 57% were worked by agency staff.

C. **There is additional information that should have been provided to the Grand Jury and included in the Report in order to provide CONTEXT, and lead to a better understanding of the evidence.** The following are some examples:

1. All of the citations cited in detail in the Grand Jury Report are F series deficiencies. Under Medicare and Medicaid certification standards, these are in the third tier from a severity point of view. The first tier is for the most dangerous deficiencies, presenting "Immediate jeopardy to resident health or safety". The second tier is for the next most dangerous deficiencies presenting "Actual harm that is not immediate jeopardy." The F series deficiencies, the third tier, lower in terms of severity than the first and second tiers, presents "No actual harm with potential for more than minimal harm that is not immediate jeopardy." It is not clear whether this system was ever explained to the Grand Jury. It is not included by way of explanation in the Grand Jury Report, but should be for context purposes.

2. On page 13 of the Grand Jury Report, Ms. Robinson is referred to as an "Agency LPN", but that term is never really explained. Agency nurses are nurses who are employed by outside contractors and whose services are provided to Gracedale under a contract arrangement between Gracedale and the outside contractor. Credentialing of an agency nurse, making sure the nurse is qualified and competent to perform the contracted for nursing services, is primarily the responsibility of the outside contractor. In addition, Ms. Robinson had served approximately 8 prior shifts at Gracedale without incident before the event described in the Report. No effort appears to have been made to investigate the steps Gracedale took after the incident to take Ms. Robinson off the panel of nurses, and to remove the nursing services contractor from the list of approved contractors. Ms. Bierman did testify on page 36 of the Report that she notified Pennsylvania and New Jersey licensure authorities regarding the Robinson incident, but that information does not appear to have been further explored in the testimony, or if it was, it is not further mentioned in the Report. The point, which should have been included in the Report, is that Gracedale immediately took appropriate action to terminate the nurse and the contract service.

3. On page 19, Officer Wambold is reported to have testified that he was unable to collect any physical evidence related to the assault, because the room had been cleaned while he was interviewing witnesses. There is an implication that the destruction of evidence was intentional, but there is no testimony that Gracedale staff were instructed not to clean up the room; cleaning up the room is, after all, what should normally be done from a patient care perspective, especially given that there were other residents of the room and that biohazards were

present from the incident.

4. Talavera is a clearing house service for agency nurses. It recruits other agencies who supply qualified nurses and CNA's to supplement the staff directly employed by Gracedale. Using Talavera in place of a large number of nursing agencies has saved the County money and substantially improved the staff/patient ratio which is now consistently above 3.2.

5. Only matters involving sexual abuse and/or physical injury require reporting to the State DOH within two hours. When an incident clearly meets these criteria, it is reported within that time frame. In some instances, an investigation occurs first to determine whether sexual abuse and/or physical injury has in fact occurred.

6. Nursing homes are subject to strict rules regarding discharge of residents under both Federal and State regulations. Once a resident has been accepted, they cannot be discharged without, among other things, a discharge care plan and another appropriate placement. This includes residents who pose an elopement risk and who engage in other high-risk behavior, to themselves and others. Had Michelle Morton been asked about this, based upon her statements to me, I believe she would have testified that she instituted measures to screen out high risk applicants and that Jennifer Stewart, when serving as Admissions Director, refused to abide by those directives, and admitted residents that should not have been admitted. This is an example of why it is so important that persons who provided testimony and are criticized in the Report be given an opportunity to review and respond to the Report so that conflicting accounts can be fully brought to the surface.

7. The Risk Manager's primary responsibilities are to investigate incidents and to make sure they are properly reported to the regulatory authorities. Primary responsibility for quality improvement and quality assurance activities, including the development and implementation of policies and procedures and Plans of Correction, rests with the Administrator, the Assistant Administrator, the Director of Nursing and the QAPI Director. The fact that Michelle Morton did not recognize the Risk Manager as a key factor in the quality assurance and improvement efforts at Gracedale does not suggest that she does not take these tasks seriously. It's merely a reflection of how the responsibilities for these efforts are actually distributed among Gracedale staff. Additional questioning of Michelle Morton could have brought all of that out more clearly and accurately, but as noted elsewhere in this response, there appears to have been some effort to put her in a negative light.

8. It is also <u>not</u> stated in the Report that each of the deficiencies assessed against Gracedale by DOH and described in Paragraphs 1-13 of the Report was corrected in a timely manner by a Plan of Correction, and that the Plans of Correction were approved by DOH, implemented by Gracedale, and the implementation was confirmed by DOH.

9. It is also <u>not</u> stated in the Report that while regretable, deficiencies are frequently found at nursing homes in Pennsylvania. For example, while Gracedale's annual survey in 2026 resulted in 4 violations (a substantial improvement over 2025 and a fact which also could have been

shared with the Grand Jury), the State average for 2026 was 9.3 violations per nursing home.

D. **Several of the descriptions in the Report of Department of Health deficiencies are inaccurate depictions of the deficiencies:**

1. April 16, 2025 (F0641) (paragraph 1, page 6 of the Report): The actual deficiency was described as follows by the Department of Health: "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 1 of 36 residents." The mistake was that the MDS assessment stated that the resident had been prescribed antipsychotic medication, when in fact the resident was not on antipsychotic medication. The Report completely misrepresents this, making it seem like Gracedale failed to administer prescribed antipsychotic medication.
2. The second part of Paragraph 4 of the Report and Paragraph 5 of the Report (pages 7 and 8 of the Report), describe the same deficiency relating to range of motion exercises for Resident 380. There is no reason to repeat this twice, thereby making it look like there were 2 separate deficiencies.
3. April 16, 2025 (F0761) (paragraph 6, page 8 of the Report): The actual deficiency was described as follows: "Based on a review of facility policy and observation, it was determined that the failure to ensure that medications/biologicals were securely stored in a medication or treatment card on one of 12 nursing units." It is important to note that this was on one day, in one out of twelve units, involving one nurse and not necessarily indicative of a pattern or practice throughout the facility.
4. April 16, 2025 (F0812) (paragraph 7, page 8 of the Report): The nourishment room refrigerator which is one of the subjects of this deficiency contained resident food items, stored in the refrigerator by residents, family members and/or visitors. The foods in question were not provided by the facility for general consumption by residents; in other words, these deficiencies did not arise out of the facility's food service.
5. September 23, 2025 (F0689) paragraph 10, page 10 of the Report): Contrary to the Report, the resident involved in this elopement was not the same resident involved in the elopement incident referred to in paragraph 9 of the Report.
6. September 23, 2025 (F0656) paragraph 11, page 10 of the Report): To be clear, this resident did not actually elope. Further, the deficiency relating to the alert bracelet was that the facility failed to include monitoring of the alert bracelet in the care plan. The Report makes it seem like the alert bracelet was not used at all.
7. October 17, 2025 (F0600) (paragraph 13, page 11 of the Report):
   Second incident (Residents3 and 4): The Report summary mixes up Residents 3 and 4, their conditions and which was the victim and which was the abuser.

With many of the facts being wrongly stated, this raises questions about the reliability of the rest of the Report.

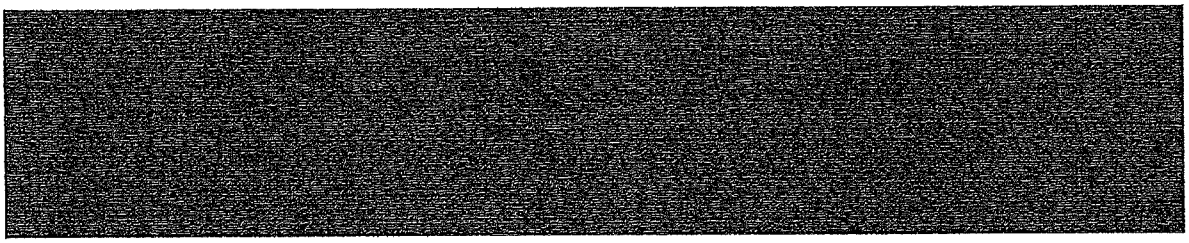
For all of the reasons set forth above, my position regarding the report of The Grand Jury is as

follows:

The Grand Jury Report should be quashed and/or sealed and not made available to the public.

Further, as noted above, I respectfully request that if notwithstanding this response, you determine the Grand Jury Report should be released with or without redactions, you stay the release of the Report so that I may file a Petition for Review with the Supreme Court of Pennsylvania, and that the stay remain in place during the pendency of the Petition.

In addition, as noted above, if you decline to grant such a stay of your own accord, I intend to include a request for a stay with our Petition, and I respectfully request that you hold the release of the Report until the request for a stay is resolved by the Supreme Court.



Finally, the following are my responses to the Grand Jury recommendations:

1. **Recommendation:** Gracedale should move away from agency staff at Gracedale in favor of county-employed personnel.

   **Response:** The Administration is well aware of the issue and is doing everything within its power to increase County employed personnel and reduce reliance on agency nursing staff. The biggest constraining factor is the wage rate that the County is able to pay, based on the County's approved budget for 2026 and the intense competition among hospitals, skilled nursing facilities and private nursing services due to the overall shortage of qualified nurses and CNA's in Pennsylvania. Additional revenue will be required to turn this around. Potential sources that are being pursued include: additional services revenue (rehab, for example); additional levels of care; charitable donations; grant funds; and increased funding (and prompter payment) from the State. A description of other steps Gracedale has taken to increase the number of directly employed staff is attached as Exhibit A, under the heading "Recruiting Efforts."

   Further, as noted above, significant progress has already been made.

2. **Recommendation:** Gracedale should revise its policies and work toward better documentation and follow up on resident care and staff training.

   **Response:** Skilled nursing facilities are highly regulated by the federal and state governments. Gracedale has appropriate policies in place. Staff training occurs on an

ongoing basis. It is not clear what documentation shortcomings the recommendation is referring to, but documentation is assessed on a regular basis for completeness and accuracy, and there is regular follow up on resident care and staff training with respect to documentation. The Grand Jury did not obtain testimony from Gracedale staff persons regularly engaged in quality improvement activities such as the Nursing Department, the Quality Assurance officer, etc. A description of steps Gracedale has taken over the last year or so to assure quality improvement are stated in the attached Exhibit B under the heading "Quality Improvement Changes Over the Last Year."

3. **Recommendation:** Gracedale should address security issues, and consider retaining a private security firm or revising the duties of the Sheriff's Office at the facility.

   **Response:** Security arrangements at Gracedale are under evaluation.

4. **Recommendation:** A separate Cabinet level position should be created for Gracedale:

   **Response:** Agreed, this is already an initiative of the current County Executive, and has recently been approved by County Council.

5. **Recommendation:** Gracedale Supervisors should in person check on each resident that makes a 911 call after the call, and document the supervisors' findings.

   **Response:** Supervisors have many responsibilities. Floor staff may be counted on for this follow up. There are documentation policies in place.

6. **Recommendation:** Policies should be put in place to establish in-house training for CNA's working at the facility.

   **Response:** Such policies are in place and such trainings are conducted on an ongoing basis. Gracedale previously was accredited to provide CNA certification, but that accreditation was discontinued several years ago, due to cost and because it did not typically result in additional recruits for Gracedale. This may be reconsidered in the future but depends upon a large number of factors.

7. **Recommendation:** There should be additional investigation of Upper Nazareth Twp police policies regarding the handling of calls from Gracedale.

   **Response:** Agreed. County and Gracedale officials were already planning to meet with representatives of the Upper Nazareth Police Department in the near future to discuss better coordination and cooperation.

Thank you for your courtesy and cooperation.

Very truly yours,

Tara M. Zrinski
County Executive

EXHIBIT A

- Recruiting efforts:
  - HR meets with all graduating classes at local universities and trade schools
  - HR attends large Senior High School career fair at Steel Stacks
  - HR attends the LTI and Falcon practical nurse graduating class events
    - HR also participates in mock interviews for trade schools
  - Continues advertising free daycare and County benefits
  - Utilizes Indeed, NeoGov, social media, university, college, and trade school job boards for advertising
  - Works with 3rd Street Alliance and Career Link for new hires
    - Outreach to homeless shelters that provide transportation
  - HR works with the new communications director to highlight Gracedale staff, events, recruitment, and retention
    - HR assists the communications director with the website blog
  - HR attends career days
  - Streamlined application process
  - Enhanced employer branding

EXHIBIT B

## Quality Improvement Changes in the Past Year:

- Completed Quality Assurance/Performance Improvement (QAPI) self-assessment and repeat self-assessment every 6 months. (This helps Gracedale evaluate its QAPI plan itself, including making sure that QAPI is a part of everyday work, not just a "program" that gets talked about at QAPI meetings and then forgotten until the next meeting.)
- Updated structure of Performance Improvement Process (PIPs) to make it more structured and to include team members "closest to the problem" and from all disciplines. This helps team members be involved, including better identification of root-cause analysis, better ideas for solutions, more "buy-in", and more sustainability of corrective actions.
- Joined CMS Mid-Atlantic QIN-QIO. (A Center for Medicare and Medicaid Services (CMS) funded program to bring together communities of healthcare providers across the care continuum, stakeholders, and patients in data-driven initiatives to achieve national health quality goals. Participation is voluntary and free and includes many resources for QAPI and improvement.)
- Restructured plan of correction work so that Gracedale's QAPI coordinator, a full-time administrative position, is managing Gracedale's plans of correction to ensure that all audits are being completed, that changes are being sustained to avoid repeat duplication, etc.) More structured review of audits weekly and also at QAPI meeting.
- Working with each department to ensure each has identified what and how they will measure performance in their department to ensure monitoring systems are in place to prevent quality issues.
- Implemented use of Critical Element Pathways (CEPs). These are the tools that the surveyors use in assessing each area of Gracedale. They include what to look for in records, what to observe, what questions to ask residents, families and staff.
- Continued annual staff competency checks and annual trainings.
- Annual staff evaluations.
- Some of the changes related to incidents:
    - Elopements
        - Changed key pads on the two floors for residents living with dementia from numerical key pad to badge access key pad.
        - Updated preadmission screening process for residents with elopement risk.
        - Updated policy and procedures related to elopements to give staff more direction on prevention and response
        - Updated policies related to residents who receive a new wander guard or who have removed a wander guard
        - Re-trained staff, including directed in-service
        - Sent a message to every resident's responsible person regarding not taking anyone they don't know off the floor, out of the building or off campus without signing them out.
    - Behaviors, especially substance abuse
        - Updated preadmission screening process for residents with behavioral challenges and / or history of substance abuse
        - Updated Leave Of Absence policies and policies related to residents who appear to be under the influence of any substance.
        - Updated policies related to managing residents with unmanageable behaviors, including suggestions for those residents' care plans.
        - Re-training, including directed in-service.

## *RESPONSE TO REPORT NO. 1*

### *INTRODUCTION*

In the opinion of the Undersigned, this is not the report of the Northampton County Investigating Grand Jury of 2024 but rather a politically motivated hit job on the Undersigned launched at a time when the current District Attorney Stephen G. Baratta believed he could damage the Undersigned's Congressional campaign. In attempting to criminalize policy choices and differences, it is the opinion of the Undersigned that Baratta additionally seeks to minimize his own incompetence and petty corruption as District Attorney.

If Baratta was truly interested in placing all of the facts before the Grand Jury, he would have called the Undersigned, the former Director of Human Services, who was ultimately responsible for Gracedale, the Deputy Director of Human Services who performed extensive work at Gracedale, the Director of Human Resources and the Deputy Director of Human Resources whose job is solely to provide human resources support to Gracedale, to testify before the Investigating Grand Jury. The "Recommendations" and "Conclusions"—really unfounded theories built on unproven assumptions--are not supported by any competent evidence in the record. This is quite simply meant to be an assault on the reputation of the Undersigned, an attack on the reputation of the current Administrator with the unfortunate result of further harming Gracedale and its residents.

Report No. 1 is a thesis in search of facts which it never establishes and is thus fatally flawed. As such, there exist innumerable obvious reasons that Report No. 1 should never have been issued. Even a cursory review demonstrates that the report improperly conflates issues in order to come to a conclusion that is entirely unsupported by competent evidence.

The Report contains no evidence demonstrating that so-called "staffing shortages" actually lead to the isolated incidents outlined in Report No. 1. In fact, there is evidence that staffing had no relationship to the incidents and no impact as the Department of Health did not cite staffing in any of its reports as being a factor in any of the reported incidents. Gracedale Nursing Home was never cited for "short staffing" during the time any of the incidents investigated took place. The glaring causal deficiency in Report No. 1 continues as there is no allegation that substantiates the assertion that, because some of the nurses involved in the isolated incidents detailed in the Report were agency nurses, that that fact caused and/or contributed to the incidents.

Evidence of the perversion of the grand jury process is verified by fact that it claims to only be investigating the year 2025, yet it used uncorroborated, unsubstantiated and untruthful testimony about events 8 years ago to draw its conclusions. In fact, there is no evidence contained in the Report that so-called "fiscal mismanagement", which Baratta intentionally made no effort to learn about, had any relationship to the isolated incidents that were being investigated.

The intentional failure to interview the Undersigned, the former Director of Human Services, the Deputy Director of Human Services, the Director of Human Resources or the Deputy Director of Human Resources allowed the uncorroborated, unsubstantiated and untruthful testimony of a disgruntled former employee to remain unchallenged and unexamined. Consider as well that the original mandate of the grand jury was only to investigate isolated incidents occurring in 2025, and yet the grand jury was guided to improperly use a 2023 report by a company called Affinity to help it draw its conclusions.

Had the grand jury not been blocked from the testimony of the Undersigned, the former Director of Human Services, the Deputy Director of Human Services, the Director of Human Resources or the Deputy Director of Human Resources it would have been able to hear that the recommendations of the 2023 report were almost entirely implemented by the Undersigned and his administrators and deputies before leaving office. The grand jury would also have heard about the challenges posed by the Covid-19 global pandemic and the long-term consequences that it had for both the census and staffing.

Report No. 1 never should have been issued as the Investigating Grand Jury was neither investigating criminal activity nor public corruption with respect to the Undersigned. Any unbiased review of the disconnected allegations contained in the report when measured against the obvious attempt to distort the original charge to the grand jury reveals that this is nothing more than an attempt by Baratta to place the Undersigned's name in the Report and attempt to cast blame on the Undersigned by implication rather than objective fact. Report No. 1 is nothing more than the politicization of a grand jury by a hopelessly biased District Attorney designed to stain the constitutionally protected reputation of the Undersigned.

***FINDING OF FACT THAT WERE NEVER DISCOVERED (INTENTIONALLY)***

***WHY IS BARATTA'S REPORT NO.1 A SHAM***

1. In the first instance, Baratta seeks to damage the constitutionally protected reputation of the Undersigned by bootstrapping wholly unrelated and isolated incidents and tying it all together with the uncorroborated, unverified and untruthful testimony of a former disgruntled employee.
2. One need only look at the uncorroborated, unsubstantiated and untruthful "testimony" of Jennifer Stewart and how Baratta managed to ham-handedly get the Undersigned's name into the report.
3. Here it is again important to note that the testimony of Director of Human Services Susan Wandalowski, Deputy Director of Human Services Robyn Barbosa, Director of Human Resources Mary L. Zieger and Deputy Director of Human Resources Dr. Lore McFadden would have been vital in almost completely refuting Jennifer Stewart's claims. If Baratta was pursuing impartial justice as required by his oath of office, he would have tested Stewart's testimony by placing it alongside that of her co-workers.
4. An example is Stewart's alleged conclusory testimony. "She believes Gracedale was thriving under the management of Premiere Healthcare, although she feels that it took a step back under the administration of Ray Soto. Stewart strongly believes that the prior county administration failed the residents at Gracedale by canceling the partnership with Premiere Healthcare, by forcing an increase in the census at the expense of resident safety, and by forcing reliance on outside nursing agency." There's a lot to unpack and most of it are lies by commission or omission.
5. Premiere Healthcare no longer exists in the form it did when its contract ended with the County nearly 8 years ago. No witness from the Administration—not one—was called to test the veracity of this contention or to provide any context about Premier.
6. Even Stewart, as blatantly untruthful as she was in her testimony, acknowledged that the service that Premiere Healthcare was providing in the person of Ray Soto "took a step back" by the time the contract was terminated with the County.
7. Stewart's so-called testimony failed to acknowledge that Premiere, presumably under the direction of the Brown Administration, refused to fill at least 200 and possibly as many as 300

positions at Gracedale Nursing Home. A trend that the Undersigned was reversing when the global Covid-19 pandemic struck. This information would have been available to the grand jury had Baratta allowed the testimony of any of her co-workers.

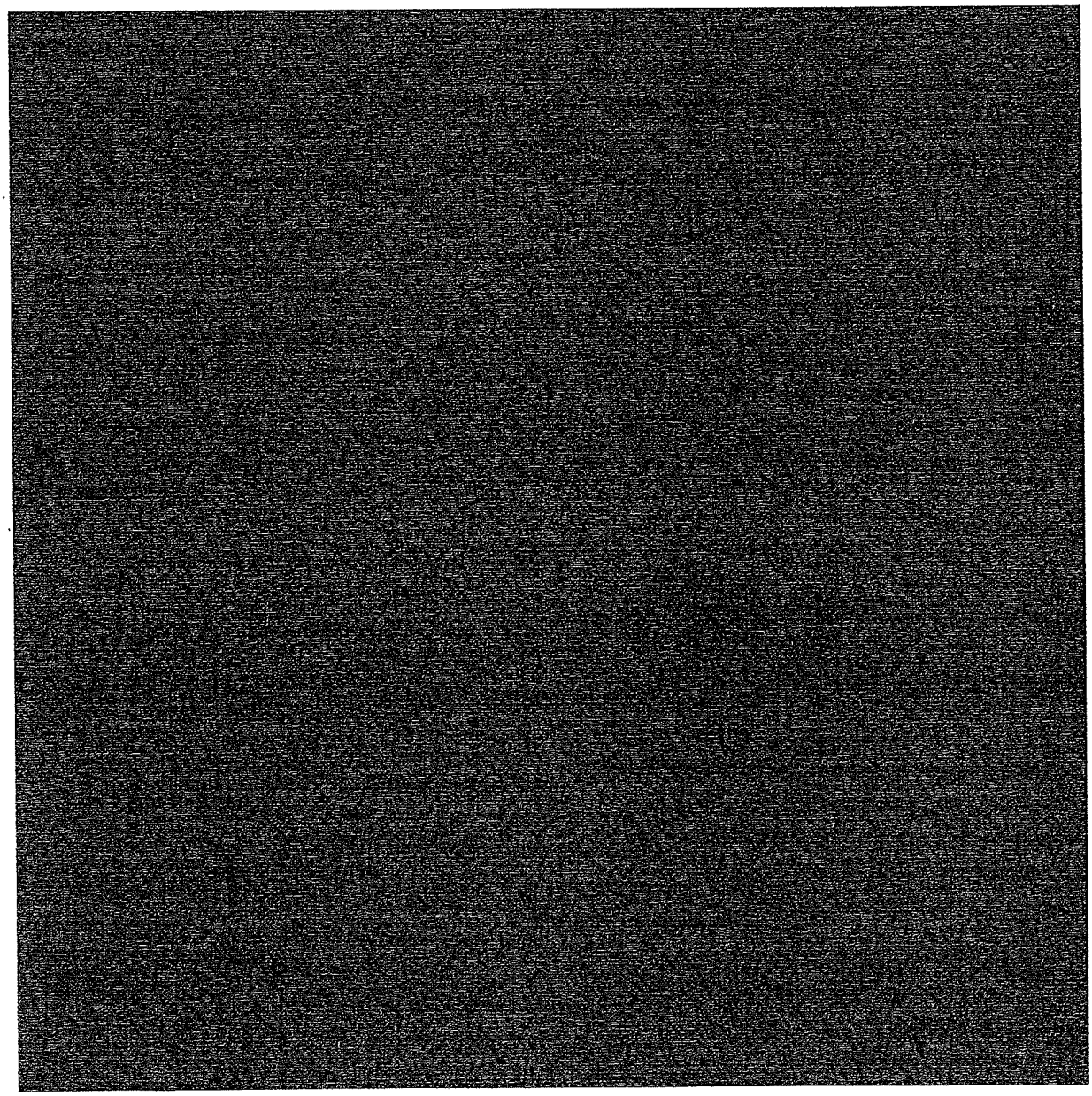
8. **The Report is a sham as it barely makes any reference to the global Covid-19 pandemic. A pandemic that struck Long Term Care Facilities like Gracedale Nursing Home most harshly.**
9. One cannot begin to understand the state of Gracedale Nursing Home in the Fall of 2025 without an in-depth exposition of how the Covid-19 pandemic affected census and staff. Which, again, would have been important for the grand jury to know and which testimony was available from the Administration and her co-workers.
10. Let us discuss Stewart's claim about "forcing an increase in the census at the expense of resident safety." Stewart points to no testimony in front of County Council, no contemporary emails or messages and provides no dates for discussions during which she warned about this.
11. To the contrary, the testimony of the Administration and her co-workers—had Baratta had the courage to test Stewart's veracity--would have shown that Stewart was an unwavering advocate of reaching the maximum census of 688 and that her newly adopted concerns were nothing more than *post hoc* justifications arising both from personal animus and a desire to shield herself from the consequences of decisions she made.
12. Except during the height of the pandemic, when nurses decided *en masse,* they no longer wanted to work in long term care, there was never any discussions between the Undersigned and Stewart regarding staffing and resident safety.
13. It is notable that, during the Pandemic the Undersigned did in fact restrict the census to 400 residents due to the fact that nurses no longer wished to work in long term care facilities. On two different occasions during the worst of Covid-19 staffing shortages became so severe that the National Guard needed to come to Gracedale's assistance. These facts, which are counter indicative of the desired narrative, escape mention by the Report or by Stewart.
14. In fact, even during the Pandemic, Gracedale was often well above the regulatory minimum for nursing hours per resident day or what is commonly referred to PPD.
15. Stewart well knows that the census is the financial life blood Gracedale Nursing Home. Gracedale is a special and unique place. It is the home of last resort for many people afflicted with Alzheimer's and Dementia, and only have Medicaid as a provider of health insurance for them.
16. Virtually every resident of Gracedale is Medicaid only.
17. It takes nearly a year for Medicaid to reimburse Gracedale Nursing Home, for care that is being provided today.
18. There is a census number under which Gracedale will require a County contribution until the Medicaid Pending turns into Medicaid reimbursements. It is a moving target, but that number is generally thought to be between 500-525.
19. Stewart's testimony is remarkable in that for most of the "previous administration" she was either the Administrator, Deputy Administrator or Director of Admissions.
20. Stewart had nothing but the unwavering support of the Undersigned – especially during the Covid-19 pandemic.
21. Jennifer Stewart ran Gracedale the way Jennifer Stewart saw fit during most of the "previous administration."

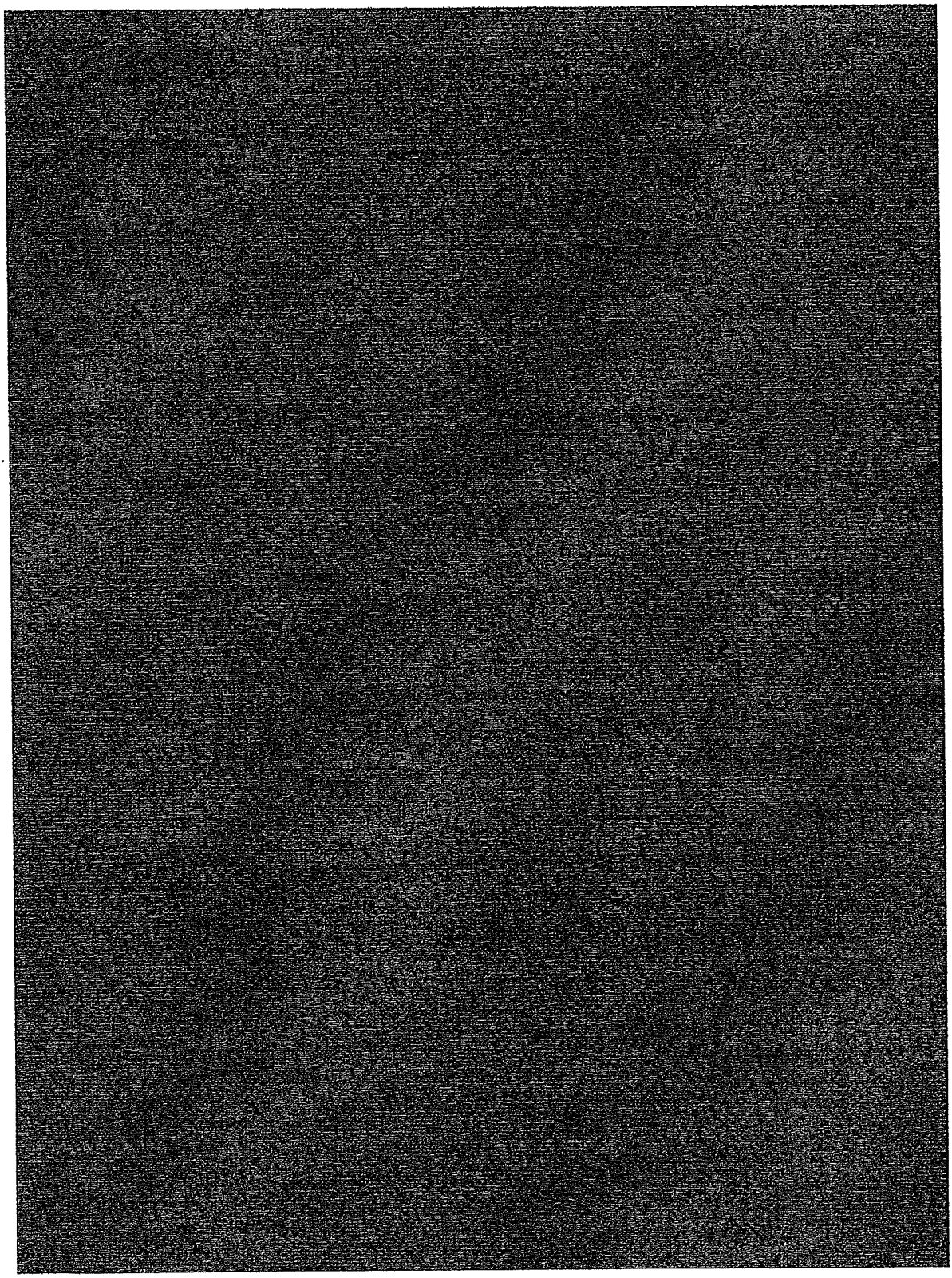
22. At some point, in the last 3 years, in the opinion of the Undersigned, Jennifer Stewart became unable or unwilling to fulfill her duties as the Administrator at Gracedale Nursing Home. For at least a year, she became an absentee Administrator.
23. She acknowledged this herself when she unilaterally suggested that she be demoted back to Admissions Director.
24. If the grand jury had been exposed to the testimony of the Administration and her co-workers, it would have heard corroborated testimony from multiple witnesses that Jennifer Stewart was going to be terminated by the Administration.
25. The grand jury would have heard concerns about Stewart's use of doctor's excuses to apply for FMLA and intermittent FMLA immediately before the initiation of discipline. All this testimony would have exposed Stewart's testimony to an examination of her potential bias which is the role of any legitimate use of the grand jury process. The fact that this testimony was never sought demonstrates the obvious bias and shoddy work of the District Attorney.
26. **This is a critical point with respect to census and staffing. Stewart, except for the height of the pandemic, consistently advocated for a higher census. She did this because she knew that a census below 500-525 would require a County contribution of millions of dollars and would imperil the County's ability to keep the home open for impoverished, demented residents who had quite literally nowhere else to go.**
27. **The record of Stewart's advocacy on this point is well documented and any testimony or evidence demonstrating Stewart's efforts would have allowed a grand jury to test the sincerity of her newly discovered, after the fact, concerns.**
28. **More importantly the desire for a higher census did not lead to reduced staffing. In fact, the nursing hours per patient day or PPD remained well above the regulatory requirement of 3.2 post pandemic.**
29. **The PPD was so high at one point it caused the County to contribute to the Gracedale budget of 10 million dollars in 2024. (The reasons for this can be found in an exposition the Undersigned made in a report to County Council on June 5, 2025. It can be found on YouTube. Additionally, those remarks were published on the County's Facebook page on June 31, 2025.)**
30. The original charge of Report No. 1 was limited to the year 2025. The fact that this limitation is scope was not observed and the Report's scope expanded demonstrates the District Attorney's desperate attempt to substitute a disparate string of unsubstantiated allegations for objective facts.
31. Here, for example, are some objective facts. The Commonwealth's regulatorily required nursing hours or PPD for Gracedale is **3.2**. The actual PPD by month achieved by the County in 2025: was January 3.68, February 3.59, March 3.49, April 3.43, May 3.37, June 3.5, July 3.64, August 2.83, Sept. 3.2 and October 3.34. If the Administration's policy choices exceeded the Commonwealth's mandated hours, then the conclusion that the Administration's supervision of Gracedale harmed residents is laid bare as completely unwarranted.
32. Staffing was not low. For most of the year, it was more than sufficient to meet the demands of the census. August is the exception. That will be explained in the next paragraphs.
33. Gracedale was projected to need at 10-million-dollar contribution for 2025. Two back-to-back 10-million-dollar County contributions would have imperiled the future of Gracedale.
34. In the Spring or Summer of 2025, former Asst. Administrator Beth Plovesan and Administrator Michele Morton came to the Undersigned with an idea to get Agency staffing costs under control.

35. Agency staffing is more expensive to the County in the short run. Agency staffing costs were the reason the County had to make a 10-million-dollar contribution to Gracedale in 2024 and they are why it was predicted to be 10 million dollars again in 2025. (Agency nurses give up health care and other benefits provided to the employees of the institution they work at - for a higher hourly wage.)
36. County Council's recent independent auditor found that Gracedale only need a 3.5 million contribution in 2025, down from the 10 million dollars estimate due to the implementation of Piovesan and Morton's plan.
37. So contrary to the "Conclusions" of this report, the home was not being financially mismanaged in 2025, it was yet again being saved for a third time by the decisions made by both the Undersigned and implemented by members of the Administration.
38. Stewart knows she is not telling the truth when she says the "previous administration" forced a reliance on more expensive outside agency nursing.
39. Stewart knows that during the pandemic nurses began leaving long-term care in droves both nationally and here locally.
40. Stewart knows that post-pandemic new nurses were choosing not to work in long-term care both nationally and here locally.
41. Stewart knows that Premiere and John Brown left Gracedale at least 200 employees short and that the Undersigned was well on his way to reversing that course when the pandemic struck.
42. Stewart knows that the reliance on agency staffing was not "forced" on Gracedale by the "previous administration," but was a desperate by-product of the Covid-19 pandemic.
43. Stewart knows that if anyone or anything "forced" agency nursing staffing on Gracedale it was the PA Department of Health during the worst of Covid-19 pandemic.
44. Stewart knows that at the behest of the PADOH **SHE** contracted with some of the most expensive agencies doing business in the Commonwealth of Pennsylvania at the time.
45. Stewart knows that even post-pandemic she still contracted with these very same expensive agencies.
46. Stewart knows that during one of her long absences that agency staff spending was out of control, in the opinion of the Undersigned, due to the mismanagement of two former administrative employees doing the scheduling at the time, and concealing that fact from the Undersigned. (See the County Facebook post dated June 31, 2005, or watch the YouTube meeting recording of June 5, 2025.)
47. Stewart knows that it wasn't the "previous administration" that forced "expensive agency staffing" on Gracedale. She knows that it was Premiere/John Brown leaving us at least 200 employee vacancies pre-Pandemic short, the Covid-19 Pandemic, the PA Department of Health and finally her own decisions and actions that caused Gracedale Nursing Home to become so heavily reliant on agency nursing staffing.
48. ***It's a good time here, to stop and remind everyone, that there is no evidence, in any record, and no demonstrated causal connection sustaining any connection between the fact that: 1) some of the nurses involved were agency nurses; or 2) that short staffing had anything to do with the isolated incidents discussed in the report.***
49. The Piovesan/Morton plan to reduce agency staffing costs, which was so wildly successful in 2025, essentially was designed to reduce agency nursing staffing costs by bringing Gracedale agency staffing under the umbrella of one coordinating agency. In this case, the name of the company is

Tallavera. As we have seen, it is working, and the Undersigned is made to be aware that it is working in 2026 too.

50. The Piovesan/Morton Tallavera plan was implemented in August 2025 which is the only month in 2025 when Gracedale's PPD was below 3.2 – the regulatory requirement.
51. It is the opinion of the undersigned, based upon information provided by the Director of Nursing at Gracedale, (Who *also* should have been called as a witness before the IGJ.), that the 2.83 August PPD was due to the transition to Tallavera, and the two largest incumbent Agencies refusal to provide Gracedale with their contractually obligated nurses. (In the opinion of the Undersigned, Stewart had been overpaying these Agencies for years, and these Agencies had the most to lose from the Piovesan/Morton Plan.)





[redacted]

Submitted by: _____
Lamont G. McClure

Date: 8/3/2026

Post & Schell P.C.
ATTORNEYS AT LAW

[redacted]

August 3, 2026

[redacted]

**Re: Investigating Grand Jury of 2024**
**Misc. No. 406-2024**
**GJ Case No. C-9**

Dear Judge Dally:

This firm represents Michelle Morton who is the administrator of Gracedale Nursing Home ("Gracedale"), in connection with Grand Jury Report C-9 ("Report"). We are providing this response to the report pursuant to your Order dated July 14, 2026. Ms. Morton received the report on July 16, 2026.

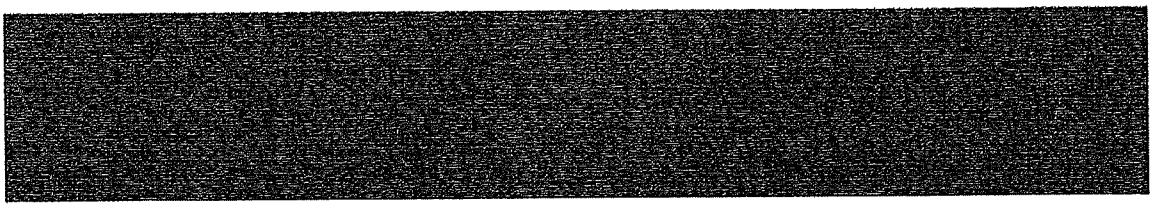
The Grand Jury report is not fully accurate and does not provide context regarding the safety of Gracedale Nursing Home. The Report makes a series of findings that are taken out of context and do not reflect the actual realities of operation of a nursing facility, especially a county-owned facility that is often deemed a last resort for county residents who do not have any other viable place to go.

The Report should not be made public as it does not comply with the requirements of the Investigatory Grand Jury Act (IGJA), 42 Pa. C.S. § 4542 in that it does not relate to organized crime or public corruption, or propose recommendations for legislative, executive or administrative action in the public interest. *See In re Thirtieth Cnty. Investigating Grand Jury*, 325 A.3d 573 (Pa. 2024). Instead, the report summarizes a number of publicly available Department of Health inspection surveys (called CMS 2657s) and takes issues out of context. As discussed below, the Department of Health is responsible for oversight of nursing homes and



[redacted]

nursing home administrators. It investigated all the incidents and found that Gracedale had corrected or was in the process of correcting these deficiencies. Nursing home performance is also publicly available to potential residents on the CMS Nursing Home Compare website, https://www.medicare.gov/care-compare. Hence, there is no public purpose in releasing the report other than to potentially sully the reputations of individuals at Gracedale and the County.



Thus, the Report should not be released. If, however, the Court deems that the Report should be released, we ask that this response also be released with the report to provide some context regarding these complicated administrative issues.

## I. BACKGROUND REGARDING NURSING HOME REGULATION

Gracedale, like all nursing homes in Pennsylvania, is regulated by the Pennsylvania Department of Health ("DOH") and is subject to ongoing surveys by State Agencies for compliance with regulatory standards. Nursing homes are also regulated by Federal law to the extent that they accept reimbursement from Medicare or Medicaid for any of the residents. Gracedale accepts both Medicare and Medicaid reimbursement.

Failure to meet either Pennsylvania or Federal requirements can result in the imposition of significant fines and potential loss of license. DOH has not revoked Gracedale's license, and it has not been prohibited from participation in either the Medicare or Medicaid programs. Furthermore, if the Department of Health perceives that there are significant issues with a nursing home, it has a variety of options available to it, including the imposition of monitoring, and temporary management of the facility pursuant to 28 Pa. Code § 201.15a.

The Pennsylvania Regulations govern staffing ratios to be implemented and provide as follows:

> Certified Nurse Assistants: 1 per every 10 residents (day); 1 per 11 (evening); 1 per 15 (night)
>
> Licensed Practical Nurses: 1 per 25 residents (day); 1 per 30 (evening); 1 per 40 (night)
>
> Registered Nurses: 1 per 250 residents in all shifts.

[1] Further, the 2019 Report on Grand Juries recommended prohibiting Grand Jury reports from commenting on individuals unless the comment relates to charges filed against these individuals. The Report does not recommend any charges against the individuals named, and to that effect, does not even recommend charges against the Staff Nurse perpetrator. Report and Recommendations of the Investigating Grand Jury Task Force at 58 (2019), available at https://www.pacourts.us/Storage/media/pdfs/20210508/140812-file-8214.pdf.

> Facility must have staff to provide 3.2 hours of direct care per resident for each 24-hour period (PPD)

28 Pa. Code § 211.12.

These ratios are monitored by the Department of Health. If a facility is considerably below the standards, it can be cited with a deficiency.[2] Gracedale is substantially compliant.

At the time of the incidents referenced in the Report, its compliance was as follows:

> May 23, 2026: PPD = 3.44 on unit; 3.64 overall. Meet staffing ratios.
>
> September 19, 2025: PPD = 3.26 on unit; 3.33 overall. Meet staffing ratios.
>
> September 23, 2025: PPD = 3.3 on unit; 3.47 overall. Ratios other than Aide were within regulations. Aide ratio only slightly below requirement.
>
> October 2, 2025: PPD = 3.29 on unit; 3.38 overall. Ratios other than Aide were within regulations. Aide ratio only slightly below requirement.
>
> October 17, 2025: PPD = 3.28 on unit; 3.48 overall. Ratios other than Aide were within regulations. Aide ratio only slightly below requirement.

Furthermore, none of the issues cited by the DOH were related to staffing issues.

## II. THE REPORT'S EMPHASIS ON AGENCY STAFFING IS MISLEADING

The Report suggests that Gracedale's utilization of Agency Staff somehow compromises resident care and recommends the hiring of additional staff. See Report, Recommendation No. 1 (Gracedale should move away from agency staffing). This conclusion fails to take into account the lack of available workforce members to fill positions at Gracedale.

Staffing shortages remain a fundamental issue for all nursing homes in the Commonwealth of Pennsylvania. Unfortunately, there is a shortage of personnel willing to fulfill these roles in the nursing home setting. Many facilities, including Gracedale, struggle to recruit Certified Nurse Aides to meet the mandatory Pennsylvania staffing ratios.

As a result, it must utilize outside agencies to provide such staffing so that it can be compliant with the Pennsylvania mandates. As noted in the Report, agency staffing is usually more expensive than employed staff. While Gracedale has made strides to reduce its utilization of Agency Staff, this remains challenging for all facilities in Pennsylvania. In this regard, Gracedale has reduced

[2] Contrary to the Report, there is no federally required staffing ratio. Rather, under Federal regulations, the facility must simply ensure there is enough staff to provide care.

the utilization of Agency Staff from approximately 80% in February of 2025 down to about 56% at the current time.

On its own, staffing does not result in higher quality and the push for specific ratios often merely drives up costs for the facility. As discussed, none of the issues raised in the Report were related to insufficient staffing.

Thus, while Gracedale is attempting to reduce agency staffing, the lack of an available workforce makes this goal challenging to achieve. In this regard, Gracedale has taken significant steps to increase the number of employed caregivers, and beginning in 2025, implemented the following:

**Expand Outreach Channels** – Leverage professional networks, targeted job boards, community organizations, and in-person/virtual career fairs to reach underrepresented and high-demand talent pools.

- Utilizing the Indeed job board posting and Neo Gov
- Connected with the 3rd Street Alliance for a diverse population
- Postings on all University job boards
- Postings on all Nursing School job boards
- Posting on all Trade School (dietary) job boards
- Local signage at diners, grocery stores, pharmacies
- Attend all Career Days and Job Fairs (41 events in 2025)
- Member of The Century Promise for underserved community members
- Highlight Free Daycare

**Streamline Application Process** – Simplify job postings, reduce unnecessary requirements, and ensure clear, inclusive language to improve applicant experience. For th

**Enhance Employer Branding** – Highlight our organizational culture, career growth opportunities, medical benefits, pension plan, tuition reimbursement, and impact-driven work through social media, website updates, employee testimonials, and updated recruitment materials.

**Data-Driven Recruitment** – Use analytics to track applicant demographics, source effectiveness, and time-to-hire, adjusting strategies accordingly.

**Candidate Engagement** – Maintain timely communication, provide feedback where possible, and create a positive, respectful candidate journey including recruitment efforts with staffing agency.

Next Steps:

- Continue recruitment of agency personnel to transition to Gracedale
- HR to continue positive recruitment trajectory
- HR to implement updated job posting templates by January 31, 2026.
- Develop increased outreach channels
- HR to increase social media presence with TikTok to engage younger demographics
- Department heads to identify priority roles and outreach partners by January 15, 2026.
- Quarterly review of recruitment metrics starting January 1, 2026, for the last quarter of 2025 and March 31, 2026, for Q1.
- Additional promotion of the Free Daycare at Gracedale Nursing Home through the Lehigh Valley, Stroudsburg, New Jersey, and Pocono Mountains.

These efforts have begun to turn the tide and hiring has outpaced employee departures.

The Report notes further that Gracedale has limited the number of admissions to between 400 to 450 residents, despite a maximum capacity of 688 residents. Again, this finding lacks the context that under Pennsylvania regulations, it is required to maintain specific staffing ratios. Without the ability to meet these requirements, it must limit the number of residents so that it remains in compliance with the regulations. In general, the limitation on the number of residents is a direct function of the ratios imposed upon it by regulation.

Tied with lack of an available skilled workforce, increasing the number of residents would only result in the need to rely more heavily upon costly agency staffing.

## III. GRACEDALE HAD APPROPRIATE POLICIES IN PLACE

The Report recommends that Gracedale implement additional policies and procedures and develop policies regarding training of Nurse Aides. (See Recommendations 2, 5, and 7). Such policies and procedures were already in place.

The incident giving rise to the investigation, arose from the act of one individual at Gracedale who was suffering from a delusional episode and believed that a resident was possessed by demons.

This individual was a nurse employed by a staffing agency. The individual was trained and supervised by Gracedale. The acts of the individual were unprecedented and could not be anticipated by Gracedale. By all accounts, this individual gave no inclination that she was suffering from delusions until the incident in question.

Gracedale was cited for abuse under Federal Tag F600. This tag imposes almost strict liability for any physical abuse by a staff member on a resident. Gracedale disputed the citation, as it is permitted to do to an outside agency, Quality Insights. Quality Insights noted that Gracedale acted appropriately but upheld the deficiency as any harm by staff is deemed to violate F600:

> The deficiency that was cited, F600, outlines the requirement for the facility to maintain an abuse free environment at all times to their residents. *The facility had no reason to believe that the LPN was a risk for their residents, however, the facility is responsible at all times for the care and needs of the residents.* This unfortunate isolated incident did inflict harm to three residents as stated in the 2567. R1 was physical, mental, and psychosocial harm. R2 and 3 also were harmed by the nurse, not allowing them to leave the room, or utilize the bathroom in addition to emotional harm. ***The facility reacted to this isolated incident accurately and thoroughly. The facility followed all policies and procedures and reporting requirements.***

Hence, with regard to the incident which gave rise to the investigation, the outside agency that reviewed the matter concluded that there was nothing Gracedale could have done to prevent the incident.

Gracedale appropriately reported the incident and reported the individual to the appropriate authorities in Pennsylvania and New Jersey.

**A. Gracedale Provided Adequate Training to Staff.**

The Report further calls into question Gracedale's training of its staff. Again, the Report does not reflect the full context of Gracedale's training of its staff. This training also includes Agency Staff.

The individual in question passed all required background checks and received appropriate training in areas of abuse, reporting abuse, and handling abuse situations. All of this training was in place prior to the incident in question. It goes without saying, however, that the individual did not follow her training as it is doubtful that any training could have prevented the event given the delusional state of the individual involved in the abuse.

Not only was the individual trained, but staff also shadowed her to ensure that she was properly trained and competent to care for residents. Orientation and training consist of over 40 areas of training, including abuse and abuse reporting.

Gracedale did have adequate training structures in place.

### B. The Incident Involving the Agency Staff Nurse Was Not a Function of Inadequate Policies.

The incident involving the assault by an Agency LPN on a resident is truly horrific. While it is always easy to find flaws in a process in hindsight, this incident did not occur because of insufficient policies. It is rare for an individual working at a health care facility to have such a significant mental health breakdown. The individual in question showed no signs of distress prior to this incident.

The Report faults Gracedale for not taking appropriate action. As discussed above, the external organization which reviewed the incident found that Gracedale did follow all appropriate policies and responded appropriately to the incident.[3]

The time between the calls was relatively short, and there were only minutes between the first and second calls from 911. Upon receiving the first call, staff called to the floor to check on the status. Upon receiving the second call from 911, staff went to the room to investigate, saw the nurse over the resident, and ordered her to stop. The nurse refused and began throwing things at Gracedale staff. The staff member left the room to call 911 and seek additional help. She came back quickly to attempt to get the nurse to stop, and, as there were two other residents in the room, staff did everything they could to protect the other residents. Gracedale staff were eventually able to get the other two residents out of the room. Local police arrived shortly thereafter and took the agency nurse into custody.

This was not an incident that could have been prevented by additional policies.

### C. The Other Incidents Cited in the Report Do Not Reflect Gracedale's Overall Compliance.

The Report cites a number of incidents suggesting that Gracedale lacks proper procedures and policies to ensure the safety of its residents.[4] This is not a correct assumption. The Report cites two elopements occurring within a short span of each other. These residents had significant issues and perhaps should not have been admitted to Gracedale.

Gracedale's admission process was slow in responding to referral requests. As a result, it was accepting difficult referrals, some of whom it should have rejected. Gracedale reinstituted its admissions screening, but some staff were not as diligent in complying with the policy and continued to admit residents with psychiatric issues it should not have admitted. It is now more carefully screening residents with significant behavioral issues.

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[3] The Report also faults local police for not responding in a more expedient manner.

[4] Due to patient confidentiality concerns, Gracedale will not set forth the specific facts of each of the resident care issues cited in the Report.

Regardless, Gracedale has improved its process, and as of the last DOH survey, it did not have any significant deficiencies.[5]

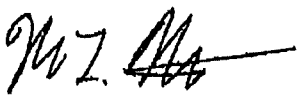
## IV. CONCLUSION

The Report suggests that Gracedale has multiple significant issues regarding the quality of the services it provides to residents. This is not a correct conclusion. As discussed above, skilled nursing facilities operate in very difficult and challenging environments. This is especially true for county-owned facilities which are often a last resort for individuals needing services.

The incident giving rise to the Grand Jury Investigation was a unique and unprecedented anomaly that involved one caregiver suffering from apparent delusions. Based upon the most recent inspection from the Department of Health, Gracedale has made great strides to fix any areas of weakness.

We hope that the Report, if released, may be viewed in light of the considerable challenges facing Gracedale and other skilled nursing facilities.

Respectfully submitted,



Mark L. Mattioli

MLM/dma

[5] The Report also references a report by Affinity that was done in 2023. This report predated the current administrator. Nevertheless, the Affinity report notes that financially, Gracedale exceeds other county-owned homes in terms of revenue. In 2023, the Affinity report notes it had an operating margin of 12% compared to the -3% for county homes.