STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Rehabilitation and Healthcare Center	55 Grand Street New Britain, CT 06052

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, facility documentation, facility policy and interviews for 1 (one) of 3 (three) residents (Resident #1) reviewed for abuse, the facility failed to ensure the resident was free from abuse from a staff member. The findings include: Resident #1's diagnoses included anxiety disorder and hypertension (high blood pressure). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental status (BIMS) of fifteen (15) indicative of intact cognition, exhibited no behaviors and required supervision for activities of daily living and was independent with transfers and ambulation. A Resident Care Plan (RCP) dated 9/10/24 identified Resident #1 is a current smoker with interventions that included to educate the resident on safe smoking, educating the resident that smoking materials must be held by the facility staff and to offer smoking cessation. Review of the facility Accident and Investigation (A&I) dated 9/18/24 identified Resident #1 was outside for a scheduled smoke break when the resident became upset with the brand of cigarettes, he/she was given and confronted Nurse Aide (NA) #1. Resident #1 then went back inside, and NA #1 followed him/her to the elevator, where NA #1 was observed yelling at the resident to open the doors. Staff immediately intervened and brought NA #1 to the Director of Nurse's (DNS) office. Review of facility statement written by Licensed Practical Nurse (LPN) #4 identified that she worked 7:00 AM to 3:00 PM on 9/18/24 and as she was approaching the afternoon smoke break, she observed the NA on duty (NA #1) to be visibly irritated and NA #1 then stated to the residents, nobody talk to me on smoke break. She reported that when smoke break had concluded, Resident #1 came back inside and was very upset reporting that NA #1 talked to and treated him/her poorly. Review of a Social Service note dated 9/18/24 identified that the resident had an altercation with a staff member, support was provided, and a referral was made to psychiatric services to follow up with the resident. Review of psychiatric progress notes identified that the resident was seen on 9/18, 9/19 and 9/25/24 for support regarding the verbal altercation with a staff member, he was able to recall the incident and was upset with the staff member. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Interview with Resident #1 on 10/9/24 at 10:45 AM identified that he/she recalled the incident with NA #1, reporting that NA#1 was yelling at him/her and trying to lunge and get at him/her in the elevator after the resident approached her about receiving the wrong cigarettes at smoke break. Resident #1 reported that NA #1 had a threatening presence and reacted towards him/her like she was trying to fight him/her on the streets, identifying that it made him/her feel angry and upset with how they were treated. Interview with LPN #1 on 10/9/24 at 10:53 AM identified that around 2:30 PM on 9/18/24, Resident #1 was getting on the elevator and NA #1 came running down the hall after the resident, yelling profanities at and using derogatory language towards the resident. She reported that the elevator door had started to shut, and NA #1 began hitting the door with closed fists and demanding that Resident #1 open the elevator door, appearing that she was trying to fight the resident. She identified that Resident #1 continued in the elevator, and she was able to convince NA #1 to move away from the door, reporting that LPN #2 then came to assist her and called the nursing supervisor to notify them of the incident while she notified the DNS. Additionally, she identified that Resident #1 was shaken up following the incident and reported to her that NA #1 was crazy and acting like a man. Interview with RN #1 (Nursing Supervisor) on 10/9/24 at 2:05 PM identified that she was walking to her office on the first floor towards the end of the 7:00 AM to 3:00 PM shift and saw Resident #1 waiting at her door, which was surprising to her because the resident does not usually complain. She reported that the resident was very upset, stating that NA #1 was trying to fight me. The resident reported that when he/she was getting into the elevator, NA #1 had her her hands balled up into fists and tried getting onto the elevator with him/her while yelling at him/her. Interview with RN #3 (also a Nursing Supervisor) on 10/9/24 at 2:37 PM identified that LPN #2 called her regarding the incident involving NA #1 and Resident #1. She reported that she immediately went to speak with the resident, who was visibly upset and reported that NA #1 was loud, speaking disrespectfully to him/her and had bad mannerisms. Interview with the DNS on 10/9/24 at 12:38 PM identified that the interaction between NA#1 and Resident #1 was inappropriate. Subsequent to the incident the staff immediately brought NA #1 to his office, ensuring she was not able to interact with any other residents. He reported that he requested that the NA write a statement regarding the incident to which she refused, and subsequently resigned. Although attempted, an interview with NA #1, Social Worker #1 and LPN #4 were unable to be obtained. Review of the Abuse, Neglect and Exploitation policy dated 1/18/24 directed, in part, that abuse means the willful infliction of injury, intimidation or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse. It includes verbal abuse, sexual abuse, physical abuse and mental abuse. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written and will provide complete and thorough documentation of the investigation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on clinical record review, facility documentation review, facility policy review, and interviews for three (3) of three (3) residents (Resident #1, 3 and 5) reviewed for abuse, the facility failed to ensure the residents were provided social services support timely after abuse within the facility. The findings include: 1. Resident #1's diagnoses included anxiety disorder and hypertension (high blood pressure). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was cognitively intact, exhibited no behaviors and required supervision for bed mobility and was independent with transfers and ambulation. The Resident Care Plan dated 9/10/24 identified that Resident #1 has limited physical mobility related to weakness. Interventions included that the resident is independent with ambulation with the use of a rolling walker. Review of the facility Accident and Investigation (A&I) dated 9/18/24 identified that on 9/18/24 at 2:30 PM, Resident #1 was outside for a scheduled smoke break when he/she became upset with the brand of cigarettes he/she was given and confronted NA #1. Resident #1 then went back inside, and NA #1 followed him/her to the elevator, where NA #1 was observed around 2:30 PM yelling at the resident to open the doors. It reported that staff immediately intervened and brought NA #1 to the DNS's office where she was requested to write a statement but refused to comply, made vulgar comments and resigned. Review of social service progress notes dated 9/18/24 through 10/9/24 identified that Resident #1 was seen by social services on 9/18/24, reporting that social services would continue to support the resident. The clinical record failed to identify any follow-up with Resident #1 following the 9/18/24 documentation. 2. Resident #3's diagnoses included dementia and type II diabetes mellitus. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #3 was severely cognitively impaired, exhibited no behaviors and required substantial assistance for bed mobility and was dependent on staff for personal hygiene and transfers. The Resident Care Plan (RCP) dated 7/10/24 identified that Resident #3 requires assistance with Activities of Daily Living (ADLs) due to dementia with interventions that included an assist of one to two staff for bed mobility, an assist of two with a Hoyer lift for transfers, and ambulation was to be performed with rehab staff only. Review of facility A & I dated 9/9/24 identified that on 9/9/24 at 4:00 PM, there was a resident-to-resident abuse where Resident #2 went into Resident #3's room and pulled Resident #3's hair, witnessed by Resident #3's spouse. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of social service progress notes for September 2024 identified that Resident #3 was not seen by social services until 9/11/24 (2 days after the incident) which identified that the social worker would continue to follow-up with the resident. The clinical record failed to identify any further follow-up after the 9/11/24 documentation. 3. Resident #5's diagnoses included lack of coordination, weakness, cognitive communication deficit, bipolar disorder and post-traumatic stress disorder. The discharge return anticipated Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 was cognitively intact, exhibited no behaviors and required setup assistance for transfers and supervision assistance with ambulation. The Resident Care Plan (RCP) dated 8/23/24 identified that Resident #5 had an Activity of Daily Living (ADL) deficit due to deconditioning, hypothyroidism and weakness with interventions that included to praise all efforts of self-care and PT/OT evaluation and treatment per physician orders. Review of facility A & I dated 8/15/24 identified that on 8/15/24 at 5:30 PM there was a resident-to-resident abuse where Resident #4 struck Resident #5 on the back while ambulating in the hallway. Resident #4 denied the allegation, reporting that he/she only patted Resident #5 on the back as he/she was walking by. Review of social service progress notes from 8/15/24 through 8/31/24 identified that Resident #5 was seen by social services on 8/16/24 when a wellness check was conducted. The note did not identify the resident-to-resident incident that occurred on 8/15/24 but reported that social services would continue to support Resident #5. The clinical record failed to identify any further follow-up after the 8/15/24 documentation. Interview with Social Worker #1 (Director of Social Services) on 10/9/24 at 1:34 PM identified that with any actual or alleged abuse, he is responsible for meeting with the residents who were involved on the day of the incident if able, or within 24 hours. He reported that he is also then responsible for meeting with the resident(s) daily for 72 hours to discuss with them their adjustment and psychological status and then documenting the encounters in the medical record. He reported that he was unsure when he met with Residents #1, 3 and 5 but identified that when he is lacking time, he'll write notes in his paper notebook and then document the encounters when time permits, stating that he's aware that if it's not documented, it didn't occur. Although requested, paper notes from Social Worker #1 on Residents #1, 3 and 5 were not provided. Interview with the DNS on 10/9/24 at 2:38 PM identified that social services is responsible for meeting with all residents involved in any abuse incident as soon as possible or by the next day. He reported that after the initial encounter, it is his expectation that social services is then following-up with the resident(s) daily for 72-hours and documenting the encounters in the clinical record timely. He was unsure why Residents #1, 3 or 5 had not been followed-up with by social services following the abuse incidents. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Social Service job description (undated) identified that the Social Worker is responsible for interviewing residents as necessary and in a private setting and recording and maintaining Social Service progress notes indicating response to the treatment plan and/or adjustment to institutional life. Review of the Documentation in Medical Record policy (undated) directed, in part, that documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation or care service occurred.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on clinical record review, facility documentation review, facility policy review, and interviews for three (3) of three (3) residents (Resident #1, 3 and 5) reviewed for abuse, the facility failed to ensure the medical records were complete and accurate to include nursing documentation after incidences of abuse within the facility. The findings include: 1. Resident #1's diagnoses included anxiety disorder and hypertension (high blood pressure). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was cognitively intact, exhibited no behaviors and required supervision for bed mobility and was independent with transfers and ambulation. The Resident Care Plan dated 9/10/24 identified that Resident #1 has limited physical mobility related to weakness. Interventions included that the resident is independent with ambulation with the use of a rolling walker. Review of the facility Accident and Investigation (A&I) dated 9/18/24 identified that on 9/18/24 at 2:30 PM, Resident #1 was outside for a scheduled smoke break when he/she became upset with the brand of cigarettes he/she was given and confronted NA #1. Resident #1 then went back inside, and NA #1 followed him/her to the elevator, where NA #1 was observed around 2:30 PM yelling at the resident to open the doors. It reported that staff immediately intervened and brought NA #1 to the DNS's office where she was requested to write a statement but refused to comply, made vulgar comments and resigned. Nursing progress note dated 9/18/24 at 6:50 PM identified that the police arrived at 5:45 PM to investigate a reported incident regarding Resident #1. An officer badge number and case number was provided to the facility. Review of nursing progress notes dated 9/18/24 through 10/9/24 failed to identify any details on the incident or any further follow-up or monitoring of with Resident #1. Interview with LPN #1 on 10/9/24 at 10:53 AM identified that she did not document the incident in the clinical record because both RN # 3 (Nursing Supervisor) and the DNS were notified and she assumed they would be documenting the incident. Interview with RN #3 (the nursing supervisor) on 10/9/24 at 2:37 PM identified that she did not document the 9/18/24 incident in the clinical record, as she was under the impression that the DNS would document the occurrence because he was doing the investigation but did not clarify with him before she left for the shift. 2. Resident #3's diagnoses included dementia and type II diabetes mellitus. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #3 was severely cognitively impaired, exhibited no behaviors and required substantial assistance for bed mobility and was dependent on staff for personal hygiene and transfers. The Resident Care Plan (RCP) dated 7/10/24 identified that Resident #3 requires assistance with Activities of Daily Living (ADLs) due to dementia with interventions that included an assist of one to two staff for bed mobility, an assist of two with a Hoyer lift for transfers, and ambulation was to be performed with rehab staff only. Review of facility A & I dated 9/9/24 identified that on 9/9/24 at 4:00 PM, there was a resident-to-resident abuse where Resident #2 went into Resident #3's room and pulled Resident #3's hair, witnessed by Resident #3's spouse. Nursing progress note dated 9/9/24 at 3:15 PM identified that Resident #2 went into Resident #3's room and pulled his/her hair and then wandered back out of Resident #3's room. It reported that a body audit was completed, and no injury was noted. The progress note identified that neither resident had any recollection of the incident. Further review of nursing progress notes for September 2024 failed to identify any further follow-up after the 9/9/24 documentation. 3. Resident #5's diagnoses included lack of coordination, weakness, cognitive communication deficit, bipolar disorder and post-traumatic stress disorder. The discharge return anticipated Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 was cognitively intact, exhibited no behaviors and required setup assistance for transfers and supervision assistance with ambulation. The Resident Care Plan (RCP) dated 8/23/24 identified that Resident #5 had an ADL deficit due to deconditioning, hypothyroidism and weakness with interventions that included to praise all efforts of self-care and PT/OT evaluation and treatment per physician orders. Review of facility A & I dated 8/15/24 identified that on 8/15/24 at 5:30 PM there was a resident-to-resident abuse where Resident #4 struck Resident #5 on the back while ambulating in the hallway. Resident #4 denied the allegation, reporting that he/she only patted Resident #5 on the back as he/she was walking by. Nursing progress note dated 8/15/24 at 5:00 PM identified that Resident #5 reported that Resident #4 slapped him/her on the back when he/she was walking by, causing him/her to jolt forward. Resident #5 identified that Resident #4 then followed him/her back to his/her unit and reported to the staff that he/she didn't hit Resident #5 hard, demonstrating how he/she touched Resident #5's shoulder. The residents were separated, a skin check was performed on Resident #5 with no irregularities and Resident #5 denied any pain. The APRN and Resident #5's responsible party was notified, as well as the police. Further review of nursing progress notes dated 8/15/24 through 8/31/24 failed to identify any further follow-up after the 8/15/24 documentation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the DNS on 10/9/24 at 12:38 PM identified that following any incident that has the potential for a change in condition, nursing staff is responsible for documenting the initial incident that occurred followed by a progress note every shift for 72 hours. He reported that he was unsure why documentation was not located in the clinical record for Residents #1, 3 or 5 but identified that it was his expectation that either the floor nurse responsible for the resident that shift, or the nursing supervisor documented in the clinical record of each resident involved with unbiased details of the incident. Further, he identified that staff should have followed the Incidents and Accidents policy. Review of the Incidents and Accidents policy (undated) directed, in part, that documentation in the resident's medical record should include the date, time, nature of the incident, location, initial findings, notifications and any orders obtained. Review of the Documentation in Medical Record policy (undated) directed, in part, that documentation shall be accurate, relevant and complete, containing sufficient details about the resident's care and/or responses to care.