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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075182 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/11/2024 |
| NAME OF PROVIDER OR SUPPLIER Grandview Rehabilitation and Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
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| <p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682</p> <p>Based on clinical record review, facility documentation review, facility policy review and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure a privacy curtain was not removed. The findings include:</p> <p>Resident #1's diagnoses included end stage renal disease, psychoactive substance abuse, and major depressive disorder.</p> <p>Record review identified Resident #1 had a court appointed Conservator of Person (COP).</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15), indicative of being alert and oriented, required assistance for mobility.</p> <p>The Resident Care Plan (RCP) dated 10/24/2024 identified Resident #1 was at risk for injury to self and others secondary to unsafe smoking practices and had stored smoking supplies on his/her person and/or in his/her room. Interventions directed to provide one-to-one (1:1) staff for supervision, assign a companion to go on all (outpatient) dialysis appointments to ensure no vapes (pens) are acquired, voluntary searches in room/belongings as needed, review facility smoking policy, re-sign smoking contract, COP approved list of visitors, and all purchases to be made by the COP (to avoid purchase of smoking supplies).</p> <p>Record review identified Resident #1 was on 1:1 observation on 11/6, 7, 8 and 9, 20204.</p> <p>Facility reportable event dated 11/6/2024 at 10:45 AM identified Resident #1 pulled out a vape pen and used it inside the facility, in front of the 1:1 staff, and Resident #1 gave the vape pen to staff when they requested it. Resident #1 stated that he/she obtained the vape pen from his/her family member; family member denied giving Resident #1 the vape pen.</p> <p>Facility reportable event dated 11/9/2024 at 6:40 AM identified as the RN Supervisor came into Resident #1's room to administer medications, Resident #1 was observed using a vape pen; he/she took a puff off a vape pen, and then tried to hide the vape when he/she saw the nurse. The report identified the staff assigned for 1:1 observation had their back to the resident: the 1:1 in that moment, had just repositioned the bedside table and had his back to Resident #1 as he walked back to his chair. Resident #1 surrendered the vape pen.</p> <p>(continued on next page)</p> |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: | Facility ID: 075182 |
| | | If continuation sheet Page 1 of 5 |

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| <p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The reportable event further identified the facility intervention included, but was not limited to, the privacy curtain was removed from room so Resident #1 could not use it to help conceal his/her actions.</p> <p>Observation of Resident #1's room during the survey identified Resident #1 had a roommate and the roommate had a privacy curtain. Additional observation identified Resident #1 had a privacy curtain that did not provide full privacy for Resident #1.</p> <p>Interview with the DON on 12/11/2024 at 10:50 AM identified Resident #1 continued to obtain vape pens and refused to say how he/she obtained them, and the facility continued to provide educate regarding facility smoking policy. The DON stated the facility removed the privacy curtain for a short time, to ensure he/she was not hiding behind the curtain or using it to block staff's view to enable him/her to vape. The DON stated the curtain has since been re-installed.</p> |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682</p> <p>Based on clinical record review, facility documentation review, facility policy review and interviews for two of three residents (Resident #1, #2, and #3) reviewed for accidents, the facility failed to ensure residents on one-to-one observation did not use a vape pen inside the facility and did not have possession of items not permitted in the facility, including knives and a machete. The findings include:</p> <p>1. Resident #1's diagnoses included end stage renal disease, psychoactive substance abuse, and major depressive disorder.</p> <p>Record review identified Resident #1 had a court appointed Conservator of Person (COP).</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15), indicative of being alert and oriented, required assistance for mobility. The Resident Care Plan (RCP) dated 10/24/2024 identified Resident #1 was at risk for injury to self and others secondary to unsafe smoking practices and had stored smoking supplies on his/her person and/or in his/her room. Interventions directed to provide one-to-one (1:1) staff for supervision, assign a companion to go on all (outpatient) dialysis appointments to ensure no vapes (pens) are acquired, voluntary searches in room/belongings as needed, review facility smoking policy, re-sign smoking contract, COP approved list of visitors, and all purchases to be made by the COP (to avoid purchase of smoking supplies).</p> <p>Record review identified Resident #1 was on 1:1 observation on 11/6, 7, 8, and 9, 2024.</p> <p>Facility reportable event dated 11/6/2024 at 10:45 AM identified Resident #1 pulled out a vape pen and used it inside the facility, in front of the 1:1 staff, and Resident #1 gave the vape pen to staff when they requested it. Resident #1 stated that he/she obtained the vape pen from his/her family member; family member denied giving Resident #1 the vape pen.</p> <p>Facility reportable event dated 11/9/2024 at 6:40 AM identified as the RN Supervisor came into Resident #1's room to administer medications, Resident #1 was observed using a vape pen; he/she took a puff off a vape pen, and then tried to hide the vape when he/she saw the nurse. The report identified the staff assigned for 1:1 observation had their back to the resident: the 1:1 in that moment, had just repositioned the bedside table and had his back to Resident #1 as he walked back to his chair. Resident #1 surrendered the vape pen.</p> <p>Interview with DON on 12/11/2024 at 10:50 AM identified Resident #1 should not have used a vape pen inside the facility and was unable to identify how Resident #1 had possession of the vape pen while on 1:1 observation.</p> <p>2. Resident #2's diagnoses included anxiety disorder, and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15), indicative of being alert and oriented, and was independent with transfers and wheelchair mobility.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The Resident Care Plan (RCP) dated 11/11/2024 identified Resident #2 was at risk for injury to self and others secondary to unsafe smoking practices, shared smoking supplies (lighters, cigarettes, vapes, e-cigs) with other residents and stored smoking supplies on his/her person and/or in his/her room. Interventions directed for 1:1 supervision, provide smoking education, staff to request to be present when opening deliveries, and room/belongings search as needed.</p> <p>Facility reportable event dated 11/13/2024 at 1:30 PM identified Resident #2 was found with several vapes, empty cigarette boxes, a pocketknife and a machete during a room change. Resident #2 stated that the vapes and cigarette boxes were empty, and the knives were planned to be given away as gifts.</p> <p>Record review identified Resident #2 was placed on a one-to-one (1:1) observation after the items were found on 11/13/2024.</p> <p>Facility reported event dated 11/14/2024 at 6:15 PM identified while the 1:1 staff was putting Resident #2's belongings away (with the resident's permission) after the room change, multiple specialty knives were found. Resident #2 refused a room search and stated he/she ordered the two (2) knives from an on-line website.</p> <p>Facility summary dated 11/15/2024 identified when psychiatric services discussed with Resident #2, he/she was unable to stated where or how long ago the knives were obtained. Record review identified Resident #2 was to remain on 1:1 observation.</p> <p>Interview with DON on 12/11/2024 at 10:50 AM identified Resident #2 should not have had the pocketknife, machete, and the specialty knives. The DON stated Resident #2 likely obtained the items by ordering and having the items delivered to the facility, or when out of the facility on an LOA. The interview identified although Resident #2 was placed on 1:1 observation on 11/13/2024, the interview failed to identify how Resident #2 continued to obtain items while on the 1:1 staff observation.</p> <p>Review of the Smoking Policy identified under smoking rules, residents are not permitted to carry any smoking materials, such as: cigarettes, cigars, vapes, pipes, and lighting devices (matches, lighter). Anyone in violation of this rule will be reassessed, and re-educated. If non-compliance continues, the resident could receive an involuntary discharge notice.</p> | | |

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| <p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>41682</p> <p>Based on clinical record review, facility documentation review, facility policy review, and interviews for facility Administration review, the facility failed to ensure the facility administered its resources effectively and to ensure effective administrative oversight of staff and resident care timely to maintain the highest practicable physical, mental and psychosocial well-being of residents. The findings include:</p> <p>The facility administration failed to:</p> <p>Ensure residents who were on one-to-one (1:1) observation did not have possession of contraband in the facility.</p> <p>Ensure residents did not smoke vape pens inside the facility.</p> <p>Ensure residents did not have knives of a machete in the facility.</p> <p>Please cross reference F583 and F689.</p> <p>Please cross reference F689 survey exit dates 7/23/2024, 9/17/2024 and 10/9/2024.</p> <p>Interview with Medical Director #1 (MD #1) on 12/11/24 at 9:00 AM identified the facility was experiencing a high level of vaping occurrences among residents. MD #1 stated smoking cessation and counseling were offered, and the residents with multiple occurrences have 1:1 observation in place to help prevent instances of obtaining items not allowed in the facility.</p> <p>Interview with the DON on 12/11/2024 at 10:50 AM failed to identify a process for administrative oversight of the facility processes for residents on 1:1 observation and staff education for preventing access to items not allowed in the facility. The DON identified all residents who have been found on multiple occasions with smoking paraphernalia or knives had been placed on 1:1 observation. During interview, although the DON stated he assumed contraband items were delivered in packages, from visitors or obtained when on Leave of Absence, he was unable to identify how, or where residents on 1:1 observation were able to obtain items that were not allowed in the facility without the 1:1 staff observing the delivery of such items.</p> <p>The facility failed to utilize resources effectively to attain/maintain the resident's well-being.</p> <p>No facility policy was provided for review.</p> | | |