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	07/24/2025

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. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical records, review of documentation, and facility policy for 1 of 8 sampled residents (Resident #58) reviewed for abuse, the facility failed to protect the residents' right to be free from verbal abuse. The findings include:Resident #58's diagnoses included fracture of the left arm humerus, fracture of the left femur, displaced fracture of the right tibia, and acute pain due to trauma. Review of a Grievance form dated 7/1/2025 (written in response to an allegation that occurred on 6/28/2025) identified Resident #58 had reported to the facility that a staff member referred to him/her as the N-word. The Grievance form further identified that the facility made him/her aware that the incident was under investigation and the facility would adhere to the facility policy. The grievance form stated that the staff member was educated but continued to demonstrate an inability to adhere to policies, exhibited insubordination, and was non-compliant. Additionally, the staff member lacked adequate customer service skills, and, as a result, their employment was terminated. (later identified that NA #6 was not terminated as an employee but made a Do Not Return to the facility from the staffing agency). The Grievance form was signed by the facility's Administrator on 7/4/2025. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #58 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, did not experience episodes of delusions or verbal behavioral symptoms towards others, and was dependent for his/her personal hygiene and rolling left and right in bed.The Resident Care Plan (RCP) in effect from 5/15/2025 through 7/20/2025 identified Resident #58 required assistance with activities of daily living and had a history of refusing care and medications. Interventions included encouraging the resident to participate in his/her care and praising all efforts at self-care. The RCP failed to include any allegation of verbal abuse.Interview on 7/16/2025 at 10:03 AM with Resident #58 identified on 6/28/2025 Nurse Aide (NA) #6 called her a F***ing N-word and he/she reported feeling abused to a Social Worker (SW). Resident #58 further identified since the incident of verbal abuse he/she had difficulty sleeping due to being afraid of retaliation by other staff for reporting the abuse, and he/she was not sure what people will do these days.Review of nursing notes for June 2025 and July 2025 failed to identify any documentation in Resident #58's Electronic Medical Record (EMR) or in the paper chart, that there was an allegation of verbal abuse that had occurred on 6/28/2025. Review of physician notes for June 2025 and July 2025 failed to identify any documentation of Resident #58's allegation of verbal abuse or that any verbal altercation had occurred or been reported for the grievance dated 6/28/2025. Review of social service notes written by Social Worker (SW) #3 identified that wellness checks had been performed with Resident #58 on 6/30/2025 and 7/1/2025. The notes indicated he/she was in a good mood, was alert and oriented, and that SW would continue to conduct 1:1 visits as needed. The notes failed to identify the reason wellness checks were being conducted with Resident #58. Review of a Psychiatric Advanced Practice Registered Nurse (APRN) note dated 6/30/2025 identified that Resident #58 was seen for a previous allegation of verbal abuse (called a bitch) which occurred on 5/16/2025. Although the APRN had seen Resident #58 for the previous allegation, the note failed to address the grievance dated 6/28/2025 (2 days prior to the visit). The APRN note indicated that during the 6/30/2025 visit, Resident #58 was alert, pleasant, and engaging. The resident presented in good spirits, no agitation or restlessness was noted and Resident #58 denied a depressed mood or anxiety.Interview on 7/18/2025 at 9:50 AM with Social Worker (SW) #1 identified that he was made aware through a daily report that a staff member used the N-word directed toward Resident #58 but did not indicate on what date. SW #3 collected information on the incident but did not perform an investigation into the allegation nor was he a part of the investigation, stating it was the Nursing Department's responsibility to conduct any investigation. SW #1 indicated that social work did perform wellness checks on Resident #58 as use of the N-word could cause pain and he wanted to be certain the resident was safe. SW #1 failed to document the details of the wellness check within the EMR or paper chart. SW #1 stated he did not report the incident of abuse to administration because they were already aware. Interview on 7/18/2025 at 10:23 AM with SW #3 identified that Resident #58 notified her during rounds, on the day after the incident (6/29/2025) that a Nurse Aide (NA) called him/her the N-word, that the racial slur made him/her feel uncomfortable, and he/she requested not to receive care from that NA going forward. SW #3 stated she notified her supervisor (SW #1) and the DNS of the allegation of abuse, and she was not involved with completing an investigation as the DNS and her supervisor (SW #1) were responsible for investigations. Interview on 7/18/2025 at 10:33 AM with the Director

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, documents, facility policy, and interviews for 1 of 8 residents (Resident #4) reviewed for abuse, the facility failed to ensure a resident was free from misappropriation of his/her bank card and use of the bank card. The findings include:Resident #4's diagnoses included mononeuropathy, type 2 diabetes, and chronic respiratory failure with hypoxia (low level of oxygen).A nurse's note dated 6/30/2025 at 2:22 PM by Licensed Practical Nurse (LPN) #7 identified that Resident #4 informed her that he/she went to the bank on 6/30/2025 with Person #3 (Resident #4's family member) and noticed his/her bank card was missing and money was missing from his/her bank account. The nurse's note further identified her supervisor, Registered Nurse (RN) #6, was made aware, the Police Department was called, and social services had started an investigation.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #4 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition, required set-up assistance with personal hygiene, used a wheelchair for mobility, and was independent with chair/bed-to-chair transfers.The Resident Care Plan (RCP) in effect from 5/3/2025 through 7/22/2025 identified Resident #4 needed socialization and independent activities at his/her own leisure to support his/her independence. Interventions included participating in smoke breaks, providing independent leisure activity materials, and visits by the Recreation Department 2 to 3 times weekly.A nurse's note dated 6/30/2025 at 2:22 PM by Registered Nurse (RN) #6 identified that LPN #7 informed her that Resident #4 was missing his/her bank card. RN #6 spoke with Resident #4 and was informed he/she went to the bank on 6/30/2025 and noticed the bank card was missing. He/she identified a charge that was made on the account that was not made by him/her when reviewing the bank statement. The nurse's note further identified the Director of Nursing Services (DNS), and the Administrator were made aware of the incident.A social services note dated 6/30/2025 at 3:44 PM identified Resident #4 was offered talk therapy and assured that all facility protocols would be followed, including reporting to the police and the State Agency (SA).A psychiatric Advanced Practice Registered Nurse (APRN) note dated 7/2/2025 identified that Resident #4's mood was stable after the 6/30/2025 allegation of misappropriation of funds. The psychiatric APRN note further identified that the resident had not checked the location of the bank card in about a month.Interview on 7/16/2025 at 10:57 AM with Resident #4 identified his/her bank card was stolen from his/her room and around $25.00 was charged at a grocery store approximately 10 miles away from the facility. He/she stated a police report was filed but the facility had not returned the money that had been stolen.A bank statement for Resident #4 dated 6/25/2025 identified that bank account activity on 6/9/2025 had occurred at a grocery store approximately 10 miles away from the facility in the amount of $25.80. No other charges were made to his/her account for the dates 4/30/2025 through 6/25/2025.A signed police report dated 7/18/2025 identified the police were dispatched to the facility on 7/2/2025 at 11:40 AM. The report identified Resident #4 signed a sworn statement that he/she used the debit card on 5/5/2025 at the bank to directly withdraw $400.00. The report further identified he/she had neither left the facility nor used her card after 5/5/2025. The report indicated he/she would like to press charges against the individual who stole his/her bank card and used it to make a purchase at the grocery store. Interview on 7/21/2025 at 9:16 AM with Person #3 identified he/she took Resident #4 to the bank on 6/30/2025 when the resident discovered his/her bank card was missing and there was a charge at a grocery store approximately 10 miles away from the facility made by an unauthorized person. Person #3 further identified no one other than him/her takes Resident #4 out of the facility, he/she had not taken the resident out of the facility on any other date in June, and that he/she did not take or borrow Resident #4's bank card for any reason.Interview on 7/21/2025 at 1:55 PM with the DNS identified a complete investigation into the allegation of misappropriation of funds was not performed. The DNS indicated that she failed to review the facility video cameras for potential evidence, she failed to obtain a copy of Resident #4's bank statement, and she failed to obtain written statements from all staff who worked with Resident #4 during the time of the incident. The DNS identified that she had unsubstantiated the allegation of misappropriation of funds because she could not substantiate or unsubstantiate the event had actually occurred. She stated the rationale for marking the investigation as unsubstantiated was she did not want to be late filing her summary. The DNS indicated the only way someone would have access to Resident #4's bank card, if kept in his/her wallet, would be if it was stolen. Review of the facility's Abuse, Neglect, and Exploitation policy identified in part that the facility will complete an immediate investigation when a report of

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F 0603 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). (continued on next page)

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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 0603 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policy, and interviews for 1 of 8 sampled residents (Resident #3) reviewed for abuse, the facility failed to ensure a resident was not involuntarily secluded and had access to all facility locations. The findings include:Resident #3's diagnoses included encounter for orthopedic aftercare (cervical laminectomy), type 2 diabetes, and schizoaffective disorder bipolar type.Observation and interview on 7/16/2025 at 12:38 PM identified that Resident #3 was not visible from the doorway. He/she was observed behind a privacy curtain, lacked any engaging activities such as television, radio, or personal activity, and lay in bed silently. Resident #3 stated he/she wanted to go outside but was told by staff that he/she could not leave the floor without a staff member and most times there was no staff to assist with outdoor privileges. Further, Resident #3 stated he/she was told he/she could only go outside when the smokers went out, but he/she did not smoke, and was upset due to seeing other residents leave the floor during non-smoking times when he she could not, stating It's not fair. Resident #3 indicated that he/she felt stuck on his/her unit and that it was like being in prison. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition, did not exhibit the behavior of wandering, required substantial assistance with chair/bed-to-chair transfers, and was independent in wheeling 50 feet with 2 turns in a manual wheelchair.The Resident Care Plan (RCP) in effect 3/13/2025 through 7/22/2025 identified Resident #3 preferred to pursue independent leisure activities as he/she was at the facility for short term rehab. Interventions included encourage independent leisure activities, and assist the resident as needed/requested by facilitating self-directed activities of interest.Interview on 7/22/2025 at 12:01 PM with Licensed Practical Nurse (LPN) #7 and Advanced Practice Registered Nurse (APRN) #1 identified that LPN #7 has never let Resident #3 off the floor nor has she ever seen him/her leave the floor as there were no Leave of Absence (LOA) orders in place that would allow him/her to leave the floor. APRN #1 identified that he was responsible for evaluating residents for LOA orders and he had not placed any orders for Resident #3 to leave the floor. Further he indicated the reason Resident #3 had no LOA privileges was because his/her conservator did not want him/her outside or leaving the building.Interview on 7/22/2025 at 12:07 PM with Person #2 (Resident #3's conservator) identified that no one from the facility had ever contacted him/her or asked him/her if Resident #3 could leave the floor or go outside. Person #2 further identified that Resident #3 had told him on multiple occasions that he/she asked staff to leave the floor, and the nurses tell him/her no. Person #2 stated he/she would like Resident #3 to be able to go outside in the courtyard area near the gazebo when he/she wanted to as it would do him/her good to get out into the fresh air to get some sunshine and Vitamins('s). A second observation of Resident #3 on 7/22/2025 at 12:32 PM identified he/she was independently locomoting up and down the hallway in a manual wheelchair. Resident #3 watched 3 other residents (Resident #27, Resident #68, and Resident #75) get badged out, off the floor, into the elevator to go outside independently. Resident #3 was noted to frown and wheeled his/herself back down the hallway to his/her room.Interview on 7/23/2025 at 8:54 AM with the Director of Nursing (DNS) identified that she brought up, in May, to the Director of Recreation, the issue of Resident #3 not being allowed outside to the resident area. The DNS stated that there is a resident-maintained garden, and she requested chairs be placed outside in that resident area to sit outside and enjoy the weather. Further, the DNS indicated she was aware that Resident #3 could only go outside if he/she smoked and believed it was unfair that smokers could go outside 4 times a day and non-smokers could not. The DNS stated she had previously brought up, during morning meeting, the subject of residents wanting to go outside and not being allowed to, and that staff needed to be educated. She further indicated that she was aware when Resident #3 had not been allowed off the floor or outside to the resident area, the resident was being involuntary secluded. Additionally, other residents wanted to leave the floor to go to the resident area and staff had not allowed this to occur.Interview on 7/23/2025 at 10:41 AM with the Director of Recreation identified that she was notified by the DNS in May to place chairs outside for the residents to sit outside in the fresh air. She submitted a concern form to the Maintenance Department and told maintenance verbally in June to place chairs outside. Further, she identified she was notified by Resident Council that they also wanted to go outside, and they requested a cover from the facility to provide shade. The Director of Recreation indicated she had never taken Resident #3 outside and does not want to use the gazebo as shade, as the area near the gazebo may smell like

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 3 of 8 sampled residents (Resident #15, Resident #55, and Resident #58) reviewed for abuse, the facility failed to report or report timely, allegations of abuse. The findings include: 1. Resident #15's diagnoses included encephalopathy, cirrhosis of the liver and a personal history of a traumatic brain injury.Review of the facility Reportable Event (RE) form dated 7/16/25 at 10:00 AM identified Resident #15 reported a staff member placed his hands around his/her neck and used derogatory names towards the resident and his family. The RE indicated a state classification indicating abuse. The Advanced Practice Registered Nurse (APRN) was notified of the incident at 10:30 AM and the RE was signed and dated on 7/16/25 by the Director of Nursing (DNS).The annual Minimum Data Set (MDS) dated [DATE] identified Resident #15 was severely cognitively impaired and required partial/moderate assistance with bed mobility and was dependent with transfers and toileting. The Resident Care Plan (RCP) dated 7/16/25 identified Resident #15 had impaired cognitive function with the potential to be verbally aggressive related to ineffective coping skills and poor impulse control. Interventions included monitoring behaviors, providing emotional support, and giving positive feedback for good behavior. Review of RN #4's written statement dated 7/16/25 indicated that on 7/16/25 he was asked to speak to Resident #15 because the resident was refusing care. Attempts to interview RN #4 were unsuccessful. Interview and review of facility documentation with the DNS on 7/22/25 at 1:30 PM identified on 7/16/25 at 10:00 AM Resident #15 had reported an allegation of physical abuse, the RE form was completed on 7/16/25 and signed by her on 7/16/25 but she had not reported the event to the state agency until 7/17/25 at 6:00 PM (32 hours post allegation). The DNS indicated that it would have been her responsibility to report Resident #15's allegation to the SA timely, she had made a mistake because the reporting criteria required the allegation be reported to the state agency within 24 hours of facility notification, and she was unable to identify why the late reporting occurred. 2. Resident #55 ‘s diagnoses included legal blindness, type 2 diabetes, and bipolar disorder.Review of the Reportable Event form dated 7/17/2025 at 1:00 PM identified Resident #55 alleged that he/she was verbally and physically assaulted by RN #4 on 7/16/2025 at approximately 7:00 PM, the resident notified police, the APRN was notified by the facility, an investigation was initiated, and statements were pending. RN #4 was suspended while the investigation was in progress.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #55 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment, required partial assistance with sit-to-lying positioning, was dependent on staff for sit-to-stand and chair to bed positioning changes, and walking 10 feet was not attempted.The Resident Care Plan (RCP) dated 6/18/2025 identified Resident #55 had a history of accusatory behavior. Interventions directed staff to approach Resident #55 with 2 staff members when providing Activities of Daily Living (ADL) care. A physician's order in effect from 7/1/25 through 7/24/2025 directed staff to approach Resident #55 with 2 staff members at all times every shift. Interview with Resident #55 on 7/17/2025 at 3:12 PM identified that he/she had returned to the facility with pizza the evening of 7/13/2025 and requested that it be refrigerated. On 7/16/2025, Resident #55 asked NA #9 to retrieve and heat the pizza, however, when NA #9 returned, she stated she did not find any pizza in the refrigerator. Resident #55 became upset and called RN #4 on the phone asking to be reimbursed for the missing pizza. RN #4 stated someone from social services would follow up with the resident the next day. Further, Resident #55 indicated that at approximately 6:00 PM RN #4 entered his/her room unexpectedly and alleged he began yelling profanities, including I am tired of your s***, you f****** p**** you little s*** and then he proceeded to spit in his/her face. Resident #55 indicated when he/she stated that he/she was going to call 911, RN #4 responded that he didn't care. Resident #55 called 911, began to speak with dispatch but dropped the cell phone. Resident #55 indicated that when he/she attempted to pick up the phone, RN #4 shoved him/her in the chest causing him/her to stumble and twist his/her left ankle. Resident #55 managed to retrieve the cell phone from the ground and informed the dispatcher, who was still on the call, that he/she had been assaulted by a staff member and was now hurt. At 7:00 PM the police had not arrived so Resident #55 placed another call to 911 and dispatch informed the resident the police were on their way. The police arrived at approximately 7:20 PM and a report was filed. Resident #55 further indicated that he/she was transported to the hospital secondary to chest and left foot pain. At the hospital Resident #55 identified he/she was diagnosed with a sprained left ankle, given a splint, and returned to the facility later that evening

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 5 of 8 sampled residents (Resident #4, Resident #43, Resident #55, Resident #58, and Resident #59) reviewed for abuse, the facility failed to ensure complete, thorough, and timely investigations were conducted. The findings include:F610 Grandview merged Based on review of the clinical record, facility documentation, facility policy, and interviews for 5 of 8 sampled residents (Resident #4, Resident #43, Resident #55, Resident #58, and Resident #59) reviewed for abuse, the facility failed to ensure complete, thorough, and timely investigations were conducted. The findings include: 1. Resident #4's diagnoses included mononeuropathy, type 2 diabetes, and chronic respiratory failure with hypoxia (low level of oxygen). A nurse’s note dated 6/30/2025 at 2:22 PM by Registered Nurse (RN) #6 identified that LPN #7 informed her that Resident #4 was missing his/her bank card. RN #6 spoke with Resident #4 and was informed he/she went to the bank on 6/30/2025 and noticed the bank card was missing. He/she identified a charge that was made on the account that was not made by him/her when reviewing the bank statement. The nurse’s note further identified the Director of Nursing Services (DNS), and the Administrator were made aware of the incident. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #4 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition, required set-up assistance with personal hygiene, used a wheelchair for locomotion, and was independent with chair/bed-to-chair transfers. The Resident Care Plan (RCP) in effect from 5/3/2025 through 7/22/2025 identified Resident #4 needed socialization and independent activities at his/her own leisure to support his/her independence. Interventions included participating in smoke breaks, providing independent leisure activity materials, and visits by the Recreation Department 2 to 3 times weekly. A nurse’s note dated 6/30/2025 at 2:22 PM by Licensed Practical Nurse (LPN) #7 identified that Resident #4 informed her that he/she went to the bank on 6/30/2025 with Person #3 (Resident #4’s family member) and noticed his/her bank card was missing and money was missing from his/her bank account. The nurse’s note further identified her supervisor, Registered Nurse (RN) #6, was made aware, the Police Department was called, and social services had started an investigation. A social services note dated 6/30/2025 at 3:44 PM identified Resident #4 was offered talk therapy and assured that all facility protocols would be followed, including reporting to the police and the State Agency (SA). A psychiatric Advanced Practice Registered Nurse (APRN) note dated 7/2/2025 identified that Resident #4’s mood was stable after the 6/30/2025 allegation of misappropriation of funds. The psychiatric APRN note further identified that the resident had not checked his/her wallet in about a month. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Reportable Event summary form dated 7/8/2025 and investigation documentation identified the DNS unsubstantiated the allegation of abuse and that the Police Department was conducting their own investigation into the allegation of misappropriation of Resident #4’s personal funds. Review of the facility’s investigation documentation identified 6 staff members provided single sentence statements attesting they were not aware of Resident #4’s missing bank card. The facility failed to ensure the forms were complete and contained a supervisory staff signature (blank) indicating that supervisory staff discussed the provided written statement with the staff member as indicated on the form. The investigation failed to obtain statements from all staff members from different shifts who had access to the resident during the time in question, failed to include an interview with the resident’s roommate, and failed to conduct an interview with the resident, Resident #4, who had the bank card taken. Interview on 7/16/2025 at 10:57 AM with Resident #4 identified his/her bank card was stolen from his/her room and around $25.00 was charged at a grocery store approximately 10 miles away from the facility. He/she stated a police report was filed, and the facility had not reimbursed the money that had been stolen. After requesting and obtaining approval to review, the bank statement for Resident #4 dated 6/25/2025 identified that bank account activity on 6/9/2025 had occurred at a grocery store approximately 10 miles away from the facility in the amount of $25.80. No other charges were made to his/her account for the dates from 4/30/2025 through 6/25/2025. A signed police report dated 7/18/2025 identified the police were dispatched to the facility on 7/2/2025 at 11:40 AM. The report identified Resident #4 signed a sworn statement that he/she used the debit card on 5/5/2025 at the bank to directly withdraw $400.00. The report further identified that he/she had neither left the facility nor used his/her card after 5/5/2025 and that he/she would like to press charges against the individual who stole his/her bank card, making a charge to his/her account. Interview on 7/21/2025 at 9:16 AM with Person #3 identified he/she took Resident #4 to the bank on 6/30/2025 when the resident discovered his/her bank card was missing and found out there had been unauthorized use of Resident #4’s bank card. Person #3 further identified no one other than him/her takes Resident #4 out of the facility, he/she had not taken the resident out of the facility any date in June, and he/she did not take or borrow Resident #4’s bank card for any reason. Interview on 7/21/2025 at 1:55 PM with the DNS identified a complete investigation into the allegation of misappropriation of funds was not performed. The DNS indicated that she failed to review the facility video cameras for potential evidence, she failed to request/obtain a copy of Resident #4’s bank statement, and she failed to obtain written statements from all staff who worked with Resident #4 during the time of the incident. The DNS identified that she had unsubstantiated the allegation of misappropriation, and her rationale was due to time constraints. The DNS indicated the only way someone would have access to Resident #4’s bank card, if it was kept in his/her wallet, would be if it was stolen. 2. Resident #43's diagnoses included anxiety and depressive disorder. (continued on next page)

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #43 on 7/15/25 at 11:15AM identified that he/she had reported to Registered Nurse (RN) #1 that $10.00 was missing from the drawer in his/her room a few weeks ago. Resident #43 could not recall the date but stated it was on a weekend. Resident #43 indicated that RN #1 told her she would have to report the missing money to the police. Resident #43 stated he/she asked that RN #1 not to report the missing $10.00 to the police as he/she did not want anyone to get in trouble. Resident #43 identified he/she did not report the missing $10.00 to any other staff member. Furthermore, Resident #43 stated that her locked box was broken when the incident happened and he/she had placed the $10.00 under the locked box. Resident #43 indicated that the locked box was repaired by maintenance not too long after the incident. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #43 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment and was independent with activities of daily living. The Resident Care Plan dated 7/15/25 identified Resident #43 reported $10.00 missing, and interventions included to follow the facility policy for reports of missing items, educate the resident on the use of a locked box, and encourage the resident to utilize a locked box for safe keeping of personal items and money. Interview with the DNS on 7/15/25 at 12:15 PM identified that she was unaware Resident #43 was missing $10.00, and the missing money had not been reported to her. Subsequently, the DNS filed an Accident & Incident report with the State Agency for Resident #43's missing $10.00 and initiated an investigation. During an interview with RN #1 on 7/15/25 at 1:50 PM, she denied that Resident #43 reported missing $10. 00 and if Resident #43 had reported the missing money she would have reported the occurrence and completed an Accident and Incident report. RN #1 indicated that she only worked on the weekends. Re-interview with Resident #43 on 7/17/25 at 12:00 PM confirmed that he/she had reported the missing $10. 00 to RN #1 when he/she noticed the $10.00 was missing. Resident #43 stated that he/she had asked RN#1 not to report the missing money to the police. A review of nursing notes and social service notes for June and July 2025 failed to identify documentation that Resident #43 had reported the missing $10.00 to RN #1. An interview and review of the investigation for Resident #43's missing money with the DNS on 7/23/25 at 12:00 PM indicated that the DNS had completed her investigation. The DNS stated the only remaining issue was that the facility was going to reimburse Resident #43 for the missing $10.00. A review of statements with the DNS identified that the investigation lacked a statement from RN #1 or any other staff members that worked on Resident #43's unit. The only statement that was obtained was from Resident #43. The DNS indicated that statements from RN #1 and staff members who had worked on Resident #43's unit should have been obtained for the investigation and that the investigation was not thoroughly completed. Furthermore, the DNS indicated that it was her responsibility to ensure investigations were completed per the facility policy. 3. Resident #55 ‘s diagnoses included legal blindness, type 2 diabetes, and bipolar disorder. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Reportable Event form dated 7/17/2025 at 1:00 PM identified Resident #55 alleged that he/she was verbally and physically assaulted by RN #4 on 7/16/2025 at approximately 7:00 PM, the resident notified police, the APRN was notified by the facility, an investigation was initiated, and statements were pending. RN #4 was suspended while the investigation was in progress. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #55 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment, required partial assistance with sit-to-lying positioning, was dependent on staff for sit-to-stand and chair to bed positioning changes, and walking 10 feet was not attempted. The Resident Care Plan dated 6/18/2025 identified Resident #55 had a history of accusatory behavior. Interventions directed staff to approach Resident #55 with 2 staff members when delivering activities of daily living (ADL) care. Physician’s orders that were in effect from 7/1/2025 through 7/24/2025 directed staff to approach Resident #55 with 2 staff members at all times every shift. Review of the facility Accident and Investigation Report indicated that the facility was unable to substantiate the allegation following the completion of the investigation, but the documentation was incomplete as there was no statement from Resident #55 and 2 statements were written but lacked signatures as to who had completed the statements. Interview with Resident #55 on 7/17/2025 at 3:12 PM identified that he/she had returned to the facility with pizza the evening of 7/13/2025 and requested that it be refrigerated. On 7/16/2025, Resident #55 asked NA #9 to retrieve and heat the pizza, however, when NA #9 returned, she stated she did not find any pizza in the refrigerator. Resident #55 became upset and called RN #4 on the phone asking to be reimbursed for the missing pizza. Resident #55 indicated that RN #4 stated someone from social services would follow up with the resident the next day. Further, Resident #55 identified that at approximately 6:00 PM RN #4 entered his/her room unexpectedly and began yelling profanities, including “I am tired of your s***, you f****** p**** you little s***” and then according to Resident #55, RN #4 proceeded to spit in his/her face. Resident #55 indicated when he/she stated that he/she was going to call 911, RN #4 responded that he didn’t care. Resident #55 stated he/she called 911and began to speak with dispatch but dropped the cell phone. Resident #55 indicated that when he/she attempted to pick up the phone, RN #4 shoved him/her in the chest causing him/her to stumble and twist his/her left ankle. Resident #55 managed to retrieve the cell phone from the ground and informed the dispatcher, who was still on the call, that he/she had been assaulted by a staff member and was now hurt. At 7:00 PM the police had not arrived so Resident #55 placed another call to 911 and dispatch indicated the police were on their way. The police arrived at approximately 7:20 PM, and a report was filed. Resident #55 indicated that he/she was transported to the hospital secondary to chest and left foot pain. At the hospital Resident #55 identified he/she was diagnosed with a sprained left ankle, given a splint, and returned to the facility later that evening. Resident #55 went on to state that on 7/17/2025 (the next morning) he/she became upset upon hearing RN #4 being paged. Resident #55 indicated that he/she believed RN #4 would no longer be working at the facility due to the incident that happened the night before. Resident #55 stated that he/she requested to speak to the Administrator (did not recall who he/she asked) but was told the Administrator was busy and then Resident #55 indicated he/she contacted the facility ombudsman and his/her conservator. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the hospital Discharge summary dated [DATE] at 1:22 AM identified Resident #55’s was diagnosed with a sprained ankle, given an ankle splint air cast, and discharged back to the facility. Interview with Social Worker (SW) #3 on 7/21/2025 at 12:44 PM identified that during his morning rounds on 7/17/202, Resident #55 seemed very upset. Resident #55 told Social Worker #3 that he/she was disturbed after hearing RN #4 paged and was confused as to why he was still in the building due to being physically assaulted by RN #4 the previous evening. Resident #55 told SW #3 about the pizza incident and recounted that RN #4 went into the resident’s room and just started yelling at him/her, spit in his/her face, and then physically assaulted him/her. Resident #55 also stated the police were called and that he/she needed to go to the hospital. Social Worker #3 immediately reported the allegations to his supervisor around 9:15 AM on 7/17/2025 who then requested he write a statement and give the statement to the DNS and Administrator. Interview with RN #4 on 7/21/2025 at 1:07 PM, identified he first learned about the missing pizza when Resident #55 called him on the phone and reported the pizza had been thrown away. RN #4 offered to replace the pizza through the kitchen and stated that social services would follow up the next day. He felt the resident was agreeable to the plan. He next received a call from NA #9 indicating the resident was upset and she asked him to come up and speak with the resident. RN #4 indicated he was involved in another matter and could not go up stating he had already spoken with Resident #55. RN #4 stated NA #9 then reported Resident #55 was yelling and throwing things in his room. Although Resident #55 required a 2 person approach at all times, RN #4 indicated he went to the resident’s room alone and stood at the resident’s doorway. He reported Resident #55 was throwing things and yelling profanities. RN #4 asked Resident #55 to calm down. He stated the resident swore at him and then threatened to call 911. He took a few steps into the room to try to calm the resident, and then Resident #55 called 911, stating he/she had been assaulted by a staff member and was now hurt. RN #4 denied arguing or touching Resident #55. He reported that he left the room after he heard Resident #55 tell 911 that he was hurt and he returned to his office thinking to himself, let me go, this guy is accusing me of a serious allegation. About an hour later, an officer arrived, and RN #4 shared his account with the officer. The officer left to speak with Resident #55 and approximately five minutes later, RN #4 was informed by the LPN charge nurse that Resident #55 was being sent to the emergency room for chest and foot pain. RN #4 stated he then called the DNS to inform her that Resident #55 was going to the Emergency room, indicating he had told the DNS of the allegation of mistreatment. He later recanted he had told the DNS of the allegation in a subsequent interview. RN #4 then resumed his duties, completed his 3:00 PM to 11:00 PM shift and returned to the building on 7/17/2025 for the 7:00 AM to 3:00 PM shift. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 7/21/2025 at 4:35 PM, identified RN #4 contacted her on the evening of 7/16/2025. Although she could not remember the exact time, she indicated RN #4 informed her that Resident #55 had “gone off” on him and the resident had subsequently called the police. RN #4 told the DNS he had entered the resident’s room, asked the resident to calm down, and left after the resident began yelling at him. The DNS reported RN #4 stated that Resident #55 had later complained of chest pain and foot pain and was sent to the hospital. The DNS stated RN #4 did not report that Resident #55 had alleged that he (RN #4) was the perpetrator and was accused of verbally and physically abusing Resident #55. The DNS said she only became aware of the full context the next morning when rounding on the unit and learning from Resident #55 that there had been a serious allegation of verbal and physical abuse involving RN #4. She stated that once she became aware of the situation, the DNS reported the allegation to the State Agency and started an investigation. She stated she obtained statements from all those involved but was unable to produce the full investigation and did not substantiate the allegation of abuse. 4. Resident #58's diagnoses included fracture of the left arm humerus, fracture of the left femur, displaced fracture of the right tibia, and acute pain due to trauma. A Grievance form dated 7/1/2025 (written in response to an allegation that occurred on 6/28/2025) identified Resident #58 had reported to the facility that a staff member referred to him/her as the “N-word”. The Grievance form further identified that the facility made him/her aware that the incident was under investigation and the facility would adhere to the facility policy. The grievance form stated that “the staff member was educated but continued to demonstrate an inability to adhere to policies, exhibited insubordination, and was non-compliant. Additionally, the staff member lacked adequate customer service skills, and, as a result, their employment was terminated.” (later identified that NA #6 was not terminated as an employee but made a Do Not Return to the facility from the staffing agency). The Grievance form was signed by the facility’s Administrator on 7/4/2025. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #58 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, did not experience episodes of delusions or verbal behavioral symptoms towards others, and was dependent for his/her personal hygiene and rolling left and right in bed. The Resident Care Plan (RCP) in effect from 5/15/2025 through 7/20/2025 identified Resident #58 required assistance with activities of daily living and had a history of refusing care and medications. Interventions included encouraging the resident to participate in his/her care and praising all efforts at self-care. The RCP was not revised for the grievance dated 7/1/2025 that occurred on 6/28/2025. A. Interview on 7/16/2025 at 10:03 AM with Resident #58 identified on 6/28/2025 Nurse Aide (NA) #6 called him/her a “F***ing N-word” and he/she reported feeling abused to a Social Worker (SW). Resident #58 further identified since the incident of verbal abuse he/she had difficulty sleeping due to being afraid of retaliation by other staff for reporting the abuse, and he/she was “not sure what people will do these days”. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 7/18/2025 at 10:23 AM with SW #3 identified that Resident #58 notified her during rounds that a Nurse Aide (NA) called him/her the “N-word”, that the racial slur made him/her feel uncomfortable, and he/she requested not to receive care from that NA going forward. SW #3 stated she notified her supervisor (SW #1) and the DNS of the allegation of abuse, and she was not involved with completing an investigation as the DNS and her supervisor (SW #1) were responsible for investigations. Interview on 7/18/2025 at 9:50 AM with Social Worker (SW) #1 identified that he was made aware through daily report that a staff member used the “N-word” to Resident #58 and SW #3 collected information on the incident. He stated that social services did not perform an investigation into the allegation nor was he a part of the investigation, as it was the Nursing Department’s responsibility to do so, but social services did perform wellness checks on Resident #58 as use of the “N-word” can cause pain and he wanted to be certain he/she was safe. SW #1 failed to document the details of the wellness check within the clinical record. SW #1 stated he did not report the incident of abuse to administration because they were already aware. Interview on 7/18/2025 at 10:33 AM with the Director of Nursing Services (DNS) identified that she was made aware of the allegation of abuse by social services, that Resident #58 had reported he/she was called the “N-word”, and it was a team decision to place the NA #6 on a do not return list for future assignments. She stated that she did not conduct an investigation and believed that social work had completed an investigation. The DNS further identified that the incident of abuse was documented as a grievance and not reported to the State Agency (SA) per a directive from the facility Administrator. The DNS stated that the NA calling the resident the racial slur of the “N-word” constituted verbal abuse and that the incident should have been reported to the SA. A second interview on 7/18/2025 at 10:46 AM with the DNS, SW #1, SW #3, and SW #4 identified that an investigation was not completed. SW #1 stated the reason an investigation was not completed was because the incident was labeled a Grievance and that nursing or administration would be responsible for investigating verbal abuse. The DNS stated the social workers should have investigated the occurrence as verbal abuse. The DNS, SW #1, SW #3, and SW #4 all stated they had received abuse training, that use of the racial slur “N-word” was a form of verbal abuse. An interview on 7/18/2025 at 11:15 AM with the Administrator identified that he was notified of the allegation of verbal abuse towards Resident #58 by SW #1. Further, he identified he signed the Grievance form and determined the incident was not reportable to the SA because he believed the use of the “N-word” was said in Resident #58’s presence but was not said directly to him/her. The Administrator disagreed that a NA referring to a resident as a “f***ing N-word” in the presence of that resident was an allegation of verbal abuse. B. According to punch in and punch out records: NA #6 punched in on 6/28/2025 at 3:00 PM and punched out on 6/28/2025 at 11:15 PM and was scheduled to work on Resident #58’s floor; punched in on 6/29/2025 at 3:00 PM and punched out on 6/29/2025 at 10:45 PM and was scheduled to work on Resident #58’s floor; punched in on 7/5/2025 at 3:00 PM and punched out on 7/5/2025 at 11:00 PM and was not scheduled to work on Resident #58’s floor; and punched in on 7/6/2025 at 3:00 PM and punched out on 7/6/2025 at 11:00 PM and was scheduled to work on Resident #58’s floor. The facility failed to protect Resident #58 from abuse on 3 out of 3 occasions after the allegation of verbal abuse was made. When NA #6 continued to work at the facility, the facility failed to protect Resident #58 from further abuse as NA #6 still had access to Resident #58. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 7/22/2025 at 1:40 PM with the Nurse Scheduler identified that NA #6 was placed on the Do Not Rehire (DNR) list because she called Resident #58 the “N-word”. The Nurse Scheduler further identified it was either social services or the DNS who provided her with the reason for placing NA #6 on the DNR list. Interview on 7/22/2025 at 1:40 PM with Person #1 identified the facility told him/her that NA #6 had called a resident the “N-word”. He/she further identified that NA #6 continued to work at the facility after the incident even though Person #1 told her not to go back to the facility. Review of text messages dated 7/7/2025 at 11:54 AM between Person #1 (staffing agency) and NA #6 identified that NA #6 was asked to not return to the facility by Person #1 because an investigation into NA #6’s actions on 6/28/2025 had not been completed. NA #6 responded via text, that the DNS had told her she was off Resident #58’s assignment but the DNS had not told her not to come back to work. 5. Resident #59’s diagnoses included obstructive hydrocephalus, difficulty in walking and unspecified vision loss. A nurse note dated 6/17/25 at 6:22 PM identified Resident #59’s left eye was swollen, bruised, and dark purple. He/she was noted to be in pain and stated that he/she rolled over and hit his/her eye on the side of the bed the night before. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #59 was severely cognitively impaired, required supervision or touch assistance for walking 150 feet or more and was independent for transfers. The Resident Care Plan dated 6/27/25 identified Resident # 59 had an ADL self-care performance deficit related to altered mental status and hydrocephalus. Interventions included the assistance of 1 staff with the use of a standard single point cane. Review of the Accident and Incident Report dated 6/17/25 identified Resident #59 sustained a left periorbital bruise. His/her mental status was described as confused and forgetful, and physical status noted to be independent with transfers, ambulation, and eating. The summary conclusion report submitted to the State Agency (SA) by the Director of Nurses on 6/20/25 identified that upon investigation the origin of the left orbital bruise could not be determined (an injury of unknown origin). Additionally, upon interviewing the resident, he/she did not know how the left orbital bruise had occurred and that Resident #59 was a poor historian. Interview with Licensed Practical Nurse (LPN) #2 on 7/22/25 at 12:15 PM identified the facility policy directed the charge nurse or the supervisor to fill out an Accident and Incident Report upon discovery of an injury that was not witnessed. She stated that on 6/17/25 around 6:00 PM it was reported to her that Resident #59 had a dark blue, swollen bruise to his/her left eye. LPN #2 stated Resident #59 told her that he/she sustained the bruise from rolling over in bed, but the bruising was to her left inner eye so it could not have been caused by rolling over. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and clinical record review with the Director of Nurses (DNS) on 7/22/25 at 1:00 PM identified it was the facility policy that Accident and Incident reports were initiated by the charge nurse and supervisor, and if the occurrence was identified by the DNS to be a Reportable Event that needed to be submitted to the SA, this information was completed by the DNS. The DNS further indicated that the facility policy was to include a 72 hour look back investigation during the period prior to the event on the resident's unit that consisted of staff interviews for all staff who worked during that 72-hour period. A review of the Accident and Incident Report investigation dated 6/17/25 for Resident #59 identified the current investigation consisting of 4 employee statements that were all dated 6/17/25 were attached. The DNS could not identify if the attached interviews were the only ones obtained since “there were quite a few missing” and stated she would double-check the supervisor’s office. Additionally, the DNS identified that she was responsible for overseeing Accident and Incident form completion, and since it was an injury of unknown origin, investigation statements should have included all staff that worked on the unit for all shifts, dating back to 6/14/25. Interview and observation with Registered Nurse Supervisor (RN) #6 on 7/22/25 at 3:20 PM in the supervisor's office identified that although the DNS stated that 72-hour look back statements were kept in the supervisor’s office, RN #6 indicated that statements had never been kept in the supervisor’s office. RN #6 indicated that the Assistant Director of Nurses (ADNS) was responsible to keep track of and store investigation statements. RN #6 looked through the stacks of paper waiting to be filed but was unable to identify that any 72- hour look back statements for Resident #59 were located in the supervisor’s office. Interview and clinical record review with the ADNS on 7/22/25 at 3:30 PM identified she was responsible for the 72-hour look back statements, however, did not currently have any investigation statements for Resident #59 for the Accident and Incident report dated 6/17/25. The ADNS indicated that all the statements obtained had already been already attached (4 employee statements) to the current documentation, and that the statements did not include everyone that the facility policy directed a statement to be obtained from, as only 4 statements had been completed. Further, the ADNS indicated that she did not currently have any statements whatsoever in her office area. A review of the Abuse, Neglect and Exploitation policy dated 1/18/2024 directed, in part, that written procedures for investigations include to identify and interview all involved persons, including the alleged victim, alleged perpetrator, witnesses, and any others who might have knowledge of the allegations; focusing the investigation on determining if abuse, neglect, exploitation and/or mistreatment has occurred, the extent, and cause: and providing complete and through documentation of the investigation, that an immediate investigation will take place when there is a suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. A report will be made to the SA immediately but no later than 2 hours after the allegation is made, and the Administrator will follow-up with the SA to report the results of the investigation within 5 working days of the incident. Additionally, the facility will make efforts to ensure all residents are protected from physical and psychosocial harm as well as additional abuse, during and after the investigation. The Incidents and Accidents

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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	07/24/2025

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

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of the clinical record, review of documentation, and facility policy for 1 of 8 sampled residents (Resident #58) reviewed for abuse, the facility failed to revise the Resident Care Plan (RCP) to include allegations of abuse. The findings include:Resident #58's diagnoses included fracture of the left arm humerus, fracture of the left femur, displaced fracture of the right tibia, and acute pain due to trauma.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #58 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, did not experience episodes of delusions or verbal behavioral symptoms towards others, and was dependent for his/her personal hygiene and rolling left and right in bed.The Resident Care Plan (RCP) in effect from 5/15/2025 through 7/20/2025 failed to indicate Resident #58 had reported 2 allegations of mistreatment and failed to ensure the RCP had interventions that Resident #58 would be monitored for psychosocial well-being, or what interventions would be used to assist the resident in dealing with emotional distress. A. Review of a Reportable Event Form sent to the State Agency (SA) on 5/15/2025 identified Resident #58 reported a Nurse Aide (NA) was verbally inappropriate towards him/her, used profanities at him/her, and sat at his/her door the rest of the night after the incident and stared at him/her.Review of a Psychiatric Advanced Practice Registered Nurse (APRN) note dated 5/16/2025 identified Resident #58 was evaluated for an allegation of NA #9 being verbally abusive towards him/her, calling him/her a bitch, and tormenting the resident. The note further identified Resident #58 was found to be frustrated, with clear emotional distress, and that he/she indicated being mistreated and felt unsafe because he/she cannot defend his/herself due to a disability. The note indicated he/he was reporting disturbed sleep due to fear of what NA #9 might do while he/she was sleeping, and that other staff members have witnessed NA #9's mistreatment of him/her but no disciplinary action had been taken against NA #9 due to racial bias. The Psychiatric APRN note stated Resident #58's insight was intact and not delusional in nature.Review of the facility summary, identified the allegation was unsubstantiated because the resident changed her story during a police interview, stating he/she did not like the NA.B. Review of a Grievance form dated 7/1/2025 (written in response to an allegation that occurred on 6/28/2025) identified Resident #58 had reported to the facility that a staff member referred to him/her as the N-word. The Grievance form further identified that the facility made him/her aware that the incident was under investigation and the facility would adhere to the facility policy. The grievance form stated that the staff member was educated but continued to demonstrate an inability to adhere to policies, exhibited insubordination, and was non-compliant. Additionally, the staff member lacked adequate customer service skills, and, as a result, their employment was terminated. (later identified that NA #6 was not terminated as an employee but made a Do Not Return to the facility from the staffing agency). The Grievance form was signed by the facility's Administrator on 7/4/2025. Interview on 7/16/2025 at 10:03 AM with Resident #58 identified on 6/28/2025 Nurse Aide (NA) #6 called her a F***ing N-word and he/she reported feeling abused to a Social Worker (SW). Resident #58 further identified since the incident of verbal abuse he/she had difficulty sleeping due to being afraid of retaliation by other staff for reporting the abuse, and he/she was not sure what people will do these days.Review of nursing notes for June 2025 and July 2025 failed to identify any documentation in Resident #58's Electronic Medical Record (EMR) or in the paper chart, that there were allegations of verbal abuse that occurred on 5/15/25 and 6/28/2025. Review of physician notes for June 2025 and July 2025 failed to identify any documentation of Resident #58's allegation of verbal abuse that there were allegations of verbal abuse that occurred on 5/15/25 and 6/28/2025. An interview with the DNS on 7/21/2025 at 1:16 PM identified that she was aware of a history of staff to resident abuse for Resident #58 and that he/she was care-planned for accusatory behaviors. The DNS failed to identify that the 5/15/2025 incident of a staff member calling the resident a bitch nor the 6/28/25 incident of a staff member calling the resident a f***ing N-word were included in the RCP. She indicated she should have initiated an intervention that the resident has 2 people present during care due to accusatory behaviors. The DNS failed to identify why the resident should be care planned for accusatory behaviors as opposed to allegations of verbal abuse. Subsequent to surveyor inquiry, a revision to Resident #58's RCP dated 7/21/25 and effective 7/1/2025 identified that he/she was newly care-planned for a behavioral problem related to accusatory behaviors related to the resident reporting that a staff member called him/her a derogatory name. Interventions included encouraging him/her to express feelings appropriately and intervening as necessary to protect the rights and safety of others and remove

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of the clinical record, and facility policies for 1 of 5 sampled residents (Resident #1) reviewed for nutrition, the facility failed to provide treatment in accordance with standards of care for a resident with heart failure. The findings included: Resident #1's diagnoses included hypertensive heart disease with heart failure, diabetes mellitus, and hyperlipidemia.The Resident Care Plan (RCP) dated 6/23/25 identified Resident #1 had altered cardiovascular status related to hypertension and hyperlipidemia. Interventions included encouraging a low fat low/salt intake and obtain lab testing as needed.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was moderately cognitively impaired, independent for transfers and toileting, and required substantial/maximal assistance for lower body dressing. Additionally, the MDS identified Resident #1 had a weight gain of 5% or more in the last month or 10% or more in the last 6 months and was not a physician prescribed weight gain regimen.A review of Resident #1's weights identified a weight of 171 pounds (lbs.) on 6/10/25, a weight of 179 lbs. on 6/17/25, a weight of 182.2 lbs. on 7/1/25, and 188.6 on 7/7/25 indicating a significant weight gain of 10.29 % in 27 days. A review of the Nutrition/Dietary note dated 7/10/25 at 10:45 AM identified Resident #1 was triggered for a significant, undesirable, but anticipated weight change due to edema and diuretic (fluid reducing medication) therapy in place.Interview and record review with the supervisor, Registered Nurse (RN) #3 on 7/24/25 at 9:26 AM identified it was the facility policy to assess residents who had a diagnosis of heart failure for lung sounds, respiratory status, and pedal pulses daily, as well as notify the provider of a weight gain of 2.5 lbs. in one day or 5 lbs. in 1 week. Review of the clinical record with RN #3 identified he/she was receiving diuretic medication 3 times per week as well as being weighed monthly. RN #3 was unable to identify how the facility would be aware of Resident #1 gaining weight on a daily or weekly basis if the resident was only weighed monthly. Further, RN #3 was unable to provide documentation that any nursing assessments for heart failure had been conducted, unable to locate a physician order directing the dietary restrictions as indicated in the RCP, or physician orders directing staff to perform assessments for Resident #1's condition that would indicate signs and symptoms of heart failure.Interview and clinical review with APRN #1 on 7/24/25 at 10:15 AM identified that the facility policy to manage heart failure was to track the residents fluid intake and output for renal function, check laboratory values (BMP and CBC which indicate values related to heart failure) and have the individual seen by cardiology monthly. APRN #1 identified Resident #1 was not compliant with education on his/her fluid restriction, and staff was managing his/her heart failure by assessing if he/she had an altered mental status that deviated from his/her baseline as well as assessing for edema of his/her face and feet. Although APRN #1 indicated Resident #1 was on intake and output monitoring, a review of the clinical record failed to identify an order for a fluid restriction or intake and output monitoring, failed to identify an order for a no added salt diet per the RCP, and failed to identify an order to assess the resident for edema or daily weights. Additionally, APRN #1 identified an awareness of Resident #'1's weight gain, believed it was due to dietary intake, however, after reading the Registered Dietitian's note, indicated that Resident #1 would be evaluated today and daily weight monitoring and edema monitoring would be added to the plan of care. Subsequent to surveyor inquiry APRN #1 initiated a physician's order dated 7/26/25 for daily weights and to inform the provider of a weight gain of 2 lbs. or greater in 24 hours to be completed daily as well as orders for laboratory work (BMP) to be done the next day.Although requested a Heart Failure Policy was not provided. Although requested a Resident Assessment Policy was not provided.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical records, interviews, and review of facility documentation and policy for 5 of 15 residents (Residents #8, 57, 68, 108, & 114) reviewed for physical environment, the facility failed to ensure an effective pest control program was maintained to prevent rodents. The findings include:1. Resident #8's diagnoses included multiple sclerosis, type 2 diabetes, and paraplegia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 had a Brief Mental Interview for Mental Status (BIMS) of 15 indicative of intact cognition. Interview with Resident #8 on 7/15/2025 at 12:45 PM identified he/she observed mice and ants on 7/14/2025 in his/her room. Further, Resident #8 stated he did not make anyone aware at the time because everyone knows. 2. Resident #57's with diagnoses included diabetes, post-traumatic stress disorder (PTSD), coronary artery disease, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #57 had a Brief Mental Interview for Mental Status (BIMS) of 15 indicative of intact cognition. Interview and observation with Resident #57 on 7/15/2025 at 6:59 PM identified that he/she had seen mice in the room the previous night. A mouse trap was noted to be in the room. 3. Resident #68's diagnosis included cerebrovascular accident (stroke), coronary artery disease, and hypertension. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #68 had a Brief Mental Interview for Mental Status (BIMS) of 15 indicative of intact cognition. Interview with Resident #68 on 7/16/2025 at 11:49 AM identified that mice come out of the radiator hole in the room and that the facility was aware. Further the resident noted that a mouse had just been present in the unit hallway. 4. Resident #108's diagnosis included diabetes, heart failure, kidney transplant failure, and dependence on hemolytic treatments. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #108 had a Brief Mental Interview for Mental Status (BIMS) of 14 indicative of intact cognition. Interview and observation with Resident #108 on 7/15/2025 at 7:30 PM identified that the resident observed mice in his room and a mouse trap was present. 5. Resident #114's diagnosis included spina bifida, neurogenic bladder, depression, and bipolar disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #114 had a Brief Mental Interview for Mental Status (BIMS) of 15 indicative of intact cognition. Interview with Resident #114 on 7/15/2025 at 11:10 AM identified he/she observed mice in the room every night. Interview and observation with Resident #114 on 7/16/2025 at 10:45 AM identified that mice were typically observed by the garbage can and under the radiator, but no one had come into the room to install traps. In the corner of Resident #114's room an area of numerous small, black granular pellets approximately the size of grains of rice was observed under the radiator between the wall and the dresser. Interview with Licensed Practical Nurse (LPN) #4 identified that mice are seen on day shift, but that it is mostly nights that they are a problem. Further, LPN #4 identified that although the facility has attempted to treat the issue, the mice continue to run around the floor. Interview with Person #3 on 7/17/2025 at 9:50 AM identified that pest control is provided weekly, but they have not been asked to do resident rooms. Further, Person #3 identified that three (3) mice were caught on the 2nd floor during the 7/17/2025 visit. Person #3 noted that the facility has been told about structural deficiencies since August 2024 however no repairs have been made. Person #3 noted that radiator pipes needed to be sealed so rodents could not enter and that the facility was instructed to keep the ambulance entrance dock area doors closed as a preventative measure, however he always observed the doors open. Further, Person #3 stated closing the dock doors was a behavioral change to prevent rodents, not a structural issue. Interview with Nurse Aide (NA) #10 On 7/15/2025 at 2:10 PM identified that on 7/4/2025 on the 3:00 PM to 11:00 PM shift she saw what she believed to be a rat jumping off a resident wheelchair. NA #10 stated he/she began to record the encounter with a cell phone. Further, NA #10 stated they notified another NA on the unit, whose name she did not know, but they brushed it off, stating that rodents were always there. NA #10 identified that he/she made the decision to leave the facility prior to the end of shift due to feeling uncomfortable with the physical environment. Review of the facility contracted pest management Service Inspection Reports dated 6/13/2025 through 7/10/2025 identified that pest control services were provided weekly and noted the presence of mice in the facility at each visit. The Service Inspection Report for 7/10/2025 included notation that on 8/29/2024 it was reported to the facility that an exterior emergency exit door was not rodent proof with a severity level of High and recommended adding or replacing the door sweep. The report noted that this concern was last reviewed with the facility on 5/29/2025. Additionally, the