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	03/03/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for two (2) of five (5) residents (Resident #1 and Resident #2) reviewed for medication administration, the facility failed to ensure self-administration of medication evaluations were completed by licensed nursing staff prior to the residents self-administering the first dose of a controlled substance according to facility policy. The findings include:1. Resident #1?s diagnoses included opioid dependence, adjustment disorder and anxiety disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 10) and was independent with Activities of Daily Living (ADLs), bed mobility, transfers and ambulation.The Resident Care Plan (RCP) dated 12/08/25 identified Resident #1 was at increased risk for pain due to a history of substance use disorder (SUD) and utilized Methadone for treatment. Interventions included anticipating the resident's need for pain relief and responding immediately to complaints of pain, monitoring/recording/reporting to the licensed nurse complaints of pain or request for pain treatment and communicating and complying with the facility's contracted agency for the resident's continued involvement in the treatment plan.A. Review of the clinical record identified Resident #1 was discharged to the hospital on 2/11/26 and readmitted to the facility on [DATE].A physician's order dated 2/13/26 directed to administer Methadone concentrate 10 milligrams (mg) per milliliter (mL), give 10 mg by mouth one time a day for Methadone Maintenance Therapy and Resident #1 was approved for supervised self-administration.The Methadone Chain of Custody Record dated 2/14/26 identified Resident #1 received Methadone 10 mg per mL from 2/14/26 through 2/18/26.A nurse's note by RN #1 dated 2/19/26 at 7:09 AM identified at approximately 6:10 AM, while administering morning medications, she inadvertently selected the wrong bottle of Methadone for Resident #1. Resident #1 received Methadone 120 mg by mouth rather than the prescribed 10 mg dose. The APRN was notified immediately of the error, and an order was received to transfer Resident #1 to the Emergency Department (ED) for evaluation and monitoring due to significant overdose risk.Review of the clinical record identified that a Medication Self-Administration Evaluation had not been completed since 7/18/25.B. Review of the clinical record identified Resident #1 was discharged to the hospital on 2/19/26 and readmitted to the facility on [DATE].The Methadone Chain of Custody Record dated 2/22/26 for Resident #1 identified Resident #1 received Methadone 10 mg per mL on 2/23/26 and 2/24/26.A Medication Self-Administration Evaluation was completed on 2/24/26 at 11:38 AM (2 days after readmission and after 2 doses had already been received) indicating Resident #1 may self-administer medications with supervision. 2. Resident #2?s diagnoses included long term use of opiate analgesic and wedge compression fracture of the first lumbar vertebrae (the front part of the lower spinal vertebra collapses into a wedge shape due to excessive pressure, causing severe back pain).The admission Evaluation dated 2/3/26 identified Resident #2 was alert and oriented to person, place, time and situation and required limited assistance with transfers and was independent with bed mobility.The Methadone Chain of Custody Record dated 2/4/26 for Resident #2 identified Resident #2 received Methadone 120 mg per mL from 2/5/26 through 2/24/26.A physician's order dated 2/7/26 directed to administer Methadone concentrate 120 mg per mL, give 120 mg orally one (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time a day for Methadone Maintenance Therapy and noted Resident #2 was approved for supervised self-administration.Review of the clinical record failed to identify a Medication Self-Administration Evaluation had been completed until 2/24/26 at 12:40 PM (20 days after starting on Methadone and after 20 doses had already been received).The Resident Care Plan (RCP) dated 2/24/26 identified Resident #2 is at risk for substance use disorder (SUD) with a history of substance use and utilized Methadone. Interventions included communicating with and complying with the prescribing clinic's contract/needs for continued involvement in the treatment plan.Interview and clinical record review with the DON on 2/25/26 at 10:40 AM identified the Medication Self-Administration Evaluation is to be completed on admission and readmission to the facility for all residents on Methadone and upon initiation of all new Methadone orders. She reported residents on Methadone must be able to self-administer the medication and identified that the Medication Self-Administration Evaluation should have been completed prior to any resident self-administering the medication. The DON identified the Medication Self-Administration Evaluation should have been completed for Resident #1 on both the 2/13/26 and 2/22/26 readmissions to the facility and for Resident #2 on 2/8/26 when the Methadone was first initiated. She identified that it is the responsibility of either the charge nurse or the nursing supervisor to ensure the evaluation is completed when the Methadone order is entered.Review of the Residents Receiving Methadone for Opioid Addiction policy dated 7/18/24 directed, in part, an order will be obtained for the resident to self-administer Methadone after successfully completing a self-administration evaluation. Prior to the first administration of Methadone, a Methadone self-administration evaluation will be completed.Review of the Self Medication policy (undated) directed, in part, that a resident must be physically capable of handling medication containers, including the opening and closing of the container, using locked storage boxes and pouring the dose. A resident must be able to communicate clearly with nursing staff regarding administration problems, errors and cooperate with monitoring and accountability practices. Residents must be cognitively capable of understanding administration directions and of accepting responsibility for protocol implementation. Upon admission and periodically, each resident is assessed by interdisciplinary team members for capacity to participate in the self-medication program. If the resident is deemed a candidate for self-medication, and should the resident wish to participate, a physician's order for self-medication will be maintained and will include the drug name, dose, frequency, route and self-medication approval.Review of the Schedule of Evaluations policy dated 7/22/24 directed, in part, for all residents at the time of admission, at the time a resident desires to exercise their right to self-administer their medications, quarterly, annually and change in condition for any resident who wishes to self-administer their medication or when there is a change in his/her ability to safely self-administer.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #6) reviewed for a change in condition, the facility failed to notify the provider timely of the resident's change in behavior and cognition resulting in a delay of treatment. The findings include:Resident #6's diagnoses included vascular dementia without behavioral disturbances, alcohol dependence, opioid dependence, generalized anxiety disorder, depressive episodes and chronic pain.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 12), and was independent with bed mobility, transfers and ambulation. Additionally, it identified that the resident had no wandering behaviors.The Resident Care Plan (RCP) dated 1/22/26 identified Resident #6 had impaired cognitive function/dementia or impaired thought processes related to altered mental status, encephalopathy (disease of the brain that alters brain function or structure), a history of Traumatic Brain Injury (TBI), poor impulse control, a history of altercations with another resident, utilized psychoactive drugs, was a fall risk, had a history of alcohol abuse and was at risk for disorientation, confusion, unsteady gait and slurred speech. Interventions included monitoring/documenting/reporting as needed any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status, cueing, reorienting and supervising as needed, monitoring for any clinical and behavioral changes, maintaining a safe environment for the resident and placing the resident on every fifteen (15) minute monitoring. A physician's order dated 1/23/26 directed every fifteen (15) minute observations every shift. A nurse's note by RN #3 on 1/23/26 at 10:04 AM identified Resident #6 expressed a desire to leave the facility and was subsequently placed on every fifteen (15) minute checks. A nurse's note by LPN #3 on 1/24/26 at 2:21 PM identified Resident #6 was confused, exit seeking, going into other residents' rooms and attempting to get to the elevator.A nurse's note by LPN #4 on 1/29/26 at 6:36 AM identified exit seeking behaviors and identified Resident #6 stated he/she would leave the facility and not return and further identified Resident #6 did not have on a Wanderguard (a wearable tracking device that triggers an automated security response when a resident at risk for exit seeking approaches an exit door).A psychiatric evaluation and consultation note written by MD #2 on 2/4/26 identified Resident #6 had a functional and cognitive decline that remained evident.Review of the clinical record from 1/23/26 through 2/10/26 failed to identify that a provider had been notified of increased confusion, wandering or exit seeking.A psychiatric APRN note dated 2/11/26 identified he was asked to see the resident after an incident in the dining room where Resident #6 threw something in frustration. The note identified Resident #6 was on every 15-minute checks for exit seeking behavior. No new recommendations were made.A nurse's note by LPN #3 on 2/12/26 at 11:50 PM identified increased confusion, wandering, looking for family members, attempting to enter the elevator and exit seeking behaviors.A nurse's note by LPN #4 on 2/13/26 at 6:39 AM identified increased confusion, wandering, looking for family members, attempting to enter the elevator and exit seeking behaviors.A psychiatric APRN note dated 2/13/26 identified she was asked to see Resident #6 for exit seeking behavior, increased confusion and agitation. The note reported education was provided regarding the nature and progression of vascular dementia, however, Resident #6 demonstrated limited insight. The note identified a new order for hydroxyzine 25 milligrams (mg) every twelve (12) hours as needed for anxiety/restlessness.A nurse's note by LPN #3 on 2/17/26 at 12:30 AM identified increased confusion, wandering and trying to get to the elevator.A nurse's note by LPN #5 on 2/17/26 at 6:19 AM identified confusion and wandering the hallways the majority of the shift.A psychiatric APRN note dated 2/20/26 identified she met with Resident #6 to follow-up on medication management. Resident (continued on next page)

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	075182	A. Building B. Wing	03/03/2026

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#6 reported confusion at night and staff reported continued confusion, worsening at night, sundowning, wandering and exit-seeking. The note identified evidence of cognitive decline and directed a new order for trazodone 50 mg daily at bedtime for insomnia. A nurse's note by LPN #3 on 2/20/26 at 11:34 PM identified increased confusion, wandering the halls and into other residents' rooms.A nurse's note by LPN #3 on 2/22/26 at 11:08 PM identified wandering and continuously checking the elevator attempting to exit.A nurse's note by LPN #6 on 2/23/26 at 7:40 AM identified confusion, wandering, exit seeking and searching for family members most of the night.A nurse's note by LPN #2 on 2/25/26 at 1:55 PM identified when she returned to the unit at 1:55 PM the NA (NA #1) and Housekeeper (Housekeeper #1) on the unit notified her that Resident #6 was not in his/her room or on the unit. The note identified she immediately checked the resident's room and unit and a call was placed to the Nursing Supervisor to report the resident was not in his/her room and possibly left the building. All rooms on three (3) units were checked and a call was placed to notify the DON and ADON. The DON was later notified that the resident was located and was headed back to the unit. The note identified the last time she observed the resident was at 1:00 PM.Interview with the psychiatric APRN on 2/27/26 at 3:35 PM identified she had not been notified by staff of Resident #6's increased confusion, wandering or exit seeking until 2/13/26. She identified that once she was made aware she evaluated Resident #6 immediately and started him/her on medication to treat anxiety, restlessness and insomnia. She identified that upon interview, Resident #6 communicated he/she was aware of the increased confusion at night and the psychiatric APRN reported that if the facility notified her when the symptoms developed around 1/23/26, she could have treated the resident sooner which could have prevented the incident on 2/25/26 when Resident #6 exited the building unbeknownst by staff.Interview with the Medical Director on 3/2/26 at 10:17 AM identified he was not notified of Resident #6's initial change in cognition. The change in condition was discussed during the interdisciplinary teams weekly ?At Risk' meeting, but he did not believe the increased confusion and behaviors were due to an acute medical issue but more a psychiatric change. He reported a psychiatric provider should have been notified by nursing of the change at the time it was identified so Resident #6 could have been treated for the symptoms immediately. He identified Resident #6 displays poor judgement and if a psychiatric provider had been notified timely, a neuro cognitive evaluation could have been ordered to determine the plan of care.Interview with the DON on 3/2/26 at 9:00 AM identified nursing should have immediately notified the psychiatric APRN when it was identified Resident #6 was increasingly confused, wandering and exit seeking. She reported had the psychiatric APRN been notified timely, Resident #6 could have been treated sooner.Review of the Notification of Changes policy dated 1/18/24 directed, in part, the facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring notification. Circumstances requiring notification include: Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status, circumstances that require a need to alter treatment and a change in resident rights.

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	075182	A. Building B. Wing	03/03/2026

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #2) reviewed for high-risk medications, the facility failed to ensure a baseline Resident Care Plan (RCP) was developed for a resident receiving a high-risk controlled substance. The findings include:Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #2) reviewed for high-risk medications, the facility failed to ensure a baseline Resident Care Plan (RCP) was developed for a resident receiving a high-risk controlled substance. The findings include:Resident #2?s diagnoses included long term use of opiate analgesic and wedge compression fracture of the first lumbar vertebrae (the front part of the lower spinal vertebra collapses into a wedge shape due to excessive pressure, causing severe back pain).The admission Evaluation dated 2/3/26 identified Resident #2 was alert and oriented to person, place, time and situation and required limited assistance with transfers and was independent with bed mobility.The Methadone Chain of Custody Record dated 2/4/26 for Resident #2 identified Resident #2 received Methadone 120 mg per mL from 2/5/26 through 2/24/26.A physician's order dated 2/7/26 directed to administer Methadone concentrate 120 mg per mL, give 120 mg orally one time a day for Methadone Maintenance Therapy.Review of the clinical record failed to identify an RCP had been developed for the use of Methadone for Methadone Maintenance Therapy.Interview with the DON on 2/25/26 at 10:40 AM identified Methadone is considered a high-risk medication and an RCP should have been developed prior to Resident #2 receiving the medication. She identified nursing is responsible for initiating the RCP, but the MDS Coordinator is responsible for reviewing the RCPs and should have identified at the 72-hour care plan meeting and while completing the 2/9/26 admission Minimum Data Set (MDS) assessment, that an RCP had not been developed for Methadone use.Interview with the MDS Coordinator (RN #4) on 2/25/26 at 11:07 AM identified Methadone is considered a high-risk medication, and a baseline RCP should have been developed by nursing prior to Resident #2 starting Methadone. She identified a 72-hour care plan meeting was held on 2/5/26 and she was responsible for reviewing the RCPs. She did not realize an RCP had not been developed for the use of Methadone at that time. She reported she was responsible for reviewing the RCP with the MDS assessment dated [DATE], and that although she signed the RCP as complete on 2/16/26, an RCP for Methadone use had still not been developed.Subsequent to surveyor inquiry, an RCP was initiated on 2/24/26 identifying that Resident #2 is at risk for substance use disorder with a history of substance use and utilized Methadone. Interventions included communicating with and complying with the prescribing clinic's contract/needs for continued involvement in the treatment plan.Review of the Baseline Care Plan policy (undated) directed, in part, that the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan will be developed within 48 hours of a resident's admission and include the minimum healthcare information necessary to properly care for a resident including, but not limited to: Initial goals based on admission orders, physician orders, dietary orders, therapy services, social services and PASARR recommendations if applicable. The admitting or supervising nurse on duty shall gather information from the admission physical assessment, hospital transfer information and physician orders. Interventions shall be initiated that address the resident's current needs including: Any health and safety concerns to prevent decline or injury and any special needs. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed.

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	03/03/2026

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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 review of the clinical record, facility documentation, facility policy and interviews for two (2) of three (3) sampled residents (Resident #6 and #7) reviewed for wandering behaviors, the facility failed to ensure a Wander Risk Evaluation was completed according to facility policy. The findings include:1. Resident #6's diagnoses included vascular dementia without behavioral disturbances, alcohol dependence, opioid dependence, generalized anxiety disorder, and depressive episodes.A Wander Risk Evaluation dated 2/4/25 identified Resident #6 was a low risk for wandering.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 12), and was independent with bed mobility, transfers and ambulation. The MDS identified Resident #6 had no wandering behaviors.The Resident Care Plan (RCP) dated 1/22/26 identified Resident #6 had impaired cognitive function/dementia or impaired thought processes related to altered mental status, encephalopathy (disease of the brain that alters brain function or structure), a history of Traumatic Brain Injury (TBI), poor impulse control, a history of altercations with another resident, utilized psychoactive drugs, was a fall risk, had a history of alcohol abuse and was at risk for disorientation, confusion, unsteady gait and slurred speech. Interventions included monitoring/documenting/reporting as needed any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status, cueing, reorienting and supervising as needed, monitoring for clinical and behavioral changes, maintaining a safe environment and placing the resident on every fifteen (15) minute monitoring.A nurse's note by RN #3 on 1/23/26 at 10:04 AM identified Resident #6 expressed a desire to leave the facility and was subsequently placed on every fifteen (15) minute checks.Review of the clinical record from 2/5/25 through 2/27/26 failed to identify further Wander Risk Evaluations had been completed for Resident #6.Interview with the DON on 2/27/26 at 12:04 PM identified Wander Risk Evaluations should be completed in entirety at least quarterly and was unable to explain why Resident #7's Wander Risk Evaluation dated 11/12/25 was not completed, why a subsequent Wander Risk Evaluation had not been completed or why Resident #6 had not had a Wander Risk Evaluation completed since 2/4/2025. Additionally, the DON identified that on 1/23/26, when Resident #6 communicated a desire to leave the facility and was subsequently placed on every 15-minute checks, a Wander Risk Evaluation should have been completed by licensed nursing staff.2. Resident #7?s diagnoses included dementia without behavioral disturbances, altered mental status and a history of falls.A physician's order dated 5/29/25 directed Resident #7 had a Wanderguard (a wearable tracking device that triggers an automated security response when a resident at risk for exit seeking approaches an exit door) applied to the right wrist and to check placement and function every shift.A Wander Risk Evaluation dated 11/12/25 identified Resident #7 was a low risk for wandering/elopement. The assessment was not completed with only one (1) out of eight (8) questions answered.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 had severely impaired cognition, had short-term and long-term memory problems and required supervision assistance for bed mobility and transfers.The Resident Care Plan (RCP) dated 12/22/25 identified Resident #7 was at risk for wandering and/or elopement. Interventions included a Wanderguard was applied to Resident #7's right wrist.Review of the clinical record failed to identify a Wander Risk Evaluation was completed following the 11/12/25 evaluation.Review of the Schedule of Evaluations policy dated 7/22/24 directed, in part, the facility will utilize evaluations and/or other tools to collect and analyze specific data in order to aid facilities in the development of resident-centered care plans. Elopement/Wander Risk evaluations are to be conducted on admission, readmission, quarterly, annually, and with a significant change in condition.Review of the Elopements and Wandering Residents policy (undated) directed, in part, that residents will be assessed for risk of (continued on next page)

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	075182	A. Building B. Wing	03/03/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary team.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #2) reviewed for medication administration, the facility failed to ensure a physician's order was in place prior to the resident receiving a high-risk controlled medication. The findings include:Resident #2?s diagnoses included long term use of opiate analgesic and wedge compression fracture of the first lumbar vertebrae (the front part of the lower spinal vertebra collapses into a wedge shape due to excessive pressure, causing severe back pain).The admission Evaluation dated 2/3/26 identified Resident #2 was alert and oriented to person, place, time and situation and required limited assistance with transfers and was independent with bed mobility.The Methadone Chain of Custody Record dated 2/4/26 for Resident #2 identified Resident #2 received Methadone 120 mg per mL from 2/5/26 through 2/24/26.A physician's order dated 2/7/26 directed to administer Methadone concentrate 120 mg per mL, give 120 mg orally one time a day for Methadone Maintenance Therapy (after Resident #2 had already received two (2) doses of Methadone).Interview with the DON on 2/25/26 at 10:40 AM identified medications should not be administered without a physician's order and reported she was unaware that Resident #2 did not have a physician's order for the Methadone until 2/7/26, after receiving doses on both 2/5/26 and 2/6/26. She identified the facility utilized the Methadone Chain of Custody Record as the Methadone Administration Record, but a physician's order should have been entered into the electronic medical record.Review of the Residents Receiving Methadone for Opioid Addiction policy dated 7/18/24 directed, in part, the attending physician and pharmacy will be notified of the resident's participation in the Methadone Maintenance program, and an order will be obtained for the resident to self-administer Methadone after successfully completing a self-administration evaluation.Review of the Medication Administration policy (undated) directed, in part, to ensure that the six rights of medication administration are followed to include: right resident, right drug, right dosage, right route, right time and right documentation. Compare medication source with the Medication Administration Record to verify the resident's name medication name, form, dose, route and time.

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	075182	A. Building B. Wing	03/03/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, observation, and interviews, for one (1) of three (3) residents (Resident #6) reviewed for accidents, the facility failed to provide adequate supervision for a resident who was identified as a fall risk, had a provider documented cognitive decline with ongoing exit-seeking behaviors, and had a provider order directing every fifteen (15) minute safety checks. The facility failed to ensure effective monitoring and environmental safeguards, which resulted in the resident accessing a secured stairwell door without staff awareness, descending approximately 4.5 flights of stairs, and exiting the building to a main roadway and walking approximately 0.5 miles away from the facility without staff knowledge. The findings include: Resident #6's diagnoses included generalized muscle weakness, lack of coordination, chronic pain, polyneuropathy (malfunction of many peripheral nerves throughout the body causing numbness, tingling, burning pain and muscle weakness), vascular dementia without behavioral disturbances, alcohol dependence, opioid dependence, generalized anxiety disorder and depressive episodes.A Fall Risk Evaluation dated 2/23/24 identified Resident #6 was at a moderate risk for falling.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 12), and was independent with bed mobility, transfers and ambulation.A nurse's note dated 1/10/26 at 5:51 AM identified Resident #6 was observed on the floor between two (2) beds and sustained a small contusion (soft tissue injury) under his/her left eye but that no other injuries were observed.The Resident Care Plan (RCP) dated 1/22/26 identified Resident #6 had a history of falls and was at risk for falls related to confusion, unawareness of safety needs, psychoactive drug use, a sedative/hypnotic medication for insomnia, a history of alcohol abuse increasing his/her risk for disorientation, confusion, falls with associated injury, slurred speech and unsteady gait, has impaired cognitive function/dementia or impaired thought processes related to altered mental status, encephalopathy (disease of the brain that alters brain function or structure), a history of Traumatic Brain Injury (TBI), and poor impulse control. Interventions included maintaining a safe environment, anticipating and meeting needs, placing the resident on every fifteen (15) minute monitoring, monitoring for clinical and behavioral changes, monitoring/documenting/reporting changes in cognitive function.The Interdisciplinary Plan Meeting documentation dated 1/22/26 identified Resident #6 was a fall risk.A physician's order dated 1/23/26 directed Resident #6 was on every fifteen (15) minute observations every shift.A nurse's note by RN #3 on 1/23/26 at 10:04 AM identified Resident #6 expressed a desire to leave the facility and was subsequently placed on every fifteen (15) minute checks.A nurse's note written by LPN #3 on 1/24/26 at 2:21 PM identified Resident #6 was confused, exit seeking, going into other residents' rooms and attempting to get to the elevator. A nurse's note written by LPN #4 on 1/29/26 at 6:36 AM identified exit seeking behaviors and identified Resident #6 stated he/she would leave the facility and not return and further identified Resident #6 did not have on a Wanderguard (a wearable tracking device that triggers an automated security response when a resident at risk for exit seeking approaches an exit door). A psychiatric evaluation and consultation note written by the psychiatric physician, MD #2 on 2/4/26 identified Resident #6 had a functional and cognitive decline that remained evident.A psychiatric APRN note dated 2/11/26 identified he was asked to see the resident after an incident in the dining room where Resident #6 threw something in frustration. The note identified Resident #6 was on every 15-minute checks for exit seeking behavior. A nurse's note by LPN #3 on 2/12/26 at 11:50 PM identified increased confusion, wandering, looking for family members, attempting to enter the elevator and exit seeking behaviors.A nurse's note by LPN #4 on 2/13/26 at 6:39 AM identified increased confusion, wandering, looking for family members, attempting to enter the elevator and exit seeking behaviors.A psychiatric APRN note dated 2/13/26 identified she (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	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was asked to see Resident #6 for exit seeking behavior, increased confusion and agitation. The note reported education was provided regarding the nature and progression of vascular dementia, however, Resident #6 demonstrated limited insight. The note identified a new order for hydroxyzine 25 milligrams (mg) every twelve (12) hours as needed for anxiety/restlessness.A nurse's note by LPN #3 on 2/17/26 at 12:30 AM identified increased confusion, wandering and trying to get to the elevator.A nurse's note by LPN #5 on 2/17/26 at 6:19 AM identified confusion and wandering the hallways the majority of the shift.A psychiatric APRN note dated 2/20/26 identified she met with Resident #6 to follow-up on medication management. Resident #6 reported confusion at night and staff reported continued confusion, worsening at night, sundowning, wandering and exit-seeking. The note identified evidence of cognitive decline and directed a new order for trazodone 50 mg daily at bedtime for insomnia. A nurse's note by LPN #3 on 2/20/26 at 11:34 PM identified increased confusion, wandering the halls and into other residents' rooms.A nurse's note by LPN #3 on 2/22/26 at 11:08 PM identified wandering and continuously checking the elevator attempting to exit.A nurse's note by LPN #6 on 2/23/26 at 7:40 AM identified confusion, wandering, exit seeking and searching for family members most of the night.A nurse's note by LPN #2 on 2/25/26 at 1:55 PM identified when she returned to the unit at 1:55 PM the NA (NA #1) and Housekeeper (Housekeeper #1) on the unit notified her that Resident #6 was not in his/her room or on the unit. The note identified she immediately checked the resident's room and unit and a call was placed to the Nursing Supervisor to report the resident was not in his/her room and possibly left the building. All rooms on three (3) units were checked and a call was placed to notify the DON and ADON. The DON was later notified that the resident was located and was headed back to the unit. The note identified the last time she observed the resident was at 1:00 PM.Observation of the stairwell door on the North-2 unit on 2/27/26 at 12:04 PM identified a pin pad secured door and 4.5 flights of stairs leading to an exit door that led to the street. The exit door was unsecured.Interview with Resident #6 on 2/27/26 at 12:09 PM identified on 2/25/26 he/she was upset with RN #3 because she would not give him/her her badge to open the elevator, so he/she went into the hallway and watched staff at the secured stairwell until he/she was able to see the code entered and when staff were in other rooms, he/she entered the code to the door, and with difficulty went down the stairs, exited a door to the street, and walked into downtown.Interview with RN #3 on 2/27/26 at 12:52 PM identified that since Resident #6's room was changed on 1/8/26, Resident #6 had been searching for a way out of the facility by pacing the hallways, going in and out of other residents' rooms and hovering by the elevator searching for exit doors. She reported that although the resident had been on every 15-minute checks, staff could not constantly have an eye on the resident. She identified that on the morning of 2/25/26, Resident #6 expressed wanting to leave the facility, but she told him/her that he/she could not leave because he/she did not have a Leave of Absence (LOA) order. RN #3 identified Resident #6 appeared to accept her explanation but then several hours later she was notified Resident #6 was unable to be located and she went outside to search for him/her. RN #3 identified Resident #6 was a fall risk and she located him/her about 0.5 miles away from the facility on the sidewalk of a main street and Resident #6 reported he/she wanted to go find women and alcohol. She identified Resident #6 was unharmed and was brought back to the facility without incident but Resident #6 was not safe to be outside in the winter unsupervised, and staff were unaware he/she had exited the building.Interview with the DON on 2/27/26 at 12:04 PM identified after watching the camera footage, Resident #6 was seen at 12:36 PM looking around in the hallway to ensure no one was around and then approached the keypad and exited the secured door through the unit stairwell and down 4.5 flights of stairs. She reported the camera at the ambulance entrance did not capture the resident so Resident #6 must have exited through an unsecured door at the bottom of the stairwell onto the sidewalk. She identified it had snowed earlier in the day, Resident #6 was a fall risk, and it was unsafe for him/her to have gone down the stairwell, outside and walked about 0.5 miles away without staff knowledge. Resident #6 had a physician's order for every 15-minute monitoring for safety. Additionally, she identified the pin pad code remained the same after (continued on next page)

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	075182	A. Building B. Wing	03/03/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the incident, as they were unsure how to change it. She indicated Resident #6 had a decline in mentation but no further cognitive testing had been performed. The DNS identified that following the incident, a one-to-one staff observation was initiated and was still in place for safety. Further, she identified that a missing person (Dr. Hunt) code had never been called by staff and due to her not being made aware of the incident until around 2:15 PM, after Resident #6 had already been located, law enforcement was not notified, and the facility's policy was not followed. The ?every 15-minute check sheet' dated 2/25/26 identified NA #2 signed the sheet every 15- minutes from 7:00 AM through 1:15 PM although Resident #6 was seen on camera exiting the unit via the stairwell at 12:36 PM. The sheet identified Resident #6 was in the hallway at 12:45 PM, 1:00 PM and 1:15 PM when Resident #6 was outside of the facility. Interview with NA #2 on 3/2/26 at 12:35 PM identified although she was not assigned to Resident #6 on the 7:00 AM to 3:00 PM shift on 2/25/26, and had not completed any 15 minute checks on Resident #6 that shift, the ADON approached her after Resident #6 was unable to be located inside the building and directed her to fill out the sheet although she had not completed the every 15 minute checks for Resident #6. NA #2 reported she knew she should not have documented incorrectly but identified that the ADON demanded that the 'every 15-minute check sheet' was completed and she was afraid she would lose her job if she did not do what was directed. Additionally, she identified she was unsure when Resident #6 had last been seen and estimated the time, which is why she signed off at 12:45 PM, 1:00 PM and 1:15 PM.The February 2026 Documentation Survey Report for Resident #6 identified that NA #3 had documented on Resident #6 on the 7:00 AM to 3:00 PM shift on 2/25/26.Interview with NA #3 on 3/2/26 at 12:29 PM identified although her initials indicate that she documented on Resident #6 on the 7:00 AM to 3:00 PM shift on 2/25/26, she did not complete any of the 15 minutes checks on Resident #6 per the plan of care that shift. She identified that she had a very heavy assignment and was busy and could not recall Resident #6 being on her assignment.Interview with LPN #2 on 3/2/26 at 12:44 PM identified she last observed Resident #6 between 12:30 PM and 12:45 PM on 2/25/26, she then went on break. She identified when she returned from her break, NA #1 communicated they were unable to locate Resident #6, so she (LPN #2) notified RN #2 (nursing supervisor) who immediately went to search for Resident #6 outside. LPN #2 identified the ADON went to the unit, and they discovered that the ?every 15-minute check sheet' had not been filled out the entire 7:00 AM to 3:00 PM shift and the ADON told both NA #2 and LPN #2 that they needed to figure out how to complete it. She reported NA #2 was hesitant on filling in the ?every 15-minute check sheet' for Resident #6 but eventually completed it.Interview with the ADON on 3/2/26 at 1:37 PM identified when she was made aware on 2/25/26 that Resident #6 was unable to be located, she went to the unit and discovered the ?every 15 minute check sheet' had not been filled out for Resident #6 for the entire shift so she directed NA #2 and LPN #2 to complete it. The ADON further identified the ?every 15-minute check sheet' should have been filled out at the time of the observation and not completed afterwards.Re-interview with the DON on 3/2/26 at 9:00 AM and 1:15 identified nursing should have immediately notified the psychiatric APRN when it was identified Resident #6 was increasingly confused, wandering and exit seeking. She reported had the psychiatric APRN been notified timely, Resident #6 could have been treated sooner, interventions could have been put into place, and potentially prevented Resident #6 from exiting the building without staff knowledge on 2/25/26. Additionally, she reported that Resident #6's clinical record should have been complete and accurate and the every 15 minute checks should have been filled out at the time of the observations and not afterwards, nor should the ADON have directed NA #2 and LPN #2 to fill out the ?every 15 minute check sheet' after Resident #6 was unable to be located. The DON reported Resident #6 was off the unit at 12:45 PM, 1:00 PM and 1:15 PM so the documentation was inaccurate on the ?every 15-minute check sheet' and staff should have supervised Resident #6 as directed.Interview with the Medical Director on 3/2/26 at 10:17 AM identified a psychiatric provider should have been notified of Resident #6's change of cognition and increased behaviors at the time they were identified so Resident #6 could have been treated for the symptoms immediately. He (continued on next page)

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	075182	A. Building B. Wing	03/03/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified Resident #6 had poor judgement and his/her LOA order was revoked for returning to the facility intoxicated. He identified that if a psych provider had been notified timely, a neuro cognitive evaluation could have been ordered to determine the plan of care. The Medical Director reported that staff should have ensured Resident #1 was monitored at least every 15-minutes per physician's order for safety and identified Resident #6 was not safe to have descended 4.5 flights of stairs to the sidewalk and walked approximately 0.5 miles into downtown.Review of the Fall Prevention Program Policy directed in part that each resident be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. High Risk protocols include a fall prevention indicator on the door, and interventions including but not limited to assistive devices, increased rounds, a sitter, medication regimen review, low bed, alternate call system, scheduled ambulation, family/caregiver education and therapy services referral.Review of the Documentation in the Medical Record policy (undated) directed, in part, each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate and timely documentation. Documentation shall be factual, objective and resident centered and false information shall not be documented. When documentation occurs after the fact, outside acceptable time limits, the entry shall be clearly indicated as late entry. Although requested, a policy on every 15 minute checks was not available.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility documentation and interviews for five (5) of twelve (12) residents (Resident #2, #8, #9, #10 and #11) reviewed for physician's orders, the facility failed to ensure provider orders were reviewed and signed by the physician following resident admissions to the facility and monthly. The findings include:1. Resident #12 was admitted to the facility on [DATE].Review of physician orders identified orders were not reviewed and signed on 1/14/26 or 2/1/26 in accordance with facility practices.2. Resident #10 was admitted to the facility on [DATE].Review of physician orders identified orders were not reviewed and signed on 1/20/26 or 2/1/26 in accordance with facility practices.3. Resident #9 was admitted to the facility on [DATE].Review of physician orders identified orders were not reviewed and signed on 1/21/26 or 2/1/26 in accordance with facility practices.4. Resident #2 was admitted to the facility on [DATE].Review of physician orders identified orders were not reviewed and signed on 2/6/26 in accordance with facility practices.5. Resident #8 was admitted to the facility on [DATE].Review of physician orders identified orders were not reviewed and signed on 2/18/26 in accordance with facility practices.Interview with the DON on 3/2/26 at 9:00 AM identified the admitting physician was responsible for reviewing and signing orders when completing the initial history and physical within 48 to 72 hours of admission to the facility and then monthly. The DON was unaware that the orders were not consistently signed.Interview with the Medical Director (MD #1) on 3/2/26 at 10:17 AM identified when a resident is newly admitted , the admitting physician is responsible for signing the admission orders within 72 hours of admission to the facility when completing the history and physical and then monthly thereafter. He reported that when the clinical record is accessed, there is no prompt to sign the orders, and unsigned orders must have been missed.Although requested, the facility was unable to provide a policy detailing the frequency that physician's orders were to be reviewed.

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	075182	A. Building B. Wing	03/03/2026

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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** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #6) reviewed for wandering behaviors, the facility failed to provide social service support to the resident and failed to obtain a repeated Brief Interview for Mental Status (BIMS) evaluation following a documented change in cognition. The findings include:Resident #6's diagnoses included vascular dementia without behavioral disturbances, alcohol dependence, opioid dependence, generalized anxiety disorder, depressive episodes and chronic pain.A Wander Risk Evaluation dated 2/4/25 identified Resident #6 was a low risk for wandering.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 12), and was independent with bed mobility, transfers and ambulation. The MDS additionally identified that the resident had no wandering behaviors.The Resident Care Plan (RCP) dated 1/22/26 identified Resident #6 had impaired cognitive function/dementia or impaired thought processes related to altered mental status, encephalopathy (disease of the brain that alters brain function or structure), a history of Traumatic Brain Injury (TBI), poor impulse control, a history of altercations with another resident, utilized psychoactive drugs, was a fall risk, had a history of alcohol abuse and was at risk for disorientation, confusion, unsteady gait and slurred speech. Interventions included monitoring/documenting/reporting changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status, cueing, reorienting and supervising as needed, monitoring for clinical and behavioral changes, maintaining a safe environment and placing the resident on every fifteen (15) minute monitoring.A nurse's note by RN #3 on 1/23/26 at 10:04 AM identified Resident #6 expressed a desire to leave the facility and was subsequently placed on every fifteen (15) minute checks.A nurse's note by LPN #3 on 1/24/26 at 2:21 PM identified Resident #6 was confused, exit seeking, going into other residents' rooms and attempting to get to the elevator.A nurse's note by LPN #4 on 1/29/26 at 6:36 AM identified exit seeking behaviors and identified Resident #6 stated he/she would leave the facility and not return and further identified Resident #6 did not have on a Wanderguard (a wearable tracking device that triggers an automated security response when a resident at risk for exit seeking approaches an exit door).A psychiatric evaluation and consultation note written by MD #2 on 2/4/26 identified Resident #6 had a functional and cognitive decline that remained evident.A psychiatric APRN note dated 2/11/26 identified he was asked to see the resident after an incident in the dining room where Resident #6 threw something in frustration. The note identified Resident #6 was on every 15-minute checks for exit seeking behavior. No new recommendations were made.A nurse's note by LPN #3 on 2/12/26 at 11:50 PM identified increased confusion, wandering, looking for family members, attempting to enter the elevator and exit seeking behaviors.A nurse's note by LPN #4 on 2/13/26 at 6:39 AM identified increased confusion, wandering, looking for family members, attempting to enter the elevator and exit seeking behaviors.A psychiatric APRN note dated 2/13/26 identified she was asked to see Resident #6 for exit seeking behavior, increased confusion and agitation. The note reported education was provided regarding the nature and progression of vascular dementia, however, Resident #6 demonstrated limited insight. The note identified a new order for hydroxyzine 25 milligrams (mg) every twelve (12) hours as needed for anxiety/restlessness.A nurse's note by LPN #3 on 2/17/26 at 12:30 AM identified increased confusion, wandering and trying to get to the elevator.A nurse's note by LPN #5 on 2/17/26 at 6:19 AM identified confusion and wandering the hallways the majority of the shift.A psychiatric APRN note dated 2/20/26 identified she met with Resident #6 to follow-up on medication management. Resident #6 reported confusion at night and staff reported continued confusion, worsening at night, sundowning, wandering and exit-seeking. The note identified (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evidence of cognitive decline and directed a new order for trazodone 50 mg daily at bedtime for insomnia. A nurse's note by LPN #3 on 2/20/26 at 11:34 PM identified increased confusion, wandering the halls and into other residents' rooms.A nurse's note by LPN #3 on 2/22/26 at 11:08 PM identified wandering and continuously checking the elevator attempting to exit.A nurse's note by LPN #6 on 2/23/26 at 7:40 AM identified confusion, wandering, exit seeking and searching for family members most of the night.A nurse's note by LPN #2 on 2/25/26 at 1:55 PM identified when she returned to the unit at 1:55 PM the NA (NA #1) and Housekeeper (Housekeeper #1) on the unit notified her that Resident #6 was not in his/her room or on the unit. The note identified she immediately checked the resident's room and unit and a call was placed to the Nursing Supervisor to report the resident was not in his/her room and possibly left the building. All rooms on three (3) units were checked and a call was placed to notify the DON and ADON. The DON was later notified that the resident was located and was headed back to the unit. The note identified the last time she observed the resident was at 1:00 PM. Review of the clinical record from 1/23/26 through 2/25/26 failed to identify social services had met with or assessed Resident #6 following the 1/23/26 change in cognition.Review of the clinical record from 1/23/26 through 3/1/26 failed to identify a repeat BIMS had been completed for Resident #6.Interview with the Director of Social Services on 3/2/26 at 11:47 AM identified he was aware Resident #6 had a decline in cognition and had been increasingly confused and wandering the unit since January 2026. He identified he did not meet with Resident #6 or reassess his/her BIMS as required with a change in cognition.Interview with the DON on 3/2/26 at 9:00 AM identified social services should have met with and evaluated Resident #6 as soon as it was determined there was a change in behavior and/or cognition and that with any change in cognition, a repeat BIMS evaluation should be completed.Review of the Dementia Care policy directed, in part, it is the policy of the facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental and psychosocial well-being. The care plan goals and interventions will be monitored on an ongoing basis for effectiveness and will be reviewed and revised as necessary. Appropriate referrals will be made if current interventions are ineffective or resident shows a decline in psychosocial, mood or behavioral status (i.e. physician, mental health provider, licensed counselor, pharmacist, social worker).Although requested policies on change in cognition and BIMS evaluations were not available.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) sampled resident reviewed for medication administration the facility failed to ensure Resident #1, who was prescribed a controlled substance (Methadone) for substance use disorder (SUD) was administered Methadone per physician's order when the licensed nurse removed two (2) residents Methadone from the lock box at the same time, stored the Methadone on the top of the medication cart and then administered Resident #1 another resident's Methadone which was a 1100 percent (%) higher dose than prescribed subsequently leading to a significant medication error which required hospitalization. The findings include: Resident #1?s diagnoses included opioid dependence, adjustment disorder, anxiety disorder, Chronic Obstructive Pulmonary Disorder (COPD) and deviated nasal septum (one side of the nose is wider and the other side is narrower altering the pattern of airflow through the nose). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 10)and was independent with Activities of Daily Living (ADLs), bed mobility, transfers and ambulation. The Resident Care Plan (RCP) dated 12/08/25 identified Resident #1 was at increased risk for pain due to a history of SUD and utilized Methadone for treatment. Interventions included anticipating the resident's need for pain relief and responding immediately to complaints of pain, monitoring/recording/reporting to the licensed nurse complaints of pain or request for pain treatment and communicating and complying with the facility's contracted agency for the resident's continued involvement in the treatment plan. A physician's order dated 2/13/26 directed to administer Methadone concentrate 10 milligrams (mg) per milliliter (mL), give 10 mg orally one time a day for Methadone Maintenance Therapy. A nurse's note by LPN #1 dated 2/19/26 at 7:01 AM identified Resident #1 was transferred to the hospital related to a medication administration error. The nursing supervisor (RN #1) administered 120 mg of Methadone instead of the prescribed 10 mg dose. The error was identified after administration. Resident #1 was immediately assessed, and his/her vital signs were within normal limits. The note identified Resident #1 was monitored for signs of opioid overdose, including respiratory depression and decreased level of consciousness, and due to the excessive dose and potential for adverse effects, Emergency Medical Services (EMS) was activated, and Resident #1 was transferred to the hospital for further evaluation and monitoring. A nurse's note by RN #1 dated 2/19/26 at 7:09 AM identified at approximately 6:10 AM, while administering morning medications, she inadvertently selected the wrong bottle of Methadone for Resident #1. Resident #1 received Methadone 120 mg by mouth rather than the prescribed 10 mg dose. The APRN was notified immediately of the error, and an order was received to transfer Resident #1 to the Emergency Department (ED) for evaluation and monitoring due to significant overdose risk. The hospital Discharge summary dated [DATE] identified Resident #1 was admitted from the facility due to an accidental Methadone overdose (given 120 mg rather than 10 mg). Resident #1 required an Intensive Care Unit (ICU) stay with a Narcan drip (used to reverse the effects of Methadone). The Narcan drip was weaned off in the early morning of 2/20/26 and Resident #1 was restarted on Methadone 10 mg daily. Resident #1 was discharged back to the facility on 2/22/26. Interview with Resident #1 on 2/24/26 at 12:14 PM identified on 2/19/26, RN #1 went to administer his/her Methadone and the bottle containing the Methadone contained an unusually large amount of liquid. Resident #1 asked RN #1 if she was sure that was his/her dose to which she reported, yes. Resident #1 reported he/she drank the Methadone as instructed and then shortly after, RN #1 returned to his/her room and reported he/she was correct in questioning the Methadone dose and she administered someone else's Methadone bottle, and he/she was subsequently overdosed. Resident #1 identified he/she was then told he/she would be transferred to the ED and reported he/she could not recall anything after entering the ambulance on 2/19/26 until the day he was transferred back to the facility on 2/22/26, (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	03/03/2026

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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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	further stating he/she blacked out. Interview with RN #1 on 2/24/26 at 1:09 PM identified on 2/19/26, she opened the locked Methadone cart and removed Resident #1 and Resident #2's Methadone bottles, along with the associated Methadone Chain of Custody Records (Documentation that tracks the handling, transfer, and storage of methadone from receipt to administration or disposal to ensure accountability and prevent diversion). and placed them on top of the medication cart. She reported she had the cart positioned in the doorway of Resident #1's room and asked Resident #1 his/her name and Methadone dose and verified the bottle and the record were correct. She then turned and picked up the Methadone bottle without verifying she had the correct Methadone bottle for Resident #1 and handed it to him/her. After Resident #1 drank the liquid from the Methadone bottle, he/she asked if RN #1 was sure she gave him/her the right dose because there was a lot of liquid in the bottle and he/she usually had a small amount. RN #1 identified she immediately checked the bottle and realized she gave Resident #1, Resident #2's bottle of Methadone, which was a significantly higher dose. She immediately notified Resident #1 that she administered the wrong dose, notified the APRN and transferred Resident #1 to the ED. She reported she should not have removed two (2) residents Methadone doses out of the lock boxes at the same time and should have verified she handed Resident #1 the correct Methadone bottle. She identified Resident #1 was highly nervous and anxious following the incident. Interview with APRN #1 on 2/24/26 at 1:34 PM identified Resident #1 had a history of respiratory issues therefore was at risk for respiratory depression and sedation. Interview with the DON on 2/24/26 at 2:20 PM identified RN #1 should not have removed the Methadone from the lock boxes in the medication cart for two (2) residents at the same time and should not have left one (1) of the Methadone bottles on top of the medication cart unattended while delivering Resident #1 his/her Methadone. The DON identified RN #1 should have ensured the bottle of Methadone she brought to Resident #1 was intended for Resident #1 and was the correct dose and should have verified with Resident #1 his/her name and dose of Methadone at the bedside prior to handing the bottle to Resident #1 to administer. The DON reported RN #1 continued to administer Methadone to residents following the incident and stated she worked an additional shift after the incident where she administered Methadone to residents in the facility. Review of the Medication Administration policy (undated) directed, in part, to ensure that the six rights of medication administration are followed to include: right resident, right drug, right dosage, right route, right time and right documentation. Compare medication source with the Medication Administration Record to verify the resident's name medication name, form, dose, route and time.

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	03/03/2026

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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 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** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #6) reviewed for accidents, the facility failed to ensure a complete and accurate clinical record when a physician's order directed Resident #6 was to be on every fifteen (15) minute checks and the checks were not completed but were later documented as completed. The findings include:Resident #6's diagnoses included vascular dementia without behavioral disturbances, alcohol dependence, opioid dependence, generalized anxiety disorder, depressive episodes and chronic pain.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 12), and was independent with bed mobility, transfers and ambulation. The MDS identified Resident #6 had no wandering behaviors.The Resident Care Plan (RCP) dated 1/22/26 identified Resident #6 had impaired cognitive function/dementia or impaired thought processes related to altered mental status, encephalopathy (disease of the brain that alters brain function or structure), a history of Traumatic Brain Injury (TBI), poor impulse control, a history of altercations with another resident, utilized psychoactive drugs, was a fall risk, had a history of alcohol abuse and was at risk for disorientation, confusion, unsteady gait and slurred speech. Interventions included monitoring/documenting/reporting changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status, cueing, reorienting and supervising as needed, monitoring for clinical and behavioral changes, maintaining a safe environment and placing the resident on every fifteen (15) minute monitoring. A physician's order dated 1/23/26 directed Resident #6 was on every fifteen (15) minute observations every shift.A nurse's note written by RN #3 on 1/23/26 at 10:04 AM identified Resident #6 expressed a desire to leave the facility and was subsequently placed on every fifteen (15) minute checks.A nurse's note by LPN #2 on 2/25/26 at 1:55 PM identified when she returned to the unit at 1:55 PM the NA (NA #1) and Housekeeper (Housekeeper #1) on the unit notified her that Resident #6 was not in his/her room or on the unit. The note identified she immediately checked the resident's room and unit and a call was placed to the Nursing Supervisor to report the resident was not in his/her room and possibly left the building. All rooms on three (3) units were checked and a call was placed to notify the DON and ADON. The DON was later notified that the resident was located and was headed back to the unit. The note identified the last time she observed the resident was at 1:00 PM. Interview with the DON on 2/27/26 at 12:04 PM identified after watching the camera footage, Resident #6 was seen at 12:36 PM looking around in the hallway to ensure no one was around and then approached the keypad and exited the secured door through the unit stairwell and down 4.5 flights of stairs. She reported the camera at the ambulance entrance did not capture the resident so Resident #6 must have exited through an unsecured door at the bottom of the stairwell onto the sidewalk. The ?every 15-minute check sheet' dated 2/25/26 identified NA #2 signed the sheet every 15- minutes from 7:00 AM through 1:15 PM although Resident #6 was seen on camera exiting the unit via the stairwell at 12:36 PM. The sheet identified Resident #6 was in the hallway at 12:45 PM, 1:00 PM and 1:15 PM when Resident #6 was outside of the facility. Interview with NA #2 on 3/2/26 at 12:35 PM identified although she was not assigned to Resident #6 on the 7:00 AM to 3:00 PM shift on 2/25/26, and had not completed any 15 minute checks on Resident #6 that shift, the ADON approached her after Resident #6 was unable to be located inside the building and directed her to fill out the sheet although she had not completed the every 15 minute checks for Resident #6. NA #2 reported she knew she should not have documented incorrectly but identified that the ADON demanded that the 'every 15-minute check sheet' was completed and she was afraid she would lose her job if she did not do what was directed. Additionally, she identified she was unsure (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when Resident #6 had last been seen and estimated the time, which is why she signed off at 12:45 PM, 1:00 PM and 1:15 PM.The February 2026 Documentation Survey Report for Resident #6 identified that NA #3 had documented on Resident #6 on the 7:00 AM to 3:00 PM shift on 2/25/26.Interview with NA #3 on 3/2/26 at 12:29 PM identified although her initials indicate that she documented on Resident #6 on the 7:00 AM to 3:00 PM shift on 2/25/26, she did not complete any of the 15 minutes checks on Resident #6 per the plan of care that shift. She identified that she had a very heavy assignment and was busy Interview with LPN #2 on 3/2/26 at 12:44 PM identified she last observed Resident #6 between 12:30 PM and 12:45 PM on 2/25/26, she then went on break. She identified when she returned from her break, NA #1 communicated they were unable to locate Resident #6, so she (LPN #2) notified RN #2 (nursing supervisor) who immediately went to search for Resident #6 outside. LPN #2 identified the ADON went to the unit, and they discovered that the ?every 15-minute check sheet' had not been filled out the entire 7:00 AM to 3:00 PM shift and the ADON told both NA #2 and LPN #2 that they needed to figure out how to complete it. She reported NA #2 was hesitant on filling in the ?every 15-minute check sheet' for Resident #6 but eventually completed it. Interview with the ADON on 3/2/26 at 1:37 PM identified when she was made aware on 2/25/26 that Resident #6 was unable to be located, she went to the unit and discovered the ?every 15 minute check sheet' had not been filled out for Resident #6 for the entire shift so she directed NA #2 and LPN #2 to complete it. The ADON further identified the ?every 15-minute check sheet' should have been filled out at the time of the observation and not completed afterwards.Interview with the DON on 3/2/26 at 1:15 PM identified the clinical record should have been complete and accurate and the every 15 minute checks should have been filled out at the time of the observations and not afterwards. The ADON should not have directed NA #2 and LPN #2 to fill out the ?every 15 minute check sheet' after Resident #6 was unable to be located. The DON reported Resident #6 was off the unit at 12:45 PM, 1:00 PM and 1:15 PM so the documentation was inaccurate on the ?every 15-minute check sheet'.Review of the Documentation in the Medical Record policy (undated) directed, in part, each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate and timely documentation. Documentation shall be factual, objective and resident centered and false information shall not be documented. When documentation occurs after the fact, outside acceptable time limits, the entry shall be clearly indicated as late entry.