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	05/06/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of two residents (Resident #1) reviewed for smoking, the facility failed to ensure the resident was treated with respect and dignity and the resident's rights were honored, and failed to ensure the resident was not prevented from leaving the facility for a Leave of Absence (LOA) and LOA time was not limited. The findings include: Resident #1 was admitted with diagnoses that included schizoaffective disorder, dementia, bipolar, nicotine dependence, anxiety, and a history of substance abuse. Record review identified Resident #1 had a court appointed conservator. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14 indicated alert and oriented), had no behavioral symptoms, no wandering, and was independent with personal hygiene and walking. A resident care plan (RCP) dated 2/16/2026 identified Resident #1 exhibited noncompliance with care, was a smoker, and was independent with ambulation with a rolling walker. Interventions directed to protect rights of resident and others, independent to smoke on leave of absence unsupervised, allow resident to express emotions and provide resident with meaningful activities. An APRN note dated 3/6/2026 identified Resident #1's cognitive capacity for treatment decisions remained intact for routine care. Baseline dementia was noted but not significantly impacting medication adherence with facility support. Gait maintained with rolling walker assistance; balance adequate, no acute neurological deficits, speech fluent, mood stable, thought process logical and judgement intact. A physician's order dated 3/6/2026 directed Resident #1 may go on leave of absence (LOA) for one (1) hour. An APRN note dated 3/23/2026 indicated an evaluation for competency that identified thought processes were logical, goal directed, speech fluent and clear, and fine motor coordination was intact. Resident #1 was cooperative and engaged. Resident #1 demonstrated understanding of medical condition and need for ongoing care, judgement appeared intact for routine decisions, no concerns with impulse control. The note indicated, based on clinical assessment, Resident #1 demonstrated adequate cognitive capacity to participate in decision-making discussions. No acute psychiatric symptoms or cognitive impairment was noted that precluded participation in advanced care planning. Baseline cognitive function appeared preserved with ability to understand and express preferences regarding medical care. Cognitive capacity for healthcare decision making intact with appropriate orientation, logical thinking and ability to understand medical information. A nursing note dated 4/17/2026 at 7:13 PM identified the conservator was updated that the resident was on LOA from 2:30 and did not return till 7 PM. Conservator expressed that resident is not to exceed no more than and hour. Stated that if resident acts up can send out and that any further behaviors can hold LOA till comes in Tuesday to speak to him/her. Resident is made aware of the situation and what can happen. Record review failed to identify additional information regarding limitations on Resident #1's resident rights and his/her ability to leave the facility for an LOA. A nursing note dated 4/19/2026 at 6:25 PM identified Resident #1 fell while outside the facility while on LOA and upon notification to the conservator, the conservator clarified that the one-hour LOA was meant to be one (1) hour daily, not multiple one (1) (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
	075182	A. Building B. Wing	05/06/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hour LOAs. (in one day). A physician order dated 4/19/2026 directed Resident #1 may go on LOA for one (1) hour once daily. Record review failed to identify additional information regarding limitations on Resident #1's resident rights and his/her ability to leave the facility for an LOA. A physician order dated 4/29/2026 directed to discontinue Resident #1 may go on LOA for one (1) hour daily. Interview with LPN #3 on 4/30/2026 identified she had cared for Resident #1 regularly and was his/her nurse on 4/17 and 4/18/2026. LPN #3 stated Resident #1 was very independent and took frequent independent smoke breaks but was only allowed per the conservator to go on LOA for one (1) hour at a time. Resident had signed out for an LOA on 4/17/2026 at 2: 30 PM. Resident #1 notified her when he/she returned to the facility and indicated he/she was delayed returning to the facility within the one (1) hour required due to shopping at a local supermarket. LPN #3 stated that was not the first time Resident #1 had exceeded the one (1) hour LOA time limit. Then on 4/18/2026, Resident #1 reported to LPN #3 that while he/she was on an LOA, he/she had smoked marijuana and drank two (2) beers. The conservator and the APRN were notified. The APRN gave new orders to hold medications that potentially would cause sedation. Interview with psychiatric APRN #1 on 4/30/2027 at 2:07 PM identified she evaluated Resident #1 on 4/17/2026 for behaviors dealing with noncompliance to smoking policy at the facility and noncompliance with LOA time limit. There was no safety concerns noted at the time and no psychotic symptoms. APRN #1 indicated the focus was on behavior accountability and impulse control with Resident #1 actively participating. APRN #1 stated she evaluated Resident #1 on 4/23/2026 per facility request, for sleep issues and medication for sleep (Ambien). Resident #1 reported anxiety and sleep deprivation but cognition was unchanged from previous evaluations. Interview with SW #1 on 4/30/2026 at 12:50 PM identified SW #1 stated when any resident signs out on LOA, they are responsible for themselves and they do not need supervision. Resident #1's LOA order was modified on 4/19/2026 per request of the conservator due to Resident #1 not complying with the one (1) hour limitation when on LOA shopping; Resident #1 was on LOA for approximately 5 hours. SW #1 was unsure when the one (1) hour limit was initially placed on Resident #1's right to leave the facility on an LOA. SW #1 stated Resident #1 was known to be non-compliant at times, but was cognitively alert and oriented. SW #1 stated, with the conservator approval and recommendation, the one (1) hour LOA time limit was implemented due to poor decision making. Interview and review of medical record with psychiatric APRN #2 on 4/30/2026 at 1:00 PM identified that she followed up with Resident #1 on 4/20/2026 after Resident #1's self-report of substance abuse on LOA. APRN #2 stated Resident #1's insight was fair, and Resident #1 had expressed some remorse and stated the intent not to repeat behaviors. Resident #1 was redirectable but continued to demonstrate poor choices while on LOA. Resident #1 was alert, anxious at times, cooperative and easily engaged with no signs of psychosis or changes in mood, and stated due to Resident #1's history of opioid use disorder, drug seeking behaviors could occur. APRN #2 stated Resident #1 was not considered a danger to self or others. She evaluated Resident #1 again on 4/29/2026 to address ongoing behavioral concerns by staff, and stated Resident #1 had no significant changes to mentation. APRN #2 stated changes to Resident #1's LOAs were completed due to facility request per facility policy, not per her recommendations. Interview with RN #1 on 4/30/2026 at 1:15 PM identified on 4/28/2026 an episode dealing with LOA privileges had resulted in police intervention when Resident #1 was unable to be re-directed and had increased agitation. Resident #1 refused to go to the hospital and was able to be calmed by EMS. RN #1 stated, upon notification to the conservator, the conservator requested that the independent LOAs be discontinued. Nursing note dated 4/29/2026 at 3 PM identified Resident #1 did not return from an LOA and when Resident #1 returns to the facility, his/her independent LOA will be restricted per resident conservator. Record review failed to identify why the right for LOAs was taken away from Resident #1. Interview with the Director of Nurses (DON) on 4/30/2026 at 2:00 PM identified that Resident #1's LOA orders were based on recommendations from the conservator and the conservator was responsible for medical and financial decisions for Resident #1. The DON stated changes to Resident #1's LOA orders were completed based on the (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	05/06/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conservator's directions with collaboration by the medical team. The DON identified that on 4/30/2026, the conservator had directed Resident #1 not be allowed to go on LOAs and that the conservator would decide for how long, as Resident #1 was not abiding by the one (1) hour independent LOAs by staying out past the time limits. When Resident #1 asked how long the limits would be in place, the conservator replied that they would revisit it a few days later. The DON stated the facility was were following the conservator's direction for the LOA restrictions. Interview failed to identify why the facility did not honor Resident #1's rights. APRN #3 was unavailable for interview during survey. Although requested the facility did not provide a policy for Leave of Absence for surveyor review during the survey. The facility's Resident [NAME] of Rights dated 1/8/2023 directed in part, that residents have the right to be informed of and participate in, his or her treatment plan including the right to establish goals and outcomes of care, the type, amount, frequency and duration of care including the right to request or refuse treatment. The resident had the right to exercise his or her rights and be supported by the facility to exercise their rights. The resident had the right to a dignified existence and self-determination. The facility must promote and facilitate resident's self-determination through support of residents' choice.