

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Grandview Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Grand Street New Britain, CT 06052	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880</p> <p>Based on clinical records and staff interviews for 1 of 4 residents (Resident # 68) reviewed for abuse, the facility failed to ensure staff interacted with residents in a dignified manner. The findings include:</p> <p>Resident #68 was admitted with diagnoses that included legal blindness, bipolar disorder, and impulse disorder.</p> <p>A Resident Care Plan (RCP) dated 10/5/2024 identified Resident #68 had the potential to be verbally aggressive, shouting at staff and exhibited anger easily due to poor impulse control and mental/emotional illness. Interventions included: Interventions before agitation escalate, engaging calmly in conversation, and if the resident's response was aggressive, staff were directed to walk calmly away and approach later.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #68 was cognitively intact and exhibited verbal behavioral symptoms directed toward others.</p> <p>An Accident and Incident report (A&I) dated 1/17/2025 indicated Resident #68 had been yelling at staff and the Social Work Assistant had become verbally disrespectful towards the resident. The A&I further indicated the presence of witnesses, the Human Resource Manager, and the Business Office Manager. However, a review of the clinical record failed to identify documentation of the staff-to-resident incident.</p> <p>On 2/6/2025 at 11:24 AM, an interview with the Human Resources Manager indicated Resident #68 was yelling at the Social Work Assistant, Human Resources Manager, and Business Office Manager regarding his/her lost iPad and air-pods (a type of headphone). The Human Resources Manager further indicated the Social Work Assistant had raised her voice when speaking to Resident #68 and that is when the resident indicated she/he wanted to leave, the Social Work Assistant said, Goodbye, have a good life. Additionally, the Human Resources Manager indicated the Social Work Assistant continued to attempt to talk to Resident # 68 despite the resident yelling at the Social Work Assistant to leave his/her room.</p> <p>(continued on next page)</p>

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

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: 075182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Grandview Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Grand Street New Britain, CT 06052	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/6/2025 at 11:40 AM an interview with the Administrator identified the expectation of the Social Work Assistant in interacting with an agitated resident was to de-escalate the situation and believed the Social Work Assistant's behavior may have been her reaction to the resident's foul language. The Administrator further indicated the Social Work Assistant was terminated based on customer service-related issues.</p> <p>On 2/6/2025 at 11:55 AM an interview with the Business Office Manager identified the Social Work Assistant had raised her voice when speaking to Resident # 68 and told the resident to calm down. The Business Office Manager indicated that the Social Work Assistant did not yell but rather raised her voice to be heard over the residents yelling. The Business Office Manager indicated the Social Work Assistant did not use foul language or derogatory statements. The Business Office Manager further indicated Resident #68 yelled to the Social Work Assistant to get out of his/her life, to which the Social Work Assistant responded, Have a nice life.</p> <p>On 2/11/2025 at 11:14 AM an interview with The Social Work Assistant indicated Resident # 68 had been yelling that his/her iPad had been stolen and the Social Work Assistant tried informing the resident that it was not an iPad missing but his/her air-pods and that the social work was working on locating the missing item. The Social Work Assistant indicated she did not yell or use profanity towards Resident #68. The Social Work Assistant further denied treating Resident # 68 in an undignified way or saying to the resident to have a nice life.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Grandview Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Grand Street New Britain, CT 06052	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880</p> <p>Based on clinical record review, policy review and interviews for 1 of 2 residents reviewed for choices (Resident #27), the facility failed to honor the resident's choices regarding personal food. The findings include:</p> <p>Resident #27 was admitted on [DATE] with diagnoses that included a heart attack, diabetes mellitus, and stroke.</p> <p>A physician's order dated 12/27/2024 directed a consistent carbohydrate diet with regular texture and a thin consistency of liquids.</p> <p>The admission MDS assessment dated [DATE] identified Resident #27 was cognitively intact and independent with eating and that having snacks available between meals was somewhat important to the resident</p> <p>On 2/3/2024, an interview with Resident #27 indicated she/he kept personal snacks, noodles, and canned soups in his/her room because she/he did not like the facility's food. The personal food sometimes requires heating. However, Resident #27 indicated two weeks prior to the interview, staff were unwilling to heat up his/her food. Resident #27 further indicated staff indicated to her/him that heating up her/his food in the microwave was against facility policy.</p> <p>A review of nursing progress notes identified on 1/18/2025 (a Saturday), Resident #27 was requesting assistance to heat up soup. The nursing notes also indicated the staff explained to Resident # 27 that the facility protocol prohibited staff from heating food or beverages for safety reasons. Additional notes on the same day indicated that staff explained to Resident # 27 no one would be heating up soup for her/him until it was cleared by the administration on Monday 1/20/25. A nursing progress note dated 1/21/2025 (a Tuesday) indicated Resident #27 was upset about being unable to heat up soup in the microwave, and staff educated Resident # 27 on the importance of not being able to heat soup in the microwave.</p> <p>On 2/6/2025 at 1:43 PM during an interview with LPN #7 indicated staff were not allowed to heat up liquids, but she was not sure about soup. LPN #7 indicated that she was unsure how long the policy had been in place and indicated this policy could have been in place for a year or two.</p> <p>On 2/6/2025 at 1:57 PM, an interview with NA#5 indicated she had been told she was not allowed to heat up food for residents, either liquid or solid. NA#5 indicated she was made aware of this policy by another aide while on orientation but could not recall the name of the aide.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Grandview Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Grand Street New Britain, CT 06052	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/10/2025 at 2:45 PM an interview with the Administrator identified she had spoken to Resident #27 on 1/24/2025 to address the resident's concerns and that the resident was allowed to have his/her food heated in the microwave. The Administrator indicated that the current policy for heating food was the policy in effect during Resident #27's complaint. The Administrator also indicated staff may have been verbally told by the previous administration that resident food should not be reheated. The Administrator further identified that a thermometer would be required when reheating food and that the nursing units either did not have thermometers or the device had gone missing. The Administrator ordered new thermometers on 1/26/2025.</p> <p>A review of the facility policy for Food Brought in from Outside Sources and Personal Food Storage given while onsite during survey notes food can be reheated in a microwave. The policy further indicated that food should be stirred during the reheating process and reheated to at least 165 degrees Fahrenheit for 15 seconds.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Grandview Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Grand Street New Britain, CT 06052	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49100</p> <p>Based on review of the clinical record, facility policy and interviews for 1 of 4 residents for (Resident # 86) reviewed for abuse, the facility failed to ensure the resident was free from physical abuse by (Resident#29). The findings include:</p> <p>1.Resident #86 's diagnoses included unspecified dementia without behavioral disturbance, difficulty in walking and localized edema.</p> <p>The care plan dated 10/8/2024 identified mood problems related to schizophrenia, Major Depressive Disorder, anoxic brain damage, dementia. Interventions included: to administer medications as ordered, monitor/document for side effects and effectiveness and to have behavioral health consults as needed (psycho-geriatric team, psychiatrist etc.).</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #86 was cognitively impaired and dependent on staff for transfers, bed mobility and lower body dressing.</p> <p>2.Resident # 29's diagnoses included personal progressive neurological condition, cancer, schizophrenia.</p> <p>The MDS quarterly 10/24/24 identified the resident as cognitively intact, no behaviors exhibited and utilize the wheelchair manual / electrical.</p> <p>The nursing progress notes dated 1/08/25 at 1:00 PM noted in part Supervisor called to the unit regarding a resident altercation that resulted in this residents' feet getting run into and over by another resident.</p> <p>The nursing progress notes dated 1/08/25 at 10:47 identified Resident #29 was upset because he/she wanted to go to another unit and wanted to be pushed. The NA stated that she needed to finish what she was doing and then she could take him/her. Resident # 29 became angry calling the NA names, began to speak profanity and told her to get away from him/her if they were going to help them now. The note indicated that staff tried to explain to Resident #29 she (NA) would help him/her, but he/she needed to wait, and the NA is trying to tell him/her that there is another resident (Resident #86) behind him/her. Resident #29 started to speak profanity and stated I don't care who's behind me. He/she needs to move, or I will hit his/her. This resident (Resident # 29) proceeded to push back forcefully hitting Resident #86 by running over his/her feet. This writer tried to move Resident#29, but she/he kept swearing yelling and was not redirectable.</p> <p>The interview with LPN #6 on 2/5/25 2:05 PM indicated Resident #29 was aware that Resident #86 was behind her/him prior to moving his/her chair. LPN #6 recounted the note above, stating Resident # 29 was so agitated that he/she was unable to be redirected and stated he/she did not care that Resident #86 was behind him/her.</p> <p>The facility Abuse, Neglect and Exploitation in part indicated that ongoing assessment, care planning for appropriate interventions and revision of resident care plan.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Grandview Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Grand Street New Britain, CT 06052	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49100</p> <p>Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 4 residents for (Resident # 86) reviewed for abuse, the facility failed to implement interventions to prevent further physical abuse from Resident # 29. The findings include:</p> <p>1.Resident #86 's diagnoses included unspecified dementia without behavioral disturbance, difficulty in walking and localized edema. he nursing progress notes dated 1/08/25 at 1:00 PM noted in part Supervisor called to the unit regarding a resident altercation that resulted in this residents' feet getting run into and over by another resident.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #86 was cognitively impaired and dependent on staff for transfers, bed mobility and lower body dressing.</p> <p>2.Resident # 29's diagnoses included personal progressive neurological condition, cancer, schizophrenia.</p> <p>The MDS quarterly 10/24/24 identified the resident as cognitively intact, no behaviors exhibited and utilize the wheelchair manual / electrical.</p> <p>The nursing progress notes dated 1/08/25 at 10:47 AM identified Resident #29 was upset because he/she wanted to go to another unit and wanted to be pushed. The NA stated that she needed to finish what she was doing and then she could take him/her. Resident # 29 became angry calling the NA names, began to speak profanity and told her to get away from him/her if they were going to help them now. The note indicated that staff tried to explain to Resident #29 she (NA) would help him/her, but he/she needed to wait, and the NA is trying to tell him/her that there is another resident (Resident #86) behind him/her. Resident #29 started to speak profanity and stated I don't care who's behind me. He/she needs to move, or I will hit his/her. This resident (Resident # 29) proceeded to push back forcefully hitting Resident #86 by running over his/her feet. This writer tried to move Resident#29, but she/he kept swearing yelling and was not redirectable.</p> <p>The interview with LPN #6 on 2/5/25 2:05 PM indicated Resident #29 was aware that Resident #86 was behind her/him prior to moving his/her chair. LPN #6 recounted the note above, stating Resident # 29 was so agitated that he/she was unable to be redirected and stated he/she did not care that Resident #86 was behind him/her.</p> <p>LPN #6 also reported she does not recall if any interventions were put in place subsequent to the incident.</p> <p>Review of Resident #86 care plan was not updated with interventions on how to prevent any further abuse/unintended altercations by Resident # 29.</p> <p>The facility Abuse, Neglect and Exploitation in part indicated that ongoing assessment, care planning for appropriate interventions and revision of resident care plan.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Grandview Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Grand Street New Britain, CT 06052	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046</p> <p>Based on review of clinical records, observations, facility policy and staff interviews for 2 of 4 residents for (Residents (#17 and # 42) reviewed for pressure ulcers , the facility failed to ensure staff revised the resident's care plan to reflect the resident's need to offload heels from pressure and current pressure ulcer status. The findings included.</p> <p>1. Resident #17's diagnosis included diabetes mellitus and dementia.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #17's cognitive status was severely impaired, the resident was at risk for pressure ulcers and had one unstageable Deep Tissue Injury (DTI) and noted the resident was receiving pressure ulcer care.</p> <p>A physician's order dated 12/18/2024 directed to utilize an offloading boot to the left foot while in bed every shift for off-loading pressure to the left heel.</p> <p>Resident #17's care plan dated 1/15/2025 for resident at risk for exhibiting non-compliance with treatment. Interventions included: to allow the resident to make decisions regarding daily care, clothing and meals educate on importance of compliance with the plan of care and to consult with psychiatric services as needed and to reapproach later if refuses.</p> <p>Interview and record review with LPN # 3, the Infection Preventionist (IP) and wound nurse, identified she/he did not find an intervention in the care plan regarding off-loading Resident #17's heels and she/he would update the care plan.</p> <p>The facility policy labeled Care Plan Revisions Upon Change in Status indicated in part the care plan would be updated with the new or modified interventions.</p> <p>2. Resident #42's diagnoses included paraplegia, pressure ulcer of right hip, and pressure ulcer of left hip.</p> <p>The Resident Care Plan with a revision date of 10/3/24 identified resident had an actual impairment to skin integrity of the right ischium and right hip stage 4 decubitus ulcer. Interventions included following the protocols for treatment of injury.</p> <p>The annual Minimum Data Set assessment dated [DATE] identified Resident #42 was cognitively intact and required moderate assistance for showering, upper body dressing and personal hygiene.</p> <p>A physician's order dated 2/1/25 directed to monitor skin weekly.</p> <p>The Weekly Skin Audit tool dated 2/1/25 indicated the resident had a right hip and right buttock pressure ulcer stage III.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Grandview Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Grand Street New Britain, CT 06052	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/5/25 8:45 AM an observation of Resident # 42's wound care with LPN #8 identified the following : Upon rolling the resident onto his/her side identified a DTI on the right heel and a cream color fibrous area on the bottom of his/her foot in the plantar area. No drainage from either. Interview with LPN #8 identified that this was her/his first time doing wound care on this resident and indicated she/he was only told about the areas on the resident's left foot, not the right foot.</p> <p>Review of the Treatment Administration Record from 1/1/25 through 2/4/25, indicated off-loading boots were applied bilaterally while resident was asleep and in the wheelchair.</p> <p>Observation and interview on 2/5/25 with IP nurses at 10:50 AM who measured the wounds identified the right heel was a DTI measuring 2 Centimeter (CM) x 3 CM and the plantar was calloused and was 3 CM x 2. 3CM. The IP indicated they were unaware of those areas. The resident stated those areas have been there for some time and the nurses have been putting skin prep on them. The IP nurse stated the resident is non-compliant with off loading boots on the right foot. After surveyor inquiry, the IP nurse attached the right leg rest to the resident's wheelchair. The IP nurse further indicated there is no indication on the resident's care plan that Resident # 42 refuses to wear the off-loading boots. Observation on 2/3 through 2/5/2025 identified Resident # 42 had a left leg rest on the wheelchair, but did not have a right leg rest. Resident # 42 wore an off-loading boot on the left foot, however, did not wear one on his/her right foot.</p> <p>In an Interview with wound Advanced Registered Practice Nurse (APRN) on 2/5/25 at 11:00AM confirmed that she was there on Monday to evaluate the wounds and she did not notice anything on the resident's right foot. The APRN stated that in her opinion a DTI could develop within hours. Not sure about the calloused area. The APRN further indicated she would evaluate the wounds. Further she stated the resident is a paraplegic and is often non complaint with off-loading.</p> <p>Interview with NA # 3 on 2/5/25 at 11:30 AM identified the last time she/he provided care to Resident # 42 on 2/4/25 she/he did not notice on any area on the resident's right foot. NA # 3 also indicated that Resident # 42 only wears left offloading boot daily.</p> <p>In an interview with LPN#1 on 2/6/25 at 12:00 PM identified she regularly provides wound care to Resident # 42 and did not notice the areas on the right heel and right plantar areas.</p> <p>In an interview with the Medical Director on 2/5/25 at 12:05 PM identified a DTI could develop quickly, however a callous type of area would develop over time and with this resident it is probably due to him/her propelling with his/her right foot in the wheelchair.</p> <p>A progress note written by the Wound APRN on 2/5/25 at 2:41 PM after surveyor inquiry identified the resident had 2 new areas, both DTIs. The right plantar non blanching purple with cluster of 2 epithelial. The right plantar was due to foot pressure and the right heel was due to pressure.</p> <p>In an interview on 2/10/25 at 12:50 PM with the INC identified the care plans have not been regularly updated and may not be accurate. The INC further indicated that the MDS Coordinator and the DNS have only been at the facility for a short time therefore there has not been a consistent person supervising the care planning process. She stated that the care plans are being reviewed at the morning meeting to ensure they are accurate and up to date.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Grandview Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Grand Street New Britain, CT 06052	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy, Care Plan Revisions Upon Status Chage, undated and currently in effect, directed in part, the comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change.</p> <p>48792</p> <p>49100</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Grandview Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Grand Street New Britain, CT 06052	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>48792</p> <p>Based on observation, facility policy, and staff interview for 1 of 4 residents reviewed for accidents (Residents #32), the facility failed to ensure safe smoking receptacles were readily accessible for residents. The findings include:</p> <p>Observations on 2/10/2025 at 9:45 AM of the facility's supervised resident smoke break identified the following: The resident smoke break took place under a covered patio. Seven residents attended the smoking break, all sitting against the edges of the covered patio. There were three metal cigarette disposal receptacles also located at the edges of the covered patio not readily accessible to residents. There were also two staff members supervising the smoking session: a Smoking Monitor and NA #4. Resident #32 was observed smoking one cigarette, and after she/he had finished the cigarette, Resident # 32 was unable to dispose of the cigarette butt. Resident #32 handed the cigarette to the Smoking Monitor, who then disposed of the cigarette butt into a receptacle.</p> <p>An interview with NA#4 indicated residents would ask for assistance to extinguish cigarette butts and dispose of them in the cigarette disposal receptacles. An interview with the Smoking Monitor identified it was difficult to ensure all residents in the smoking session had readily access to the cigarette disposal receptacles because residents would congregate with each other depending on the type of cigarette they smoked. Both NA# 4 and the Smoking Monitor were unaware if the cigarette disposal receptacles were movable.</p> <p>The facility policy on smoking indicated that safety measures for the designated smoking area would include the provision of ashtrays made of noncombustible material and safe design, as well as accessible metal containers with self-closing covers into which ashtrays can be emptied.</p> <p>48880</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Grandview Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Grand Street New Britain, CT 06052	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49100</p> <p>Based on review of the clinical record, observations, facility policy and interviews for the only sampled resident (Resident #6) reviewed for Respiratory Care, the facility failed to follow physicians order related to oxygen liter flow rate. The findings include:</p> <p>Resident #6 's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), Pulmonary Fibrosis and Type 2 diabetes mellitus.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 was moderately cognitively impaired and required moderate assistance with personal hygiene and bed mobility and was independent with eating.The MDS also identified Resident #6 as receiving Oxygen Therapy.</p> <p>The care plan dated 12/20/24 identified Resident #6 is at risk for altered respiratory status/ difficult breathing related to sleep apnea. Interventions in part included: to administers medications as ordered, monitor for signs and symptoms of respiratory distress and shortness of breath.</p> <p>A physician's order dated (facility did not provide requested orders dates) directed nasal cannula to be at 1-4 liters and indicated the oxygen should be off in the morning.</p> <p>Observation on 2/3/25 at 11:37 AM identified Resident # 6's oxygen was set at 5liter (slightly above red line).</p> <p>Observation on 2/4/25 at 8:59 AM of nasal canula oxygen at 5L</p> <p>Interview with LPN #5 on 2/4/25 at 9:12 AM identified she was unsure why the oxygen was set at 5lites. She indicated all nurses are responsible for ensuring that physician's orders are administered correctly. LPN #5 identified that she had not completed her morning rounds therefore was unable to adjust sooner.</p> <p>After surveyors' inquiry, LPN #5 adjusted Resident's #6 oxygen setting to reflect physicians' order 1-4 liters.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Grandview Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Grand Street New Britain, CT 06052	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046</p> <p>Based on review of the clinical record, review of facility policy and staff interviews for 1 of 5 residents (Resident #17) reviewed for Medication Regimen Review, the facility failed to ensure target behaviors were being monitored while a resident was receiving psychoactive medications including an antipsychotic medication. The findings include:</p> <p>Resident #17 was readmitted to the facility on [DATE].</p> <p>A physician's order dated 12/8/2024 directed to provide Rexulti (an antipsychotic medication) 2.0 Milligrams (MG) orally once a day for dementia.</p> <p>A physician's order dated 12/8/2024 directed to provide Trazadone 25 MG by mouth twice daily (an antidepressant).</p> <p>A pharmacist Drug Regimen Review completed on 12/9/2024 indicated the need to add behavioral monitoring with appropriate target behaviors for Resident #17 utilization of psychoactive medications.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #17 as severely cognitively impaired, the resident exhibited physical and verbal behavior towards others and behaviors not directed towards others 1-3 times per day. The MDS further indicated Resident #17 received an antipsychotic medication.</p> <p>The care plan dated 12/17/2025 indicated Resident #17 has a behavior of laying down on the floor, potential to be physically aggressive, hitting, spitting, slapping throwing items, banging the wall, and was at risk for wandering. Interventions included : redirection, bilateral floor mats for safety, provide physical and verbal cues to decrease anxiety, reorient to surroundings and to provide a wander guard</p> <p>A psychiatric visit note dated 12/20/2024 directed a visit to monito behavior and adjust plan of care as needed.</p> <p>A psychiatric visit note dated 1/7/2025 indicated Resident #17 no longer required an antipsychotic and the plan was gradual dose reduction (GDR) of the Rexulti with new physician's orders to decrease the Rexulti to 0.5 MG orally every AM.</p> <p>A psychiatric visit note dated 1/14/2025 directed to discontinue the Rexulti as a result of this visit.</p> <p>An interview and clinical record review on 2/11/2025 at 8:40 AM with RN #2 identified she/he could not find any physician's orders for monitoring target behaviors related to psychoactive medications and no documentation of target behaviors for 36 days while Resident #17 was on the antipsychotic. RN #2 indicated without an physician's order in place the monitoring of target behaviors will not display on the Medication Administration Kardex to monitor and document the target behaviors.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Grandview Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Grand Street New Britain, CT 06052	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A policy regarding the use of antipsychotic medications and monitoring of target behaviors was requested but not provided.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Grandview Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Grand Street New Britain, CT 06052	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046</p> <p>Based on clinical record review, observations, review of facility documentation, review of facility policy and staff interviews for 1 of 3 residents (Resident #118) reviewed for Environment, the facility failed to ensure a functioning call bell system was in place at the time of admission. The findings include:</p> <p>Resident #118's diagnosis includes Alzheimer's disease.</p> <p>Resident #118 was admitted to the facility on [DATE].</p> <p>The care plan dated [DATE] indicated Resident #118 had a self-care deficit. Interventions included: to encourage the use of the call bell for assistance.</p> <p>An Occupational Therapy Evaluation and Plan of Treatment dated [DATE] indicated Resident #118's upper extremity function and strength was within functional limits, was independent with eating and noted impaired safety awareness. The plan of treatment also noted impaired fine and gross motor coordination with goals of increasing Resident #118's independence with bathing dressing and toileting.</p> <p>The Admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #118 as severely cognitively impaired, dependent for activities of daily living but able to eat independently with set up meals.</p> <p>An observation on [DATE] at 11:25 AM identified Resident #118 without a call bell and no cord coming from the call bell box on the wall.</p> <p>An interview and observation with the regular charge nurse on the unit (LPN #2) on [DATE] at 11:30 AM identified there was never a call bell because the facility did not finish the room before the resident's admission. LPN # 2 also indicated Resident #118 may not have used the call bell anyway but indicated she/he would provide Resident #118 with a manual handbell. After obtaining the manual hand bell for Resident #118, LPN #2 further identified she/he did not tell anyone Resident #118 had no call bell and no plan was put in place with her/his knowledge of the resident not having a call bell.</p> <p>An interview with the Maintenance Director with RN #5, the facility Independent Nurse Consultant present on [DATE] at 11:35 AM indicated there had to be a call bell and they were unaware of a problem.</p> <p>An interview and observation of Resident #118's room with the Maintenance Director on [DATE] at 11:50 AM identified no call bell cord or call buttons. The call bell system was a nonfunctioning call box on the wall, different than the roommate's box who's was functioning. The Maintenance Director indicated s/he would call an electrician to install a new call box. The Maintenance Director further indicated before admission, one of the maintenance workers would have gone to the room to check to see if the call bell system was functioning and indicates she/he was not sure who was assigned to check Resident #118's room prior to admission and would follow up.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Grandview Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 55 Grand Street New Britain, CT 06052	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 11:55 AM the Maintenance Director identified she/he was not able to locate the workers who were responsible for checking the call bell system on the day of admission for an interview.</p> <p>On [DATE] at 12:20 PM the Maintenance Director indicated the electrician would be at the facility during the week which was the company's earliest availability.</p> <p>An interview and facility document review with the Admissions Coordinator #1 indicated s/he was new to the facility and was not working for the facility when Resident #118 was admitted . S/he further indicated an admission checklist was part of the process since he/she started working for the facility and had no check list for Resident #118's admission in the admission office. The Admission Coordinator #1 provided a sample list where each department is listed and is responsible for completing their section then passing the check list to the next department until completed, returning the form to Admissions Coordinator #1. A sample check list noted under the maintenance department heading to check the call bell for functioning.</p> <p>On [DATE] at 12:15 PM an interview with RN #5, the facility Independent Nurse Consultant indicated s/he was in the process of staff completing a call bell audit for the building to ensure all others were functioning.</p> <p>The facility policy labeled, Call Lights: Accessibility and Timely Response notes in part; the call bell system will be accessible to residents while in bed or other sleeping accommodations within the resident's room, staff will ensure the call bell is within reach of the resident and secured as needed. The policy indicated that staff would report problems with the call light or the call bell system immediately to the supervisor or Maintenance Director and staff will provide immediate or alternative solutions until the problem can be remedied .</p> <p>48792</p>