STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy, and interviews for 1 of 10 sampled residents (Resident #19) reviewed for Activities of Daily Living (ADLs), the facility failed to identify and implement communication devices for effective communication. The findings include:Resident #19 ‘s diagnoses included hemiplegia (paralysis 1 side) and hemiparesis (weakness on 1 side) following a stroke, sensorineural (neurological) hearing loss on both sides.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #19 was modified independence with cognitive skills and daily decision making, had inattention and disorganized thinking, highly impaired hearing and required assistance with eating, partial moderate assistance with dressing, personal hygiene, transfers, and was independent with bed mobility. Review of the Resident Care Plan dated 6/2/2025 failed to identify Resident #19 had a communication deficit related to highly impaired hearing loss (deafness). A. Observation and attempted interview on 7/15/2025 at 2:49 PM, identified Resident #19 was very hard of hearing and unable to communicate with the surveyor. Observation on 7/22/2025 at 11:46 AM identified Resident #19 was attempting to communicate with LPN #3 but was not understood. The Administrator was called to the resident's room to talk with him/her. Although the Administrator utilized a pen and paper and identified an issue with missing money in the amount of $400.00, he was unable to determine any further details. The Recreation Director was called to assist but was also unable to understand Resident #19. A fourth staff member, NA #2, a Spanish speaking staff interpreter was then utilized and identified that Resident #19 was waiting for $400.00 to be able to buy cigarettes and that his/her money had not been missing.Interview and record review with Director of Rehabilitation on 7/22/2025 at 1:20 PM identified that communication has been a problem for the resident and that cue cards and a communication board should have been utilized to assist with Resident #19's ability to communicate. B. Review of the Resident Care Plan dated 6/2/2025 failed to identify a communication deficit related to highly impaired hearing loss (deafness) or any interventions that would assist staff to communicate with Resident #19. A Speech Therapy Discharge summary dated [DATE] identified Resident #19's ability to communicate using yes/no responses with minimal initiation difficulty, with occasional cues in order to participate in vocational, avocational and social activities. Resident #19 needed intermittent cues from trained caregivers.A Physician Assistant (PA) note dated 3/27/2025 at 8:48 PM identified a sensorineural hearing loss bilaterally. A review of systems was noted to be limited to unobtainable due to hearing loss (deaf) and the use of Spanish sign language.A nurse's note dated 4/8/2025 at 7:49 PM identified that Resident #19 had a speech and hearing impairment.A nurse's note dated 4/21/2025 at 9:21 PM identified New [NAME] Police were in to see the resident but were unable to effectively communicate with Resident #19 as he/she was Spanish speaking and utilized American sign language.A nurse's note dated 5/6/2025 at 11:29 PM identified Resident #19 was nonverbal but communicated with sign language.A PA note dated 7/8/2025 at 10:30 AM identified as before, a history was limited due to expressive aphasia and possible language barrier. Resident #19 shook his/her head no to all questions asked.Interview and record review with the Director of Rehabilitation on 7/22/2025 at 1:20 PM identified that communication had been a problem for the resident and that cue cards and a communication board should have been utilized to assist with Resident #19's ability to communicate. Further, the Director of Rehabilitation identified that those interventions, or any other type of intervention should have been placed on the care plan or on the Nurse Aid (NA) care card (directive for NA as to how to provide care) to assist with communication.Interview and record review with RN #2 on 7/23/2025 at 11:52 AM identified that the facility had been without a Minimum Data Set (MDS) Coordinator since September 2024. RN #2 indicated that she had been overseeing the Resident Assessment Instrument (RAI) process, mostly remotely, and that a contract company had been assisting to complete the MDS assessments and subsequent creation and review and revision of RCPs. RN #2 identified no communication care plan was in place for Resident #19 but there should have been since he/she utilized sign language and was Spanish speaking. Additionally, the nurse who completed the MDS assessment would have been responsible to write a communication care plan, and RN #2 was unable to explain why a communication care plan had not been implemented. Subsequent to surveyor inquiry, RN #2 indicated that she would have to contact the contract company that had completed the MDS assessment.Review of the Activities of Daily Living (ADL), supporting policy dated 2018 directed, in part, appropriate care and services will be provided for residents who are unable to carry out ADL's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility's Personal Funds Account, facility documentation, facility policy, and interviews for 3 of 6 sampled resident (Residents #7, #104, and #114) reviewed for personal funds, the facility failed to honor same day requests for withdrawals of personal funds and failed to provide access to resident funds outside of the facility's posted banking hours. The findings include:1.Interview with Resident #7 on 7/16/2025 at 9:50 AM identified that he/she had a personal fund account with the facility but was unable to take out funds from the account on weekends. Resident # 7 ‘s diagnoses included quadriplegia, anxiety, and chronic pain.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 had a Brief Interview for Mental Status (BIMS) score of 12, indicating Resident #7 had moderate cognitive impairment. 2. Interview with Resident #104 on 7/22/2025 at 11:21AM identified he/she had a personal fund account with the facility and had been told he/she could not take out any money since June from the account.Resident # 104‘s diagnoses included anxiety, depression, and had a seizure disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #104 had a Brief Interview for Mental Status (BIMS) score of 13, indicating Resident #7 had no cognitive impairment.3. Interview with Resident #114 on 7/15/2025 at 11:10 AM identified that he/she had a personal fund account with the facility and was unable to take out funds from the account at night or on weekends. Resident #114 reported that the facility only allowed withdrawals during banking hours and that he/she could only take out $20.00 at a time because the facility was in transition. Resident #114 reported he/she received $75.00 per month that was placed in the personal fund account.Resident # 114 ‘s diagnoses included anxiety, Post Traumatic Stress Syndrome, and bipolar. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #114 had a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #114 had no cognitive impairment. Interview with the Business Office Manager and the Administrator on 7/23/2025 at 1:58 PM identified Residents # 7, #104, and #114 had personal fund accounts with the facility. The Business Office Manager indicated that residents were only allowed to take money out of their account during the posted banking hours which were Monday - Friday from 9:00 AM to 3:00 PM. She explained that residents did not have any access to their personal funds after 3:00 PM or on weekends. The facility also limited how much a resident could take out of their personal funds account as they had been going through a change in ownership. The Business Office Manager indicated the facility was having difficulty accessing the bank accounts. She reported the facility limited the amounts a resident could withdrawal based on the amount of money the facility had on-hand. She reported that although the maximum withdrawal amount was $75.00, if cash was unavailable, then a check would need to be generated, which would take about 24 hours and then the Administrator would need to cash the check in order for the residents to receive their funds. The Administrator identified the facility would need to implement a process that allowed a resident to withdraw funds at night and on the weekends.A Personal Funds policy was requested, but the facility stated they did not have a policy. Review of the Resident's Rights Policy directed, in part, that residents have the right to manage his or her financial affairs, this includes the right to know, in advance, what charges a facility may impose against a resident's funds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, facility policy, and interviews for 10/122 of sampled residents (Resident #2, #19, #39, #98, #99, #106, #107, #500, #501, #502) reviewed for personal funds, the facility failed notify residents when their accounts were within $200.00 of the Social Security Income (SSI) resource limit and failed to covey personal funds within 30-days of a resident's discharge from the facility. The findings include:Review of the facility's Trial Balance report and interview with the Business Office Manager and Administrator on [DATE] at 1:58 PM identified on [DATE] Residents #2, #19, #39, #98, #99, #106, #107 resided in the facility, were on Medicaid, and had account balances exceeding the SSI resource limits as follows:Resident #2 had an account balance of $1,620.65Resident #19 had an account balance of $1,799.39Resident #39 had an account balance of $2,125.10Resident #98 had an account balance of $2,234.64Resident #99 had an account balance of $1,611.98Resident #106 had an account balance of $2,127.64Resident #107 had an account balance of $2,042.28Further interview with the Business Office Manager and Administrator identified for Residents #500, #501, and #502 that although these residents had been discharged from the facility over 30 days prior, the facility had not distributed the Resident's personal fund balance from the facility account as follows:Resident #500 had been discharged on [DATE] and had an account balance of $150.00 (facility was 14 days late)Resident #501 had been discharged on [DATE] and had an account balance of $45.00 (facility was 73 days late)Resident #502 had been discharged on [DATE] and had an account balance of $2,301.80 (facility was 14 days late)Interview with the Administrator on [DATE] at 12:35 PM reported the facility standard when a resident approaches $1,600.00 in their personal funds account was to work with Social Services, Recreation, and the resident's family to purchase items for the resident in an effort to spend down on their account. He reported that while he was aware there was a backlog of Medicaid residents who have balances over the SSI limits, the Business Office Manager was working hard to rectify the accounts, and the facility now had a process in place to avoid this from happening in the future. The Administrator further indicated that he was not aware there were residents that were not deceased whose funds had not been returned to them within 30 days of discharge.Subsequent to the surveyor's inquiry, the facility processed a check request for the remaining balance in Resident #501 and Resident #502's personal funds account. A Personal Funds policy was requested, but the facility stated they did not have a policy. Review of the Resident's Rights Policy directed, in part, that residents have the right to manage his or her financial affairs, this includes the right to know, in advance, what charges a facility may impose against a resident's funds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interviews for 2 of 3 sampled residents (Resident #48 and Resident #55) reviewed for advanced directives and for the only sampled resident (Resident #120) reviewed for death, the facility failed to ensure a choice for an advance directive was completed. The findings include: 1. Resident #48’s diagnosis included schizoaffective disorder, metabolic encephalopathy (brain dysfunction), and borderline intellectual functioning. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #48 had a Brief Interview of Mental status score of 15 indicating no cognitive impairment and was independent with Activities of Daily Living (ADL’s) The Resident Care Plan in effect for [DATE] failed to identify a care plan for an advanced directive. A physician’s orders in effect for [DATE] identified that Resident #55 was to be fully coded (receive Cardiopulmonary Resuscitation, CPR) in the event of his/her heart stopping. Interview and review of the clinical record with the Director of Nurses (DNS) on [DATE] at 12:05 PM failed to identify a signed consent from Resident #48’s conservator for an advanced directive choice and the physician order directed a full code. The DNS indicated that the advance directive consent should have been signed on admission and placed in the paper record or scanned to the Electronic Health Record. 2. Resident #55’s diagnosis included diabetes, legal blindness, anxiety, and bipolar disorder. The annual Minimum Data Set assessment dated [DATE] identified Resident #55 had a Brief Interview of Mental status score of 15 indicating no cognitive impairment, required set up assistance with eating, dependent on staff to transfer, and partial/moderate assistance with personal and oral hygiene. The Resident Care Plan in effect for [DATE] identified Resident #55 wanted a full code, CPR. Interventions included to respect the family and resident’s request regarding their choice for advanced directive. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of Resident #55’s clinical record on [DATE] at 11:23 AM with LPN #1 identified an unsigned Advanced Directive in the chart coded as Do Not Intubate, Do Not Resuscitate (DNI/DNR). LPN #1 indicated that a physician order could not be written in the clinical record until the advanced directive form had a choice from the resident or resident representative and was signed by the physician. LPN #1 indicated that she would make the Social Work Department aware that the conservator had not filled out the appropriate paperwork. The facility procedure was to have the advanced directive choice signed on the day of admission, but if the resident was unable to sign due to being conserved or confused, a nurse or social worker should have left a message with the conservator/family and scheduled a meeting to complete the paperwork. Some conservators have asked to have the information faxed, sometimes it was tricky to get family in if a resident was not conserved. Interview and review of the clinical record on [DATE] at 11:54 AM with the Director of Nursing Services (DNS) identified that there was no signed advanced directive or a physician order documented in Resident #55’s clinical record. The DNS indicated that social work had conducted an audit for the entire facility, and she thought any missing advanced directive documentation had been addressed. She identified that the social worker had written a note on [DATE] indicating a full code but was unable to identify where the social worker’s information came from. The DNS indicated that on admission the protocol was for the nurse to get the advanced directive form signed, when possible, but in the past the facility has had difficulty reaching conservators. Further, Resident #55 arrived in March so should have been part of the audit and should have had his/her advanced directive signed by now. Interview with Social Worker (SW) #3 on [DATE] at 11:40 AM identified that the SW’s work together, but he had not been informed that Resident #55’s advanced directive had not been signed. SW #3 indicated that a Resident Care Conference (RCC) was held last week, but the conservator did not attend and does not respond to calls, and the facility had called the court, but they did not respond. Interview with SW #1 on [DATE] identified that he had conducted a facility wide audit of advanced directive documentation but was unsure how Resident #48 was not listed as a resident included in the audit. He further indicated Resident #55 was a full code on the audit and a side note stated, “call conservator” and “nursing”. SW #1 was unable to provide documentation the conservator was notified but stated that he had left a message. Subsequent to surveyor inquiry, the conservator was contacted and signed an advance directive on [DATE] to attempt resuscitation, do not intubate for Resident #55. 3. Resident #120‘s diagnoses included cauda equina syndrome, chronic obstructive pulmonary disease, and morbid obesity. The admission Minimum Data Set assessment dated [DATE] identified Resident #120 was cognitively intact and required was dependent on staff for toileting hygiene, shower/bathing self, and transfers. The Resident Care Plan from [DATE] through [DATE] identified Resident #120 had an advance directive for Cardiopulmonary Resuscitation (CPR) meaning in the event of his/her heart stopping, they would be a full code (perform CPR). Interventions included that needs would be anticipated and met by staff and to respect the family and resident request regarding their choice for advanced directive. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A social services note dated [DATE] at 12:39 identified that Resident #120’s 72-hour meeting was conducted and that Resident #120’s code status was a full code. A review of Resident #120’s clinical record identified that the resident’s advance directive had not been signed by the resident and/or a physician. An interview and document review with the Director of Admissions on [DATE] at 11:52 AM identified that for a newly admitted resident, an admission packet was provided and included paperwork for an advance directive choice. The admission nurse was responsible to ensure the advance directive was completed. The document would then be uploaded into the resident’s electronic health record and then the Social Services Department assisted with this process. An interview and review of the clinical record with Social Worker #3 on [DATE] at 12:11 PM identified that although the admitting nurse should ensure the advance directive was fully completed, the Social Services Department would review the admission packet at the resident's 72-hour post admission care conference meeting to ensure the advance directive documentation was properly completed. SW #3 indicated that Resident #120’s advance directive was missing the residents and physicians’ signature which was required to complete Resident #120’s advance directive choice. SW #3 was unable to indicate why the advance directive was not completed. Review of the residents’ rights regarding treatment and advance directives policy directed, in part, that on admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. Additionally, the facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advanced directive.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 upon review of the clinical record, staff interviews, and facility policy for 1 of 5 sampled resident (Resident #84) reviewed for unnecessary medications, the facility failed to notify the physician of an elevated blood sugar. The findings include: Resident #84's diagnosis included diabetes, schizophrenia, and chronic kidney disease. Review of Resident #84's Medication Administration Record (MAR) for 7/11/25 at 5:25 PM identified a blood sugar level of 331 (normal is 70 - 100). Physician's orders in effect from 7/1/25 through 7/24/25, directed to notify the physician if results of Resident #84's blood sugars were elevated. The order failed to include any blood sugar parameters, which would direct staff, when the physician should be notified. Review of clinical record, nursing notes and physician notes failed to identify that the physician was notified of Resident #84's elevated blood sugar level. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #84 had a Brief Interview of Mental Status score of 12 indicating moderate cognitive impairment, was independent with eating, dressing, bed mobility, and ambulation. Additionally, Resident #84 received insulin daily. The Resident Care Plan dated in effect for July 2025 identified Resident #84 had diabetes. Interventions directed staff to monitor/document for side effects and effectiveness and obtain a fasting serum blood sugar as ordered by doctor. Interview with LPN #8 on 7/24/25 at 11:23 AM, identified he could not recall if he was the nurse who took Resident #84's blood sugar level on 7/11/25, but stated if the results were initialed by him, then he must have taken the reading. LPN #8 further identified he knew Resident #84 well, and although he documented a blood sugar level of 331, he indicated he did not think the reading could have been that high. LPN #8 reported that if the provider was notified, the notification would have been documented in the resident's clinical record. Additionally, LPN #8 identified if the order and facility policy directed him to notify the physician of an elevated blood sugar level he should have done so but was unable to state why he did not notify the provider when Resident 84's blood sugar level (331) read higher than the normal range. During an interview with APRN #2 on 7/24/25 at 12:43 PM, she was unable to recall if she had been notified of Resident #84's elevated blood sugar. APRN #2 indicated that had she been notified, she would have directed facility staff to monitor Resident #84's blood sugar levels more frequently for trending purposes, and that no increased blood sugar monitoring had been directed following Resident #84's abnormal blood sugar Subsequent to surveyor's inquiry, APRN #2 directed monthly blood sugar monitoring for Resident #84. Review of the Notification of Change policy dated 1/18/24 directed, in part, that the physician is notified when there is a change that requires notification.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, documents, facility policy, and interviews for 1 of 8 residents (Resident #4) reviewed for abuse, the facility failed to ensure a resident was free from misappropriation of his/her bank card and use of the bank card. The findings include:Resident #4's diagnoses included mononeuropathy, type 2 diabetes, and chronic respiratory failure with hypoxia (low level of oxygen).A nurse's note dated 6/30/2025 at 2:22 PM by Licensed Practical Nurse (LPN) #7 identified that Resident #4 informed her that he/she went to the bank on 6/30/2025 with Person #3 (Resident #4's family member) and noticed his/her bank card was missing and money was missing from his/her bank account. The nurse's note further identified her supervisor, Registered Nurse (RN) #6, was made aware, the Police Department was called, and social services had started an investigation.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #4 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition, required set-up assistance with personal hygiene, used a wheelchair for mobility, and was independent with chair/bed-to-chair transfers.The Resident Care Plan (RCP) in effect from 5/3/2025 through 7/22/2025 identified Resident #4 needed socialization and independent activities at his/her own leisure to support his/her independence. Interventions included participating in smoke breaks, providing independent leisure activity materials, and visits by the Recreation Department 2 to 3 times weekly.A nurse's note dated 6/30/2025 at 2:22 PM by Registered Nurse (RN) #6 identified that LPN #7 informed her that Resident #4 was missing his/her bank card. RN #6 spoke with Resident #4 and was informed he/she went to the bank on 6/30/2025 and noticed the bank card was missing. He/she identified a charge that was made on the account that was not made by him/her when reviewing the bank statement. The nurse's note further identified the Director of Nursing Services (DNS), and the Administrator were made aware of the incident.A social services note dated 6/30/2025 at 3:44 PM identified Resident #4 was offered talk therapy and assured that all facility protocols would be followed, including reporting to the police and the State Agency (SA).A psychiatric Advanced Practice Registered Nurse (APRN) note dated 7/2/2025 identified that Resident #4's mood was stable after the 6/30/2025 allegation of misappropriation of funds. The psychiatric APRN note further identified that the resident had not checked the location of the bank card in about a month.Interview on 7/16/2025 at 10:57 AM with Resident #4 identified his/her bank card was stolen from his/her room and around $25.00 was charged at a grocery store approximately 10 miles away from the facility. He/she stated a police report was filed but the facility had not returned the money that had been stolen.A bank statement for Resident #4 dated 6/25/2025 identified that bank account activity on 6/9/2025 had occurred at a grocery store approximately 10 miles away from the facility in the amount of $25.80. No other charges were made to his/her account for the dates 4/30/2025 through 6/25/2025.A signed police report dated 7/18/2025 identified the police were dispatched to the facility on 7/2/2025 at 11:40 AM. The report identified Resident #4 signed a sworn statement that he/she used the debit card on 5/5/2025 at the bank to directly withdraw $400.00. The report further identified he/she had neither left the facility nor used her card after 5/5/2025. The report indicated he/she would like to press charges against the individual who stole his/her bank card and used it to make a purchase at the grocery store. Interview on 7/21/2025 at 9:16 AM with Person #3 identified he/she took Resident #4 to the bank on 6/30/2025 when the resident discovered his/her bank card was missing and there was a charge at a grocery store approximately 10 miles away from the facility made by an unauthorized person. Person #3 further identified no one other than him/her takes Resident #4 out of the facility, he/she had not taken the resident out of the facility on any other date in June, and that he/she did not take or borrow Resident #4's bank card for any reason.Interview on 7/21/2025 at 1:55 PM with the DNS identified a complete investigation into the allegation of misappropriation of funds was not performed. The DNS indicated that she failed to review the facility video cameras for potential evidence, she failed to obtain a copy of Resident #4's bank statement, and she failed to obtain written statements from all staff who worked with Resident #4 during the time of the incident. The DNS identified that she had unsubstantiated the allegation of misappropriation of funds because she could not substantiate or unsubstantiate the event had actually occurred. She stated the rationale for marking the investigation as unsubstantiated was she did not want to be late filing her summary. The DNS indicated the only way someone would have access to Resident #4's bank card, if kept in his/her wallet, would be if it was stolen. Review of the facility's Abuse, Neglect, and Exploitation policy identified in part that the facility will complete an immediate investigation when a report of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policy, and interviews for 1 of 8 sampled residents (Resident #3) reviewed for abuse, the facility failed to ensure a resident was not involuntarily secluded and had access to all facility locations. The findings include:Resident #3's diagnoses included encounter for orthopedic aftercare (cervical laminectomy), type 2 diabetes, and schizoaffective disorder bipolar type.Observation and interview on 7/16/2025 at 12:38 PM identified that Resident #3 was not visible from the doorway. He/she was observed behind a privacy curtain, lacked any engaging activities such as television, radio, or personal activity, and lay in bed silently. Resident #3 stated he/she wanted to go outside but was told by staff that he/she could not leave the floor without a staff member and most times there was no staff to assist with outdoor privileges. Further, Resident #3 stated he/she was told he/she could only go outside when the smokers went out, but he/she did not smoke, and was upset due to seeing other residents leave the floor during non-smoking times when he she could not, stating It's not fair. Resident #3 indicated that he/she felt stuck on his/her unit and that it was like being in prison. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition, did not exhibit the behavior of wandering, required substantial assistance with chair/bed-to-chair transfers, and was independent in wheeling 50 feet with 2 turns in a manual wheelchair.The Resident Care Plan (RCP) in effect 3/13/2025 through 7/22/2025 identified Resident #3 preferred to pursue independent leisure activities as he/she was at the facility for short term rehab. Interventions included encourage independent leisure activities, and assist the resident as needed/requested by facilitating self-directed activities of interest.Interview on 7/22/2025 at 12:01 PM with Licensed Practical Nurse (LPN) #7 and Advanced Practice Registered Nurse (APRN) #1 identified that LPN #7 has never let Resident #3 off the floor nor has she ever seen him/her leave the floor as there were no Leave of Absence (LOA) orders in place that would allow him/her to leave the floor. APRN #1 identified that he was responsible for evaluating residents for LOA orders and he had not placed any orders for Resident #3 to leave the floor. Further he indicated the reason Resident #3 had no LOA privileges was because his/her conservator did not want him/her outside or leaving the building.Interview on 7/22/2025 at 12:07 PM with Person #2 (Resident #3's conservator) identified that no one from the facility had ever contacted him/her or asked him/her if Resident #3 could leave the floor or go outside. Person #2 further identified that Resident #3 had told him on multiple occasions that he/she asked staff to leave the floor, and the nurses tell him/her no. Person #2 stated he/she would like Resident #3 to be able to go outside in the courtyard area near the gazebo when he/she wanted to as it would do him/her good to get out into the fresh air to get some sunshine and Vitamins('s). A second observation of Resident #3 on 7/22/2025 at 12:32 PM identified he/she was independently locomoting up and down the hallway in a manual wheelchair. Resident #3 watched 3 other residents (Resident #27, Resident #68, and Resident #75) get badged out, off the floor, into the elevator to go outside independently. Resident #3 was noted to frown and wheeled his/herself back down the hallway to his/her room.Interview on 7/23/2025 at 8:54 AM with the Director of Nursing (DNS) identified that she brought up, in May, to the Director of Recreation, the issue of Resident #3 not being allowed outside to the resident area. The DNS stated that there is a resident-maintained garden, and she requested chairs be placed outside in that resident area to sit outside and enjoy the weather. Further, the DNS indicated she was aware that Resident #3 could only go outside if he/she smoked and believed it was unfair that smokers could go outside 4 times a day and non-smokers could not. The DNS stated she had previously brought up, during morning meeting, the subject of residents wanting to go outside and not being allowed to, and that staff needed to be educated. She further indicated that she was aware when Resident #3 had not been allowed off the floor or outside to the resident area, the resident was being involuntary secluded. Additionally, other residents wanted to leave the floor to go to the resident area and staff had not allowed this to occur.Interview on 7/23/2025 at 10:41 AM with the Director of Recreation identified that she was notified by the DNS in May to place chairs outside for the residents to sit outside in the fresh air. She submitted a concern form to the Maintenance Department and told maintenance verbally in June to place chairs outside. Further, she identified she was notified by Resident Council that they also wanted to go outside, and they requested a cover from the facility to provide shade. The Director of Recreation indicated she had never taken Resident #3 outside and does not want to use the gazebo as shade, as the area near the gazebo may smell like

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 3 of 8 sampled residents (Resident #15, Resident #55, and Resident #58) reviewed for abuse, the facility failed to report or report timely, allegations of abuse. The findings include: 1. Resident #15's diagnoses included encephalopathy, cirrhosis of the liver and a personal history of a traumatic brain injury.Review of the facility Reportable Event (RE) form dated 7/16/25 at 10:00 AM identified Resident #15 reported a staff member placed his hands around his/her neck and used derogatory names towards the resident and his family. The RE indicated a state classification indicating abuse. The Advanced Practice Registered Nurse (APRN) was notified of the incident at 10:30 AM and the RE was signed and dated on 7/16/25 by the Director of Nursing (DNS).The annual Minimum Data Set (MDS) dated [DATE] identified Resident #15 was severely cognitively impaired and required partial/moderate assistance with bed mobility and was dependent with transfers and toileting. The Resident Care Plan (RCP) dated 7/16/25 identified Resident #15 had impaired cognitive function with the potential to be verbally aggressive related to ineffective coping skills and poor impulse control. Interventions included monitoring behaviors, providing emotional support, and giving positive feedback for good behavior. Review of RN #4's written statement dated 7/16/25 indicated that on 7/16/25 he was asked to speak to Resident #15 because the resident was refusing care. Attempts to interview RN #4 were unsuccessful. Interview and review of facility documentation with the DNS on 7/22/25 at 1:30 PM identified on 7/16/25 at 10:00 AM Resident #15 had reported an allegation of physical abuse, the RE form was completed on 7/16/25 and signed by her on 7/16/25 but she had not reported the event to the state agency until 7/17/25 at 6:00 PM (32 hours post allegation). The DNS indicated that it would have been her responsibility to report Resident #15's allegation to the SA timely, she had made a mistake because the reporting criteria required the allegation be reported to the state agency within 24 hours of facility notification, and she was unable to identify why the late reporting occurred. 2. Resident #55 ‘s diagnoses included legal blindness, type 2 diabetes, and bipolar disorder.Review of the Reportable Event form dated 7/17/2025 at 1:00 PM identified Resident #55 alleged that he/she was verbally and physically assaulted by RN #4 on 7/16/2025 at approximately 7:00 PM, the resident notified police, the APRN was notified by the facility, an investigation was initiated, and statements were pending. RN #4 was suspended while the investigation was in progress.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #55 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment, required partial assistance with sit-to-lying positioning, was dependent on staff for sit-to-stand and chair to bed positioning changes, and walking 10 feet was not attempted.The Resident Care Plan (RCP) dated 6/18/2025 identified Resident #55 had a history of accusatory behavior. Interventions directed staff to approach Resident #55 with 2 staff members when providing Activities of Daily Living (ADL) care. A physician's order in effect from 7/1/25 through 7/24/2025 directed staff to approach Resident #55 with 2 staff members at all times every shift. Interview with Resident #55 on 7/17/2025 at 3:12 PM identified that he/she had returned to the facility with pizza the evening of 7/13/2025 and requested that it be refrigerated. On 7/16/2025, Resident #55 asked NA #9 to retrieve and heat the pizza, however, when NA #9 returned, she stated she did not find any pizza in the refrigerator. Resident #55 became upset and called RN #4 on the phone asking to be reimbursed for the missing pizza. RN #4 stated someone from social services would follow up with the resident the next day. Further, Resident #55 indicated that at approximately 6:00 PM RN #4 entered his/her room unexpectedly and alleged he began yelling profanities, including I am tired of your s***, you f****** p**** you little s*** and then he proceeded to spit in his/her face. Resident #55 indicated when he/she stated that he/she was going to call 911, RN #4 responded that he didn't care. Resident #55 called 911, began to speak with dispatch but dropped the cell phone. Resident #55 indicated that when he/she attempted to pick up the phone, RN #4 shoved him/her in the chest causing him/her to stumble and twist his/her left ankle. Resident #55 managed to retrieve the cell phone from the ground and informed the dispatcher, who was still on the call, that he/she had been assaulted by a staff member and was now hurt. At 7:00 PM the police had not arrived so Resident #55 placed another call to 911 and dispatch informed the resident the police were on their way. The police arrived at approximately 7:20 PM and a report was filed. Resident #55 further indicated that he/she was transported to the hospital secondary to chest and left foot pain. At the hospital Resident #55 identified he/she was diagnosed with a sprained left ankle, given a splint, and returned to the facility later that evening

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 5 of 8 sampled residents (Resident #4, Resident #43, Resident #55, Resident #58, and Resident #59) reviewed for abuse, the facility failed to ensure complete, thorough, and timely investigations were conducted. The findings include:F610 Grandview merged Based on review of the clinical record, facility documentation, facility policy, and interviews for 5 of 8 sampled residents (Resident #4, Resident #43, Resident #55, Resident #58, and Resident #59) reviewed for abuse, the facility failed to ensure complete, thorough, and timely investigations were conducted. The findings include: 1. Resident #4's diagnoses included mononeuropathy, type 2 diabetes, and chronic respiratory failure with hypoxia (low level of oxygen). A nurse’s note dated 6/30/2025 at 2:22 PM by Registered Nurse (RN) #6 identified that LPN #7 informed her that Resident #4 was missing his/her bank card. RN #6 spoke with Resident #4 and was informed he/she went to the bank on 6/30/2025 and noticed the bank card was missing. He/she identified a charge that was made on the account that was not made by him/her when reviewing the bank statement. The nurse’s note further identified the Director of Nursing Services (DNS), and the Administrator were made aware of the incident. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #4 had a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognition, required set-up assistance with personal hygiene, used a wheelchair for locomotion, and was independent with chair/bed-to-chair transfers. The Resident Care Plan (RCP) in effect from 5/3/2025 through 7/22/2025 identified Resident #4 needed socialization and independent activities at his/her own leisure to support his/her independence. Interventions included participating in smoke breaks, providing independent leisure activity materials, and visits by the Recreation Department 2 to 3 times weekly. A nurse’s note dated 6/30/2025 at 2:22 PM by Licensed Practical Nurse (LPN) #7 identified that Resident #4 informed her that he/she went to the bank on 6/30/2025 with Person #3 (Resident #4’s family member) and noticed his/her bank card was missing and money was missing from his/her bank account. The nurse’s note further identified her supervisor, Registered Nurse (RN) #6, was made aware, the Police Department was called, and social services had started an investigation. A social services note dated 6/30/2025 at 3:44 PM identified Resident #4 was offered talk therapy and assured that all facility protocols would be followed, including reporting to the police and the State Agency (SA). A psychiatric Advanced Practice Registered Nurse (APRN) note dated 7/2/2025 identified that Resident #4’s mood was stable after the 6/30/2025 allegation of misappropriation of funds. The psychiatric APRN note further identified that the resident had not checked his/her wallet in about a month. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Reportable Event summary form dated 7/8/2025 and investigation documentation identified the DNS unsubstantiated the allegation of abuse and that the Police Department was conducting their own investigation into the allegation of misappropriation of Resident #4’s personal funds. Review of the facility’s investigation documentation identified 6 staff members provided single sentence statements attesting they were not aware of Resident #4’s missing bank card. The facility failed to ensure the forms were complete and contained a supervisory staff signature (blank) indicating that supervisory staff discussed the provided written statement with the staff member as indicated on the form. The investigation failed to obtain statements from all staff members from different shifts who had access to the resident during the time in question, failed to include an interview with the resident’s roommate, and failed to conduct an interview with the resident, Resident #4, who had the bank card taken. Interview on 7/16/2025 at 10:57 AM with Resident #4 identified his/her bank card was stolen from his/her room and around $25.00 was charged at a grocery store approximately 10 miles away from the facility. He/she stated a police report was filed, and the facility had not reimbursed the money that had been stolen. After requesting and obtaining approval to review, the bank statement for Resident #4 dated 6/25/2025 identified that bank account activity on 6/9/2025 had occurred at a grocery store approximately 10 miles away from the facility in the amount of $25.80. No other charges were made to his/her account for the dates from 4/30/2025 through 6/25/2025. A signed police report dated 7/18/2025 identified the police were dispatched to the facility on 7/2/2025 at 11:40 AM. The report identified Resident #4 signed a sworn statement that he/she used the debit card on 5/5/2025 at the bank to directly withdraw $400.00. The report further identified that he/she had neither left the facility nor used his/her card after 5/5/2025 and that he/she would like to press charges against the individual who stole his/her bank card, making a charge to his/her account. Interview on 7/21/2025 at 9:16 AM with Person #3 identified he/she took Resident #4 to the bank on 6/30/2025 when the resident discovered his/her bank card was missing and found out there had been unauthorized use of Resident #4’s bank card. Person #3 further identified no one other than him/her takes Resident #4 out of the facility, he/she had not taken the resident out of the facility any date in June, and he/she did not take or borrow Resident #4’s bank card for any reason. Interview on 7/21/2025 at 1:55 PM with the DNS identified a complete investigation into the allegation of misappropriation of funds was not performed. The DNS indicated that she failed to review the facility video cameras for potential evidence, she failed to request/obtain a copy of Resident #4’s bank statement, and she failed to obtain written statements from all staff who worked with Resident #4 during the time of the incident. The DNS identified that she had unsubstantiated the allegation of misappropriation, and her rationale was due to time constraints. The DNS indicated the only way someone would have access to Resident #4’s bank card, if it was kept in his/her wallet, would be if it was stolen. 2. Resident #43's diagnoses included anxiety and depressive disorder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #43 on 7/15/25 at 11:15AM identified that he/she had reported to Registered Nurse (RN) #1 that $10.00 was missing from the drawer in his/her room a few weeks ago. Resident #43 could not recall the date but stated it was on a weekend. Resident #43 indicated that RN #1 told her she would have to report the missing money to the police. Resident #43 stated he/she asked that RN #1 not to report the missing $10.00 to the police as he/she did not want anyone to get in trouble. Resident #43 identified he/she did not report the missing $10.00 to any other staff member. Furthermore, Resident #43 stated that her locked box was broken when the incident happened and he/she had placed the $10.00 under the locked box. Resident #43 indicated that the locked box was repaired by maintenance not too long after the incident. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #43 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment and was independent with activities of daily living. The Resident Care Plan dated 7/15/25 identified Resident #43 reported $10.00 missing, and interventions included to follow the facility policy for reports of missing items, educate the resident on the use of a locked box, and encourage the resident to utilize a locked box for safe keeping of personal items and money. Interview with the DNS on 7/15/25 at 12:15 PM identified that she was unaware Resident #43 was missing $10.00, and the missing money had not been reported to her. Subsequently, the DNS filed an Accident & Incident report with the State Agency for Resident #43's missing $10.00 and initiated an investigation. During an interview with RN #1 on 7/15/25 at 1:50 PM, she denied that Resident #43 reported missing $10. 00 and if Resident #43 had reported the missing money she would have reported the occurrence and completed an Accident and Incident report. RN #1 indicated that she only worked on the weekends. Re-interview with Resident #43 on 7/17/25 at 12:00 PM confirmed that he/she had reported the missing $10. 00 to RN #1 when he/she noticed the $10.00 was missing. Resident #43 stated that he/she had asked RN#1 not to report the missing money to the police. A review of nursing notes and social service notes for June and July 2025 failed to identify documentation that Resident #43 had reported the missing $10.00 to RN #1. An interview and review of the investigation for Resident #43's missing money with the DNS on 7/23/25 at 12:00 PM indicated that the DNS had completed her investigation. The DNS stated the only remaining issue was that the facility was going to reimburse Resident #43 for the missing $10.00. A review of statements with the DNS identified that the investigation lacked a statement from RN #1 or any other staff members that worked on Resident #43's unit. The only statement that was obtained was from Resident #43. The DNS indicated that statements from RN #1 and staff members who had worked on Resident #43's unit should have been obtained for the investigation and that the investigation was not thoroughly completed. Furthermore, the DNS indicated that it was her responsibility to ensure investigations were completed per the facility policy. 3. Resident #55 ‘s diagnoses included legal blindness, type 2 diabetes, and bipolar disorder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Reportable Event form dated 7/17/2025 at 1:00 PM identified Resident #55 alleged that he/she was verbally and physically assaulted by RN #4 on 7/16/2025 at approximately 7:00 PM, the resident notified police, the APRN was notified by the facility, an investigation was initiated, and statements were pending. RN #4 was suspended while the investigation was in progress. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #55 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment, required partial assistance with sit-to-lying positioning, was dependent on staff for sit-to-stand and chair to bed positioning changes, and walking 10 feet was not attempted. The Resident Care Plan dated 6/18/2025 identified Resident #55 had a history of accusatory behavior. Interventions directed staff to approach Resident #55 with 2 staff members when delivering activities of daily living (ADL) care. Physician’s orders that were in effect from 7/1/2025 through 7/24/2025 directed staff to approach Resident #55 with 2 staff members at all times every shift. Review of the facility Accident and Investigation Report indicated that the facility was unable to substantiate the allegation following the completion of the investigation, but the documentation was incomplete as there was no statement from Resident #55 and 2 statements were written but lacked signatures as to who had completed the statements. Interview with Resident #55 on 7/17/2025 at 3:12 PM identified that he/she had returned to the facility with pizza the evening of 7/13/2025 and requested that it be refrigerated. On 7/16/2025, Resident #55 asked NA #9 to retrieve and heat the pizza, however, when NA #9 returned, she stated she did not find any pizza in the refrigerator. Resident #55 became upset and called RN #4 on the phone asking to be reimbursed for the missing pizza. Resident #55 indicated that RN #4 stated someone from social services would follow up with the resident the next day. Further, Resident #55 identified that at approximately 6:00 PM RN #4 entered his/her room unexpectedly and began yelling profanities, including “I am tired of your s***, you f****** p**** you little s***” and then according to Resident #55, RN #4 proceeded to spit in his/her face. Resident #55 indicated when he/she stated that he/she was going to call 911, RN #4 responded that he didn’t care. Resident #55 stated he/she called 911and began to speak with dispatch but dropped the cell phone. Resident #55 indicated that when he/she attempted to pick up the phone, RN #4 shoved him/her in the chest causing him/her to stumble and twist his/her left ankle. Resident #55 managed to retrieve the cell phone from the ground and informed the dispatcher, who was still on the call, that he/she had been assaulted by a staff member and was now hurt. At 7:00 PM the police had not arrived so Resident #55 placed another call to 911 and dispatch indicated the police were on their way. The police arrived at approximately 7:20 PM, and a report was filed. Resident #55 indicated that he/she was transported to the hospital secondary to chest and left foot pain. At the hospital Resident #55 identified he/she was diagnosed with a sprained left ankle, given a splint, and returned to the facility later that evening. Resident #55 went on to state that on 7/17/2025 (the next morning) he/she became upset upon hearing RN #4 being paged. Resident #55 indicated that he/she believed RN #4 would no longer be working at the facility due to the incident that happened the night before. Resident #55 stated that he/she requested to speak to the Administrator (did not recall who he/she asked) but was told the Administrator was busy and then Resident #55 indicated he/she contacted the facility ombudsman and his/her conservator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the hospital Discharge summary dated [DATE] at 1:22 AM identified Resident #55’s was diagnosed with a sprained ankle, given an ankle splint air cast, and discharged back to the facility. Interview with Social Worker (SW) #3 on 7/21/2025 at 12:44 PM identified that during his morning rounds on 7/17/202, Resident #55 seemed very upset. Resident #55 told Social Worker #3 that he/she was disturbed after hearing RN #4 paged and was confused as to why he was still in the building due to being physically assaulted by RN #4 the previous evening. Resident #55 told SW #3 about the pizza incident and recounted that RN #4 went into the resident’s room and just started yelling at him/her, spit in his/her face, and then physically assaulted him/her. Resident #55 also stated the police were called and that he/she needed to go to the hospital. Social Worker #3 immediately reported the allegations to his supervisor around 9:15 AM on 7/17/2025 who then requested he write a statement and give the statement to the DNS and Administrator. Interview with RN #4 on 7/21/2025 at 1:07 PM, identified he first learned about the missing pizza when Resident #55 called him on the phone and reported the pizza had been thrown away. RN #4 offered to replace the pizza through the kitchen and stated that social services would follow up the next day. He felt the resident was agreeable to the plan. He next received a call from NA #9 indicating the resident was upset and she asked him to come up and speak with the resident. RN #4 indicated he was involved in another matter and could not go up stating he had already spoken with Resident #55. RN #4 stated NA #9 then reported Resident #55 was yelling and throwing things in his room. Although Resident #55 required a 2 person approach at all times, RN #4 indicated he went to the resident’s room alone and stood at the resident’s doorway. He reported Resident #55 was throwing things and yelling profanities. RN #4 asked Resident #55 to calm down. He stated the resident swore at him and then threatened to call 911. He took a few steps into the room to try to calm the resident, and then Resident #55 called 911, stating he/she had been assaulted by a staff member and was now hurt. RN #4 denied arguing or touching Resident #55. He reported that he left the room after he heard Resident #55 tell 911 that he was hurt and he returned to his office thinking to himself, let me go, this guy is accusing me of a serious allegation. About an hour later, an officer arrived, and RN #4 shared his account with the officer. The officer left to speak with Resident #55 and approximately five minutes later, RN #4 was informed by the LPN charge nurse that Resident #55 was being sent to the emergency room for chest and foot pain. RN #4 stated he then called the DNS to inform her that Resident #55 was going to the Emergency room, indicating he had told the DNS of the allegation of mistreatment. He later recanted he had told the DNS of the allegation in a subsequent interview. RN #4 then resumed his duties, completed his 3:00 PM to 11:00 PM shift and returned to the building on 7/17/2025 for the 7:00 AM to 3:00 PM shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DNS on 7/21/2025 at 4:35 PM, identified RN #4 contacted her on the evening of 7/16/2025. Although she could not remember the exact time, she indicated RN #4 informed her that Resident #55 had “gone off” on him and the resident had subsequently called the police. RN #4 told the DNS he had entered the resident’s room, asked the resident to calm down, and left after the resident began yelling at him. The DNS reported RN #4 stated that Resident #55 had later complained of chest pain and foot pain and was sent to the hospital. The DNS stated RN #4 did not report that Resident #55 had alleged that he (RN #4) was the perpetrator and was accused of verbally and physically abusing Resident #55. The DNS said she only became aware of the full context the next morning when rounding on the unit and learning from Resident #55 that there had been a serious allegation of verbal and physical abuse involving RN #4. She stated that once she became aware of the situation, the DNS reported the allegation to the State Agency and started an investigation. She stated she obtained statements from all those involved but was unable to produce the full investigation and did not substantiate the allegation of abuse. 4. Resident #58's diagnoses included fracture of the left arm humerus, fracture of the left femur, displaced fracture of the right tibia, and acute pain due to trauma. A Grievance form dated 7/1/2025 (written in response to an allegation that occurred on 6/28/2025) identified Resident #58 had reported to the facility that a staff member referred to him/her as the “N-word”. The Grievance form further identified that the facility made him/her aware that the incident was under investigation and the facility would adhere to the facility policy. The grievance form stated that “the staff member was educated but continued to demonstrate an inability to adhere to policies, exhibited insubordination, and was non-compliant. Additionally, the staff member lacked adequate customer service skills, and, as a result, their employment was terminated.” (later identified that NA #6 was not terminated as an employee but made a Do Not Return to the facility from the staffing agency). The Grievance form was signed by the facility’s Administrator on 7/4/2025. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #58 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, did not experience episodes of delusions or verbal behavioral symptoms towards others, and was dependent for his/her personal hygiene and rolling left and right in bed. The Resident Care Plan (RCP) in effect from 5/15/2025 through 7/20/2025 identified Resident #58 required assistance with activities of daily living and had a history of refusing care and medications. Interventions included encouraging the resident to participate in his/her care and praising all efforts at self-care. The RCP was not revised for the grievance dated 7/1/2025 that occurred on 6/28/2025. A. Interview on 7/16/2025 at 10:03 AM with Resident #58 identified on 6/28/2025 Nurse Aide (NA) #6 called him/her a “F***ing N-word” and he/she reported feeling abused to a Social Worker (SW). Resident #58 further identified since the incident of verbal abuse he/she had difficulty sleeping due to being afraid of retaliation by other staff for reporting the abuse, and he/she was “not sure what people will do these days”. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 7/18/2025 at 10:23 AM with SW #3 identified that Resident #58 notified her during rounds that a Nurse Aide (NA) called him/her the “N-word”, that the racial slur made him/her feel uncomfortable, and he/she requested not to receive care from that NA going forward. SW #3 stated she notified her supervisor (SW #1) and the DNS of the allegation of abuse, and she was not involved with completing an investigation as the DNS and her supervisor (SW #1) were responsible for investigations. Interview on 7/18/2025 at 9:50 AM with Social Worker (SW) #1 identified that he was made aware through daily report that a staff member used the “N-word” to Resident #58 and SW #3 collected information on the incident. He stated that social services did not perform an investigation into the allegation nor was he a part of the investigation, as it was the Nursing Department’s responsibility to do so, but social services did perform wellness checks on Resident #58 as use of the “N-word” can cause pain and he wanted to be certain he/she was safe. SW #1 failed to document the details of the wellness check within the clinical record. SW #1 stated he did not report the incident of abuse to administration because they were already aware. Interview on 7/18/2025 at 10:33 AM with the Director of Nursing Services (DNS) identified that she was made aware of the allegation of abuse by social services, that Resident #58 had reported he/she was called the “N-word”, and it was a team decision to place the NA #6 on a do not return list for future assignments. She stated that she did not conduct an investigation and believed that social work had completed an investigation. The DNS further identified that the incident of abuse was documented as a grievance and not reported to the State Agency (SA) per a directive from the facility Administrator. The DNS stated that the NA calling the resident the racial slur of the “N-word” constituted verbal abuse and that the incident should have been reported to the SA. A second interview on 7/18/2025 at 10:46 AM with the DNS, SW #1, SW #3, and SW #4 identified that an investigation was not completed. SW #1 stated the reason an investigation was not completed was because the incident was labeled a Grievance and that nursing or administration would be responsible for investigating verbal abuse. The DNS stated the social workers should have investigated the occurrence as verbal abuse. The DNS, SW #1, SW #3, and SW #4 all stated they had received abuse training, that use of the racial slur “N-word” was a form of verbal abuse. An interview on 7/18/2025 at 11:15 AM with the Administrator identified that he was notified of the allegation of verbal abuse towards Resident #58 by SW #1. Further, he identified he signed the Grievance form and determined the incident was not reportable to the SA because he believed the use of the “N-word” was said in Resident #58’s presence but was not said directly to him/her. The Administrator disagreed that a NA referring to a resident as a “f***ing N-word” in the presence of that resident was an allegation of verbal abuse. B. According to punch in and punch out records: NA #6 punched in on 6/28/2025 at 3:00 PM and punched out on 6/28/2025 at 11:15 PM and was scheduled to work on Resident #58’s floor; punched in on 6/29/2025 at 3:00 PM and punched out on 6/29/2025 at 10:45 PM and was scheduled to work on Resident #58’s floor; punched in on 7/5/2025 at 3:00 PM and punched out on 7/5/2025 at 11:00 PM and was not scheduled to work on Resident #58’s floor; and punched in on 7/6/2025 at 3:00 PM and punched out on 7/6/2025 at 11:00 PM and was scheduled to work on Resident #58’s floor. The facility failed to protect Resident #58 from abuse on 3 out of 3 occasions after the allegation of verbal abuse was made. When NA #6 continued to work at the facility, the facility failed to protect Resident #58 from further abuse as NA #6 still had access to Resident #58. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 7/22/2025 at 1:40 PM with the Nurse Scheduler identified that NA #6 was placed on the Do Not Rehire (DNR) list because she called Resident #58 the “N-word”. The Nurse Scheduler further identified it was either social services or the DNS who provided her with the reason for placing NA #6 on the DNR list. Interview on 7/22/2025 at 1:40 PM with Person #1 identified the facility told him/her that NA #6 had called a resident the “N-word”. He/she further identified that NA #6 continued to work at the facility after the incident even though Person #1 told her not to go back to the facility. Review of text messages dated 7/7/2025 at 11:54 AM between Person #1 (staffing agency) and NA #6 identified that NA #6 was asked to not return to the facility by Person #1 because an investigation into NA #6’s actions on 6/28/2025 had not been completed. NA #6 responded via text, that the DNS had told her she was off Resident #58’s assignment but the DNS had not told her not to come back to work. 5. Resident #59’s diagnoses included obstructive hydrocephalus, difficulty in walking and unspecified vision loss. A nurse note dated 6/17/25 at 6:22 PM identified Resident #59’s left eye was swollen, bruised, and dark purple. He/she was noted to be in pain and stated that he/she rolled over and hit his/her eye on the side of the bed the night before. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #59 was severely cognitively impaired, required supervision or touch assistance for walking 150 feet or more and was independent for transfers. The Resident Care Plan dated 6/27/25 identified Resident # 59 had an ADL self-care performance deficit related to altered mental status and hydrocephalus. Interventions included the assistance of 1 staff with the use of a standard single point cane. Review of the Accident and Incident Report dated 6/17/25 identified Resident #59 sustained a left periorbital bruise. His/her mental status was described as confused and forgetful, and physical status noted to be independent with transfers, ambulation, and eating. The summary conclusion report submitted to the State Agency (SA) by the Director of Nurses on 6/20/25 identified that upon investigation the origin of the left orbital bruise could not be determined (an injury of unknown origin). Additionally, upon interviewing the resident, he/she did not know how the left orbital bruise had occurred and that Resident #59 was a poor historian. Interview with Licensed Practical Nurse (LPN) #2 on 7/22/25 at 12:15 PM identified the facility policy directed the charge nurse or the supervisor to fill out an Accident and Incident Report upon discovery of an injury that was not witnessed. She stated that on 6/17/25 around 6:00 PM it was reported to her that Resident #59 had a dark blue, swollen bruise to his/her left eye. LPN #2 stated Resident #59 told her that he/she sustained the bruise from rolling over in bed, but the bruising was to her left inner eye so it could not have been caused by rolling over. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and clinical record review with the Director of Nurses (DNS) on 7/22/25 at 1:00 PM identified it was the facility policy that Accident and Incident reports were initiated by the charge nurse and supervisor, and if the occurrence was identified by the DNS to be a Reportable Event that needed to be submitted to the SA, this information was completed by the DNS. The DNS further indicated that the facility policy was to include a 72 hour look back investigation during the period prior to the event on the resident's unit that consisted of staff interviews for all staff who worked during that 72-hour period. A review of the Accident and Incident Report investigation dated 6/17/25 for Resident #59 identified the current investigation consisting of 4 employee statements that were all dated 6/17/25 were attached. The DNS could not identify if the attached interviews were the only ones obtained since “there were quite a few missing” and stated she would double-check the supervisor’s office. Additionally, the DNS identified that she was responsible for overseeing Accident and Incident form completion, and since it was an injury of unknown origin, investigation statements should have included all staff that worked on the unit for all shifts, dating back to 6/14/25. Interview and observation with Registered Nurse Supervisor (RN) #6 on 7/22/25 at 3:20 PM in the supervisor's office identified that although the DNS stated that 72-hour look back statements were kept in the supervisor’s office, RN #6 indicated that statements had never been kept in the supervisor’s office. RN #6 indicated that the Assistant Director of Nurses (ADNS) was responsible to keep track of and store investigation statements. RN #6 looked through the stacks of paper waiting to be filed but was unable to identify that any 72- hour look back statements for Resident #59 were located in the supervisor’s office. Interview and clinical record review with the ADNS on 7/22/25 at 3:30 PM identified she was responsible for the 72-hour look back statements, however, did not currently have any investigation statements for Resident #59 for the Accident and Incident report dated 6/17/25. The ADNS indicated that all the statements obtained had already been already attached (4 employee statements) to the current documentation, and that the statements did not include everyone that the facility policy directed a statement to be obtained from, as only 4 statements had been completed. Further, the ADNS indicated that she did not currently have any statements whatsoever in her office area. A review of the Abuse, Neglect and Exploitation policy dated 1/18/2024 directed, in part, that written procedures for investigations include to identify and interview all involved persons, including the alleged victim, alleged perpetrator, witnesses, and any others who might have knowledge of the allegations; focusing the investigation on determining if abuse, neglect, exploitation and/or mistreatment has occurred, the extent, and cause: and providing complete and through documentation of the investigation, that an immediate investigation will take place when there is a suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. A report will be made to the SA immediately but no later than 2 hours after the allegation is made, and the Administrator will follow-up with the SA to report the results of the investigation within 5 working days of the incident. Additionally, the facility will make efforts to ensure all residents are protected from physical and psychosocial harm as well as additional abuse, during and after the investigation. The Incidents and Accidents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of the clinical record, and facility policies for 1 of 5 sampled residents (Resident #1) reviewed for nutrition, the facility failed to provide treatment in accordance with standards of care for a resident with heart failure. The findings included: Resident #1's diagnoses included hypertensive heart disease with heart failure, diabetes mellitus, and hyperlipidemia.The Resident Care Plan (RCP) dated 6/23/25 identified Resident #1 had altered cardiovascular status related to hypertension and hyperlipidemia. Interventions included encouraging a low fat low/salt intake and obtain lab testing as needed.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was moderately cognitively impaired, independent for transfers and toileting, and required substantial/maximal assistance for lower body dressing. Additionally, the MDS identified Resident #1 had a weight gain of 5% or more in the last month or 10% or more in the last 6 months and was not a physician prescribed weight gain regimen.A review of Resident #1's weights identified a weight of 171 pounds (lbs.) on 6/10/25, a weight of 179 lbs. on 6/17/25, a weight of 182.2 lbs. on 7/1/25, and 188.6 on 7/7/25 indicating a significant weight gain of 10.29 % in 27 days. A review of the Nutrition/Dietary note dated 7/10/25 at 10:45 AM identified Resident #1 was triggered for a significant, undesirable, but anticipated weight change due to edema and diuretic (fluid reducing medication) therapy in place.Interview and record review with the supervisor, Registered Nurse (RN) #3 on 7/24/25 at 9:26 AM identified it was the facility policy to assess residents who had a diagnosis of heart failure for lung sounds, respiratory status, and pedal pulses daily, as well as notify the provider of a weight gain of 2.5 lbs. in one day or 5 lbs. in 1 week. Review of the clinical record with RN #3 identified he/she was receiving diuretic medication 3 times per week as well as being weighed monthly. RN #3 was unable to identify how the facility would be aware of Resident #1 gaining weight on a daily or weekly basis if the resident was only weighed monthly. Further, RN #3 was unable to provide documentation that any nursing assessments for heart failure had been conducted, unable to locate a physician order directing the dietary restrictions as indicated in the RCP, or physician orders directing staff to perform assessments for Resident #1's condition that would indicate signs and symptoms of heart failure.Interview and clinical review with APRN #1 on 7/24/25 at 10:15 AM identified that the facility policy to manage heart failure was to track the residents fluid intake and output for renal function, check laboratory values (BMP and CBC which indicate values related to heart failure) and have the individual seen by cardiology monthly. APRN #1 identified Resident #1 was not compliant with education on his/her fluid restriction, and staff was managing his/her heart failure by assessing if he/she had an altered mental status that deviated from his/her baseline as well as assessing for edema of his/her face and feet. Although APRN #1 indicated Resident #1 was on intake and output monitoring, a review of the clinical record failed to identify an order for a fluid restriction or intake and output monitoring, failed to identify an order for a no added salt diet per the RCP, and failed to identify an order to assess the resident for edema or daily weights. Additionally, APRN #1 identified an awareness of Resident #'1's weight gain, believed it was due to dietary intake, however, after reading the Registered Dietitian's note, indicated that Resident #1 would be evaluated today and daily weight monitoring and edema monitoring would be added to the plan of care. Subsequent to surveyor inquiry APRN #1 initiated a physician's order dated 7/26/25 for daily weights and to inform the provider of a weight gain of 2 lbs. or greater in 24 hours to be completed daily as well as orders for laboratory work (BMP) to be done the next day.Although requested a Heart Failure Policy was not provided. Although requested a Resident Assessment Policy was not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policy, and staff interviews for 1 of 10 residents (Resident #99) reviewed for Activities of Daily Living (ADLs), the facility failed to ensure fingernail care was provided to a dependent resident. The findings include: Resident #99 diagnoses included dementia, anxiety disorder, and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #99 had a BIMS score of 13, indicating no cognitive impairment, and was dependent for showering/bathing and personal hygiene.The Resident Care Plan dated 5/6/2025 identified Resident #99 has an ADL self-care performance deficit related to deconditioning and multiple comorbidities. Interventions include that the resident requires assist of one for bathing.Physician's orders in effect for July 2025 directed staff to provide a shower every Thursday on the day shift and every Sunday on the evening shift. Observation and interview with Resident #99 on 7/15/2025 at 11:53AM identified that the length of his/her nails was not by choice and he/she would have preferred to have his/her fingernails cut. Observations on 7/16/2025 at 10:18 AM identified Resident #99's fingernails remained unchanged. A review of the Treatment Administration Record (TAR) dated 7/17/2025 for the day shift indicated Licensed Practical Nurse LPN #1 had signed off that Resident #99 had received his/her shower. Interview and observation with Licensed Practical Nurse (LPN) #2 on 7/17/25 at 3:31 PM identified that Resident #99's fingernails were long and with dark brown debris under the nails. LPN #2 indicated nail care should have been provided with the residents shower during the day and could not explain why the nail care had not been provided. Subsequent to survey inquiry, LPN #2 indicated fingernail care would be provided that evening. Review of the Activities of Daily Living (ADLs), policy directed, in part, residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good grooming and personal and oral hygiene.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical records, facility documentation, facility policy and interviews for 3 of 4 sampled residents (Resident #2, Resident #24, and Resident #45) reviewed for activities, the facility failed to ensure individualized activities were provided to bedbound residents, dependent residents, and failed to ensure activity calendars were revised to reflect actual activities provided. The findings include:1.Resident #2's diagnoses included chronic pain syndrome and pressure induced deep tissue damage of sacral region. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment and was totally dependent on staff for bed mobility, washing, dressing, and did not transfer out of bed.The Resident Care Plan dated 6/9/25 identified that Resident #2 needed socialization and self-directed leisure pursuits to support feelings of fulfillment and empowerment. Interventions included assistance in transportation to activities, provide 1:1 visits that inform resident of current events, offers music, activity packet, and independent leisure activity material as needed.Interview and observation on 7/15/25 at 11:20 AM with Resident #2 identified he/she was lying in bed on his/her right side facing the cubicle curtain. without the benefit of any activities such as music, television, or other sensory stimulation. Resident #2 identified that he/she could not recall the last time someone from the Recreation Department came for a visit. Resident #2 stated that he/she was very particular and liked things a certain way, but activities provided in his/her room were limited.Observation on 7/17/25 at 10:00 AM identified Resident #2 lying in bed without the benefit of any activities such as music, television, or any other sensory stimulation. A review of Resident #2's recreation participation calendar identified all of the available facility recreation programs. For June 2025, out of 30 available days, Resident #2 received 1:1 visits 8 times, had 1 communion visit, and had 1 refusal of activity participation. From July 1 to July 22, 2025, out of 22 available days, 1:1 was provided 6 times with 1 communion visit, and 2 documented refusals.2. Resident #24's diagnoses included osteoarthritis and adjustment disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #24 had a Brief Interview of Mental Status (BIMS) score of 7 indicating severe cognitive impairment and was totally dependent on staff for washing, dressing, and w/c mobility. The Resident Care Plan in effect for June and July 2025 identified Resident #24 had little or no activity involvement and their primary language was Albanian. Interventions included to encourage the resident's family to attend activities with Resident #24 to support participation.A review of Resident #24's recreation participation calendar identified all of the available facility recreation programs. For June 2025, out of 30 available days, Resident #2 received 1:1 visits 10 times, 5 family visits (3 of occurred on the same days as the 1:1) and attended the monthly birthday party. From July 1 to July 22, 2025, out of 22 available days, 1:1 was provided 4 times, 8 family visits (4 on the same days as the 1:1) and attended the July 4th picnic and the monthly birthday party.Observations on 7/15/25 at 10:00 AM and 2:00 PM and on 7/16/25 at 11:30 AM identified Resident #24 sitting in w/c by the nursing station with no activities provided.3. Resident #45's diagnoses included schizoaffective disorder and osteoarthritis. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment and required maximum assistance from staff for bed mobility, washing, dressing, and did not transfer out of bed.The Resident Care Plan dated 6/12/25 identified that Resident #45 preferred self-directed independent activities in the comfort of his/her room. Interventions included TV, listening to music, reading, writing and assistance with telephone and facetime/zoom calls. Interview and observation on 7/15/25 at 11:00 AM, identified Resident #45 in bed with the overbed table in place. He/she was noted to be using copy paper to write. Resident #45 indicated he/she was unable to get out of bed and that he/she had requested a notebook from recreation several times but had not yet received one. Resident #45 could not recall the last time a recreation representative had spent any time in his/room. Observations on 7/16/25 at 1:00 PM and 7/22/25 at 11:30 AM identified Resident #45 laying on his/her back in bed without the benefit of any activities such as music, television, or any other sensory stimulation. A review of Resident #45's recreation participation calendar identified all of the available facility recreation programs. For June 2025, out of 30 available days, Resident #45 received 1:1 visits 8 times and 1 communion visit. From July 1 to July 22, 2025, out of 22 available days, 1:1 was provided 7 times with 1 communion visit, and 1 documented refusal.None of the participation calendars signified what type of 1:1 activity occurred, or the amount of time spent with Resident #2, 24, or 45. 4. During a review of recreation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 5 sampled residents (Resident #2) reviewed for medication administration, the facility failed to follow the physician's orders to obtain a blood sugar level and failed to administer insulin at the correct time and for 1 of 4 sampled residents (Resident #27) reviewed for pressure ulcers, the facility failed to follow a physician's order for wound care. The findings include: Resident #2 ‘s diagnoses included diabetes with ketoacidosis without coma, and long-term drug therapy. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 had a Brief Interview of Mental Status (BIMS) score of 15 indicating no cognitive impairment, required set up assistance with eating, substantial maximum assistance with upper body dressing and personal hygiene, and was dependent for bed mobility. Additionally, Resident #2 received insulin injections for the previous 7 days. The Resident Care Plan dated 6/12/2025 identified diabetes mellitus. Interventions included diabetes medication as ordered. Monitor and document for side effects and effectiveness, monitor, document, and report as needed any signs or symptoms of hyper or hypoglycemia. Physician’s orders in effect for July 2025 directed to check Resident #2’s blood sugar and administer Lyumjev (insulin) 100 units/milliliter (ml) inject 10 units subcutaneously before meals related to type 2 diabetes. Hold the medication if a blood sugar level was less than 90 or less that 25% of a meal was consumed. An additional, separate order directed to provide Lyumjev injection solution 100 units/ml inject per sliding scale: if blood sugar was 150-200 give 2 units, 200-250 give 4 units, 251- 300 give 6 units, 301- 350 give 8 units, 351- 400 give 10 units, 401-459 give 12 units subcutaneously before meals related to type 2 diabetes. Inform the physician for a blood sugar less than 70 or greater than 300. During medication reconciliation on 7/17/2025 at 10:30 AM of Resident #2’s medication regimen, the Medication Administration Record (MAR) failed to indicate that the residents 8:00 AM blood sugar level had been obtained or that the Lyumjev injection had been given. An interview and review of the MAR with LPN #4 on 7/17/2025 at 10:42 AM identified that LPN #4 had not obtained a blood glucose level and had not provided Resident #2 with his/her insulin injection at 8:00 AM as directed. LPN #4 explained that the Assistant Director of Nursing (ADNS) relieved her from her previously assigned unit and reassigned her to Resident #2’s unit at approximately 8:30 AM. Although the supervisor, RN #4, had initially assumed responsibility for Resident #2’s unit he had not passed any medications or conducted any blood sugar testing. LPN #4 stated she knew she was out of compliance for administration, but that RN #4 should have started the medication administration and blood glucose testing prior to her arrival. Subsequent to surveyor inquiry, LPN #4 stated she would check Resident # 2’s blood sugar when it was due again at 12:00 PM. (A subsequent blood sugar test at 12:00 PM identified a result of 275 (normal 70-100 mg/dL.). Interview with the Director of Nursing Service (DNS) on 7/17/2025 at 12:00 PM identified she had not been made aware that Resident #2 had an omission error for checking Resident #2’s blood sugar level and subsequent insulin administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Registered Nurse Supervisor (RN) #4 on 7/17/2025 at 12:28 PM identified that he assumed responsibility for Resident #2’s unit at 7:30 AM due to the originally scheduled nurse’s absence. RN #4 indicated that he had to leave the facility to obtain methadone for a resident because no other nurse, including the ADNS, DNS, or IP was available. RN #4 indicated that he informed both the ADNS and the Administrator that he needed help prior to leaving the facility. RN #4 indicated the shift-to-shift report as well as the MAR was available to any nurse who could have covered Resident #2’s unit in his absence. Subsequent to surveyor inquiry, on 7/22/2025 a Reportable Event document/Medication Error Report created by the DNS identified the missing blood sugar level and missed dose of insulin that had occurred on 7/17/2025. Review of the Medication Administration and Documentation policy directed, in part, medications are to be administered within a 2-hour time frame, i.e. 1 hour before or after the medication order time. Review of the Blood Glucose Monitoring policy dated 2023, directed, in part, the facility will perform blood glucose monitoring as per physician’s orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy, and interviews for 1 of 10 sampled residents (Resident #19) reviewed for Activities of Daily Living (ADLS), the facility failed to appropriately assess a contracture, failed to initiate splint use to prevent potential worsening of a contracture, failed to correctly code the Minimum Data Set (MDS) related to a contracture, and failed to include the contracture in the Resident Care Plan. The findings include: Resident #19's diagnoses included hemiplegia (paralysis) and hemiparesis (weakness) following a stroke, muscle weakness, and limitation of activities due to a disability.Resident #19's quarterly Minimum Data Set (MDS) assessment dated [DATE] identified modified independence with cognitive skills for daily decision making with inattention and disorganized thinking. Further Resident #19 required assistance with eating, partial moderate assistance with dressing, personal hygiene, and transfers. and was independent with bed mobility. The MDS was not coded to indicate a functional limitation in range of motion impairment on one side for the upper extremity.A. The Resident Care Plan (RCP) dated 6/2/2025 identified left sided weakness and difficulty walking. Interventions included providing the assistance of 1 person for transfers and ambulation via a large base quad cane and was independent with wheelchair mobility.Observations on 7/15/2025 at 2:48 PM, 7/16/2025 at 9:20 AM, and 7/16/2025 at 10:15 AM identified Resident #19 with a contracted left hand and wrist, but without the benefit of splint use.Review of the physician orders from 11/18/2024 through 7/16/2025 failed to include use of a splint or a diagnosis for a contracture.Review of the Occupational Therapy (OT) evaluation and plan of treatment documentation dated 11/18/2024 through 1/16/2025 identified Goal #3: Resident #19 would wear the least restrictive splinting/orthotic device 2 hours on 2 hours off without complaints of discomfort and skin irritation in order to maintain joint integrity and maintain joint mobility. There was a left upper extremity impairment with impairment of the shoulder, elbow/ forearm, wrist, and hand. Functional limitations were present due to contracted left fingers, left hand, and left wrist. Recommendations were for orthotics/splinting: it was recommended to further assess and order/fabricate a splint for the left hand in order to manage tone, maintain joint integrity, maintain joint mobility, and increase ability to perform self-care tasks. The OT evaluation failed to include contracture measurements. OT progress notes and OT treatment encounter notes dated 11/18/2024 through 12/10/2024 identified that the splint/orthotic Goal #3 was excluded but failed to identify a reason for the exclusion.An OT Discharge Summary which included dates of treatment from 11/18/2024 through 1/3/2025 failed to indicate why Goal #3: Resident # 19 would safely wear the least restrictive splinting/orthotic device 2 hours on/2 hours off without complaints of discomfort and skin irritation in order to maintain joint integrity and maintain joint mobility was discontinued on 1/3/2025 when Resident #19 was discharged from OT.An interview and record review with the Director of Rehabilitation on 7/22/2025 at 1:20 PM identified Resident #19 did not have a splint for his/her contractures but should have had one in order to prevent worsening of the contractures. The Rehabilitation Director was unable to find documentation that Resident #19's contractures/immobility had been measured (to indicate stability or worsening), or that the resident was unable to tolerate a splint. Although the Director of Rehabilitation indicated Resident #19 had documentation of working with OT, he/she had previously refused to work with OT. The Director of Rehabilitation was unable to provide documentation of any refusals, stating if the resident had refused, the refusals should have been documented in the notes. She indicated that the facility policy directed quarterly screens but was unable to identify why the screens dated 5/6/2025, 7/7/2025 failed to identify that Resident #19 had contractures or that rehabilitation had addressed or provided any splinting. Additionally, she was unable to indicate if a splint had been previously trialed for tolerance or if contracture measurements had been obtained, as there were no rehabilitation notes. Due to a lack of documentation, she could not identify if Resident #19's contractures had stabilized or worsened since being discharged from OT on 1/3/2025. Subsequent to surveyor inquiry, the Director of Rehabilitation indicated that she would request a screen for contracture/Range of Motion (ROM) management and place a referral for Resident #19's splinting needs. B. Resident #19's quarterly Minimum Data Set (MDS) assessment dated [DATE] was incorrectly coded failing to indicate a functional limitation in range of motion impairment on one side for the upper extremity that had been previously documented by OT.C. Review of the Resident Care Plan dated 11/18/2024 to 7/22/2025 failed to identify Resident #19 had a contracture of the left hand.In an interview and clinical record review with RN #2 on 7/23/2025 at 11:52 AM, she identified that the facility had been without a Minimum Data Set

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 6 sampled residents (Resident #6) reviewed for accidents, the facility failed to update the Resident Care Plan with new interventions following falls and failed to complete neurological checks following a fall, for 1 of 4 sampled residents (Resident #27) reviewed for accidents, the facility failed to ensure a safe and effective system was in place during non-medical Leave of Absences (LOA), to account for residents in the event of an emergency, for 1 of 8 sampled residents (Resident #59) reviewed for abuse, the facility failed to follow a physician's order for an assist of 1 staff to keep a resident free from accidents/incidents and for 6 of 31 sampled residents (Resident #1, #31, #33, #85, #91, and #122) reviewed for the environment, the facility failed to maintain an accident free environment for resident with impaired cognition, due to a lack of water temperature monitoring from September 2024 to 7/18/2025. The findings include:1. Resident #6‘s diagnoses included dementia with severe agitation, unsteadiness on feet, and syncope and collapse. The admission Minimum Data Set, dated [DATE] identified Resident #6 had a Brief Interview for Mental Status (BIMS) score of 9 indicating moderate cognitive impairment, required set up assistance with eating, partial moderate assistance with dressing, personal hygiene, and was not assessed for bed mobility, transfer and ambulation. The Resident Care Plan (RCP) dated 1/21/2025 identified Resident #6 was at risk for falls related to gait and balance problems from psychoactive medication use and was unaware of his/her safety needs. Interventions included call bell within reach and encourage use for assistance as needed, prompt response to all requests for assistance, follow fall protocol, and Physical Therapy to evaluate and treat as ordered or as needed. The RCP failed to indicate the level of assistance required for ambulation. A physician’s order dated 1/21/2025 and in effect through May 2025 directed assistance of 1 for out of bed transfers using a rolling walker. Additionally, orders directed to administer quetiapine [an antipsychotic known to cause orthostatic hypotension (low blood pressure)] 25 mg 1 tablet at bedtime for agitation, quetiapine 50 mg give 1 tablet in the morning for agitation, and Mirtazapine 30 mg at bedtime for depression. Review of a Reportable Event dated 3/10/2025 at 7:00 AM identified Resident #6 was found on the bedroom floor. Resident #6 denied pain or injury, the fall was unwitnessed, and the fall protocol and assistance of 1 for activities of daily living for him/her was initiated. It was further identified that Resident #6 was lying in bed prior to fall and was unable to identify the cause of the fall, stating “I was just walking around. A nurse’s note dated 3/10/2025 at 7:12 AM identified Resident #6 was lying on the floor on his/her right side, dressed in a hospital gown, barefoot, had range of motion to all extremities, denied striking his/her head, and was assisted off the floor and back to bed by the charge nurse and the supervisor. Resident #6’s bed was in the lowest position, and he/she was reoriented to use call light for assistance. The Advanced Practice Registered Nurse (APRN) was notified and gave orders to notify the clinician of any changes in condition, monitor neurological checks per protocol, initiate fall precautions, and assess pain per protocol. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #6’s fall risk assessment dated [DATE] identified a score of 80, indicating a high risk for falls. The Resident Care Plan revised on 3/10/2025 identified Resident #6 had an actual fall without injury due to poor balance and unsteady gait. Interventions included a Physical Therapy (PT) consult for strength and mobility. (The clinical record indicated Resident #6 was already receiving PT). A nurse’s note dated 4/2/2025 at 5:59 AM identified Resident #6 was found lying on the floor in a supine (facing up) position and had an unwitnessed fall. Resident #6 was assisted by 2 staff to get up off the floor and his/her blood pressure was noted to be low at 104/50 (normal 120/80). The APRN was notified and gave orders to assess pain, initiate fall precautions, and monitor neurological checks per protocol, notify the clinician of any changes in condition, and indicated there was no need to send Resident #6 to the hospital. A Reportable Event for the 4/2/2025 fall was requested from the facility but never provided. A Fall Risk assessment dated [DATE] at 9:31 AM identified a score of 90 indicating a high risk for falling. Although the Resident Care Plan had an entry dated 4/2/2025 indicating the resident fell, the facility failed to implement a new intervention to prevent future falls, for 7 days, until the RCP was updated on 4/9/2025 to keep the bed in the lowest position. Review of the Reportable Event and fall investigation dated 4/15/2025 at 4:45 AM identified Resident #6 was observed lying on the floor in a supine position and not aware he/she was on the floor. Resident #6’s mental status was at baseline (moderate cognitive impairment). Resident #6 was assessed and transferred back to bed, re-educated and reinforced to use the call bell for assistance. The fall investigation identified Resident #6 did not remember what happened, was forgetful, and staff continued to remind him/her what the call bell was used for and to keep the bed in the lowest position at all times (Repeat RCP interventions for call bell use and to keep the bed in low). An unsigned written statement by NA #9 signed and dated on 4/15/2025 by the supervisor identified Resident #6 was very restless all night, sat up and down in bed 15 times, and around 4:45 AM, tried to stand up on the left side of bed, lost his/her balance, and fell backwards onto the bed causing him/her to roll and gently slid off the right side of the bed. It was further identified that the fall was witnessed, the bed broke his/her fall, Resident #6 did not hit his/her head, and landed on their side. The Resident Care Plan revised on 4/15/2025 identified Resident #6 had a fall without injury due to poor balance, unsteady gait, and hypotension. The interventions included monitor, document, and report as needed for 72 hours for signs or symptoms of pain, bruises, change in mental status, new onset of confusion, sleepiness, inability to maintain posture or agitation, neurological checks per protocol. The Resident Care Plan failed to include a new intervention to prevent future falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Reportable Event dated 5/20/2025 at 2:05 PM identified Resident #6 was lying on the floor in the dining room, his/her mental status was alert to self and place, he/she had a Brief Interview of Mental Status (BIMS) score of 8 which indicated moderate cognitive impairment and required the assistance of 2 people with transfers and assist of 1 in the wheelchair. The APRN was notified and gave orders to hold his/her 5:00 PM dose of Carvedilol (a medication for high blood pressure) related to hypotension (low blood pressure), encourage fluids, transfer Resident #6 to bed and position him/her in the Trendelenburg position, (feet up, head down), perform skin and neurological assessments, perform pain and range of motion evaluations, and notify the family. A nurse’s note dated 5/20/2025 at 3:51 PM identified that at 2:50 PM Resident #6 was observed in a side lying position on the floor in the dining room. Upon assessment he/she denied pain, his/her skin was intact, he/she was able to follow simple commands, and had hand grasps that were strong and equal bilaterally. At the time of the fall Resident #6’s blood pressure was noted to be 74/54 (normal 120/80). The APRN was notified and gave orders to place Resident #6 in bed in the Trendelenburg position and to recheck blood pressure in 20 minutes (20-minute check of blood pressure was 84/61). Resident #6 denied pain or dizziness. New orders directed to hold Carvedilol 3.125 mg one dose only and encourage fluid intake, the conservator was notified. The fall investigation dated 5/20/25 identified Resident #6 was unable to describe the unwitnessed fall related to his/her cognitive impairment and had no skin issues or complaints of pain. The fall risk assessment dated [DATE] at 7:28 PM identified a fall risk score of 75 indicating a high fall risk. Although the Resident Care Plan was revised on 5/20/2025 and identified Resident #6 had an unwitnessed fall, the RCP failed to include a new intervention to prevent Resident #6 from future falls. Review of the clinical record failed to indicate neurological checks had routinely been performed other than 2 entries in the nursing notes, a partial assessment conducted on 5/20/2025 at 3:51 PM noted hand grasps and on 5/20/2025 at 9:23 PM, neurological checks were identified as intact without further information. Although neurological checks were requested no documentation was provided. Interview and record review with the Director of Nursing (DNS) on 7/23/25 at 2:56 PM identified Resident #6 had a subsequent fall on 5/22/2025 and that a new intervention for bilateral floor mats at the bedside was implemented as well as repeating the intervention to keep the bed in a low position. She further stated this was communicated to the staff through the Nurse Aid (NA) care card (directs resident care) and the nurse worksheet. Review of the NA care card and nurse worksheet failed to identify interventions for floor mats or for keeping the bed in low position. The DNS indicated that the Assistant Director of Nursing (ADNS) was responsible for the fall program. An interview on 7/24/2025 at 10:34 AM with RN #3 identified the timeframe to update a RCP should occur immediately, or if on a weekend, on the Monday following the weekend. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and record review with the ADNS on 7/23/2025 at 3:25 PM identified the fall that occurred on 3/10/2025 had a Resident Care Plan intervention to refer to Physical Therapy (PT) however Resident #6 was already working with PT. Review of the fall on 4/2/2025 identified a new intervention had been put in place (late) 7 days post fall and directed the bed be kept in the lowest position. Review of the 4/15/2025 and 5/20/2025 falls failed to identify any new fall prevention interventions had been put in place, and there was no further documentation (other than the 2 nurses notes) of neurological signs being completed for the 5/20/2025 fall. Although monitoring for pain and change of mental status were in place as an intervention for the fall on 4/15/2025, the ADNS indicated this would not prevent any future falls, and the ADNS added that following all falls, a new intervention should have been added to Resident #6’s Resident Care Plan. The ADNS indicated the facility protocol was to review falls during the morning meeting and the At-Risk meeting, however the NA care cards, and Resident Care Plans were not brought to or reviewed during these meetings. Further, the ADNS indicated that she and the supervisors were responsible to initiate a new intervention following each fall and resident assessment, however, she was unable to explain the lack of Resident Care Plan interventions for Resident #6. The ADNS was unable to provide neurological signs following Resident #6’s fall on 5/20/2025. The ADNS indicated that on 5/22/2025 Resident #6 was sent to the emergency room following a fall and abnormal vital sign reading (low blood pressure of 64/22 mmHg, and high pulse) which may have contributed to Resident #6’s fall. Review of the Fall Prevention policy dated 2023 directed, in part, the nurse will evaluate resident risk factors (for falls), and environmental hazards will be evaluated when developing the resident’s comprehensive plan of care. The plan of care will be revised as needed. When a resident experiences a fall the facility will assess the resident, complete a post fall assessment, complete an incident report, notify the physician and family, review the resident’s care plan and update as indicated, document all assessments and actions and obtain witness statements in the case of injury. Review of the Incidents and Accidents policy dated 2023 directed, in part, in the event of an unwitnessed fall or a blow to the head, the nurse will initiate neurological checks as per protocol and document on the neurological flow sheet. Abnormal findings will be reported to the practitioner. Although requested a Resident Assessment Policy was not provided. Review of the Documentation in the Medical Record Policy directed in part that each resident's medical record shall contain an actual representation of the actual experiences of the resident. Review of the Head Injury Policy directed in part to assess the resident following a suspected, known or verbalized head injury by completing a neurological evaluation and continue to do so for 72 hours. 2. Resident #27‘s diagnoses included paraplegia, chronic osteomyelitis, pressure ulcer of the left hip and bilateral feet. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #27 had a Brief Interview of Mental Status (BIMS) score of 14, indicating no cognitive impairment. Resident # 27 required a wheelchair for mobility, was dependent for bathing and all transfers, required maximal assistance with toileting, dressing, personal care, and some assistance with bed mobility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Care Plan dated 5/25/2025 identified Resident #27 was non-compliant with his/her treatment plan. Interventions included educate on the importance of compliance with the plan of care. Interview with Resident #27 on 7/15/2025 at 1:57 PM identified he/she had leave of absence (LOA) privileges but could not independently leave the facility without being “badged out” by a nurse or staff member. Observation on 7/15/2025 at 3:30 PM identified Resident #27 was across and down the street in his/her wheelchair smoking a cigarette. Observation on 7/16/2025 at 8:28 AM identified Resident #27 was alone outside the facility between the upper and lower parking lots, sitting in his/her wheelchair. Observation on 7/17/2025 at 8:24 AM identified Resident #27 was in the lower parking lot, sitting in a wheelchair, smoking a cigarette, and was sitting next to another resident from the facility. Interview with LPN #7 on 7/22/2025, at 12:32 PM identified that Resident #27 regularly went outside of the facility to smoke. When she reviewed Resident #27’s chart, she could not locate a physician’s order for independent LOA. She stated residents should not leave the facility without an LOA order. LPN #7 indicated she did not check to see if Resident #27 had an order because she assumed he/she had one, as Resident #27 had left the facility frequently. She acknowledged it was her responsibility to verify the order before allowing a resident to exit (badge out) the facility and that she should have made sure Resident had a current LOA physician order. Interview with RN #8 on 7/22/2025, at 12:41 PM identified Resident #27 did not have a LOA order. He believed Resident #27 may have had an order in the past but thought the order may have been discontinued months ago when Resident 27’s was discharged to the hospital but must not have been reinstated when he/she returned. RN #8 stated a LOA requires a physician’s order. Further criteria for the LOA included, a resident must be alert, oriented, safe to have LOA privileges, and they must sign the LOA book before leaving the unit. LOA orders were maintained in the electronic medical record and reviewed every three months. He confirmed Resident #27 had not signed out of the facility using the unit sign out LOA book but indicated a second book was kept at the reception desk. Interview with Receptionist #1 on 7/22/2025, at 2:30 PM identified the facility kept one LOA book at the reception desk for residents who left the facility for non-medical reasons. She stated she had no knowledge of an LOA order for Resident #27, nor did she have access to this information in the electronic medical record, or a list of residents with LOA privileges. Receptionist #1 reviewed the July LOA log tracking sheet and found multiple entries that were illegible or missing identifying information, which prevented her from confirming which residents had left the building according to the listings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Recreation on 7/22/2025, at 2:40 PM in the presence of the Administrator identified residents who left the facility for non-medical reasons were required to have a physician’s order. She stated the order would provide guidelines such as the length of time a resident was permitted to be outside. The Director of Recreation reviewed the July 2025 LOA tracker log that was at the receptionist desk and acknowledged that the log lacked pertinent information such as legible time and date information, incomplete information, and there were 2 entries that had no name and only time and date had been completed. Additionally, there were no entries for Resident #27’s observed LOA dates and times. She indicated the system needed to be reviewed as the facility could not identify which residents had left or for how long. She stated that in the event of an emergency, the current system would not allow staff to determine who was off the premises or for what duration. Interview with the DNS on 7/22/2025, at 4:10 PM identified residents who left the facility for non-medical reasons were required to have a physician’s order. She stated she would have expected Resident #27 to have an LOA order in the chart and would have expected nursing staff to verify the order before allowing the resident to leave the facility. Subsequent to surveyor inquiry, staff obtained an LOA order for Resident #27. Review of the Therapeutic Leave policy dated 1/15/2024 directed, in part, the nurse to obtain an order from the practitioner specifying approval of a therapeutic leave. Also, the facility will document in the medical record the resident’s leave of absence. 3. Resident #59’s diagnoses included obstructive hydrocephalus, difficulty in walking, and unspecified vision loss. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #59 had a Brief Interview of Mental Status score of 2 indicating severe cognitive impairment, required supervision or touch assistance for walking 150 feet or more, and was independent for transfers. The Resident Care Plan in effect for June and July 2025 identified Resident #59 had an ADL self-care performance deficit related to altered mental status and hydrocephalus. Interventions included assistance from 1 staff member with the use of a standard single point cane. The physician’s order in effect for June and July 2025 directed for Resident #59 to be assisted by 1 staff member with no assistive device due to confusion and fall risk. Review of Resident #59’s Resident Care Card (nurse aid care provision) directed an independent transfer status and identified Resident #59 was a high risk for falls. The Fall Risk Evaluations dated 5/2/25 identified Resident #59 had a fall risk score of 65, indicating a high risk for falling. The Accident and Incident Report dated 6/17/25 identified Resident #59 sustained a left periorbital bruise classified as an injury of unknown origin. Resident #59’s mental status was confused/forgetful, and physical status was independent with transfers, ambulation (not reflective of the physician order), and eating. The intervention was to apply an ice pack for 15 to 20 minutes as needed for 3 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Accident and Incident Report dated 6/21/24 identified Resident #59 sustained bruising to her/his left shoulder and a bump to her/his head when he/she was witnessed walking independently into the corner of a door while ambulating without assistance from staff. Resident #59’s mental status was alert/confused, and physical status was assistance from 1 staff. The intervention was to send Resident # 59 to the hospital. The Accident and Incident Report dated 7/22/25 identified Resident #59 seated on the floor next to the elevator after an unwitnessed fall and was noted to have been independently ambulating. Resident #59’s mental status was confused/forgetful, and physical status was assistance from 1 staff member. The intervention was to send Resident #59 to the hospital. Observations on 7/15/25 at 11:25 AM, 7/17/25 at 3:43 PM, and 7/22/25 at 11:15 AM identified although staff were in the area, Resident #59 was ambulating independently on the unit without an assistive device or staff assistance. Interview with Nursing Assistant (NA) #4 on 7/23/25 at 12:48 PM identified she was the NA for Resident #59 and that he/she wandered throughout the unit frequently without staff assistance because he/she was independent for ambulation. Interview with Licensed Practical Nurse (LPN) #2 on 7/22/25 at 12:15 PM identified Resident #59 wandered independently throughout the day and would get tired as the day went on, resulting in accidents or incidents. LPN #2 added she was a strong advocate for Resident #59 to be moved to a secure unit due to the shorter length of the hallways. Interview and clinical record review with the Director of Rehab, Physical Therapist (PT) #1 on 7/23/25 at 10:11 AM identified Resident #59 was currently being seen by PT as of 7/10/25 with goals that included leg strengthening, balance and ambulation, and by Occupational Therapy (OT) as of 7/15/25. From 5/21/25 to 7/3/25 Resident #59 was seen by OT but was not referred to PT because he/she was noted to be independent, without an assistive device, for ambulation. Review of the physician’s orders in effect for June 2025 and July 2025 identified that Resident #59 currently had an order to be assisted by 1 staff member meaning that a staff member should be next to the resident when he/she was walking and transferring. PT # 1 stated that for optimal safety the physician’s order originally dated 11/5/24 and in place during the Resident #59’s 2 falls should have been followed. 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. 4. The quarterly Minimum Data Set assessment identified Resident #1, #31, #33, #85, #91, and #122 had a Brief Interview for Mental Status (BIMS) score between 0 and 12, indicating Residents #1, #31, #33, #85, #91, and #122 were mildly to severely cognitively impaired but were independently mobile and could have accessed the resident sink areas with high hot water temperatures readings. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 7/18/2025 at 10:30 AM identified hot water temperatures exceeded 120 degrees Fahrenheit (F) in 15 out of 27 rooms observed. Water temperatures ranged from 120.2-degrees F to 148.5 degrees F. Observation and Interview with the Director of Maintenance on 7/18/2025 at 12:10 PM identified a discrepancy during validation of hot water temperatures between the facility and state surveyors thermometers. The Director of Maintenance utilized an infrared thermometer (typically used to test ambient air temperatures) while the surveyor’s thermometer was a probe type thermometer. During temperature validation testing of the sink in the lower-level staff break room, the state surveyor’s calibrated probe read 132.4 degrees Fahrenheit (F) and the Director of Maintenance infrared thermometer recorded a temperature of 119 degrees F. The facility had failed to monitor water temperatures using a probe type thermometer and had instead relied on an infrared thermometer. Furthermore, the Director of Maintenance identified that the facility had not monitored hot water temperatures since September 2024. He stated that it was the responsibility of his Assistant Maintenance worker to ensure temperatures were routinely checked. Although this task had been delegated to his assistant, the Director of Maintenance indicated that, ultimately, he had the responsibility to ensure the temperatures had been properly monitored. He stated the facility had a daily temperature log, and per the facility protocol, daily temperatures should have been completed. Subsequent to Surveyor inquiry, the facility purchased appropriate temperature monitoring probes and completed a whole house water temperature assessment. The facility also made necessary repairs to the boiler system to mitigate the hot water temperature rising above 120 degrees F. Although a maintenance water monitoring policy was requested, the facility stated they did not have a policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policy, and interviews for 1 of 5 sampled residents (Resident #9) reviewed for unnecessary medications, the facility failed to ensure a pharmacy recommendation for lab work was completed and failed to include interventions in the Resident Care Plan for the occurrence of behavioral issues, other than to use medications. The findings include:Resident #9's diagnoses included schizophrenia, paranoia, and HIV.The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #9 was moderately cognitively impaired and required substantial/maximal assistance with dressing and rolling in bed.A. The Resident Care Plan (RCP) dated 11/29/2024 identified a self-care performance deficit. Interventions included praise efforts, Physical Therapy/Occupation Therapy, and assist of 1 staff with ambulation.Physician's orders in effect from 11/1/2024 and 7/23/2025 directed to administer Dolutegravir lamivudine 50-300 milligrams (mg) 1 tablet by mouth in the morning for HIV.Review of the pharmacy recommendation dated 2/4/2025 requested laboratory work be drawn for the use of the antiretroviral (Dolutegravir) therapy, and then every 6 months thereafter. The physician signed in agreement to the recommendation on 2/7/2025 and a physician's order was written.Interview and review of the clinical record with the Assistant Director of Nursing (ADON) on 7/22/2025 at 11:30 AM identified that when Resident #9 had the physician ordered lab work scheduled to be drawn on 2/7/2025. The lab work was not drawn due to the resident being at an appointment. The ADON indicated that Resident #9's lab work had never been rescheduled to be drawn following the missed appointment. Further, the ADON stated that it was the responsibility of the Registered Nurse Supervisor to ensure the lab work was rescheduled once a lab draw day was missed. Although the ADON indicated that there was a system currently in place to ensure that all lab work had been completed, she was unable to find documentation of lab work oversite. The ADON indicated that going forward a new system would be in place to ensure all lab work was drawn.The facility did not have a policy for laboratory work.B. Review of the RCP dated 11/1/2024 through 7/23/2025 identified the use of an antipsychotic medication but failed to identify alternate interventions to treat behavioral symptoms should the resident experience behavioral issues.The physician's order dated 11/1/2024 through 7/23/2025 directed the use of Seroquel (an antipsychotic).Interview and review of the RCP with the Care Plan Coordinator on 7/23/2025 at 12:16 PM identified that the RCP should include interventions for alternatives to medication use per the requirement. Review of the undated facility Resident Care Plan policy identified that care plans would be modified with new or modified interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, clinical record review, facility documentation, facility policy, and interviews, the facility failed to administer its resources effectively and ensure timely and effective administrative oversight of staff and resident care to maintain the highest practicable physical, mental, and psychosocial well-being of residents. The findings include: The facility administration failed to: Ensure residents were provided with an environment free from verbal abuseEnsure residents were provided with an environment free from involuntary seclusion.Ensure the State Agency was notified, in a timely manner, of events needing to be reported according to the requirement. Ensure allegations of abuse were investigated timely and thoroughly and that staff accused of abuse were removed from the schedule timely. Ensure resident personal needs accounts were managed according to the requirements. Ensure individualized activities were provided to bedbound residents, dependent residents, and failed to ensure activity calendars were revised to reflect actual activities provided.Ensure physician's orders were followed.Ensure the environment was free from accidents due to high water temperatures.Ensure the facility maintained an adequate pest control environment. Please cross reference: F600, F603, F609, F610, F657, F659, F679, F689, and F925. Based on the deficiencies during the survey, actual harm occurred in the area of Freedom from Abuse, Neglect, and Exploitation. Review of the Administrator Job Description signed and dated by the Administrator on 2/24/25, identified that the major purpose of their position was to plan, organize, develop, direct, control and supervise the overall operations of the facility in accordance with applicable federal, state and local laws, regulations, standards and guidelines. Additionally, to direct all departments, delegate authority, responsibility and accountability to department head and supervisor as appropriate, submits Reportable Event reports to appropriate state agencies according to defined procedures, and protects the personal and property rights of all residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	07/24/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of clinical records, interviews, and review of facility documentation and policy for 5 of 15 residents (Residents #8, 57, 68, 108, & 114) reviewed for physical environment, the facility failed to ensure an effective pest control program was maintained to prevent rodents. The findings include:1. Resident #8's diagnoses included multiple sclerosis, type 2 diabetes, and paraplegia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 had a Brief Mental Interview for Mental Status (BIMS) of 15 indicative of intact cognition. Interview with Resident #8 on 7/15/2025 at 12:45 PM identified he/she observed mice and ants on 7/14/2025 in his/her room. Further, Resident #8 stated he did not make anyone aware at the time because everyone knows. 2. Resident #57's with diagnoses included diabetes, post-traumatic stress disorder (PTSD), coronary artery disease, and hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #57 had a Brief Mental Interview for Mental Status (BIMS) of 15 indicative of intact cognition. Interview and observation with Resident #57 on 7/15/2025 at 6:59 PM identified that he/she had seen mice in the room the previous night. A mouse trap was noted to be in the room. 3. Resident #68's diagnosis included cerebrovascular accident (stroke), coronary artery disease, and hypertension. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] identified Resident #68 had a Brief Mental Interview for Mental Status (BIMS) of 15 indicative of intact cognition. Interview with Resident #68 on 7/16/2025 at 11:49 AM identified that mice come out of the radiator hole in the room and that the facility was aware. Further the resident noted that a mouse had just been present in the unit hallway. 4. Resident #108's diagnosis included diabetes, heart failure, kidney transplant failure, and dependence on hemolytic treatments. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #108 had a Brief Mental Interview for Mental Status (BIMS) of 14 indicative of intact cognition. Interview and observation with Resident #108 on 7/15/2025 at 7:30 PM identified that the resident observed mice in his room and a mouse trap was present. 5. Resident #114's diagnosis included spina bifida, neurogenic bladder, depression, and bipolar disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #114 had a Brief Mental Interview for Mental Status (BIMS) of 15 indicative of intact cognition. Interview with Resident #114 on 7/15/2025 at 11:10 AM identified he/she observed mice in the room every night. Interview and observation with Resident #114 on 7/16/2025 at 10:45 AM identified that mice were typically observed by the garbage can and under the radiator, but no one had come into the room to install traps. In the corner of Resident #114's room an area of numerous small, black granular pellets approximately the size of grains of rice was observed under the radiator between the wall and the dresser. Interview with Licensed Practical Nurse (LPN) #4 identified that mice are seen on day shift, but that it is mostly nights that they are a problem. Further, LPN #4 identified that although the facility has attempted to treat the issue, the mice continue to run around the floor. Interview with Person #3 on 7/17/2025 at 9:50 AM identified that pest control is provided weekly, but they have not been asked to do resident rooms. Further, Person #3 identified that three (3) mice were caught on the 2nd floor during the 7/17/2025 visit. Person #3 noted that the facility has been told about structural deficiencies since August 2024 however no repairs have been made. Person #3 noted that radiator pipes needed to be sealed so rodents could not enter and that the facility was instructed to keep the ambulance entrance dock area doors closed as a preventative measure, however he always observed the doors open. Further, Person #3 stated closing the dock doors was a behavioral change to prevent rodents, not a structural issue. Interview with Nurse Aide (NA) #10 On 7/15/2025 at 2:10 PM identified that on 7/4/2025 on the 3:00 PM to 11:00 PM shift she saw what she believed to be a rat jumping off a resident wheelchair. NA #10 stated he/she began to record the encounter with a cell phone. Further, NA #10 stated they notified another NA on the unit, whose name she did not know, but they brushed it off, stating that rodents were always there. NA #10 identified that he/she made the decision to leave the facility prior to the end of shift due to feeling uncomfortable with the physical environment. Review of the facility contracted pest management Service Inspection Reports dated 6/13/2025 through 7/10/2025 identified that pest control services were provided weekly and noted the presence of mice in the facility at each visit. The Service Inspection Report for 7/10/2025 included notation that on 8/29/2024 it was reported to the facility that an exterior emergency exit door was not rodent proof with a severity level of High and recommended adding or replacing the door sweep. The report noted that this concern was last reviewed with the facility on 5/29/2025. Additionally, the