

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  395623	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/03/2025
NAME OF PROVIDER OR SUPPLIER  Grandview Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  78 Woodbine Lane Danville, PA 17821	

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.  (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0580  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on a review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to notify the attending physician of a significant change in condition for one of nine residents reviewed (Resident CR1). This failure resulted in a delay in physician notification following a documented decline in the resident ' s physical and mental condition. Findings include: Review of the facility policy titled Acute Changes in Condition: Policy/Clinical Protocol last reviewed by the facility on January 23, 2025, revealed the facility shall identify a sudden, significant deterioration in the resident's baseline health status including identifying potential changes, reporting the changes, conducting a thorough assessment, implementing necessary interventions and communicating with the resident, family and healthcare providers, with the goal of addressing the change promptly and monitoring to prevent further complications. The facility shall manage acute changes in condition, and notify the resident, his or her attending physician, and representative of the change. A review of the clinical record revealed Resident CR1 was admitted to the facility on [DATE], with diagnoses that included polyosteoarthritis (a degenerative joint disease that affects multiple joints), osteomyelitis of the vertebra (infection of the bones of the spine), spondylosis of the lumbosacral region (degenerative changes that affect the lower back and base of the spine), and muscle weakness. A review of a quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 2, 2025, revealed that Resident CR 1 was severely cognitively impaired with a BIMS score of 6 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 0-7 indicates severe cognitive impairment). Nursing documentation dated September 22, 2025, at 4:47 AM, revealed that Resident CR1 experienced an unwitnessed fall after rolling out of bed and was found face down on the floor wrapped in blankets. The note indicated the resident complained of forehead pain. The nurse documented swelling to the right forehead, and ice was applied to reduce the swelling. The note further described that although no bruising was noted, the forehead presented with a scant, faint pink raised area measuring approximately 2 centimeters by 2 centimeters. The left inner forearm was documented as having a purple bruise measuring approximately 2 centimeters by 3 centimeters in the shape of a Y. The entry indicated the medical doctor (MD) was notified, the resident ' s responsible party (RP) was to be made aware, and that the resident ' s vital signs and neurological checks were within normal limits. Nursing documentation dated September 24, 2025, at 11:25 AM, revealed the licensed practical nurse (LPN) reported a change in mental status for Resident CR 1. The resident was repeatedly asking Where am I? over and over and reported a headache. The PA (physician assistant) was at the bedside for an assessment. Nursing documentation at 2:58 PM the same day revealed the resident had increased confusion and complained of pain in her head and neck. Her blood pressure and heart rate were elevated. The PA was notified and ordered clonidine 0.1 mg and an x-ray of the cervical spine. The nursing notes dated September 25, 2025, at 4:15 AM and 1:48 PM, revealed the resident continued to complain of head and neck pain. X-ray by mobile x-ray company completed at 11:50 AM. Review of the x-ray report dated September 25, 2025, at 12:39 PM revealed no acute fracture or subluxation (misalignment of bones) by plain radiography (plain x-ray) of the cervical area. Dorsal hardware (surgical implants placed on the back of the neck to stabilize) were noted at the cervical region at C3-C7. Nursing documentation dated September 27, 2025, at 1:08 AM, revealed the resident complained, Nurse, my head hurts and I get dizzy when they roll me. Nursing documentation dated September 29, 2025, at 6:40 PM revealed staff spoke with the resident ' s daughter on the telephone regarding the x-ray results. The daughter reported that her mother was complaining of head and neck pain. The daughter was concerned about her mother being in pain. Nursing documentation dated September 30, 2025, at 9:26 AM revealed Tramadol 50 mg (opioid pain medication) was ordered. On October 7, 2025, at 8:30 AM, nursing documentation revealed the resident spit out all medications, and the RN Supervisor was notified. Documentation at 11:46 AM revealed the resident was yelling out, complaining of pain, spitting out food and medications, and refusing fluids and noted to have a general decline. The RN Supervisor and Certified Registered Nurse Practitioner (CRNP) were notified. At 1:52 PM, a new order was received to change the resident ' s transfer status from assist of two with a rolling walker to total dependence with use of a mechanical lift (a hydraulic device that raises and transfers residents using a sling). A message was left for the resident ' s daughter. Documentation at 2:15 PM</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on a review of clinical records, select facility policy, and staff interviews, it was determined that the facility failed to develop and implement a comprehensive, person-centered care plan that reflected individualized fall-prevention interventions for one of ten sampled residents (Resident 2). Findings include: A review of the clinical record revealed Resident 2 was admitted to the facility September 22, 2022, with diagnoses including dementia (a condition characterized by a progressive loss of cognitive function including memory, intellectual ability, and decision making).A quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated September 19, 2025, documented Resident 2 demonstrated fluctuating attention and focus, and was easily distractible Resident 2 had a BIMS score of 00 (Brief Interview for Mental Status, a tool to assess the residents' attention, orientation, and ability to register and recall new information). A BIMs score of 00 indicates severe cognitive impairment, meaning the resident requires extensive assistance with daily decision-making and memory recall. The MDS also documented that Resident 2 required supervision and touching assistance for transfers and ambulation and required a walker for ambulation.A review of the facility policy titled Comprehensive Care Planning (last reviewed and revised January 2025) revealed that the interdisciplinary team (IDT), comprising nursing, therapy, dietary, and social service staff, is responsible for developing, implementing, and monitoring an individualized baseline and comprehensive care plan for each resident to ensure coordinated care across all disciplines.A review of clinical records associated fall investigation documentation, and interview with Employee 1 (Certified Nursing Assistant) on October 22, 2025, at 11:14 AM, revealed that Resident 2 sustained a fall on October 11, 2025, at 10:35 AM. According to Employee 1, prior to the fall, Resident 2 was in the dining room with her walker and exited the dining area quickly without it. Employee 1 assisted the resident back to her room, helped her with toileting, and then seated her on the bed to engage in scrapbooking activities. Employee 1 returned to the dining room to retrieve the resident ' s walker but was momentarily redirected to assist another resident. During that brief period (approximately 10 minutes), Resident 2 ' s cousin entered the room, noticed the walker was missing, and went to retrieve it. Resident 2 then attempted to follow her cousin without the walker and fell. The resident was subsequently transferred to an acute-care hospital, where she received three sutures to the forehead and underwent surgery on October 12, 2025, to repair a right hip fracture, as confirmed by review of the acute-care hospital records.The interview with Employee 1 nurse aide (NA) on October 22, 2025, at 10:35 AM, in the presence of the Director of Nursing (DON), confirmed Resident 2 is impulsive and is known to forget her walker when ambulating. Employee 1 (NA) stated that she has cared for Resident 2 since her admission and often anticipates the resident ' s needs to ensure safety.A review of Resident 2 ' s comprehensive care plan (initiated September 22, 2022) identified that the resident was at risk for falls related to impaired mobility and impaired safety awareness, yet the care plan failed to specify individualized interventions to keep the resident ' s walker within reach or to address the resident ' s known pattern of forgetting to use the walker. The absence of this specific intervention resulted in a failure to develop a plan that reflected Resident 2 ' s cognitive deficits, established behavior patterns, and identified safety needs.The information regarding Resident 2's care plan and lack of interventions to include resident-specific interventions addressing her safety needs related to ambulation and known history of forgetting to use her walker was reviewed with the Nursing Home Administrator on October 22, 2025, at 1:38 PM.28 Pa. Code 211.10 (d) Resident care policies.28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.</p>		

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F 0686  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing.  (continued on next page)

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on a review of clinical records, facility policy, and staff interviews, it was determined that the facility failed to implement planned interventions and provide necessary treatment and services to prevent the worsening of a pressure ulcer for one resident out of four residents reviewed for pressure ulcer care (Resident CR1). Findings include: According to the US Department of Health and Human Services, Agency for Healthcare Research &amp; Quality, the pressure ulcer best practice bundle incorporates three critical components in preventing pressure ulcers: comprehensive skin assessment, standardized pressure ulcer risk assessment, and care planning and implementation to address the areas of risk. The American College of Physicians (ACP) is a national organization of internists who specialize in the diagnosis, treatment, and care of adults. Clinical Practice Guidelines indicate that the treatment of pressure ulcers should involve multiple tactics aimed at alleviating the conditions contributing to ulcer development (i.e., support surfaces, repositioning, and nutritional support); protecting the wound from contamination and creating and maintaining a clean wound environment; promoting tissue healing via local wound applications, debridement, and wound cleansing; using adjunctive therapies; and considering possible surgical repair. Review of the facility policy titled Pressure Ulcers/Skin Breakdown, Clinical Protocol, last reviewed by the facility on January 23, 2025, revealed that residents will be evaluated for the risk for skin breakdown on admission and re-admission to the facility. After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment. Nursing staff will monitor response to interventions through weekly skin evaluations, skin inspections during routine care and weekly showers/baths and modifications to interventions will be made when indicated. The practitioner will evaluate and document the progress of wound healing, especially for those with complicated, extensive, or poorly-healing wounds. The practitioner will guide the care plan as appropriate, especially when wounds are not healing as anticipated or new wounds develop despite existing interventions. A review of the clinical record revealed Resident CR1 was admitted to the facility on [DATE], with diagnoses that included polyosteoarthritis (a degenerative joint disease that affects multiple joints), osteomyelitis of the vertebra (infection of the bones of the spine), and muscle weakness. A review of Resident CR1's quarterly Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated July 2, 2025, revealed that Resident CR1 was severely cognitively impaired with a BIMS score of 6 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 0-7 indicates severe cognitive impairment). The MDS also identified that the resident required moderate to maximal staff assistance for daily activities, was at risk for pressure injuries, and was always incontinent of bowel and bladder. The care plan initiated December 3, 2020, included interventions to prevent skin breakdown such as repositioning every two to three hours, keeping linens clean and wrinkle-free, checking and changing the resident for incontinence every two to three hours, using a gel-matrix wheelchair cushion with Dycem (a non-slip material), and maintaining a low air loss mattress on the bed. A review of the resident's care plan initiated December 3, 2020, identified a focus area related to the potential for alterations in skin integrity and pressure with planned interventions to prevent skin breakdown such as repositioning every two to three hours, perform weekly skin integrity checks on bath day, keeping linens clean and wrinkle-free, checking and changing the resident for incontinence every two to three hours, using a gel-matrix wheelchair cushion (wheelchair cushion designed to provide pressure redistribution) with Dycem (a non-slip material placed on the seat of the wheelchair), and maintaining a low air loss mattress on the bed. A review of nursing documentation dated August 3, 2025, at 11:21 AM revealed Resident CR1 had developed an open area to the left gluteal fold (the crease separating the buttocks from the upper thigh). No wound measurements were documented. Review of the facility's weekly skin observation records revealed no documentation that weekly skin assessments were completed between July 16 and August 11, 2025. During this interval, the resident developed the open area to the left gluteal fold. Review of the Wound Assessment Report dated August 8, 2025, completed by the wound care consultant, described the wound as an abrasion to the left gluteal fold (it was originally documented as the right gluteal fold however the wound care consultant</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on a review of clinical records, select facility policy, and staff interviews, it was determined that the facility failed to implement procedures to ensure the timely acquisition and administration of prescribed medications for one of twelve sampled residents (Resident CR2). Findings include: A review of the facility policy titled Administering Medications, last reviewed January 23, 2025, revealed medications should be administered in a safe and timely manner, and as prescribed. Further review revealed that medications must be administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meals). A review of the clinical record revealed that Resident CR2 was admitted to the facility on [DATE], with diagnoses that included bipolar disorder (a mental health condition that causes unusual shifts in mood, energy, and activity levels) and major depressive disorder (a mental health condition characterized by persistent low mood, lack of energy, poor concentration, and changes in sleep or appetite). A review of an admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment process conducted periodically to plan resident care) dated September 28, 2025, revealed that Resident CR2 was cognitively intact with a BIMS score of 13 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13-15 indicates cognition is intact). A review of the clinical record for Resident CR2 revealed a physician's order dated September 22, 2025, for Lamotrigine 25 milligrams (mg), one tablet, to be given with a 200 mg tablet to equal 225 mg, at bedtime for bipolar disorder. Review of the Medication Administration Record (MAR) for September 2025 revealed that on September 22 for the 9:00 PM dose, the entry was blank, indicating no documentation that the medication was given or omitted. On September 23, the MAR entry was coded to see nurse ' s note, which indicated the medication was not available and was awaiting delivery from the pharmacy. A review of the clinical record for Resident CR2 revealed a physician's order dated September 22, 2025, for Olanzapine 10 mg, one tablet, to be given with a 2.5 mg tablet to equal 12.5 mg, at bedtime for bipolar disorder and Olanzapine 2.5 mg, one tablet, to be given with a 10 mg tablet to equal 12.5 mg, at bedtime for bipolar disorder. Review of the MAR revealed blank entries for September 22, and for September 23 and September 24 the nurse ' s notes indicated that the medications were not available and were awaiting pharmacy delivery. A review of the clinical record for Resident CR2 revealed a physician's order dated September 22, 2025, for Clonazepam 2 mg, one tablet at bedtime, for bipolar disorder and generalized anxiety. Review of the MAR for September 24 revealed the 9:00 PM entry was blank with no indication that the medication was given or omitted. A review of the clinical record for Resident CR2 revealed a physician's order dated September 22, 2025, for Lithium 150 mg (one tablet) and Lithium 300 mg (two tablets) to be given together for a total dose of 750 mg at bedtime for bipolar disorder. Review of the MAR for September 24 revealed blank entries with no documentation that the medications were administered. A review of the clinical record for Resident CR2 revealed a physician's order dated September 22, 2025, for Simethicone 20 mg before meals and at bedtime for gas relief. Review of the MAR revealed that on September 25 at 9:00 PM and on September 26 at 7:30 AM and 11:30 AM, the nurse ' s notes stated the medication was not available and the facility was awaiting delivery from the pharmacy. A review of the clinical record for Resident CR2 revealed a physician's order dated September 22, 2025, Cefepime 1 gram (IV into a vein) three times daily for pneumonia (an infection of the lungs). Review of the MAR for September 2025 revealed delayed administration times, including the 10:00 PM dose on September 22 given at 2:11 AM on September 23 (a 4-hour delay) and the 10:00 PM dose on September 27 given at 12:37 AM on September 28. An interview with the Nursing Home Administrator (NHA) on October 3, 2025, at 2:00 PM, revealed that there had been a misunderstanding between the nursing staff and the pharmacy regarding medication availability. The NHA acknowledged the facility did not ensure medications were obtained and administered in a timely manner as prescribed for Resident CR2. The facility failed to ensure prescribed medications were acquired and administered in a timely manner for the resident. (Resident CR2). 28 Pa. Code 211.12 (d)(1)(5) Nursing services. 28 Pa Code 211.10 (a)(c) Resident care policies. 28 Pa Code 211.9 (c)(k) Pharmacy services. 28 Pa Code 211.5(f)(x) Clinical records.</p>		