STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395623	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Nursing and Rehabilitation	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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (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 0554 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 observation, review of select facility policy and clinical records, and staff and resident interviews, it was determined that the facility failed to assess and determine a resident's capability to self-administer medications for one of 13 residents reviewed (Resident 1).Findings include: A review of the facility policy titled Self-Administration of Medications, last reviewed September 2025, revealed that residents have the right to self-administer medications if the interdisciplinary team determines it is clinically appropriate and safe. The policy required:Residents who express the desire to self-administer medications will be assessed to determine ability to self-administer medications.In addition to the general evaluation of a resident's decision-making capacity, the nursing staff will perform a more specific skill assessment, including (but not limited to) the resident'sability to read and understand medication labels.The comprehension of the purpose and proper dosage and administration time for his or her medications.Comprehension of the purpose and proper dosage and administration time for his or her medications.The ability for safe storage of medications.If the team determines that a resident cannot safely self-administer medications, the nursing staff will administer the resident's medicationsFor self-administering residents, the nursing staff will determine who will document medication administration.If the resident is able and willing to take responsibility for documenting their self-administration of medications, the resident will be instructed on how to complete a record indicating the administration of the medication.Self-administered medications must be stored in a safe and secure place, which is not accessible to other residents. A review of Resident 1's clinical record revealed admission on [DATE], with diagnoses including aftercare following abdominal surgery, asthma (a chronic respiratory condition), anxiety, and depression. A review of an admission Minimum Data Set assessment (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated October 20, 2025 revealed a BIMS score of 15 (brief interview for mental status, a tool to assess the residents attention, orientation and ability to register and recall new information, a score of 13-15 equates to being cognitively intact). A physician's order dated October 14, 2025, included the following medications:Bupropion HCL extended release 150 mg and 300 mg (antidepressant medications)Acidophilus 1 capsule twice daily (digestive aide)Docusate Sodium 100 mg twice daily (stool softener)Gabapentin 600 mg twice daily (antiseizure medication also used for nerve pain)Topiramate 100 mg twice daily (antiseizure medication also used for migraine prevention)Budesonide inhalation suspension 0.5 mg/2 ml once daily (inhaled corticosteroid for asthma) A physician's order dated October 15, 2025, included:Alfuzosin extended release 10 mg daily (treatment for enlarged prostate)Vitamin B2 100 mg tablets, four daily (nutritional supplement)Folic Acid 400 mcg, two tablets daily (nutritional supplement)Loratadine 10 mg daily (antihistamine used for allergies)Multivitamin one daily (nutritional supplement)Potassium Chloride extended release 20 mEq daily (electrolyte replacement)Senna 8.6 mg, two tablets daily (laxative medication)Sertraline HCL 100 mg, three tablets daily (antidepressant medication)Singulair 10 mg daily (medication for asthma or allergies)Spironolactone 25 mg daily (diuretic medication) A physician's order dated October 25, 2025, included:Ciprofloxacin HCL 500 mg one by mouth twice daily (antibiotic medication)During an observation and interview with Resident 1 on December 4, 2025, at 10:15 AM, the resident was seated on the side of the bed with an overbed table positioned in front of him. A plastic medication cup containing 22 pills was observed on the table. A respiratory nebulizer machine (a device used to deliver inhaled medications) was on the top of the dresser in front of the resident. The nebulizer cup already contained Budesonide inhalation solution, prepared and ready for administration. Resident 1 stated that nursing staff sometimes left his medications at the bedside and sometimes remained with him during administration. He stated that he planned to take the respiratory treatment after completing his morning care. During an interview on December 4, 2025, at approximately 10:30 AM, Employee 1 stated that she had left the medications and the prepared respiratory treatment at Resident 1's bedside. Employee 1 stated that she viewed the resident as cognitively intact and able to take his medications independently. She was not able to confirm that a required self-administration assessment had been completed or approved for Resident 1. During an interview on December 4, 2025, at 1:00 PM, the Director of Nursing stated that the resident's clinical record did not contain a current physician order authorizing self-administration, did not contain a self-administration assessment, and did not contain a care plan indicating that Resident 1 self-administers his medications. 28 Pa. Code: 211.9(a)(1)(k) Pharmacy services. 28 Pa Code 211.10 (c) Resident care

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of select facility policy, resident grievance forms, and resident and staff interviews, it was determined that the facility failed to make prompt and adequate efforts to resolve ongoing resident complaints regarding delayed call bell response times expressed during interviews, including those voiced by four of four residents interviewed. (Residents 1,3,4 and 5).Findings include: A review of a facility policy titled Grievance Policy, last reviewed in January 2025, revealed it is the policy of the facility to ensure each resident has the ability to communicate grievances/concerns to appropriate facility staff for proper and timely follow up according to regulation and resident rights.A review of a quarterly Minimum Data Set assessment for Resident 5 (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated November 12, 2025 revealed a BIMS score of 14 (brief interview for mental status, a tool to assess the resident's attention, orientation and ability to register and recall new information, a score of 13 to 15 equates to being cognitively intact) A review of a written grievance submitted by Resident 5 dated November 9, 2025, revealed the resident reported waiting two hours for a nurse aide to return to her room to assist with setting up her bedside table and electronic tablet and headphones. The grievance included additional concerns about care issues. The grievance record indicated the complaint was listed as resolved on November 14, 2025, with the corrective action identified as staff education regarding answering call bells in a timely manner. During an interview on December 4, 2025, at 11:00 AM, Resident 5, a competent resident (competent meaning capable of making her own decisions and accurately reporting her experiences) residing on the Pavilion unit, stated she continues to wait more than 30 minutes at times for staff to answer her call bell.A review of an admission MDS for Resident 1 dated October 20, 2025, revealed a BIMS score, of 15. During an interview on December 4, 2025, at 10:00 AM, Resident 1, a competent resident residing on the west unit, complained that staff do not answer call bells in a timely manner on all shifts. The resident stated that he waits for more than 30 minutes for his call bell to be answered.A review of a quarterly MDS for Resident 3 dated October 30, 2025, revealed a BIMS score, of 14. During an interview on December 4, 2025, at 10:15 AM., Resident 3, a competent resident residing on the west unit, complained that staff do not answer call bells in a timely manner on all shifts. The resident stated that he waits for more than 30 minutes to sometimes up to 2 hours for his call bell to be answered.A review of a quarterly MDS for Resident 4 dated November 12, 2025, revealed a BIMS score, of 14. During an interview on December 4, 2025, at 9:30 AM, Resident 4, a competent resident residing on the west unit, complained that staff do not answer call bells in a timely manner on all shifts. The resident stated that she waits for more than 30 minutes for her call bell to be answered. The facility did not demonstrate that residents' repeated concerns regarding delayed call bell response times had been effectively resolved, despite a prior written grievance and multiple verbal grievances voiced during resident interviews conducted during the survey. Delayed call bell response impacts timely access to assistance with basic needs, including toileting, mobility, and safety.During an interview with the Nursing Home Administrator (NHA) on December 4, 2025, at 2:00 PM, the NHA was unable to provide documented evidence that the facility followed up with residents to determine whether the corrective actions taken in response to their complaints were effective in resolving ongoing concerns about call bell response times. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.29(a)(b) Resident Rights. 28 Pa. Code 211.10 (c) Resident care policies.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, resident and staff interviews, and review of the facility's meal service schedule, it was determined that the facility failed to consistently maintain sufficient staffing in the dietary department to effectively and efficiently carry out the functions of the food and nutrition service department. This failure resulted in delayed meal service and meals not served at palatable temperatures for residents on the East unit.Findings include:A review of resident interviews conducted on December 4, 2025, revealed multiple concerns about the timeliness and palatability (how acceptable food is to eat based on taste, smell, texture and serving temperature) of meals. Resident 8, interviewed at 10:15 AM, reported meals were often late by an hour or more and served cold and unpalatable.Resident 9, interviewed at 10:35 AM, stated that over the last several weeks, meals, especially dinner, were generally thirty minutes or more past the scheduled time and were ice cold and unpalatable. The resident's visitor reported bringing food from the minimart at times out of concern for the resident's timely nutritional intake, noting the resident received insulin and did not want their blood sugar to drop. (Insulin is a hormone used to lower blood sugar; a delay in eating after receiving insulin may increase the risk of low blood sugar.)Resident 10, interviewed at 11:25 AM, stated meals were never served hot or palatable and that dietary was short staffed. Additional interviews with nursing staff conducted on December 4, 2025, at 12:00 PM, revealed staff reported the meal carts were consistently delivered late to the nursing units. Staff requested anonymity. A document titled Times Meals Arrive at Units revealed that the first cart of lunch trays was expected to arrive at the East unit at 11:30 AM.An observation of the East unit lunch tray pass on December 4, 2025, at 11:30 AM, revealed that the first meal cart was scheduled to arrive at that time. The meal cart did not arrive until 12:23 PM, fifty-three minutes past the scheduled arrival time. Unit staff immediately began passing trays. The final resident tray was passed at 12:33 PM.A test tray (a tray pulled to assess temperature and palatability for quality control) was removed from the meal cart on December 4, 2025, at 12:33 PM. After the last resident received their meal. Temperatures were recorded as follows:Beef tips: 109.9 degrees FahrenheitGarden rice: 108.5 degrees FahrenheitMixed vegetables: 118.2 degrees FahrenheitBrownie: 72.1 degrees Fahrenheit Meals intended to be served hot are expected to be maintained at a sufficiently warm temperature, so they remain palatable to residents. A taste analysis revealed the beef tips, garden rice, and mixed vegetables were lukewarm and not served at a palatable temperature. The rice and vegetables were unseasoned and bland. The brownie was palatable. A review of the dietary department's schedule for breakfast and lunch on Thursday, December 4, 2025, revealed one AM cook, one prep cook, and four dietary aides. However, two 7AM-3PM dietary aides were scheduled off and not replaced due to lack of available staff, and no additional prep cook was available to fill the open position. Also, the dietary manager was the manager during day shift and working as the PM cook. The facility failed to provide adequate staffing levels in the dietary department to meet the needs of their current census at 168 residents as evidence of observed untimely meal delivery and unpalatable meals served. An interview with the Nursing Home Administrator on December 4, 2025, at 1:45 PM, revealed the dietary department had experienced staffing turnover. The NHA indicated the facility had been attempting to hire additional dietary staff and acknowledged ongoing concerns related to staffing levels. The facility failed to maintain sufficient dietary staff to prepare and serve meals in a timely manner and ensure meals were consistently served at palatable temperatures in accordance with regulatory requirements. Cross Ref. F80428 Pa. Code 201.14(a)(b) Responsibility of licensee.28 Pa. Code 201.18 (b)(1) Management.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, resident and staff interview, and test tray results, and food committee minutes, it was determined that the facility failed to serve meals that were palatable, attractive, and at safe and appetizing temperatures for a test tray completed on East Unit during the lunch room tray service.Findings included: According to the federal regulatory guidance at 483.60(i)-(2) Food safety requirements the definition of Danger Zone, found under the Definitions section, is food temperatures above 41 degrees Fahrenheit and below 135 degrees Fahrenheit that allow rapid growth of pathogenic microorganisms that can cause foodborne illness. A review of a facility evaluation form titled Meal Evaluation Form -Temperatures revealed that hot food items were assessed based on being greater than or equal to 120 degrees Fahrenheit and on palatability. Palatable means acceptable to taste, including appropriate temperature, texture, and flavor. A review of the facility's Menu Committee meeting minutes dated November 5, 2025, indicated residents reported that food was being served cold. A review of a grievance form filed by Resident 7, dated November 25, 2025, revealed Resident 7, who was cognitively intact, reported the turkey cutlet served was burnt and inedible and the green beans had no flavor. Interviews conducted on December 4, 2025, with alert and oriented residents on both the East and [NAME] Units revealed consistent concerns that meals arrived late to the units and were frequently unpalatable due to being served cold. These residents stated the dietary department was short staffed, resulting in delayed meal carts.A review of the facility's meal cart delivery schedule revealed that the East Unit lunch cart was scheduled to arrive on the unit at 11:30 AM.A review of the planned lunch menu for Thursday, December 4, 2025, revealed the main entree was breaded fish, and the alternate meal was beef tips with beef gravy, mixed vegetables, garden rice, and a brownie.An observation of the lunch tray pass on the East Unit on December 4, 2025, beginning at 11:30 AM, revealed that the meal cart scheduled for that time did not arrive on the unit until 12:23 PM, which was fifty-three minutes past the scheduled delivery time. Unit staff immediately began passing meal trays at that time.The final resident meal tray was provided at 12:33 PM. A test tray was then obtained from the meal cart, and the following food temperatures were recorded:Beef tips were served at 109.9 degrees FahrenheitGarden rice was served at 108.5 degrees FahrenheitMixed vegetables were served at 118.2 degrees FahrenheitBrownie was served at 72.1 degrees FahrenheitA taste analysis of the test tray revealed the beef tips, garden rice, and mixed vegetables were lukewarm and not palatable in temperature or flavor. The rice was hard, crunchy, and bland. The mixed vegetables were unseasoned and bland. The brownies were served palatable.The facility did not deliver the lunch meal to the East Unit at the scheduled time and did not ensure the meal was served at temperatures and flavors that were palatable.An interview with the Nursing Home Administrator on December 4, 2025, at 1:45 PM indicated the results of the test tray were reviewed and that resident meals were expected to be served timely and at palatable temperatures and flavors. 28 Pa. Code 201.14(a)(b) Responsibility of licensee. 28 Pa. Code 201.18 (b)(1) Management.