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	07/18/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and facility provided investigative documentation, the facility displayed past non-compliance by failing to protect one of 32 sampled residents (Resident 25) from neglect by not implementing the individualized care plan intervention for transfers, resulting in actual harm in the form of a left tibial periprosthetic fracture.Findings include: A review of the facility policy titled “Abuse Prevention Program,” last reviewed by the facility in January 2025, revealed it is the facility’s policy that residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The policy indicates that as part of abuse prevention, the administration shall protect the residents from abuse from anyone, including but not limited to facility staff and other residents. Also, the policy indicates the facility will implement measures to address factors that may lead to abusive situations, for example, providing staff with opportunities to express challenges related to their job and work environment without reprimand or retaliation. A clinical record review revealed Resident 25 was admitted to the facility on [DATE], with diagnoses that include chronic heart failure (a condition that occurs when the heart can't pump enough blood to the body) and polyosteoarthritis (a condition when at least five joints are affected with inflammation). Further clinical record review revealed Resident 25 had a care plan to address activities of daily living (ADLs fundamental care tasks such as bathing, dressing, and transferring) initiated on January 17, 2025. Interventions implemented to assist Resident 25 with her goal of receiving assistance necessary to meet her ADL needs specifically required use of a Hoyer lift (a mechanical device used to transfer persons with limited mobility) with two staff to complete all transfers. A physician’s order also confirmed this requirement as of January 17, 2025. A review of a quarterly Minimum Data Set assessment (MDS a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 19, 2025, revealed that Resident 25 was cognitively intact with a BIMS score of 15 (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). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A witness statement dated June 12, 2025, provided by Employee 1, Nurse Aide (NA), revealed that on June 12, 2025, Employee 1 was transferring Resident 25 when she heard a crack and reported it to the nurse. Employee 1, NA, explained when she repositioned Resident 25’s legs, she heard the crack. Employee 1, NA, documented that “I transferred her myself because I couldn’t find anyone. I know you’re supposed to have two people for the lift. I feel really bad for what I did. I wouldn’t ever hurt any residents on purpose.” A witness statement dated June 12, 2025, provided by Employee 2, Licensed Practical Nurse (LPN), revealed that on June 12, 2025, at approximately 2:45 PM, Employee 1, NA, made her aware that during a transfer she heard the resident’s knee “pop.” Resident 25 initially presented with no swelling, pain, or discoloration. Employee 2, LPN, indicated that on a follow-up observation on June 12, 2025, at 3:20 PM, Resident 25 presented with swelling to the left knee and reported pain. The RN supervisor was made aware for further evaluation. A progress note dated June 12, 2025, at 8:12 PM revealed Employee 13, Registered Nurse (RN) was called to the resident's bedside by Employee 2, LPN following an injury. At the time of the assessment, Resident 25 appeared to be exhibiting facial cues and verbal indicators of pain. Resident 25 was able to repeat back the events that had occurred. Resident 25 stated she was being transferred by a Hoyer lift, and her leg got caught, and that was when she heard a crack. The resident continued to mention having pain. Pain medication and ice applied. Physician extender notified. It was determined to get quick, appropriate care for the resident, the best course of action was to send her to the emergency room for evaluation. A progress note dated June 12, 2025, at 3:55 PM revealed Resident 25 was transferred to the emergency department at the hospital. A review of hospital emergency department documentation dated June 12, 2025, at 7:41 PM revealed Resident 25 had a history of bilateral total knee arthroplasty (surgical reconstruction or replacement of a joint) as well as a right total hip arthroplasty done in 2019. She had her bilateral distal femur fixed in 2021. The assessment indicated Resident 25's status post-incident with the Hoyer lift was a left tibial periprosthetic type 2 closed fracture (a break in the tibial bone occurring around a knee joint replacement). The plan indicated compressive wraps (elastic bandages to reduce swelling, offer support, and help with pain relief during recovery) for tibial hematoma, maintaining the knee immobilizer, pain control per the primary physician, and a plan pending consultation. A review of the hospital after-visit summary dated June 17, 2025, revealed Resident 25 was seen by orthopedics for her left tibial periprosthetic fracture. She did not require surgery. She cannot walk on her leg, and she should wear a knee immobilizer at all times. Follow-up appointments were scheduled with an orthopedic surgeon. The document indicated new medication, including oxycodone (a narcotic pain medication). A progress note dated June 17, 2025, at 2:12 PM revealed Resident 25 returned from the hospital at 10:45 AM with a diagnosis of a periprosthetic fracture around the internal prosthetic left knee joint and a closed fracture of the proximal end of the left tibia. She had an immobilizer to remain on at all times. The resident was alert and oriented with a pain level 3 out of 10 (0 being least amount of pain and 10 being the worst amount of pain). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A physician’s order for a knee immobilizer on Resident 25’s left knee at all times was initiated on June 17, 2025. A physician’s order for Oxycodone HCl Oral Tablet 5 mg with directions to give 2.5 mg by mouth every 4 hours as needed for moderate pain levels 4 through 6 was initiated on June 17, 2025. A physician’s order for Oxycodone HCl Oral Tablet 5 mg with directions to give 5 mg by mouth every 4 hours as needed for moderate pain levels 7 through 10 was initiated on June 17, 2025. A review of the Medication Administration Records dated June 2025 and July 2025 revealed Resident 25 received Oxycodone HCl Oral Tablet 2.5 mg for pain 38 times from June 17, 2025, through July 18, 2025. A review of the Medication Administration Records dated June 2025 and July 2025 revealed Resident 25 received Oxycodone HCl Oral Tablet 5.0 mg for pain 59 times from June 17, 2025, through July 18, 2025. During an interview on July 17, 2025, at 11:05 AM, Resident 25 explained that last month when she was being transferred from her chair to the bed, she was injured. Resident 25 indicated that a female aide with dark hair was helping her to get to bed. She indicated the nurse aide was the only staff present when she was transferred to bed that day. During the transfer, the nurse aide attempted to reposition her, and they both heard a crack. Resident 25 explained that her leg did not hurt at first, but it became painful a little while later. Resident 25 indicated the nurses and physician were in to see her, then sent her to the emergency department for further evaluation. Resident 25 indicated t she has had to wear an immobilizer as her leg heals and described her pain as intermittent at about a level of 6 out of 10 when it is the worst. Resident 25 indicated she takes medication when the pain is bad, and it seems to help. During an interview on July 17, 2025, at 1:15 PM, Employee 1, NA, indicated that on June 12, 2025, at about 2:30 PM, she used the mechanical lift to transfer Resident 25 without the help of any other staff. Employee 1, NA, explained that Resident 25 wanted to get into bed and there were no other staff around, so she hooked her up to the lift and raised her a bit. When she was attempting to adjust the resident’s legs, she heard a “pop” and a “crack.” Employee 1, NA, indicated she went to get the nurse immediately after she heard the crack. Employee 1, NA, explained that she knew that two staff were required to transfer Resident 25, but there were no other staff at that moment. During an interview on July 17, 2025, at approximately 11:15 AM, the Nursing Home Administrator (NHA) indicated the facility identified through their investigation that Employee 1, NA, failed to follow Resident 25’s care plan and physician’s orders, which state she requires an assist of two for all transfers, resulting in serious physical injury (a closed left tibia fracture). This deficiency is cited as past non-compliance. The facility's corrective action plan included the following: Nurse Aide involved in transfer with Resident 25 was suspended pending investigation for neglect on June 12, 2025. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Identify all residents who require the assistance of a Hoyer lift for transfer. Review documentation related to staff assistance with the Hoyer lift transfer and ensure the transfer status is correct to the plan of care. Immediate education provided for all working nursing staff on Hoyer lift transfers. Education continued with nursing staff prior to the start of their next shift. Education completed on June 16, 2025. Audits will be completed weekly for eight weeks to ensure that Hoyer lift transfers are completed per the plan of care. Results of audit findings will be reviewed through the Quality Assurance Performance Improvement Committee. The facility's compliance date was June 21, 2025. 28 Pa. Code 201.14 (a) Responsibility of licensee. 28 Pa. Code 201.18 (e)(1) Management. 28 Pa. Code 201.29 (a) Resident rights. 28 Pa. Code 211.10 (c) Resident care policies. 28 Pa. Code 211.12 (d)(5) Nursing services.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 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 a review of facility provided documentation, clinical records, the facility's abuse prohibition policy, and staff interviews, it was determined the facility failed to conduct an investigation to rule out a reported allegation of misappropriation of a resident's finances and failed to report to the State Survey Agency within five working days of the incident, for one resident (Resident 104) out of 32 sampled residents. Findings include:A review of a facility entitled Abuse Prevention Program last reviewed by the facility on January 23, 2025, indicated residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. As part of the resident abuse prevention, the administration shall protect the residents from abuse by anyone including but not necessarily limited to facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, or any other individuals. All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown origin sources (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations shall also be reported. If an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown origin source is reported, the Administrator shall conduct or assign the investigation to an appropriate individual. The Administrator shall suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. Resident 158's clinical record review revealed he was admitted to the facility on [DATE], with diagnoses that included hemiplegia (is a symptom that involves one-sided paralysis and affects either the right or left side of the body typically caused by brain or spinal cord injuries and conditions) and hemiparesis (is one-sided muscle weakness that happens because of disruptions in the brain, spinal cord or the nerves that connect to the affected muscles) following cerebral infarction (occurs when the blood supply to part of the brain is blocked or reduced and prevents brain tissue from getting oxygen and nutrients and the brain cells begin to die in minutes) affecting right dominant side, dysphagia (difficulty swallowing), and heart failure (happens when the heart cannot pump enough blood and oxygen to support other organs in the body). Review of Resident 158's admission MDS (Minimum Data Set a federally mandated standardized assessment process conducted periodically to plan resident care) assessment dated [DATE], section C Cognitive Patterns revealed the resident had a BIMS score (Brief Interview for Mental Status a tool used to evaluate cognitive impairment and assist with dementia diagnosis) of 15, which indicated the resident was cognitively intact.A review of Resident CR1's clinical record revealed she was admitted to the facility on [DATE], with diagnoses that included alcoholic cirrhosis (is permanent scarring that damages your liver and interferes with its functioning that can lead to liver failure. Cirrhosis is the result of persistent liver damage over many years due to alcohol and drugs abuse, viruses and metabolic factors are the most common causes), encephalopathy (damage or disease that affects the brain), muscle weakness, and insomnia (inability to fall asleep or stay asleep). Review of Resident CR1's 5-day MDS (Minimum Data Set - a federally mandated standardized assessment process conducted periodically to plan resident care) assessment dated [DATE], section C Cognitive Patterns revealed the resident had a BIMS score (Brief Interview for Mental Status a tool used to evaluate cognitive impairment and assist with dementia diagnosis) of 15, which indicated the resident was cognitively intact. A review of a facility provided resident concern form completed by Resident CR1 on June 21, 2025, revealed for the summary of concern section to see witness statement stapled to back of information. Resident CR1's witness statement indicated she was concerned that Employee 4, a Nurse Aide (NA), was accepting money from Resident 158. The statement noted that when she talked to Resident 158, he said when he got discharged that he was planning to give her seven thousand dollars ($7,000.00) for a new car but just gave her twenty dollars ($20.00) for gas last week and told Resident CR1 that she (Employee 4) asked for his credit card, which was with his sister and stated Employee 4 was taking advantage of him. The statement further indicated that Resident 104 told Resident CR1 he had offered Employee 4 his truck, and that he had given her so much money he no longer remembered the total amount. Resident 104 also stated that Employee 4 and her boyfriend were planning to take him home to live with them and take care of him, and that they wouldn't need to worry about paying for anything. Despite the gravity of these statements, the facility's internal concern form left the sections Is this concern an abuse or neglect allegation? and NHA aware? incomplete. The documentation of the facility's investigation noted that the Director of Nursing (DON) and Employee 10, an LPN, interviewed Resident CR1

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, a review of clinical records, and staff interviews, it was determined the facility failed to develop and implement a comprehensive person-centered care plan that included specific and individualized interventions to address a resident's need for oxygen therapy for one out of 32 residents sampled (Resident 1) and failed to address a resident's hydration needs for one resident out of 32 sampled (Resident 140). Findings include: A clinical record review revealed Resident 1 was admitted to the facility on [DATE], with diagnoses that include chronic respiratory failure (a condition where the respiratory system is unable to remove carbon dioxide from or provide oxygen to the body), quadriplegia (a form of paralysis affecting all four limbs and the torso), and care related to a tracheostomy (a surgical procedure that creates an opening in the neck to access the trachea for breathing or to bypass an obstruction in the upper airway). A review of the physician’s order revealed Resident 1 was to receive oxygen at 10 liters per minute by nasal cannula or tracheostomy collar (a device made of soft straps or bands that fit around the neck, holding a tube securely within the windpipe) continuously every shift initiated on April 8, 2025. A review of Resident 1’s comprehensive person-centered care plan revealed Resident 1 was at risk for respiratory impairment due to chronic respiratory failure and the presence of a tracheostomy. Interventions implemented to ensure Resident 1 exhibits no acute respiratory distress include oxygen at 2.0 liters per minute (L/min) by nasal cannula or tracheostomy collar, initiated December 12, 2025. A review of Resident 1’s Kardex (a nursing documentation system that provides a quick reference for patient information, including medications, treatments, and care plans) indicated oxygen therapy at 2.0 liters per minute. Observation on July 15, 2025, at 10:30 AM revealed Resident 1 was receiving oxygen at 10.0 liters per minute via tracheostomy tube and collar. During an interview on July 17, 2025, at approximately 1:00 PM, the observations were reviewed with the Director of Nursing (DON) and Nursing Home Administrator (NHA), and they confirmed there was a discrepancy between the physician’s orders and Resident 1’s plan of care and Kardex. Following the interview, the resident’s care plan and Kardex were updated to reflect the current physician’s order. A review of Resident 140's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses to include Parkinson’s disease (a disorder of the central nervous system that affects movement, often including tremors), and hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following a cerebral infarction (stroke). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission Minimum Data Set assessment (MDS-standardized assessment completed at specific intervals to identify specific resident care needs) dated January 15, 2025, indicated the resident was cognitively intact with a BIMS (brief interview to assess cognitive status) score of 15 (13-15 represents cognitively intact responses). MDS Section GG indicated the resident required total staff assistance with eating. Section V of the MDS triggered a Care Area Assessment for Dehydration/Fluid Maintenance, which stated this concern would be addressed in the care plan. A review of Resident 140’s current care plan, dated September 15, 2023, revealed the resident had several nutritional concerns, including gastroesophageal reflux disease (GERD), an altered diet texture due to dysphagia (difficulty swallowing), a history of cerebrovascular accident (stroke), Parkinson’s disease, frequent stomach discomfort including nausea and vomiting, and the presence of only two natural lower teeth. The care plan included goals for the resident to avoid choking or aspiration, minimize episodes of high or low blood sugar, consume more than 75% of meals, maintain a stable weight, avoid dehydration, and maintain adequate nutrition through safe swallowing using compensatory strategies. Interventions listed in the care plan included offering snacks between meals, monitoring for signs of dehydration, monitoring food and fluid intake as needed (PRN), monitoring weight and lab results, notifying the physician of any significant weight changes as needed, offering alternate menu choices, honoring the resident’s preference to eat meals in bed, providing food and beverage preferences when available, providing the prescribed diet, administering supplements, vitamins, and minerals as ordered, taking the resident’s temperature every shift, performing mouth care twice daily, and ensuring the resident received a puree-texture, thin-liquid consistency diet. The resident was documented as dependent for meals and receiving pleasure feeds. The plan also included notifying speech therapy if the resident experienced difficulty chewing or swallowing. However, the care plan failed to identify that Resident 140 was fully dependent on staff for hydration and did not include individualized interventions to ensure the resident’s fluid needs were proactively assessed and met. During an interview with Resident 140 on July 15, 2025, at 11:10 AM, he revealed he is completely dependent on staff for hydration due to tremors and poor coordination. He stated that staff only offered fluids at meals and that he had to use the call bell to request drinks at other times, resulting in long delays. He expressed frustration in these long wait times as he has no means to provide himself with a drink. The findings were reviewed with the Nursing Home Administrator (NHA) on July 17, 2025, at 1:30 PM and confirmed there was no documentation of individualized, person-centered interventions in the care plan that addressed the resident’s dependence for hydration or strategies to proactively meet his hydration needs. 28 Pa Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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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 a review of clinical records and staff interview, it was determined the facility failed to provide nursing services consistent with professional standards of practice by failing to ensure that licensed nurses followed physician orders for the administration of medications as prescribed to one resident of the 32 sampled residents (Resident 82).Findings include:A review of the facility policy titled Subcutaneous Injections last reviewed by the facility on January 23, 2025, indicated that in preparation of administering subcutaneous (under the skin) injections licensed nursing staff must verify there is a physician's medication order for the procedure. Staff are to verify the order for the resident's name, drug name, dose, time and route of administration.A clinical record review revealed that Resident 82 was admitted to the facility on [DATE], with diagnoses that included type 2 diabetes mellitus (a condition in which the body has difficulty controlling blood sugar and using it for energy) and long-term use of insulin (a hormone that regulates blood sugar).A physician order, dated April 24, 2025, indicated that Resident 82 was to receive Novolog injection solution 100 unit/ml (Insulin Aspart) at a dose of 7 units subcutaneously with meals, and to hold the dose if the resident's blood glucose level (Accu-Chek) was less than 100 mg/dl.According to the resident's Medication Administration Record (MAR) for April 2025, nursing staff administered Novolog insulin injection to the resident on April 28, 2025, at 5:00 PM despite an Accu-Chek reading of 78 mg/dl, which was below the physician prescribed parameter of 100 mg/dl. The resident's June [DATE] indicated that nursing administered Novolog insulin injection to Resident 82 on June 5, 2025, at 5:00 PM but the resident's Accu-Chek was 92 mg/dl, which was below the physician prescribed parameters of 100 mg/dl. Nursing staff again administered Novolog insulin injection to the resident on June 10, 2025, at 5:00 PM for an Accu-Chek reading of 96 mg/dl. During an interview on July 17, 2025, at 10:55 AM the above findings were reviewed with the Director of Nursing and confirmed that Resident 82's Medication Administration Records indicated the resident was administered medication outside of the physician's prescribed parameters for administration.28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing Services.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of select facility policy, and staff interview, it was determined the facility failed to consistently provide restorative nursing services as planned to maintain mobility to the extent possible for one resident out of 32 residents sampled (Resident 8). Findings include:Findings include:A review of the facility policy titled Restorative Nursing Services, last reviewed on January 23, 2025, revealed that residents will receive restorative nursing care as needed to help promote optimal safety and independence. Further review of the policy revealed the resident's restorative goals and objectives are individualized and resident-centered and are outlined in the residents' plan of care. A review of the clinical record for Resident 8 revealed the resident was admitted to the facility on [DATE], with diagnoses to include Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks) and muscle atrophy (muscle wasting that causes progressive loss of muscle mass and strength). A quarterly Minimum Data Set Assessment (MDS a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated May 17, 2025, revealed the resident was severely cognitively impaired with 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 score of 0-7 indicates severe cognitive impairment) and the resident required substantial/maximal assistance for rolling left and right and was dependent for mobility.Further review of the clinical record revealed that physical therapy was provided to the resident from May 13, 2025, until June 13, 2025.A review of the resident's physical therapy Discharge summary dated [DATE], indicated at the time of discharge that the resident required partial to moderate assistance while rolling left and right and was dependent for sitting to lying and lying to sitting on the side of the bed. Discharge recommendations included that Resident 8 was appropriate for ROM (Range of Motion) RNP (Restorative Nursing Program), but it was noted the resident was not participating at that time. Further review of the discharge summary report revealed the range of motion program established and resident trained was ROM to bilateral lower extremities to reduce contractures. A review of Resident 8's care plan in effect through the survey end date of July 18, 2025, revealed the resident had an ADL self-care performance deficit related to decreased mobility and required assistance. There was no evidence of Resident 8's RNP program in their resident-centered care plan. A review of Resident 8's task report (an electronic record that summarized planned resident-centered tasks completed by nursing) and Documentation Survey Report v2 (care tasks completed for the resident) for July 2025 revealed no documented evidence the resident's restorative program was being implemented. Further review of the clinical record for Resident 8 revealed no documented evidence that licensed staff were aware the resident's RNP program was not being implemented as planned to ensure the resident's mobility to the extent possible. The above findings were reviewed during an interview with the Nursing Home Administrator (NHA) on July 17, 2025, at approximately 1:00 PM. The NHA could not provide evidence that the facility consistently implemented the planned restorative nursing program for Resident 8 to maintain functional abilities and deter declines to the extent possible. 28 Pa Code 211.10 (d) Resident care policies.28 Pa Code 211.12(c)(d)(5) Nursing services.

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Grandview Nursing and Rehabilitation	78 Woodbine Lane Danville, PA 17821

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, select facility policy, and resident and staff interviews, it was determined the facility failed to ensure the availability of necessary emergency supplies for one of three residents reviewed who received hemodialysis (Resident 70). Findings include:According to the National Kidney Foundation, patients receiving hemodialysis (a machine that filters waste, salts, and fluid from the blood when the kidneys are no longer healthy enough to do this work adequately) should have access to emergency care supplies, including at bedside, to promptly respond to complications such as bleeding from the dialysis access site. For residents with an arteriovenous (AV) fistula, a surgically created connection between an artery and a vein commonly used for dialysis access, rapid access to emergency supplies is critical, as complications such as ruptures or bleeds from the site can result in life-threatening blood loss.A review of the facility policy titled Hemodialysis Care, last reviewed by the facility on January 23, 2025, revealed it is the policy of the facility to adhere to established guidelines and physicians' orders related to the care of each resident receiving outpatient hemodialysis services. A review of Resident 70's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses that included end-stage renal disease (the final stage of kidney decline where the kidneys are no longer able to function to meet the body's needs) with dependence on hemodialysis.A physician's order dated November 13, 2024, directed staff to ensure an emergency kit was present at the bedside. (An emergency dialysis kit typically contains items such as gloves, gauze, medical tape, scissors, and hemostatic dressings to control active bleeding at the fistula site, which can be a medical emergency if not addressed immediately).A review of a quarterly Minimum Data Set assessment (MDS a federally mandated standardized assessment process conducted periodically to plan resident care) dated June 3, 2025, revealed that Resident 70 was cognitively intact with a BIMS score of 15 (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).The resident's care plan, in effect through the survey end date of July 18, 2025, included interventions such as checking the AV fistula site for signs of infection, bleeding, or swelling and ensuring emergency equipment was available at the bedside.A review of Resident 70's Medication Administration Record (MAR) for July 2025 revealed that it was signed off on July 15, 2025, for the day shift confirming the emergency kit was present at the bedside. However, an observation conducted on July 15, 2025, at 1:45 PM, revealed there were no emergency supplies at Resident 70's bedside. During an interview conducted at that time, the resident confirmed returning from dialysis within the hour and confirmed the absence of emergency supplies in the room.An interview with Employee 3 LPN (licensed practical nurse) on July 15, 2024, at approximately 1:50 PM, confirmed there were no emergency supplies for Resident 70's dialysis access site available in the resident's room. Employee 3 further confirmed the emergency supplies were to be available at the bedside and are usually located on the back of the resident's headboard of their bed. The above findings were reviewed during an interview with the Nursing Home Administrator on July 16, 2025, at approximately 1:00 PM, and confirmed the facility failed to ensure that emergency dialysis access supplies were available as ordered and required by the resident's care plan.28 Pa. Code 211.12 (d)(3)(5) Nursing services.28 Pa.Code 211.10 (d) Resident care policies.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of select facility policy and controlled substance records, observation, and staff interview, it was determined the facility failed to implement established pharmacy procedures for the reconciliation of controlled substances on one of five medication carts reviewed (Pavilion cart #2).Findings include:A review of facility policy titled Controlled Substances last reviewed by the facility on January 23, 2025, indicated that nursing staff must count controlled medications (medications with high potential for abuse) at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services.An observation of the Pavilion medication cart #2 on July 17, 2025, at 8:35 AM, revealed Employee 5 (Registered Nurse) actively working from the medication cart. A review of a document titled Change of Shift Controlled Medication Count Sheet, identified by Employee 5 as the change of shift controlled substance count sheet for July 2025, for the Pavilion cart #2, revealed that the on-coming nurse and/or off-going nurse failed to sign the sheets during shift change on the following dates to verify completion of the task to count the controlled substances in the respective medication cart:July 6, 2025, 2nd shiftJuly 9, 2025, 2nd shiftJuly 11, 2025, 2nd shiftJuly 11, 2025, 3rd shiftInterview with Employee 3, on July 17, 2025, at 8:38 AM, confirmed the observation and acknowledged the licensed nurses are expected sign the count verification at the change of shift. The facility failed to ensure that licensed nursing staff consistently followed established procedures for the reconciliation of controlled substances in accordance with facility policy to timely identify any discrepancies.28 Pa. Code 211.9(a)(1)(k) Pharmacy services.28 Pa. Code 211.10(d) Resident care policies.28 Pa. Code 211.12 (d)(3)(5) Nursing services.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 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 a review of resident clinical records, select facility policy, facility investigative reports, and staff interviews, it was determined the facility failed to ensure that one of 32 residents reviewed was free of significant medication errors. (Resident 123).Findings include:A review of the facility policy titled Administering Medications, last reviewed on January 23, 2025, revealed that medications shall be administered in a safe and timely manner as prescribed and the individual administering medications must verify the resident's identity before giving the resident their medications. Methods of identifying the resident include checking their identification band, checking their photograph attached to the medical record, and, if necessary, verifying the resident identification with other facility personnel. Further review revealed the individual administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time, and right method of administration before giving the medication.A clinical record review revealed that Resident 123 was admitted to the facility on [DATE], with diagnoses to include hypertension (blood pressure that is higher than normal) 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 June 13, 2025, revealed that Resident 123 had moderately impaired cognition with a BIMS score of 11 (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 8-12 indicates cognition is moderately impaired). A clinical record review for Resident 123 revealed a nurse's progress note from a Registered Nurse (RN) supervisor, dated July 12, 2025, at 8:00 P.M., which revealed that Resident 123 was given the wrong medication by Employee 14, a Licensed Practical Nurse. Further review of the progress note revealed the resident had received Keppra (an anti-convulsant medication to prevent seizures) 500 milligrams (mg), Remeron 15 mg (an anti-depressant), Lyrica 100 mg (an anti-convulsant drug used for various reasons), Trazodone 50 mg (an anti-depressant), and Warfarin 2.5 mg (a blood thinning agent). The RN supervisor then called the physician on call and was directed to send the resident to the emergency room for evaluation due to the resident's age and a recent fall earlier in the day. A review of the clinical record revealed that on July 12, 2025, at 8:26 P.M., Resident 123's blood pressure was 92/54 (normal blood pressure is 120/80). A review of a facility investigative report dated July 14, 2025, revealed that on July 12, 2025, at 8:00 P.M., Resident 123 was given medications not prescribed to him by Employee 14. It was noted that Employee 14 did not verify the resident's identification before administering medications and had never worked on that medication cart or unit prior to and was unfamiliar with the resident. Further review revealed the medications administered, which included Keppra, Lyrica, Remeron, Trazodone, and Warfarin, were those medications of Resident 123's roommate, Resident 95. Resident 123 was assessed after the medication error, and the physician was notified, who then requested a transfer to the emergency department for evaluation. It was noted that Employee 14 would receive education on medication administration and complete a medication competency prior to working the next shift, which was provided in the report. A review of Resident 123's Medication Administration Record for July 2025 revealed the resident was not due for any nighttime medications for 9:00 P.M. Resident 123 received medications that were not prescribed to him. The resident did not have a diagnosis to require these specific medications. A review of Resident 123's hospital clinical records revealed an emergency room provider note, dated July 12, 2025, the resident arrived at 9:26 P.M. for evaluation of a medication error and a fall that occurred earlier that day. It was noted the resident had an unwitnessed fall at 5:00 P.M. that day and was given another resident's medications at 8:00 P.M. Resident 123 was evaluated and then discharged . A review of a nursing progress notes dated July 13, 2025, at 8:05 A.M., revealed Resident 123 returned from the emergency room after observation. It was noted that the resident was lethargic upon arrival and that a computed tomography (CT) scan (a noninvasive medical procedure that uses x-rays to create detailed images of the body) was not performed on the resident due to age and code status. An interview with the Nursing Home Administrator and Director of Nursing confirmed that Employee 13 failed to verify the correct resident and administered the incorrect medications to Resident 123, resulting in a significant medication error.28 Pa. Code 211.10 (d) Resident care policies.28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, a review of select facility policy, and staff interview, it was determined the facility failed to ensure that medications and pharmaceutical products were stored in accordance with expiration date guidelines in one of three medication storage areas (Pavilion medication storage room).Findings include:A review of the facility policy titled Storage of Medications last reviewed by the facility on January 23, 2025, indicated all medications will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with the Destruction of Unused Drugs Policy. An observation conducted on July 17, 2025, at 9:00 AM in the Pavilion medication storage room revealed ten medication/supplement items that were expired or had illegible expiration dates, as outlined below:1 bottle of Multi-Vitamin with Iron with an expiration date of February 20242 bottles of Aspirin 325 mg with an expiration date of December 20241 bottle of Sodium Bicarbonate (antacid) with an expiration date of January 20251 bottle of Glucosamine and Chondroitin (dietary supplement) with an expiration date of January 20251 bottle of Meclizine (antiemetic) with an expiration date of February 20251 bottle of Glucosamine and Chondroitin with an expiration date of May 20251 bottle of Vitamin E 450 mg with an expiration date of June 20251 bottle of Guaifenesin Liquid (expectorant) with an expiration date of June 20251 bottle of Copper Glycinate (dietary supplement) with an illegible expiration date During an interview with Employee 6 (Licensed Practical Nurse) on July 17, 2025, at 9:11 AM, the staff member confirmed the presence of the expired and improperly labeled medications/supplements in the Pavilion medication storage room.The facility failed to ensure the timely removal of expired medications and supplements, which is not in compliance with manufacturer guidelines and the facility's own policies.28 Pa. Code 211.9 (a)(1)(k) Pharmacy Services.28 Pa. [NAME] 211. 10(d) Resident care policies.28 Pa. Code 211.12 (d)(3)(5) Nursing services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, it was determined the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness in the dietary department.Findings include:Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food).According to the United States Department of Agriculture (USDA), food that is mishandled can become contaminated with invisible, odorless, or tasteless pathogens. Proper storage practices including keeping items off the floor and away from ceilings are critical to preventing contamination. Food and items intended to contact food must be stored in a clean, dry location at least six inches above the floor and at a safe distance from ceilings and structural elements, in accordance with food safety inspection standards. These guidelines are designed to minimize the risk of exposure to dust, condensation, leaks, pests, or physical debris.A review a facility policy entitled Food Receiving and Storage last reviewed by the facility on January 23, 2025, indicated that all foods and goods should be stored in a manner that maintains the integrity of the packaging until ready to be used and all bulk food should be removed from their original packaging, placed in bins, and labeled with a use by date. During the initial tour of the dietary department conducted on July 15, 2025, at 10:21 AM with the dietary manager, the following unsanitary conditions were observed:Unlidded garbage cans containing trash were positioned near the tray line and cook's preparation areas, increasing the risk of contamination from airborne or physical debris in food preparation zones.In both the First Floor East and Ground Floor dry storage areas, multiple cases of disposable dishware and paper products were stored directly on the floor. In some instances, plastic packaging was open and unsealed, exposing the contents to contamination from floor debris, cleaning solutions, and pests.In the Ground Floor dry storage/equipment area, multiple cases of dishware, supplies, and dietary-related materials were stored in close proximity to the ceiling, limiting air circulation and increasing the risk of contamination from overhead surfaces, dust, or ceiling-based hazards.During an interview with the Nursing Home Administrator (NHA) on July 16, 2025, at 1:35 PM, the above observations were reviewed. The NHA acknowledged that the dietary department should be maintained in a sanitary condition to prevent contamination and reduce the risk of foodborne illness.28 Pa. Code 201.18 (e) (2.1) Management. 28 Pa. Code 211.6 (f) Dietary Services.28 Pa. Code 211.10 (d) Resident care policies.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of select facility policy, clinical records, and staff interview, it was determined the facility failed to ensure the resident or resident's representative was provided education regarding the benefits and potential side effects of the pneumococcal immunization for one of five residents reviewed. (Resident 47)A review of facility policy titled Pneumococcal Vaccine, last reviewed in January 2025, revealed it is the facility's policy that all residents shall be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Furthermore, the policy indicates residents and resident representatives have the right to refuse the vaccination. If refused, appropriate entries shall be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination.A clinical record review revealed Resident 47 was admitted to the facility on [DATE].A review of Resident 47's immunization tab section of the electronic health record revealed pneumovax dose 1 was refused.Further review of the clinical record revealed no documented evidence the facility provided Resident 47 or Resident 47's representative education regarding the benefits and potential side effects of pneumococcal immunization.During an interview on July 18, 2025, at approximately 11:00 AM, Employee 7, Infection Preventionist, confirmed there was no documented evidence in the clinical record indicating Resident 47 or Resident 47's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa Code 211.5 (f)(iv) Medical records. 28 Pa. Code 211.10(d) Resident care policies.28 Pa code 211.12 (c)(d)(1)(5) Nursing services.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, relevant facility policies, resident and staff interviews, and direct observations, it was determined the facility failed to follow its established policy and procedures related to safe smoking practices for one of 32 sampled residents (Resident 139).Findings include:Review of the facility policy titled Resident Smoking Policy last reviewed by the facility January 23, 2025, indicated that the facility shall assess residents to determine safe smoking practices while allowing them to smoke supervised or independently. Policy procedure included Smoking supplies for Supervised and Independent residents will be kept in the locked nursing medication room. Residents are not entitled to keep smoking supplies in their possession.A clinical record review revealed that Resident 139 was admitted to the facility on [DATE], with diagnoses to include quadriplegia (partial or complete paralysis of all four limbs and torso), and chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breathe).A review of an annual Minimum Data Set assessment (MDS a federally mandated standardized assessment process conducted periodically to plan resident care) dated May 2, 2025, revealed that Resident 139 was cognitively intact with a BIMS score of 15 (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 form titled Smoking Safety dated May 2, 2025, indicated that Resident 139 had been assessed with the ability to safely smoke independently. The assessment indicated that Resident 139 understood and agreed that smoking accessories (cigarettes, lighters, matches, etc.) must be returned to and kept under the control of the facility staff when not in use.An observation on July 16, 2025, at 12:25 PM in resident room revealed that Resident 139 had smoking materials in his room including two (2) cigarette lighters and a pack of cigarettes. At the time of the observation Resident 139 was holding one cigarette in an adapted cigarette holder on his left finger. The two lighters were resting in between his legs on his power wheelchair cushion and the pack of cigarettes was placed on his right leg. During an interview with Resident 139 at the time of the observation, he stated that he is an independent smoker and keeps his smoking supplies in his room in the top drawer of his bedside cabinet. A drawer was observed with a locking mechanism in the resident's bedside cabinet.During an interview on July 16, 2025, at 1:00 PM, the Nursing Home Administrator (NHA) confirmed that per facility policy, all smoking supplies must be secured by staff in the medication storage room when not in use, regardless of a resident's independent smoking status. The NHA was unable to provide evidence that staff were monitoring Resident 139's personal storage of smoking materials to ensure safety compliance.28 Pa. Code 201.18 (b)(1)(e)(1) Management. 28 Pa. Code 209.3 (a) Smoking.28 Pa. Code 211.10 (d) Resident care policies.