STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415020	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Center	100 Chambers Street Cumberland, RI 02864

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 39496 Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to ensure that services provided meet professional standards of quality, relative to the use of borrowed medications and inaccurately documenting in the narcotic count book for 2 of 2 residents reviewed, Resident ID #s 2 and 3. Findings are as follows: Review of a facility reported incident submitted to the Rhode Island Department of Health on 2/10/2025, revealed, Resident ID #3 was on hospice and received an order for Lorazepam Intensol 2 milligram (mg)/milliliter (ml) 0.25 ml every four hours and 0.25 ml every hour as needed. Resident ID #3 was presenting with symptoms, and the pharmacy was unable to deliver the Lorazepam Intensol, due to the medication being on back order. Resident ID #2 had an unused bottle of Lorazepam Intensol that was borrowed by the nurses to administer to Resident ID #3. a. Record review revealed Resident ID #3 was admitted to the facility in January of 2025 with diagnoses including but not limited to, a malignant neoplasm (a cancerous tumor) of the bronchus and a secondary malignant neoplasm of the digestive organs. Record review of a hospice visit dated 2/2/2025 for Resident ID #3 revealed a recommendation for Lorazepam 2mg/ml give 0.5mg (0.25ml) sublingually (under the tongue) every 4 hours, as needed for restlessness. Record review of a progress note dated 2/3/2025 at 1:22 PM, revealed that the hospice recommendations were reviewed with and approved by the physician. Record review revealed the following physician's orders dated 2/3/2025 for Resident ID #3: -Lorazepam 2mg/ml inject 0.5 mg (0.25 ml) every 4 hours subcutaneously (under the skin) for restless/anxiety, not sublingually as recommended by the hospice provider and approved by the physician -Lorazepam 2mg/ml inject 0.25 ml subcutaneously every hour as needed for restless/anxiety, not sublingually as recommended by the hospice provider and approved by the physician. Record review of the Narcotic book documentation revealed the following: (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident ID #2 had 30 ml of Lorazepam Intensol 2mg/ml delivered by the pharmacy on 9/20/2024. On the bottom of the page, it was written that the medication was transferred to the North team 2 Narcotic book on 2/3/2025. Resident ID #3 had 15 mls of Lorazepam Intensol entered into the book on 2/3/2025 for administration. Additional review failed to reveal evidence that 30 mls Lorazepam Intensol was transferred to Resident ID #3 from Resident ID #2 or if it was received from the pharmacy. During a surveyor interview on 5/7/2025 at approximately 1:15 PM, with Registered Nurse, Staff A, she revealed that she transcribed 15 mls in error for the Lorazepam, as it was 30 mls of medication that was received from Resident ID #2. b. Record review of a facility policy titled, Medication Administration dated 1/2025, reveals in part, . Medications supplied for one resident are never administered to another resident . Record review of Resident ID #3's February 2025 Medication Administration Record revealed s/he received Resident ID #2's Lorazepam Intensol on the following dates and times: 2/3/2025 at 10:45 AM 2/3/2025 at 5:00 PM 2/3/2025 at 7:50 PM 2/3/2025 at 9:18 PM 2/4/2025 at 1:00 AM 2/4/2025 at 5:00 AM During a surveyor interview on 5/7/2025 at approximately 1:15 PM, with Staff A, she revealed that hospice had recommended that Resident ID #3 start on Lorazepam due to increased anxiety. Staff A, acknowledged that the physician's order should have been entered as sublingual. She further stated that the pharmacy was unable to fill the order, so she borrowed Resident ID #2's bottle of Lorazepam, that was unopened and not being used, for administration to Resident ID #3. She revealed that the Lorazepam was transferred from Resident ID #2 to Resident ID #3 in the Narcotic book, and it was being administered to Resident ID #3 sublingually. During a surveyor interview on 5/7/2025 at 3:15 PM with the Staff Educator, Staff B, she acknowledged that Resident ID #2's medication should not have been borrowed for Resident ID #3, and that the Narcotic book documentation was inaccurate and incomplete. Additionally, she acknowledged that the Lorazepam order was entered as subcutaneous and should have been entered as sublingual.