STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395623	A. BLDG: 00 B. WING:	10/04/2025

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GRANDVIEW NURSING AND REHABILITATION STATE LICENSE NUMBER: **591602**	**78 WOODBINE LANE** **DANVILLE, PA 17821**

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F 0000	INITIAL COMMENT Based on an abbreviated complaint survey completed on October 3, 2025, it was determined that Grandview Nursing and Rehabilitation center, was not in compliance with the following requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0584 SS=D		F 0584		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0584 SS=D	Continued from page 1 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	1. Rooms W 8,9,11, & 16 including floors and any fall mats, were deep cleaned. Incontinence care was provided to Resident # 12 on 10/4/25. Resident # 12 w/c seat and wheels were cleaned. 2. EVS supervisor to complete an initial audit of all resident rooms, fall mats, and wheelchairs to ensure cleanliness. Any items identified as not clean will be cleaned. 3. EVS supervisor with provide education to housekeeping staff on room cleanliness standards. 4. EVS Supervisor or designee will complete room audits 3 x week for cleanliness of flooring, fall mats and chairs. Audits will be completed 3 x week x 4 weeks, then weekly x 4 weeks. Results of audits will be reviewed at facility QAPI committee.	Completion Date: **11/12/2025** Status: **APPROVED** Date: **10/23/2025**

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F 0584 SS=D	Continued from page 2 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584		

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F 0584 SS=D	Continued from page 3 Based on observation and staff interviews, it was determined that the facility failed to maintain a clean and sanitary environment in one of three resident care units (the West Resident Unit). Findings include: An environmental tour of the West Resident Unit was conducted on October 3, 2025. An observation of Room W-16 revealed a large amount of a white substance inside an incontinent brief (a disposable garment worn to manage urinary or fecal incontinence) that was strewn under and around Bed 3. The floor contained liquid stains, visible dirt, and paper debris. A fall mat (a cushioned floor pad placed beside a bed to minimize injury if a resident falls) was propped against the bathroom door frame. The fall mat was visibly soiled with dark liquid stains and dirt. Rooms W-9 and W-11 were observed to have dried liquid stains and dirt on the floors. At 9:30 AM, Resident 12 was observed seated in her wheelchair outside of the room. A brown liquid substance was noted on the resident ' s clothing, wheelchair seat, and wheelchair tires. Multiple large puddles of the same brown liquid were present under the wheelchair and extended along the floor leading to Bed 1 of Room W-08. During an interview at the time of the observation, Resident 12 stated	F 0584		

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F 0584 SS=D	Continued from page 4 she had " an accident " (a bowel incontinence episode with liquid stool) while seated in the chair. She reported activating her call bell (a device used by residents to request assistance from staff) and being told by staff that someone would come to assist her. Resident 12 stated she had been sitting in the soiled condition for more than fifteen minutes. During an interview conducted on October 3, 2025, at 9:40 AM, the Assistant Director of Nursing (ADON) stated that the nurse aide assigned to Resident 12 that shift had to leave the facility due to an emergency. The ADON stated that other nurse aides were completing their assigned resident care tasks and that assistance would be provided shortly. At 10:00 AM, the Director of Nursing (DON) confirmed that all resident care and common areas are required to be kept clean and sanitary. Pa Code 211.12 (D)(1)(3)(5) Nursing services. Pa Code 201.18(b)(1) (3) Management.	F 0584		
F 0684 SS=G		F 0684		

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F 0684 SS=G	Continued from page 5 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	1. Unable to retro correct deficient practice for Resident CR1 2. Facility will review residents on anticoagulation therapy who have had a fall in the past 48 hours. Physician will be contacted with post fall assessment findings including neurological evaluation to determine whether residents need to be transferred to the hospital for evaluation. 3. Nursing Educator/ designee will provide education to licensed staff facility on post fall protocols including MD notification to include anticoagulant use and neurological evaluation. 4. Director of Nursing / designee to complete audits on 5 falls weekly to ensure that interventions are initiated to address risk for falls and interventions to prevent reoccurrence. Audits will also include neurological evaluations on unwitnessed falls and q 15-minute checks if applicable, and MD notification if the resident is on anticoagulation therapy. Audits will continue x 8 weeks and findings will	Completion Date: **11/12/2025** Status: **APPROVED** Date: **10/23/2025**

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F 0684 SS=G	Continued from page 6	F 0684	be reviewed by the facility QAPI committee.	

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F 0684 SS=G	Continued from page 7 Based on a review of select facility policies, clinical records, investigative reports, and staff interviews, it was determined that the facility failed to ensure that residents received treatment and care according to professional standards of practice, which included a failure to implement necessary interventions after a fall, such as close supervision and neurological assessments for one of two residents reviewed for falls resulting in actual harm with a subdural hematoma (brain bleed). Resident CR1. Findings include: A review of a select facility policy for "Anticoagulation," last reviewed January 23, 2025, revealed it is the policy of the facility that some medications, including anticoagulants (blood thinners), are associated with greater risks of adverse consequences (increased risk of bleeding and hemorrhage) than other medications. Further review revealed the resident ' s plan of care should alert staff to monitor adverse consequences risks associated with anticoagulants, which include bleeding and hemorrhage. A review of the facility policy titled "Neurological Testing," (include, at a minimum, pulse, respiration, and blood pressure measurements; assessment of pupil size and reactivity; and equality of hand grip strength)last reviewed January 23, 2025, revealed it is the policy of the	F 0684		

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F 0684 SS=G	Continued from page 8 facility to identify and treat suspected head injury promptly, and if a resident is suspected of having a head injury, has an unwitnessed fall and it is unclear if they hit their head, or a resident has a change in mental status, a full neurological exam will be performed and any abnormal results will be provided to the physician immediately. Neurological testing will be completed immediately and at specified intervals over a 72-hour period (every 15 minutes × 4 days, every 30 minutes × 2 days, every hour × 2 days, every 4 hours × 5 days, then every shift × 6 days), and that abnormal findings are to be reported to the physician immediately. A review of a facility policy titled "Assessing Falls and Their Causes," last reviewed January 23, 2025, revealed it is the policy of the facility to provide guidelines for assessing a resident after a fall, to assist staff in identifying causes of the fall, and that falls are a leading cause of morbidity and mortality among the elderly in nursing homes. Further review revealed that after a fall, if a resident has just fallen or is found on the floor without a witness to an event, evaluate for possible injuries to the head, neck, spine, and extremities, and observe for delayed complications of a fall for 48 hours after an observed or suspected fall. Professional literature and national emergency care guidance support that anticoagulated patients who sustain	F 0684		

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F 0684 SS=G	Continued from page 9 head trauma should undergo prompt evaluation, including initial neuroimaging and close monitoring. According to the Centers for Disease Control and Prevention (CDC), referencing the American College of Emergency Physicians (ACEP) 2023 Clinical Policy, advises that for patients on anticoagulation or antiplatelet therapy (other than aspirin), clinicians should " highly consider imaging " and " not use clinical decision rules to exclude the need for head CT. " (CDC 2023 Mild Traumatic Brain Injury Management Guideline). The Eastern Association for the Surgery of Trauma (EAST) Practice Management Guideline likewise recommends that clinicians perform a brain CT scan on patients presenting with suspected brain injury in the acute setting and cautions that those on anticoagulation require heightened vigilance and observation when coagulopathy is present. Falls are the leading cause of injury among people 65 and older. The CDC recommends that injured older persons be triaged to trauma centers whenever possible. Following traumatic brain injury (TBI), older individuals had greater rates of morbidity and death than younger patients due to changes in brain structure, a higher burden of comorbidities, and more frequent use of anticoagulants and antiplatelet medications. Some of the factors that can affect the accuracy of prehospital triage in older adults include frailty, age-related physiological reactions to injuries, polypharmacy (concurrent use of multiple medications), major trauma from low-energy impact mechanisms (low-level falls) that are not detected by the current triage tools, and the use of anticoagulants and	F 0684		

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F 0684 SS=G	Continued from page 10 antiplatelet medications. Anticoagulated patients are more likely to experience intracranial hemorrhage, or brain bleeding, hence early CT scanning (computed tomography scan, a medical imaging technique that uses X-rays and a computer to create detailed cross-sectional images of the body) may be utilized more frequently in these patients. Traumatic intracranial hemorrhage has been documented to occur at an epidemic rate in patients 55 years of age or older who are taking anticoagulants. Compared to younger patients with comparable injuries, older adults who present with polytrauma are at risk for more serious injuries, longer hospital stays, and a higher chance of death. Closed clinical record review revealed that Resident CR1 was admitted to the facility on September 2, 2025, with diagnoses to include muscle weakness and cervical (bones at the top of the spine) fracture due to a fall at home prior to admission, which required surgical intervention of a cervical fusion (a procedure that joins two or more vertebrae, the bones in the spine, in the neck) on August 1, 2025, and was to wear a cervical collar (neck brace to support the neck and spine to stabilize an injury/surgery to promote healing) at all times. A review of a quarterly Minimum Data Set assessment (MDS a federally mandated standardized assessment process conducted periodically to plan resident care) dated September 8, 2025, revealed that Resident CR1 was cognitively intact with a BIMS score of 15 (Brief Interview	F 0684		

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F 0684 SS=G	Continued from page 11 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 physician ' s order dated September 2, 2025, prescribed enoxaparin (blood thinner) 40 milligrams (mg) every 12 hours to prevent blood clots (anticoagulation) related to cervical fracture, and an order dated September 8, 2025, prescribed Dilaudid (a high-alert Schedule II opiate narcotic medication) 8 milligrams (mg) every 6 hours for pain related to cervical fracture and chronic pain. A review of the resident ' s fall-risk care plan, initiated on September 2, 2025, revealed the resident was identified as being at risk for falls related to a history of falls at home and unsteady gait, with the goal to minimize the risk for injury related to falls. Interventions included keeping the call bell within reach, ensuring non-skid footwear, and reinforcing the need for the resident to request assistance for mobility or transfers. A review of a nurse ' s progress note documented by Employee 6, Registered Nurse (RNS) Supervisor dated September 15, 2025, at 11:15 a.m. revealed Resident CR1 slid from her recliner chair onto her buttocks and was assisted back into the recliner. The immediate post-fall intervention included placement of a Dycem (a brand of a non-slip material used to stabilize seating surfaces) on the	F 0684		

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F 0684 SS=G	Continued from page 12 recliner to prevent further sliding. A review of a nurse ' s progress note from Employee 7, RN, dated September 17, 2025, at 4:10 p.m. revealed that Resident CR1 was found seated on the floor in an upright position in front of her wheelchair, located next to her bed. Documentation reflected that a new intervention was added to offer the resident the opportunity to rest in bed after meals. A review of a nurse ' s progress note from Employee 8, RN, dated September 22, 2025, at 10:10 p.m. revealed that Resident CR1 was found on the floor near her bathroom after attempting to ambulate independently, lost balance, and fell. An abrasion measuring 4.5 centimeters (cm) in length and 0.2 centimeters (cm) in width was noted on her back. New interventions implemented after the fall included a therapy referral and direction that the resident wear non-skid socks instead of slippers. A review of a nurse ' s progress note written by Employee 7, RN, dated September 27, 2025, at 12:15 p.m. revealed Resident CR1 was found on the floor beside the bed after attempting to self-transfer from her wheelchair to the bed following a self-transfer to the toilet. Documentation indicated that she was assisted to the bedside for assessment, and that her cervical collar was in place at the time of evaluation.	F 0684		

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F 0684 SS=G	Continued from page 13 A review of the corresponding facility provided investigative documentation for the September 27, 2025, 12:15 p.m. fall revealed the intervention entered following this fall was to schedule toileting upon rising, before and after meals, and at bedtime. Review of the resident ' s electronic task record (an electronic record that summarized planned resident centered tasks completed by nursing) dated September 8, 2025, revealed this intervention had already been initiated prior to the fall. There was no documentation that any new or revised interventions were developed to address the resident ' s continued pattern of falls. A review of the clinical record revealed a physician ' s order entered on September 27, 2025, at 9:48 p.m. directing staff to perform 15-minute safety checks following multiple falls within a 24-hour period. Further review of a nurse ' s progress note from Employee 9, RN, dated September 27, 2025, at 9:51 p.m. revealed that at approximately 7:40 p.m. that evening, Resident CR1 sustained an unwitnessed fall and was found lying on her left side at the foot of the bed with her head positioned under the bed frame after reportedly attempting to reach for an item on the bedside table and sliding off the bed. The resident ' s cervical collar was noted to be in place, and the on-call physician was notified. The physician ordered safety checks every 15 minutes due to two falls within a 24-hour period. Documentation indicated that neurological	F 0684		

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F 0684 SS=G	Continued from page 14 checks were initiated and recorded as within normal limits at the time of this assessment. A review of the neurological assessment flow sheet documented assessments at 8:00 p.m., 8:15 p.m., 8:30 p.m., 9:30 p.m., 10:00 p.m., 10:30 p.m., 11:00 p.m., 1:00 a.m., 2:00 a.m., 3:00 a.m., and 4:00 a.m. There were additional times written on the neurological sheet for assessments and vitals to be completed at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM remained blank. The facility was unable to provide documentation that 15-minute checks for safety were completed due to two falls in 24 hours, as ordered by the physician. An interview with the Director of Nursing (DON) on October 3, 2025, at 4:00 p.m., revealed that Employee 9, RN, did not relay to other staff members that Resident CR1 was ordered 15-minute checks, so they were unaware that the resident was on every 15-minute safety checks. The DON stated it is not their normal protocol at the facility to put someone on 15-minute checks after a fall, unless ordered by the physician. There was no evidence that the facility modified the plan of care to include heightened monitoring or further assessment following repeated falls, despite the resident ' s anticoagulation therapy, unsteady gait, and history of head and neck injury.	F 0684		

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F 0684 SS=G	Continued from page 15 A review of a medication administration note from Employee 10, LPN, dated September 28, 2025, at 7:09 AM revealed Resident CR1 ' s Dilaudid 8 mg for 6:00 AM administration was held because the resident could not be awakened to take the medication, and the vital signs recorded at that time were identical to those documented during the 4:00 a.m. neurological check., blood pressure of 128/64 (normal is 120/80), pulse of 94 (normal is 60-100), and respirations of 18 (normal is 12-20) completed at that time by Employee 10, LPN. A review of a nurse ' s progress note written by Employee 11, RN, dated September 28, 2025, at 9:00 a.m. revealed that Resident CR1 was not responding to verbal stimulation (spoken words) or to touch. The resident ' s vital signs at that time were a temperature of 97.6 degrees Fahrenheit, pulse of 60 beats per minute (BPM), respirations of 16 per minute (normal range 12-20), blood pressure of 142/85 millimeters of mercury (mm Hg; normal 120/80), and oxygen saturation of 88 percent on room air (normal is above 90 percent). The record showed that oxygen at 2 liters per minute was applied to the resident, and the on-call physician was notified. The physician ordered that the resident be transferred to the emergency department for evaluation. Further review of the same progress note revealed that on September 28, 2025, at 9:15 a.m., staff called 911 emergency medical services. At 9:33 a.m., documentation indicated	F 0684		

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F 0684 SS=G	Continued from page 16 that Resident CR1 had no spontaneous respirations (stopped breathing) and staff began assisting with breathing using an Ambu bag (a hand-squeezed device that delivers air and oxygen into the lungs). Oxygen flow was increased to 10 liters per minute. It was noted that the resident had a pulse in the 70's (BPM) at that time, oxygen saturation improved to 99 percent, and the resident ' s pupils were dilated (enlarged) and unresponsive to light (a sign of neurologic impairment). Upon the arrival of paramedics, the resident was intubated (a breathing tube was inserted into the airway to provide mechanical ventilation) and transported to the emergency department. A review of the clinical record further revealed that five hours had elapsed between the last documented neurological assessment (4:00 a.m.) and the time the resident was found unresponsive at 9:00 a.m. on September 28, 2025. At that time, the resident was noted to be unresponsive to verbal and tactile stimulation. The on-call physician was again notified, and emergency medical services were called. The resident was subsequently transferred to the hospital for evaluation, 13 hours after the fall occurred. A review of a nurse ' s progress note documented by Employee 12, LPN, dated September 28, 2025, at 5:42 p.m. revealed that Resident CR1 was admitted to the hospital for evaluation of brain bleeding.	F 0684		

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F 0684 SS=G	Continued from page 17 A review of outside hospital documentation provided by the facility, dated September 29, 2025, revealed that a computed tomography (CT) scan of the brain (a diagnostic imaging test that uses X-rays and computer processing to create detailed cross-sectional images) showed a large left subdural hematoma (a collection of blood between the brain surface and its outer covering), a substantial midline shift (movement of brain structures away from their normal position due to pressure from bleeding), and multi-compartmental intracranial hemorrhage (bleeding in multiple areas within the skull). A CT scan of the abdomen and pelvis also showed a left lateral thigh subcutaneous contusion (a bruise under the skin). Hospital records indicated that the resident underwent further neurological evaluation and was pronounced deceased on September 29, 2025. An interview with the Director of Nursing (DON) on October 3, 2025, at 5:00 p.m. confirmed that Resident CR1 had a history of falls in the facility. The DON stated that documentation of the 15-minute safety checks ordered on September 27, 2025, following the fall at 7:40 p.m., and documentation of completion of all required neurological assessments, were not present in the resident ' s medical record. The record and documentation reviews revealed that after an unwitnessed fall with possible head impact Resident CR1, who was receiving anticoagulation therapy, was not	F 0684		

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F 0684 SS=G	Continued from page 18 transferred for immediate medical evaluation or diagnostic imaging. Neurological assessments and safety monitoring were not completed as ordered after the fall. The resident was found unresponsive 13 hours later and was transferred to the hospital, where diagnostic imaging identified multiple areas of brain bleeding. 28 Pa. Code 211.12 (d)(1)(5) Nursing services. 28 Pa Code 211.10 (a)(c) Resident care policies.	F 0684		
F 0689 SS=J		F 0689		

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F 0689 SS=J	Continued from page 19 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	Investigation was completed on 9/22/2025. Root cause determined to be isolated staff member improperly using a drink pitcher to store a cleaning sanitizer. Medical team made aware. Poison Control Center consulted. East Unit residents were assessed, and additional orders were implemented for the 10 residents found to have ingested some of the diluted sanitizer. These orders included vital sign monitoring, additional fluids, and oral assessments. Resident Representatives notified. Completed on 9/22/2025. DON/designee to complete follow up clinical needs determined by post incident evaluations of affected residents. Completed 9/23/2025. The chemicals in the kitchen were reviewed for proper storage and labeling; sanitizing solutions were secured. Dietary staff are to store drink pitchers on the shelf under the beverage preparation station. Open	Completion Date: **11/12/2025** Status: **APPROVED** Date: **10/23/2025**

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F 0689 SS=J	Continued from page 20	F 0689	chemicals that are in current use are to be stored under the 3-compartment sink. All other chemicals are to be stored in a remote storage area. Dietary staff are to complete pH testing on diluted 3 compartment sink chemicals and keep a log. Chemicals are only to be used for intended purposes and in labeled containers. Completed on10/3/2025. DON/designee to complete chemical safety education for nursing staff for specifics on chemical storage and container labeling. Date of completion 10/3/2025. Dietary policies for labeling and storing of chemicals were reviewed and updated. Dietary Manager/designee to complete chemical safety training for dietary staff to include Food and Chemical Storage (NO chemicals can be in food storage containers), Sanitation Bucket Use, Labeling and Dating, Hazardous Chemicals, Food Storage, SDS, and Hazard Communications.	

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F 0689 SS=J	Continued from page 21	F 0689	Date of Completion 10/3/2025. Dietary Manager/ designee to complete post education audits to ensure compliance with remediation. Audits to be completed 5X weekly for 4 weeks. Audit findings to be reviewed at facility QAPI. Audits initiated on 10/3/2025 and continue. DON/designee to complete post education audits to ensure compliance with remediation. Audits to be completed 5X weekly for 4 weeks. Audit findings to be reviewed at the facility QAPI. Audits initiated on 10/3/2025 and continue.	

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F 0689 SS=J	Continued from page 22 Based on observation, staff interviews, review of facility policies, manufacturer instructions for use (IFU), clinical record reviews, and facility investigative documentation, it was determined that the facility failed to ensure residents were protected from potential hazards in the environment by failing to implement safe and sanitary food handling practices in the facility kitchen. Specifically, the facility failed to ensure that hazardous chemical cleaning and sanitizing solutions were properly labeled, stored, and used in accordance with manufacturer instructions and facility policy. This deficient practice resulted in a corrosive sanitizing chemical being mistaken for a beverage, prepared and served to ten residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) out of 57 residents who resided on the East unit of the facility. The failure created a condition of Immediate Jeopardy to resident health and safety by exposing residents to a poisonous chemical substance capable of causing burns to skin and mucous membranes, poisoning, and potentially life-threatening illness. Findings include: A review of the facility policy titled " Chapter 3: Food Production and Safety, " last reviewed and revised by the facility on July 7, 2025, revealed it is facility policy to keep foods safe, wholesome, and appetizing. Food will be stored in an area that is clean, dry, and free from contaminants. The policy indicated chemicals must be clearly labeled,	F 0689		

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F 0689 SS=J	Continued from page 23 kept in original containers, when possible, kept in a locked area, and stored away from food items. Further review of this policy ' s subsection titled " Sanitation Buckets " revealed the objective of the document is for participants to learn the guidelines for different sanitation solutions and their proper use in sanitation buckets. The policy ' s subsection titled " Hazardous Chemicals " revealed the objective of the document is for participants to learn to identify hazardous products in the workplace and follow directions on labels to protect themselves. A chemical is classified as hazardous if it can damage an employee internally, changes or damages the surface it contacts, causes an allergic reaction with repeated use, is poisonous or causes cancer, or causes chemical reactions, fires, or explosions. Employees will read Safety Data Sheets (SDS- document provided by chemical manufacturers that detail the properties and potential hazards of a chemical substance) on five key chemicals used in the department. The policy ' s subsection titled " Chemical Safety Chart " revealed that all chemicals and cleaning products are not stored near food and are labeled so that staff know what chemical they are using. An observation and an interview October 3, 2025, at 10:00 AM with the corporate dietary manager verified that the	F 0689		

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F 0689 SS=J	Continued from page 24 liquid sanitizing/disinfectant/virucide solution utilized by the facility kitchen was " Knoxville " solution. A review of a Manufactures Minimum Safety Data Sheet (MSDS-a document that provides detailed information about the risks and safety precautions and safe-handling instructions of a hazardous chemical) revealed that the product " Knoxville " , a disinfectant/sanitizer/virucide (kills viruses) and the container label revealed, " Danger, this chemical is a hazard to humans and animals. Keep out of reach of children. Corrosive: causes irreversible eye damage and skin burns. Do not get in eyes, on skin, or clothing. Wear goggles or face shield, rubber gloves and protective clothing. Harmful if swallowed. If swallowed, call poison control center or doctor immediately for treatment advice. Have person sip a glass of water if able to swallow. Do not induce vomiting unless told to do so by the poison control center or doctor." A review of facility investigative documentation dated September 22, 2025, at 1:00 PM revealed that staff notified facility administration that the " pink juice " served at lunchtime on the East unit tasted " odd " . Upon examination of the liquid, no odor was noted; however, when tasted, it did not taste like pink lemonade, which the facility served on a regular basis. Further investigation revealed that the contents in the pitcher was kitchen sanitizer. The pitcher with the pink	F 0689		

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F 0689 SS=J	Continued from page 25 liquid was placed on the beverage cart served to residents on the East wing that day. At the time of discovery, the food trays and beverage cups had already been gathered and returned to the kitchen. Investigation and interviews with nursing staff (as noted below) confirmed that 10 residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) were served the liquid. The facility was not able to determine the amount of liquid that may have been consumed by each resident as the trays had been removed from the residents ' rooms and washed. Ten residents were confirmed to have received the liquid and immediately assessed for any symptoms of adverse reactions. The Physicians were notified. The MSDS sheets were reviewed, the poison control center contacted, and recommendation was made to encourage fluid consumption. Physicians ' orders were obtained for all residents on the east unit for nursing staff to administer 240 cc of water every hour for 4 hours, vital sign monitoring every 2 hours for 8 hours, then every shift for 24 hours and an oral evaluation for all residents on the east unit for any redness, pain or open lesions. Families of the affected residents were contacted. A clinical record review revealed Resident 7 was admitted to the facility on May 8, 2018, with diagnoses that included chronic kidney disease (gradual loss of kidney function) and dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and	F 0689		

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F 0689 SS=J	Continued from page 26 reasoning to an extent that interferes with daily life). A review of a quarterly Minimum Data Set (MDS, a federally mandated standardized assessment conducted periodically to plan resident care) dated September 8, 2025, revealed that Resident 7 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS, a cognitive tool used to assess attention, orientation, and ability to register and recall new information) score of 03 (a score of 00-07 indicates cognition is severely impaired). A progress note dated September 22, 2025, at 3:25 PM revealed that Resident 7 experienced two episodes of emesis (vomiting) after eating lunch. New orders were noted for vital signs and fluid administration. A subsequent progress note dated September 22, 2025, at 4:08 PM revealed that Resident 7 was served and possibly consumed an unknown amount of kitchen sanitizer. The physician, resident representative, and poison control center were notified. New physician orders directed that vital signs be monitored every two hours for eight hours and then each shift for 24 hours; an oral evaluation be performed for redness or irritation; and 240 cc of fluid be administered immediately and 240 cc every hour for four hours. A review of the clinical record revealed no documentation that the ordered vital signs or fluid administration were completed as directed. There was no evidence that an oral cavity assessment was performed at the time of the	F 0689		

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F 0689 SS=J	Continued from page 27 incident. Nursing notes revealed that an oral assessment was documented on September 23, 2025, at 1:27 PM. A clinical record review revealed that Resident 1 was admitted to the facility on December 2, 2022, with diagnoses that included chronic kidney disease. A review of a quarterly MDS dated July 16, 2025, revealed that Resident 1 was cognitively intact with a BIMS score of 14, (a score of 13-15 indicates cognition is intact). A progress note dated September 22, 2025, at 4:04 PM revealed that Resident 1 was served and possibly consumed an unknown amount of kitchen sanitizer. The physician, resident representative, and poison control center were notified. New physician orders were received as noted above. A review of the clinical record revealed no documentation that the ordered vital signs or fluid administration were completed as directed, or that an oral cavity assessment was performed at the time of the incident. Nursing documentation revealed that an oral assessment was completed on September 23, 2025. During an interview conducted on October 3, 2025, at 11:46 AM Resident 1 stated that he had not been made aware that he had been served and may have consumed kitchen sanitizer. Resident 1 stated that no facility employee had discussed the incident or the potential health risks	F 0689		

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F 0689 SS=J	Continued from page 28 associated with ingestion of the chemical. A clinical record review revealed that Resident 2 was admitted to the facility on August 25, 2021, with diagnoses that included cerebral infarction (damage to brain tissue due to interruption of blood flow). A review of a quarterly MDS dated June 25, 2025, revealed that Resident 2 was severely cognitively impaired with a BIMS score of 03. A progress note dated September 22, 2025, at 4:07 PM revealed that Resident 2 was served and possibly consumed an unknown amount of kitchen sanitizer. The physician, resident representative, and poison control center were notified. New physician orders were received and noted as above. A review of the clinical record revealed no documentation that the ordered vital signs or fluid administration were completed as directed, or that an oral cavity assessment was performed at the time of the incident. Nursing documentation revealed that an oral assessment was completed on September 23, 2025. A clinical record review revealed that Resident 3 was admitted to the facility on September 15, 2023, with diagnoses that included dementia (a condition characterized by the loss of cognitive functioning such as thinking, remembering, and reasoning, to an extent that it interferes with daily life). A review of a quarterly MDS	F 0689		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
GRANDVIEW NURSING AND REHABILITATION STATE LICENSE NUMBER: **591602**	**78 WOODBINE LANE DANVILLE, PA 17821**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=J	Continued from page 29 dated September 14, 2025, revealed that Resident 3 was severely cognitively impaired as documented in Section C1000 Cognitive Skills for Daily Decision Making. Sections C 700 and C 800 revealed that Resident 3 had problems with short-term memory (information retained for seconds to a few minutes) and long-term memory (information or skills retained from the past). A progress note dated September 22, 2025, at 4:08 PM revealed that Resident 3 was served and possibly consumed an unknown amount of kitchen sanitizer. The physician, resident representative, and poison control center were notified. New physician orders were received as noted above. A review of the clinical record revealed no documentation that the ordered vital signs or fluids were provided as directed, or that an oral cavity assessment was performed at the time of the incident. Nursing documentation revealed that an oral assessment was completed on September 23, 2025. A clinical record review revealed that Resident 4 was admitted to the facility on October 9, 2024, with diagnoses that included chronic obstructive pulmonary disease (COPD, a lung condition that blocks airflow and makes breathing difficult). A review of a quarterly MDS dated September 3, 2025, revealed that Resident 4 was severely cognitively impaired with a BIMS score of 02.	F 0689		

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F 0689 SS=J	Continued from page 30 A progress note dated September 22, 2025, at 4:08 PM revealed that Resident 4 was served and possibly consumed an unknown amount of kitchen sanitizer. The physician, resident representative, and poison control center were notified. New physician orders were received as noted above. A review of the clinical record revealed no documentation that the ordered vital signs or fluids were provided as directed, or that an oral cavity assessment was performed at the time of the incident. Nursing documentation revealed that an oral assessment was completed on September 23, 2025. A clinical record review revealed that Resident 5 was admitted to the facility on September 19, 2023, with a diagnosis of chronic kidney disease (gradual loss of kidney function). A review of a quarterly MDS dated September 4, 2025, revealed that Resident 5 was severely cognitively impaired with a BIMS score of 03. A progress note dated September 22, 2025, at 4:09 PM revealed that Resident 5 was served and possibly consumed an unknown amount of kitchen sanitizer. The physician, resident representative, and poison control center were notified. New physician orders were received as noted above.	F 0689		

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F 0689 SS=J	Continued from page 31 A review of the clinical record revealed no documentation that the ordered vital signs or fluids were provided as directed, or that an oral cavity assessment was performed at the time of the incident. Nursing documentation revealed that an oral assessment was completed on September 23, 2025. A clinical record review revealed that Resident 6 was admitted to the facility on November 2, 2023, with diagnoses that included cerebral infarction (damage to brain tissue caused by interruption of blood flow). A review of a quarterly MDS dated June 23, 2025, revealed that Resident 6 was severely cognitively impaired as documented in Section C1000 -Cognitive Skills for Daily Decision Making. Sections C 700 and C 800 revealed that Resident 6 had problems with short-term and long-term memory. A progress note dated September 22, 2025, at 4:09 PM revealed that Resident 6 was served and possibly consumed an unknown amount of kitchen sanitizer. The physician, resident representative, and poison control center were notified. New physician orders were received as noted above. A review of the clinical record revealed no documentation that the ordered vital signs or fluids were provided as directed, or that an oral cavity assessment was performed at the time of the incident. Nursing documentation revealed	F 0689		

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F 0689 SS=J	Continued from page 32 that an oral assessment was completed on September 23, 2025. A clinical record review revealed that Resident 8 was admitted to the facility on January 15, 2024, with diagnoses that included dementia. A review of a quarterly MDS dated June 26, 2025, revealed that Resident 8 was severely cognitively impaired with a BIMS score of 05. A progress note dated September 22, 2025, at 4:10 PM revealed that Resident 8 was served and possibly consumed an unknown amount of kitchen sanitizer. The physician, resident representative, and poison control center were notified. New physician orders were noted as above. A review of the clinical record revealed no documentation that the ordered vital signs or fluids were provided as directed, or that an oral cavity assessment was performed at the time of the incident. Nursing documentation revealed that an oral assessment was completed on September 23, 2025. A clinical record review revealed that Resident 9 was admitted to the facility on December 3, 2020, with diagnoses that included peripheral neuropathy (nerve damage that interferes with the function of the peripheral nervous system). A review of a quarterly MDS dated July 2, 2025, revealed that Resident 9 was severely cognitively	F 0689		

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F 0689 SS=J	Continued from page 33 impaired with a BIMS score of 06. A progress note dated September 22, 2025, at 4:09 PM revealed that Resident 9 was served and possibly consumed an unknown amount of kitchen sanitizer. The physician, resident representative, and poison control center were notified. New physician orders as noted above. A review of the clinical record revealed no documentation that the ordered vital signs or fluids were provided as directed, or that an oral cavity assessment was performed at the time of the incident. Nursing documentation revealed that an oral assessment was completed on September 23, 2025. A clinical record review revealed that Resident 10 was admitted to the facility on October 11, 2002, with diagnoses that included cerebral palsy (a condition caused by abnormal brain development or brain damage that affects movement and coordination). A review of a quarterly MDS dated September 17, 2025, revealed that Resident 10 was cognitively intact with a BIMS score of 15. A progress note dated September 22, 2025, at 4:08 PM revealed that Resident 10 was served and possibly consumed an unknown amount of kitchen sanitizer. The physician, resident representative, and poison control center were notified. New physician orders as noted above.	F 0689		

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F 0689 SS=J	Continued from page 34 A review of the clinical record revealed no documentation that the ordered vital signs or fluids were provided as directed, or that an oral cavity assessment was performed at the time of the incident. Nursing documentation revealed that an oral assessment was completed on September 23, 2025. During an interview on October 3, 2025, at 12:30 PM Resident 10 indicated that staff checked on him after the incident a few weeks ago. He recalled staff asking him if the pink juice tasted funny but explained that he had no knowledge that he was served and may have consumed kitchen sanitizer. He indicated that no facility employee reviewed the dangers or risks associated with ingesting the chemical. Resident 10 expressed frustration that additional information about the incident had not been provided. A review of an interview statement dated September 22, 2025 (no time indicated) revealed that Employee 13 NA (Nurse Aide) reported, " I was doing the assisted feed with Resident 11 and noticed that Resident 6 was not drinking his juice. Then Resident 3 made a nasty face after she took a sip of her juice, and Resident 4 refused to drink hers. Resident 7 ' downed ' two cups of the juice by this time while waiting on her tray. " Employee 13 explained that residents in the dining room were served beverages prior to meal delivery. She stated, " I figured it didn ' t have no taste that no one would drink it, meaning, Resident 6 drinks anything and everything. I poured a cup and tried it.	F 0689		

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F 0689 SS=J	Continued from page 35 I spit it out all over. It tasted chemically, with no flavor. " Employee 13 stated that she then took the pitcher to the Director of Nursing (DON), who also noted the same taste. She reported, " We, (me and the DON) took the pitcher to dietary, same outcome. At this time, Resident 7 started throwing up. " Interviews and documentation reviewed during the investigation revealed the following information regarding the circumstances leading to residents being served sanitizer instead of a beverage. An interview with Employee 14 (Licensed Practical Nurse, LPN) revealed that Employee 13 NA informed her that the red or pink beverage on the drink cart appeared to cause residents to make faces while drinking it. Employee 13 reported tasting the beverage and stated it had a " chemical " flavor. Employee 14, LPN, directed Employee 13 NA to remove the beverage from the residents ' possession and notify the DON. Employee 14, LPN, stated that staff were informed of the concern and that residents were encouraged to drink fluids and were monitored. A review of a written witness statement by Employee 1 (cook) no date or time indicated revealed, " Last night (September 21, 2025), I, Employee 1 (cook) used a pitcher for sanitizer to clean the kitchen. As I finished, I placed the pitcher in the sink and left " .	F 0689		

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F 0689 SS=J	Continued from page 36 During a telephone interview on October 3, 2025, at 2:08 PM, Employee 1, cook, explained that on September 22, 2025, he was tired after working multiple hours (a review of the facility ' s dietary department assignments for September 22, 2025, revealed Employee 1, Cook, began his shift at 5:00 AM, and the incident occurred at approximately 11:00 AM). He indicated that he began his normal responsibility of cleaning and disinfecting the food prep areas of the kitchen. Employee 1, cook, explained that there were no available sanitation buckets for mixing the sanitizing solution. Instead, he used a dirty clear plastic gallon drink pitcher to mix the " red " sanitizer agent with water, then proceeded to clean the kitchen surfaces. When he finished cleaning, Employee 1 explained he put the drink pitcher with the remaining pink/red liquid in the dirty compartment of the sink. He indicated that he was wrong to use the clear pitcher as a cleaning bucket. Employee 1, cook, explained he was suspended and then fired from the facility after the incident. He confirmed that he had never received any education regarding his job in the facility kitchen. A review of Employee 1 ' s personnel file, maintained by the contracted dietary company, revealed he was hired on July 20, 2025, and terminated on September 22, 2025. The file contained no evidence of a written job description or documentation of orientation or training related to his position as cook.	F 0689		

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F 0689 SS=J	Continued from page 37 A review of written documentation dated September 21, 2025, with no time indicated, revealed that Employee 5 (Assistant Dietary Manager) stated, " I completed the drink cart for lunch. The Kool-Aid tub we generally use to make the drink was full of the same pink lemonade we use for drinks. " Employee 5 explained that the " Kool-Aid tub " referred to a five-gallon, covered plastic container kept in the kitchen refrigerator and used to prepare and store beverages prior to meal service. The beverage from this container was routinely poured into clear plastic pitchers that were placed on drink carts for delivery to resident dining areas. Employee 5 further stated, " I automatically assumed that someone pre-made the Kool-Aid (in the pitcher} and I used it. I did not know it was sanitizer. " The investigation determined that the facility ' s kitchen utilized a three-compartment sink system for manually washing, rinsing, and sanitizing cookware and utensils. The sanitizing step required the use of a red chemical sanitizer solution (a concentrated cleaning agent formulated to kill bacteria and viruses on food-contact surfaces). The solution was prepared by mixing the sanitizer with water in accordance with manufacturer instructions and was intended only for use within the sanitizing sink compartment. Based on staff interviews and documentation reviewed, it was determined that sanitizer prepared for the three-compartment sink had been placed into a clear plastic drink pitcher rather than an appropriately labeled container, resulting in the chemical	F 0689		

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F 0689 SS=J	Continued from page 38 solution being mistaken for pink lemonade and subsequently served to residents. Employee 5 (assistant dietary manager) resigned his position at the facility prior to the survey on September 30, 2025, and was not available for a telephone interview at the time of the survey. A review of Employee 5 ' s personnel file revealed that he was hired on July 20, 2025, and voluntarily terminated employment on September 30, 2025. The file contained no documentation of a job description or evidence of education or training provided by the contracted dietary company or the facility. Interviews conducted on October 3, 2025, with current dietary staff revealed the following: Employee 15, dietary aide, stated that she had been employed in the kitchen for a few months. She reported that she received education regarding labeling drink pitchers only after the September 22, 2025, event and stated that she had not received any prior education regarding her kitchen duties. Employee 16, dietary aide, stated that he had worked in the kitchen for a few months and had not received any education or training related to kitchen operations.	F 0689		

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F 0689 SS=J	Continued from page 39 Employee 17 (cook) stated that she had been employed in the kitchen for several months and had never received any education or training regarding her job responsibilities in the kitchen. During an interview conducted on October 3, 2025, at 3:30 PM the facility ' s Dietary Manager stated that most of the kitchen staff were newly hired and had been employed for only a few months. She confirmed that the kitchen was operated under contract with an outside food-service agency and that she was employed by that agency. The manager stated that education and training for dietary employees were completed upon hire and annually but described the process as informal, consisting of being " walked through " the job duties on the first day of employment. She confirmed that there were no written competencies or job descriptions available for staff reference. Immediate Jeopardy was identified and declared on October 3, 2025, at 3:30 PM due to the facility ' s failure to properly label and identify a pitcher that contained a sanitizing solution used in the three-compartment sink. The unlabeled solution was mistaken for pink lemonade and subsequently served to approximately ten residents. This failure resulted in the exposure of residents to a hazardous chemical substance and placed them in a condition of Immediate Jeopardy to health and safety.	F 0689		

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F 0689 SS=J	Continued from page 40 The facility was notified of the Immediate Jeopardy findings at 3:30 PM on October 3, 2025, and the Immediate Jeopardy Template was provided to the Nursing Home Administrator at that time. In response, the facility submitted a written Immediate Jeopardy action plan at 7:30 PM on October 3, 2025. The plan included the following corrective actions: A root-cause analysis was completed, which determined that a staff member had improperly used a drink pitcher to mix and store a sanitizing chemical in the kitchen. All residents on the East Unit were reassessed for injury or adverse effects, and physician orders were implemented for care and monitoring. All chemicals in the kitchen were reviewed for proper labeling and storage. Education was provided to all dietary and nursing staff regarding chemical safety, labeling, and segregation of food and cleaning supplies. All chemicals not in active use were removed from the kitchen area and placed in a secure, designated chemical-storage area.	F 0689		

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F 0689 SS=J	Continued from page 41 Facility dietary policies regarding chemical labeling, storage, and use were reviewed and revised. Post-education audits were initiated to verify continued staff compliance with labeling and storage procedures. Verification of implementation of the Immediate Jeopardy action plan was completed, and the Immediate Jeopardy was determined to have been removed on October 4, 2025, at 11:30 AM, after it was verified that the corrective actions had been fully implemented and were effective in removing the immediate threat to resident health and safety. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18 (e)(1) (2.1) (3) Management 28 Pa. Code 211.6 (f) Dietary services 28 Pa. Code 211.10 (d) Resident care policies	F 0689		
F 0812 SS=F		F 0812		

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F 0812 SS=F	Continued from page 42 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. Three compartment sinks were emptied cleaned and sanitizer test strips were obtained. Area around 3 compartment sink was cleaned and dirty mop bucket was emptied and cleaned. Cleaning equipment stored by the 3-compartment sink was moved to avoid possible contamination of food-contact areas. Log obtained for documentation of sanitizer concentrations. Unlabeled drink pitchers removed from window sill and cleaned. Window sill cleaned of dirt and lint. Cleaning bucket moved away from spice shelf with cooking products. Kitchen maintenance room was checked for contamination and hazards and all equipment and cleaning products were removed and/or relocated. Floor of maintenance storage room was cleaned and detergent was stored. 3 tier metal shelving unit in storage room was cleaned. Floor of storage room was cleaned of dirt and debris. All meal delivery carts have been cleaned. Kitchen refrigerator fans have been cleaned as well as ceiling. Unlabeled and use by	Completion Date: **11/12/2025** Status: **APPROVED** Date: **10/23/2025**

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F 0812 SS=F	Continued from page 43	F 0812	10/1/25 deli meat has been discarded. Coffee cups with white film in Pavillon dining room have been discarded as well as open cereal bag in box. Metal banquet pans have been cleaned. Refrigerator has been cleaned and outdated sandwiches and unmarked peaches have been discarded. Resident Pavillon pantry has been cleaned, all undated, outdated, or opened food items have been discarded, dirty dishes have been removed for cleaning. Refrigerator and freezer have been cleaned. 2. Corporate Dietary Service manager will complete detailed and thorough audit of main kitchen, maintenance storage area, food storage area, walk in refrigerator and freezer areas as well as all pantries on nursing units and ensure areas are compliant. 3. Dietary Manager/ designee with educate dietary staff on regulation requirements for food procurement/storage and food preparation and serving and maintaining a sanitary environment.	

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F 0812 SS=F	Continued from page 44	F 0812	4. Corporate Dietary Service manager or designee will complete visual inspection and audits of kitchen areas as well as pantries 2 x week x 8 weeks. Results of audits will be reviewed by the QAPI committee.	

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F 0812 SS=F	Continued from page 45 Based on observation of the dietary department, Pavilion unit dining room, and resident pantry areas, review of relevant facility policy, and staff interviews, it was determined the facility failed to maintain food service sanitation practices in accordance with acceptable professional standards for the safe preparation, handling, and service of food. 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	F 0812		

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F 0812 SS=F	Continued from page 46 and executing federal laws related to food). During a tour of the facility kitchen on October 3, 2025, at 10:00 a.m., with the Corporate Dietary Manager, multiple sanitation concerns were identified that could introduce contaminants into food. The facility used a three-compartment sink system (a manually operated method used in food service operations to wash, rinse, and sanitize dishes and utensils). According to the Food and Drug Administration (FDA, the federal agency that regulates food safety), each sink compartment serves a distinct purpose. The FDA requires commercial foodservice establishments to both clean and sanitize their dishes in their manual washing process. Three compartment sinks have a logical order to help properly clean and sanitize dishes. While those who misunderstand the terms use them interchangeably, cleaning and sanitizing refer to two	F 0812		

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F 0812 SS=F	Continued from page 47 separate functions.: The first sink (wash) removes food residue using detergent and water at approximately 110 degrees Fahrenheit. The second sink (rinse) removes detergent with clean, warm water. The third sink (sanitize) uses either a chemical agent or hot water to destroy bacteria invisible to the eye. Cleaning refers to the removal of visible debris, while sanitizing refers to the process of using a chemical or heat treatment to kill bacteria and other pathogens on already-clean surfaces. A review of the facility ' s policy titled " Cleaning Dishes and Manual Dishwashing " (last reviewed July 8, 2025) directed staff to clean and sanitize cookware after each meal. The policy required water temperatures of 110 °F for washing and 75-100 °F for sanitizing, with chlorine sanitizer maintained between 50-100 parts per million (PPM, a measure of concentration used to verify sanitizer	F 0812		

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F 0812 SS=F	Continued from page 48 strength). The policy also required the use of chemical test strips to confirm sanitizer concentration and cleaning of sinks and faucets after use. The policy further outlined the following detailed procedures for manual dishwashing: 1. Scrape dishes into a clean waste basket or garbage disposal prior to washing. 2. Rinse dishes and stack them carefully to prevent re-contamination. 3. Clean and sanitize the sinks prior to beginning the dishwashing process. 4. Prepare the sinks according to a posted chart specifying: Sink 1 (Wash): Fill with detergent and warm water at 110 °F, changing water frequently to maintain cleanliness. Sink 2 (Rinse): Fill with clean, warm water and rinse dishes thoroughly before sanitizing. Sink 3 (Sanitize): Prepare sanitizer solution at 75-100 °F according to manufacturer guidelines, verify concentration using test strips to ensure 50-100 PPM, submerge items for required contact	F 0812		

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F 0812 SS=F	Continued from page 49 time, then air-dry inverted in a single layer. 5. After washing is complete, clean and sanitize sinks and faucets and check sanitizer strength frequently throughout use. The policy emphasized that failure to monitor sanitizer concentration or to clean and sanitize sinks between uses could result in contamination of dishes and utensils. Observation of the three-compartment sink on October 3, 2025 at 10:00 AM revealed the following: The first sink contained multiple dirty pots and pans. All three compartments contained food debris. No sanitizer test strips (paper strips used to confirm that sanitizer concentration is at the correct strength to destroy bacteria) were present. The surrounding area was dirty with paper debris, liquid stains, and a sticky residue on the floor. A mop bucket filled with dirty water and cleaning equipment was stored adjacent to the sink, creating potential for contamination of food-contact areas.	F 0812		

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F 0812 SS=F	Continued from page 50 During an interview at that time, the Corporate Dietary Manager confirmed the observations and stated sanitizer test strips could not be located. He further stated there was no documentation verifying that sanitizer concentrations were checked in accordance with facility policy. He reported that most dietary staff were recently hired and had not been trained (in-serviced) on proper three-compartment sink use. Additional environmental observations conducted between 10:00 AM and 3:00 PM revealed widespread sanitation concerns throughout the kitchen, maintenance, storage, and service areas: Four unlabeled drink pitchers stored upside-down on a dirty windowsill with food particles and lint. An unlabeled bucket containing a rag in chemical solution stored on a shelf next to food items such as cooking oil and spices. In the kitchen maintenance room, two portable	F 0812		

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F 0812 SS=F	Continued from page 51 machines were observed, which the Dietary Manager could not identify. An open bottle of degreaser was placed on one of the machines. Several electrical extension cords were strewn across the machines and floor, posing both contamination and safety concerns. A nearby metal cart was visibly soiled with food debris, paper waste, and an open bottle of dish detergent. The floor throughout the area contained visible dirt, paper, and plastic debris, with a black sticky substance on the vinyl flooring that adhered to shoes when walked upon. In the storage room, an uncovered three-tiered metal shelving unit held metal banquet pans, cooking racks, serving utensils, and bowls, several of which contained standing water and water stains. Dust, dirt, cobwebs, empty cardboard boxes, and open containers of paper dining products were observed scattered across the floor. During the lunch meal service at 12:30 PM, the kitchen ' s meal tray delivery cart had visible liquid	F 0812		

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F 0812 SS=F	Continued from page 52 stains on its exterior. On both the east and west resident hallways, open food carts were noted with food and liquid stains on their exteriors. In the kitchen refrigerator, a heavy buildup of lint-like material was observed on the two fans along the back wall, along with a black sticky residue on the ceiling surface. A zip-lock bag containing sliced deli meat lacked any label or date, as did another open bag of lunch meat. An open container of soup labeled " use by 10/1/25 " was also present. Observation of the Pavilion resident dining area on October 3, 2025, at 12:45 PM revealed multiple clean coffee cups with a white film on the inside, an open bag of cereal in a cardboard box, and several metal banquet pans with liquid stains. The refrigerator was dirty with food debris, paper waste, and dirt accumulation. Four sandwiches were dated September 30, 2025, and three covered bowls of peaches were undated and unlabeled. Observation of the Pavilion resident pantry revealed	F 0812		

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F 0812 SS=F	Continued from page 53 dirty dishes on the counter, a microwave with dried food residue, and sticky countertops with visible food and liquid stains. The cabinet under the sink contained dirty trays, a plastic bag of dishwasher pods (chemical cleaning agents), and was unlocked at the time of observation. Additional cabinets contained disorganized, open packages of paper napkins, plastic lids, and plates. A drawer contained an open container of cookies. The refrigerator held multiple unlabeled and undated food containers, including an open plastic container of " sweet tea " with a use-by date of September 18, 2025, three unlabeled bags of pizza slices, and an unlabeled cup of coffee from an outside restaurant. The freezer contained an open, undated package of waffles. The refrigerator interior was dirty with food, liquid, and dirt debris. During an interview on October 3, 2025, at 2:45 PM, the Corporate Dietary Manager confirmed that dietary staff were responsible for cleaning and maintaining both the resident pantry and dining areas. During an additional interview on October 3,	F 0812		

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F 0812 SS=F	Continued from page 54 2025, at approximately 3:00 PM, the Nursing Home Administrator confirmed that the above conditions constituted food safety and sanitation issues. 28 Pa. Code 211.6 (f) Dietary services.	F 0812		
F 0835 SS=D		F 0835		

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F 0835 SS=D	Continued from page 55 483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 0835	1. Unable to retro correct deficient practice. 2. NHA/ designee will direct and lead and direct the overall operations of the facility and ensure that the Corporate Dietary Service manager provided education to all dietary staff on proper use and storage of kitchen chemicals. NHA will ensure that Corporate Dietary Service manager/ designee is present in the facility to inspect, direct and oversee the dietary personnel to ensure regulatory compliance. In the absence of the NHA, DON will assume these responsibilities. 3. Regional Director of Operations/ designee will provide education to the NHA and DON on Administrative Duties and responsibilities. 4. Regional Director of Operations/designee will follow-up weekly by reviewing audits to ensure the NHA and DON are providing effective and efficient administrative oversight. Audit findings will be reviewed at facility QAPI meeting.	Completion Date: **11/12/2025** Status: **APPROVED** Date: **10/23/2025**

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F 0835 SS=D	Continued from page 56 Based on observations, a review of clinical records, select facility policies, documentation provided by the facility, and interviews with residents and staff, it was determined that the facility ' s administration failed to effectively use its resources to promote resident safety and maintain the highest practicable physical and mental well-being of residents in the facility. Specifically, the administration failed to ensure resident safety when the facility ' s dietary department served a hazardous cleaning chemical to residents and failed to prevent ten out of fifty-seven residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) from ingesting the chemical. This deficient practice placed all fifty-seven residents residing in the East Wing at risk of consuming a hazardous cleaning substance and resulted in an immediate jeopardy to resident health and safety. Findings included: A review of the job description for the Nursing Home Administrator (NHA) dated June 3, 2024, revealed the administrator will lead and direct the overall operations of the facility. The NHA ' s essential duties and responsibilities include hiring, training, and developing department staff, verifying that the building and grounds are maintained appropriately, and that equipment and work areas are clean, safe and orderly, and any hazardous conditions are addressed, overseeing regular rounds to monitor operation of support departments, and consulting with department managers concerning the operation of	F 0835		

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F 0835 SS=D	Continued from page 57 their departments to assist in eliminating/ correcting problem areas and/ or improving services. The Job Description for Director of Nursing (DON) Services dated March 10, 2025, revealed the DON in the absence of the NHA will assume responsibility for the facility, participate in safety committee meetings, quality assessment and assurance committee meetings, and assuring residents a comfortable, clean, orderly, and safe environment. The facility failed to ensure these administrative responsibilities were carried out, as evidenced by the facility served a hazardous cleaning chemical to residents during meal service, and ten out of fifty-seven residents ingested the chemical. (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10). This event demonstrated a lack of effective oversight to address a failure to implement safe handling, storage and labeling of hazardous chemicals. Interviews with staff confirmed that dietary personnel had not received effective training or competency evaluation regarding the safe handling, storage, and labeling of hazardous chemicals in accordance with facility policy and procedure to ensure the safety of residents. The deficiency cited under the Code of Federal Regulatory Groups for Long Term Care, Quality of Care (F689) 483.25(d)(1)(2) Accidents, revealed the Administrator and Director of Nursing failed to fulfill essential administrative	F 0835		

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F 0835 SS=D	Continued from page 58 duties to monitor departmental operations, identify systemic risks, and ensure the implementation of facility policies to maintain resident safety. The lack of oversight and resource utilization contributed to the immediate jeopardy situation. Refer F689 28 Pa. Code: 201.14 (a) Responsibility of licensee 28 Pa. Code: 201.18 (e)(1) Management 28 Pa Code 211.6(f) Dietary services. 28 Pa. Code 211.12 (d)(3) Nursing services	F 0835		

Certified End Page

GRANDVIEW NURSING AND REHABILITATION

STATE LICENSE NUMBER: 591602

SURVEY EXIT DATE: 10/04/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

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