STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Rehabilitation and Healthcare Center	55 Grand Street New Britain, CT 06052

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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 0567 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. 19953 Based on review of Resident #322's personal funds and staff interview, the facility failed to obtain consent from Resident #322's or Resident #322's responsible party for the diversion of Resident #322's monthly Social Security payments from Resident #322's financial institution into a Resident Trust Account at the facility. The facility also failed to obtain consent to automatically withdrawal from Resident #322's personal trust account the monthly money owed to the facility. The findings include: Resident #322's diagnoses included anxiety disorder, chronic obstructive pulmonary disease and diabetes. The face sheet in the electronic clinical record identified Person #1 was Resident #322's Responsible Person. A quarterly Minimum Data Set date 2/16/22 identified Resident #322 was moderately cognitively impaired. A corresponding Resident Care Plan identified a problem with having impaired cognitive function/dementia or impaired thought processes related to dementia. Interventions included to ask yes/no questions in order to determine resident's needs, and communicate with the resident/family/caregivers regarding resident's capabilities and needs. Interview with the Business Office Manager (BOM) on 9/22/22 at 12:45 PM identified that Person #2 was Resident #322's Power of Attorney (POA) and Responsible Person. Resident #322 was was granted Title 19 but not until 7/1/22. Additionally, the BOM identified that prior to March 2022, Resident #322's Social Security check ($1707.00) was directly deposited into Resident #322's credit union, but she had notified Social Security to deposit the check directly into Resident #322's Resident Trust Account at the facility because Person #2 would not pay the facility for Resident #322's stay pending Title 19. The BOM further indicated she did not obtain consent from Resident #322 or Person #2 to re-route Resident #322's Social Security check from Resident #322's credit union to the Resident Trust Account at the facility. The BOM further identified she would withdraw $1632.00 from Resident #322's Resident Trust Account each month to pay for Resident #322's stay without obtaining consent because she had previously done that at another facility and was unaware of the requirement to obtain consent. (continued on next page)

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

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

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F 0567 Level of Harm - Potential for minimal harm Residents Affected - Some	Resident #322's Resident Trust Account statement identified the facility withdrew $1632.00 from his/her Resident Trust Account on 3/14/22, 4/1/22, 5/3/22, 6/3/22, 7/1/22, and 8/3/22 for care costs. A Resident's [NAME] of Rights facility document (revised July 2021) identified residents have the right to manage their personal financial affairs and cannot be required to deposit their personal funds with the facility.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31310 Based on clinical record reviews, facility documentation, facility policy and interviews for two of three sampled residents (Resident #14 and R #98) who were reviewed for an allegation of resident to resident abuse, the facility failed to notify the Conservator of Person and the physician after the residents had an incident of inappropriate sexual conduct with each other. The findings include: 1. Resident #14's diagnoses included dementia without behavioral disturbance and dysthymic disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 was not able to make decisions regarding tasks of daily living, exhibited no behavioral symptoms, was independent with walking in the room, and required one (1) person supervision with walking in the corridor. The nurse's note dated 3/21/22 at 2:26 AM noted the 11PM-7AM charge nurse found Resident #14 standing in the dining room kissing Resident #98, both residents were fully clothed, and the Supervisor was made aware. Upon further review, the clinical record failed to reflect documentation the Conservator of Person and the physician were notified after the incident of inappropriate sexual conduct on 3/21/22. Interview with Resident #14's Conservator, Person #1, on 9/21/22 at 4:15 PM identified he/she was unaware of the incident on 3/21/22 and had he/she known, Resident #98 would not be on the same unit as Resident #14. Interview with the Advanced Practical Registered Nurse (APRN) #3 on 9/26/22 at 2:20 PM identified she could not recall if she was notified after the incident on 3/21/22. APRN #3 indicated had she been notified she would have seen the resident, document her encounter and any recommendations in the progress note. 2. Resident #98's diagnoses included anxiety and dementia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #98 had some short- and long-term memory recall deficits and required limited one (1) person assistance with walking in the room and corridor. The nurse's note dated 3/21/22 at 2:22 AM noted the 11PM-7AM charge nurse found Resident #14 standing in the dining room kissing Resident #98, both residents were fully clothed, and the Supervisor was made aware. Upon further review, the clinical record failed to reflect documentation the Conservator of Person and the physician were notified after the incident of inappropriate sexual conduct on 3/21/22. Interview with the Director of Nursing (DON) #1 on 9/23/22 at 11:10 AM identified the expectation was for the nursing staff to notify the physician and the residents' conservators after the incident of inappropriate sexual conduct on 3/21/22. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Advanced Practical Registered Nurse (APRN) #3 on 9/26/22 at 2:20 PM identified she could not recall if she was notified after the incident of inappropriate sexual conduct between Resident #14 and #98 on 3/21/22. APRN #3 indicated had she been notified she would have seen Resident #98, document her encounter and any recommendations in the progress note. APRN #3 indicated she would have implemented some type of treatment, first line would have been starting Resident #98 on an antidepressant to decrease his/her sexual drive, implement environmental changes such as moving Resident #98 to a different unit, continue behavioral therapy and Resident #98 should have been watched closely after the incident. Review of the Change of Condition Notification policy directed in the event of a change of resident condition (a deterioration in health, mental or psychosocial status either life threatening condition or clinical complications) both Family/Responsible Party and Physician will be notified in a timely manner.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 31310 Based on clinical record reviews, facility documentation, facility policy and interviews for one of three sampled residents (Resident #14) who was reviewed for sexual abuse, was not able to make decisions for himself/herself and had a Conservator of Person, the facility failed to ensure the resident was free from inappropriate sexual conduct by another resident and failed to communicate and follow through to ensure new interventions were implemented to prevent future incidences with Resident #14 and other residents on the dementia unit after the resident had an incident of physical contact with Resident #14. The failures resulted in a finding of Immediate Jeopardy. The findings include: Resident #14's diagnoses included dementia without behavioral disturbance and dysthymic disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 was not able to make decisions regarding tasks of daily living, exhibited no behavioral symptoms, was independent with walking in the room, and required one (1) person supervision with walking in the corridor. The Resident Care Plan dated 1/20/22 identified Resident #14 had impaired cognitive function and impaired thought process related to the diagnoses of dementia, bipolar disorder, and schizoaffective disorder. Interventions directed to ask yes/no questions to determine Resident #14 ' s needs, communicate with Resident #14 and his/her family regarding the resident's capabilities and needs, present just one thought, idea, question, or command at a time. Upon further review, the Resident Care Plan identified Resident #14 had a history of exhibiting behaviors including wandering, exit seeking and resistance to care. Resident #14 did exit seeking looking for his/her children and at times was difficult to redirect. Interventions directed wanderguard in place, re-approach at later time, when the resident refuses care another staff member to re-approach, and psychiatric consult routinely and as needed. The psychiatric evaluation and consultation dated 3/2/22 identified Resident #14 was oriented to time and loosely oriented to situation ant circumstantial thought process and per the nursing staff Resident #14 was at his/her baseline with occasional anxiety but redirectable. The assessment identified Resident #14 was alert but confused with no meaningful contribution to history of present illness or the review of symptoms and no agitation or aggression was noted. The evaluation identified Resident #14 ' s targeted behavior of wandering appeared to be adequately managed at this time and the plan was to continue to provide consistency of care and redirection. Resident #98's diagnoses included anxiety and dementia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #98 had some short- and long-term memory recall deficits, was cognitively impaired and required limited one (1) person assistance with walking in the room and corridor. The undated Resident Care Plan associated to the MDS assessment dated [DATE] identified Resident #98 was a registered sex offender and was at risk for exhibiting inappropriate behavior. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interventions directed to intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, remove from situation, and take to alternate location as needed, follow facility, state, and federal protocols related to sex offenders, maintain contact with police department, psychiatrist to follow, provide medications as ordered by physician, the resident may not attend any recreation activities that have minors present. The psychiatric evaluation and consultation dated 2/24/22 identified Resident #98 was oriented to time, partially to the situation and his/her thought process was relevant and was cooperative and engaging in today's evaluation. The evaluation identified Resident #98 denied hastened anxiety or symptoms of depression, no agitation or aggression was noted and there were no concerns of sleep or appetite per nursing. The evaluation indicated Resident #98 was offered emotional support and positive feedback for engaging in today's evaluation and the plan was to continue the current medications and psychiatric follow up with the resident. Review of Resident #14 and #98's nurse's note dated 3/21/22 at 2:26 AM identified the 11PM-7AM charge nurse found Resident #14 standing in the dining room kissing Resident #98, both residents were fully clothed, and the Supervisor was made aware. Upon further review, the clinical records failed to reflect documentation the residents were assessed to determine if they had the capacity to consent to sexual activity and the Conservators of both Residents #14 and #98 were notified. The 24-Hour Supervisor Report dated 3/20/22 11PM-7AM shift, identified Resident #98 was observed kissing Resident #14 in the dining room. Resident #14 was standing, and Resident #98 was sitting, both residents were fully clothed, the residents were separated and redirected with no further kissing. Although the 24-Hour Supervisor Report identified Resident #98 and Resident #14 had engaged in an inappropriate physical conduct, review of the clinical records and facility documentation failed to reflect an investigation was initiated and followed through to ensure interventions were put into place to protect Resident #14 and other residents on the dementia unit. Resident #98's Resident Care Plan that identified Resident #98 a registered sex offender and was at risk for exhibiting inappropriate behavior was revised on 3/21/22 which now included the incident when Resident #98 was found sitting in the dining room kissing another resident on 3/21/22. Upon further review of the care plan, the interventions directed to intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, remove from situation, and take to alternate location as needed, follow facility, state, and federal protocols related to sex offenders, maintain contact with police department, psychiatrist to follow, provide medications as ordered by physician, the resident may not attend any recreation activities that have minors present. The resident care plan failed to reflect documentation that new interventions were implemented to prevent further incidences of inappropriate sexual contact. The 11PM-7AM shift nurse's note dated 9/11/22 identified at 11:05 PM Resident #98 was observed sitting adjacent to Resident #14 in the lounge, Resident #98's hand was in between the thighs of Resident #14, Resident #98 was rubbing the genital area over the nightgown, the residents were fully clothed, and the Supervisor was notified. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Facility Reported Incident form dated 9/11/22 at 11:15 PM identified Resident #14 was observed sitting in a chair in the lounge, Resident #98 was sitting next to Resident #14 and Resident #98 was observed to have his/her fingertips inside of the Resident #14's genitals with the nightgown between Resident #98's fingers and Resident #14's genitals. The report indicated Resident #14's brief was on the floor next to him/her, the residents were immediately separated, and both residents were sent to the hospital for evaluation. The Inter-Agency Patient Referral Report dated 9/12/22 at 2:03 AM identified Resident #14 presented to the hospital after the nursing staff found Resident #98 had digitally penetrated Resident #14. The report identified the hospital staff examined Resident #14 and saw no injury. The report identified Resident #14 was non-verbal, unable to explain the incident, and a vaginal exam was completed at the bedside and no signs of trauma or bleeding were noted. The psychiatric evaluation and consultation note dated 9/13/22 identified Resident #98 was sent to the hospital on 9/12/22 after Resident #98 was observed to be making inappropriate advances toward Resident #14. The note identified Resident #98 disclosed that he/she became too friendly with Resident #14 prior to being sent to the hospital on 9/11/22, Resident #98 reported he/she perceived Resident #14 was in love with him/her and Resident #98 wanted to put his/her hands on Resident #14's shoulder. The note identified Resident #98 could not recall any other physical contact except for touching Resident #14's shoulder, psychiatry and Resident #98 discussed appropriate boundaries and Resident #98 acknowledged that he/she intended to maintain appropriate boundaries. The note indicated Resident #98 reported he/she will not seek out any residents inappropriately, there will be no sexual proclivity (tendency to do something you should not). The evaluation identified Resident #98 contracted for safety towards self and others, Resident #98 verbalized a desire to maintain appropriate boundaries with other residents, stated I need to remember to keep my hands to myself, and Resident #98 was provided with positive feedback for verbalizing his/her desire to maintain appropriate boundaries with other residents. Interview with Resident #14 on 9/21/22 at 9:40 AM identified there was no eye contact or acknowledgement of the surveyor or a translator. Resident #14 did not answer any questions asked by the translator. Resident #14 was observed sitting at a table in the lounge/dining room and was moving his/her hand in a circular motion like he/she was cleaning the table he/she was sitting at. Interview with Resident #98 on 9/21/22 at 9:45 AM identified Resident #98 was alert and oriented to person, place, and time at the time of the interview. Resident #98 identified the incident happened in the recreation room and he/she denied everything to protect Resident #14. Resident #98 indicated he/she should not have done it and it was hard to explain why he/she did it. Resident #98 identified he/she also had a psychiatric evaluation done and denied everything. Resident #98 indicated he/she was Resident #14's partner. Interview with the 11PM-7AM charge nurse, Licensed Practical Nurse (LPN) #3, on 9/21/22 at 12:10 PM identified on 3/21/22 she observed Resident #98 and Resident #14 sitting in chairs next to each other in the lounge/dining room. LPN #3 explained Resident #98 was hugging and feeling Resident #14's body and kissed Resident #14 on the cheek. LPN #3 indicated Resident #98 was touchy and feely, Resident #98 was touching Resident #14 down the side of his/her body, feeling his/her curves. LPN #3 identified Resident #98 was going for Resident #14's lips, when she separated them, both residents were redirected back to their rooms and went to sleep. LPN #3 indicated she reported the incident to the supervisor on duty. LPN #3 indicated the Supervisor notified the Director of Nursing. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Resident #14's Conservator, Person #1, on 9/21/22 at 4:15 PM identified Resident #14 had dementia, could not consent to a relationship, and did not really know what was going on. Person #1 indicated he/she was never contacted by the facility staff and asked if he/she would consent to Resident #14 and Resident #98's relationship. Person #1 identified she was unaware of the incident on 3/21/22 and had he/she known, Resident #98 would not be on the same unit as Resident #14. Person #1 indicated he/she visited Resident #14 after the incident 9/11/22 and Resident #14 was fine, and timid but Resident #14 was okay. Interview with 11PM-7AM Nursing Supervisor, Registered Nurse (RN) #3, on 9/22/22 at 11:17 AM identified she was unable to recall the incident between Resident #98 and Resident #14 on 3/21/22 and was unable to recall if she notified the Director of Nursing about the incident. Interview with the Director of Nursing (DON) #1 on 9/23/22 at 11:10 AM identified she did not remember hearing about the incident between Resident #98 and Resident #14 on 3/21/22 because there was a lot of reportable events in March of 2022. DON #1 indicated had she known about the incident she would have reported the incident to the state agency, she would have investigated the incident and put measures in place to protect Resident #14. DON #1 identified monitoring of Resident #98's behaviors, any type of interactions with other residents, should have been implemented after the incident on 3/21/22. Review of the Abuse Prevention policy directed to maintain the rights of all residents to be free from abuse. In the event there was evidence of suspected or reported abuse by another resident the facility will intervene and follow these guidelines. During the investigation, the facility will protect the resident as appropriate, including but not limited to the following: separation and/or redirection of residents, institute visual checks/monitors as appropriate, notify physician of resident behavior and discuss appropriate measures. Appropriate actions will be taken to manage and monitor the behavior of a resident against whom there was a substantiated charge of abuse. Actions may include but not limited to discharging the resident.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31310 Based on clinical record reviews, facility documentation, facility policy and interviews for one of three sampled residents (Resident #14) who was not able to make decisions for himself/herself and had a Conservator of Person, the facility failed to immediately report the allegation of abuse to the administrator or his/her designee and to the state agency not later than two (2) hours after an observation of inappropriate sexual conduct by another resident. The findings include: Resident #14's diagnoses included dementia without behavioral disturbance and dysthymic disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 was not able to make decisions regarding tasks of daily living, exhibited no behavioral symptoms, was independent with walking in the room, and required one (1) person supervision with walking in the corridor. Resident #98's diagnoses included anxiety and dementia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #98 had some short- and long-term memory recall deficits and required limited one (1) person assistance with walking in the room and corridor. Review of Resident #14 and #98's clinical record identified the nurse's note dated 3/21/22 at 2:26 AM, the 11PM-7AM charge nurse found Resident #14 standing in the dining room kissing Resident #98, both residents were fully clothed, and the Supervisor was made aware. The 24-Hour Supervisor Report sheet dated 3/20/22 11PM-7AM shift, identified Resident #98 was observed kissing Resident #14 in the dining room. Resident #14 was standing, and Resident #98 was sitting, both residents were fully clothed, the residents were separated and redirected with no further kissing. Although the 24-Hour Supervisor Report identified Resident #98 and Resident #14 had engaged in an inappropriate physical conduct, review of the clinical records and facility documentation failed to reflect documentation the incident was communicated, investigated, and followed through to ensure interventions were put in place to protect Resident #14 and other residents on the dementia unit. Interview with 11PM-7AM Nursing Supervisor, Registered Nurse (RN) #3, on 9/22/22 at 11:17 AM identified she was unable to recall the incident between Resident #98 and Resident #14 on 3/21/22 and was unable to recall if she notified the Director of Nursing about the incident. Interview with the Director of Nursing (DON) #1 on 9/23/22 at 11:10 AM identified she did not remember hearing about the incident between Resident #98 and Resident #14 on 3/21/22 because there was a lot of reportable events in March of 2022. DON #1 indicated had she known about the incident she would have reported the incident to the state agency.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35682 Based on clinical record review, facility documentation review, facility policy review, and interviews for one resident (Resident #110) reviewed for hospitalization , the facility failed to ensure the Ombudsman received notice of resident hospital transfers and for one resident (Resident #1) reviewed for hospitalization , the facility failed to ensure the Ombudsman received notice timely for a facility initiated, involuntary discharge. The findings include: a. Resident #110 was admitted to the facility on [DATE] with diagnoses that included pneumonitis, morbid obesity and schizoaffective disorder. On 9/21/22, review of the Census List (which documents all transfers out to the hospital and returns to the facility) identified Resident #110 transferred to the hospital from 8/5/22 to 8/23/22. Further review identified Resident #110 was currently not in the facility with discharge to the hospital on 9/13/22. A nurse's note dated 9/13/22 identified Resident #110 was transferred by stretcher and sent to the hospital. A nurse's note dated 9/14/22 identified Resident #110 was admitted to the hospital with diagnoses of urinary tract infection and dehydration. Interview with Social Worker (SW) #1 on 9/21/22 at 10:00 AM identified she had been the SW for the facility for the past 4 months but had not been aware that the Ombudsman needed to be notified with all hospital transfers until recently. SW #1 indicated although she had received information from the Ombudsman on 7/27/22 on how she would like to receive the transfer notifications using a spread sheet, she had not yet implemented the process. SW #1 also identified she could not find evidence to support that the Ombudsman notification was being done prior to her arrival. Subsequent to surveyor inquiry, SW #1 indicated she initiated the portal the Ombudsman informed her about and had just completed Augusts' transfers, completed the spread sheet and would upload the information to the Ombudsman. Going forward, SW #1 identified she would be uploading the spread sheet at the end of each month for all resident transfers out of the facility according to how the Ombudsman instructed and will store the information in a binder. Interview with RN# 2 on 9/26/22 at 11:00 AM identified that the SW was responsible for notifying the Ombudsman of hospital transfers and it should have been done. Although a policy was requested, none was provided. (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Many	b. Resident #1's diagnoses included traumatic brain injury, subarachnoid hemorrhage and adjustment disorder with mixed anxiety and depressed mood. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 was alert and oriented and required limited assistance with one-person assistance for transfers and ambulation. The Resident Care Plan dated 4/18/2022 identified Resident #1 had impaired cognitive function and/or impaired thought processes related to a head injury. Interventions directed to administer medications as ordered, reduce any distractions, (i.e., turn off TV, radio etc.), use consistent, simple, and directive sentences with cues. Review of the clinical record and facility documentation identified Resident #1 threatened to smother another resident and was seen by APRN #1 at 2 PM, was identified to be a risk of injury to self/others, and was discharged to the hospital on 9/23/2022 with a Physician's Emergency Certificate (PEC). Interview and facility documentation review with SW #1 on 10/12/2022 at 10:45 AM identified she submitted notification to the Ombudsman for Resident #1's involuntary discharge on 9/23/2022 (6 days after Resident #1's discharge). SW #1 identified she was unaware of the responsibility to notify the Ombudsman regarding discharges from the facility. SW #1 indicated she was recently educated to notify the Ombudsman during the current survey to notify the Ombudsman agency in a timely manner regarding any discharges. Interview with the Ombudsman on 10/12/2022 at 2:15 PM identified when a resident is involuntarily discharged , the facility must notify the Ombudsman agency immediately, (not the standard 30-day notice). The Ombudsman identified although the facility involuntarily discharged Resident #1 on 9/23/2022, but the Ombudsman agency did not receive a notice until 9/29/2022 (6 days after the discharge occurred). Review of the facility Transfer/Discharge Notifications Policy, dated September 2022, directed in part, before a facility transfers or discharges a resident, the facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman in accordance with state and federal regulations. 41682

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075182	A. Building B. Wing	10/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Rehabilitation and Healthcare Center	55 Grand Street New Britain, CT 06052

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31310 Based on clinical record review, facility documentation, facility policy and interviews for one of three sampled residents (Resident #98) who were reviewed for an allegation of resident to resident abuse, the facility failed to review and revise the resident care plan to ensure new interventions were implemented to protect the residents on the dementia unit after an incident of physical contact with Resident #14 to prevent future incidences and for 2 of 3 residents (Resident #4 and #100) reviewed for Resident Care Plan (RCP), the facility failed to conduct an admission or the quarterly RCP meetings inviting the resident or resident's representative to participate. The findings include: 1. Resident #98's diagnoses included anxiety and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #98 had some short- and long-term memory recall deficits and required limited one (1) person assistance with walking in the room and corridor. The undated Resident Care Plan associated to the MDS assessment dated [DATE] identified Resident #98 was a registered sex offender and was at risk for exhibiting inappropriate behavior. Interventions directed to intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, remove from situation, and take to alternate location as needed, follow facility, state, and federal protocols related to sex offenders, maintain contact with police department, psychiatrist to follow, provide medications as ordered by physician, the resident may not attend any recreation activities that have minors preset. Review of Resident #14 and #98's clinical record identified the nurse's note dated 3/21/22 at 2:26 AM noted the 11PM-7AM charge nurse found Resident #14 standing in the dining room kissing Resident #98, both residents were fully clothed, and the Supervisor was made aware. Resident #98's Resident Care Plan that identified Resident #98 a registered sex offender and was at risk for exhibiting inappropriate behavior was revised on 3/21/22 which now included the incident that Resident #98 was found sitting in the dining room kissing another resident on 3/21/22. Upon further review, the interventions directed to intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, remove from situation, and take to alternate location as needed, follow facility, state, and federal protocols related to sex offenders, maintain contact with police department, psychiatrist to follow, provide medications as ordered by physician, the resident may not attend any recreation activities that have minors preset. The resident care plan failed to reflect documentation that new interventions were implemented after 3/21/22 to prevent further incidences. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 24-Hour Supervisor Report sheet dated 3/20/22 11PM-7AM shift, identified Resident #98 was observed kissing Resident #14 in the dining room. Resident #14 was standing, and Resident #98 was sitting, both residents were fully clothed, the residents were separated and redirected with no further kissing. Although the 24-Hour Supervisor Report identified Resident #98 and Resident #14 had engaged in an inappropriate physical conduct, review of the clinical records and facility documentation failed to reflect documentation the incident was communicated, investigated, and followed through to ensure interventions were put in place to protect Resident #14 and other residents on the dementia unit. The 11PM-7AM shift nurse's note dated 9/11/22 identified at 11:05 PM Resident #98 was observed sitting adjacent to Resident #14 in the lounge with his/her hand in between the thighs of Resident #14 rubbing the genital area over the nightgown, the residents were fully clothed, and the Supervisor was notified. The Facility Reported Incident form dated 9/11/22 at 11:15 PM identified Resident #14 was observed sitting in a chair in the lounge, Resident #98 was sitting next to Resident #14 and Resident #98 was observed to have his/her fingertips inside of the Resident #14's genitals with the nightgown between Resident #98's fingers and Resident #14's genitals. The report indicated Resident #14's brief was on the floor next to him/her, the residents were immediately separated, and both residents were sent to the hospital for evaluation. Interview with the Director of Nursing (DON) #1 on 9/23/22 at 11:10 AM identified the care plan should have been reviewed and/or revised for both residents after the incident on 3/21/22 and 9/11/22. The DON indicated it was the responsibility of the charge nurse, the supervisor or the MDS Coordinator to review and revise the resident care plan to ensure new interventions were implemented to protect Resident #14 and the residents on the dementia unit after the 3/21/22 incident. DON #1 identified monitoring of Resident #98's behaviors, any type of monitoring his/her interactions with other residents should have been implemented. The Care Planning Process Policy directed that care plans were developed upon admission and reviewed by the Interdisciplinary Team by day 21 of admission and quarterly thereafter (every ninety-two (92) days) or when a significant change occurred in the resident's condition. Care plans were designed to provide guidance to all staff caring for the resident. 2. Resident # 4 was admitted to the facility in 3/2021 with diagnoses that included lymphoma, syncope with falls, and Covid-19 infection. A quarterly MDS assessment 7/20/22 identified Resident #4 had intact cognition and required no assistance with activities of daily living. The RCP conference sign in sheet failed to identify a RCP was conducted since 1/31/22 (RCP meetings not conducted for April 2022 and July 2022). The Social Service progress notes dated 2/1/22 through 9/21/22 did not identify there was a quarterly interdisciplinary care conference in April and July including the resident was able to participate in his/her plan of care. (continued on next page)

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	075182	A. Building B. Wing	10/12/2022

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Resident #4 on 9/20/22 at 10:01 AM noted he/she had not had a meeting with the interdisciplinary team for the care conference since January 2022. Resident #4 indicated he/she had not had this meeting every 3 months, but the meeting would be helpful for some issues he/she had and he/she would have attended. Interview with SW #1 on 9/21/22 at 11:16 AM indicated SW #1 indicated she was in the process of preparing and using a new form for the resident or resident representative, the SW, the therapist, and the MDS Coordinator for all to sign they attended the meeting. SW #1 indicated Resident #4's last care conference was 1/20/22 and did not conduct the interdisciplinary resident care conferences in April 2022 or July 2022 and noted that no one had. 3. Resident #100 was admitted to the facility on [DATE] with diagnoses that included compression fractures of the vertebra, osteomyelitis, and diabetes. The admission MDS assessment dated [DATE] identified Resident #100 was moderately cognitively impaired and required extensive assistance of 1 with dressing and personal hygiene. The Social Service (SS) admission assessment dated [DATE] , SS and nurse's notes dated 7/31/22 through 9/21/22 did not identify Resident #100 was invited to participate in an interdisciplinary care conference from admission to the facility. Interview with Resident #100 on 9/19/22 at 1:13 PM indicated he/she had not had any meetings with the interdisciplinary care team since being a resident at the facility in order to discuss his/her plan of care or discharge potential. An interview with RN #2 on 9/21/22 at 10:00 AM indicated the facility was not conducting the 72 hour initial care plan meetings for awhile and Resident #100 had not had one since admission. RN#2 indicated she was currently changing the process and had spoken with Social Worker (SW) #1 about making sure all new admissions have the initial 72-hour care conferences and scheduling the quarterly and annual resident interdisciplinary meetings. Interview with SW #1 on 9/21/22 at 11:16 AM indicated Resident #100 did not have the 72 initial care conference with the interdisciplinary team and Resident #100 only met with the SW. SW #1 indicated the SW Consultant who was no longer at the facility was only meeting with the resident and not conducting the 72-hour interdisciplinary care plan meetings. SW #1 indicated she was in the process of preparing and using a new form for the resident or resident representative, the SW, the therapist, and the MDS Coordinator for all to sign they attended the meeting. SW #1 indicated Resident #100 had not had a care conference since admission about 2 months ago. Additionally, SW #1 indicated the residents were supposed to have admission and quarterly meetings with the Interdisciplinary team. Interview with the ADNS on 09/21/22 at 2:42 PM indicated she was responsible to schedule admission and quarterly interdisciplinary care plan meetings but had not scheduled one since 1/20/22. The ADNS indicated she was on leave from the end of January 2022 until April 2022. The ADNS indicated there was someone temporarily covering while she was on leave, but the resident care conferences weren't conducted. (continued on next page)

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	075182	A. Building B. Wing	10/12/2022

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the SW #1 on 9/26/22 at 10:00 AM indicated she was working on and provide a care conference calendar for October indicating the interdisciplinary Review of the facility 72-hour entry meeting form identified the resident, residents' family member or conservator, Social Worker and MDS Coordinator had a signature space to be signed for attendance. Review of the facility Care Plan policy identified care plans are developed upon admission within 24 hours. A care plan meeting must be held by the interdisciplinary team by day 21 and reviewed quarterly thereafter or when a significant change occurs. These care plan meetings must include members of the interdisciplinary team and the resident and the resident's family. Documentation of this meeting and what was discussed must be in the resident's medical record including who attended this meeting. All residents should be invited to their care plan meeting unless contraindicated. Family members, next of kin, POA's, conservators may be invited to attend. 42117

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	075182	A. Building B. Wing	10/12/2022

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31310 Based on clinical record reviews, review of facility documentation, facility policy and interviews for one of two sampled residents (Resident #98) who were registered sex offenders and at risk for exhibiting inappropriate behavior, the facility failed to provide supervision when the resident was noted to gravitate towards and engage in physical contact with another resident of the opposite sex to ensure the safety of that resident and the other residents on the dementia unit to prevent future incidences. The findings include: Resident #98's diagnoses included anxiety and dementia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #98 had some short- and long-term memory recall deficits and required limited one (1) person assistance with walking in the room and corridor. The undated Resident Care Plan associated to the MDS assessment dated [DATE] identified Resident #98 was a registered sex offender and was at risk for exhibiting inappropriate behavior. Interventions directed to intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, remove from situation, and take to alternate location as needed, follow facility, state, and federal protocols related to sex offenders, maintain contact with police department, psychiatrist to follow, provide medications as ordered by physician, the resident may not attend any recreation activities that have minors present. The nurse's note dated 3/21/22 at 2:26 AM identified the 11PM-7AM charge nurse found Resident #14 standing in the dining room kissing Resident #98, both residents were fully clothed, and the Supervisor was made aware. Review of Resident #98's care plan identified Resident #98 was a registered sex offender and was at risk for exhibiting inappropriate behavior was revised on 3/21/22 which now included the incident that Resident #98 was found sitting in the dining room kissing another resident on 3/21/22. Upon further review, the interventions directed to intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, remove from situation, and take to alternate location as needed, follow facility, state, and federal protocols related to sex offenders, maintain contact with police department, psychiatrist to follow, provide medications as ordered by physician, the resident may not attend any recreation activities that have minors present. The resident care plan failed to reflect documentation that new interventions were implemented to prevent further incidences. The 11PM-7AM shift nurse's note dated 9/11/22 identified at 11:05 PM Resident #98 was observed sitting adjacent to Resident #14 in the lounge, Resident #98's hand was in between the thighs of Resident #14, Resident #98 was rubbing the genital area over the nightgown, the residents were fully clothed, and the Supervisor was notified. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Reported Incident form dated 9/11/22 at 11:15 PM identified Resident #14 was observed sitting in a chair in the lounge, Resident #98 was sitting next to Resident #14 and Resident #98 was observed to have his/her fingertips inside of the Resident #14's genitals with the nightgown between Resident #98's fingers and Resident #14's genitals. The report indicated Resident #14's brief was on the floor next to him/her, the residents were immediately separated, and both residents were sent to the hospital for evaluation. Interview with Resident #14 on 9/21/22 at 9:40 AM identified there was no eye contact or acknowledgement of the surveyor or a translator. Resident #14 did not answer any questions asked by the translator. Resident #14 was observed sitting at a table in the lounge/dining room and was moving his/her hand in a circular motion like he/she was cleaning the table he/she was sitting at. Interview with Resident #98 on 9/21/22 at 9:45 AM identified Resident #98 was alert and oriented to person, place, and time at the time of the interview. Resident #98 identified the incident happened in the recreation room and he/she denied everything to protect Resident #14. Resident #98 indicated he/she should not have done it and it was hard to explain why he/she did it. Resident #98 identified he/she also had a psychiatric evaluation done and denied everything. Resident #98 indicated he/she was Resident #14's partner. Interview with the 11PM-7AM charge nurse, Licensed Practical Nurse (LPN) #3, on 9/21/22 at 12:10 PM identified on 3/21/22 she observed Resident #98 and Resident #14 sitting in chairs next to each other in the lounge/dining room. LPN #3 explained Resident #98 was hugging and feeling Resident #14's body and kissed Resident #14 on the cheek. LPN #3 indicated Resident #98 was touchy and feely, Resident #98 was touching Resident #14 down the side of his/her body, feeling his/her curves. LPN #3 identified Resident #98 was going for Resident #14's lips, when she separated them, both residents were redirected back to their rooms and went to sleep. Interview with the Director of Nursing (DON) #1 on 9/23/22 at 11:10 AM identified she did not remember hearing about the incident between Resident #98 and Resident #14 on 3/21/22 because there was a lot of reportable events in March of 2022. DON #1 indicated had she known about the incident she would have reported the incident to the state agency, she would have investigated the incident and put measures in place to protect Resident #14. DON #1 identified monitoring of Resident #98's behaviors, any type of monitoring his/her interactions with other residents should have been implemented after the incident on 3/21/22. Review of the Abuse Prevention policy directed to maintain the rights of all residents to be free from abuse. In the event there was evidence of suspected or reported abuse by another resident the facility will intervene and follow these guidelines. During the investigation, the facility will protect the resident as appropriate, including but not limited to the following: separation and/or redirection of residents, institute visual checks/monitors as appropriate, notify physician of resident behavior and discuss appropriate measures. Appropriate actions will be taken to manage and monitor the behavior of a resident against whom there was a substantiated charge of abuse. Actions may include but not limited to discharging the resident.

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	075182	A. Building B. Wing	10/12/2022

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31310 Based on clinical record reviews, facility documentation, facility policy and interviews for two of three sampled residents (Resident #14 and #98) who were reviewed for an allegation of resident to resident abuse, the facility failed to document in the clinical record psychosocial support was provided to the residents after an incident of inappropriate sexual conduct. The findings include: Resident #14's diagnoses included dementia without behavioral disturbance and dysthymic disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 was not able to make decisions regarding tasks of daily living, exhibited no behavioral symptoms, was independent with walking in the room, and required one (1) person supervision with walking in the corridor. Resident #98's diagnoses included anxiety and dementia. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #98 had some short- and long-term memory recall deficits and required limited one (1) person assistance with walking in the room and corridor. The11PM-7AM shift nurse's note dated 9/11/22 identified at 11:05 PM Resident #98 was observed sitting adjacent to Resident #14 in the lounge with his/her hand in between the thighs of Resident #14 rubbing the genital area over the nightgown, the residents were fully clothed, and the Supervisor was notified. The Facility Reported Incident form dated 9/11/22 at 11:15 PM identified Resident #14 was observed sitting in a chair in the lounge, Resident #98 was sitting next to Resident #14 and Resident #98 was observed to have his/her fingertips inside of the Resident #14's genitals with the nightgown between Resident #98's fingers and Resident #14's genitals. The report indicated Resident #14's brief was on the floor next to him/her, the residents were immediately separated, and both residents were sent to the hospital for evaluation. The Inter-Agency Patient Referral Report dated 9/12/22 at 2:03 AM identified Resident #14 presented to the hospital after the nursing staff found Resident #98 had digitally penetrated Resident #14. The report identified the hospital staff examined Resident #14 and saw no injury. The report identified Resident #14 was non-verbal, unable to tell anything, and a vaginal exam was completed at the bedside and no signs of trauma or bleeding were noted. The psychiatric evaluation and consultation dated 9/13/22 identified Resident #98 was sent to the hospital on 9/12/22 after Resident #98 was observed to be making inappropriate advances toward Resident #14. Review of Resident #14 and #98's clinical records failed to reflect documentation psychosocial support was provided to the residents after the 9/12/22 incident of inappropriate sexual conduct. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Social Worker, Social Worker #1, on 9/21/22 at 4:50 PM identified she saw Resident #14 on 9/13/22 when she found out about the incident. Social Worker #1 indicated Resident #14 was walking, she tried to talk to Resident #14, however, the resident just stood there and looked at her. Social Worker #1 identified Resident #14 did not show any signs of distress after the incident of inappropriate sexual conduct by another resident and was back to his/her usual self. Social Worker #1 indicated she also saw Resident #98 after the incident and the resident did not remember the incident. Social Worker #1 indicated Resident #98 was back to his/her usual self after the incident. Social Worker #1 identified she did not document the interactions with Resident #14 and Resident #98 in the clinical record as she should have. Although provided, a facility policy for Social Services Abuse Protection did not include the Social Worker's responsibilities after an allegation of resident to resident abuse.