

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 075182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/04/2020
NAME OF PROVIDER OF SUPPLIER GRANDVIEW REHABILITATION AND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 55 GRAND STREET NEW BRITAIN, CT 06052	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 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** Based on review of the clinical records, facility documentation, policy review, and interviews for one of three sampled residents (Resident #1) who were reviewed for an allegation of staff mistreatment, the facility failed to report the allegation of mistreatment to the state agency when the incident was first reported to the administrative team. The findings include: Resident #1's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had no memory recall problems, was alert and oriented, able to make decisions regarding tasks of daily life, was independent with transfers in and out of the bed and chair, and ambulating in the room, the corridor, and on the unit, required one (1) person assistance with toilet use and personal hygiene, and had no history of falls. The social service progress note dated 2/11/20 at 1:59 PM identified the social worker met with Resident #1 and Resident #1 reported that he/she was pushed by two (2) nurse aides and the resident had a recent fall out of bed. The note indicated the social worker continued to ask for more details, Resident #1 stated it might have happened in the hallway or in my room, I do not know which nurse aides and Resident #1 was unable to give a date, time, or location. The note identified although Resident #1 was alert, oriented and confused, Resident #1 was unable to give correct information and a chain of events. A late entry nurse's note written on 2/14/20 at 2:50 PM, no date was denoted for when the incident was reported, identified Resident #1 stated two (2) nurse aides pushed him/her down over the weekend and the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were notified. Review of the facility documentation, witness statement and interview documentation, identified on 2/11/20 the social worker reported to the Director of Nursing (DON) that Resident #1 stated two (2) nurse aides pushed the resident down. Review of the Reportable Event Forms from 2/1/20 through 2/14/20 failed to reflect documentation that the allegation of mistreatment was reported to the State Survey Agency and adult protective services. Interview with Resident #1 on 3/4/20 at 10:00 AM identified that maybe three or four weeks ago two (2) nurse aides pushed him/her to the floor, the incident happened, at night on the weekend and Resident #1 indicated that he/she reported the incident to the 7PM-7AM charge nurse. Interview and review of the facility documentation with the Director of Nursing (DON) on 3/4/20 at 3:12 PM identified that she had a file regarding the allegation of mistreatment voiced by Resident #1 and that she conducted in-house investigation. The DON indicated that the conclusion of the investigation was inconclusive. The DON identified that she failed to report the allegation of mistreatment to the state agency when she became aware on 2/11/20. The Abuse prevention policy identified that the facility will immediately initiate an internal investigation and report credible suspicion and/or allegations to the appropriate state enforcement/regulatory agencies within two hours.		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

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.