STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265374	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	201 GRAND AVE WASHINGTON, MO 63090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, facility staff failed to create an environment respectful of the rights of each resident to make choices about significant aspects of their lives for one (Resident #12) of five sampled residents when staff failed to promote the resident's self determination through	F 561		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dora Bailey — TITLE: Administrator — (X6) DATE: 8/2/24

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265374	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	**201 GRAND AVE WASHINGTON, MO 63090**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 1	F 561		

support of resident choices when staff failed to allow the resident the choice of independently going outside the facility. The facility census was 48.

1. Review of the facility's Nursing Home Residents' Rights policy, undated, showed the resident had the right to self determination including the choice of activities, the reasonable accommodation of needs and preferences, and participation in developing and implementing a person-centered plan of care incorporates personal and cultural preferences.

2. Review of Resident #12's quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 07/10/24, showed staff assessed the resident as follows:

-Cognitively Intact;
-Required total dependence for transfers;
-Independent using a motorized wheelchair;
-Diagnosis of multiple sclerosis and depression.

Review of the resident's admission sheet shows the resident is his/her own legal representative.

Review of the resident's care plan, dated 04/10/24, showed staff assessed the resident's preferred activity is to go across the street to the park in his/her motorized wheelchair.

Review of the resident's medical record did not contain documentation the resident with safety concerns for his/her perferred activity to go across the street to the park.

Review of the resident's smoking assessment, dated 07/10/24, showed staff assessed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265374	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	201 GRAND AVE WASHINGTON, MO 63090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 2 resident as a safe smoker. During and interview on 07/10/24 at 10:59 A.M., the resident said he/she used to be able to independently go across the road to the park but recently was told they could no longer do so and this caused him/her stress. The resident said he/she is able to operate the wheelchair without problems and would use the cell phone to ask for help if needed. During an interview on 07/10/24 at 3:05 P.M., the resident's family member said he/she would like the resident to be able to go to the park because it helps him/her with depression and anxiety, and that is important for the quality of the resident's life. During an interview on 07/11/24 at 10:34 A.M., the Assistant Director of Nursing said the resident was found to be an unsafe smoker and started hitting things with their wheelchair causing the decision to made not allowing independent trips to the park. During an interview on 07/11/24 at 10:39 A.M., the MDS coordinator said staff had a care plan meeting to addressed using a smoking apron and not allowing the resident to go to the park unsupervised due to concerns it was a health risk and the resident said he/she did not want to be supervised going to the park. During an interview on 07/11/24 at 10:41 A.M., the administrator said the resident's unsupervised trips to the park were stopped due to concerns about the residents safety. During an interview on 07/11/24 at 2:00 P.M.,	F 561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265374	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	201 GRAND AVE WASHINGTON, MO 63090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 3 Certified Nurse Aid (CNA) A said he/she would ask a charge nurse to see if a resident was independent and allowed to go to the park or outside on their own. He/She said they were not aware the resident could no longer go by themselves to the park. During an interview on 07/11/24 at 2:46 P.M., the Director of Nursing said a resident who is alert and orientated should be able to make their own choices but we were concerned for the resident's safety going across the road to the park alone.	F 561		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265374	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	201 GRAND AVE WASHINGTON, MO 63090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
F 640	Continued From page 4 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility staff failed to transmit the required Minimum Data Sets (MDS), a federally mandated resident assessment completed by facility staff, for ten residents (Resident #2, #6, #11, #13, #18, #26, #32, #42, #44 and #53) of sixteen sampled residents. The facility census was 48. 1. Review of Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.18.11, dated October 2023, showed:	F 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265374	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	**201 GRAND AVE WASHINGTON, MO 63090**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
F 640	Continued From page 5 -The CMS Long-Term Care Facility RAI User's Manual is the primary source of information for completing an MDS assessment; - All Medicare and/or Medicaid-certified nursing homes must transmit MDS data records to CMS' Internet Quality Improvement and Evaluation System (iQIES); -Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (no later than 14 days from the resident's admission date and/or assessment reference date (ARD) plus seven days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date; -A comprehensive or quarterly assessment is due every quarter unless the resident is no longer in the facility. There must be no more than 92 days between assessments. A comprehensive assessment is due every year unless the resident is no longer in the facility. There must be no more than 366 days between comprehensive assessments. Review of the facility's MDS and Care Planning Guidelines, dated October 2015, directed staff to use the most current CMS MDS Resident Assessment Instrument (RAI) Manual, any published interim RAI manual errata documents, and applicable federal guidelines as the authoritative guide for completion of MDS and care planning. 2. Review of Resident #2's MDS data in the Electronic Health Record (EHR), showed a quarterly MDS completion date of 06/05/24. Review showed the assessment was not transmitted as required within 14 days of	F 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265374	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	201 GRAND AVE WASHINGTON, MO 63090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
F 640	Continued From page 6	F 640		

completion.

3. Review of Resident #6's MDS data in the EHR, showed a quarterly MDS completion date of 06/10/24. Review showed the assessment was not transmitted as required within 14 days of completion.

4. Review of Resident #11's MDS data in the EHR, showed an annual MDS completion date of 05/17/24. Review showed the assessment was not transmitted as required within 14 days of completion.

5. Review of Resident #13's MDS data in the EHR, showed a Significant Change of Status (SCSA) comprehensive assessment completion date of 06/10/24. Review showed the assessment was not transmitted as required within 14 days of completion.

6. Review of Resident #18's MDS data in the EHR, showed an annual MDS completion date of 06/06/24. Review showed the assessment was not transmitted as required within 14 days of completion.

7. Review of Resident #26's MDS data in the EHR, showed a SCSA completion date of 06/07/24. Review showed the assessment was not transmitted as required within 14 days of completion.

8. Review of Resident #32's MDS data in the EHR, showed a SCSA completion date of 04/18/24. Review showed the assessment was not transmitted as required within 14 days of completion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265374	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	201 GRAND AVE WASHINGTON, MO 63090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
F 640	Continued From page 7 9. Review of Resident #42's MDS data in the EHR, showed a SCSA completion date of 05/29/24. Review showed the assessment was not transmitted as required within 14 days of completion. 10. Review of Resident #44's MDS data in the EHR, showed a quarterly MDS completion date of 06/20/24. Review showed the assessment was not transmitted as required within 14 days of completion. 11. Review of Resident #52's MDS data in the EHR, showed an admission MDS completion date of 05/27/24. Review showed the assessment was not transmitted as required within 14 days of completion. 12. During an interview on 07/11/24 at 2:00 P.M., the MDS Coordinator said he/she only completes the MDS. The Director of Nursing (DON) signs off and submits them. During an interview on 07/11/24 at 2:50 P.M., the DON said he/she is responsible for submitting the MDS data and does not have a back-up person. He/She said he/she submits the data every other week but took vacation twice in June and then just forgot. During an interview on 07/11/24 at 3:24 P.M., the administrator said he/she is not sure how often the MDS data should be submitted but is usually the responsibility of the DON. The administrator said they do not have a back-up person when the DON is unavailable.	F 640		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265374	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	**201 GRAND AVE WASHINGTON, MO 63090**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 8 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265374	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	**201 GRAND AVE WASHINGTON, MO 63090**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility staff failed to change and store oxygen tubing and/or clean oxygen concentrator filters in a manner to decrease the risk of the spread of infection for four (Resident #8, #25, #36, and #42) out of four sampled residents. The facility census was 48. 1. Review of the facility's Oxygen Administration policy, dated March 2015, showed:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265374	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	**201 GRAND AVE WASHINGTON, MO 63090**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 10 -At regular intervals, check and clean oxygen equipment, masks, tubing, and cannulas; -Change humidifier and tubing per cleaning guidelines; -At regular intervals, check liter flow contents of oxygen cylinder, fluid level in humidifier and access resident's respiration to determine further need for oxygen therapy. 2. Review of Resident #8's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 05/18/24 showed staff assessed the resident as: -Severely cognitively impaired; -Used oxygen. Review of the Physician Order Sheet (POS), dated July 2024, showed an order to change the oxygen tubing and humidity bottle monthly on the first, on the evening shift and to ensure the tubing and bottle is labeled. Observation on 07/09/24 at 11:08 A.M., showed the resident wore his/her oxygen via nasal cannula. The oxygen tubing did not contain a label with a date. Observation on 07/10/24 at 8:14 A.M., showed the resident with his/her oxygen on via nasal cannula. The oxygen tubing did not contain a label with a date. 3. Review of the Resident #25's annual MDS, dated 05/11/24, showed facility staff assessed the resident as follows: -Cognitively intact;	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265374	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	201 GRAND AVE WASHINGTON, MO 63090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11 -Received oxygen therapy; -Diagnoses respiratory failure. Review of the resident's POS for July 2024 showed the physican ordered oxygen three to five liters per minute (lpm) per nasal cannula, change oxygen tubing monthly and change nebulizer tubing monthly. Ensure tubing is dated. Observation on 07/09/24 at 11:41 A.M., showed the resident with his/her nasal cannula on dated 03/11 and the oxygen condenser filter covered with a white residue. Observation showed the resident's nebulizer tubing dated 11/8. Observation on 07/11/24 at 09:46 A.M., showed the resident with his/her nasal cannula on dated 03/11 and the oxygen condenser filter covered with a white residue. Observation showed the resident's nebulizer tubing dated 11/8. 4. Review of the Resident #36's Quarterly MDS, dated 04/23/24, showed facility assessed the resident as follows: -Cognitively intact; -Received oxygen therapy; -Diagnoses lung disease, and respiratory failure. Review of the resident's POS, dated July 2024, showed physician orders for oxygen two to five lpm per nasal cannula as needed for shortness of breath and Bilevel positive airway pressure ((BiPap) a device that helps with breathing) with a forced air pressure of 15/10 every night as tolerated. Observation on 07/09/24 at 12:00 P.M., showed the resident oxygen on per lasal cannula.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265374	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	201 GRAND AVE WASHINGTON, MO 63090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 Observation showed the tubing not date. Observation on 07/10/24 at 10:12 A.M., showed the resident oxygen on per lasal cannula. Observation showed the tubing not date. Observation on 07/11/24 at 9:41 A.M., the resident oxygen on per lasal cannula. Observation showed the tubing not date. During an interview on 07/10/24 at 10:12 A.M., the resident said he/she uses oxygen. 5. Review of Resident #42's Significant Change of Status MDS, dated 05/29/24, showed staff assessed the resident as: -Cognitively impaired; -Used oxygen; -Diagnosis of heart failure and lung disease. Review of the resident's POS, dated July 2024, showed an order to change the oxygen tubing and humidity bottle monthly, first of the month, on the evening shift and to ensure the tubing and bottle is labeled. Observation on 07/09/24 at 11:42 A.M., showed the resident wore his/her oxygen via nasal cannula. The oxygen tubing did not contain a date and the humidifier bottle dated 06/01/24. Observation showed the filter on the machine was covered with a white substance. Observation on 07/10/24 at 08:13 A.M,showed the resident wore his/her oxygen via nasal cannula. The oxygen tubing did not contain a date and the humidifier bottle was dated 06/01/24. Observation showed the filter on the machine	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265374	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	201 GRAND AVE WASHINGTON, MO 63090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 13 was covered with a white substance. 6. During an interview on 07/10/24 at 11:34 A.M., Licensed Practical Nurse (LPN) B said oxygen tubing should be changed monthly by nursing, and it is triggered by an order in the Treatment Administration Record (TAR). The tubing change is indicated in the TAR, and the tubing should be dated. LPN B said filters were not regularly cleaned. During a telephone interview on 07/11/24 at 2:50 P.M., the Director of Nursing (DON) said oxygen tubing should be labeled and dated when changed and should be changed monthly. He/She said nursing does not have a preventative maintenance for cleaning oxygen filters. The DON said it is his/her responsibility to ensure the tubing is being changed. During an interview on 07/11/24 at 03:24 P.M., the administrator said oxygen tubing should be changed on a regular basis, but he/she was not sure whether this is weekly or monthly. The administrator said the new tubing and new bag should be dated. If the tubing was marked with an earlier date, the tubing was not changed after that date. He/She said it was the responsibility of the charge nurse to ensure the tubing changes occurred as ordered.	F 880		

Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15045	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	201 GRAND AVE WASHINGTON, MO 63090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETE DATE
A4086	19 CSR 30-85.042(77) Infection Control/Communicable Disease Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II This regulation is not met as evidenced by: Class II Please refer to F880	A4086		
A4108	19 CSR 30-85.042(98)(B) Clinical Records - assessment/interventions Facilities shall ensure that the clinical record contains sufficient information to- (B) Reflect the initial and ongoing assessments and interventions by each discipline involved in the care and treatment of the resident; and II/III This regulation is not met as evidenced by: Refer to F640 Class III	A4108		
A8020	19 CSR 30-88.010(20) Exercise Rights/Voice Grievances Each resident shall be encouraged and assisted, throughout his or her period of stay, to exercise his or her rights as a resident and as a citizen and	A8020		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15045	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANDVIEW HEALTHCARE CENTER	201 GRAND AVE WASHINGTON, MO 63090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETE DATE
A8020	Continued From page 1 to this end a resident may voice grievances and recommend changes in policies and services to facility personnel or to outside representatives of his or her choice. A staff person shall be designated to receive grievances and the residents shall be free to voice their complaints and recommendations to the staff designee, an ombudsman or to any person outside the facility. Residents shall be informed of and provided a viable format for recommending changes in policy and services. The facility shall assist residents in exercising their rights to vote. II/III This regulation is not met as evidenced by: Class III Please refer to F561	A8020		

PLAN OF CORRECTION

Provider/Supplier Name:	Grandview Healthcare Center
Street Address, City, Zip:	201 Grand Ave Washington, MO 63090
Date of Survey:	7/11/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction (POC) is submitted as required under State and Federal Law. The submission of this POC does not constitute an admission on the part of Grandview Healthcare Center as to the accuracy of the surveyor's findings, nor the conclusion drawn there from. The facility's submission of this POC does not constitute an admission on the part of the facility that the findings cited are accurate, that the scope and severity regarding the deficiencies cited are correctly applied. This POC is intended to constitute the facility's credible letter alleging compliance. Compliance has been and will be achieved no later that August 21, 2024	
F561 A8020	Self Determination CFR(s): 483.10(f)(1)-(3)(8)	8/21/2024
	The facility staff will create an environment respectful of the rights of each resident to make choices about significant aspects of their lives	
	All residents were potentially affected by the alleged deficient practice	
	Resident #12 preferance to attend activities out of facility unattended reviewed with resident and IDT and careplan updated accordingly	
	DON/designee will educate staff on residents rights including resident self determination through support of resident choices	
	Any concerns identified will be corrected immediately and reviewed at the quarterly QA meeting	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

PLAN OF CORRECTION

Provider/Supplier Name:	Grandview Healthcare Center
Street Address, City, Zip:	201 Grand Ave Washington, MO.65560
Date of Survey:	07/11/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265225

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction (POC) is submitted as required under State and Federal Law. The submission of this POC does not constitute an admission on the part of Grandview Healthcare Center as to the accuracy of the surveyor's findings, nor the conclusion drawn there from. The facility's submission of this POC does not constitute an admission on the part of the facility that the findings cited are accurate, that the scope and severity regarding the deficiencies cited are correctly applied. This POC is intended to constitute the facility's credible letter alleging compliance. Compliance has been and will be achieved no later than August 21,2024.	
F 640 A4108	The facility will ensure to transmit the required Minimum Data Sets a federally mandated Resident assessment.	08/21/24
	MDS Coordinator/Designees will complete and submit MDS assessments for the following residents: #2,#6, #11, #13, #18, #26, #32, #42, #44, & # 53.	
	Admin/Designee will educate nursing administration and MDS coordinator regarding transmission of the MDS with in the Transmission time requirements.	
	DON/Desinee will Audit assessments for resident #2,#6, #11, #13, #18, #26, #32, #42, #44, & # 53 for completion of MDS assessments.	
	DON/Designee will Audit the completion of the future transmission of the MDS weekly x1 month and then bi-monthly x2 months if addition concerns are noted the auditing will continue until resolved.	
	Any concerns identified will be corrected immediately and reviewed at the Quarterly QA meeting.	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

PLAN OF CORRECTION

Provider/Supplier Name:	Grandview Healthcare Center
Street Address, City, Zip:	201 Grand Ave Washington, MO.65560
Date of Survey:	07/11/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	265225

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction (POC) is submitted as required under State and Federal Law. The submission of this POC does not constitute an admission on the part of Grandview Healthcare Center as to the accuracy of the surveyor's findings, nor the conclusion drawn there from. The facility's submission of this POC does not constitute an admission on the part of the facility that the findings cited are accurate, that the scope and severity regarding the deficiencies cited are correctly applied. This POC is intended to constitute the facility's credible letter alleging compliance. Compliance has been and will be achieved no later than August 21,2024.	
F 880 A4086	The facility will ensure to change and store oxygen tubing and/or clean oxygen concentrator filters in a manner to decrease the risk of the spread of infection.	08/21/24
	Resident #8 oxygen tubing and been replaced with new and a label with date applied. Resident # 25 oxygen tubing (nasal cannula & nebulizer) replaced with new and a label with date added. Oxygen filter condenser will be cleaned and if it can't be cleaned will be replaced. Resident #36 oxygen tubing replaced with new and a label with a date applied. Resident #42 oxygen tubing & humidifier bottle replaced with new and a label with a date applied. Filter on O2 machine will be cleaned and if not able to clean will be replaced.	
	DON/Designee will educate nursing staff on infection control practices related to oxygen tubing storage, dating, and cleanliness of oxygen concentrator filters.	
	DON/Designee will complete an initial audit of all residents receiving oxygen therapy to ensure tubing is dated, humidifier bottles are dated, and oxygen concentrator filters are cleaned.	

	DON/Designee will conduct audits weekly x4 weeks and then bi-monthly x2 months of oxygen therapy tubing, humidifier bottles and oxygen concentrators filters.	
	Any concerns identified will be corrected immediately and reviewed at the Quarterly QA meeting.	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.