STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165340	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Healthcare Center	800 Fifth Street SE Oelwein, IA 50662

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on clinical record review, staff interview, and facility policy review, the facility failed to ensure that 1 out of 5 residents reviewed for unnecessary medications was provided with education regarding the risks and benefits of psychotropic medications (Resident #33). Additionally, the facility failed to offer alternative treatment options prior to the administration of the medications. The facility reported a census of 59 residents. Findings include: The admission Minimum Data Set (MDS) Assessment for Resident #33, dated 3/9/26, documented diagnoses that included late onset Alzheimer's Disease. The MDS recorded the resident's admission date to the facility was 3/2/26. Review of Resident #33's Medication Administration Record (MAR) dated March 2026 reflected the resident was ordered Escitalopram, an antidepressant medication, start date of 3/3/26, Quetiapine, an antipsychotic medication, start date of 3/2/26, Trazodone, an additional antidepressant, start date of 3/25/26, and Lorazepam, an antianxiety medication, start date of 3/4/26.A clinical record review of the Resident's Electronic Health Record (EHR) failed to reveal consent obtained for any of the medications prior to initial administration. Additionally, no progress notes or assessments were revealed of providing education of the side effects, risk vs benefits of psychotropic medications or offering of any alternative treatments prior to administering the medications.On 4/15/26 at 9:12 am the Interim Director of Nursing (DON) stated the facility staff were to contact the family and discuss the side effects before any new psychotropic medication was started. She added if a current resident had a medication that was increased or a new medication added, the staff was again to contact the family first to discuss the medication. For new residents to the facility, it was a priority along with completing the admission assessment to complete the education of medications prior to the resident receiving the first dose in the facility.The facility policy titled Usage for Psychotropic Medications Guidance, revision date 3/2025 directed:Prescribing New Medications and/or Increasing Dosage:-Before prescribing new psychotropic medications or increasing doses, document nonpharmacological approaches used and their outcomes.-Assess and document the benefits, risks, and treatment goals.-The facility will obtain informed consent from residents and/or their representatives before initiating or increasing psychotropic medication use. Inform the resident, family, or representative of the benefits, risks, and alternatives, including black box warnings, before initiating or increasing medication. -Provide educational materials to residents and/or their representatives from manufacturers or in collaboration with consultant pharmacists.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165340	A. Building B. Wing	04/15/2026

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review, staff interview, guidance from the 2025 Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual and facility policy review, the facility failed to develop and implement a timely, comprehensive care plan for one of fifteen residents (Resident #33) reviewed. The facility reported a census of 59 residents. Findings include: The admission Minimum Data Set (MDS) Assessment of Resident #33, dated 3/9/26, documented an admission date to the facility of 3/2/26. The MDS triggered nine Care Area Assessment (CAA) categories. Of these, the facility identified six of those areas would be addressed in the Comprehensive Care Plan: Cognitive Loss/Dementia, Communication, Urinary incontinence, Behavioral Symptoms, Nutritional Status, and Psychotropic Drug Use. The MDS documented both a CAA completion date and a care plan completion date of 3/13/26. A record review conducted on 4/13/26 revealed only one of the six identified CAAs was documented on the Comprehensive Care Plan of the above indicated categories.Per the RAI manual guidelines, the IDT (interdisciplinary team) must develop a comprehensive plan that addresses the triggered CAA findings within 7 days of the CAA completion date.The required assessment summary in the RAI manual details the CAA completion date must be no later than the 14th calendar day of the resident's admission, and the Care Plan completion date must be no later than the CAA completion date + 7 calendar days. (21 days after admission to the facility, the Care Plan must be complete).On 4/15/26 at 8:25 am the MDS Coordinator stated she met with the MDS team regarding the missed care plan. She stated the team (herself, the kitchen manager, social services and the activities coordinator) has a virtual schedule accessible to everyone of when all MDS assessments need completed, reviewed and the care plan implemented or updated. She stated Resident #33 was somehow missed on this schedule and they are looking into how that happened.The MDS Coordinator further described their normal process as each member of the MDS team completing their portion of the assessment and then the care plan. When that is completed, the Activities Coordinator then sets up a care conference to discuss the care plan, the goals and interventions with the resident and/or their representative. She stated when Resident #33 was missed, the team initiated having a weekly meeting to rectify this and ensure no further residents are missed.On 4/15/26 at 9:12 am the interim Director of Nursing (DON) stated her expectation for care planning is to have a minimum of Activities of Daily Living (ADL), Fall Risk, High Risk Medications, Behaviors (if applicable), and Code Status included on the baseline care plan, and having that done within 48 hours of resident admission. She stated regarding a Comprehensive Care Plan, all of the same items and all needed additional items should be completed within 7 days of the admission MDS being completed. The facility policy titled Care Plan Policy revision date 3/2025 directed: 1. During admission, the facility will put in place baseline care plans within 48 hours to address resident's care.2. The baseline care plan at a minimum should include initial goals, physician orders, dietary orders, therapy services, social services, and PASARR recommendations if applicable. 3. The facility will provide the resident/representative a written summary of the baseline care plan by the completion of the comprehensive care plan. 4. After the comprehensive assessment (state/federal-required MDS) is completed, the facility will put in place person-centered care plans outlining care for the resident.5. These will be reviewed and revised by the interdisciplinary team after completion of MDS assessments when applicable and with changes that warrant a care plan revision.