

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/11/2024
NAME OF PROVIDER OR SUPPLIER  Grandview Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Grand Ave Washington, MO 63090	

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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>18236</p> <p>Based on interview and record review, facility staff failed to connect one resident's (Resident #1) nasal cannula tubing to the residents oxygen concentrator and failed to turn the oxygen concentrator on. The facility census was 53.</p> <p>1. Review of the facility's oxygen administration policy, dated March 2015, showed when administering oxygen staff are directed to attach a face mask or cannula tubing to the humidifier and set the flow meter to the rate ordered by the physician.</p> <p>2. Review of Resident #1's Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 11/30/23, showed staff assessed the resident as follows:</p> <ul style="list-style-type: none"> <li>-Severe Cognitive Impairment;</li> <li>-Dependent on staff to roll right or left in bed;</li> <li>-Dependent on staff to move from sitting to a lying position;</li> <li>-Atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), and dementia (a group of thinking and social symptoms that interferes with daily function);</li> <li>-Received oxygen therapy.</li> </ul> <p>Review of the resident's plan of care, dated 11/30/23, showed the plan of care did not contain direction for staff to provide oxygen therapy.</p> <p>Review of resident's physician orders, dated 6/30/23, showed an order for two to five liters of oxygen per minute per nasal cannula as needed.</p> <p>Review of resident's nurses notes, dated 12/10/23 at 3:37 P.M., showed the resident with diminished lung sounds and oxygen saturation at 55%. Review showed the nurses note did not contain documentation staff notified the resident's physician of the change in condition.</p> <p>(continued on next page)</p>

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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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/10/24 at 2:59 P.M., Certified Nurse Assistant (CNA) A said he/she worked with the resident on 12/10/23 on the day shift, he/she last worked with the resident around 1:30 P.M. that day. and as far as he/she knew the resident's nasal cannula was on and connected to the oxygen concentrator.</p> <p>During a telephone interview on 1/10/24 at 3:10 P.M., the resident's attending physician said he expected staff to follow physician's orders to include for oxygen therapy.</p> <p>During an interview on 1/10/24 at 3:16 P.M., Licensed Practical Nurse (LPN) B said he/she was assigned to the resident's hall on the day shift of 12/10/23, and CNA A worked with the resident around 1:30 P.M., but at the end of the shift the resident was found with his nasal cannula tubing not connected to the concentrator and the concentrator was not turned on. He/She said they plugged the oxygen back up and turned it on to get the residents oxygen sats back up by utilizing the concentrator and portable tank. He/She at one point the resident could remove the oxygen but was no longer strong enough to do so.</p> <p>During a telephone interview on 1/10/24 at 4:05 P.M., CNA C said he/she worked evening shift with the resident on 12/10/23 and he/she had came in around 3:00 P.M. for evening shift. CNA C said soon after the start of the shift while passing ice, he/she observed the resident with his/her nasal cannula on his/her face, without the tubing connected to the concentrator, and the oxygen concentrator was not turned on.</p> <p>During a telephone interview on 1/11/24 at 9:47 A.M., CNA A said I'm pretty sure I did hook the tubing back and turn on the concentrator. He/She said he/she did not know whether anyone else provided care after 1:30 P.M. to the resident or not.</p> <p>During a telephone interview on 1/11/24 at 10:15 A.M., the Director of Nursing (DON), said on 12/10/23 he/she was at the facility and the charge nurse reported to him/her that CNA A had removed the resident's nasal cannula tubing from the resident's portable oxygen tank but forgot to attach it to the resident's oxygen concentrator while working with the resident. He/She said the next day he/she spoke to CNA C who told him/her, he/she observed the resident's nasal cannula tubing not connected to the concentrator and didn't say anything about the concentrator not being turned on.</p> <p>During a telephone interview 1/11/24 at 11:26 A.M., LPN B said the resident would not have been able to pull his/her nasal cannula from the concentrator independently because he/she was too lethargic and sleepy.</p> <p>During a telephone interview on 1/11/24 at 3:17 P.M., the administrator said she expected staff to follow the physician's order for oxygen administration. She also said she expected staff to take the time to make sure residents' nasal cannula tubing is properly connected to the concentrator and flowing properly to the resident.</p> <p>MO00230021</p>		