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	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Healthcare Center	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)
F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review, facility staff failed to provide professional standards of care for two residents (Residents #1 and #2) out of eight sampled residents, when staff failed to monitor and document residents' bowel movements, which resulted in Resident #1 being admitted to the hospital with a diagnosis of fecal impaction (a condition where a hard, dry mass of stool becomes stuck in the rectum or colon). The facility census was 48. The administrator was notified on 09/09/25 of past Non-Compliance which occurred on 08/15/25 when the administrator implemented new policies and procedures to ensure aides documented residents' bowel movements each shift, and licensed staff monitored residents' bowel movements daily. Staff were in-serviced on 8/15/25 regarding documentation and monitoring of residents' bowel movements. 1. Review of the facility's' Daily Care Needs policy, undated, showed staff are directed to determine if a resident has had a bowel movement each day. If the resident is confused, staff are to check the bowel records and determine if the resident needs a laxative or enema. If a resident has not had a bowel movement in three days, staff are directed to notify the charge nurse. 2. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 08/13/25, showed staff assessed the resident with impaired cognition and occasionally incontinent or bowel. Review of the resident's Care Plan, updated 07/11/25, showed staff assessed the resident at risk for constipation and dehydration. Review showed staff are directed to monitor the resident's intake and output every shift and report if the resident did not have bowel movement in two days to the charge nurse.Review of the resident's Physician's Order Sheet (POS), dated July 2025, showed the resident with a diagnosis of long-term use of an opiate analgesic (a pain-relieving medication, with the possible side effect of constipation). Review the POS showed orders for the following:-Docusate Sodium (a laxative) 100 milligrams (mg) one capsule daily for constipation;-Miralax (a laxative) 17 grams (gm) per dose 17 gm once a day for constipation;-Senna (a laxative) 8.6 mg one tablet every evening; -Bisacodyl suppository (a laxative) one suppository rectally daily as needed for constipation;-Milk of Magnesia (a laxative) 400 mg/5 ml 30 ml as needed for constipation. Review of the resident's Medication Administration Record (MAR), dated July 2025, showed the MAR did not contain documentation staff administered the resident's Bisacodyl or Milk of Magnesia. Review of the resident's vital sign sheet, dated 07/25/24 through 08/01/25, showed the vital signs sheet showed staff documented the last bowel movement the resident had on 07/24/25. Review of the resident's nurses' notes, dated 08/01/25 , showed Registered Nurse (RN) A documented the resident sent to the hospital for respiratory distress. Review of the hospital records, dated 08/01/25, showed a diagnosis of a stool impaction and a moderate amount of fecal matter present in the resident's colon. During an interview on 08/25/25 at 11:45 A.M., Certified Nurse Aide (CNA) E said he/she did not know when the resident last had a bowel movement. He/She said CNA's are responsible for monitoring residents' bowel movements every shift, and to document the information in the computer. He/She said he/she notifies licensed staff if a resident has not had a bowel movement in three days. During an interview on 08/29/25 at 9:38 A.M., RN A said staff notified him/her at approximately 8:00 A.M. on 8/01/25 the resident had a change in condition. He/She said no one notified him/her the resident had not had a bowel movement since 07/24/25. eating was declining, but so was everything else, and had been. Dr aware. During an interview on 08/29/25 at 10:00 A.M., CNA F said CNA's are responsible for documenting residents' bowel movements every shift. He/She said if a resident has not had a bowel movement in three days, they are supposed to notify the charge nurse. He/She said he/she did not know the resident had not had a bowel movement since 07/24/25, and staff did not report to him/her the resident was constipated. 3. Review of Resident #2's quarterly MDS, a federally mandated assessment tool, dated 08/13/25, showed staff assessed the resident as occasionally incontinent of bowels. Review of the resident's Care Plan, updated 07/23/25, showed staff assessed the resident at risk for constipation and dehydration. Review showed staff are directed to monitor the resident's bowel movements every shift and to report no bowel movement in two days to the nurse.Review of the resident's POS, dated July 2025, showed a diagnosis of constipation. Review showed physician's orders for the following:-Celexa 20 mg daily (an antidepressant, with the possible side effect of constipation) 10 mg one tablet daily;-Docusate Sodium 100 mg two capsules daily at bedtime;-Famotidine (an antihistamine, with the possible side effect of constipation) 10 mg every morning;-Bisacodyl suppository 10 mg one suppository rectally daily as needed for constipation;-Milk of Magnesia 400 mg/5 ml 30 ml as needed for constipation;-Miralax 17 gm/dose 17 gm daily as needed for constipation, Ondansetron (an antinausea meditation, with the possible side effect of