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 01/14/2026
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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interviews and record review, facility staff failed to initiate and complete a thorough investigation of misappropriation of resident funds which affected one resident (Resident #64) of five sampled. The facility census was 52.1. Review of the facility's policy titled Abuse Prohibition Protocol Manual, undated, showed staff were directed to:-Resident has the right to be free from abuse, neglect, misappropriation of property, and exploitation; -Administrator or designee must report to the state survey agency no later than two hours after an allegation is made;-The facility must take the following actions in response to an alleged violation of abuse, neglect, exploitation, or mistreatment: -Thoroughly investigate the alleged violation; -Prevent further abuse, neglect, exploitation, or mistreatment from occurring while the investigation is in process; -Take appropriate corrective action as the result of the investigation findings.2. Review of Resident #64's Significant Change Minimum Data Set (MDS), a federally mandated assessment tool, dated 04/23/25, showed staff assessed the resident as cognitively intact. Review of the facility's prior abuse and neglect investigations did not contain documentation staff completed an investigation for the misappropriation. Review of Housekeeper O's employee file showed a hire date of 11/13/17 and termination date of 09/16/25. During an interview on 01/13/26 at 9:45 A.M., the detective said he/she had been notified by another officer that the resident's family had reported multiple fraudulent charges on the resident's credit card over an extended period. The detective said Housekeeper O was caught using the resident's credit card at a gas pump and then going inside the gas station and using his/her personal card inside. During an interview on 01/13/26 at 3:30 P.M., Administrator B said he/she worked at the facility until 10/15/25. Administrator B said the facility had not been made aware of any incidents with the resident's credit card until after the resident had been discharged . Administrator B said he/she started an investigation, but he/she did not know what happened to the investigation or if it had been finished. Administrator B said when he/she spoke to Housekeeper O and he/she denied making the fraudulent changes. During an interview on 01/14/26 at 4:00 P.M., Administrator A said he/she did not work at the facility at the time of the incident. Administrator A said he/she started at the facility on 11/03/25. Administrator A said he/she did not know anything about this incident or facility reported incident until the survey team started annual survey. Administrator A said if a report of misappropriation of a resident's money had been made to the facility, he/she would expect the Administrator to complete a detailed investigation, document the investigation, and keep the investigation at the facility. Administrator A said he/she would also expect a facility reported incident to be reported to DHSS timely. Administrator A said a detailed investigation should have been completed to determine if there were any other residents affected and to prevent other residents from being victims. Administrator A said he/she would have expected an all-staff in-service for abuse, neglect, and misappropriation completed at the time of the report as well. Administrator A said the facility discourages residents from keeping valuable in their rooms, and they do have a lock box in the BOM office for residents to lock items up. Complaint #2616438

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: 265374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER Grandview Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 201 Grand Ave Washington, MO 63090	

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to review and revise the plan of care with changes in the residents' needs for six residents (Resident #2, #6, #7, #17, #22, and #27) out of 21 sampled residents. The facility census was 52.Review of the facility's policy titled Care Plan Comprehensive, undated, showed an individualized comprehensive care plan that includes measurable goals and time frames will be developed to meet the resident's highest practicable physical, mental, and psychosocial well-being. The comprehensive care plan will be based on a thorough assessment that includes but is not limited to the Minimum Data Set (MDS), a federally mandated assessment tool. A well-developed care plan will be oriented to preventing avoidable declines in functioning or functional levels, managing risk factors to the extent possible or indicating the limits of such interventions, applying current standards of practice in the care planning process, assessing and planning for care to meet the resident's medical, nursing, mental and psychosocial need, and addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting. The interdisciplinary care plan team is responsible for the periodic review and updating of care plans when a significant change in the resident's condition has occurred, at least quarterly, and when changes occur that impact the resident's care (i.e. change in diet, discontinuation of therapy, changes in care areas that do not require a significant change assessment).1. Review of Resident #2's Quarterly MDS, dated [DATE], showed staff assessed the resident as:-Severely cognitively impaired;-Weight of 158 pounds (lbs.);-Did not have weight loss;-Diagnoses of stroke, dementia with agitation, anxiety, depression, violent behavior, and stage three chronic kidney disease .Review of the resident's Physician Order Sheet (POS), dated January 2026, showed the physician directed staff as follows:-Diet: Level Six soft and bite sized (a diet for people with mild chewing difficulties, requiring foods that are soft, moist, and cut into small pieces), no fried foods, dated 03/22/25;-Boost Breeze Nutritional (food supplement, lactose-reduced) liquid, 120 milliliters (mL) three times a day, dated 05/01/25;-Super Cereal (a calorie-dense, fortified hot cereal enhanced with ingredients like cream, butter, milk, and sugar to combat unintended weight loss and malnutrition) at breakfast, dated 12/01/25;-Weight: Weekly until stable, on Monday, dated 12/01/25.Review of the resident's monthly weights showed the resident weight as follows:-On 08/01/25 weighed 155.4 lbs;-On 01/12/26, weighed 140.4 lbs a 9.65% loss.Review of the resident's care plan, dated 12/03/25, showed staff did not update the care plan to include the resident's recent weight loss, use of nutritional supplements, or change in frequency of weights.During an interview on 01/14/26 at 3:02 P.M., Certified Nurse Aide (CNA) A said the resident will spit his/her food out, like a behavior, but he/she will get the resident other things, like snacks throughout the day, and he/she did not know the resident had weight loss. The CNA said if he/she was aware the resident had weight loss, he/she would try to get him/her to eat more throughout the day.During an interview on 01/14/26 at 3:13 P.M., the MDS Coordinator said weight loss should be on the care plan, without interventions the resident could continue to lose weight, and the interventions are put in place to prevent and help regain some loss, and it should show supplements, food preferences, and assistance level needed with eating.3. Review of Resident #6's Quarterly MDS, dated [DATE], showed staff assessed the resident as: -Rarely/never understood;-Short and long-term memory problems;-Weight of 154 lbs.,-Did not have weight loss;-Received a mechanically altered diet (a diet that provides moist, soft-textured foods that are chopped, ground, or mashed for easier chewing and swallowing);-Dependent on staff for eating;-Diagnoses of anoxic brain damage (occurs when the brain receives no oxygen at all), diabetes, stroke, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dementia, schizophrenia, gastroparesis (a chronic stomach condition in which the muscles in the stomach do not move food as they should for it to be digested), depression, and anxiety.Review of the resident's POS, dated January 2026, showed physician directed staff as follows:-Add yogurt yummy (a protein rich yogurt) with breakfast and lunch, twice a day A.M. and P.M., dated 10/01/25;-Diet: Level Six soft and bite size, dated 10/23/25;-Check weight weekly, on Monday, dated 11/17/25;-2.0 Supplement (a high-calorie, high-protein liquid nutritional drink) once daily, 90 milliliters (mL) once a day in the A.M., dated 11/18/25.Review of the resident's monthly weights showed staff documented the resident weight as:-On 08/01/25 weighed 179.2 lbs:-On 01/12/26, weighed 151.6 lbs. a 15.4% loss in five month.Review of the resident's care plan, dated 12/15/25, showed staff did not document the resident's recent significant weight loss, use of nutritional supplements, or change in frequency of weights.During an interview on 01/14/26 at 3:02 P.M., CNA A said staff feed the resident because his/her hands do not work. The CNA said he/she did not know the resident had lost weight. The CNA said if he/she was aware the resident had weight loss, he/she would try to get him/her to eat more throughout the day.During an interview on 01/14/26 at 3:13 P.M., the MDS Coordinator said weight loss should be on the care plan, without interventions the resident could continue to lose weight, and the interventions are in place to prevent and help regain some loss, and it should show supplements, food preferences, and assistance level needed with eating.During an interview on 01/14/26 at 4:05 P.M., the Director of Nursing (DON) said he/she often sits with the resident to assist with breakfast and lunch, and the resident will say no, no, and he/she has to encourage the resident to get him/her to eat.4. Review of Resident #7's admission MDS, dated [DATE], showed staff assessed the resident as cognitively intact.Review of the resident's care plan, dated 10/03/25, showed the care plan did not contain direction for the use of bed rails.Observation on 01/11/26 at 12:45 P.M., showed the resident in bed with the right grab bar in the upright position on the bed.Observation on 01/12/26 at 9:56 A.M., showed the resident in bed with the right grab bar in the upright position on the bed.Observation on 01/14/26 at 8:10 A.M., showed the resident in bed with the right grab bar in the upright position on the bed.During an interview on 01/14/26 at 3:13 P.M., the MDS Coordinator said if a resident used bedrails, it should be listed on the care plan.6. Review of Resident #17's Significant Change in Status Assessment (SCSA), dated 12/31/25, showed staff assessed the resident as:-Severely cognitively impaired;-Had delusions and behavioral symptoms not directed towards others daily;-Had identified symptoms that put the resident at risk for physical illness or injury;-Had significant interferences with participation in activities or social interaction;-Weight of 118 lbs.;-Did not have weight loss;-Dependent on staff for eating-Diagnoses of dementia with agitation, anxiety, and depression.Review of the resident's POS, dated January 2026, showed the physician orders as followed:-House supplement, dated 12/28/25;-Diet:Regular, dated 12/28/25;-Weight: weekly times four weeks, on Monday, dated 12/28/25.Review of the resident's monthly weights showed staff documented:-On 08/01/25, weighed 129.8 lbs:-On 01/12/2026, weighed 103.6 lbs. a 20.18% loss in five month.Review of the resident's care plan, dated 12/22/25, showed staff did not document the resident's significant weight loss, use of nutritional supplements, and change in frequency of weights.During an interview on 01/14/26 at 3:02 P.M., CNA A said it depends on the day, if staff can get the resident out of the merry walker (a walker/chair combination decided to provide stability and promote independent mobility for people with walking difficulties), then he/she will sit there and eat, but if the resident is sat down too early, then staff will have to feed the resident. The CNA said he/she did not know the resident had weight loss. The CNA said if he/she was aware the resident had weight loss, he/she would try to get him/her to eat more throughout the day.During an interview on 01/14/26 at 3:13 P.M., the MDS Coordinator (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said weight loss should be on the care plan, without interventions the resident could continue to lose weight, and the interventions are in place to prevent and help regain some loss, and it should show supplements, food preferences, and assistance level needed with eating.During an interview on 01/14/26 at 4:05 P.M., the DON said that staff will get the resident into the dining room chair from his/her merry walker, and he/she can feed himself/herself, but when the resident is ready to get up, he/she is ready and will not stay.7. Review of Resident #22's admission MDS, dated [DATE], showed staff assessed the resident as severely cognitively impaired with a diagnosis of Alzheimer's disease.Review of the resident's care plan, dated 11/12/25, showed staff did not document the resident's Alzheimer's diagnosis or include any interventions related to cognitive impairment. During an interview on 01/14/26 at 3:13 P.M., the MDS Coordinator said the resident should have his/her diagnosis of Alzheimer's/dementia on the care plan so that staff know what to do for the resident.8. Review of Resident #27's Quarterly MDS, dated [DATE], showed staff assessed the resident as cognitively impaired, required substantial/maximal assistance to roll left to right, sit to lying position, and lying to sitting on side of bed.Review of the resident's care plan, dated 10/23/25, showed staff did not document direction for use of an assist bar on the bed.Observation on 01/11/26 at 11:35 A.M., showed the resident in bed with a left assist bar in the upright position on the bed. Observation on 01/12/26 at 9:05 A.M., showed the resident's bed had an assist bar on the left side in the upright position.Observation on 01/14/26 at 8:51 A.M., showed the resident's bed had an assist bar on the left side in the upright position.9. During an interview on 01/14/26 at 3:02 P.M., CNA A said he/she can look at care plans in the point of care (POC) care plan tab, and the care plan will say if a resident needs nutritional supplements, but the nurses also tells him/her that, so he/she does not have to look. CNA A said bed rails should be listed on the care plans for residents who use them, and if a resident has a diagnosis of dementia or Alzheimer's that should be on the care plan, so staff know how to take care of them.During an interview on 01/14/2026 at 3:13 P.M., the MDS Coordinator said he/she has worked at the facility for a couple of months and has never done MDS or care plans before, and he/she is trying to learn. The MDS coordinator said care plans should be updated with every change of condition, quarterly and annually.During an interview on 01/14/26 at 3:40 P.M., the DON said the MDS nurse is responsible to update the care plans. The DON said he/she expects the care plan to be individualized to fit the resident's needs. The DON said the care plan directs the resident's care. The DON said he/she would expect the care plan to have bed rails, weight loss and weight loss interventions, and frequency of weight checks. During an interview on 01/14/26 at 4:00 P.M., Administrator A said the MDS Coordinator is responsible to update the care plans quarterly and as needed with changes. Administrator A said he/she would expect the care plan to be individualized and reflect the resident's needs to direct staff on their cares. Administrator A said he/she would expect the care plan to have if a resident has bed rails, and the amount of assistance a resident need from staff. Additionally, the care plan should include nutritional supplements, weight changes with interventions and cognitive status. Administrator A said the facility has a morning meeting to discuss incidents or changes at that time. Administrator A said he/she expects the care plan to be updated if needed for those incidents or changes discussed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, facility staff failed to provide care, to maintain personal hygiene and grooming for three residents (Resident #5, #16, and #46) out of 21 sampled. The facility census was 52.1. Review of the facility's policy titled Daily Care Needs, undated showed assist a resident to do as much of his/her care needs as possible. Encourage self-care when possible. 2. Review of Resident #5's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 12/02/25, showed staff assessed the resident with severe cognitive impairment, did not have behaviors or refuse care, and independent with all Activities of Daily Living (ADL's). Review of the resident's care plan, revised 05/21/25, showed staff were directed to monitor facial hair and remove as needed. Observation on 01/11/26 at 11:53 A.M., showed the resident with long facial hair. Observation on 01/12/26 at 8:07 A.M., showed the resident with long facial hair. Observation on 01/13/26 at 8:14 A.M., showed the resident with long facial hair. Observation on 01/14/26 at 8:04 A.M., and 11:14 A.M., showed the resident with long facial hair. 3. Review of Resident #16's admission MDS, dated [DATE], showed staff assessed the resident with severe cognitive impairment, did not have behaviors or refuse care, and required extensive assistance with hygiene, dressing and bathing.Review of the resident's care plan, dated 12/02/25, showed staff documented the resident required assistance from two staff for all ADL's and staff are to provide clean appropriate clothing daily. Observation on 01/11/26 at 11:34 A.M., showed the resident wore a grey sweatshirt and with long facial hair. Observation on 01/12/26 at 8:12 A.M., showed the resident wore the same grey sweatshirt as the day before and long facial hair. Observation on 01/13/26 at 8:11 A.M., and 1:54 P.M., showed the resident wore the same grey sweatshirt he/she had on two days prior and long facial hair. Observation on 01/14/26 at 8:10 A.M., and 11:09 A.M., showed the resident wore the same grey sweatshirt and long facial hair. 4. Review of Resident #46's Quarterly MDS, dated [DATE], showed staff assessed the resident with severe cognitive impairment, did not have behaviors and did not refuse care, independent with dressing and required moderate assistance for hygiene and bathing. Review of the resident's care plan, dated 09/26/25, showed the resident required supervision and assistance by staff for all ADLs. Provide clean appropriate clothing daily.Observation on 01/11/26 at 11:37 A.M., showed the resident wore a green sweatsuit and long facial hair. Observation on 01/12/26 at 8:10 A.M., and 1:30 P.M., showed the resident wore the same green sweatsuit as the day before and had long facial hair. Observation on 01/13/26 at 8:09 A.M., showed the resident wore the same green sweatsuit and had long facial hair. Observation on 01/14/26 at 8:07 A.M., showed the resident wore the same green sweatsuit for three days and had long facial hair. 5. During an interview on 01/14/26 at 2:13 P.M., Licensed Practical Nurse (LPN) C said the aides are responsible to assist the residents to change their clothes and shave. LPN C said the charge nurse is expected to ensure the aides complete the cares for each resident. LPN C said he/she expects a resident to be shaved with his/her shower and as needed. LPN C said he/she expects resident's clothes to be changed every day and as needed when soiled. LPN C said he/she was not aware the resident's clothes were not changed, and they had not been shaved. LPN C said if residents refuse cares another staff member should try and if the resident continues to refuse staff should document the refusals. During an interview on 01/14/26 at 3:40 P.M., the Director of Nursing (DON) said the aides are responsible to assist residents to change their clothes and shave. The DON said the charge nurse is responsible to ensure the aides complete the cares needed for each resident. The DON said he/she expects residents to change their clothes daily and as needed when soiled for their dignity. The DON said staff should assist residents to shave as needed, but especially with the resident's showers. The (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON said he/she was not aware the resident's clothes were not changed nor were their faces not shaved The DON said if a resident refuse cares another staff member should make an attempted. The DON said if the resident continues to refuse, he/she expects the staff to document the refusal.During an interview on 01/14/26 at 4:00 P.M., Administrator A said he/she expects staff to assist residents to change their clothes daily and as needed when soiled. Administrator A said a resident should not wear the same clothes for more than one day. Administrator A said the aides are responsible to assist residents to shave when needed and the charge nurse is responsible to ensure the aides complete the care. Administrator A said he/she was not aware the resident's clothes were not changed nor were their faces not shaved Administrator A said if a resident refuse cares another staff member should make an attempted. Administrator A said if the resident continues to refuse, he/she expects the staff to document the refusal. Complaint#: 2652199, 2626155