STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265258	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belleview Valley Nursing Home	23144 Highway 32 Belleview, MO 63623

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 45693 Refer to Event ID J4LN13 for SOD Complaint #MO241216 This deficiency is uncorrected. For previous examples, refer to the Statement of Deficiencies dated 07/18/24. Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #8) was free from physical abuse when Resident #7 punched Resident #8 in the back of the head after an earlier verbal altercation. This resulted in Resident #8's head going forward and smacking his/her face into the medication cart. This caused bruising and swelling to Resident #8's cheek bone. The facility census was 83.

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
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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	Ensure services provided by the nursing facility meet professional standards of quality. 45693 Refer to Event ID J4LN13 for SOD. Complaint #MO241561 and 241643 This deficiency is uncorrected. For previous examples, refer to the Statement of Deficiencies dated 04/16/24 and 06/11/24. Based on observation, interview and record review, the facility failed to ensure staff followed professional standards of practice when staff did not check on one resident (Resident # 6) out of six sampled residents for over seven hours on the night shift. The resident had fallen around midnight and lay on the floor of his/her bedroom until staff entered the resident's room at 6:55 A.M. The facility also failed to identify, assess, and care plan interventions related to falls. The facility census was 83.