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	10/31/2024

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32751 Based on interview and record review, the facility failed to provide an appropriate facility-initiated discharge notice, failed to provide an appropriate discharge plan prior to providing the discharge notice, failed to reassess a resident's status after being discharged from an acute care hospital, and refused to allow one resident (Resident #1) to return to the facility. The sample size was five residents. The facility census was 80. Record review of the facility's undated Discharge Policy showed: 1. The facility must permit each resident to remain in the facility, and not discharge the resident from the facility unless: - The resident's welfare and needs cannot be met in the facility; - The resident's health has improved sufficiently so no longer needs services provided by the facility; - The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; - Health of individuals in the facility would otherwise be endangered. - The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility; - The facility ceases to operate. 2. The facility may not transfer or discharge the resident while an appeal is pending. 3. The facility must ensure the discharge is documented in the resident's medical record, including: - Physician's order for the discharge; - Basis for the transfer; (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Specific resident needs that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the needs. 1. Review of Resident #1's Pre-Admission Screening/Resident Review (PASRR) Level II Evaluation, dated 04/13/12, showed: - The resident's needs could be met in a nursing facility; - The resident did not need specialized services beyond those typically provided by a nursing facility; - Diagnoses include schizoaffective disorder (a mental health condition where people experience psychosis as well as mood symptoms); - A history of facility placement since childhood due to adult abuse; - Had a legal guardian; - History of verbal aggression. Review of the resident's medical record showed: - admitted on [DATE]; - Diagnoses of schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), Type II Diabetes (a long-term condition resulting in too much sugar in the blood) Chronic Obstructive Pulmonary Disease (COPD) (a group of diseases that block airflow and make it difficult to breathe); - Had a legal guardian (a court appointed person who had the authority to make decisions for a person); - The resident was delusional and had episodes of reliving a family member's homicide; - On 10/10/24, the nursing notes showed the resident was very happy and talking delusional. He/she was carrying a bag with a teddy bear and showing it to staff; - On 10/11/24 the resident was sent to the hospital for evaluation and treatment of an altered mental status; - No documentation of any harmful behaviors of the resident prior to discharge to the hospital; - No documentation from the physician regarding the specific needs or services the current facility cannot meet; - No documentation from the physician of the efforts the facility had attempted in meeting those needs; (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation from the physician of the specific services the receiving facility would provide that the current facility could not; - No documentation of a discharge plan prior to providing the discharge notice to the resident and/or the resident's legal guardian; - No documentation of the facility's reassessment of the resident's status after being discharged from the hospital. Review of the resident's discharge Minimum Data Set (MDS - a federally mandated assessment instrument required to be completed by the facility staff), dated 10/11/24 showed the resident was discharged with return not anticipated. Review of the resident's Notice of Discharge for Emergency Situation - Safety of Individuals Endangered, dated 10/11/24, informed the resident and his/her legal representative the reason behind the discharge was the facility could no longer meet the resident's needs and the safety of others in the facility were endangered by the resident's continued presence. The letter went on to say the safety of others was compromised by Resident #1's refusal of treatments, need for security guards for safety during treatment at the hospital, altercations with other residents, false accusations against other residents and making threats to harm self and others. The resident was discharged to the hospital. There was nothing in the letter from the physician. Review of the resident's Physician Order Sheet (POS) dated October 2024 showed: - The resident Physician Order Sheet (POS) dated October 2024 showed on 10/11/24 an order to send to hospital for evaluation and treatment; - An order dated 10/08/24 for Divalproex Delayed Release (a drug used to treat Schizophrenia) 500 Milligram (MG) three times daily: - An order dated 04/18/24 for Amlodipine (a drug used to treat high blood pressure)10 mg in the morning; - An order dated 10/08/24 for Clozapine (a drug used to treat Schizophrenia) 50 mg in the morning. Review of the resident's Medication Treatment Record (MAR) dated October 2024 showed: - Divalproex Time Delayed 500 mg - two missed doses out of three on 10/09/24 and two missed doses out of three on 10/11/24; - Amlodipine 10 mg - one missed dose on 10/09/24; - Clozapine 50 mg - one missed dose on 10/09/24. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/31/24 at 1:00 P.M., the Director of Nurses (DON) said the resident was sent to the hospital for a mental status change evaluation. The resident was taken by a staff member to the hospital. The staff member reported the resident threatening to kill the staff member on the way to the hospital. The resident did not ever become physical with the staff member. The hospital security had to help remove the resident from the vehicle. The staff member called the corporate office and spoke with the corporate nurse (CN). It was then decided to do an emergency discharge with the resident. During an interview on 10/31/24 at 1:25 P.M., Certified Nurse Aide (CNA A) said the resident was threatening to kill him/her on the drive to the hospital. At the hospital the security guard assisted the resident in the building because the resident would not allow CNA A to help. Originally, the resident refused care at the hospital but calmed and allowed it. CNA A said he/she called the CN. CNA A did not say why he/she called the CN instead of the DON. The CN told CNA A, the facility would not be taking the resident back. During an interview on 10/31/24 at 2:00 P.M., the DON said when Resident #1 left the building it was the intention to bring him/her back. The resident had not exhibited any physical aggression with residents or staff. The resident was not considered a danger to self or others, was just exhibiting delusional behaviors. The hospital called and said the resident was fine to return. The DON said he/she was informed the CN had made the decision to not accept the resident back based on the resident's behavior at the hospital. During an interview on 11/04/24 at 7:50 A.M., the Licensed Clinical Social Worker (LCSW) from the hospital said the resident was transported to the hospital. The resident was assisted from the car by a security guard into the hospital with no issue. The resident was seen and evaluated and found to be pleasantly delusional. The facility staff member stayed in the parking lot in a parked car. Upon determining that the resident would be discharged back to the facility the staff left the parking lot. At this time, the LCSW began to reach out to the facility and received no answer. The CN then sent information by fax to the hospital. The hospital tried to tell the facility the resident was fine to return to the facility and they refused to accept the resident back. Complaint #MO243467