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	05/29/2026

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify, assess, and provide supportive interventions for three residents (Residents #4, #21, and #81) with a diagnosis of post-traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event) out of three sampled residents. The facility's census was 77. Review of the facility's policy titled, Policy and Procedure PTSD, dated 03/26/26, showed: - This policy establishes mandatory requirements for identification, assessment, care planning, service delivery, documentation, and follow-up applicable to residents with a history of trauma and/or PTSD;- The purpose of this policy is to promote resident safety, dignity, psychosocial well-being, and quality of life; reduce the risk of re-traumatization, and maintain compliance with applicable federal requirements, Missouri law, and professional standards of practice. 1. Review of Resident #4's medical record showed:- admitted on [DATE];- Diagnoses of PTSD, major depressive disorder (MDD - long-term loss of pleasure or interest in life), recurrent severe with psychotic symptoms (may involve hallucinations or delusions) schizoaffective disorder (mental health condition that includes features of both schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves) and a mood disorder) depressive type (only major depressive bouts), and suicidal ideations (suicidal thoughts). Review of the resident's physician order sheet (POS), dated May 2026, showed:- An order for sertraline (an antidepressant medication) 50 milligram (mg) by mouth one time a day for depression, dated 02/14/26;- An order for quetiapine (an antipsychotic medication) 200 mg by mouth at bedtime for general anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry about everyday issues) and MDD, dated 02/25/25;- An order for bupropion (an antidepressant medication) extended release (ER) 300 mg by mouth in the morning for MDD, dated 02/25/25;- An order for bupropion ER 150 mg by mouth in the afternoon for MDD after lunch, dated 02/25/25;- An order for quetiapine 400 mg by mouth in the evening related to schizoaffective disorder depressive type, dated 11/05/24;- An order for Effexor (an antidepressant medication) extended release (XR) 150 mg by mouth in the morning related to MDD recurrent severe with psychotic symptoms, give with 75 mg capsule, dated 09/01/24;- An order for Effexor XR 75 mg by mouth in the morning related to MDD recurrent severe with psychotic symptoms, give with 150 mg capsule, dated 09/01/24. Review of resident's Trauma Informed Care Assessment, dated 10/10/25, showed:- Resident experienced this kind of event;- Had nightmares about the event(s) or thought about the event(s) when you did not want to;- Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s);- Felt numb or detached from people, activities, or your surroundings;- Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused. Review of the resident's psychiatric progress notes, dated 12/28/25, showed:- Reported unknown substance abuse history, reported history of methamphetamine abuse, and alcohol abuse. Physical or sexual abuse: patient reported history of physical and sexual abuse;- Patient increased irritability and yelling at staff. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed (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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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by the facility staff), dated 03/03/26, showed:- Diagnoses of depression, schizophrenia, and PTSD;- No behaviors;- Antipsychotic and antidepressant medication use. Review of the resident's comprehensive care plan, revised 05/08/26, showed:- A diagnosis of PTSD related to trauma;- No goals to maintain the resident's psychosocial and mental health;- No documentation showing the resident had past trauma, physical or verbal abuse, substance or alcohol abuse or any triggers that would cause the resident trauma;- No non-pharmacological interventions for how the facility would address behaviors if they occurred;- Resident uses antidepressant medication related to MDD, and schizoaffective disorder depressed type. No non-pharmacological interventions for diagnoses;- Resident uses psychotropic medications related to behavior management, PTSD, suicidal ideations, schizoaffective depressed disorder, history of polysubstance abuse, and MDD, and did not include non-pharmacological interventions;- Suicidal ideations diagnosis not addressed. During an observation and interview on 05/26/26 at 11:39 A.M., showed:- The resident was fidgety and anxious when talking about his/her past. He/She became quiet, looked around the room, readjusted himself/herself in bed, and avoided eye contact and further conversation;- The resident said he/she did have a history of trauma/PTSD from when he/she was a kid. People being loud freaked him/her out and he/she had nightmares sometimes. He/She stayed to himself/herself. 2. Review of Resident #21's medical record showed: - admission date of 03/12/26;- Diagnoses of PTSD and schizoaffective disorder bipolar type (mood disorder that can cause intense mood swings). Review of the resident's POS, dated May 2026, showed:- An order for prazosin (a blood pressure medication also used to treat PTSD nightmares) 2 mg three capsules by mouth at bedtime for nightmares, dated 03/12/26. Review of the resident's comprehensive care plan, initiated on 05/8/26, showed:- Did not address triggers that would cause resident trauma;- Did not address past trauma or any triggers that would cause the resident to have behaviors;- No goals to maintain the resident's psychosocial and mental health;- No documentation showing the resident had past trauma, physical or verbal abuse, substance or alcohol abuse or any triggers that would cause the resident trauma;- No non-pharmacological interventions for how the facility would address behaviors if they occurred. Observation and interview on 05/29/26 at 2:36 P.M., showed:- The resident sounded regretful, fidgety, and anxious while talking about his/her nightmares, experiences with church leaders, mental healthcare providers, and police. He/She was tearful, looked around the room, and readjusted in his/her chair;- The resident said he/she had a medication used for night terrors, but he/she woke up yelling sometimes, the bad dreams were reoccurring. Some of the facility residents' behaviors were triggering. He/She could use someone to talk to about his/her triggers and the day staff were friendlier. 3. Review of Resident #81's medical record showed: - admission date of 7/06/22;- Diagnoses of PTSD, anxiety, bipolar disorder, and generalized anxiety disorder;- Cognition impairment. Review of the resident's POS, dated May 2026, showed:- An order for Klonopin (a benzodiazepine medication) 0.5 mg two times a day for mood, dated 05/04/26;- An order for Invega Sustenna (an antipsychotic medication) inject 234 mg intramuscular (into the muscle) every day shift every 28 days related to bipolar disorder and PTSD, dated 03/05/25;- An order for risperidone (an antipsychotic medication) 2 mg by mouth twice daily for mood disorder, dated 05/04/26;- An order for benztropine (an anticholinergic medication) 0.5 mg by mouth two times a day for bipolar, dated 07/06/22. Review of the resident's comprehensive care plan, initiated on 07/06/22, showed:- Takes a psychotropic (medication that affects mental function, behavior, and experience) medication related to PTSD;- Did not address triggers that would cause resident trauma;- Did not address past trauma or any triggers that would cause the resident to have behaviors. Observation on 05/26/26 at 1:45 P.M., of the resident showed:- The resident changed moods from being upset to happy during a sentence, very distracted and fidgety, and hard to understand what he/she was referring to because the subject of conversation changed in the middle of each subject discussed. During an interview on 05/29/26 at 2:44 P.M., Licensed Practical Nurse P said when he/she worked with PTSD affected residents, he/she approached the residents and talked about PTSD and coping skills. The nurse practitioner can also be reached, and we look at medication (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviews. He/She said he/she also looked at care plans for ways to help the residents. There should be information on PTSD included in the care plan to give him/her a starting point when dealing with a resident that had been triggered. During an interview on 05/29/26 at 4:07 P.M., the Director of Nursing said the care plan should reflect resident's needs, diagnoses, and interventions, including non-pharmacological interventions. If there was a resident with a diagnosis of PTSD, the care plan should include triggers and interventions for the triggers. During an interview on 05/29/26 at 4:18 P.M., the Administrator said care plans should reflect the needs of the residents with interventions, including non-pharmacological interventions.