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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received care and services in accordance with physician orders for six residents (Residents #4, #5, #6, #34, #41, and #69) out of 18 sampled residents. The facility also failed to ensure the Hospice Coordinated Plan of Care addressed necessary treatments, supplies, and appliances for two residents (Residents #3 and #27) out of three sampled residents receiving hospice services. These failures had the potential to result in delayed treatment, ineffective symptom management, uncontrolled blood glucose levels, and compromised continuity of care. The facility census was 77.Review of the facility's policy titled, Hospice Plan of Care, showed:- The purpose of this policy is to ensure coordinated, person-centered end-of-life care;- All hospice care and services furnished to residents who elect hospice shall be provided in accordance with an individualized written hospice plan of care;- The hospice plan of care must be individualized and based on the initial assessment, the comprehensive assessment, and updated assessments as the resident's condition changes;- Required content includes: drugs, treatments, medical supplies, and appliances necessary for palliation (relieving pain, symptoms, or suffering caused by a serious illness without curing the underlying disease) and management of the terminal illness and related conditions, identification of needs not related to the terminal illness, and clarification of who is responsible for addressing them. Review of the facility's policy titled, Feeding Tubes, dated 01/06/24, showed:- Did not address a resident's care plan. The facility did not provide a policy for following physician orders. 1. Review of Resident #3's physician order sheet (POS), dated May 2026, showed:- admitted to the facility on [DATE];- admitted to hospice on 02/18/26;- An order for gentamicin (an antibiotic) ointment 0.1% apply to percutaneous endoscopic gastrostomy (PEG - a surgical insertion of a tube through the abdominal wall into the stomach under endoscopic guidance) tube site topically every day shift for infection to the tube site, dated 05/21/26;- An order for doxycycline (an antibiotic) 100 milligrams (mg), give one tablet two times a day for abdominal infection for 10 days, started 05/19/26, with an end date of 05/29/26;- No physician order for the PEG tube and the care of the PEG tube. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 04/23/26, showed:- Cognitively intact;- Received hospice services. Review of the resident's care plan, last revised 05/11/26, showed- Did not address the PEG tube with interventions of monitoring the PEG tube site, drainage, infection, treatment, or related care needs. Review of the resident's Hospice Coordinated Plan of Care, dated 02/18/26, showed:- Did not address the PEG tube with the responsibility of supplies or care; - The facility failed to develop and maintain a coordinated care plan addressing the resident's PEG tube and related treatment needs and failed to ensure physician orders contained sufficient direction for implementation. During an interview on 05/27/2026 at 8:43 A.M., the Director of Nursing (DON) said Resident #3 had a PEG tube in place but did not use it, ate by mouth, and the PEG tube site was infected and treated with antibiotics. 2. Review of Resident #4's POS, dated May 2026, showed:- admitted on [DATE];- Diagnosis of type 2 diabetes mellitus (DM - a metabolic disease);- An order for Lantus (a long-acting insulin) pen 22 units subcutaneously (under the skin) at bedtime related to type 2 DM, dated 03/27/25;- An order for Humalog (a fast-acting insulin) Kwik Pen (continued on next page)

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inject 6 units subcutaneously before meals related to type 2 DM, give in addition to sliding scale, dated 10/26/25;- An order for Humalog Kwik Pen inject as per sliding scale: if blood sugar 111 - 140 = 0 units, 141 - 180 = 2 units, 181 - 220 = 3 units, 221 - 260 = 4 units, 261 - 300 = 5 units, 301 -350 = 6 units, over 351 = 8 units, if over 350 on two consecutive blood sugar checks, notify the primary care provider (PCP),subcutaneously before meals and at bedtime related to type 2 DM, dated 12/25/24;- An order for Glucagon (a medication used to treat low blood sugar) emergency injection kit 1 milligram (mg) Inject intramuscularly (administered into the muscle) as needed for hypoglycemia (low blood sugar) related to type 2 DM, dated 09/20/24;- An order to notify the physician if blood sugar is greater than 400 or lower than 60 as needed related to type 2 DM, dated 09/20/24. Review of the resident's medication administration record (MAR), dated May 2026, showed:- Lantus not administered one out of 26 opportunities;- Humalog per sliding scale not administered two out of 79 opportunities;- Blood sugar checks not obtained two out of 104 opportunities. Review of the resident's progress notes showed:- No documentation showed the physician was notified of the missed insulin administration and missed blood glucose monitoring;- On 05/27/26 at 5:53 A.M., Humalog per sliding scale, missed;- On 05/27/26 at 5:54 A.M., Lantus 22 units subcutaneously at bedtime, missed;- On 05/27/26 at 8:18 A.M., the nurse was informed upon arriving for shift that the overnight blood sugar was not completed by the night shift nurse. The resident already ate breakfast. The DON was made aware. Instructed to inform the provider upon arrival;- No documentation regarding the resident received Humalog sliding scale, Lantus, and blood sugar check administered or obtained on 05/04/26, 05/26/26, and/or 05/27/26. 3. Review of Resident #5's POS, dated May 2026, showed:- admitted on [DATE];- Diagnosis of Diabetes Mellitus (DM - a metabolic disease);- An order for Lantus Pen-injector inject per sliding scale for blood sugar: 0 - 99 = 0, 100 - 170 = 29 units, over 171 = 58 units, two times a day in the morning and evening, dated 05/06/26;- An order for blood sugar checks before each meal and at bedtime, dated 03/25/26;- An order for Novolog 70/30 (a short acting insulin) FlexPen inject per sliding scale for a blood sugar of: 151 - 200 = 3 units, 201 - 250 = 4 units, 251 - 300 = 6 units, 301 - 350 = 8 units, 351 - 999 = 11 units, if over 350 administer 11 units and contact the physician, administer subcutaneously (beneath the skin) before meals and at bedtime, dated 05/17/26. Review of the resident's MAR, dated May 2026, showed:- Lantus not administered one out of 42 opportunities;- Novolog 70/30 not administered two out of 44 opportunities;- Blood sugar checks not obtained one out of 105 opportunities. Review of the resident's progress notes showed:- No documentation showed the physician was notified of the missed insulin administration and missed blood glucose monitoring. 4. Review of Resident #6's POS, dated May 2026, showed:- admitted on [DATE];- Diagnosis of DM;- An order for Lantus Pen-injector inject 40 units at bedtime, dated 02/06/26;- An order for Novolog injection inject 10 units two times a day, in the morning and evening, dated 02/27/26;- An order for Novolog injection inject per sliding scale for a blood sugar of: 150 - 199 = 1 unit, 200 - 249 = 2 units, 250 - 299 = 3units, 300 - 349 = 4 units, over 350 = 5 units before meals, dated 02/27/26;- Insulin pen needle use subcutaneously before meals and bedtime, dated 10/06/25;- Invega Sustenna (an antipsychotic (medication used to treat psychosis of delusions, hallucinations, paranoia, or disordered thoughts) medication) 234 milligram (mg)/1.5 milliliters (ml) intramuscularly (into the muscle) every 28 days, due 05/18/26, last administered 04/20/26, dated 07/15/24. Review of the resident's MAR, dated May 2026, showed:- Lantus not administered one out of 27 opportunities;- Novolog not administered one out of 57 opportunities;- Novolog sliding scale not administered one out of 85 opportunities;- Insulin pen needle not used one out 113 opportunities;- Invega Sustenna not administered one out of one opportunity. Review of the resident's progress notes showed:- On 05/27/26 at 7:56 A.M., the nurse was informed upon arriving for shift that the overnight blood sugar was not completed by the night shift nurse. The resident already ate breakfast. The DON was made aware. Instructed to inform the physician upon arrival; - No documentation showed the physician was notified of the missed insulin administration, missed blood glucose monitoring, and Invega Sustenna injection.Observation on 05/29/26 at 10:30 A.M., of the resident's medications in the B wing (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication room showed:- Two Invega Sustenna injections dated 04/24/26 and 05/20/26. 5. Review of Resident #27's POS, dated May 2026, showed:- admitted to the facility on [DATE];- admitted to hospice on 10/28/25;- Diagnosis of chronic obstructive pulmonary disease (COPD - a lung disease);- An order for oxygen at 2 liters per minute (LPM) continuously per nasal cannula (NC - device used to deliver oxygen with two small tubes that fit into the nostrils) due to hypoxia (low oxygen blood level), dated 05/15/22;- An order to attempt to use supplemental oxygen during showering and restroom use. May turn oxygen up to 3 LPM during activity, dated 03/03/26. Review of the resident's quarterly MDS, dated [DATE], showed:- Mild cognitive impairment;- Received hospice;- Received oxygen therapy. Review of the resident's care plan, last revised 05/09/26, showed:- Requires oxygen therapy due to ineffective gas exchange from COPD. Oxygen at 2 LPM via NC every day and night. Monitor for signs and symptoms of respiratory distress and report. Review of the resident's Hospice Coordinated Plan of Care, dated 10/28/25, showed:- Did not address the responsibility for oxygen equipment, supplies, monitoring, or adjustments of the continuous oxygen.Observations on 05/24/26 at 10:45 A.M., and 3:30 P.M., 05/25/26 at 8:15 A.M., and 1:40 P.M., and 05/26/26 at 9:30 A.M., showed:- The resident lay in bed with his/her eyes closed with oxygen at 3 LPM via NC. 6. Review of the Resident #34's POS, dated May 2026, showed:- Diagnoses of gastroesophageal reflux disease (GERD - stomach contents leak backwards into the esophagus);- An order for famotidine (a medication used to treat and prevent GERD, heartburn and stomach ulcers (an open sore in the inner lining of the stomach) 20 milligrams (mg) by mouth two times a day for ulcer, dated 06/18/24. Observation on 05/27/26 at 12:05 P.M., of the resident's medication administration showed:- Certified Medication Technician (CMT) K failed to administer the resident's famotidine dose;- CMT K documented the famotidine dose was unavailable on the resident's MAR;- CMT K did not notify the charge nurse, the DON, and the pharmacy. The physician was not notified;- The facility failed to administer the famotidine as ordered by the physician and failed to notify the physician when the medication was unavailable. Review of the resident's progress notes showed:- No documentation the resident's famotidine dose not administered on 05/27/26;- No documentation the charge nurse, the DON, the pharmacy, or the physician was notified of the resident's famotidine dose not administered on 05/27/26, and not available at the facility. During an interview on 05/27/26 at 12:05 P.M., CMT K said the resident's famotidine dose was a stock medication (over-the-counter medication kept in stock by the facility), but he/she gave the last pill to another resident earlier and there were none left in the facility. CMT K said the medication should be ordered, but it might come today if the pharmacy delivered at 2:30 P.M. 7. Review of Resident #41's POS, dated May 2026, showed:- admitted on [DATE];- Diagnosis of DM;- An order of insulin aspart (a short acting insulin) Pen-injector inject per sliding scale for blood sugar of: 251 - 300 = 2 units, 301 - 350 = 3 units, 351 - 400 = 4 units, if over 400 call physician, dated 02/17/25;- An order for use of an insulin pen needle subcutaneously before meals, dated 10/06/25. Review of the resident's MAR, dated May 2026, showed:- Insulin aspart not administered one out of 85 opportunities;- Insulin pen needle not used one out of 85 opportunities. Review of the resident's progress notes showed:On 05/27/26 at 7:55 A.M., the nurse was informed upon arriving for shift that overnight blood sugar was not completed by the night shift nurse. The resident already ate breakfast. The DON was made aware. Instructed to inform the physician upon arrival;- No documentation regarding the resident received insulin aspart sliding scale and blood sugar check administered or obtained on 05/27/26. 8. Review of Resident #69's POS, dated May 2026, showed:- admitted on [DATE];- Diagnosis of type 2 DM;- An order for Lantus inject 30 units subcutaneously two times a day related to type 2 DM with diabetic nephropathy, dated 12/16/25;- An order for insulin aspart Penfill inject 30 units subcutaneously before meals for DM related to type 2 DM with diabetic nephropathy, dated 12/16/25. Observation on 05/27/26 at 6:38 A.M., of the resident's medication administration showed:- Licensed Practical Nurse (LPN) J failed to administer the resident's insulin aspart medication per physician order;- LPN J looked for the resident's insulin aspart in the A Hall medication room and the medication was not available;- LPN J did not look for the resident's insulin (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	aspart in the B Hall medication room;- LPN J did not notify the Director of Nursing (DON), the pharmacy, or the physician. Review of the resident's diabetic MAR, dated May 2026, showed:Review of the resident's diabetic MAR, dated May 2026, showed:- On 05/27/26 at 6:30 A.M., dose of insulin aspart pen inject 30 units subcutaneously before meals documented as not given and see progress notes;- Insulin aspart not administered four out of 79 opportunities;- Blood sugar checks not obtained five out of 81 opportunities. Review of the resident's progress notes showed:- No documentation regarding the resident's insulin aspart, and blood sugar check not being administered or obtained on 05/04/26, or the 6:30 A.M., dose on 05/27/26;- No documentation the DON, the pharmacy, or the physician was notified of the resident's insulin aspart dose not administered on 05/27/26 at 6:30 A.M., and not available at the facility;- On 05/27/26 at 11:30 A.M., insulin aspart Penfill inject 30 unit subcutaneously before meals for DM related to type 2 DM with diabetic nephropathy, medication on order from the pharmacy;- On 05/27/26 at 11:41 A.M., insulin aspart Penfill inject 30 unit subcutaneously before meals for DM related to type 2 DM with diabetic nephropathy, medication on order from the pharmacy. Provider aware;- On 05/27/26 at 1:53 P.M., resident morning blood sugar reading of 407, 30 units of long acting administered per orders. Order for 30 units of Novolog not available. DON notified and said she would reorder medication. Noon blood sugar reading of 556. Provider notified of resident blood sugar reading and that Novolog was not available however, was ordered. An order for 8 units Novolog was given at this time. Pharmacy contacted by Registered Nurse (RN) L, pharmacy said medication would be delivered at next pass. ADON made aware of situation. ADON contacted pharmacy and informed them needed the medication as soon as possible. Pharmacy said medication was in route. Medication was delivered and a one-time order for 8 units Novolog was administered;- On 05/27/26 at 3:17 P.M., blood sugar reading of high. Provider notified. A one-time order for 10 units sliding scale insulin, continue with order for long acting. During an interview on 05/27/26 at 6:42 A.M., LPN J said he/she must locate the insulin aspart pen for the resident within the facility or reorder it from the pharmacy. Sometimes a resident's medication would be taken down to the A Hall medication room when the medications arrived from the pharmacy. During an interview on 05/29/26 at 3:00 P.M., the Assistant Director of Nursing (ADON) said the night nurse did not administer insulin that night or morning of 05/27/26 because he/she didn't realize there was a DM MAR. The nurse was told if he/she got behind to let administration know and they would help. There was no excuse. The floor nurse was told to contact the physician who said to obtain current blood sugars on everyone and administer morning insulin even if it was late. There should have been documentation showing that on all of the residents. If there were two boxes of Invega for Resident #6, then the 05/18/26 dose was not administered. During an interview on 05/29/26 at 3:38 P.M., LPN D said if the facility was out of a resident's insulin, the nurse should notify the physician and get an order. The physician should know, and a resolution figured out. During an interview on 05/29/26 at 3:45 P.M., the Assistant Director of Nursing (ADON) said if a medication was out of stock and was a stock medication, then staff should contact the physician or the pharmacy if needed. During an interview on 05/29/26 at 4:18 P.M., the DON said the hospice coordinated plan of care should reflect the coordinated care for the resident and be updated as needed. All medications including insulin and Invega should be administered as ordered. She said missing medications and insulin should be documented and the physician notified. Physician orders should be followed. If a resident was out of insulin, staff should notify the physician and the pharmacy. During an interview on 05/29/26 at 4:25 P.M., the Administrator said she expected the hospice coordinated plan of care to reflect what the resident required and what equipment hospice would provide. She expected orders to be administered as ordered and physician orders to be followed. If medications were not available, the physician should be notified. Expectations would be if a medication was unavailable, for staff to check the Cubex (an automated dispensing cabinets used for the secure storage, tracking, and management of controlled substances and emergency first-dose medications), call the pharmacy, and contact the physician. During a phone interview on 06/02/26 at 11:38 A.M., LPN E said he/she did not remember (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	failing to complete blood sugar checks or administration of insulin on the night shift of 05/26/26, or the morning shift of 05/27/26, for the residents who had orders to do so. There was no reason not to administer insulin if the blood sugar check required insulin to be administered and there was an order. He/She did not remember reporting to the oncoming nurse about blood sugar checks not being completed or insulins not administered.

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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 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;- (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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.

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement an infection prevention and control program to prevent the transmission of infectious organisms. The facility failed to follow Enhanced Barrier Precautions (EBP - precautions used during high-contact resident care activities for residents infected or colonized with a multidrug-resistant organism (MDRO - microorganisms resistant to one or more classes of antimicrobial agents) or for residents with chronic wounds and/or indwelling medical devices) for one resident (Resident #2) out of four sampled residents. The facility failed to perform appropriate hand hygiene and glove changes during incontinent care for two residents (Residents #50 and #76) out of five sampled residents. The facility failed to properly clean and disinfect a shared glucometer (a machine used to check blood sugars), perform hand hygiene, and prevent cross-contamination during blood glucose testing and medication pass activities for four residents (Residents #8, #23, #42, and #69) out of 13 sampled residents. The facility also failed to maintain documentation of tuberculosis (TB - an infectious bacterial disease that affects the lungs) screening and testing for three residents (Residents #2, #8, and #23) out of five sampled residents. These deficient practices created the potential for transmission of infectious organisms to residents and staff. The facility census was 77.Review of the facility's policy titled, Incontinence Care, dated 03/30/26, showed:- Place soiled linens and clothing in the appropriate linen containers;- Did not address the infection control aspects of care. Review of the facility's policy titled, Enhanced Barrier Precautions, dated 03/30/26, showed:- This facility's policy is to implement EBP for preventing transmission of MDRO's;- High-contact resident activities include device care or use including urinary catheter (a sterile tube inserted into the bladder to drain urine). Review of the facility's policy titled, Urinary Catheter Care, dated 03/30/26, showed:- Always wash hands before and after handling the catheter, tube, or bag. Review of the facility's policy titled, Glucometer Cleaning and Disinfection, dated 03/21/26, showed:- This policy establishes requirements for safe cleaning and disinfection of blood glucose meters (glucometers) used in the facility to reduce the risk of transmission of bloodborne pathogens and other infectious agents;- Required supplies included facility-approved professional-use blood glucose meter(s), if sharing is necessary. Manufacturer-approved cleaning and disinfection products for the specific meter model;- Perform hand hygiene before gathering supplies and before putting on gloves;- Prepare supplies in a clean area;- If a meter must be shared, only use a device designed for professional multi-patient use;- After each resident use, inspect the meter for visible soil or blood. Clean and then disinfect the meter exactly as directed by the manufacturer, including required wet contact time;- Allow the meter to remain wet for the full contact time specified by the disinfectant or manufacturer instructions, then allow to dry as directed before next use;- Remove gloves and perform hand hygiene after completing the test and device processing;- Do not use a shared meter on another resident until cleaning and disinfection are fully completed;- If a manufacturer does not provide cleaning and disinfecting instructions for shared use, the meter must not be shared between residents;- Medication carts, supply trays, and testing surfaces must be kept clean and organized to reduce cross-contamination;- Unused supplies taken to the bedside during testing should not be used for another resident if contamination is possible. Review of the CareSens N Blood Glucose Monitoring System's Owner Manual, undated, showed:- Use a soft cloth or tissue to wipe the meter exterior;- If necessary, the soft cloth or tissue might be dipped in a small amount of alcohol;- Did not address the glucometer was validated for multi-patient use;- Did not address the disinfecting instructions for shared use. Review of the facility's policy titled, Policy and Procedure Resident Tuberculosis Testing, dated 01/18/26, showed:- To establish a standardized procedure for TB testing using the tuberculosis skin test (TST - type of testing for TB) for residents and staff, ensuring early detection and prevention of TB transmission within the facility;- All incoming residents and newly hired staff will undergo TB screening using an approved method unless a documented (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	history of prior positive TB test or completed treatment for latent TB infection is provided. The TST is used for a resident's baseline test and if there is no documented prior two-step testing, a two-step TST will be completed. Residents with prior positive, an x-ray will be required. An annual TB screening assessment for residents will be required. An annual TB screening assessment for residents will be completed, including review of symptoms, risk factors, and any known exposure, with additional evaluation initiated when clinically indicated or required by local health regulations. 1. Observation on 05/27/26 at 5:20 A.M., of Resident #2's urinary catheter drainage bag care showed:- EBP signage on the door; - Certified Nurse Assistant (CNA) C entered the room, did not put on a gown, did not perform hand hygiene, and put on gloves;- CNA C placed a container on the floor without a barrier, filled the container with urine from the catheter drainage bag, did not clean the spout of the catheter bag before putting back into the hub, and emptied the container full of urine;- CNA C again placed the container on the floor without a barrier, emptied the catheter drainage bag, did not clean the spout of the catheter before putting back into the hub, and emptied the container with urine; - CNA C removed gloves and performed hand hygiene. 2. Observation on 05/27/26 at 5:31 A.M., of Resident #23's blood glucose testing showed:- Licensed Practical Nurse (LPN) E did not perform hand hygiene and put on gloves;- LPN E entered the resident's room, placed the glucometer on the unclean bedside table without a barrier, performed the blood glucose test, did not remove gloves, did not perform hand hygiene, and exited the room;- LPN E placed the glucometer on top of the medication cart without a barrier;- LPN E removed gloves, did not perform hand hygiene, and touched the laptop to enter the blood glucose test results;- LPN E did not clean and disinfect the glucometer. 3. Observation on 05/27/26 at 5:39 A.M., of Resident #8's blood glucose testing showed: - LPN E did not perform hand hygiene and put on gloves;- LPN E entered the resident's room, placed the same uncleaned and unsanitized glucometer on the unclean bedside table without a barrier, performed the blood glucose test, removed gloves, did not perform hand hygiene, and exited the room;- LPN E placed the glucometer on top of the medication cart without a barrier and touched the laptop to enter the blood glucose test results;- LPN E did not clean and disinfect the glucometer, placed the uncleaned and unsanitized glucometer in the medication cart drawer and did not perform hand hygiene;- LPN E entered the supply closet near the B Hall nurse's station, exited the supply closet, sat in a chair behind the B Hall nurse's station, and did not perform hand hygiene. 4. Observation on 05/27/26 at 6:27 A.M., of Resident #42's blood glucose testing showed: - LPN J performed hand hygiene and put on gloves;- LPN J entered the resident's room, placed the same uncleaned and unsanitized glucometer on the resident's bed without a barrier, performed the blood glucose test, did not remove gloves, did not perform hand hygiene, and exited the room;- LPN J placed the glucometer on top of the medication cart without a barrier, removed gloves, and performed hand hygiene;- LPN J did not clean or disinfect the glucometer. 5. Observation on 05/27/26 at 6:38 A.M., of Resident #69 blood glucose testing and insulin administration showed:- EBP signage on the door;- LPN J performed hand hygiene and put on gloves, gown and a mask;- LPN J entered the resident's room; exited the resident's room; returned to the medication cart and removed the resident's empty insulin pen; did not remove gloves, gown, or mask; walked to the B Hall medication room, touched the outside door knob, the refrigerator, multiple packages of insulin pens, and the inside of the door knob; returned to the medication cart; changed gloves; did not perform hand hygiene; and did not change gowns;- LPN J changed gloves, did not perform hand hygiene; opened the medication cart and removed a different insulin pen for the resident; entered the resident's room; performed the blood glucose test with the same uncleaned and unsanitized glucometer; administered the resident's insulin; removed the gown, gloves, and mask; did not perform hand hygiene; and exited the room;- LPN J cleaned the glucometer with an alcohol wipe for four seconds, did not appropriately clean and sanitize the glucometer, placed the glucometer on top of the medication cart without a barrier, and performed hand hygiene. 6. Observation on 05/27/26 at 10:04 P.M., of Resident #76's incontinent care, urinary catheter drainage bag care, and transfer showed:- EBP signage on the door;- CNA A and CNA B put on gowns, performed hand hygiene, put on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gloves, and entered the resident's room;- CNA A cleaned the front peri area with the same area of the washcloth, did not perform hand hygiene, and did not change gloves;- CNA A removed the soiled brief with fecal material, cleaned the same area of the resident's buttocks of fecal material four times with the same area of the washcloth, the washcloth soiled with fecal material touched the Hoyer lift (a mechanical lift used to transfer residents from one position to another) sling, did not change gloves, and did not perform hand hygiene;- CNA A put a clean brief under the resident, did not perform hand hygiene, did not change gloves, put barrier cream on the resident's peri area, performed hand hygiene, and changed gloves;- CNA A placed a clean cylinder on the resident's bed and held it against his/her gown, filled the container with urine from the urinary catheter drainage bag, did not clean the spout of the catheter bag before putting back into the hub, placed the urinary catheter drainage bag on the bed between the resident's legs, emptied the container full of urine, did not perform hand hygiene, and did not change gloves;- CNA A and CNA B transferred the resident from the bed to the wheelchair with a Hoyer lift and the Hoyer lift sling soiled with fecal material and left the Hoyer lift sling soiled with fecal material under the resident in the wheelchair; - CNA A and CNA B removed gowns and gloves, performed hand hygiene, and exited the room. 7. Observation on 05/27/26 at 9:30 A.M., of Resident #50's incontinent care showed:- EBP signage on the door;- CNA F and CNA G performed hand hygiene, put on gowns and gloves, and entered the room;- CNA F cleaned the resident's front peri area, did not perform hand hygiene, did not change gloves, retrieved a clean brief out of the package, and placed the clean brief under the urine-soaked brief;- CNA F and CNA G performed hand hygiene, changed gloves, removed the urine-soaked brief, did not perform hand hygiene, did not change gloves, fastened the new brief, dressed the resident, and transferred the resident from the bed to the wheelchair;- CNA F and CNA G removed gloves, performed hand hygiene and exited the room. 8. Review of Resident #2's medical records showed:- admitted on [DATE];- Annual TB TST administered on 11/28/23, with a negative 0.0 millimeter (mm) result and no read date;- No documentation of an annual TB screening assessment. 9. Review of Resident #8's medical records showed:- admitted on [DATE];- First step TB TST administered on 01/01/26, with a negative 0.0 mm result and no read date;- Second step TB TST administered on 01/11/26, with a negative 0.0 mm result and no read date. 10. Review of Resident #23's medical records showed:- Annual TB TST administered on 11/29/23 with no read date or result;- No documentation of an annual TB screening assessment. During an interview on 05/28/26 at 3:31 P.M., LPN J said hand hygiene should be completed between residents, and before and after care. If the glucometer was set on a bedside table or another surface in a resident's room, the area or surface should have a clean barrier placed first. The glucometer should be cleaned and disinfected with alcohol pads for at least 30 seconds, or clean with a disinfectant wipe.During an interview on 05/29/26 at 2:15 P.M., the Director of Nursing (DON)/Infection Preventionist and the Administrator said they would expect hand hygiene and glove changes to be completed according to the policy, and there should be a clean barrier placed if setting the glucometer or supplies down in a resident's room. It was expected that TST be documented with read dates and completed per policy. They were unaware the glucometer was not intended for multi-resident use, was not being cleaned and disinfected, and they would expect manufacturer guidelines to be followed.During an interview on 05/29/26 at 3:45 P.M., the Assistant Director of Nursing (ADON) said hand hygiene and gloves changes should be done before, after, and in between for resident care, including blood glucose monitoring. The glucometer should not be placed anywhere without a barrier and should be cleaned and wrapped in a minute wipe when done. Gowns used for EBP should not be worn outside the resident's room.During a phone interview on 06/02/26 at 11:38 A.M., LPN E said hand hygiene should be done before and after care and tasks. The glucometer should be cleaned before and after use each time. The same glucometer can be used for multiple residents if it was cleaned before and after each person. He/She did not know the facility's policy on checking blood sugars or cleaning the glucometer due to it being the first time he/she had worked in the facility.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure staff treated residents with dignity and in a respectful manner by leaving one resident (Resident #76) out of five sampled residents exposed during incontinent care and emptying of a urinary catheter (a sterile tube inserted into the bladder to drain urine) drainage bag. The census was 77. Review of the facility's policy titled, Dignity and Privacy, dated 03/13/26, showed:- This policy establishes standards to protect and promote each resident's privacy, dignity, individuality, and self-determination in the nursing home;- Personal care, bathing, dressing, toileting, transfers, examinations, and treatments will be provided with visual and auditory privacy to the fullest extent practicable;- In shared rooms and common area, staff will balance each resident's privacy and preferences with the rights of roommates and other residents, using curtains or closed doors, whenever possible. 1. Review of Resident #76's medical record showed:- admission date of 02/07/25;- Diagnoses of anxiety disorder (persistent worry and fear about everyday situations), diabetes mellitus (DM - a metabolic disease), and schizoaffective disorder (a condition characterized by abnormal thought processes and deregulated emotions). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 05/26/26, showed:- Cognition intact;- Dependent on staff for dressing, bed mobility, transfers, and toileting;- Always incontinent of bowel and had an indwelling catheter. Observation of the resident on 05/27/26 at 10:04 A.M., showed:- Certified Nursing Assistant (CNA) A and CNA B entered the room to perform incontinent care and empty the catheter drainage bag;- CNA A and CNA B left the door open, did not pull the privacy curtain, and started to perform incontinent care; - At 10:07 A.M., another resident stood at the open door while staff performed incontinent care for Resident #76;- At 10:09 A.M., while staff continued to provide incontinent care for the resident, a staff member and a resident walked past the open door;- CNA A emptied the resident's urinary catheter drainage bag;- CNA A and CNA B failed to provide privacy during incontinent care and emptying of the catheter drainage bag for the resident. During an interview on 05/29/26 at 1:30 P.M., CNA B said the resident's door should remain closed during incontinent care and emptying of a urine catheter drainage bag for a resident's privacy. During an interview on 05/29/26 at 4:07 P.M., the Director of Nursing (DON) said she would expect staff to always protect a resident's privacy during care by pulling the curtain and/or closing the door. During an interview on 05/29/26 at 4:18 P.M., the Administrator said she would expect a resident's privacy to be protected during all care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, the facility failed to update and revise care plans with specific interventions tailored to meet individual needs for one resident (Resident #3) out of 18 sampled residents. The facility census was 77.Review of the facility's policy titled, Revising Care Plans, undated, showed:- It is the policy of this facility to ensure that all comprehensive care plans are reviewed and revised promptly to reflect changes in the resident's condition, treatment, or goals of care;- Care plan revisions are essential to ensure individualized, person-centered, and safe care and to promote accurate, updated interventions that reflect the resident's needs and preferences;- Care plans must be reviewed and revised quarterly, upon a significant change, new physician's orders that impact resident care, after hospitalizations or acute medical events, and upon resident/family request or concerns;- Nurses and other direct care staff must promptly notify the Interdisciplinary Team (IDT - a group of healthcare professionals from diverse fields who work in a coordinated effort toward a common goal for a resident) new pressure injuries, falls, behaviors, infections, or weight changes;- Revised care plans must identify the reason for revision, include updated goals, interventions, and timetables. 1. Review of Resident #3's medical record showed:- admitted to the facility on [DATE];- admitted to hospice on 02/18/26;- Diagnoses of diabetes mellitus (DM - a metabolic disease) muscle wasting, post-polio syndrome (a progressive neurological disorder that affects some polio survivors), major depressive disorder (long-term loss of pleasure or interest in life), paranoid schizophrenia (a long term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations), delusional disorder (a mental disorder marked by false beliefs), and atherosclerotic heart disease of native coronary artery (the buildup of cholesterol, fats and other substances in and on the artery walls). Review of the resident's May 2026 physician order sheet (POS) showed:- An order for gentamicin (an antibiotic) ointment 0.1% apply to percutaneous endoscopic gastrostomy (PEG - a surgical insertion of a tube through the abdominal wall into the stomach under endoscopic guidance) tube site topically every day shift for infection to the tube site, dated 05/21/26;- An order for doxycycline (an antibiotic) 100 mg, give one tablet two times a day for abdominal infection for 10 days, started 05/19/26, with an end date of 05/29/26. Review of the resident's nurse's notes, showed:- On 03/24/26, an order to cleanse and pat dry the PEG tube site and apply a slit gauze dressing every day shift discontinued due to site was no longer draining. Dressing not needed at this time per nursing discretion;- On 05/18/26, during cleaning of the PEG tube site, purulent (containing discharge or causing the production of pus) drainage drained from the site. Upon palpation (a medical examination technique where the sense of feeling is used to assess), a lump was felt in the right lower quadrant (right lower side of the abdomen), and more purulent drainage came from the site. The site was cleansed and hospice notified. Review of the resident's care plan, revised 05/11/26, showed:- Did not address the PEG tube with interventions. Review of the resident's Hospice Coordinated Plan of Care, dated 02/18/26, showed:- Did not address the PEG tube with the responsibility of the supplies or care not specified. Observation on 05/28/26 at 10:00 A.M., showed:- The resident's abdomen exposed with a PEG tube visible. During an interview on 05/29/26 at 4:07 P.M., the Director of Nursing (DON) said she would officially start the position as the Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff) Coordinator. She said a PEG tube should be reflected on the resident's individualized care plan along with what care and type of use was in place. Resident #3's PEG tube wasn't used at all, and he/she refused to have it removed. During an interview on 05/29/26 at 4:17 P.M., the Administrator said any type of medical appliance should be reflected in the resident's individualized care plan.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure placement of the urinary catheter (a sterile tube inserted into the bladder to drain urine) drainage bag was maintained for two residents (Residents #2 and #76) out of four sampled residents. The facility census was 77.Review of the facility's policy titled, Urinary Catheter Care, dated 03/30/26, showed:- Keep the bag below the level of the resident's bladder at all times;- To empty the bag, place a large plastic container or graduated cylinder (container used to measure liquid) on the floor beneath the bag, remove the drain spout from its sleeve at the bottom of the catheter bag without touching its tip, open the slide valve on the spout, and let the urine flow out of the bag into the container, do not let the drain tube touch anything, close the slide valve and put the drain spout into its sleeve at the bottom of the bag;- Did not address keeping the catheter drainage bag off the floor. 1. Review of Resident #2's medical record showed:- admission date of 11/11/21;- Diagnosis of stage four (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcer (injury to the skin and/or underlying tissue usually over a bony prominence because of pressure or friction) of the sacral (triangular bone located above the coccyx) region. Review of the resident's physician order sheet (POS), dated May 2026, showed:- An order for a urinary catheter, 22 French (Fr. - size of catheter) with 5 milliliter (ml) balloon change every month on the 14th, dated 05/14/26; - An order for urinary catheter care every shift, dated 12/16/25. Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 03/24/26, showed:- Utilized a urinary catheter. Review of the resident's care plan, revised 05/08/26, showed:- Did not address the urinary catheter with interventions. Observation of the resident on 05/27/26 at 5:20 A.M., showed:- Certified Nurse Assistant (CNA) C unhooked the catheter drainage bag from the bed frame, laid it on the floor and the bottom of the bag rested on the floor;- CNA C then emptied the urine drainage bag into a container, tapped the spout on the side of the container multiple times, and hung the catheter drainage bag on the bed frame. During an interview on 05/27/26 at 5:30 A.M., CNA C said catheter drainage bags should not touch the floor. 2. Review of Resident #76's medical record showed:- admission date of 04/01/25;- Diagnosis of incomplete emptying of the bladder. Review of the resident's POS, dated May 2026, showed:- An order for a supra pubic (a sterile tube inserted into the bladder through the abdominal wall to drain urine) catheter change every 30 days, dated 05/19/26; - Did not address the supra pubic catheter size and balloon amount;- An order to cleanse the supra pubic catheter site with wound cleanser and apply bacitracin (an antibiotic) daily, dated 05/18/26. Review of the resident's quarterly MDS, dated [DATE], showed:- Utilized a urinary catheter. Review of the resident's care plan, revised 05/09/26, showed:- Resident with a urinary catheter 18 Fr. for neurogenic bladder (the bladder does not empty properly due to a neurological condition);- Position the catheter drainage bag and tubing below the level of the bladder;- Provide urinary catheter care every shift and as needed;- Monitor urinary output every shift and document. Observation of the resident on 05/27/26, showed:- At 10:04 A.M., CNA A picked up the catheter drainage bag and raised it higher than the resident's bladder level to drain the urine into a container. The urine drained back towards the resident's bladder in the tubing. During an interview on 05/29/26 at 2:30 P.M., CNA A said catheter drainage bags should not be on the floor and should not be lifted above the level of the resident's bladder During an interview on 05/29/26 at 3:34 P.M., Licensed Practical Nurse (LPN) D said the catheter drainage bag placement should be below the resident's bladder and it should not be on the floor. During an interview on 05/29/26 at 4:07 P.M., the Director of Nursing (DON) said catheters were expected to remain below the level of the bladder and not on the floor. During an interview on 05/29/26 at 4:18 P.M., the Administrator said she would expect staff to follow proper procedure and ensure catheters didn't touch the floor and stayed below the level of the resident's bladder.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. The facility failed to ensure care and services for one resident (Resident #59) out of a sample of one resident with a colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall) were provided in accordance with professional standards of practice. The facility allowed Resident #59 to independently perform colostomy care without evidence of a physician order authorizing self-administration of care, without a documented assessment of the resident's competency to safely perform colostomy care, and without ongoing nursing assessment and monitoring of the stoma (opening) and appliance. The facility also failed to develop and implement a comprehensive care plan that addressed the resident's colostomy care needs, including monitoring of the stoma, appliance management, supply needs, resident education, and interventions necessary to maintain the resident's highest practicable well-being. The facility census was 77.Review of the facility's policy titled, Care Plan Completion, dated 03/27/26, showed:- The facility will develop a comprehensive person-centered care plan for each resident within seven days after completion of the comprehensive assessment that includes measurable objectives and timeframes to meet resident's medical, nursing, mental, and psychosocial needs, services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and resident's goals for admission and desired outcomes and the resident's right to refuse treatment. 1. Review of Resident #59's medical record showed:- admission date of 05/24/11;- Diagnosis of colostomy status;- Cognition intact;- No documentation showed the resident assessed for competency to complete his/her own colostomy care. Review of the resident's physician order sheet (POS), dated May 2026, showed:- An order to change the colostomy every three days on the day shift, dated 05/17/22;- An order for colostomy care every day on the day shift, dated 05/17/22;- No order for the resident to provide self-care of the colostomy and monitoring of the stoma. Review of the resident's care plan, revised 05/11/26, showed:- Resident has a colostomy;- Did not address self-care of colostomy and changing of the appliance;- Did not address monitoring the stoma appearance;- Did not address colostomy supplies;- Did not address education regarding the colostomy care. Review of the resident's treatment administration record (TAR), dated May 2026, showed:- Colostomy care every day every day shift, dated 05/17/22;- No documentation of the appliance changed as ordered;- No documentation of monitoring of the stoma;- No documentation of the resident's self-care of the colostomy. Review of the resident's medication administration record (MAR), dated May 2026, showed:- No documentation related to the resident's colostomy. Observation and interview on 05/26/2026 at 7:31 P.M., of the resident showed:- The resident with a colostomy appliance in place;- The resident said he/she changed it himself/herself, cleaned it three times a day and changed the complete appliance on Tuesdays, Thursdays, and Saturdays. The facility provided the supplies. Observation on 05/28/26 at 8:52 A.M., showed:- The resident completed the colostomy appliance change during his/her shower with minimal assistance from Certified Nursing Assistant (CNA) O. During an interview on 05/28/26 at 8:52 A.M., CNA O said the resident used a pen to mark the circle on the colostomy flange (the plastic ring in a two-piece pouching system that connects and adheres to the skin around the around the stoma), and then he/she would cut it on the line to make the hole to go around the stoma, and then he/she handed the resident the second piece of the colostomy pouch when the resident asked for it. The resident did everything else himself/herself, other than cutting the hole. The resident usually did it while in the shower. During an interview on 05/28/26 at 3:22 P.M., the resident said no one had ever watched, assessed, or spoke with him/her for self-care or changing his/her colostomy since his/her admission. During an interview on 05/29/26 at 3:45 P.M., the Assistant Director of Nursing (ADON) said if a resident performed their own ostomy care, a competency assessment should be completed. During an interview on 05/29/26 at 4:07 P.M., the Director of Nursing (DON) said the care plan should reflect needs, diagnoses, and include interventions. Colostomy should be care planned and include (continued on next page)

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.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitoring of the stoma, appliance needs, and care of the colostomy. A competency assessment should be completed for ostomy care if the residents do their own care. During an interview on 05/29/26 at 4:18 P.M., the Administrator said the care plan should reflect needs and interventions. The care plan should include monitoring the stoma, and appliance change and care. Competency assessments should be completed for those doing their own care.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were labeled and/or disposed of after the expiration date in accordance with currently accepted practices. This had the potential to affect all residents. The facility census was 77.Review of the facility's policy titled, Medication Labeling Policy, dated 03/26/26, showed:- This policy establishes requirements for accurate, complete, legible, and current medication labeling in the nursing home in order to support safe medication use, prevent errors, reduce diversion risk, and maintain compliance with federal requirements, Missouri law, and pharmacy service agreements;- The facility will ensure that medications and biologicals are labeled in a manner consistent with applicable federal and Missouri requirements and in a format that supports safe storage, preparation, dispensing, and administration;- No medication may be administered from a container, package, syringe, cup, blister card, or other storage system that is unlabeled, incompletely labeled, illegible, altered without authorization, or otherwise inconsistent with current orders and applicable law;- This policy applies to all prescription medications, over-the-counter medications, biologicals, controlled substances, emergency medications, refrigerated medications, compounded products, repackaged products, topical products, inhaled products, insulin and injectable supplies, treatment items when labeled as medications, and all medication storage systems maintained by the facility or on the facility's behalf;- All medication labels must be legible, durable, and consistent with current prescribing, dispensing, and administration information;- Medication containers and administration systems must be labeled sufficiently to identify the resident when resident-specific, the medication name, strength when applicable, dosage form, directions or route when needed for safe use, and any other information required by law, pharmacy labeling standards, or facility procedure;- No medication may be transferred to another container or left in an unlabeled cup, syringe, or other device beyond the immediate preparation and administration process allowed by facility procedure and safe practice;- Medications that require dating upon opening, reconstitution, dilution, compounding, or removal from original packaging must be labeled with the applicable open date, preparation date, beyond use date, expiration date, or discard date, as required by manufacturer instructions, pharmacy labeling, or facility procedure;- Multi-dose vials, insulin, ophthalmic products, inhalers, topical preparations, nutritional medication combinations when applicable, and refrigerated products must be dated and discarded in accordance with manufacturer instructions, pharmacist guidance, and facility policy. Review of the Fiasp (a rapid-acting insulin) medication insert, revised 06/2023, showed:- The storage conditions for 10 milliliter (ml) multiple dose vial, at room temperature not in-use (unopened) to be 28 days; In-use (opened) to be 28 days. Review of the NovoLog Mix 70/30 (a dual action insulin medication) injectable suspension medication insert, revised 02/2023, showed:- The storage conditions for Novolog Mix 70/30 Flexpen, 3 ml single-patient-use flexpen, not in-use (unopened) at room temperature to be 14 days; In-use (opened) at room temperature to be 14 days (Do not refrigerate). Review of the Tresiba (a long-acting insulin medication) injection medication insert, revised 07/2022, showed:- The storage conditions for 3 ml single-patient-use Tresiba Flextouch not in-use (unopened) at room temperature to be 56 days (8 weeks); In-use (opened) at room temperature to be 56 days (8 weeks). According to the National Institute of Health, Opened nasal sprays and eye drops should generally be disposed of within 30 to 90 days after opening, even if the printed expiration date has not passed, according to general health guidelines. For specific medical, multidose, or prescription nasal sprays, the Centers of Disease Control and Prevention (CDC) and associated guidelines often recommend discarding them within 28 days of opening or as specified by the manufacturer. 1. Observation of the nurse treatment cart for B and C Halls on 05/27/26 at 7:00 A.M., showed:- Resident #5's Novolog Mix 70/30 Flexpen with an open date of 04/26/26;- Resident #38's (continued on next page)

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	265258	A. Building B. Wing	05/29/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Novolog Mix 70/30 Flexpen, with an open date of 04/14/26;- Resident #3's Tresiba Flex Touch Pen with no open date;- Resident #3's Fiasp multiple-dose vial with an open date of 01/17/26;- Resident #41's Novolog Flexpen with an open date of 03/19/26;- Resident #43's hemorrhoidal ointment with applicator with an open date of 08/12/24, and an expiration date of 10/2024;- Resident #43's clindamycin (an antibiotic medication) lotion 1%, with no open date. During an interview on 05/27/26 at 7:23 A.M., Licensed Practical Nurse (LPN) J said all insulin should have an expiration date, and show the date it was opened. Insulin was good for 30 days from the date opened. LPN J said medications should have been removed from the treatment cart when discontinued, completed, or expired. Dispose of insulin if out of date or undated. Insulin was dated when opened by the nurse who pulled the insulin or opened the insulin. He/She believed the night shift nurse was supposed to check the medication and treatment carts and restock the carts, but anyone could. LPN J said he/she checked the dates on the insulin and other medications prior to administration. 2. Observation of the nurse treatment cart for A Hall on 05/27/26 at 7:45 A.M., showed:- Resident #56's streptomycin 130 mg, meropenem180 mg, vancomycin 60 mg (a compounded antibiotic medication) dispensed on 11/10/25, with no open date, an expiration date of 04/12/26, and 55 capsules in the bottle;- 14 unidentified pink plastic vials, unlabeled and undated, lay inside of a tray in a drawer of medication cart, expired 04/2026. During an interview on 05/27/26 at 8:00 A.M., LPN M said he/she believed the vials belonged to Resident #56. Maybe someone just emptied the rest of a package into the tray and did not put the sticker with them. 3. Observation of the B Hall Certified Medication Technician (CMT) cart on 05/29/26 at 1:23 A.M., showed: - One bottle of sodium chloride (an electrolyte replenisher medication) tablet 100 mg tablets, opened and undated;- Resident #72's fluticasone (a corticosteroid medication) 50 mg with an open date of 02/26/26;- Resident #81's fluticasone 50 mg with an open date of 02/26/26;- One unlabeled Artificial Tears eye drops, opened 04/11/26, sat in Resident #81's slot. 4. Observation of the B Hall medication room on 05/29/26 at 9:32 A.M., showed:- One unlabeled vial of olanzapine (an antipsychotic (medication used to manage psychosis, including delusions, hallucinations, paranoia, and disordered thought) medication) 10 mg vial in a bag in the drawer to the left of the sink with an expiration date of 11/25. During an interview on 05/29/26 at 3:33 P.M., CMT K said all medications should be dated with date opened. Usually, whoever was on the mediation cart went through the cart to check for opened and expiration dates. During an interview on 05/29/26 at 3:38 P.M., LPN D and CMT N said medication should be dated and initialed when opened. CMTs went through the CMT medication carts to clean them out and remove expired medications. LPN D said insulin should be dated with the open date, expired treatments and medications should be wasted or thrown away. During an interview on 05/29/26 at 3:45 P.M., the Assistant Director of Nursing (ADON) said medications should be dated when opened and initialed. If medications were expired, they should be wasted. During an interview on 05/29/26 at 4:07 P.M., the Director of Nursing (DON) said medication stock and insulin should have an open date, expired and discontinued medication and treatments shouldn't be in the medication cart or treatment supplies. There should be a discard date for the eye drops and nasal sprays. Medications should be identified with names if in the carts and opened and for a specific resident. During an interview on 05/29/26 at 4:18 P.M., the Administrator said all things, insulin and medications should be dated when opened. Remove expired medications and treatments from the cart and destroy them.