STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265419	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country View Nursing	2106 West Main Bowling Green, MO 63334

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (Resident #34), in a review of 17 sampled residents, was free from abuse by staff. Certified Nursing Assistant (CNA) J slapped the resident in the face with a dirty incontinent product, was physically rough with the resident causing the resident pain and discomfort, spoke to the resident in a harsh tone and told the resident he/she could complete tasks that the resident requested help for. CNA J's actions were witnessed by Resident #34's roommate. The interaction made Resident #34 feel unsafe and angry. The facility census was 40. The administrator was notified of the past noncompliance on 01/09/26, which occurred on 01/04/26. On 01/05/26, the facility placed the agency charge nurse and aide on a Do Not Return list (meaning they could not return to the facility for a work assignment) for the allegation of staff to resident abuse. In-servicing of staff on abuse was conducted and the facility began their investigation into the allegation. In-servicing was completed on 01/06/26. This deficiency was corrected on 01/06/26 Review of the facility policy, Abuse, Prevention and Prohibition Policy, revised 2021, showed the following: -Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion;-Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals;-This facility prohibits mistreatment, neglect or abuse of residents;-This presumes that all instances of abuse can cause physical harm, pain or mental anguish;-Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish;-Mental abuse includes but is not limited to, humiliations, harassment and threats of punishment or deprivation;-Neglect means failure to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress. 1. Review of Resident #34's face sheet showed the following: -He/She was responsible for self;-Diagnoses include unspecified dementia (a clinical term for cognitive decline such as memory loss or thinking problems that could affect daily life), unspecified low back pain, neuralgia and neuritis (sharp, shocking nerve pain and inflammation of the nerve, causing pain, tingling and weakness) and osteoarthritis (a degenerative joint disease causing pain, stiffness, swelling and reduced mobility). Review of the resident's care plan, revised 01/06/25, showed the following: -The resident was at risk for falls, encourage him/her to prepare for bedtime, assist with dressing and toileting prior to going to bed;-The resident had an activities of daily living (ADL) self-care performance deficit and required one assist with undergarment change and peri-care, and one assist with dressing, transfers and toileting. Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/02/25, showed the following:-Cognitively intact;-Adequate hearing and clear speech;-No delirium, hallucinations, behaviors or rejection of cares;-Set up or clean up assistance required for toileting hygiene, (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 0600 Level of Harm - Actual harm Residents Affected - Few	upper and lower body dressing;-Supervision or touch assistance from staff for sitting to standing transfers and toilet transfers;-Occasional pain that interfered with day-to-day activities. Review of the resident's electronic health record, nursing progress notes, from 01/04/26 through 01/05/26, showed the following:-On 01/05/26, at 6:39 P.M., charge nurse was directed to do a full skin assessment of the resident. The resident made allegation of abuse toward an agency staff member;-No progress note indicated for the date of the allegation. During an interview on 01/06/26 at 4:04 P.M., the resident said the following: -Last Sunday night at bedtime, he/she asked a staff member to help him/her get ready for bed;-The staff member, someone from an agency that did not work at the facility full time, told him/her do it yourself;-He/She explained he/she needed help with his/her brief change (incontinent product) and the agency staff member said, no, you don't need help;-The resident took his/her brief off, the agency staff member took it and slapped the resident in the face with it;-He/She asked for help and the agency staff member said, for what, you can do it yourself;-He/She did not know the agency staff member's name; agency staff do not wear name tags; when he/she asked the agency staff his/her name, the agency staff member said, for what?;-The agency staff gave a name of a staff member that was working (Nurse Aide NA G), but the resident knew that staff member and he/she was not in the room;-The agency staff member jerked him/her around and it made the resident's shoulder hurt. The agency staff member pulled his/her brief up and pinched the resident;-He/She told the agency staff, don't pinch me and the agency staff said, I'm not; the aide was rude and short in the way he/she spoke to him/her; -The way the agency staff member treated him/her made him/her angry and he/she felt unsafe because of the way he/she was treated;-He/She reported the incident to NA G. During an interview on 01/09/26 at 1:43 P.M., NA G said the following:-He/She was working over his/her regular scheduled shift until 9:00 P.M. on 01/04/26;-Agency staff, Certified Nurse Aide (CNA) J, was assigned to Resident #34's hall and an agency nurse was the charge nurse;-He/She was checking to make sure everyone was ready for bed before he/she left for the night;-Resident #34 said he/she was not feeling very well after the way he/she was treated by the other aide;-Resident #34 said, the other aide was aggressive, and the aide slapped him/her in the face with the resident's brief;-The resident said the other aide was very rough when taking his/her clothes off and jerked him/her around;-NA G reported to the charge nurse what occurred;-When he/she asked the resident who the other aide was, the resident described the staff member as having a big tattoo on his/her arm;-The only staff member working meeting the description was Certified Nurse Aide (CNA) J, the staff assigned to the resident's hall. 2. Review of the facility staffing assignment sheet for the night shift on 01/04/26 showed CNA J was assigned to the resident's hall from 7:00 P.M. thru 7:00 A.M.; review of the facility provided agency staff list, listed CNA J as working for the agency the facility used for staffing. 3. Review of Resident #37's quarterly MDS, dated [DATE], showed the following:-Cognitively intact;-Adequate hearing and vision;-No delusions or hallucinations. During an interview on 01/06/26 at 12:26 P.M., the resident said the following:-There was one person that did not treat his/her roommate, Resident #34, very nice the other night; that person worked for an agency; -The agency aide came in the room and took Resident #34 to the bathroom, and then he/she heard Resident #34 say, stop pinching me, you are pinching me;-The agency staff member said, I'm not pinching you; I'm just trying to care for you;-He/She did not see that part because they were in the bathroom, but the door was open, and he/she could hear the conversation;-The agency aide was really pushing Resident #34's buttons and told the resident he/she wasn't going to help the resident get ready for bed; he/she could do it himself/herself;-Resident #34 asked the agency aide what his/her name was; he/she was not wearing a name tag, and the agency staff said, [NAME] - my name is [NAME];-The resident knew [NAME] and the agency aide (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	was not [NAME];-He/She saw the agency aide smack Resident #34 back and forth in the face with gloves, back and forth a few times, in the resident's room;-The privacy curtain was not pulled because Resident #34 does not like it pulled;-The agency aide was very rude and disrespectful in the way he/she talked to Resident #34 and the tone he/she was using was harsh; the aide was very mean to the resident;-This happened about 8:30 P.M. the other night;-Resident #34 did not deserve to be treated that way;-The whole interaction made him/her feel uncomfortable;-He/She did not report this to anyone because Resident #34 reported it to staff; he/she was asked about it the next day. 4. Review of the facility investigation, Initial Reporting Form, completed by the administrator, dated 01/05/26, showed the following: -Allegation type: abuse, physical;-NA G reported that Resident #34 came to him/her at 9:00 P.M. (on 01/04/26) and said he/she was not feeling very well after an aide left his/her room;-The resident said an aide had slapped his/her face with his/her dirty incontinent product;-The staff member told the resident to take of his/her shirt himself/herself and would not listen to the resident when he/she asked the staff member for help;-The resident said he/she also hit his/her hand on the door when he/she came out of the bathroom;-The resident reported to NA G the staff member was very rough and that his/her body now hurt because of the way he/she was handled;-The resident voiced he/she was pinched, with no bruise noted;-Do Not Return (DNR) of agency CNA J and reached out to the agency used for staffing;During an interview on 01/06/26 at 10:00 A.M and 01/09/26 at 8:53 P.M., the administrator said the following: -CNA J and LPN M, who were working at the time of the allegation, have been placed on the Do Not Return list and will not be back at the facility due to the allegation of abuse and not reporting it to Director of Nursing or himself; -Abuse and neglect training took place 01/05/26 and 01/06/26 for all staff;-The local law enforcement organization (LEO) was contacted and a statement from CNA J was collected by the LEO pertaining to the allegation;-NA G has been educated on the process to report allegations of abuse or neglect. 2707975