STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265506	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine View Manor Inc	307 N Pineview Street Stanberry, MO 64489

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 Note: The nursing home is disputing this citation.	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 observation, interview, and record review the facility failed to protect one of three sampled residents right to be free from abuse when staff observed Resident #1 and Resident #2 get into a verbal argument, and a short while later, Resident #2 went into Resident #1s room and a physical altercation occurred where both residents were found on the floor. The nurse assessed Resident #1 and found he/she was upset and with physical injuries including a scraped left knee and left elbow and a red mark on the left side of his/her ribs. This affected one of three sampled residents. The facility census was 55. Review of the facilities Abuse and Neglect Protocol policy, dated 2/15/22, showed: -It was the purpose of the facility to prohibit and prevent abuse and to assist the facility staff members in recognizing incidents of abuse; -Abuse was defined as the willful infliction of injury, intimidation or punishment with resulting physical harm or pain. Review of the facilities Resident-to-Resident Altercations policy, dated 1/1/26, showed: -Facility staff will monitor residents for aggressive/inappropriate behavior towards other residents; -Review the events with the Nursing Supervisor and Director of Nursing, including interventions to try to prevent additional incidents; -Document in the resident's clinical record all interventions and their effectiveness.Review of Resident #1's Quarterly Minimum Data Set (MDS) a federally required assessment tool completed by facility staff, dated 3/23/26, showed: -The resident was cognitively intact; -The resident was independent with activities of daily living; Review of Resident #2's Comprehensive MDS, dated [DATE], showed: -The resident was cognitively intact; -The resident required minimal assistance with activities of daily living; -The resident had diagnoses of major depressive disorder, osteoarthritis (a chronic joint disease-causing breakdown of cartilage causing bones to rub together leading to pain and reduced mobility), and hypertension. Review of Resident #1's emergency room discharge instructions, dated [DATE], showed: -The resident had pain to his/her left ribs and left knee; -The resident had a contusion (bruising) of the left chest wall, contusion of the left rib, and a skin tear to the left elbow.Observation on 04/13/2026 at 1:40 P.M. showed Resident #1 with a grapefruit sized bruise to his/her left rib area. During an Interview on 04/13/2026 at 1:36 P.M. Resident #1 said: -Resident #2 had said some rude things to one of the staff members so he/she had told Resident #2 not to speak that way to staff, Resident #2 got angry and yelled at Resident #1 since he/she was angry that Resident #2 had told him/her to not speak like that; -Resident #1 went back to his/her room after Resident #2 had yelled at Resident #1; -Resident #1 told Resident #2 not to come to his/her room but Resident #2 did. -When Resident #2 went into Resident #1's room, he/she lunged at Resident #1 and both residents got into a physical altercation ended up on the floor; -Resident #1 could not remember any specific details of the physical altercation; -Resident #1 had pain to the left side of his/her ribs and was sent to the emergency room to get x-rays. During an interview on 04/13/2026 at 2:03 P.M. Resident #2 said: -Resident #1 liked to interrupt his/her conversations; -Resident #2 replied to Resident #1 in an aggressive tone; -Resident #1 went back to his/her room after the verbal argument; -Resident #2 went by Resident #1's room to get to his/her own room when Resident #1 had made a rude remark to Resident #2, Resident #2 then turned around in his/her (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 Note: The nursing home is disputing this citation.	wheelchair and went into Resident #1's room; -Resident #1 had reached toward Resident #2 and both resident's had shoved each other, Resident #2 fell forward and Resident #1 fell on his/her back; -Resident #2 was not injured during this altercation; -Resident #2 has had anger issues in the past and that was something he/she was working on improving; -Resident #2 made sure to stay away from Resident #2 after the altercation. During an interview on 04/13/2026 at 1:36 P.M. Resident #2 said: -Resident #1 had said some rude things to one of the staff members so he/she had told Resident #1 not to speak that way to staff, Resident #1 got angry and yelled at Resident #2 since he/she was angry that Resident #2 had told him/her to not speak like that; -Resident #2 went back to his/her room after Resident #1 had yelled him/her; -Resident #1 came into Resident #2's room, Resident #2 had told Resident #1 not to come into his/her room but Resident #1 went into Resident #2's room anyway and lunged at Resident #2 and both resident's ended up on the floor; -Resident #2 could not remember any specific details of the physical altercation; -Resident #2 had pain to the left side of his/her ribs During an interview on 04/13/2026 at 10:45 A.M. Certified Nursing Assistant (CNA) A said he/she was sitting by Resident #2 when Resident #2 was told by Dietary Aide A that the facility was out of grapes. -The resident told dietary aide A that he/she could shove the grapes up his/her ass. -CNA A said that it sounded like Resident #2 was joking since he/she was smiling and dietary aide A was also smiling; -Resident #1 had heard what Resident #2 had said to dietary aide A and told Resident #2 that he/she should not speak to staff that way; -Resident #2 told Resident #1 that he/she was going to hit him/her one of these days. -Licensed Practical Nurse (LPN) A had Resident #1 return to his/her room and CNA A continued to sit by Resident #2 near the nurses station for approximately 10 minutes before CNA A went outside on break; -CNA A was outside when dietary aide A came outside and had said that Resident #1 and Resident #2 had gotten into a fight; -CNA A did not witness the physical altercation between Resident #1 and Resident #2; -The physical altercation happened approximately ten minutes after the verbal altercation; -After the physical altercation the residents were separated, and Resident #1 was sent to the hospital approximately one hour after the physical altercation occurred; -Resident #2 stayed in his/her room the rest of the night after the physical altercation with Resident #1; -Neither residents were placed on one-on-one observation or 15-minute checks after the physical altercation. During an interview on 04/13/2026 at 11:14 A.M. LPN A said: -On 4/11/26 Resident #1 and Resident #2 got into a verbal argument at the nurses station, Resident #1 was assisted back to his/her room and Resident #2 continued to sit by the nurse's station with staff nearby; -A little bit later that evening LPN A was down the hallway that both residents reside on caring for another resident when he/she saw Resident #2 go by Resident #1's room in his/her wheelchair, Resident #2 then turned around and went into Resident #1's room; -LPN A had told Resident #2 to not go into Resident #1's room; -When LPN A had arrived at Resident #1's room both residents were on the floor; -Resident #1 had a red mark on his/her left ribs and he/she said that the area felt sore, LPN A had called the resident's provider who gave an order for the resident to be sent to the emergency room for x-rays to determine if the resident had any broken ribs; -Resident #2 had a scrape to his/her left knee; -Typically, 15-minute checks were done after a resident-to-resident physical altercation, 15-minute checks were not officially done after Resident #1 and Resident #2 after their physical altercation; -Resident to resident physical altercations were considered abuse. During an interview on 04/13/2026 at 2:58 P.M. CNA B said: -He/she was not working the day the altercation between Resident #1 and Resident #2 occurred but was notified of the altercation when he/she received report; -He/she was instructed to watch and listen to Resident #1 and Resident #2 and separate the two residents if there were any signs of an argument beginning; -Resident #1 and Resident #2 were not on any form of official observation; -Resident to resident physical altercations were considered abuse. During an interview on 04/13/2026 at 3:15 P.M. Registered Nurse (RN) A said he/she was not working when the altercation between Resident #1 and Resident #2 occurred but he/she was notified of the altercation when he/she received report; -He/she was instructed to keep a close watch on Resident's #1 and #2; -Resident's #1 and #2 were not on 15-minute checks or any (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	other form of increased observation; -Resident to resident physical altercations are considered abuse. During an interview on 04/13/2026 at 3:20 P.M. the Administrator said she had spoken with Resident #1 and Resident #2 and both residents had said that they would stay away from each other and neither of them wanted any issues; -Staff were instructed to keep a close eye on Resident #1 and Resident #2; -There was not a formal protocol of how often Resident #1 and Resident #2 should have been monitored by staff and no form for staff to fill out to show they monitored the residents. Review of the facilities investigation, dated 4/11/26, showed: -Resident #1 and Resident #2 got into a verbal argument at the nurses station on 4/11/26, facility staff intervened and ensured the residents were separated, later that evening Licensed Practical Nurse (LPN) A witnessed Resident #2 go into Resident #1's room, when LPN A entered Resident #1's room both residents were on the floor; -Resident #1 had a scraped left knee and left elbow and a red mark on the left side of his/her ribs; -Resident #1 was upset that the incident had happened but denied any distress; -Resident #1 and Resident #2 reside on the same hallway, both residents were offered to move to a different room and both resident's declined the room move; -Both residents were educated that physical altercations cannot occur and both residents were in agreement that any physical altercation would not happen again.Intake 2980674