STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265782	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beautiful Savior Home	1003 South Cedar Street Belton, MO 64012

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 - Minimal harm or potential for 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 observation, interview and record review, the facility failed to prevent physical abuse for one sampled resident (Resident #2) out of five sampled residents. On 4//26/26 Resident #1 struck another Resident #2 in the face with his/her fist causing redness and bruising. The facility census was 72 residents.On 5/6/26, the Administrator was notified of past non-compliance which occurred on 4/26/26. Immediate interventions were put in place for both Resident #1 and Resident #2. All staff received education prior to working their next shift. The deficiency was corrected on 4/27/26. Review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, dated April 2021, showed:-Residents had the right to be free from abuse.-The Abuse, Neglect, Exploitation and Misappropriation Prevention Program was a facility-wide commitment to support and protect residents from abuse by anyone, including other residents, and:-To establish and maintain a culture of compassion and caring for all residents and particularly those residents with behavior, cognitive or emotional problems.-To identify and investigate all possible incidents of abuse.-Protect resident from any further harm during investigations. Review of the facility's Resident to Resident policy, dated September 2024, showed:-All altercations, including those that may represent resident to resident abuse were investigated and reported to the nursing supervisor, the Director of Nursing (DON) and the Administrator.-Facility staff monitored residents for aggressive/inappropriate behaviors towards other residents.-Behaviors that may provoke a reaction by residents or others include:--Verbally aggressive behavior: screaming, cursing, bossing around, insulting, intimidating.--Physically aggressive behavior such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects.--Talking touching or rummaging through other residents' property.--Wandering into other's space. 1.Review of Resident #1's Face Sheet, undated, showed he/she admitted to the facility on [DATE] with the following diagnosis: dementia (loss of memory, language, problem-solving and other thinking abilities that were severe enough to interfere with daily life), anxiety disorder (a mental health condition causing excessive, persistent, and uncontrollable worry or fear that interferes with daily life), traumatic brain injury (TBI- damage to the brain caused by an outside physical force, such as a violent blow, jolt, or bump to the head or a penetrating object), unsteadiness on feet. Review of Resident #1's Level One Nursing Facility Pre-admission Screening for Menal Illness, Intellectual Disability or Related Condition (a federal requirement that checked people applying to Medicaid-certified nursing homes for serious mental illness or intellectual disabilities), dated 12/27/23, showed:-The resident was diagnosed with anxiety, TBI.-The resident did not require a Level 2 screening.-The resident had behavioral symptoms. Review of Resident #1's quarterly Minimum Data Set (MDS- a health status screening and assessment tool used for all residents of long-term care nursing facilities) dated 3/6/26, showed the resident was severely cognitively impaired. Review of Resident #1's Care Plan (a personalized, written guide that outlines an individual's medical, physical, and personal needs, and how those needs will be met), dated 2/11/26, showed:-The resident had potential and actual verbal and physical aggression towards staff and others.-The resident startled easily and had delusions that people were thinking and talking about (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 - Minimal harm or potential for actual harm Residents Affected - Few	him/her. Review of Resident #2's Face Sheet, undated, showed:-The resident was admitted to the facility on [DATE].-The resident had a guardian.-The resident was diagnosed with vascular dementia with agitation (a condition where brain damage caused by reduced blood flow leads to memory loss and cognitive decline, with behavioral changes), restlessness and agitation, memory deficit from a stroke (a medical emergency known as a brain attack that occurred when blood flow to part of the brain was blocked, or a blood vessel bursts). Review of Resident #2's Initial Assessment for Social and Medical (DA-124 an official document used to determine if a person qualified for Medicaid-funded nursing home care), dated 11/12/2013, showed the resident was confused, withdrawn, suspicious, supervised for safety and controlled with medication. Review of Resident #2's quarterly MDS dated [DATE], showed the resident was moderately cognitively impaired. Review of the facility's Incident Investigation, dated 4/26/26, showed:-On 4/26/26 at 4:4 P.M. Resident #1 was sitting at the nurse's station in his/her wheelchair alongside other residents.-Resident #2 was also in his/her wheelchair in the same area and was noted to be rolling in his/her wheelchair.-Both staff at the nurse's station heard Resident #2 yell out a few moments later.-Resident #2 was noted to be sitting in front of Resident #1, holding his/her left side of their face, still sitting in his/her wheelchair.-Staff asked Resident #1 what happened.-Resident #1said he/she punched Resident #2 in the face and [Resident #2] was running their mouth, so I punched him/her, and I enjoyed it.-Residents were separated.-Resident #1 was taken by staff to another room where no other residents were present.-Staff completed an assessment on Resident #2.-They were kept away from each other, and no other incident occurred. -Resident #1 was alert and oriented only to self and was moderately cognitively impaired.-Resident #2 was alert and oriented to self and was severely cognitively impaired.-Resident and staff interviews were conducted.-Review of camera footage showed Resident #2 wheeled up to Resident #1 and was holding a baby doll and was talking to it.-Resident #1 appeared to be startled by Resident #2 and his/her reaction was immediate.-Summery of incident: Behavior appeared to be unintentional related to Resident #1's severe dementia and cognitive impairment. -There was discoloration to Resident #2's lower left lip area.-No further aggression was noted by either resident.-In-services sheets showed all staff were trained in resident-to-resident abuse. Review of the local law enforcement police report, dated 4/28/26, showed:-On 4/28/26 Officer #1 took a report from Resident #2's family member.-The family reported that Resident #2 had been struck by Resident #1.-Officer #1 interviewed the Administrator.-The family elected to press charges and the case was forwarded to the County Prosecutor.-The County Prosecutor elected not to file charges on Resident #1.-No reason was cited. During an interview on 5/6/26 at 11:18 A.M., Licensed Practical Nurse (LPN) A, said: -He/She was working the day of the incident. -He/She was working on a different hall but was on that hall helping LPN C.-LPN C was working on the hall where the incident happened. -He/She heard a noise and saw Resident #2 holding his/her left side of his/her face and Resident #1 was pulling his/her fist back and maybe said he/she punched Resident #2. -Resident #1's hand was balled up in a fist.-The residents were separated, and he/she saw Resident #2's face was red right after the incident.-He/She noticed later in the evening that Resident #2's lip started to bruise, not sure how long after the incident the bruising was noted, it was close to dinner time. During an interview on 5/6/26 at 12:25 P.M., LPN C said:-He/She did not see the incident, he/she was behind the desk charting when he/she heard talking. -At first Resident #2 was on the other side of the room.-Resident #1 was in the same spot he/she had been in the last few minutes, facing the nursing desk, sitting in his/her wheelchair.-He/She heard the hit and heard Resident #2 scream, and when he/she looked up, Resident #2 was right beside Resident #1.-When Resident #2 went to dinner a bruise started to develop and was about the size of a dime on his/her bottom lip. During an interview on 5/6/26 at 12:52 P.M., the facility's Psychiatrist Nurse Practitioner (NP) said:-He/She received an email from the Director of Nursing (DON) notifying him/her of the incident.-Resident #1 was on Depakote (an anticonvulsant medication primarily used to treat epilepsy and as a mood stabilizer in the treatment of bipolar disorder). -He/She reviewed Resident #1's medications and was tapering (continued on next page)

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