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	05/15/2026

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 ensure one sampled resident (Resident #1) was free from abuse when on 5/7/26 Resident #2 forceable grabbed the resident's chin/jaw area causing discoloration and bruising out of 3 sampled residents. The facility census was 70 residents.On 5/15/26, the Administrator was notified of past non-compliance which occurred on 5/7/26. 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 5/8/26. Review of the facility's policy titled Abuse and Neglect-Clinical Protocol dated March 2018 showed:-Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.-Willful was defined as used in the definition of abuse, meaning the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Review of the facility's policy titled Resident-to-Resident Altercations dated September 2024 showed:-Facility staff were to monitor residents for aggressive/inappropriate behaviors towards other residents, family members, visitors, or to staff.-Behaviors that may provoke a reaction by residents or others included:--Verbally aggressive behavior such as screaming, cursing, bossing around/demanding, insulting race or ethnic group, and intimidating.--Physically aggressive behavior such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, and throwing objects. 1. Review of Resident #1's admission Record showed he/she was admitted to the facility with a diagnosis of hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following unspecified cerebrovascular disease (stroke) affecting left dominant side. Review of Resident #1's quarterly Minimum Data Set (MDS- a federally mandated assessment completed by facility staff) dated 3/6/26 showed the resident had moderately impaired cognition. Review of Resident #2's admission Record showed he/she admitted to the facility with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD- a lung disease). Review of Resident #2's Annual MDS dated [DATE] showed:-The resident was cognitively intact.-The resident did not have any behavioral symptoms within the seven-day look back period. Review of an undated facility Incident Report showed:-The date of the altercation was 5/7/26.-The approximate time of the altercation was 4:50 P.M.-The altercation occurred on 100 hall.-Resident #1 and Resident #2 were involved in the altercation.-The type of incident was a resident-to-resident altercation.-Description of the altercation:--Resident #1 was traveling down the 100 hall in his/her wheelchair towards the nurse's station.--Resident #2 was traveling in the opposite direction in his/her electric wheelchair toward his/her room. --It appeared that the residents' wheelchairs became too close while passing in the hallway. --As Resident #2 approached Resident #1, Resident #1 with the back of an open hand came in contact with Resident #2's left forearm.--Resident #2 then reached out with his/her left hand and came into contact with Resident #1's neck/jaw area.--The charge nurse intervened by asking Resident #2 to let go of Resident #1's neck/jaw area.--After asking a few more times, Resident #2 let go of Resident #1's neck/jaw area.-An injury of discoloration was observed to Resident #1's upper neck/jaw area.-The root cause of the altercation was that the (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	residents became too close to each other when passing in the hallway. Review of Resident #1's Health Status Note dated 5/7/26 at 7:11 P.M. by Licensed Practical Nurse (LPN) B showed:-LPN B observed Resident #2 to be passing by the nurses' station where LPN B was located.-Resident #2 had attempted to pass beside Resident #1 who was attempting to come up the hallway.-The residents then became stuck while attempting to move past each other.-Resident #2 continuously attempted to get past while the wheelchairs were stuck. -LPN B began to hear Resident #1 raising his/her voice at Resident #2. -LPN B looked up, and Resident #1 was observed to be raising his/her hand (open handed), which came in contact with Resident #2's left forearm. -LPN B was responding to the altercation when Resident #2 made contact with his/her left hand around Resident #1's upper neck/jaw area with tight grip in a chocking/grabbing manner.-LPN B observed Resident #2 then shake Resident #1's head during altercation. -LPN B and LPN A responded immediately. -LPN A began telling Resident #2 to let go and stop it providing verbal redirection multiple times.-LPN B was attempting to help move Resident #1 out of the proximity of Resident #2.-Resident #2 eventually loosened his/her grip on Resident #1 and LPN B was able to get Resident #1 away. -LPN A stayed with Resident #2 while LPN B took Resident #1 to DON's office where head to toe assessment was completed. -LPN B observed discoloration to resident's chin/jawline area upon assessment. -Resident #1 complained of minimal pain to area. -Resident #1 remained alert and responsive following incident. Review of Resident #2's Health Status Note dated 5/7/26 at 7:25 P.M. completed by LPN B showed:-LPN B observed Resident #2 to be passing by the nurses' station where LPN B was located.-Resident #2 had attempted to pass beside Resident #1 who was attempting to come up the hallway.-The residents then became stuck while attempting to move past each other.-Resident #2 continuously attempted to get past while the wheelchairs were stuck. -LPN B began to hear Resident #1 raising his/her voice at Resident #2. -LPN B looked up, and Resident #1 was observed to be raising his/her hand (open handed), which came in contact with Resident #2's left forearm. -LPN B was responding to the altercation when Resident #2 made contact with his/her left hand around Resident #1's upper neck/jaw area with tight grip in a chocking/grabbing manner.-LPN B observed Resident #2 then shake Resident #1's head during altercation. -LPN B and LPN A responded immediately. -LPN A began telling Resident #2 to let go and stop it providing verbal redirection multiple times.-LPN B was attempting to help move Resident #1 out of the proximity of Resident #2.-Resident #2 eventually loosened his/her grip on Resident #1 and LPN B was able to get Resident #1 away. During an interview on 5/15/26 at 10:20 A.M. Resident #2 said:-He/She did not want to talk about the altercation without a lawyer present.-He/She was really embarrassed about the whole incident and was remorseful. Review of Resident #1's witness statement, dated 5/7/26, showed:-He/She was coming from his/her room and sitting in the hallway speaking with a Certified Medication Technician (CMT) when Resident #2 approached him/her.-Resident #2 continued to move closer to his/her personal space.-He/She reacted by striking out at Resident #2.-During the incident, Resident #2 grabbed his/her jaw forcefully.-Resident #2 also attempted to grab his/her neck but was able to move away from Resident #2 at that point.-He/She had never been involved in a physical altercation with Resident #2 but had been in verbal altercations with Resident #2.-He/She did not have a positive relationship with Resident #2 and tried to avoid him/her.-He/She did not think that he/she was blocking the hallway at the time of the incident, and that Resident #2 had space to pass him/her without issue.-He/She felt that Resident #1 was invading his/her personal space and that was why the situation escalated.-He/She had pain in his/her jaw where Resident #2 had grabbed him/her but did not require any medical attention at that time. During an interview and observation on 5/15/26 at 11:05 A.M. Resident #1 said:-He/She was sitting in the hall and Resident #2 was getting close to him/her.-He/She popped Resident #2 in the arm.-Resident #2 responded by grabbing his/her jaw and started shaking him/her.-He/She had some bruising to his/her face afterwards.-Observation of the resident's face and neck showed no discoloration or bruising.-He/She wasn't really sure what happened after that but did remember LPN B pulling him/her away from the altercation.-He/She (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appreciated that Resident #2 was moved to a different hall after the altercation.-He/She felt like he/she had been physically abused in the altercation and wanted to press charges against Resident #2. Review of LPN A's witness statement, dated 5/7/26, showed:-At approximately 4:45 P.M. Resident #1 was wheeling himself/herself towards the nurse's station and was in the middle of 100 hall.-Resident #2 was in his/her electric wheelchair going towards his/her room.-Resident #1 and Resident #2 were side by side.-Resident #1 then tapped Resident #2 on his/her left arm.-Resident #2 then leaned forward and grabbed Resident #1 by the jaw.-LPN B then took Resident #1's wheelchair and pulled Resident #1 forward.-He/She was also telling both residents to split up from each other. During an interview on 5/15/26 at 10:32 A.M. LPN A said:-He/She had been down 100 hall when the altercation occurred.-He/She saw Resident #1 coming towards him/her and Resident #2 was going to his/her room.-He/She thought that their wheelchairs touched and that was when Resident #1 tapped/swung at Resident #2 with an open hand.-Resident #2 then reached across and started shaking Resident #1.-He/She was unable to tell exactly where Resident #2 had grabbed Resident #1.-He/She thought Resident #2 probably grabbed Resident #1 near the throat/neck/jaw area based off the having movement that Resident #1 had exhibited. During an interview on 5/15/26 at 11:10 A.M. the Administrator said:-He/She did not feel abuse had occurred.-Resident #2 overreacted in response to Resident #1's swat.-He/She did not think Resident #2 had any intent to harm Resident #1. Review of LPN B's witness statement, dated 5/7/26, showed:-At approximately 4:45 P.M. he/she overheard Resident #1 and Resident #2 yelling in the hallway.-He/She went to approach Resident #1 and Resident #2 when he/she observed Resident #1 make contact to Resident #2's left arm with an open hand.-Before he/she could make it to Resident #1 and Resident #2, Resident #2 made contact with Resident #1's neck/jawline and began to squeeze and shake Resident #1.-He/She and LPN A were verbally asking Resident #2 to let go and stop.-Multiple verbal attempts were made to get Resident #2 to let go of Resident #1.-He/She then grabbed Resident #1's wheelchair and pulled Resident #1 forward.-Resident #1 was then able to break Resident #2's grip.-He/She then assisted the resident away from Resident #2. During an interview on 5/15/26 at 11:17 A.M. LPN B said:-He/She was at the nurse's station when he/she overheard yelling.-Resident #1 and Resident #2 were moving in opposite directions towards each other.-Resident #1 and Resident #2 could not both get through the hallway.-Resident #1 then swatted Resident #2's arm.-He/She and LPN A were both walking towards the residents by that time.-Resident #2 then grabbed Resident #1's jaw and started squeezing and shaking Resident #1.-He/She then pulled Resident #1 away from the situation and too Resident #1 to the DON's office.-He/She felt that he/she and LPN A responded appropriately to the situation.-He/She would consider the altercation as physical abuse.-Resident #2 intentionally grabbed Resident #1's jaw and wouldn't let go after being told to do so, which was why the altercation would be considered as physical abuse. During an interview on 5/15/26 at 1:45 P.M. the Administrator and the DON said: -The root cause of the altercation was that Resident #1 and Resident #2 were both trying to get through the hallway at the same time and both residents escalated at that point.-There was no outcome to the altercation.-They did not think the altercation was abuse.-They thought that the altercation was behavioral related with Resident #2 overreacting to the situation. 3008385