STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265827	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belleview Care Center	1616 Weisenborn Road Saint Joseph, MO 64507

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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews and record review, the facility failed to protect one sampled resident, Resident #2, right to be free from physical abuse when Resident #1 used two hands and shoved Resident #2 to the floor. The facility census was 80. The Administrator was notified on 11/12/25 at 4:00 P.M. of the past noncompliance which began on 11/9/25. The facility staff immediately assessed and seperated Resident #2 and Resident #1, conducted an investigation, interviewed residents to ensure no others had been abused. All staff were re-trained on the facility abuse prevention policy and on monitoring residents with physical behaviors towards others. In-servicing was completed by 11/11/25. Resident #1 and #2's care plans were updated to reflect increased monitoring of both resident's whereabouts in proximity to one another. The noncompliance was corrected on 11/11/25. Review of the facility's Abuse, Neglect and Exploitation policy, revised 5/1/25, showed:- It is the policy of this facility to provide protections for the health, welfare and rights of each resident;- Abuse means the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish;- Residents will have an assessment of their functional and mood/behavior status, medical acuity, and special needs;- The facility will implement policies and procedures to prevent and prohibit all types of abuse and neglect;- Identifying, correcting and intervening in situations in which abuse or neglect is more likely to occur with the deployment of trained and qualified, registered, licensed and certified staff on each shift in sufficient numbers to meet the needs of the residents;- Possible indicators of abuse include, but are not limited to hitting, slapping, punching, biting and kicking and is the willful intent to inflict harm or injury.Review of staff training for Resident Abuse and Neglect Prevention, dated 11/10 and 11/11/25, showed 39 staff members attended the training.1.Review of Resident #1's Face Sheet, dated 11/12/25, showed the resident had impaired cognition, COPD (pulmonary disease), diabetes, chronic kidney disease, neurocognitive disorder, dementia and depression. Review of Resident's Care Plan, undated, showed:- Resident had potential to be physically aggressive related to anger and dementia and has a history of harm to others. Had poor impulse control;- Resident could be physically aggressive with staff members and attempting to break windows;- When resident becomes agitated staff are to intervene before escalation, guide resident away from source of distress;- Resident had impaired cognitive function and impaired thought processes;During an interview on 11/12/25 at 1:37 P.M., Resident #1 said he/she pushed Resident #2 once because he/she was blocking his/her way in the corridor. He/she pushed him/her to the ground. He/she didn't plan on doing it again and didn't mean to hurt Resident #2 when he/she pushed him/her, but it just happened. 2. Review of Resident #2's Face Sheet, dated 11/12/25, showed:- Diagnosis: Alzheimer's disease, dementia, anxiety disorder, GERD (acid reflux), rheumatoid arthritis, osteoarthritis of the knee, cognitive communication deficit, and depression;Review of Resident's Care Plan, undated, shows:- Resident had the right to be free from physical abuse;- Resident resides on the secured memory care unit and safety will be maintained through the next review;- Resident enjoys walking around with the other residents;- Resident had potential to be physically aggressive related to dementia and hits staff when upset or agitated;- Resident had impaired cognitive function or impaired thought processes;- Resident was at risk for falls;During an interview on 11/12/25 at 2:05 P.M., Resident #2 said he/she was pushed down by someone and fell to the ground. He/she does not remember who pushed him/her but remembered that it hurt when fell to the floor and h/she still felt minor pain near the thigh and pelvic area. He/she felt safe and said the staff take good care of him/her. He/she was not able to remember the fall well enough to provide any details. During an interview on 11/12/25 at 1:55 P.M., CNA (A) said:- He/she had been talking with Resident #1 while walking down the hall and Resident #2 was coming towards them. Resident #2 stepped in front of Resident #1 and Resident #1 pushed Resident #2 with both hands in the chest. Resident #2 fell backwards stiffly onto the floor. Staff took Resident #2's vitals and checked to check for injury. Both residents were separated. Resident #2 had no injuries and did not complain of pain. CNA A then reported the incident to the Charge Nurse, Director of Nursing (DON) and the Administrator.During an interview on 11/12/25 at 3:40 P.M. , the DON and Administrator said:- The investigation findings show that Resident #1 pushed Resident #2 to the ground. - Resident #1 used both hands and pushed Resident #2 in the chest. Resident #1's actions are that of abuse. Neurological checks and a complete assessment were completed for Resident #2 after the fall to make sure he/she was not hurt. All residents have the right to be free from abuse and not to be pushed to the ground by another resident or staff. - Resident #2 does not have a history of aggression towards residents. - Resident #1 has a history of aggression towards others and at the time of the incident, was