Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24279	A. BUILDING: _____ B. WING _____	C 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF GRAIN VALLEY	101 CROSS CREEK DRIVE GRAIN VALLEY, MO 64029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A8023	19 CSR 30-88.010(23) Develop/Implement A/N Policies The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III This regulation is not met as evidenced by: Class II* Based on observation, interview and record review, the facility failed to follow their abuse and neglect policy for reporting allegations of potential abuse between employee, Nurse Aide (NA) A and Resident #1, to the resident's physician and Hospice (end of life) contacted care provider; and failed to complete a comprehensive investigation to include interviews with the resident's contracted care provider who had provided care at the facility on 11/10/25 out of three sampled residents. The facility census of 24 residents. Review of the facility Abuse Prevention and Reporting Policy dated 2023 showed: -The facility will investigate all reports of suspected abuse of any resident and will take appropriate action to protect the resident and prevent further incidents. -The attended physician will be notified of the incident and follow-up medical care provide as	A8023		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24279	A. BUILDING: _____ B. WING _____	C 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF GRAIN VALLEY	101 CROSS CREEK DRIVE GRAIN VALLEY, MO 64029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A8023	Continued From page 1	A8023		

necessary.
-Within 24 hours the facility will form an investigator team that will thoroughly investigate the allegation and document the investigation.
-The facility administrator or designee will immediately notify the resident, resident representative of the alleged abuse, was investigation complete inform them the results of the investigation.
-The Administrator or designee completed incident reports, interview will be conducted and statements obtained from all staff members, residents, family members volunteers and other that may have witness or have knowledge with respect to the alleged incident.
-A written reports which among other things, provides an overview of the incident, pertinent medical data and summary of the statements taken, investigative findings, follow-up actions and a conclusion will be prepared. A copy of the written report shall be provided.

1. Review of Resident #1's Admission Face Sheet showed he/she admitted to the facility on 7/28/25 with the following diagnoses:
-Picks disease (frontotemporal dementia (FTD causes gradual deterioration of the frontal and temporal lobes of the brain).
-Recent urinary tract infection (UTI, infection in bladder).

Review of the resident's facility Incident Report dated 11/10/25 at 5:00 P.M. showed:
-Allegation of abuse by a staff member the morning of 11/10/25 and allegedly occurred between 11:00 A.M. -12:00 P.M.
-Employee allegedly involved was NA A.
-The resident had no physical injuries observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24279	A. BUILDING: _____ B. WING _____	C 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF GRAIN VALLEY	101 CROSS CREEK DRIVE GRAIN VALLEY, MO 64029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A8023	Continued From page 2 or reported. -The resident had reported that NA A had stuck him/her in the stomach and shoulder while being assisted to the bathroom. -The resident's family member was notified on 11/11/25 at 1:00 P.M. -The box next to "did the facility notify the resident's physician about alleged abuse incident" was marked "no". -There was no documentation that indicated the resident's Hospice Nurse or Hospice Provider was notified of the alleged incident. Review of the resident's Hospice medical record binder showed: -Documentation that a Hospice Chaplin and a Hospice Registered Nurse (RN) visited on 11/10/25, there were no times indicated for the visits. -There was no detailed Hospice nurse visit note for 11/10/25 found in the hospice binder. -There was no documentation that showed the Hospice staff were notified of the alleged employee to resident abuse incident that happened on 11/10/25. Review of the resident's medical record dated 11/10/25 to 11/18/25 showed: -There was no documentation that the resident's physician was notified of the alleged abuse incident on 11/10/25. -There was no documentation found related to Hospice staff being notified of the alleged abuse. -There was no documentation that indicated Hospice staff were included in the facility investigation interviews related to the alleged abuse that indicated happen during the day-shift (6:00 A.M. to 2:00 P.M.) on 11/10/25.	A8023		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24279	A. BUILDING: _____ B. WING _____	C 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF GRAIN VALLEY	101 CROSS CREEK DRIVE GRAIN VALLEY, MO 64029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A8023	Continued From page 3 During an interview on 11/18/25 at 1:30 P.M. the Administrator said: -He/she did not notify the resident's physician of alleged abuse on 11/10/25. -He/she did not report the incident due to the resident had no complaints of pain and no physical injury was noted related to alleged abuse incident. During an interview on 11/18/25 at 1:58 P.M., the Level 1 Medication Aide (L1MA) A said: -He/she would report any alleged abuse, or incident to the facility medical supervisor and administrator. -He/she would have notified the resident's physician, family member/durable power of attorney, and Hospice Provider if the resident was on Hospice services of any alleged incident. -He/she had not had any Abuse and Neglect training since he/she was hired over a year ago. During an interview on 11/18/25 at 2:00 P.M., the Administrator said: -He/she was notified by the owner of the allegation of abuse on 11/10/25 around 5:00 P.M. -He/she had started the facility investigation for alleged employee to resident incident. -He/she did not complete the investigation as thoroughly as he/she should have. --The investigation should have included notification of the resident's physician and Hospice agency of the alleged abuse incident. -He/she did not think about notifying and contacting the resident's Hospice provider about the incident. -He/she should have interviewed the resident's	A8023		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24279	A. BUILDING: _____ B. WING _____	C 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEEHIVE HOMES OF GRAIN VALLEY	101 CROSS CREEK DRIVE GRAIN VALLEY, MO 64029

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A8023	Continued From page 4 Hospice staff that were in building during the day shift on 11/10/25. During an interview on 11/18/25 at 2:16 P.M., the Hospice Clinical Director said: -The Hospice RN and Chaplin both had visited the resident at the facility on 11/10/25 from 12:45 P.M. to 2:00 P.M. -There was no documentation in the Hospice RN's visit note that indicated alleged abuse or any change in the resident's behavior or skin changes. -There was no documentation that the facility had notified the Hospice nurse of the alleged abuse that occurred on 11/10/25 during the day-shift. *Higher classification merited due to the extent of the violation and the violation effect on the residents. MO00259293	A8023		

PLAN OF CORRECTION

Provider/Supplier Name:	BeeHive Homes of Grain Valley
Street Address, City, Zip:	101 sw cross creek dr. Grain Valley MO.
Date of Survey:	Nov. 18th 2025

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
Tag A8023	**Plan of Correction for Deficiency Tag A8023: Beehive Homes of Grain Valley** **Deficiency:** Failure to follow abuse and neglect policy for reporting allegations of potential abuse, including failure to notify the resident's physician and Hospice provider, and failure to conduct a comprehensive investigation.	
	1. Immediate Actions Taken • **Resident Safety:** Resident #1 was assessed for injuries or changes in condition immediately upon learning of the allegation; no injuries or changes in condition were reported. • **Staff Member:** NA A was removed from direct care responsibilities pending investigation. and is no longer employed at Beehive Homes. • **Notification to Family:** The resident's family/durable power of attorney was notified of the incident on 11/11/25	
	2. Corrective Actions to Address Deficiency **a. Policy Review and Education** • All facility staff will receive retraining on the Abuse Prevention and Reporting Policy, with emphasis on:	11-25-2025

	○ Immediate reporting requirements to the resident's physician and contracted care providers (including Hospice) following any allegation of abuse or neglect. ○ Comprehensive investigation procedures, including mandatory interviews with all involved parties (staff, contracted providers, hospice, family). • Training will occur within 7 days of this plan and will be documented in personnel files. **b. Notification Protocols** • A new checklist will be implemented for all alleged abuse/neglect incidents, requiring: ○ Immediate physician notification. ○ Immediate notification of all contracted care providers (such as Hospice). ○ Documentation of all notifications, including date, time, and person contacted. • The administrator/designee will monitor compliance and sign off on each checklist. **c. Investigation Process Improvement** • The investigator team will include at least one staff member not directly involved in the incident, and will: ○ Interview all relevant individuals, including outside providers (e.g., Hospice staff present at the time of the alleged incident). ○ Obtain written statements from all parties. ○ Complete and file a written report summarizing findings, actions taken, and follow-up recommendations within 72 hours of the allegation. • **d. Documentation** • All notifications, investigation steps, and outcomes will be documented in both the resident's medical record and in the facility's incident file. • Documentation will be monitored by the Administrator for completeness and timeliness. **e. Ongoing Monitoring** The Administrator or designee will conduct random audits of abuse/neglect incident reports for six months to ensure:	

	○ All notifications and investigations have been properly completed and documented. ○ Any deficiencies identified will trigger immediate retraining and corrective action.	
	3. Systemic Prevention • Annual refresher training on reporting abuse/neglect and investigation protocols for all staff. • Feedback from contracted care providers (e.g., Hospice) will be solicited quarterly to ensure communication protocols are effective	
	4. Completion Date All corrective actions will be completed by **December 18, 2025.** Ongoing monitoring and training will continue as outlined above.	
	Prepared by: Cal Hutson, Administrator Beehive Homes of Grain Valley Date:12-4-2025	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.

Cal M. Hu