STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265877	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westgate	3130 John Duffy Dr Joplin, MO 64804

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. Based on interviews and record review, the facility failed to protect one resident's (Resident #1) right to be free from physical abuse by staff when one staff (Certified Nursing Assistant (CNA) A) physically pushed the resident's face. The facility census was 109.Based on interviews and record review, the facility failed to protect one resident's (Resident #1) right to be free from physical abuse by staff when one staff (Certified Nursing Assistant (CNA) A) physically pushed Resident #1's face. The facility census was 109. On 01/08/26, facility management became of the noncompliance that occurred on 01/08/26. The facility reported the allegation, began an investigation, took steps to protect the residents, and began facility-wide in-service regarding abuse, neglect, dignity, and respect; began monitoring the resident for any psychosocial changes; and began monitoring the resident's skin for any new bruising, redness, or other concerns. The facility put plans in place to provide training on behavior interventions for the next three months and added the noncompliance to their Quality Assurance Performance Improvement Meeting (QAPI) program. The noncompliance was corrected on 01/09/26. Review of facility policy titled Abuse Prevention Program, undated, showed the following:-The facility will not tolerate verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect, or misappropriation of resident property, by employees, family members, visitors, or other residents;-The facility shall maintain an ongoing open dialog with residents to establish an atmosphere where the residents are comfortable reporting any indications of abuse, neglect, mistreatment, or misappropriation of property. 1. Review of Resident #1's face sheet (a document that gives a resident's information at a quick glance) showed the following:-admission date of 07/10/21;-Diagnoses included Alzheimer's disease, major depression disorder, anxiety, and delusional disorder. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 09/29/25, showed the following:-Severe cognitive impairment;-Delusion, rejection of care, and wandering were exhibited;-Substantial/maximum assistance with toileting, personal hygiene, and transfers;-Partial to moderate assistance from staff with bed mobility and transfers;-Independent while walking. Review of the resident's care plan, revised 12/31/25, showed the following:-Resident was occasionally physically and verbally aggressive with staff during cares;-Undesirable behavior will be monitored/managed;-Resident has a diagnosis of dementia, depression, and anxiety. Review of the facility's investigative summary, dated 01/12/26, showed the following:-On 01/08/26, at approximately 10:15 A.M., a certified nurse aide (CNA) notified Human Resources (HR) of an alleged incident;-HR immediately contacted the Administrator and Director of Nursing (DON);-CNA A was interviewed said he/she was in the bathroom with the resident and Nurse Aide (NA) B. The resident was combative while staff were toileting him/her. CNA A leaned down to assist with clothing and the resident spit on him/her. The CNA then reached up with his/her hand and made contact with the resident's cheek. The CNA went to HR and notified him/her;-CNA A was immediately accompanied out of the building by HR;-Staff were unable to interview the resident due (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	to cognitive deficits. The resident had not had any change in behavior or mood following the alleged incident. Skin assessment completed with no new skin concerns noted;-The other staff (NA B) in the bathroom said he/she was in the bathroom with the resident and CNA A. NA B was gathering equipment with his/her head turned and heard CNA A say, It was a natural reaction. Review of resident's progress notes, dated 01/08/26, showed staff did not document regarding the allegation of abuse toward the resident. During an interview on 01/14/26, at 10:06 A.M., NA B said the following:-On 01/08/26, sometime during the day shift, NA B took the resident back to his/her room to get changed;-NA B requested assistance from CNA A due to the resident's aggressive behaviors;-The resident was spitting, hitting, and trying to bite staff, but they were able to get him/her on the toilet;-NA B turned around, and his/her back was to the resident and other staff. NA B turned around and heard laughing;-NA B saw CNA A with her hands on either side of the resident's face, telling the resident that he/she was sorry and that it was just a reaction;-CNA A told NA B that he/she (CNA A) needed to report the incident to a nurse;-They cleaned up the resident and CNA A left;-Staff should not hit a resident under any circumstance, as hitting a resident would be considered abuse.During an interview on 01/14/26, at 12:09 P.M., CNA A said the following:-On 01/8/26, around 10:00 A.M, CNA A was assisting NA B toilet the resident;-The resident was very combative, hitting at staff;-CNA A and NA B were able to get the resident on the toilet;-CNA was kneeling in front of the resident, assisting him/her with their pants;-The resident spit on CNA A and he/she (CNA A) pushed the resident's face away, and told the resident not to do that;-CNA A said it was an instant reaction, and there was no thought process behind his/her actions;-CNA A said he/she inappropriately touched the resident's face when he/she pushed the resident's face;-CNA A immediately reported the incident to HR.During an interview on 01/14/26, at 12:35 P.M., HR said the following:-On 01/08/26, around 10:00 A.M., CNA A came to HR's office and advised he/she needed to turn him/herself in;-CNA A said he/she was toileting the resident when the resident spit in his/her face;-CNA said he/she reacted on instinct and smacked her hand over the resident's mouth and told him/her to stop it;-Staff cannot hit push or put hands on resident, as it would be considered abuse. During interview on 01/14/26, at 10:35 A.M., Certified Medication Technician (CMT) C said it was never ok to hit a resident, as it would be considered abuse. During an interview on 01/14/26, at 10:50 A.M., CNA D said abuse could be mental, yelling, hitting, or pushing. It was never ok to hit a resident under any circumstances as it would be considered abuse. During an interview on 01/14/26, at 11:00 A.M., Housekeeping (HK) E said it was never okay to strike a resident as it would be considered abuse. During an interview on 01/14/26, at 11:10 A.M., CMT F said it was never okay to hit a resident as it would be considered abuse. During an interview on 01/14/26, at 11:16 A.M., Licensed Practical Nurse (LPN) G said staff may not strike a resident, even if the resident struck staff first, as it is considered abuse. During an interview on 01/14/26, at 12:19 P.M., CNA H said it was never ok to hit or push a resident as it would be considered abuse. During an interview on 01/14/26, at 12:23 P.M., Registered Nurse (RN) I said it was never okay for staff to push or strike a resident as it is considered abuse. During an interview on 01/14/26, at 12:29 P.M., the DON said the following:-On 01/08/26, CNA A reported an incident with a resident to HR;-HR escorted CNA A to the Administrator's office to speak to the Administrator and DON;-CNA A said he/she was toileting the resident with the assistance of NA B;-The resident was agitated and combative;-As CNA A was adjusting the resident's pants, the resident hit CNA A;-CNA A said he/she then reached up and touched the resident's face;-CNA A acknowledged that he/she should not have touched the resident in that manner;-CNA A was immediately terminated and escorted out of the building;-It was never acceptable to hit or push a resident, as it would be considered abuse. During an interview on 01/14/26, at 12:43 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P.M., the Administrator said the following:-On 01/08/26, HR escorted CNA into his/her office;-CNA A said he/she was assisting the resident to the restroom;-The resident was being combative, and as he/she was bent down in front of the resident, the resident spit on him/her;-CNA A said she popped the resident by putting her hand over the resident's mouth and told him/her not to do that;-Staff should never put their hands on a resident in an inappropriate manner;-Staff cannot hit or push residents, as it would be considered abuse. Complaint #2711706