STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265167	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Rehabilitation & Health Care Center	904 East 68th Street Kansas City, MO 64131

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 - 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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure one sampled resident (Resident #6) out of seven sampled residents, was free from physical abuse. On 11/21/25, Resident #5 kicked and punched Resident #6 in the left jaw resulting in a fracture of the jaw. The facility census was 125 residents. Review of the facility Abuse, Prevention and Prohibition Policy dated 11/2025 showed: -Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. -Residents must not be subjected to abuse by anyone, including, but not limited to other residents. -The facility prohibited abuse of residents. -The resident must not be subjected to abuse by anyone. -Resident to resident abuse includes the term willful, which means that the individual's action was deliberate, regardless of whether the individual intended to inflict injury or harm. -Abuse meant the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain, or mental anguish. -Physical abuse includes, but it not limited to, hitting, slapping, punching, biting, and kicking. -Willful as defined in the definition of abuse, and means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. 1. Review of Resident #5's admission Record showed the resident was admitted on [DATE] with the following diagnoses: schizoaffective disorder (a mental condition that causes loss of contact with reality and mood problems), anxiety disorder (a psychiatric disorder causing feelings of persistent anxiety), restless, and agitation. Review of Resident 5#'s Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 9/16/25 showed the resident was severely cognitively impaired. Review of Resident #5's undated Care Plan showed: -On 5/30/24 the resident had a potential psychosocial well-being problem related to nursing home placement and psychiatric background. --When conflict arises, remove resident to a calm safe environment and allow to vent and share feelings. --On 9/10/24 assist the resident to develop more appropriate methods of coping and interacting. Review of Resident #6's admission Record showed the resident was admitted on [DATE] with the following diagnoses: schizoaffective disorder and anoxic brain damage (oxygen supply to the brain is interrupted, the functioning of the brain is disturbed immediately, and irreversible damage can quickly follow). Review of Resident #6's MDS dated [DATE] showed the resident was cognitively intact. Review of Resident #6's progress note dated 11/21/25 at 6:02 P. M. showed: -Resident # 6 was sent to the emergency room (ER) related to altercation with Resident #5. -Resident #6 was grabbing Certified Nursing Assistant (CNA) C's arm. Resident #5 did not like it. -Resident #5 told Resident #6 to move his/her arm. -Resident #6 did not move his/her arm, so Resident #5 kicked Resident #6, punched Resident #6 in the stomach then punched Resident #6 in the left side of the jaw. -Resident #6 fell to the ground, hit his/her head hard and his/her eyes rolled to the back of his/her head. Review of Resident #6's progress note dated 11/21/25 at 10:45 P.M. showed he/she returned to the facility with no new orders and the results of the x-ray showed fracture to coronoid process of the mandible (broken jaw). Review of the facility Resident Abuse Investigation Report dated 11/25/25 showed: -The Administrator received report from the second floor by CNA E of a resident to resident event with Resident #5 and Resident #6.-CNA C and Resident #5 were walking up the hall when Resident #6 approached and grabbed CNA C's arm.-Resident #5 asked Resident #6 to let go of CNA C's arm.-Resident #6 continued to hold CNA C's arm.-Resident #5 then grabbed Resident #6's hand and Resident #6 said let's fight.-Resident #5 kicked and punched Resident #6.-The investigation concluded as substantiated physical contact made between Resident #5 and Resident #6 related to a misinterpretation of thoughts between Resident #5 and Resident #6 that resulted in the physical contact.-Resident #6 was diagnosed with a small fracture to the left mandible. During an interview on 11/24/25 at 11:30 A.M., the Director of Nurses (DON) said: -Resident #5 was waking up the hall and Resident #6, who often grabs or reaches out to staff, grabbed CNA C.-Resident #5 told Resident #6 to let go. -Resident #6 asked if Resident #5 wanted to fight and they engaged in a physical altercation. -Resident #6 was struck by Resident #5 and hit the floor. -Resident #6 had a fracture to the jaw. Observation and interview on 11/24/25 at 3:27 P.M., showed Resident #6:-Was in his/her room in bed -He/She recalled having an x-ray done. -He/She complained of jaw pain on both sides, rated pain a 5 on a scale of 0-10 (0=no pain, 10=the worst pain ever). During an interview on 11/24/25 at 3:40 P.M., Resident #5 said: -He/She was on 1:1 because he/she assaulted someone. -He/She hit Resident #6 on the left side of the face. -Resident #6 came towards him/her, so he/she kicked Resident #6 and then hit Resident #6 with his/her right fist to Resident #6's left jaw. -Resident #6 fell to the floor and it was over at that time. During an

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide adequate care and supervision to prevent accidents for one sampled resident (Resident #2) out of seven sampled residents, when on 11/12/25 CNA A failed to position the resident properly in the bed and then turned away from the resident which resulted in a fall from the bed onto the floor with bruising and abrasions. The facility had further failed to transfer the resident with a Hoyer lift (mechanical transfer) and two staff per policy. The facility census was 125 residents. Review of the facility Safe Lifting and Movement of Residents Policy, dated December 2024, showed: -Resident safety, dignity, comfort and medical condition will be incorporated into goals and decision regarding the safe lifting and mobbing of residents. -Manual lifting of resident shall be eliminated when feasible. -Staff responsible for direct resident care will be trained in the use of manual and mechanical lifting devices. Review of the facility undated Skills Checklist showed two staff must always assist with Hoyer lift (mechanical lift) transfers. Review of the facility Senior Living Fall Policy, dated April 2025, showed: -The purpose of the fall program in senior living is to develop, implement, observe and evaluate an interdisciplinary approach and manage strategies and interventions that foster resident independence and quality of life. -The fall program promotes safety, prevention and education of both staff and resident. -The community shall ensure that the fall program is maintained to reduce the occurrence of falls, reduce risk of injury, and promote independence and safety. -A fall is defined as the unintentional coming to the rest on the ground, floor or other lower lever. -If a resident loses balance and would have otherwise fallen, if not for someone intervening, it is considered a fall. --This includes witnessed and unwitnessed falls. --The includes falls with or without injury. -Serious injury includes but is not limited to fracture, laceration requiring sutures, any fall related injury that requires an evaluation in the emergency room or admission to the hospital. 1. Review of the Resident #2's admission Record showed the resident was admitted on [DATE] with the following diagnoses: muscle weakness, need for assistance with personal care and history of falling. Review of the resident's Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning), dated 11/14/25, showed the resident was severely cognitively impaired. Review of the resident's undated Care Plan showed: -The resident had impaired cognitive function related to vascular dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgment, and impulses). --Staff were to reduce any distractions, turn off TV and ensure the resident understands, and provide with necessary cues. --Stop and return if agitated. -The resident was at risk for falls due to cognitive and functional disabilities. --Staff to ensure bolsters and/or scoop mattress was on the bed. --Monitor for safe positioning in the bed. --The resident needed assistance to turn and reposition frequently. -The resident needed assistance with self-care due to co-morbidities. --The resident was totally dependent on staff for mobility. --The resident required the assistance of one staff to turn and reposition in bed. --The resident required two person assist with Hoyer for transfers. -The resident was resistive to care at times. --Staff to give clear explanation of all care activities prior to and as they occur during each contact. --If the resident resists with activities of daily living (ADLs), reassure resident, leave and return 5-10 minutes later and try again. Review of the camera footage still frame (screenshot) provided by Family Member A, dated 11/17/25 at 9:53 P.M., showed Certified Nursing Assistant (CNA) A was operating the Hoyer lift independently and by him/herself to transfer the resident to bed. Review of camera footage provided by Family Member A, dated 11/17/25 at 10:02 P.M., showed: -CNA A bent over the resident's bed with the resident laying on his/her right side wearing a hospital gown and no protective boots on his/her feet/lower legs, facing away from CNA A. -CNA A was standing on the door side of the bed and the resident was positioned on the edge of the window side of the bed in close proximity of the wall. -The resident's head was hanging face down over the edge of the bolster on the window side of the bed. -The resident's right leg was slightly bent and hanging off the edge of the bed between the bolsters. -CNA A had his/her right hand on the posterior left hip while wiping the resident's buttocks. -As CNA A removed his/her hand from the resident's hip the resident's body tilted forward towards the window/wall. -CNA A was positioning what appeared to be a turn sheet on the bed, his/her hands were not on the resident when he/she turned away from the resident looking towards his/her left.-CNA's back was to the resident and CNA A shifted his/her whole body away from the resident. -The resident drew the left arm up towards his/her body, and he/she began rolling in a