STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265167	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER Highland Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one sampled resident (Resident #4) was free from abuse when Resident #3 punched him/her multiple times resulting in Resident #3 fracturing his/her hand and Resident #4 scared and praying for a reason to live out of 19 residents sampled. The facility census was 127 residents.The facility staff was notified on 3/18/26 of Past Non-Compliance which occurred on 3/10/26. Facility investigation, safety measures to mitigate further occurrence, staff in-services and education was completed. The deficiencies was corrected 3/18/26. Review of the facility's Abuse, prohibition, and intervention policy, dated March 2025, showed:-Each resident had the right to be free from abuse.-The definition of abuse was the willful infliction of injury, with resulting physical harm, pain, or mental anguish. 1. Review of Resident 3's face sheet showed the resident admitted on [DATE] and some of his/her diagnoses included schizophrenia (serious mental illness that affects how a person thinks, feels, and behaves), major depressive disorder (depressed mood most of the day and a loss of interest in normal activities and relationships), schizoaffective disorder (a mental health condition that includes features of both schizophrenia and a mood disorder), and anxiety disorder (psychiatric disorder that involve extreme fear, worry and nervousness). Review of the resident's care plan, dated 5/30/24, showed the resident had:-A history of behavior problems, pacing, and had an altercation with another resident.-Some diagnoses that included mood disorder (a mental health problem that affects a person's emotional state in which a person experiences long periods of extreme happiness, extreme sadness, or both), schizophrenia, schizophrenia, and personality disorder.-Had restlessness, agitation, aggressive behavior, and pacing. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning), dated 1/8/26, showed the following staff assessment of the resident:-No hearing impairment.-Vison was moderately impaired and corrected.-Had clear speech, usually understood others and others usually understood him/her.-Was cognitively intact.-Had mood indicators that indicated moderate depression.-Had hallucinations.-Had no negative behaviors-Ambulated independently.-Had no range of motion impairment in his/her arms or legs.-Was independent with all self-cares.-Some of his/her diagnoses included anxiety disorder, depression, psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions), and schizophrenia. Review of Resident #3's skin assessment, dated 3/10/26 at 4:15 A.M., showed: -The resident's skin was warm and dry with skin color within normal range.-No skin issues were identified. 2. Review of Resident #4's face sheet showed the resident admitted on [DATE] and some of his/her diagnoses included schizophrenia and anxiety disorder. Review of the resident's care plan, dated 5/14/24, showed the resident had depression, anxiety, and schizophrenia. Review of the resident's quarterly MDS, dated [DATE], showed the following staff assessment of the resident:-Had clear speech.-Had no vision or hearing impairment.-Understood others and others understood him/her.-Cognitively intact.-Displayed mood symptoms that indicated moderate depression.-No negative behaviors.-Did not use any mobility devices.-Had no range of motion impairment in his/her legs or arms.-Was independent with almost all of his/her self-cares.-Some of his/her diagnoses (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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F 0600 Level of Harm - Actual harm Residents Affected - Few	included anxiety and schizophrenia. 3. Review of Resident #3's nurse's note and behavior note, dated 3/10/26 at 12:45 A.M., written by Registered Nurse (RN) A showed:-This resident went to use the bathroom. -He/She saw another resident in the bathroom. -The other resident was naked. -This resident physically attacked the other resident. -This resident said he/she beat up the naked resident he/she found in the bathroom. - Resident #3 hit the other resident with his/her fist a few times. -The sitter notified RN A immediately of the altercation. -RN A called the Administrator and left a voice message regarding the altercation.-RN A called the Director of Nursing (DON) and notified him/her. -The DON said he/she would call this resident's guardian, would call RN A back, and would let RN A know if this resident's guardian would authorize to transfer this resident to the hospital.-The DON called RN A back and instructed RN A to send this resident to the hospital emergency room.-This resident was transferred to the hospital emergency room. Review of Resident #4's nurse's note, dated 3/10/26 at 3:54 A.M., written by RN A showed:-Resident #4 went to the bathroom naked.-Another resident came to the bathroom while Resident #4 was in there. -The other resident attacked Resident #4 physically and hit Resident #4 with his/her fist a few times. -The sitter reported this attack to RN A.- RN A called the administrator and left a voice message.- RN A called the DON and notified him/her. -Resident #4 said that he/she was hit on the back of his/her head and back. -Resident #4 denied having any pain. -The nurse assessed Resident #4's skin and found no swelling, discoloration, bruising or drainage. Review of the facility's investigation, dated 3/10/26, showed:-Certified Nursing Assistant (CNA) A was the one-one (enhanced monitoring provided by staff) monitoring Resident #3.-Resident #3 went to the bathroom. -CNA A reported hearing noises and responded to the bathroom finding the door to the connected room side open and Resident #3 coming back into the bathroom from that side of room. -CNA A said Resident #3 said he/she beat Resident #4 up.-CNA A said he/she checked on Resident #4 and he/she reported to him/her that Resident #3 hit him/her. Review of Resident #4's Medication Administration Record (MAR), dated March 2026, showed the resident was not given pain medication on 3/10/26. Review of the resident's Electronic Medical Record (EMR) showed no pain assessments completed. During an interview on 3/17/26 at 11:39 A.M., Resident #4 said:-He/She had not had a problem with Resident #3 before.-He/She and Resident #3 were neighbors.-Resident #3 just came in and hit him/her.-Resident #3 hit him/her on his/her back and the back of his/her head maybe three or four times.-It hurt and it he/she was scared.-A staff member came and Resident #3 ran away.-After the incident, he/she prayed for a reason to live.-Resident #3 was gone, so he/she felt alright now. During an interview on 3/17/26 at 11:45 A.M., Resident #19 (quarterly MDS dated [DATE] showed he/she was moderately cognitively impaired) said:-He/She was in the room with Resident #4.-He/She saw Resident #3 throwing punches at Resident #4 in the back of his/her head.-A staff member came and stopped Resident #3. During an interview on 3/17/26 at 1:00 P.M., the Administrator said:-They gave Resident #3 an immediate discharge notice due to abuse of Resident #4 on 3/10/26.-Resident #3 was sent to the hospital and remains on the psychiatric unit. During an interview on 3/17/26 at 1:42 P.M., CNA A said:-He/She was assigned to do one-on-ones with Resident #3.-He/She was sitting in the hall outside Resident #3's room.-Resident #3 turned on his/her radio in his/her room.-Resident #3 walked in and out of his/her room mumbling to himself/herself.-He/She followed Resident #3 when he/she walked around in the hallways.-Resident #3 went into the bathroom in his/her room around 2:00 A.M.-Then he/she heard a bunch of ruffling around like someone was hitting something or someone.-Resident #3 and Resident #4 were next door neighbors and shared a bathroom between their rooms. -He/She saw Resident #4's bathroom door open and saw Resident #3 coming out and said he/she beat the mother fucker up. -Resident #3's hand looked swollen and he/she said it hurt.-Resident #4 said Resident #3 hit him/her on his/her back and head.-Resident #3's back was fire engine red with red marks up and down his/her back. During an interview on 3/18/26 at 7:54 P.M., Resident #3's guardian said:-The hospital staff told him/her the resident had a fractured right hand after the altercation.-The resident's fracture was from Resident #3 hitting Resident #4 or something else during the incident.-Resident #3 has a cast on his/her right (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	hand. During an interview on 3/18/26 at 1:00 P.M., the DON and Administrator said:-RN A called the DON on 3/10/26 and said Resident #3 had gone through the adjoining bathroom and struck Resident #4 several times.-The DON told RN A to get Resident #3 sent out to the hospital due to abusing Resident #4.-The DON spoke with Resident #3's guardian and told him/her Resident #3 struck another resident and they needed to send him/her to the hospital.-The DON asked Resident #3's guardian to request a psychiatric hold at the hospital.-Resident #3 would not allow RN A to assess him/her before leaving to the hospital.-CNA A said Resident #3 was going to the bathroom and he/she did not think he/she needed to be within reach of the resident while he/she went to the bathroom. During an interview on 3/23/26 at 11:38 P.M., RN A said:-Resident #3 would explode without any warning.-Resident #3 was unpredictable and would just lose it.-Resident #3 was on one-on-ones (on 3/9/26 P.M. into 3/10/26 A.M.).-He/She did not think Resident #3 was displaying behaviors to indicate he/she was escalating that night.-CNA A sat at Resident #3's door because he/she would not allow anyone in his/her room.-He/She told the DON that the resident didn't want anyone in his/her room.-Resident #3 said he/she understood and agreed to supervision by staff but still would not let CNA A sit in his/her room.-CNA A was one-on-one with Resident #3 by sitting outside his/her doorway.-CNA A reported to RN A:--Resident #3 went to use to the bathroom that he/she shared with Resident #4.--CNA A did not follow Resident #3 to his/her bathroom. --Resident #4 was already in the bathroom and he/she was naked.--Resident #3 hit Resident #4 multiple times.-He/She asked Resident #3 why he/she hit Resident #4 and Resident #3 said he/she did not like it when other residents were naked.-He/She reported the incident to the Administrator and DON.-The DON instructed him/her to send the resident out to the hospital.-He/She was unable to fully assess Resident #3 for injury or pain before he/she left for the hospital because of Resident #3's lack of cooperation.-He/She assessed Resident #4 and found no injuries.-Resident #4 said Resident #3 hit him/her on his/her back and the back of his/her head. -After Resident #3 hit Resident #4, Resident #4 went straight to bed. During an interview on 3/25/26 at 12:11 P.M., the primary care physician for Residents #3 and #4 said:-The DON informed him/her of the altercation right after it happened.-He/She saw Resident #4 on 3/19/26 and the resident didn't say anything about the incident.-Resident #3 was still in the hospital.-He/She did not remember if either resident was injured.-It would have been best if Resident #3 did not share a bathroom with someone else.-This incident of Resident #3 attacking and punching Resident #4 was abuse. 2799433