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	05/26/2026

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on interview and record review, the facility failed to notify Guardian A using the agreed upon protocol for one sampled resident (Resident #1) who had a change in condition out of 19 sampled residents. The facility census was 128 residents.1. Review of Resident #1's admission Record showed he/she admitted to the facility with a diagnosis of schizoaffective disorder (a mental health condition that includes features of both schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves) and a mood disorder), bipolar type (a mood disorder that can cause intense mood swings).NOTE: The admission Record showed the emergency after-hours phone number of Guardian A. Review of the resident's Behavior Note dated 5/4/26 at 5:51 A.M. completed by Licensed Practical Nurse (LPN) A showed:-The resident reported that another resident grabbed him/her by the arm and said that he/she would rape the resident.-Guardian A had been notified using the Guardian's office number.NOTE: Guardian A's office number was not the emergency after-hours phone number. Review of the resident's Health Status Note dated 5/5/26 at 1:30 P.M. showed:-Police were notified of the alleged incident.-The resident had talked to the police related to the alleged incident. During an interview on 5/21/26 at 11:34 A.M. Guardian A said:-He/She confirmed that the emergency after-hours line on the resident's admission record was the correct phone number.-He/She confirmed that the number that LPN A called was not the correct number.-The facility had signed a form related to the use of the emergency after-hours phone line back in 2025, so the facility was well aware of the correct protocol to use when notifying him/her of a change in condition after-hours. Review of the Public Administrator Emergency Call Information form on 5/21/26 at 11:40 A.M. showed:-The form had been completed on 5/28/25.-Normal business hours were considered Monday through Friday from 8:00 A.M. to 4:00 P.M.-The facility was to use the on-call (emergency) phone number for the following situations:--Significant change to ward's condition.--Ward's contact with law enforcement. During an interview on 5/22/26 at 9:30 A.M. LPN A said:-He called the number that was on the resident's face sheet.-He/She did not see that after-hours emergency phone number on the resident's face sheet.-He/She thought that he/she had followed facility protocol.-If he/she had not called the correct number, then it was a mistake.-Usually when he/she called Guardian A's office number, a message would indicate a different number be used if Guardian A was unable to pick up the phone call.-He/She could not remember if a different phone number had been provided when leaving a voicemail on Guardian A's office number. During an interview on 5/22/26 at 2:01 P.M. LPN B said:-The resident had a guardian.-If a resident had a guardian and was experiencing a change in condition, then it was the facility's responsibility to notify the guardian appropriately.-Guardian A's office phone number and emergency after-hours phone number could be found in the resident's chart.-If he/she needed to notify Guardian A after hours, then he/she did call the office number first, but if no one picked up, then he/she would also call the after-hours emergency line.-The correct number was also posted at the nurse's station.-Nursing staff had received education related to the use of the after-hours emergency line when notifying the resident's guardian.-There would be no reason for LPN A to have called the wrong number especially since LPN A was notifying Guardian A during the after-hours time frame. During an interview on 5/22/26 at 3:09 P.M. the Director of Nursing (DON) said:-He/She expected nursing staff to call the correct phone number to contact the resident's (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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	guardian. -If the resident's guardian needed to be notified of something after-hours, then he/she expected nursing staff to use the after-hours emergency phone number.-Nursing staff were not supposed to leave messages as part of a guardian's notification of change in condition.-The nursing staff were expected to speak with someone when notifying a guardian of a change in condition.-LPN A had not followed the facility's protocol to notify Guardian A of the resident's change in condition.-LPN A should have used the after-hours emergency phone number to contact Guardian A.-LPN A knew better because he/she had notified Guardian A correctly in the past. 3010522