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	06/04/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview and record review, the facility failed to prevent resident abuse when on 5/27/26 Resident #1 lunged at and grabbed Resident #2, the two residents wrestled to the floor hitting and scratching each other, out of three sampled residents. The facility census was 127 residents.The Administrator was notified on 6/4/26 of the past noncompliance which began on 5/27/26. The facility revised the resident smoking policy and the staff assignment sheets and completed education for licensed nurses and Certified Nursing Assistants (CNAs) regarding the revised resident smoking policy and assignment sheets. Education was completed with all staff on resident-to-resident abuse. The deficiency was corrected on 5/28/26. Review of the facility Abuse Prevention and Prohibition policy, dated March 2025 showed:-Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.-Instances of abuse of all residents, irrespective of any physical or mental condition, cause harm, pain, or mental anguish. 1. Review of Resident #1's admission record showed:-He/she was admitted to the facility on [DATE].-He/she had diagnoses of depression and anxiety. Review of Resident 1's care plan dated 5/22/26 showed-He/she had a history of assault (a violent physical or verbal attack).-Staff interventions included to intervene as necessary to protect the rights and safety of others, remove from the situation and report any incidents to police. Review of Resident #2's admission Record showed:-He/she was admitted to the facility on [DATE].-He/she had diagnoses of dementia (decline in mental ability that interferes with daily life), depression, psychosis (loss of contact with reality) and anxiety. Review of the Resident #2s' care plan dated 7/14/25 showed:-He/she had a mood problem including feeling down, feeling bad about himself/herself.-He/she had a history of displaying anger when antagonized by others; was verbally abusive, threatening and impulsive. Review of Resident #1's Health Status Note dated 5/27/26 showed:-At approximately 6:30 P.M. the Director of Nursing (DON) was called to the resident's living area.-The resident had a gash (a long, deep cut or wound), bleeding from his/her left eyebrow and left upper arm and would not allow assessment and cleansing of the areas.-He/she said he/she and another resident had a physical altercation and would not elaborate (explain with detail).-Resident #2 said he/she had punched the ohter resident three or four times in his/her face.-He/she was belligerent (hostile, aggressive, eager to fight or argue) toward staff and other residents.-Staff separated the residents and attempted to monitor the resident 1:1 (constant staff visual monitoring); the resident left the area.-Police and the resident's physician were notified. Review of the Resident#2's Health Status Note dated 5/27/26 showed:-The DON was called to the resident's living area for a physical altercation.-The resident said Resident #1 was calling him/her names and he/she told him/her to stop; Resident #1 jumped up and he/she then jumped up; he/she hit Resident #1 three or four times in his/her face.-Resident #2 had a scratch about 2 1/2 inches long on the center of his/her chest, a reddened area on his/her left chest, a small two centimeter (cm) scratch on the back of his/her left hand and a 5 cm (two inch) reddened area on the back of his/her back. Observation and interview with Resident #2 on 6/3/26 at 1:40 P.M. showed he/she had a scratch on his/her left wrist (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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(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	and two small red marks on his/her chest.-He/she said:-He/she and Resident #1 were in the resident smoking area with some other residents; he/she did not recall if any staff were present in the resident smoking area. -Resident #1 called him/her something he/she did not like.-He/she asked Resident #1 to not call him/her that, Resident #1 got up and then he/she got up.-Resident #1 lunged at him/her and grabbed him/her.-Resident #1 broke a necklace that he/she wore around his/her neck, scratched him/her and tried to hit him/her but he/she blocked Resident #2's punches.-He/she punched Resident #1 in the face three or four times.-Staff came and he/she left the smoking area with one of the staff.-A nurse stayed in the resident smoking area with Resident #1. Review of CNA A's Witness Statement dated 5/27/26 showed:-On 5/27/26 at 6:00 P.M. he/she was coming back up to the third floor.-He/she and DA A were entering the third floor off the elevator and saw two men fighting.-Resident #2 was standing over Resident #1 who was on the ground; as Resident #1 stood up, he/she was bleeding.-Resident #1 was on the ground and as he/she stood up, he/she was bleeding on the right side of his/her face and on his/her lower arm.-He/she and the nurse ran to break up the fight.-He/she then brought Resident #2 back inside with him/her while the nurse stayed outside trying to calm Resident #1 down. During an interview on 5/4/26 at 9:56 A.M. CNA A said:-On 5/27/26 he/she was working the evening shift on the third floor.-When he/she returned to the third floor and got out of the elevator with Dietary Aide (DA) A., he/she saw a fight with two residents in the smoking area.-At that time there were no staff in the smoking area.-He/she and the nurse went to the smoking area and broke up the fight.-He/she brought Resident #2 into the dining room from the smoke area and the nurse stayed on the smoking area with Resident #1. Review of DA A's Witness Statement dated 5/27/26 showed-DA A got off the elevator on 5/27/26 at 6:00 P.M.-Resident #2 was standing over and punching Resident #1. During an interview on 6/5/26 at 4:05 P.M. DA A said:-On 5/27/26 he/she was taking items to the third floor in preparation for the resident's evening meal.-There were no staff in the smoking area with a few residents.-As he/she and CNA A looked at the smoking area he/she saw a physical fight was going on with two residents. During an interview on 6/3/2/26 at 10:20 A.M. the Administrator said:-On 5/27/26 at around 6:30 P.M. Resident #1 and Resident #2 had a physical altercation.-His/her investigation showed that Resident #1 became aggressive toward Resident #2 and Resident #2 hit Resident #1 defending himself/herself.-Resident #1 had bleeding above his/her left eye but refused assessment and would not let staff clean him/her. Review of Resident #3's Comprehensive MDS dated [DATE] showed he/she was cognitively intact. Review of the facility Social Services Director (SSD) documentation of his/her interview with Resident #3, undated, showed:-Resident #3 said Resident #1 stood up and headed towards Resident #2.-Resident #1 then charged toward Resident #2 and grabbed Resident #2 by his/her throat.-Resident #2 then threw Resident #1 to the ground. During an interview on 6/3/26 at 2:40 P.M. Resident #3 said:-He/she saw what happened when Resident #1 and Resident #2 had a fight.-Resident #1 started the fight when he/she stood up and headed toward then charged toward and grabbed Resident 2 by his/her throat.-Resident #2 then threw Resident #1 to the ground.-A couple of other residents were nearby.-There were no staff in the smoking area at that time.-Staff separated Resident #1 and Resident #2. During an interview on 6/4/26 at 3:34 P.M. the DON said:-He/she was informed of the resident altercation on 5/27/26 right after it happened. -He/she immediately went to the Third floor.-The residents had been separated; Resident #2 was calm.-Resident #1 had blood on his/her face and would not let nurses assess him/her or clean the blood off his/her face, he/she was aggressive and threatening, refused 1:1 monitoring and left the facility and has not returned.-He/she expected staff to monitor residents during smoke breaks and whenever residents were out in the smoking area.-A new policy and assignment sheet was developed and put into place.-All staff had received training on the new policy by 5/28/26, that the third floor resident smoking area was to be unlocked for resident smoking breaks, assigned staff were to stay in the resident smoking area with residents until the all residents had gone back inside from the smoking area and staff were then to go back inside and lock the door the smoking area. 3025998