

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2025
NAME OF PROVIDER OR SUPPLIER Alpine Breeze Health and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 6124 Raytown Road Raytown, MO 64133	
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)		
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one sampled resident (Resident #2) was free from physical abuse out of 8 sampled residents when on 4/17/25 Resident #1 struck Resident #2 on the head with rock resulting in an approximately 3 centimeter (cm) laceration and a hospital visit. The facility census was 138 residents.</p> <p>The Administrator was notified on 4/23/25 of the past noncompliance which began on 4/17/25. The facility immediately completed education for staff on the facility's Abuse and Neglect policy, the facility's Behavior Management police and de-escalation techniques. Resident #1 was placed on 1:1 supervision until his/her transport to the hospital on 4/18/25. Resident #2 was treated. The deficiency was corrected on 4/18/25.</p> <p>Review of the facility's Abuse, Neglect and Exploitation Policy, dated 8/22/22, showed:</p> <p>-It was the policy of the facility to provide protections for the health, welfare and rights of each resident by implementing policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>-Abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which could include staff to resident abuse and certain resident to resident altercations.</p> <p>-Instances of abuse of all residents, irrespective of any mental or physical condition, caused physical harm, pain or mental anguish.</p> <p>-Willful meant the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p> <p>-Physical abuse included, but was not limited to hitting, slapping, punching, biting, and kicking. It also included controlling behavior by corporal punishment</p> <p>1. Review of Resident #1's facility admission Record Face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <p>-Homelessness.</p> <p>(continued on next page)</p>		

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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Anxiety disorder (a mental condition characterized by excessive fear, worry or nervousness), uncomplicated.</p> <p>-Mood disorder due to known physiological condition.</p> <p>-Major depressive disorder (persistent sadness, loss of interest or pleasure in activities) recurrent.</p> <p>-Hemiplegia (a condition characterized by paralysis on one side of the body) and hemiparesis (a condition involving weakness on one side of the body) following cerebral infarction (stroke) affecting left dominant side.</p> <p>Review of Resident #1's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff and used for care planning), dated 4/18/25, showed he/she was cognitively intact.</p> <p>Review of of Resident #1's Level One Facility Pre-admission Screening for Mental Illness, Intellectual Disability or Related Condition, dated 9/27/24, showed:</p> <p>-The person completing the document was the hospital case manager.</p> <p>-The resident did not show any signs of a major mental disorder.</p> <p>-He/She did have a current, suspected or history of a major mental illness.</p> <p>-The resident did not have any area of impairment due to serious mental illness.</p> <p>-The resident did not have a diagnoses of a major neurocognitive disorder.</p> <p>-The resident did not show behavioral symptoms.</p> <p>-The resident had a stable mental condition monitored by a physician or licensed mental health professional at least monthly or behavior symptoms exhibited in the past, but not currently present or psychiatric conditions exhibited in the past but not recently present.</p> <p>-The resident had impaired situational memory.</p> <p>-The resident displayed difficulty making decisions in new situations or occasionally required supervision with decision making and had issues with memory, mental function or ability to be understood/understand others.</p> <p>Review of Resident #1's Trauma Informed Care assessment, dated 4/13/25, showed:</p> <p>-He/She had an altercation with another resident on that date.</p> <p>-He/She was glad to be separated from the other resident, because he/she had a temper.</p> <p>-He/She stated he/she would stay to him/herself to prevent further incidents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Care Plan Report, updated 4/17/25, showed:</p> <ul style="list-style-type: none"> -He/She had a history of a traumatic event; no known triggers. Interventions included: medications as ordered to relieve anxiety or known stressors. -He/She had an altercation with a resident on 11/6/24 and was found to be the instigator in a dispute regarding a wheelchair. Interventions included: administering medications as ordered; color coding wheelchairs for easy identification. -He/She had an altercation with another resident on 4/13/25. Interventions included placing the resident on 15-minute checks for 72 hours; scheduled for team health; smoking times alternated for 48 hours; trauma informed assessment completed; determining what might lead to altercations; monitoring the resident's behavior and progress to assess effectiveness of care plan -He/She had an altercation with another resident on 4/17/25. Interventions included maintaining a calm, respectful tone of voice; listening attentively to the resident's thoughts and feelings, validating his/her emotions; use clear and simple language so the resident could understand; he/she was placed on 1:1 oversight. <p>Review of Resident #2's facility admission Record Face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Difficulty in walking. -Muscle weakness. -Long term drug therapy. <p>Review of Resident #2's quarterly MDS, dated [DATE], showed he/she was cognitively intact.</p> <p>Review of Resident #3's facility admission Record Face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:</p> <ul style="list-style-type: none"> -Displaced fracture of left femur; closed fracture with routine healing. -Encounter for orthopedic aftercare. <p>Review of Resident #3's quarterly MDS, dated [DATE], showed he/she was cognitively intact</p> <p>Review of Resident #3's Care Plan, report updated 4/13/25, showed:</p> <ul style="list-style-type: none"> -He/She had an altercation with another resident. Interventions included: monitoring for behavioral changes such as mood swings, irritability, changes in sleep patterns or decreased productivity and report changes to physician; encouraging positive coping skills; increasing social interaction with peers. <p>Review of Resident #1's progress note, dated 4/17/25 at 5:01 P.M., showed:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-A 3 cm x 0.1 cm x &lt; 0.1 cm laceration was noted to the back of the head; the area was cleansed, ice was applied.</p> <p>-He/She remained with the nurse until the ambulance arrived for transport.</p> <p>-Emergency Department (ED) evaluation was required per the resident's physician due to his/her use of blood thinner.</p> <p>-The Director of Nursing (DON), facility Administrator, physician and the resident's sister were notified.</p> <p>-His/her care plan was updated.</p> <p>Review of Resident #2's hospital Patient Visit Information, dated 4/17/25, showed:</p> <p>-He/She was seen for a scalp laceration.</p> <p>-He/She received the head injury on 4/17/25.</p> <p>-It did not appear serious at the time.</p> <p>-He/She received a head computed tomography (CT - a detailed imaging procedure that uses x-ray and computer technology to create cross-sectional pictures) which was negative.</p> <p>Review of the facility's Resident to Resident Investigation Summary, dated 4/18/25, showed:</p> <p>-On 4/17/25 Resident #1 had a resident-to-resident altercation with Resident #2.</p> <p>-Resident #1 was on the patio having a supervised smoke break.</p> <p>-Resident #1 became agitated at Resident #3 who Resident #1 felt was looking at him/her funny.</p> <p>-The Administrator attempted to intervene and deescalate.</p> <p>-Resident #1 struck the Administrator's hand, smacking his/her phone out of his/her hand.</p> <p>-Resident #1 got angry and threw a rock at Resident #3 and missed striking Resident #2.</p> <p>During an interview on 4/21/25 at 12:40 P.M., Resident #3 said:</p> <p>-On the day of the incident, he/she went outside and Resident #1 was already out there.</p> <p>-Resident #1 told him/her that he/she could not come out there and said, Get on out of here!</p> <p>-He/She was nowhere near Resident #1 who was sitting in the smoking area.</p> <p>-Resident #1 wheeled his/her chair over toward him/her, stopped at the fountain and picked up a rock.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She began backing away from Resident #1, who kept coming toward him/her.</p> <p>-He/She did not say anything to Resident #1. He/She did not think he/she could hit him/her with the rock, because he/she only had one good arm.</p> <p>-Resident #1 threw the rock and it hit the other resident, Resident #2, whose back was toward him/her.</p> <p>-He/She did not see anything else because the Administrator told him/her to go inside.</p> <p>-Resident #1 could get verbally aggressive with people. Resident #1 had his/her own room because he/she could not get along with anyone.</p> <p>During and observation and interview on 4/21/25 at 1:00 P.M., Resident #2 said:</p> <p>-Resident #1 threw the rock at someone and it hit him/her.</p> <p>-He/She was minding his/her business and Resident #1 was behind him/her and threw the rock at Resident #3.</p> <p>-He/She went to the hospital.</p> <p>-Resident #1 had a fight before with Resident #3 earlier in the week.</p> <p>-The place where the rock hit him/her was painful, but he/she had not asked for any pain medication.</p> <p>-He/She had an approximately inch long closed laceration on the back of his head. There was no discoloration or visible swelling.</p> <p>-He/she was angry and wanted to press charges.</p> <p>During an interview on 4/22/25 at 11:00 A.M., Resident #1 said:</p> <p>-He/She threw a rock at Resident #3, because Resident #3 had previously punched him/her in the face.</p> <p>-He/She was outside on a smoke break and Resident #3 was making fists at him/her.</p> <p>-He/She did not want to keep seeing the other resident when he/she was outside, so he/she picked up a rock and threw it, but it hit the other resident (Resident #2).</p> <p>-He/She and Resident #3 got along sometimes, but he/she did not like him/her.</p> <p>During an interview on 4/23/25 at 1:30 P.M., Resident #1's physician said:</p> <p>-He/She was aware of the rock throwing incident.</p> <p>(continued on next page)</p>		

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