STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265339	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alpine Breeze Health and Wellness	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)
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 of ten sampled residents, Resident #1 was free from abuse, when on 1/27/26 at approximately 2:23 A.M. Resident #2 struck Resident #1 on the face while Resident #1 was sleeping in bed, due to an auditory hallucination. As a result of the altercation, Resident #1 sustained a laceration to the inner lip and minor swelling to his/her left eye. The facility census was 142 residents.The Administrator was notified on 2/16/26 of the past noncompliance which began on 1/27/26. The residents were separated, and Resident #2 was placed on 1:1 observation. Resident #1 was transferred to the hospital for evaluation and treatment and returned to the facility with no new orders. Resident #2 was transferred to the hospital for psychiatric evaluation and admitted . The facility immediately completed education for staff on the Abuse, Neglect and Exploitation policy. The deficiency was corrected on 1/27/26. Review of the facility's Abuse, Neglect and Exploitation policy, dated 8/22/22, showed:-It was the policy of this facility to provide for the protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.-Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish.-Physical Abuse included, but was not limited to hitting, slapping, punching, biting, and kicking. It also included controlling behavior through corporal punishment. 1. Review of Resident #1's admission Record face sheet, dated 1/22/26, showed he/she was admitted with the following diagnoses:-Cerebral palsy, (a disorder caused by abnormal brain development or damage, affecting motor function, posture and balance).-Sequelae of cerebral infarction, (chronic, often permanent physical, cognitive and emotional deficits from a stroke). Review of Resident #1's Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 1/24/26, showed the resident was cognitively impaired. Review of the resident's Care Plan Report, dated 1/22/26, showed the resident had impaired cognitive function/dementia (progressive decline in memory, thinking, behavior and language severe enough to disrupt daily life), and impaired thought processes, neurological (disorders of the brain, spinal cord and peripheral nerves) symptoms. Review of Resident #2's admission Record face sheet, dated 12/2/25, showed he/she was admitted with the following diagnoses:-Personality disorder, unspecified, (long-term mental health condition caused by inflexible and unhealthy patterns of thinking, feeling and behaving).-Cognitive communication deficit, (impairment of communication resulting from underlying communication issues). Review of Resident #2's Preadmission Screening and Resident Review (PASSR/MI) Level II Evaluation, dated 5/10/23, showed:-He/She had a legal guardian.-He/She had a long-standing history of psychiatric 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

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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 - Actual harm Residents Affected - Few	including schizophrenia, paranoid type, (a chronic mental health condition characterized by intense, irrational suspicion along with prominent auditory hallucinations (a perceptions of sounds without any external sources) and delusions of persecution), chronic; schizoaffective disorder, (a mental health condition combining schizophrenia symptoms with mood disorder episodes), bi-polar type; antisocial personality disorder (a chronic mental health condition characterized by manipulating, exploiting for violating the rights of others), personality disorder, insomnia (persistent difficulty falling and staying asleep).-His/Her behaviors indicate positive symptoms of schizophrenia including auditory and visual hallucinations, delusional thinking and psychosis.-Progress notes, dated 7/22, indicated complaint of spiritual battles using metaphysical spear and a foreign presence that was attempting to steal his money.-Per progress note, dated 7/22, he/she had increased delusions and hallucination when Risperdal (risperidone-medication for treating schizophrenia and bipolar mental health issues), or Clozaril (clozapine-atypical antipsychotic used for treatment-resistant schizophrenia or schizoaffective disorders) dosages decrease . briefly taken off Clozaril due to low white blood cell count and started on Zyprexa (antipsychotic medication used to treat schizophrenia and bipolar disorder) but did not have good response.-He/She denied he/she was the aggressor in any physical altercation he/she had gotten into, but had defended him/herself if necessary, in the past.-He/She reported a history of mood dysregulation and impulsive behaviors because of it.-He/She had a longstanding history of paranoid ideation, delusional thinking and process and reality testing problems His/Her conversations tended to lean on government involvement in reading his/her thoughts. He/she presented as mostly suspicious of others.-He/She reported he/she didn't trust other residents at his/her nursing facility. He/She reported to be appropriate and largely quiet.-He/She reported that he/she used to hear what everyone thought.-He/She reported he/she was spiritual, so he/she knew the spirits of those who came before us were real. Review of Resident #2's MDS, dated [DATE], showed the resident was cognitively intact. Review of Resident #2's Care Plan Report, dated 1/27/26, showed:-The resident had a guardian for financial, medical and/or personal decision-making due to impaired capacity to make complex decisions independently.-The resident used psychotropic medications related to personality disorder disease process and symptoms of depression. Interventions included: consulting with pharmacy and physician to consider dosage reduction when clinically appropriate at least quarterly; discuss with physician and family ongoing need for use of medication; review behaviors/interventions and alternative therapies attempted.-The resident had a behavior problem of potential aggression related to his/her spiritual beliefs that others may be the devil or working with the devil. Interventions included: administering medications as orders; monitor for side effects and effectiveness.-Most recent Gradual Dosage Reduction (GDR) attempted 1/21/26 failed. Review of Resident #1's Progress Notes dated 1/27/26 showed: -At approximately 2:23 A.M., the resident approached the south nurses' station with visible bleeding from his/her nose. -He/She appeared alert and oriented but upset. -Charge nurse assisted the resident with cleaning his/her face, applied ice to the nose and administered PRN (as needed) Tylenol (non-steroidal pain medication) per order. The bleeding was controlled. The resident was immediately placed at the nurses' station for close observation.-He/She reported his/her roommate woke him/her up, and proclaimed he/she was the devil, and struck him/her in the face.-He/She denied provoking the incident and denied loss of consciousness.-No other injuries were noted at the time of assessment.-The provider was notified at 3:05 A.M. and gave orders to send him/her out for evaluation and treatment. Review of Resident #2's Progress Notes, dated 1/27/26 showed: -Following an altercation involving his/her roommate, he/she was placed on 1:1 supervision for safety.-He/She was alert but exhibited delusional and religiously occupied speech.-He/She stated, It had nothing to do with (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	the TV, it was about him/her being the devil. I've been up for a couple of days. I'm trying to trap the devil's power; trying to do the right thing. He/She was provoking me. I wasn't trying to hurt him/her. I was trying to let him/her know he/she's using his/her power - the devil's power.-He/She continued to verbalize paranoid and delusional content.-He/She ambulated to the bathroom, returned to his/her table and then to bed without difficulty. Due to his/her statements and behaviors the provider was notified.-Medication history was reviewed. He/she had recently had Gradual Dose Reduction (GDR) of medication and was being closely monitored by psychiatry.-Provider was notified at 3:05 A.M. and the resident was ordered transfer for psychiatric evaluation and treatment. Public Administrator (PA). for the resident was contacted and voicemail left, Emergency Medical Services (EMS) contacted at 3:41 A.M. Report called to receiving hospital. Review of Resident #2's Social Services - Trauma Informed Care, dated 1/27/26 at 3:23 A.M., showed:-Physical assault - did not apply.-Serious injury, harm or death you cause to someone else - did not apply.-Any other stressful event or experience - did not apply.-Did any of the events affect your overall health and well-being - No. Review of Resident #1's Trauma Informed Care, dated 1/27/26 at 2:58 A.M., showed:-He/She was interviewed by the Social Worker.-He/She had been physically assaulted. Review of Resident #1's skin check, dated 1/27/26 at 3:25 A.M., showed the resident had a laceration (tear or break in the skin) to the inner lip and minor swelling to left eye. Review of Resident #1's Emergency Provider Report, dated 1/27/26, showed:-He/She was seen for assault, head and facial contusions (bruises) and intraoral laceration (cuts to the lips, cheeks, tongue or gums).-He/She was transferred from his/her care facility for the evaluation of head/facial injuries following an assault.-He/She was reportedly struck multiple times in the face by his/her roommate while sleeping.-He/She believed he/she lost consciousness.-He/She complained of generalized headache and facial pain.-He/She denied trouble speaking or swallowing, focal weakness or neuro deficits.-All systems were reviewed and negative except skin laceration, headache and facial pain.-He/She was awake and alert, no acute distress.-Mild left infraorbital swelling, no proptosis (abnormal bulging of the eye).-Left mid-face tenderness with associated bruising, dried blood in nares with no evidence of hematoma (clotted or partially clotted blood trapped in tissue or body spaces), intraoral laceration to bottom lip.-Oriented to person, place and time; speech within normal limits.-Maxillofacial Computer Tomography (CT) scan (a non-invasive, painless imagine procedure to create cross-sectional views of the facial bones, jaw, teeth and sinuses) without contrast on 1/27/26 at 5:14 A.M. showed: no acute intracranial hemorrhage (bleeding), fracture or territorial infarct (large vessel blood flow blockage); left facial and periorbital (surrounding the eye socket) soft tissue swelling, no acute maxillofacial fracture.-Laceration Management #1 - procedure performed by Emergency Department physician.-Location of wound: Inner lower lip, wound length 2.5 centimeters (cm).-Repair skin: Chromic, suture size 4-0, 2 sutures.-Closure layers: 1.-Suture technique: simple.-Post-procedure complications: No complications, condition improved, tolerated procedure well, condition stable.-His/Her oral laceration was repaired without complications, pain improved, remained at neuro baseline. Review of the Facility Investigation Summary Resident to Resident Incident, dated 1/27/26, showed:-Residents involved were Resident #1 and Resident #2.-On 1/27/26 at approximately 2:23 A.M., Resident #1 was observed exiting a room with small bleeding noted.-Staff immediately responded and provided care.-The incident was identified as a resident-to-resident behavioral event involving Resident #2.-Resident #1 sustained a nosebleed and a laceration to the inner lip; bleeding resolved with first aid.-The event appeared acute and isolated in nature.-The event was determined to be an acute resident-to-resident behavioral incident.Review of the Police Department Report, dated 1/27/26, showed:-The victim was Resident #1.-The suspect was Resident #2.-Officer A reported being (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	dispatched to the facility regarding a reported assault on 1/27/26 at 10:51 A.M.-Upon arrival, he/she made contact with the administrator who stated that around 3:30 A.M. on 1/27/26, Resident #1 was assaulted by Resident #2. Resident #2 was at the hospital at the time for a psychiatric evaluation.-He/She contacted Resident #1 who stated earlier that morning, his/her roommate, Resident #2 approached him/her while he/she was in bed and stated, I want to suck your dick.-Resident #1 told Resident #2, No.-Resident #1 stated that Resident #2 began to punch him/her in the face multiple times with a closed fist.-He/She asked Resident #1 how many times Resident #2 struck him/her and he/she stated he/she did not know.-Resident #1 further stated while Resident #2 was striking him/her, he/she repeatedly shouted, I'm the devil.-Resident #1 stated he/she was able to push Resident #2 away from him/her and at that point was able to escape and make his/her way to the nurses' station.-Resident #1 had visible swelling and bruising on his/her right cheek and right eye, and additionally his/her bottom lip was severely swollen and visibly split on the left side.-Resident #1's eyes were very bloodshot; however he/she was unable to determine whether the bloodshot appearance was caused by the assault.-Resident #1 was transported to the hospital by the facility staff prior to the arrival by the police and was medically cleared by staff at the hospital, per the Administrator.-He/She then spoke with the Administrator regarding the incident and asked if anyone had witnessed the assault, to which he/she responded no.-The Administrator stated there were no security cameras that captured the assault.-The Administrator also advised that both residents suffered from major cognitive impairments.-It was noted that Resident #2 was not his/her own guardian. During a telephone interview on 2/16/26 at 1:20 P.M., Resident #1's family member said:-The resident had stitches in his/her mouth-The stitches were put in at the hospital-The resident was asleep and his/her roommate jumped on him/her.-Resident #2 said Resident #1 was the devil.-The resident did not show anyone at the facility the stitches, except the Administrator and the police.-The resident got the kind of stitches that would melt, so three weeks later, a person would not be able to see them. During an interview on 2/16/26 at 1:30 P.M., Resident #2 said:-He/She remembered hitting Resident #1. -Resident #1 was yelling and making weird noises. -He/She thought Resident #1 was the devil. -He/She was trying to protect him/herself. -Resident #1 was trying to put his/her spirits in him/her. -He/She was afraid of Resident #1, so he/she hit him/her with his/her fist in the face. -He/She was trying to block Resident #1's eye. -Resident #1 woke up. - He/She wasn't trying to harm Resident #1, just block his/her eye because he/she was visualizing attacking him/her with his/her spirit. -The devil took flesh from dead people from the grave, and he/she put two and two together and thought that was Resident #1. -Resident #1 did not fight him/her; he/she said, I didn't do anything! -He/She said the medicine did not have anything to do with it - it was reality.-He/She felt safe at the facility now. There was nobody else at the facility with the devil in them. During an interview on 2/19/26 at 1:30 P.M., Psychiatric Nurse Practitioner A said:-Resident #2 had been doing well.-The attack was not intentional. It was his/her response to fight off the devils.-Nothing had been reported by staff as far as behaviors.-The resident had roommates before with no issues.-The resident's mind was responding to stimuli he/she perceived.During an interview on 2/19/26 at 3:45 P.M., the Director of Nursing (DON) said:-Resident #1 would have been Resident #2's second roommate. -He/She did not have any anticipation this could happen between the two residents. -He/She got a call at 2:00 AM when the incident happened. When he/she got to the facility, at approximately 2:30 AM., the altercation had already happened, and the residents were separated. -He/She interviewed Resident #1 first. -Resident #1 was obviously surprised and trying to figure out what was going on. He/She had swelling on his/her lip. The bloodshot eyes were baseline and not from the incident. -At the time Resident #1 did not have soft tissue swelling on his face. -He/She (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	interviewed Resident #2 also. He/She felt like he/she was doing an act of service. He/She kept saying they didn't understand that the devil was in Resident #1. -This was new to him/her because Resident #2 had never talked about anything demonic in the past. -The police came to the facility after Resident #1 had returned. -Resident #2 went out for psychiatric evaluation at the hospital on 1/27/26 and came back on 2/11/26. -He/She did not feel like this could have been predicted. -He/She did not feel like this was abuse. -He/She did not feel that Resident #2 had any ill will when he/she hit Resident #1.-He/She was aware of all of his/her residents and their behaviors, and he/she would not have guessed this would happen. During an interview on 2/19/26 at 4:22 P.M., the Administrator said:-It was totally out of the norm to receive a call like that about Resident #2. -He/She had never had behaviors before that.-Resident #1 never showed him/her his/her lip. -He/She would not have known what the stitches might look like.-He/She spoke to Resident #2 since he/she came back. -When Resident #2 spoke to him/her, he/she greeted him/her normally. -Residents had the right to sleep without being struck.-Resident #2 did not understand what he/she was doing when he did it - not even a little bit. -Since Resident #2 believed Resident #1 was trying to give him/her visions of the devil, this was outside of his/her baseline. -He/She did not believe Resident #2 was acting with intent. -Acting with intent would mean he/she had the ability to make that decision, and he/she did not think he/she had that ability. -He/She did not feel like this was abuse and he/she did not think that even a little.-Resident #2 did not have the capability to make that decision to act with intent. 2745832