STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265355	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Grandview	6301 East 125th St Grandview, MO 64030

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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three sampled residents (Resident #2, Resident #4, and Resident #11) were free from abuse when on 10/10/25 Resident #1 slapped Resident #2 in the back of the head; on 10/16/25 when Resident #3 punched Resident #4 in the face multiple times which caused Resident #4 to have a small laceration to his/her right eyebrow, bruising to his/her right orbital area of his/her face, and multiple small cuts to the back of his/her head, and on 10/23/25 when Resident #3 poured hot sauce on Resident #11's face. 13 residents were selected for sample. The facility census was 106 residents.Review of the facility's policy titled Abuse-Identification of Types dated 5/6/25 showed:-Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish.-Physical abuse included but was not limited to:--Hitting.--Slapping.--Punching. --Biting.--Kicking. -Verbal abuse was considered a type of mental abuse (the use of verbal or non-verbal conduct which causes or has potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation).-Verbal abuse included the use of oral, written, gestured communication, or sounds, to residents within hearing distance regardless of age, ability to comprehend, or disability.-Examples of mental and verbal abuses included, but was not limited to:--Harassing a resident.--Mocking, insulting, ridiculing.--Yelling or hovering over a resident, with the intent to intimidate. 1. Review of Resident #1's admission Record showed he/she was admitted to the facility with a diagnosis of Hemiplegia (paralysis of one side of the body) Following Cerebral Infarction (ischemic stroke- occurs as a result of disrupted blood flow and restricted oxygen to the brain) Affecting Left Non-Dominant Side.Review of Resident #1's undated care plan showed the resident had potential to be verbally aggressive and would cuss at staff/residents and concoct situations related to ineffective coping skills and poor impulse control.Review of Resident #1's Annual Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 8/11/25 showed:-The resident was cognitively intact.-The resident had not exhibited any physical behavioral symptoms directed towards others during the look back period.Review of Resident #2's admission Record showed he/she was admitted to the facility with the following diagnoses:-Anxiety Disorder (any group of mental conditions characterized by excessive fear or apprehension about real or perceived threats), Unspecified. -Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), Unspecified.-Schizoaffective Disorder (a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania or depression).-Major Depressive Disorder (MDD- a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life.-Anoxic Brain Injury (occurs when the brain is deprived of oxygen for an extended period.Review of Resident #2's undated care plan showed:-The resident had potential for a behavioral problem related to accusatory behaviors and was easily agitated when he/she could not fully express himself/herself. -The resident had impaired cognitive ability/impaired thought processes related to Anoxic Brain Injury.Review of Resident #2's Quarterly MDS dated [DATE] showed:-The resident was cognitively intact.-The resident did not exhibit any verbal behavioral symptoms within the look back period. Review of the facility's investigation summary completed on 10/11/25 showed:-There were no witnesses to the altercation.-On 10/10/25 around 12:00 P.M. Resident #2 stated he/she was struck in the back of the head by Resident #1. -Resident #2 stated that he/she and Resident #1 were passing each other in the hallway and Resident #1 swung his/her purse at him/her striking him/her in the back of the head.-Resident #2 initially stated that nothing happened prior to Resident #1 swinging his/her purse at him/her. -Resident #2 then stated that he/she had called Resident #1 a witch, not a bitch. -Resident #2 was upset because Resident #1 would always get what he/she wanted, and he/she had to wait. -Resident #2 also said, I really didn't mean to upset Resident #1, but it just burns me that he/she is getting her way all the time. -No injury was noted. -Resident #2 denied pain or psychosocial distress. -Resident #2 was educated on boundaries, conflict resolution, and therapeutic communication.-Resident #2 was also moved to a different side of the facility. -Resident #1 stated that he/she was passing the resident in the hall in his/her wheelchair and Resident #2 called him/her a bitch. -Resident #1 stated that he/she was upset and frustrated that he/she had called him/her a name and turned around and swung at him/her with his/her hand. -Resident #1 made contact with the back of Resident #2's head. -Resident #1 also told Resident #2 that he/she should not use words like

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **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 #3) was allowed back to the facility when the facility completed an Immediate Notice of Involuntary Discharge when they sent the resident to a local hospital on [DATE] out of 13 sampled residents. The facility census was 106 residents. Review of the facility's policy titled Notices of Transfers and Discharges dated 8/5/25 showed no policy related to immediate notice of involuntary discharges.1. Review of Resident #3's admission Record showed that he/she was admitted to the facility with a diagnosis of Diabetes Mellitus (DM II- a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin).Review of the resident's Quarterly Minimum Data Set (MDS)(a federally mandated assessment instrument completed by facility staff) dated 8/7/25 showed:-The resident had moderately impaired cognition.-The resident had not exhibited any behaviors within the look back period.Review of the resident's Immediate Notice of Involuntary discharge date d 10/23/25 showed:-The resident would be forced to discharge from the facility.-The resident was being sent to a local hospital.-The safety of individuals in the facility was endangered.-The health of individuals in the facility would be otherwise endangered.-The resident was involved in a resident-to-resident altercation on 10/16/25. -The resident was involved in a resident-to-resident altercation on 10/23/25.-The resident was threatening residents and staff.Review of an emergency room Note dated 10/23/25 showed the resident was being admitted to the hospital with a primary diagnosis of Social admission Secondary to Facility Refusal for Taking Patient Back.During an interview on 10/24/25 at 8:45 A.M. the resident said:-He/She didn't know what is going on. -No one has updated him/her on anything. -He/She felt that the Administrator just want him/her out of the facility. -He/She was really upset because he/she wanted to go back to the facility because that was his/her home.During an interview on 10/24/25 at 11:04 A.M. the Administrator said:-The resident would not be allowed back to the facility.-He/She did not feel the facility was adequately equipped to take care of the resident.During an interview of 10/24/25 at 11:42 A.M. the Social Services Designee (SSD) said:-He/She had sent multiple referrals to other facilities in the area after the second resident-to-resident altercation that the resident was involved in. -The facility was not equipped to handle the resident's behaviors.-He/She had sent the Ombudsman (resident advocate) the Immediate Notice of Involuntary Discharge letter on 10/23/25. During an interview on 10/27/25 at 10:35 A.M. the Director of Nursing (DON) said:-The resident had to go. -He/She was sent to the hospital for increased behaviors and now couldn't come back to the facility. -He/She understood that the facility was not meeting regulation by not accepting the resident back, and by not providing a reevaluation after he/she received the necessary treatment. 2651315