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	06/02/2026

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 - 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 on observation, interview, and record review, the facility failed to protect one sampled resident (Resident #1) from physical abuse out of three sampled residents. On 5/24/26 Resident #2 entered Resident #1's room and hit Resident #1 on the left knee, left eye, and top of the left side of the head resulting in Resident #1 having a red mark on his/her left eye. The facility census was 108 residents.The Administrator was notified on 6/2/26 of the past noncompliance which began on 5/24/26. The facility immediately completed education for abuse & Neglect. The deficiency was corrected on 5/26/26. Review of the facility Abuse, Neglect, and Exploitation Prevention Issued 10/04/2022, reviewed 04/01/26, showed:-It was the policy of this facility to prevent and prohibit all types of abuse.-Abuse is willful, the individual must have acted deliberately, not that the individual must have intended to inflict injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish.-Physical abuse includes, but was not limited to, hitting, slapping, punching, biting, and kicking. 1. Review of Resident #1's admission Record showed he/she had been admitted to the facility on [DATE] and re-admitted on [DATE] with the following diagnoses:-Stroke with weakness and paralysis on the left non-dominant side.-Arterial Fibrillation (a-fib- irregular heart beat).-Anxiety.-Coronary Artery Disease (CAD - a narrowing or blockage of the arteries and vessels that provide oxygen and nutrients to the heart).-Congestive Heart Failure (CHF - impaired heart function). Review of Resident #1's Significant Change Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning), dated 3/25/26, showed the resident was cognitively intact. Review of Resident #1's Care Plan dated 2/4/26 showed he/she:-Had the potential to be verbally aggressive will cuss staff and residents and concocts situations related to ineffective coping skills and poor impulse control.-Uses an electric wheelchair to move around the facility. Review or Resident #2's admission Record showed he/she was admitted to the facility on [DATE] and re-admitted on [DATE] with the following diagnoses:-Stroke with weakness and paralysis on the right dominant side.-Parkinson's Disease (a brain disorder causing unintended or uncontrolled movements).-Dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life).-Major Depressive Disorder (a serious mental health condition characterized by persistent, intense sadness or loss of interest impacting daily life).-Anxiety. Review of Resident #2's Annual MDS dated [DATE] showed:-The resident had no physical, verbal, or other behaviors.-He/She was cognitively intact. Review of Resident #2's Care Plan dated 4/21/25 showed he/she:-Can propel his/her wheelchair independently.-Had impaired cognitive ability and thought processes due to a urinary tract infection (UTI - a bacterial infection that affects any part of the urinary system) which decreased his/her typical cognitive ability, the resident thought it was 1988 and was working at the Ford plant.-Administer medications as ordered by the physician. Review of the facility Investigation dated 5/26/26 showed:-On 5/24/26 at approximately 7:00 P.M., Resident #2 was physically aggressive towards Resident #1.-Certified Medication Technician (CMT) A stated he/she heard yelling and went into Resident#1's room to escort Resident #2 out of Resident #1's room.-Resident #1 stated (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#2 said that Resident #1 would let Resident #2 go to work a Ford on the elevator.-Resident #2 stated he/she aways went to work and used the elevator.-Resident #2 said Resident #1 had been shooting him/her in the arm and his/her whole body was shaking.-Resident #2 said Resident #1 would come into his/her room and mess with his/her television.-Resident #2 went to Resident#1's room to tell Resident #1 to stop and Resident #1 started calling him/her names so Resident #2 struck Resident #1.-Resident #1 said Resident #2 came into his/her room and said I got something for you then started hitting him/her, striking him/her in the left eye.-Resident #1 called for assist but no one came fast enough so Resident #1 struck Resident #1 with his/her pink cup in self-defense.Resident #1 had no injuries.-Resident #2 had redness and edematous (swelling) to the left eye. Review of the Police Report dated 5/24/26 at 7:38 P.M., showed:-Police Officer was dispatched to the facility due to a report of an assault on 5/24/26 at 7:38 P.M.-The offender was Resident #2, and the victim was Resident #1.-Upon arrival the officer contacted the facility nursing staff who stated Resident #1 and Resident #2 had a physical altercation.-The officer contacted Resident #1 who stated he/she was in his/her room when Resident #2 rolled across the hall into his/her room.-Resident #1 asked Resident #2 to leave and Resident #2 refused.-Resident #2 raised his/her fist and stated I've got something for you before striking Resident #1 in the left eye.-The officer's observation of the resident's left eye was red and swollen around the eye socket.-Resident #1 was checked by medics but declined going to the hospital.-Resident #1 stated he/she hit Resident #2 in the head with his/her pink cup after Resident #2 hit him/her.-The officer spoke with CMT A who separated Resident #1 and Resident #2.-CMT A stated he/she came into Resident #1's room and grabbed Resident #2's wheelchair and wheeled him/her back across the hall to his/her room. Review of Resident #1's Alert Note dated 5/24/26 at 11:50 P.M., showed:-Reported to Licensed Practical Nurse (LPN) A at 6:53 P.M., the resident had reported being hit by Resident #2.-The resident reported Resident #2 stated I got something for you.-The resident asked Resident #2 to leave.-Resident #2 began hitting Resident #1 and Resident #1 hit Resident #2 back.-Resident kept punching Resident #1 and punched Resident #1 in the left eye.-Resident #1 yelled for help, CMT A entered Resident #1's room and removed Resident #2 from the room. Review of Resident #1's Hospital Record dated 5/25/26 showed:-His/Her had a diagnosis of closed head injury and ankle pain.-The Computed Tomography (CT scan -a computer that takes data from several X-ray images of structures inside a human body and converts them into pictures on a monitor) did not reveal any acute traumatic injury. Review of Resident #2's Event Note dated 5/24/26 at 8:43 P.M., showed:-While LPN A was assessing Resident #1 from earlier incident with Resident #2.-Resident #2 opened his/her room door and began to yell and curse at Resident #1, from his/her room.-Resident #1's and Resident #2's rooms are straight across from each other.-Resident #2 was transported to a private room down the hall and was given water and the television was turned on to help calm Resident #2 down.-Resident #2 was assessed and did not have any injuries. During an observation and interview on 6/2/26 at 12:41 P.M., Resident #1 said:-It was not his/her fault Resident #2 came into his/her room. -Resident #2 came across the hall into his/her room and said, I got something for you and started hitting him/her with his/her fist in the left eye.-He/She pushed Resident #2 away in his/her wheelchair and Resident #2 slipped out of the wheelchair hitting Resident #1's left knee. During an interview on 6/2/26 at 1:13 P.M., LPN A said he/she:-Was notified of the incident by CMT A.-Assessed both residents for injuries Resident #1 had redness and some swelling to his/her left eye and Resident #2 had no injuries.-Notified the physician and received an order to send both residents to the hospital for evaluation and treatment.-Resident #1 refused to go to the hospital so notified the physician and was given an order to monitor the resident and send to the hospital if and changed.-Started neuro-check on Resident #1 as ordered by the physician due to possible head trauma.-Notified the Administrator, police and residents' families of the incident.-When Resident #2 returned from the hospital he/she was placed on one-to-one monitoring in his/her new room for safety. Review of CMT A's written statement dated 5/26/26 showed he/she:-Went to Resident #1's room and took Resident #2 out of the room and to another room.-Asked Resident #2 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about what Resident #2 was doing he/she said that Resident #1 won't let him/her go to work at Ford on the elevator in Resident #1's room and that he/she woke up to go to work.-Resident #2 was in bed all day when he/she gave Resident #2 his/her medications.-Resident #2 said he/she worked here at Ford since 1985 and always went down on the elevator that was in Resident #1's room.-Resident#2 said Resident #1 comes and pours water and had a bowel movement in his/her bed.-Tried to redirect Resident #2 but it did not work.-Stayed with Resident #2 until transferred to the hospital. During an interview on 6/2/26 at 2:04 P.M., CMT A said he/she:-Heard a resident scream his/her name.-He/She was busy in the bathroom at that time.-He/She went to Resident #1's room and separated Resident #1 and Resident #2, by taking Resident #2 out of the room.-Resident #1 said Resident #2 had hit him/her.-Did not witness the residents hitting each other.-Resident #1 did have a redness to his/her left eye.-Stayed with Resident #2 while LPN A was assessing Resident #1. During an interview on 6/2/26 at 2:56 P.M., Resident #2 said he/she:-Had an incident with Resident #1.-Resident #1 aggravates him/her by shooting him/her with a needle causing him/her to shake and sprayed his/her toe with something causing him/her to lose his/her toenail when he/she was asleep. During an interview on 6/2/26 at 3:56 P.M., the Administrator said he/she:-Was notified of the incident between Resident #1 and Resident #2 on 5/24/26 around 7:30 P.M.-Went to the facility to help with the investigation and start training with the staff on abuse and neglect policy.-Finished all for the education on 5/26/26, no employee worked until they were educated.-Moved Resident #2 from 200 hall to 400 hall and was placed one-to-one for three days for resident safety. 3022682