STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265425	A. Building B. Wing	12/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewood Manor Health Care Center	11900 Jessica Lane Raytown, MO 64138

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** 45403 Based on interview and record review, the facility failed to ensure one sampled resident (Resident #3) remained free from abuse. On 12/20/23 Resident #2 struck Resident #3 on top of his/her head with his/her fist causing Resident #3 to complain of a headache, a knot on top of his/her head, neck pain and was sent out to the emergency room (ER) for treatment out of four sampled residents. The facility census was 62 residents. Review of the facility Abuse and Neglect Policy dated 1/5/23 showed: -Purpose: --To outline procedures for reporting and investigating complaints of abuse and to define terms of types of abuse. --To establish actions related to the alleged perpetrator and to ensure investigation and assessment of all residents involved is completed. -Physical abuse: --Purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner. --Physical abuse also includes, but is not limited to, hitting, slapping, punching, biting, and kicking. -Policy: --Mistreatment, neglect, or abuse of resident is prohibited by this facility. --This includes physical abuse. --This facility is committed to protecting our resident from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends or any other individuals. (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 - Actual harm Residents Affected - Few	1. Review of Resident #2's Admission Record showed the resident was admitted on [DATE] with the diagnoses of Paranoid Schizophrenia (a form of schizophrenia [a chronic mental illness that interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others] characterized by persistent preoccupation with illogical, absurd, and changeable delusions, usually of a persecutory, grandiose, or jealous nature, accompanied by related hallucinations) and Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety). Review of Resident #2's Preadmission Screening and Resident Review (PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) dated 9/21/22 showed the resident: -Psychiatric Diagnoses: --Psychotic Disorder (a mental disorder in which there is a severe loss of contact with reality). --Bipolar Disorder Type I Manic Episode (mood disorders characterized usually by alternating episodes of depression and mania). --Personality Disorder (a mental health condition where people have a lifelong pattern of seeing themselves and reacting to others in ways that cause problems). --Antisocial Personality Disorder (a condition characterized by repetitive behavioral patterns that are contrary to usual moral and ethical standards and cause a person to experience continuous conflict with society). --Borderline Personality Disorder (BPD-a mental illness marked by an ongoing pattern of varying moods, self-image, and behavior). -Had a history of paranoid ideation/delusions, recurrent homelessness, belief she has been another person of fame in which her identity has been stolen repeatedly. -Had a history of becoming agitated with severe verbal and physical aggression directed at staff members at prior placements. -History of auditory and visual hallucinations, irritable mood, repeated episodes of homelessness, non-compliance with psychotropic medications. -Required 24 hour per day nursing supervision and oversight due to chronic serious mental illness associated with impaired judgement and insight. -Required ongoing evaluation of mood, thought process, behaviors to identify signs of increased anxiety, agitation, confusion which may precipitate aggression toward other due to past history. Review of Resident #2's Annual Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) dated 12/2/23 showed the resident: -Was cognitively intact. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Rejected care (such as taking medications) determined to be consistent with resident values, preferences or goals, one to three days per week. -Had diagnoses of stroke, seizures, anxiety and schizophrenia. Review of Resident #2's undated Care Plan showed he/she: -Would be in the lowest restrictive environment while maintaining protective oversight. -Was at risk for manifestations of behaviors related to his/her mental illness (paranoid schizophrenia) that may create disturbances that affect others. -Would not experience episodes of inappropriate behaviors that can affect others. -If the resident is disturbing others, encourage him/her to go to a more private area to voice concerns/feelings to assist in decreasing episodes of disturbing others. Review of Resident #2's Progress Notes dated 12/18/23 showed he/she: -Refused his/her morning medications. -Behaviors were observed and documented. -The facility called 911 regarding two employees who have apparently been signing bank documents on his/her account for years to the amount of 100 million dollars and that he/she is the New York police. Local law enforcement found this to be unsubstantiated. -Was yelling in the morning at peers, accusing them of stealing from him/her and saying he/she was a billionaire and was a famous person. -Resident #2 had to be separated on multiple occasions from Resident #3. Review of Resident #3's Admission Record showed he/she was admitted on [DATE] with the diagnoses of muscle weakness and anxiety disorder. Review of Resident #3's Annual MDS dated [DATE] showed the resident was cognitively intact. Review of Resident #3's Progress Note dated 12/20/23 showed he/she: -Was sitting outside on the smoke porch when another resident walked up and hit him/her on top of the head. -Complained of dizziness, headache, neck pain, and ringing in his/her ears. -Was sent to the emergency room for evaluation and treatment. -Had a small raised area on the top of his/her head. (continued on next page)

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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	Review of Resident #2's Progress Note date 12/20/23 showed he/she: -Walked up to Resident #3 and hit him/her on top of the head. -He/she said Resident #3 owed him/her 50 million dollars and that he/she was going to get it some how even if it meant beating Resident #3 up. -He/she was sent to the emergency room for evaluation and treatment. Review of Resident #3's Progress Note dated 12/25/23 showed he/she: -Was seen by the physician. -Was assaulted by Resident #2 and complained of headache, dizziness with neck pain. -Initially refused to go to emergency room , but did go for evaluation. -Was still having some neck pain. -When the other resident struck him/her from behind it caused his/her head to go forward causing pain. -He/she saw stars. Review of Resident #2's Investigation Report dated 12/20/23 showed: -Resident #2 approached Resident #3 and struck him/her on the head, unprovoked. -Resident #2 had been delusional, he/she believed he/she was robbed of 50 million dollars, and called the local police department to make a report. During an interview on 12/26/23 at 1:38 P.M., Resident #3 said: -Prior to the incident Resident #2 was out smoking and had become confrontational with him/her. Staff had to intervene -A couple of days later Resident #2 came up behind him/her and hit him/her on the top of the head one time. -He/she was sent to the hospital for evaluation. -He/she had a knot on top of his/her head and a headache. -He/she had requested Resident #2 be kept away from him/her. During an interview on 12/26/23 at 2:22 P.M., the MDS Coordinator said: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-He/she did not know why Resident #2 was not sent out for psychiatric evaluation for his/her increased behaviors prior to assaulting Resident #3. -The assault might have been prevented if Resident #2 had been sent out sooner for his/her increased behaviors. -Resident #2's assault on Resident #3 was abuse. During an interview on 12/26/23 at 2:00 P.M., the Regional Nurse Consultant said: -Resident #2 had a psychotic break, and his/her assault of Resident #3 was not abuse. -The facility was responsible to ensure the safety of the residents. During an interview on 12/26/23 at 3:13 P.M., the Regional MDS Coordinator said: -It would have been appropriate to send Resident #2 to the hospital for a psychiatric evaluation prior to the assault of Resident #3 due to a change in the resident's behaviors two days prior. -For an incident to be defined as abuse there must be intent. -He/she did not believe Resident #2 had intent to harm Resident #3. During an interview on 12/26/23 at 3:45 P.M. the Administrator said: -The facility was responsible for ensuring protective oversight for all residents in the facility. -Resident #2 assault of Resident #3 was abuse. During an interview on 1/10/24 at 3:44 P.M. the Nurse Practitioner said the incident with Resident #3 was consistent with the definition of abuse. MO00229028, MO00229029

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45403 Based on interview and record review, the facility failed to provide appropriate treatment and services for one sampled resident (Resident #2) who had refused his/her psychoactive medications on a consistent basis and was experiencing a change in his/her mental status. On 12/20/23 Resident #2 struck Resident #3 on top of his/her head with his/her fist causing Resident #3 to complain of a headache, a knot on top of his/her head, neck pain and was transfer to the emergency room for treatment out of four sampled residents. The facility census was 62 residents. Review of the facility Behavioral Emergency Policy dated 1/5/23 showed: -Purpose: --To provide safe treat and humane care to the resident in a behavioral crisis, to outline steps to follow to correctly care the resident in a behavioral crisis, to ensure that the resident is not being coerced, punished or disciplined for staff convenience. -Procedure: --It is the policy of Reliant Care Management to provide a safe environment and provide humane care to all residents. Review of the facility Abuse and Neglect Policy dated 1/5/23 showed: -Purpose: --To outline procedures for reporting and investigating complaints of abuse and to define terms of types of abuse. --To establish actions related to the alleged perpetrator and to ensure investigation and assessment of all residents involved is completed. -Physical abuse: --Purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner. --Physical abuse also includes, but is not limited to, hitting, slapping, punching, biting, and kicking. -Policy: --Mistreatment, neglect, or abuse of resident is prohibited by this facility. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	--This includes physical abuse. --This facility is committed to protecting our resident from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends or any other individuals. 1. Review of Resident #2's Admission Record showed the resident was admitted on [DATE] with the diagnoses of Paranoid Schizophrenia (a form of schizophrenia [a chronic mental illness that interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others] characterized by persistent preoccupation with illogical, absurd, and changeable delusions, usually of a persecutory, grandiose, or jealous nature, accompanied by related hallucinations) and Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety). Review of Resident #2's Preadmission Screening and Resident Review (PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care) dated 9/21/22 showed the resident: Please define diagnoses below -Psychiatric Diagnoses: --Schizoaffective Disorder (a mental condition that causes loss of contact with reality and mood problems). --Psychotic Disorder (a mental disorder in which there is a severe loss of contact with reality). --Bipolar Disorder Type I Manic Episode (mood disorders characterized usually by alternating episodes of depression and mania). --Personality Disorder (a mental health condition where people have a lifelong pattern of seeing themselves and reacting to others in ways that cause problems). --Antisocial Personality Disorder (a condition characterized by repetitive behavioral patterns that are contrary to usual moral and ethical standards and cause a person to experience continuous conflict with society). --Borderline Personality Disorder (BPD-a mental illness marked by an ongoing pattern of varying moods, self-image, and behavior). -Had no family supports or outside contacts. -Had a chronic mental illness and would have difficulty working with the public due to paranoia. -Had a history of paranoid ideation/delusions, recurrent homelessness, and believed he/she had been another person of fame in which his/her identity has been stolen repeatedly. -Had a history of non-compliance with medications. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-Had several in-patient psychiatric admissions in multiple mental health facilities. -Had a history of becoming agitated with severe verbal and physical aggression directed at staff members at prior placements. -Although was able to communicate needs, rambled and lost train of thought several times throughout the assessment. -Symptoms include paranoid/grandiose delusions, fixed in nature. -Had a history of psychomotor agitation with verbal and physical aggression toward prior caregivers in structure settings. -History of auditory and visual hallucinations, irritable mood, repeated episodes of homelessness, non-compliance with psychotropic medications. -Required 24 hour per day nursing supervision and oversight due to chronic serious mental illness associated with impaired judgement and insight. -Required ongoing evaluation of mood, thought process, behaviors to identify signs of increased anxiety, agitation, confusion which may precipitate aggression toward other due to past history. Review of Resident #2's Annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 12/2/23 showed the resident: -Was cognitively intact. -Rejected care (such as taking medications) determined to be consistent with resident values, preferences or goals, one to three days per week. -Had diagnoses of stroke, seizures, anxiety and schizophrenia. Review of Resident #2's Physician Orders dated 12/20/23 showed: -Behaviors: monitor for behaviors every shift. -Divalproex 250 milligram (mg) give one tablet orally two times a day related to paranoid schizophrenia. -Divalproex 500 mg give one tablet orally two times a day related to paranoid schizophrenia. -Levetiracetam 1000 mg give one tablet orally verbally two times a day related to other seizures. -Olanzapine 20 mg give one tablet by mouth at bedtime related to paranoid schizophrenia, give with 5 mg tablet for total of 25 mg. -Olanzapine 5 mg give one tablet by mouth at bedtime related to paranoid schizophrenia, give with 20 mg tablet for a total of 25 mg. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #2's Medication Administration Record dated 12/1/23 to 12/31/23 showed: -Divalproex 500 mg was refused 35 out of 38 attempts. -Divalproex 250 mg was refused 35 out of 38 attempts. -Levetiracetam 1000 mg was refused 35 out of 38 attempts. Review of Resident #2's undated Care Plan showed he/she: -Required protective oversight. -Was at risk for manifestations of behaviors related to his/her mental illness (paranoid schizophrenia) that may create disturbances that affect others. -Would not experience episodes of inappropriate behaviors that can affect others. -Was encouraged when disturbing others to go to a more private area to voice concerns/feelings to assist in decreasing episodes of disturbing others. Review of Resident #2's Progress Notes dated 12/18/23 showed he/she: -Refused morning medications. -Called 911 regarding two employees have apparently been signing bank documents on his/her account for years to the amount of 100 million dollars and that he/she was the New York police. Local law enforcement found this to be unsubstantiated. -Was yelling in the morning at peers, accusing them of stealing from him/her and saying he/she was a billionaire and was a famous person. -He/she had to be separated on multiple occasions from Resident #3. Review of Resident #2's Physician Progress Note dated 12/19/23 showed he/she: -Was seen by the physician. -Had refused medications and behaviors. -Was sent to the emergency roiagnom on [DATE] after a seizure. -On 12/6/23 was noted to have had a 21 pound weight loss. -On 12/18/23 the provider was notified of the resident calling 911 with grandiose allegations, refusing medications on a regular basis and requesting urinalysis due to mental status changes and current behavior. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-History of present illness: Was sent to the emergency room for seizure, been refusing all of his/her meds, behaviors area also worsening and he/she had been aggressive towards other patient, at least verbally. -The physician tried to encourage the resident to take his/her medications. -The resident stated he/she did not need any medications. -Had a lot of forced speech during the encounter. -The physician questioned the resident's decision making capacity. Review of Resident #3's Admission Record showed he/she was admitted on [DATE] with the diagnoses of muscle weakness and anxiety disorder. Review of Resident #3's Annual MDS dated [DATE] showed the resident was cognitively intact. Review of Resident #2's Progress Note date 12/20/23 showed the resident: -Walked up to another resident and hit the resident on top of the head. -Stated the other resident owed him/her 50 million dollars and that he/she was going to get it some how even if it meant beating him/her up. -Sent to the emergency room for evaluation and treatment. Review of Resident #2's Investigation Report dated 12/20/23 showed he/she: -Was his/her own responsible party. -Had been refusing medications for the past two weeks. -Psychiatry and medical physician were notified. -Staff noted the resident has been delusional in the he/she believed that he/she was robbed of 50 million dollars, so far as to call the local police department to make a report. -Resident #2 approached Resident #3 and struck Resident #3 on the head, unprovoked. -Transferred and admitted to the hospital. -Plan to initiate guardianship for the resident. During an interview on 12/26/23 at 2:22 P.M. the MDS Coordinator said: -Resident #2 was sent for a psychological admission at the hospital for medication refusal, non-compliance and increased behaviors after Resident #2 assaulted Resident #3. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-He/she did not know why Resident #2 was not sent out prior to the assault of Resident #3 because Resident #2 had increased behaviors and had called 911 on 12/18/23. -He/she believed the assault could have been prevented if Resident #2 had been sent out sooner. -The resident had been refusing medications since September and because he/she was his/her own person there was little that could be done about it. -He/she told the Director of Nursing (DON) and the Administrator about Resident #2's increasing behaviors. -The assault by Resident #2 was abuse. During an interview on 12/26/23 at 2:00 P.M. the Regional Nurse Consultant said: -All staff and the physician were aware of Resident #2 refusing his/her medications. -Due to the resident being his/her own person there was not much that could be done about the resident refusing medications. -Because the resident was having a psychotic break, he/she would not define the resident altercation as abuse. -The facility was responsible to ensure the safety of the residents. -He/she was working on the floor with the resident as a Certified Medication Technician (CMT) and had no formal training on Resident #2's behaviors. During an interview on 12/26/23 at 3:13 P.M. the Regional MDS Coordinator said: -It would have been appropriate to send Resident #2 to the hospital for a psychiatric evaluation prior to the assault due to a change in the resident's behaviors two days prior and it may have prevented the abuse. -He/she was unable to specify any measures within the facility to protect Resident #2 and others during a psychotic episode such as the abusive behavior. During an interview on 12/26/23 at 3:45 P.M. the Administrator said: -When Resident #2 called law enforcement on 12/18/23 it was indicative Resident #2 had a significant change in increased behaviors. -He/she expected the staff to review Resident #2's care plan and possibly complete a significant change on the MDS. -He/she expected the care plan to be updated. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-He/she was unaware the resident was upset and there had been verbal altercations between Resident #2 and Resident #3 prior to the abuse 12/20/023. -He/she said Resident #2 had been delusional in the past, just not to that extreme. -He/she did not see what could have been done to prevent the assault due to Resident #2 being his/her own person and being non-compliant with medications. -With mental health residents, the only predictable thing was that the residents were unpredictable. -When asked how the facility staff was to ensure the safety of the residents, he/she said by taking reasonable steps according to the resident's care plan. -He/she was unable to clarify any steps specific for Resident #2's care plan. -The facility was responsible for ensuring protective oversight for all residents in the facility. During an interview on 1/10/24 at 3:44 P.M. the Nurse Practitioner said: -Resident #2 has a long history of non-compliance in which he/she becomes more delusional and aggressive over the course of time. -He/she expects the staff to inform him/her each time the resident refused medications in an effort to create a plan and place interventions to ensure the safety of the resident and others. -By the time the resident has refused his/her medications for a few months it is too late and the resident will have had grandiose delusions and aggression. -The facility did not inform him/her each time the resident had refused his/her medications. -He/she was told the staff did not feel it was necessary to notify hi/her due to the resident not having a guardian, therefore non-compliance was a right and nothing could be done. -He/she does not feel there was prompt notification. -He/she was aware Resident #2 contacted law enforcement, but was not aware Resident #2 targeted Resident #3 in the past. -If he/she was aware of Resident #2 targeting another resident there may have been more preventative measures implemented to ensure the safety of both residents. -The resident contacting law enforcement on 12/18/23 with grandiose delusions was a significant indicator of the resident having a significant change in his/her mental status. -Resident #2 has not been physically aggressive with residents or other patients, but has been resistive to cares and hyperfocused on others in the past. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	-Resident #2 should have had a guardian. MO00229028, MO00229029