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	05/19/2026

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 - 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 interview and record review, the facility failed to prevent abuse for one sampled resident (Resident #2) out of three sampled residents. On 5/1/26 Resident #3 threw coffee on Resident #2 while he/she was sitting in a chair watching television, resulting in first degree burns to Resident #2's chest. Resident #2 had redness and complained of pain and burning to his/her right upper chest and face area treated with first aid. The facility census was 69 residents. On 5/11/26, the Administrator and Director of Nursing (DON) were notified of past non-compliance which occurred on 5/4/26. All staff received education prior to working their next shift. The deficiency was corrected on 5/4/26. Review of the facility's Abuse and Neglect Policy dated 6/12/24 showed:-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.-Abuse included beating, striking, wounding or injuring any resident or mistreating or maltreating a resident in a brutal or inhumane manner. 1. Review of Resident #2's admission Record face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:-Schizoaffective Disorder, Bipolar Type (a chronic mental health condition blending schizophrenia symptoms (hallucinations (false sensory perceptions that occur in the absence of external stimuli, making the brain perceive sights, sounds, smells, tastes, or touches as real when they are not) /delusions (fixed false beliefs that persist despite evidence to the contrary and are disconnected from cultural or religious norms) with mood disorder episodes such as mania (excitement manifested by mental and physical hyperactivity, disorganization of behavior, and elevation of mood) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).-Bipolar Disorder (a mental health condition characterized by mood swinging from one extreme to another). -Generalized Anxiety Disorder (a mental health disorder that produces fear, worry, and a constant feeling of being overwhelmed).-Suicidal Ideations (occurs when someone thinks about or considered death or suicide).-Cognitive Communication Deficit (occurs when someone has trouble with one or more cognitive processes involved in communication). Review of Resident #2's Quarterly Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning), dated 2/5/26, showed the resident was cognitively intact. Review of Resident #3's admission Record face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:-Post Traumatic Stress Disorder (PTSD-a mental health condition triggered by experiencing or witnessing a terrifying, life-threatening, or traumatic event).-Schizoaffective Disorder, Bipolar Type.-Major Depressive Disorder, Recurrent (involves a depressed mood or loss of pleasure or interest in activities for long periods of time). -Restlessness (being unwilling or unable to stay still or to be quiet and calm, because you are worried or bored).-Agitation (a feeling of irritability, mental distress or severe restlessness).-Generalized Anxiety Disorder (a mental health disorder that produces fear, worry, and a constant feeling of being overwhelmed). Review of Resident #3's Quarterly MDS dated [DATE], showed the resident was cognitively impaired. Review of Resident #2's Physical Aggression Involving Head Sheet dated 5/1/26 (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 - Minimal harm or potential for actual harm Residents Affected - Few	at 2:42 P.M., showed:-The resident reported to the charge nurse that he/she was hit by Resident #3 and had hot coffee poured on him/her.-The resident had redness on his/her chest and face.-The resident had coffee splattered on his/her hoodie.-The resident complained of burning to the right side of the face and upper chest.-The resident complained of pain at a level of 5 out of 10. (pain scale where 10 is extreme pain) Review of Resident #2's Skin Check assessment dated [DATE] at 3:53 P.M., showed the resident had redness on his/her face and chest. Review of Resident #3's Skin Check assessment dated [DATE] at 3:20 P.M., showed the resident had an abrasion on the left side of his/her face on the left lower lip. Review of the Full Detailed Triage Call sheet dated 5/4/26 showed:-A resident to resident physical altercation occurred on 5/1/26 where Resident #2 was the victim and Resident #3 was the aggressor.-During a group movie and snack activity, Resident #3 approached Resident #2 while he/she was seated on the couch.-Resident #3 asked Resident #2 if he/she had a problem with him/her.-Resident #2 denied having a problem with Resident #3 and asked him/her to step away.-Resident #3 then threw coffee into Resident #2's face.-Resident #2 responded by striking Resident #3 in the face.-The residents were then both separated and Resident #3 was sent to the hospital for psychiatric evaluation. -Resident #3 later reported that he/she was having auditory hallucinations that instructed him/her to harm Resident #2. During an interview on 5/11/26 at 3:00 P.M., Resident #2 said:-He/She was attacked by Resident #3 while watching a movie on 5/1/26.-Resident #3 walked up to him/her and asked if he/she had a problem and he/she responded that there was no problem.-Resident #3 then threw hot coffee on his/her face and chest.-He/She defended himself/herself and stood up and hit Resident #3 in the face.-He/She had red burns on the face and chest, and his/her hoodie was soaked with coffee.-He/She had pain for about 3 or 4 days after the incident where the coffee burned his/her skin.-He/She was unsure why Resident #3 did not like him/her.-Resident #3 has never liked him/her for some reason. -He/She has had increased anxiety due to the incident and had to be placed on anxiety medication because of it.-He/She cried a lot since the accident because he/she was embarrassed by it.-He/She was starting to counsel the next week due to the incident. During an interview on 5/11/26 at 3:45 P.M., Resident #3 said:-He/She poured coffee on Resident #2 because he/she was talking bad about him/her.-Resident #2 slapped him/her after he/she poured the coffee on him/her. During an interview on 5/11/26 at 10:45 A.M., Administrator said:-Resident #2 was sitting on a couch watching a movie when Resident #3 stood up, walked over to, and poured a cup of coffee onto Resident #2. -Resident #2 responded by hitting Resident #3 in the face.-The investigation was completed and substantiated as abuse. During an interview on 5/11/26 at 3:30 P.M., Licensed Practical Nurse (LPN) A said:-Resident #3 poured coffee on Resident #2 and then Resident #2 hit Resident #3 in the face on 5/1/26.-The residents were immediately separated and evaluated after the incident occurred. -He/She evaluated Resident #2 after the incident. -Resident #3 was anxious after the incident and had to be given his/her as needed anti-anxiety medication. -Resident #3 complained of pain after the incident but refused pain medication.-Resident #3 had red marks on his/her face and chest.-Resident #3 was crying after the incident and was very upset. -Resident #2 was sent to the hospital after the incident for evaluation. During an interview on 5/11/26 at 5:00 P.M., Director of Nursing (DON) said:-He/She completed the investigation into the incident and concluded that it was substantiated as abuse.-He/She expected all residents in the facility to be free from abuse. 3001562