STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265463	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare	128 North Hardesty Kansas City, MO 64123

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 - Immediate jeopardy to resident health or safety 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 ensure one sampled resident (Resident #1) out of five sampled residents, was free from physical abuse. On [DATE], Resident #2 struck Resident #1 multiple times on the top of his/her head with a solid wood and metal cane, which resulted in Resident #1 sustaining a laceration to the left temple with four stitches, bruising to his/her left eye socket, defensive bruising on his/her left pinky, ring finger, and a laceration to his/her second knuckle to his/her right middle finger. Resident #1 was sent to the hospital for treatment and stated he/she was afraid of Resident #2. The facility census was 112 residents. The Administrator was notified on [DATE] at 9:31 A.M., of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE] as confirmed by surveyor onsite verification. Review of the facility Resident Rights Policy, dated February 2023, showed: -The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. -The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Review of the facility Abuse, Neglect and Exploitation Policy, dated [DATE], showed: -It is policy of this facility to provide 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. -Physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. -The facility will develop and implement written polices and procedures that prohibit and prevent abuse, neglect, and exploitation of residents. (continued on next page)

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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	--The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of resident with needs and behaviors which might lead to conflict or neglect. --Addressing features of the physical environment that may make abuse, neglect, exploitation, and misappropriation of property more likely to occur. -The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation, including by not limited to: --Respond immediately. --Examining alleged victim for any sign of injury. --Increased supervision of the alleged victim and residents. --Room or staffing changes, if necessary, to protect residents from the alleged perpetrator. --Protection from retaliation. --Providing emotional support and counseling to the resident during and after the investigation, as needed. --Revision of the resident's care plan if the resident's medical, physical, mental, psychosocial needs or preferences change as a result of the incident of abuse. 1. Review of Resident #1's admission Record showed the resident was admitted on [DATE] with diagnoses including 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 generalized anxiety disorder (a psychiatric disorder causing feelings of persistent anxiety). Review of Resident #1's Quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated [DATE], showed the resident was moderately cognitively impaired. Review of Resident #1's undated Care Plan showed: -Potential for communication problem related to Spanish primary and English secondary. --Resident will be able to make basic needs known on a daily basis. ---Ensure/provide safe environment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #2's admission Record showed the resident was admitted on [DATE] with diagnoses including other psychoactive substance abuse (a disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug or medicine), liver cell carcinoma (also known as hepatocellular carcinoma (HCC), is a type of cancer that occurs when malignant tumors grow in the liver), and adjustment disorder with anxiety (excessive reactions to stress that involve negative thoughts, strong emotions and changes in behavior which can cause a lot of problems in getting along with others). Review of Resident #2's Quarterly MDS, dated [DATE], showed the resident was cognitively intact. Review of Resident #2's undated Care Plan showed: -Resident had a potential mood problem related to adjustment disorder with anxiety. --Monitor, record and report to the doctor as needed risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used a weapons. --Observe for signs and symptoms of mania (a state of abnormally elevated mood, energy, and activity) or hypomania (a state of elevated mood, increased energy, and activity that is less severe than mania), racing thoughts or euphoria, increased irritability, frequent mood changes, pressured speech, flight of ideas, marked change in need for sleep, agitation or hyperactivity. Observation of the facility video, dated [DATE], showed: -Resident #1 observed at the juice cart then walking down the hall into the vending machine room. -Resident #2 observed walking fast down the same hall holding a cane in both hands in a batting position. -Resident #1 observed with his/her back towards Resident #2 as Resident #2 entered the vending machine room. -Resident #2 went directly to Resident #1, raised the cane up with both hands and struck Resident #1 twice in the head. -Resident #1 retreated several steps from Resident #2. -Resident #2 advanced towards Resident #1 and struck Resident #1 in head with the cane again. -Resident #1 stepped towards Resident #2 and grabbed the cane. -Both residents continued to move and were no longer visible by the camera at that time. -Staff were seen on camera enroute to the vending machine room. -There was no audio to the footage. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the police report, dated [DATE] at 9:34 A.M., showed: -Incident type: Assault (Aggravated) -On [DATE] at 9:34 A.M., law enforcement was dispatched to facility on a reported disturbance. -Involved persons were Resident #1 and Resident #2. -Witnesses were Resident #3 and Resident #4. -Resident #1 reported being in the hallway when Resident #2 approached Resident #1 and began to argue with him/her. -Resident #1 separated him/herself from Resident #2 and went to the break room. -Resident #2 then followed Resident #1 into the break room and continued to argue with him/her. -Resident #2 then hit Resident #1 in the face several times with a cane. -Resident #1 took the cane from Resident #2 and began to hit Resident #2 with the cane. -They were separated by staff. -Resident #2 reported Resident #1's face got bloodied, because Resident #1 must have hit him/herself to make it look like Resident #2 assaulted him/her. -Resident #4 reported Resident #1 was in the break room when Resident #2 entered and had some words with Resident #1. Resident #2 began to hit Resident #1 with the cane. Resident #1 took the cane from Resident #2 and began to hit Resident #2 with the cane. Resident #2 then left the break room and Resident #1 followed him/her, hitting him/her with the cane. He/She went to the break room and observed blood on the floor and trailed into the hallway. -He/She observed a camera in the break room that would have captured the incident on video. -The detective from the Assault Squad advised that city charges were appropriate. -He/She was advised to contact the administrator at a later time to watch any video. -He/She was unable to issue charges at that time due to not being able to determine a primary aggressor. -The report was written prior to viewing or accessing any video recordings of the incident and may not reflect verbatim records of statements/interviews or evidence. Review of the facility Suspected Abuse Investigation, dated [DATE], showed: -Resident on resident incident occurred on [DATE] at 9:05 A.M. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident #1 was in the vending machine room, Resident #2 entered the room carrying a wooden cane. - The two began arguing, and the staff then witnessed Resident #1 swinging a broken cane at Resident #2. -There was a laceration to Resident #1's head. -The residents were separated and Resident #1 was placed on 1 on 1 supervision for safety. -Police and physician were notified. -Both residents were sent to the hospital for further evaluation. -Law enforcement arrived on [DATE] at 9:35 A.M. -Resident #1 was walking down the hall to the vending machine room and Resident #2 followed with cane in hand, not being used to walk. -Resident #2 calmly asked where Resident #1 was and staff pointed down the hall. -Upon entering the vending machine room where Resident #1 was already, Resident #2 hit Resident #1 in the head with the cane two times. -Resident #1 held his/her head where he/she was hit. -Resident #2 then hit Resident #1 in the head a third time and the cane broke in half. -Resident #1 took the cane from Resident #2 and hit Resident #2 with the broken cane. -Staff separated the residents and Assistant Director of Nursing (ADON, Director of Nursing (DON), Administrator and Law Enforcement notified. -Resident #3 and #4 were witnesses. -All involved parties were interviewed for statements. -Resident #1 sustained laceration to the left side of head, left eye black, and right pinky finger bruised and jammed. -Resident #2 had a small wound to the middle left side of forehead the size of a pea and a skin tear 1 centimeter (cm) in width in between the crease of thumb and pointer finger. -Resident #1 received three stitches to the forehead. -After hospital evaluations, both residents returned to facility and placed on 1 on 1 observation. - After thorough investigation, it was determined that Resident #2 was the assailant, and Resident #1 was the victim. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Police called and court date scheduled. Review of Resident #1's Behavior Note, dated [DATE] at 8:11 P.M., showed: -Licensed Practical Nurse (LPN) A was made aware that two residents (Resident #1 and #2) were involved in a physical altercation. -LPN A was advised Resident #1 was in his/her room and was in need of assistance, while Resident #2 was on the other side being treated by that nurse. -LPN A immediately went to Resident #1's room to treat and noted resident had a bloody towel on his/her head. -Upon removing the towel advised resident the laceration appeared deep enough to receive stitches. -Resident initially refused to go to the hospital. -Management advised to call Emergency Medical Services (EMS) and to put resident on 1 on 1 observation at that time. -Resident spoke to law enforcement before exiting the facility with EMS. -The resident refused vital signs, was watching TV and was making several phone calls prior to leaving the facility making it difficult to assess and speak with the resident. -The resident changed his/her shirt before leaving the facility with EMS. -Hospital reported resident received three stitches on his/her head and was given discharge instructions. Review of Resident #2's Behavior Note, dated [DATE] at 7:01 P.M., showed: -LPN A was advised there was a physical altercation between Resident #1 and Resident #2 at approximately 9:28 A.M. -LPN A was advised Resident #2 was being assessed and treated by the nurse on the other side of the facility. -When LPN A went to assess Resident #2, he/she had a bandage on his/her forehead and was seated at the nurses station with staff present. -At 9:31 A.M. LPN A began neuro assessments and notified management of the incident. -At 9:46 A.M. law enforcement in facility to speak with the resident. -Law enforcement advised there would be a report, provided a report number to the resident, and the resident verbalized an understanding. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-At 10:06 A.M. the resident began to complain of 10 out of 10 pain to his/her head. -Resident had a pea size wound to forehead and approximately 1 cm wound to right hand between thumb and forefinger. -As needed (PRN) pain medication given per resident's choice. -Resident complained of dizziness and continued pain. -Resident had previously refused to be assessed by EMS, at 10:12 A.M. requested to be sent to the hospital. -Resident ambulated independently with no change or concern, and denied ongoing dizziness. -Resident transported by EMS at 10:32 A.M. to the hospital. -Resident returned to the facility at 2:22 P.M. with complaint of pain, but would not quantify pain. -Resident stated he/she was poked in the back by Resident #1. -LPN A observed a pea size mark to the mid-right back, resident denied any other injuries. Review of Resident #1's hospital records, dated [DATE] at 2:40 P.M., showed: -Resident was brought by EMS from nursing home with complaint of head injury. -Resident was hit on the left side of his/her head with another resident's cane. -Resident stated the nursing home made him/her come for evaluation. -Denied headache, vision changes, weakness or numbness, neck pain or other injuries. -Irregular laceration to left forehead. -Dried blood on resident's face and t-shirt. -Presented for head injury with cane, large open laceration. -Met criteria for CT of head and neck. -CT of head and neck showed no acute evidence of bleed or fracture. -Laceration repaired with four sutures. -Alert and oriented to person, place, time and situation. -Social Services consult for assault. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Protective service type, social services, adult/elderly abuse/neglect. -Abuse/Neglect details: Resident was assaulted by another resident. -Resident was anxious to return to the nursing home. -Because resident was assaulted social worker completed adult protective services. -Social worker assisted with transportation back to facility. Review of Resident #1's Emergency Department discharge instructions, dated [DATE], showed: -Reason for visit was head injury. -CT (also known as a computerized axial tomography (CAT) scan, is a medical imaging procedure that uses X-rays to create detailed cross-sectional images of the body to diagnose and monitor various conditions, including fractures) of head and cervical spine (commonly known as the neck, is the upper portion of the spinal column that connects the skull to the thoracic spine) due to cane injury. -He/She was seen for laceration (a cut that goes through all layer of the skin). -Instructions for laceration care and follow up for stitches. Review of Resident #2's Discharge Instructions dated [DATE] showed: -Diagnosis from today's visit was assault and head injury. -Rest and ice any areas of pain. -Use your medications as previously prescribed. -Tetanus administered. -General head injury instructions given. Review of the General Ordinance citation dated [DATE] showed: -On [DATE] at 9:05 A.M. the Defendant, Resident #2, did unlawfully assault, in violation of Ordinance 50-169. -Signed by the prosecutor. During an interview on [DATE] at 11:20 A.M., the Administrator said: -Both residents remain on 1 on 1 supervision. -He/She was able to review the video of the assault. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/She was getting ready for a 30 day discharge notice for Resident #2 once placement is found, because Resident #2 was the aggressor. -Resident #1 received three sutures while at the hospital for his/her injury. -Resident #2 had superficial wounds to his/her hand and head. -They reviewed the video and observed Resident #2 was the aggressor. -The preliminary determination was an assault was made by Resident #2 and Resident #1 was protecting him/herself. -There were no prior indicators between the two residents. -Resident #2 was having a bad day as evidenced by the assault, although he/she was not exhibiting behaviors prior to attacking Resident #1. -Resident #2 alleged he/she was the victim, even after observing the video. During an interview on [DATE] at 1:18 P.M., Resident #1 said: (Communication was facilitated by Certified Medication Technician (CMT) A who was fluent in Spanish with consent from the resident.) -He/She was getting some juice and Resident #2 came out yelling at him/her trying to fight. -He/She did not engage with Resident #2 and just ignored Resident #2. -He/She went to get a soda from the machine. -He/She was bent over counting his/her credits when Resident #2 came to him/her yelling Today Motherfucker! repeatedly while hitting him/her with the cane. -He/She raised his/her arms up in a protective stance to show how he/she was trying to protect his/her face and head while Resident #2 was hitting him/her with the cane. -He/She said there was blood in his/her eyes and he/she could not see hardly at all. -He/She took the cane from Resident #2 and attempted to defend him/herself. -He/She swung the cane at Resident #2, making sure to not make contact with Resident #2's face. -He/She was not sure if he/she struck Resident #2, but he/she was sure he/she struck the door frame breaking the cane in half. -Law enforcement came, took pictures and filed a report. -Law enforcement told him/her not to worry because Resident #2 would be arrested. -He/She does not feel safe. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/She felt like his/her injury was serious, because he/she was hit was a cane. He/she was caught off guard with his/her back towards Resident #2 and bent down. -He/She said when he/she was hit it hurt really bad. -He/She was off balance and dizzy when he/she was hit with the cane. -He/She felt he/she had to defend him/herself to get back to his/her room. -He/She showed his wound to the left side of head (temple area), bruising to the left eye socket, bruising to the right pinky, right ring finger and small wound to the right middle finger. -He/She complained of pain in all three fingers and was unable to bend the fingers without grimacing in pain. -He/She complained of pain to the left side of head when it was touched or when chewing. -He/She did not understand why this happened. -He/She wanted Resident #2 to be punished and removed from the facility. -He/She did not feel it was safe with Resident #2 in the facility and he/she was afraid of Resident #2. During an interview on [DATE] at 3:06 P.M., the DON said: -There was no arrest, law enforcement came to the facility on [DATE] to see Resident #2. -Charges were filed for assault against Resident #2 and a court date was given to Resident #2. -Both residents were on 1 on 1 observation indefinitely. -Psychiatric appointments are being made for both residents. During an interview on [DATE] at 3:15 P.M., Resident #2 said: -Upon entering the room he/she said he/she was a little sore. -They were in the vending machine room and Resident #2 hit him/her in the stomach. -He/She went to his/her room and got the cane, went back to the vending machine room and hit Resident #2 in the head with the cane. -He/She hopes to get moved and was not really happy in the facility. -He/She then explained they were in the vending machine room and he/she had the cane with him/her. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/She said the incident does meet the criteria for abuse. -He/She will ensure Resident #2 remains on 1 on 1 observation until discharged . -He/She felt Resident #2 could be a threat again to possibly everyone in the building. -A solid wood brown cane which was broken in half. -There was a metal end with a large ball shape at the end of the handle, gold in color. -There were traces of a red substance which appeared to be blood noted all over the cane. During an interview on [DATE] at 3:51 P.M., LPN A said: -He/She had went to the bathroom and upon returning he/she was informed there was a resident to resident altercation and someone was bleeding. -He/She followed the blood trail and located Resident #1 in his/her room sitting on his/her bed with a bloody shirt, his/her phone in one hand, and holding a towel on his/her head with the other hand. -CMT A was present to facilitate communication. -He/She could tell right away the laceration needed stitches. -Resident #1 was fearful, but spoke to law enforcement and then was transported to the hospital by EMS. -He/She had seen Resident #2 pacing the hallways often, but never with a cane. -He/She was confused as to who's cane Resident #2 used as it was the first time he/she saw the cane. -The cane was heavy duty wood with a metal handle. -Resident #1 comes out rarely, maybe one or two times for ice water, almost always in his/her room. -He/She was shocked about the altercation, much less the use of a weapon. During an interview on [DATE] at 7:53 A.M., CMT A said: -He/She was at his/her medication cart when Resident #1 walked by talking about immigration. -Resident #2 was speed walking following Resident #1 mumbling carrying a cane in both hands in front of him/her. -Another resident came up to speak with him/her when he/she heard the commotion and called for help. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265463	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare	128 North Hardesty Kansas City, MO 64123

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/She was on the opposite end of the hall. -When he/she saw the residents, Resident #1 had the broken cane and was covered in blood. -Resident #1 was walking towards him/her covered in blood with half of the cane. -Resident #2 was following behind Resident #1 down the hall. -He/She did not feel alarmed when Resident #2 went by with the cane as he/she thought Resident #2 was just doing his/her own thing. During an interview on [DATE] at 11:10 A.M., the Physician said it was consensus the assault between Resident #1 and Resident #2 was abuse. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). MO00250034, MO00250039, MO00250065