STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265532	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkway Health Care Center	2323 Swope Parkway Kansas City, MO 64130

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** 46519 Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident #2) was free from abuse when on 2/19/24 Resident #1 punched Resident #2 in his/her face resulting in facial hematoma (solid swelling of clotted blood within the tissues) out of five sampled residents. The facility census was 91 residents. A policy was requested from the facility on abuse and this was not received. On 3/1/24, the Administrator was notified of the past noncompliance which occurred on 2/19/24. The facility administration was notified on the same day of the incidents and the investigation was started. Facility staff were educated on abuse and neglect policy, resident intervention and behaviors including de-escalation before the start of the next shift. New rules were given for the smoking porch. The residents' Care Plans were updated. The deficiency was corrected on 2/20/24. 1. Review of Resident #2's Face Sheet showed he/she admitted to the facility with the following diagnoses: -Alzheimer's Disease (a progressive metal deterioration that can occur in middle or old age, due to generalized degeneration of the brain). -Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). -Cognitive Communication Deficit (an impairment in organization/though organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 12/6/23 showed: -The resident was rarely/never understood. -The resident had not exhibited any behavioral symptoms within the seven-day look back period. Review of the resident's Care Plan dated 2/20/24 showed: -The resident became verbally aggressive towards another resident with the following interventions: (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: 265532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/01/2024
NAME OF PROVIDER OR SUPPLIER: Parkway Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2323 Swope Parkway Kansas City, MO 64130	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Administer and monitor medications as ordered by the facility physician. --Assist resident in addressing root cause of change in behavior or mood as needed. --Give positive feedback to resident for good behavior. --Resident to see counselor on a regular basis to discuss baseline roots of where aggression comes from. -The resident had emotional distress that could be triggered by overwhelming emotions, feelings, or memories with the following interventions: --Practice self-care. --Seek professional help from counselor or psychologist. 2. Review of Resident #1's Face Sheet showed he/she admitted to the facility with the following diagnoses: -Diffuse Traumatic Brain Injury (TBI- brain dysfunction caused by an outside force) with Loss of Consciousness of Unspecified Duration. -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). -Paranoid Schizophrenia (a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly, delusions and hallucinations are the two symptoms that can involve paranoia). Review of the resident's quarterly MDS dated [DATE] showed: -The resident was moderately cognitively impaired. -The resident had experienced delusions (perceptual experiences in the absence of real external sensory stimuli) within the seven-day look back period. -The resident had not exhibited any physical behaviors towards others. -The resident had exhibited other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) one to three days out of the seven-day look back period. Review of the resident's Care Plan dated 2/20/24 showed: -The resident had manifestations of behaviors related to his/her mental illness that may create disturbances that affect others including poor anger management. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had the potential to be physically aggressive towards others due to poor anger control with the flowing interventions: --Administer and monitor medications as ordered. --Assist resident in addressing root cause in behavior or mood as needed. --If 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. --The resident's triggers for physical aggression were amongst but not limited to other residents being verbally aggressive towards him/her. --Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document. --Assess and address for contributing sensory deficits. -The resident was places on a one-to-one (1:1-continuous observation of an individual resident for a period of time) until administrative staff could re-evaluate. 3. Review of an incident note from Resident #1's Electronic Medical Record (EMR) dated 2/19/24 at 9:12 P. M. completed by the Administrator showed: -Resident #1 had approached Resident #2 on the smoke porch. -Resident #1 hit Resident #2 in the face area after Resident #2 told Resident #1 to shut up. -No significant injury was noted at that time. -Resident #1 was moved to a different unit. Review of an incident note from Resident #2's EMR dated 2/19/24 at 9:14 P.M. completed by the Administrator showed: -Resident #2 had been seated on the smoke porch when Resident #1 approached him/her. -Resident #2 had told Resident #1 to shut the f*** up. -Resident #1 responded by hitting Resident #2 in the face area. -Resident #2 was evaluated and no significant injury was found. -Resident #2 had been sent tot the local hospital due to the incident involving the resident's head area. -All responsible parties were contacted. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an incident note from Resident #2's EMR dated 2/19/24 at 9:21 P.M. completed by Licensed Practical Nurse (LPN) B showed: -Resident #2 had been involved in an altercation with a resident on the smoke porch. -Resident #2 had been hit in his/her left eye. -LPN B escorted Resident #2 to the nurse's station to evaluate the resident. -No swelling or active bleeding were noted at that time. -The Director of Nursing (DON) and Administrator had been notified. -He/She sent Resident #2 to the local hospital for evaluation. Review of an investigation report dated 2/19/24 at 9:22 P.M. completed by the Administrator showed: -A physical aggression involving head incident had occurred on 2/19/24. -Resident #1 and Resident #2 were involved in the incident. -There were no staff witnesses to the incident. -Statements were received from both Resident #1 and Resident #2. -The residents' guardians had been notified of the incident on 2/19/24 at 8:00 P.M. -The facility physician was notified of the incident on 2/19/24 at 8:00 P.M. -Resident #1 and Resident #2 had been on the smoke porch. -Resident #1 said something that could not be understood to Resident #2. -Resident #2 responded verbally to Resident #1 and said Shut the f*** up b****h. -Resident #1 responded physically towards Resident #2 and punched him/her in the face. -There was no significant injury noted at the time. -Resident #1 and Resident #2 were separated after the incident. -Resident #1 was moved to a different unit after the incident. -There were no prior concerns between Resident #1 or Resident #2. -Medication reviews had been completed for Resident #1 and Resident #2. -Resident #1 was scheduled to see and counselor. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an after-visit summary from the local hospital dated 2/20/24 showed: -The resident's imaging was negative for traumatic injuries. -The resident was diagnosed with a facial hematoma (solid swelling of clotted blood within the tissues). Review of an alert note in Resident #1's EMR dated 2/20/24 at 9:38 A.M. completed by LPN A showed Resident #1 had been sent to the local hospital for a psychiatric evaluation related to the physical altercation towards Resident #2. Review of a health status note in Resident #1's EMR dated 2/20/24 at 7:40 P.M. completed by LPN C showed: -Resident #1 had returned from the local hospital. -No new orders were provided. -The resident resumed his/her 1:1 observation. During an interview on 2/22/24 at 11:54 A.M. Resident #1 said: -He/She did not respond to the question How are you doing? -He/She had a problem with Resident #2. -Resident #2 had told him/her to shut up. -He/She had felt threatened by Resident #2. -The resident started to fall asleep during the interview. NOTE: The resident was very difficult to understand throughout the interview. During an interview on 2/22/24 at 12:08 P.M. Resident #2 said: -He/She had been sitting on the smoke porch. -He/She had been hit in the left eye. -He/She was angry with Resident #1 due to the physical altercation. -He/She did not have any problems with Resident #1 in the past. -No other residents have tried to hit him/her in the past. During an interview on 3/1/24 at 1:45 P.M. Resident #2 said: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She told Resident #1 that his/her family member had married a black man and he/she did not like that. -Resident #1 hit him/her in response. -He/She was not afraid of Resident #1. -He/She had not been involved in any altercations with Resident #1 or any other residents in the past. -He/She enjoyed living at the facility and felt safe at the facility. Observation on 3/1/24 at 1:55 P.M. showed Resident #1 was still on 1:1 observation. Observation on 3/1/24 at 2:10 P.M. of the video footage on 2/19/24 of the smoke porch showed: -Resident #2 was sitting on a bench on the smoke porch. -Resident #1 went out onto the smoke porch and said something to Resident #2. -Resident #2 responded with verbal aggression towards Resident #1. -Resident #1 responded by punching Resident #2 one time in the face. -The altercation had ended after the punch to Resident #2's face. During an interview on 3/1/24 at 2:15 P.M. the Administrator said: -Resident #1 and Resident #2 had no recent history of behaviors towards each other or other residents. -The staff had intervened appropriately to the incident and would not have had them do anything differently. -He/She had started education on abuse/neglect, preventing aggressive behavior, and the new smoke porch rules following the incident. During an interview on 3/1/24 at 2:40 P.M. Certified Nursing Assistant (CNA) A said: -He/She had not been present at the facility during the altercation. -Resident #1 and Resident #2 did not have any history of altercations with each other or other residents. -He/She had been educated on abuse/neglect and how to diffuse aggressive behaviors. -There were also new smoke porch rules in place following the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #1 had also been moved to a different unit following the incident. During an interview on 3/1/24 at 3:16 P.M. LPN A said: -He/She had not been present at the facility during the altercation. -Resident #1 and Resident #2 did not have a history of physical aggression towards each other or other residents. -He/She had been educated on the new smoke porch rules, performing 1:1 observation, and abuse/neglect. -There would not have been any reason that Resident #1 or Resident #2 would not have been able to be left alone on the smoke porch. -The staff now had to be outside on the smoke porch with the residents and the smoke porch door remained locked until staff could be present on the smoke porch. During an interview on 3/1/24 at 3:25 P.M. CNA B said: -He/She was on a different unit with the incident happened. -He/She was getting ready for the 7:00 P.M. smoke break. -The incident happened around 10-15 minutes prior to the smoke break time. -He/She was unaware that an incident had occurred until he/she saw Resident #2 with a red eye and asked Resident #2 what had happened to cause the red eye. -Resident #2 said Resident #1 had hit him/her. -He/She reported the incident to the nurse. -The nurse was already ware of the incident when he/she told the nurse about the incident. -The residents had already been separated at that time. -He/She had been educated on abuse/neglect, the new smoke porch rules, and de-escalation tactics for residents exhibiting aggression toward others. During an interview on 3/1/24 at 3:44 P.M. LPN B said: -He/She had been informed that Resident #1 and Resident #2 had been fighting. -When he/she went to assess the situation, Resident #1 was already headed inside form the smoke porch and had separated him/herself from Resident #2. -He/She had told Resident #1 to go to his/her room and he/she had been placed on 1:1 observation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She assessed Resident #2's eye and did not note any serious injury. -He/She then informed management of the incident. -He/She sent Resident #2 to the local hospital for evaluation due to being hit in the face. -Resident #2's eye had been pink/red before being sent to the local hospital but had turned purple upon return from the hospital. -Resident #1 had been moved to a different unit. -When Resident #2 returned from the hospital he/she had started playing dominoes with other residents. -Resident #1 and Resident #2 had no history of altercations with each other or other residents. -He/She did not think the incident could have been prevented. -The residents had been safe to be with each other prior to the incident. -He/She had been educated on abuse/neglect and the new smoke porch rules. -He/She would not have done anything differently in that situation. MO00232091 MO00232092