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Form Approved OMB
No. 0938-0391

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	06/04/2024

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 - 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** 46519 Based on observation, interview, and record review, the facility failed to protect one resident (Resident #1) from physical abuse when a staff member threw a plastic meal tray at the resident, hitting the resident on his/her upper lip and causing the resident to go to the hospital and receiving eight stiches to the space between his/her lip and nose. Facility staff failed to protect three residents (Resident #2, #3, and #10) out of 10 sampled residents, from abuse by another resident. On 5/22/24, Resident #2 self-propelled him/herself towards Resident #10 unprovoked and struck him/her in the face causing his/her nose to bleed. On 5/28/24, Resident #2 called Resident #3 a racial slur and struck the resident. In response, Resident #3 struck Resident #2 multiple times, causing two skin tears and a knot on the resident's head. The facility census was 92. The Administrator was notified on 6/4/24 at 9:44 A.M. of an Immediate Jeopardy (IJ) Past Non-Compliance which occurred on 5/29/24. On 5/30/24, the facility Interim Director of Nurses (DON) reported to the Administrator. The facility in-serviced staff before the start of their next shift. CNA A was terminated. The IJ was corrected on 5/30/24. Review of the facility's policy titled Abuse and Neglect Policy, dated 5/29/24, showed: -The definition of 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. -It included verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. -Physical abuse was 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 included but was not limited to hitting, slapping, punching, biting, and kicking. 1. Review of Resident #1's Face Sheet showed he/she admitted to the facility with the following diagnoses: (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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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	-Vascular Dementia (a common form of dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses) caused by impaired supply of blood to the brain). -Primary Insomnia (a decreased ability to fall asleep and/or stay asleep). -Need for Assistance with Personal Care. Review of Resident #1's Annual Minimum Data Set (a federally mandated assessment instrument completed by facility staff for care planning), dated 3/21/24, showed: -The resident was severely cognitively impaired. -The resident had not exhibited any behaviors within the seven days look back period in which the assessment was completed. -The resident had clear speech. -The resident was usually able to make himself/herself understood (difficulty communicating some words or finishing thought, but able if prompted or given time). -The resident was able to understand others. Review of the resident's care plan, showed no care plan prior to 5/31/24 related to any resident behaviors. Review of the late entry nurse skin note, dated 5/29/24, showed: -Incident occurred, resident threw glass of water on staff member. -Staff member threw tray and accidentally hit resident above the lip and below nose causing a laceration which would need stiches. Review of an Admin/(Registered Nurse) RN Investigation, dated 5/30/24, showed: -The date the incident occurred was 5/29/24. -The incident involved Resident #1 and Certified Nurse Aide (CNA) A. -Resident #1 had been wandering on the unit with a drinking cup in his/her hand. -Resident #1 had been mumbling to himself/herself. -Resident #1 was observed walking towards CNA A pointing at the cup in his/her hand, nodding, and smiling. (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 approached CNA A and gestured like he/she was raising his/her arms up, but threw the contents of the cup onto CNA A's face. -CNA A was startled and unsure of what had been thrown on his/her face and responded by holding up a food tray that was in his/her hands. -CNA A stated, It must have come out of my hand and struck him/her, I didn't even know. -CNA A was then sent home. -Resident #1 had fallen backwards after being struck with the tray and fell on his/her buttocks. -Upon assessment. Resident #1 had a laceration to his/her upper lip with active bleeding. -Resident #1 had an irregular shaped linear laceration approximately four centimeters in length to his/her upper lip. -When first aid was administered the bleeding was controlled with a cloth and pressure. -After notifying the physician, an order was given to send Resident #1 to the emergency room for evaluation and treatment. -The resident was sent to the emergency room and returned to the facility at 2:10 A.M. on 5/30/24. -Resident #1 had eight nylon sutures placed to his/her upper lip with an order for an antibiotic ointment and oral antibiotic. -The surrounding skin of the sutures was edematous (swollen) and discolored after arriving back to the facility. -Resident #1 nodded yes when asked if he/she had pain and pain medication was given to the resident. -Resident #1 was unable to verbalize what had happened. -In conclusion to the investigation it was found CNA A showed poor judgement in response to the action of Resident #1 which caused bodily harm and needed to be terminated. -This altercation was determined as abuse. Review of the resident's hospital After Visit Summary, dated 5/30/24 at 1:45 A.M., showed: -Resident #1 had been seen due to a facial laceration. -Resident #1 had received eight sutures. Review of the resident's Psychosocial Post-Incident Impact Questionnaire, dated 5/30/24, showed the only response the resident gave was that he/she had not felt safe. (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 resident's Skin and Wound Evaluation, dated 5/30/24, showed: -The resident had a wound to his/her upper lip. -The wound measured 2.9 centimeters (cm) x 1 cm x 4 cm. Review of a witness Statement, dated 5/30/24 completed by CNA A, showed: -He/She first interacted with Resident #1 while completing resident rounds. -He/She had seen Resident #1 during these rounds. -He/She had gone behind the steam table to get a table for a different resident on the unit. -The steam table had trays on top of it. -While setting up the table he/she overheard Resident #1 speaking with CNA C. -He/She then turned around and saw Resident #1 approaching him/her. -Resident #1 yelled something. -Resident #1 had a cup in his/her hands and threw it in CNA A's face. -He/She closed his/her eyes not knowing what liquid had been thrown on his/her face. -Resident #1 yelled something again and thought the resident still had the cup in his/her hands. -He/She could not recall if he/she already had the tray in his/her hand or not but ended up throwing a tray in Resident #1's direction. -He/She walked away from Resident #1 wiping the liquid from his/her face. -He/She walked out onto the smoke patio as CNA C retrieved a towel for Resident #1. -He/She walked back into the unit and apologized to Resident #1. -He/She spoke to the charge nurse and was instructed to leave. During an interview on 5/30/24 at 1:46 P.M., CNA A said: -The altercation occurred on 5/29/24 at approximately 10:00 P.M. -He/She had seen Resident #1 at approximately 9:50 P.M. when performing face checks. -At that time, Resident #1 was lying in bed, and he/she had placed a cover over Resident #1. (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 had been standing behind a steam table preparing a table for a different resident on the unit. -He/She had seen Resident #1 speaking with CNA C, but could not determine what they were saying. -Resident #1 then started to approach him/her and threw a cup with an unknown liquid towards him/her. -In response to this, he/she threw a meal tray towards Resident #1. -He/She had not known the tray hit Resident #1 at first, because he/she was wiping the liquid from his/her eyes. -He/She had thrown the tray towards Resident #1 out of defense, but had not intended to hurt the resident. -He/She apologized to Resident #1 and left the unit. -He/She was told to go home after the altercation occurred and left the building around 10:59 P.M. -He/She had not participated in any resident care after the altercation occurred. -Resident #1 was known to be aggressive and had thrown things at other staff and residents before. -He/She was very remorseful of his/her actions and kept repeating that he/she had worked with this population frequently and he/she was appalled by his/her actions. -He/She had not responded to the situation appropriately. -He/She should have tried to re-direct Resident #1 and called for help. Review of a Witness Statement, dated 5/30/24 completed by CNA B, showed: -He/She had seen CNA A turning away from the resident and wipe away something from his/her eyes. -CNA A had not been able to see, because Resident #1 had thrown water in CNA A's face. -CNA A had been trying to put a tray down on the steam table and it slid off the steam table and hit Resident #1. -CNA A had not known the tray hit Resident #1. -The incident occurred around 10:00 P.M. -CNA A had been trying to place the tray on to the steam table and ended up hitting Resident #1 in the face. (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 fell back onto the floor and he/she noticed the resident was bleeding from his/her mouth. -He/She grabbed towels and a different shirt for Resident #1. -CNA A apologized to Resident #1 and walked out of the unit. During interviews on 5/31/24 at 11:43 A.M. and 12:36 P.M., CNA B said: -Resident #1 walked up to CNA A and threw water in his/her face. -CNA A had been standing behind the steam table when the water was thrown into his/her face. -From his/her point-of-view the incident had not seemed purposeful. -The incident happened really fast, within a minute, and the tray had barely tapped Resident #1. -CNA A hadn't hit the resident with the tray while the tray was still in CNA A's hands, the tray had left CNA A's hands when it hit the resident. -After the altercation occurred, he/she grabbed towels to put on Resident #1's face and a new shirt for Resident #1 to wear. -He/She also had to mop the floor due to the amount of blood that came from Resident #1's injury. -Resident #1 returned to the facility during the same shift and seemed to be acting at baseline. -Resident #1 had aggressive behaviors before this altercation, including hitting staff. -CNA A had not responded to Resident #1's actions appropriately. -CNA A should have tried to re-direct Resident #1 and determine what might have been the trigger to Resident #1's actions. Review of a Witness Statement, dated 5/30/24 completed by CNA C, showed: -He/She had been standing in the dining area when Resident #1 had turned the corner and was heading in his/her direction. -The resident had been upset about something and had asked Resident #1 what was wrong. -He/She could not understand what Resident #1 was saying. -Resident #1 had been pointing to the cup that he/she was holding. -He/She told Resident #1 that the cup in his/her hands had not belonged to CNA C. -Resident #1 then went around him/her and walked towards CNA A. (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 started to complain to CNA A and CNA A had asked him/her what was wrong. -Resident #1 pretended like he/she was going to throw the cup at CNA A and CNA A leaned back. -As CNA A moved upright then Resident #1 threw the water on him/her. -CNA A had been shocked at what Resident #1 had done and grabbed a food tray and hit the resident with it, but the resident had blocked the hit. -CNA A then lost control of the tray, when CNA A grabbed the tray again, he/she hit Resident #1 with the tray under his/her nose. -The nurse on the unit asked him/her what had been going on. -He/She told the nurse CNA A had hit Resident #1 with a tray and the resident was bleeding due to being hit. -The nurse returned to the office. -He/She walked towards Resident #1 and used a towel that CNA B had given him/her to help stop the bleeding. During an interview on 5/31/24 at 6:32 P.M., CNA C said: -The incident occurred around 10:00 P.M. on 5/29/24. -He/She had seen Resident #1 storm out of his/her room and had been mumbling something under his/her breath. -Resident #1 had a cup in his/her hands and Resident #1 was pointing at it. -He/She joked with Resident #1 stating that the cup had not belonged to CNA C. -Then Resident #1 pointed at CNA A and started to approach CNA A. -Resident #1 gestured like he/she was going to throw the cup at CNA A, but then had actually threw the cup at CNA A. -CNA A tried to block the cup with a tray that CNA A had in his/her hands, but ended up throwing it towards Resident #1. -CNA A had thrown the tray like a Frisbee. -He/She had not been able to determine whether or not CNA A had purposefully thrown the tray at Resident #1. -He/She went to Resident #1 after the tray had hit him/her and Resident #1 was bleeding a lot. (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 tried to stop the bleeding and left the unit. Once back on the unit, Resident #1's wound had stopped bleeding. -CNA A had not responded appropriately to Resident #1's action. -There would be no reason for any item to be thrown at a resident in response to a resident's behaviors. -CNA A should have removed himself/herself from the situation and tried to determine what Resident #1 might have needed. During an interview on 6/5/24 at 9:45 A.M. Registered Nurse (RN) A said: -He/She had been getting medications ready on the unit when the incident occurred between Resident #1 and CNA A. -He/She had not seen the altercation, but had been informed immediately afterwards. -He/She had seen CNA C throw his/her hands up in the air, so he/she exited the booth and tried to figure what happened. -He/She had seen the resident on the floor with a towel covering his/her face. -He/She had been told Resident #1 had been joking around and threw water at CNA A. -CNA A had told him/her that he/she had not intended to hit Resident #1 with a tray. -CNA A stated that he/she was irritated and had attempted to put the tray up on the steam table but ended up throwing it towards the resident. -He/She thought CNA A's actions were unlike him/her and had not thought CNA A meant to hurt Resident #1. -CNA C had told him/her that CNA A had meant to throw the tray at Resident #1. -He/She had instructed staff to write statements related to what happened. -He/She told CNA A to exit the unit. -He/She sent Resident #1 to the hospital and the resident's came back at 2:10 A.M. on 5/30/24. -He/She thought the resident felt bad about joking around with CNA A. -Resident #1 had been fine for the remainder of the shift. -Resident #1 tended to wander through the night but exhibited more behaviors during the day shift. -CNA A's response to the resident's action was not appropriate. (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 would have tried to prevent the resident's action from happening. Observation and interview on 5/31/24 at 9:45 A.M., the resident said: -He/She could not remember how he/she had been injured. -He/She had eight sutures under his/her nose above his/her lip. The area was reddened and slightly swollen with dried blood around the site. During an interview on 6/4/24 at 11:08 A.M., Guardian A said: -He/She was told that Resident #1 had thrown water on a staff member and that staff member threw a tray back at the resident. -The staff member should not have thrown the tray at the resident. -The staff member should have known his/her limits when working with this type of resident population and controlled his/her own behavior. During an interview on 6/4/24 at 11:18 A.M., Nurse Practitioner (NP) A said: -He/She had been made aware of the incident between the resident and CNA A on the night of the incident. -He/She was told a CNA had been aggressive towards the resident, but was unsure of what had happened. -He/She knew that physical contact had been made and the resident needed to be sent to the emergency room for treatment. -The staff person should not have thrown a tray at the resident. During an interview on 6/4/24 at 2:42 P.M. the Director of Nursing (DON) said: -CNA A had worked with the resident prior to the incident. -When he/she was first notified of the incident, the staff had made it seem like it had just been horseplay and the resident had been injured through that with a tray. -He/She had been told CNA A had been specifically involved, so he/she had sent CNA A home. -The injury Resident #1 received was not consistent with horseplay. -CNA A's first statement had been too vague, so they needed CNA A to complete a new statement. -CNA A was brought in and told the following: --There were three trays on a beside table near the steam table. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	--CNA A had been behind the steam table and was getting something for a different resident. --CNA A had made it sound like the tray had slid off and hit Resident #1, but as CNA A continued to explain, it was determined that it had been thrown more like a Frisbee. --CNA A had not been able to remember if a tray had been in his/her hands when Resident #1 threw the water at him/her. -CNA A's decision to throw the tray at Resident #1 had not been rational. -He/She would have expected CNA A to have ducked and to determine the reasoning behind Resident #1's action. -CNA A could have walked away if he/she felt like his/her response would not have been appropriate. -CNA A should have also asked for help from the other staff on the unit. -Nothing should ever be thrown at a resident regardless of a resident's action or behavior. During an interview on 5/31/24 at 11:06 A.M., the Administrator said that the employee-to-resident altercation was determined to be abuse. 2. Review of Resident #2's Face Sheet showed he/she admitted to the facility with the following diagnoses: -Early Onset Alzheimer's Disease (a progressive mental deterioration that can occur in middle or old age, due to generalized degeneration of the brain). -Insomnia. -Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). -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). -Delusional Disorders (a type of psychotic disorder with the main symptom of the presence of one or more delusions) -Dementia. -Cognitive Communication Deficit (an impairment in organization/thought organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). -Personal History of Traumatic Brain Injury (TBI- brain dysfunction caused by an outside force). -Unspecified Psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with external reality). (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 Quarterly MDS, dated [DATE], showed the resident was severely cognitively impaired. Review of Resident #10's Face Sheet showed he/she admitted to the facility with the following diagnoses: -Dementia. -Insomnia. -Anxiety Disorder. Review of Resident #10's Quarterly MDS, dated [DATE], showed the resident was severely cognitively impaired. Review of an Admin/RN Investigation, dated 5/22/24, showed: -Resident #10 and Resident #2 had been involved in physical aggression involving the head. -Resident #2 had been the aggressor and Resident #10 the victim. -On 5/22/24 staff observed Resident #2 self-propel towards the table where Resident #10 had been sitting. -Resident #2 struck Resident #10 suddenly in the nose. -Resident #10 sustained an injury to his/her nose. -Resident #10 had been sent to the emergency room for evaluation due to taking a blood thinner. -Resident #10 was typically non-verbal, but could respond to yes/no questions and would follow directions. -Staff that observed the altercation had not seen any triggers that would have caused Resident #2 to strike Resident #10. -Upon interview of Resident #2, the resident remembered hitting someone after being called a bitch. -Resident #2 had a history of aggression towards others. During an interview on 6/4/24 at 2:18 P.M. Resident #10 said he/she felt safe at the facility. 3. Review of Resident #3's Face Sheet showed he/she admitted to the facility with the following diagnoses: -Diffuse traumatic brain injury (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Paranoid Schizophrenia (a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly, delusions and hallucinations are two symptoms that can involve paranoia). Review of Resident #3's Quarterly MDS dated [DATE] showed: -Resident #3 had moderately impaired cognition. During an interview on 5/31/24 at 10:12 A.M. Resident #3 said: -The altercation started when Resident #2 was cursing at others and then directed the cursing towards Resident #3. -He/She had told Resident #2 that he/she could not talk to people like that. -Resident #2 then got up and punched Resident #3 in the face. -In response Resident #3 punched Resident #2 back underneath his/her right eye, bridge of his/her nose, and lower left jaw. -Staff intervened after that. -He/She had punched Resident #2 in self-defense. -There were no other issues after that altercation. -He/She had received no injuries during the altercation, but had taken some pain medication. -He/She had been in a previous physical altercation with Resident #2. -He/She was not sure what interventions were put in place after the first altercation. -He/She was not afraid of Resident #2. -Resident #2 had been in other physical altercations with other residents. During an interview on 5/31/24 at 10:32 A.M., CNA D said: -He/She had been asked to go relieve the staff person that was monitoring Resident #2. -Resident #3 approached the table where he/she had been sitting with Resident #2 and introduced himself/herself. -Resident #2 turned to Resident #3 and called him/her a racial slur. -Resident #3 responded to Resident #2 and said, You can't call people that. -Resident #2 then repeated himself/herself and CNA D realized that something was about to go down. (continued on next page)

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 06/04/2024
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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(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 attempted to pull Resident #2 away from the table, but was unsuccessful. -Resident #2 was able to get to Resident #3 and punched Resident #3. -Resident #3 responded to Resident #2 by punching Resident #2 back. -Resident #3 continued to punch Resident #2 and in doing so hit him/her and took both Resident #2 and him/her to the ground. -He/She then called out a Code [NAME] (a behavioral emergency). -There had been another staff person on the unit and had not intervened. -The other residents on the unit started to come towards the altercation. -He/She tried to get Resident #3 off Resident #2, but was unsuccessful. -He/She got elbowed to the back of his/her head, so he/she then tried to remove Resident #2 from the altercation, which again was unsuccessful. -The other staff person then called a Code Green. -Less than a minute later Resident #2 and Resident #3 were separated. -He/She took Resident #2 over to the nurse's station to be assessed as Resident #2 had blood coming from his/her nose and mouth. -It was determined Resident #2 needed to go to the hospital, so he/she stayed with Resident #2 until emergency services arrived. -He/She then gave a statement related to the incident and went home. -He/She had never worked on the unit before. During an interview on 5/31/24 at 11:48 A.M., CMT A said: -He/She had been the staff person assigned to the locked unit when the altercation between Resident #2 and Resident #3 occurred. -He/She had not seen the beginning of the altercation. -He/She had been passing out cigarettes at the start of the altercation. -By the time he/she had looked over to Resident #2 and Resident #3, the residents were already in a fist fight. -He/She had called a Code [NAME] before going over to the altercation. (continued on next page)

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 06/04/2024
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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/She saw Resident #2 laying on the ground while Resident #3 was punching Resident #2. -He/She then leaned over Resident #3 and tried to pull Resident #3 off of Resident #2 and told Resident #3 to stop hitting Resident #2. -That was when the Code [NAME] team arrived, and Resident #2 and Resident #3 were separated. -He/She had been told that Resident #2 called Resident #3 a racial slur. -Resident #2 and Resident #3 had been in a physical altercation before. -Resident #3 had been moved to the locked unit when the first altercation occurred. -Resident #2 had moved down to the unit within the last month due to getting into altercations on other units. -Resident #2 had been in a previous altercation on the locked unit. -Resident #2 had been put on 1:1 monitoring, due to an altercation prior to the one on 5/28/24. -Resident #3 had not had any altercations with other residents. -He/She only remembered seeing blood on Resident #2's forehead after the altercation. -He/She had not heard an argument or seen any triggers that would have initiated the altercation. -Resident #2 was known for using derogatory language. -Resident #2 would say the derogatory words under his/her breath, but just loud enough for others to hear. Review of Resident #4's Quarterly MDS, dated [DATE], showed the resident was cognitively intact. During an interview on 5/31/24 Resident #4 said: -He/She had heard a Code [NAME] called. -Resident #2 called Resident #3 a racial slur then punched Resident #3. -Resident #3 responded by hitting Resident #2 back. -CMT A pulled Resident #3 off of Resident #2. -Resident #2 had never called him/her any names. -Resident #2 was known to call other staff and resident names. -He/She was unsure if Resident #2 had been involved in any other altercation. (continued on next page)

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 06/04/2024
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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(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 felt a lot safer since Resident #2 was no longer on the unit. During an interview on 5/31/24 at 3:25 P.M. Resident #2 said: -He/She had fallen off the bed and that was how he/she had sustained the skin tears and injury to his/her head. -Resident #3 had started the fight with him/her. -He/She hit Resident #3 in the jaw and nose. -He/She had not been in any altercation before the altercation on 5/28/24 with Resident #3. -He/She had not been in any physical altercations with other residents. -He/She had not remembered if any words were exchanged between Resident #3 and him/her during the altercation. -He/She felt safe at his/her new facility. Observation on 5/31/24 at 3:25 P.M., showed Resident #2: -with a small, penny sized, pink/red bump to his/her forehead just above his/her right eye; -a skin tear to his/her right proximal elbow that was pink and beginning to scab over; and -a skin tear to his/her left posterior hand that had been scabbed over but was red and swollen surrounding the wound site. During an interview on 6/4/24 at 11:18 A.M., NP A said: -He/She had been made aware of the altercation between Resident #2 and Resident #3. -All he/she had been informed of was the altercation was physical. -When he/she was informed of the altercation, the staff also requested a PRN medication for Resident #2. -He/She was unsure about Resident #2's altercation history. -Resident #2 was known to be verbally aggressive towards staff and other residents. -Resident #3 had been aggressive towards staff before. During interviews on 6/4/24 at 2:42 P.M. and 6/7/24 at 9:37 A.M. the DON said: -He/She had de-briefed with staff after each altercation that Resident #2 had with the other residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident #2 had a TBI and needed increased monitoring overtime. -All the resident-to-resident altercations that Resident #2 had been involved in were behavioral incidents and not abuse. -Resident #10 and Resident #2 had not had any issues prior to their altercation and a root cause was not able to be determined outside of Resident #2 being impulsive. During an interview on 6/7/24 at 10:12 A.M. the Administrator said: -All of the resident-to-resident altercations that Resident #2 had been involved in were behavioral incidents and not abuse. -The root cause of all the resident-to-resident altercations stemmed from the derogatory language that Resident #2 used. MO00236823 and MO00236892