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	06/29/2026

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** Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident #6) was free from abuse when on 5/28/26 Resident #6 was hit by Resident #7 causing a skin tear to Resident #6's right eyebrow area out of 13 sampled residents. The facility census was 60 residents.On 6/29/26, the Administrator was notified of past non-compliance which occurred on 5/28/26. Immediate interventions were put into place for both Resident #6 and Resident #7. All staff received education prior to their next working shift. The deficiency was corrected on 5/29/26. Review of the facility's policy titled Abuse and Neglect Policy dated 6/12/2024 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.-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 manner whatsoever mistreating or maltreating a resident in brutal or inhumane manner.-Physical abuse also included, but was not limited to, hitting, slapping, punching, biting, and kicking. 1. Review of Resident #7's admission Record showed he/she admitted to the facility with a diagnosis of epilepsy (a seizure disorder). Review of Resident #7's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff) dated 4/14/26 showed:-The resident was cognitively intact.-The resident did not exhibit any behavioral symptoms within the seven-day look back period. Review of Resident #6's admission Record showed he/she admitted to the facility with a diagnosis of bipolar disorder (mood disorder that can cause intense mood swings). Review of Resident #6's quarterly MDS dated [DATE] showed:-The resident was cognitively intact.-The resident did not exhibit any behavioral symptoms within the seven-day look back period. Review of an Admin/Registered Nurse (RN) Investigation dated 5/28/26 showed:-The incident occurred on 5/28/26.-The incident type was physical aggression involving the head.-Resident #6 and Resident #7 were the involved residents.-Resident #12 witnessed the incident.-The investigative narrative was as follows:--Resident #6 was upset during mealtime that he/she did not get a peanut butter and jelly sandwich.--Resident #6 left the dining room and walked to the smoke deck.--Resident #7 had been standing by the smoke deck door.--Resident #6 became more agitated when he/she could not go out the door due to it being locked.--Resident #7 responded to this by stating I cannot help that the door is locked.--Resident #6 then began to mumble stuff under his/her breath and walk back to the dining room.--Resident #7 followed Resident #6 and they exchanged words.--Resident #6 then called Resident #7 a derogatory name which caused Resident #7 to become upset.--Resident #6 then said, what are you going to do about it?--Resident #6 walked closer to Resident #7 and swung at Resident #7.--Resident #6 missed Resident #7 and Resident #7 responded by swinging at Resident #6.--Resident #7 made contact with Resident #6's right eye and nose.--Staff responded to the incident once they heard the noise and separated the residents.--Resident #6 initially refused to be assessed. --Once Resident #6 calmed down, he/she let the nurse look at his/her face.--Two small skin tears were noted to Resident #6's (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
	265532	A. Building B. Wing	06/29/2026

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	right eyebrow.--The skin tears were cleaned and steri-strips (thin adhesive strips which can be used to close small wounds) were placed over the wounds. Review of Resident #6's Skin Check dated 5/28/26 at 7:14 P.M. showed:-The resident had a new skin issue located to his/her right eye.-The issue type was a skin tear.-The resident was in pain.-The interventions included to medicate after dressing changes. Review of Resident #6's Behavior Note dated 5/28/26 at 9:20 P.M. showed:-At approximately 6:48 P.M. Resident #6 began arguing with another resident.-Resident #6 was agitated from dinner when he/she did not receive a peanut butter and jelly sandwich that he/she thought had been ordered.-Resident #6 walked to the smoke deck and was upset that it was locked.-Resident #6 wanted another resident to help him/her get outside to smoke a cigarette.-The resident told Resident #6 that he/she was unable to help Resident #6 outside.-This caused Resident #6 to have increased agitation.-Resident #6 then began mumbling under his/her breath as he/she was walking back to the dining room.-Both residents started to exchange words.-Resident #6 then swung at the other resident.-Resident #6 missed but the other resident swung back at Resident #6.-The other resident made contact with Resident #6's right eye and nose.-Staff then separated the residents.-Resident #6 refused for the nurse to assess him/her.-Eventually the nurse was able to cleanse the wounds and placed steri-strips on the wounds.-The resident complained of 8/10 aching/throbbing pain on the pain scale (aero as no pain and ten as the worst pain imaginable) where the contact was made to his/her face.-Pro re nata (PRN- as needed) pain medication was given, and a cold compress was applied. Review of Resident #7's Behavior Note dated 5/28/26 at 9:36 P.M. showed:-At approximately 6:48 P.M. Resident #7 began arguing with another resident.-The other resident wanted him/her to help the other resident outside to light a cigarette.-Resident #7 told the other resident that he/she was unable to help the other resident get outside.-This caused increased agitation.-The other resident started mumbling under their breath and was walking back to the dining room.-Both residents started to exchange words.-The other resident swung at Resident #7 and missed.-Resident #7 responded by swinging back at the other resident, making contact with the other resident's right eye and nose. During an interview and observation on 6/29/26 at 1:33 P.M. Resident #6 stated:-He/She and Resident #7 were arguing.-He/She called Resident #7 a bitch, which he/she thought was not derogatory.-Resident #7 then pushed him/her to the ground and punched him/her in the face/forehead area.-The staff then separated him/her from Resident #7.-He/She was injured from getting hit in the face.-The nurse had to apply a cold compress and steri-strips to his/her injury.-He/She had no prior history of issues with Resident #7.-He/she had a pink scar above and below his/her right eyebrow, which was where he/she had been injured in the incident. During an interview on 6/29/26 at 1:55 P.M. Resident #7 said:-He/She was unsure of what incident everyone was asking about.-Once remembered, he/she recalled the incident.-He/She said that Resident #6 had called him/her a racial slur which made him/her angry.-Resident #6 swung first and he/she dodged the hit.-He/She then swung at Resident #6 and hit Resident #6 in the eye area. Review of Resident #12's quarterly MDS dated [DATE] showed the resident had moderately impaired cognition. During an interview on 6/29/26 at 2:02 P.M. Resident #12 said:-Resident #6 and Resident #7 were arguing.-Resident #6 then tried to hit Resident #7.-Resident #7 dodged the swing.-Resident #7 then hit Resident #6 in the face.-Staff then separated the residents.-Resident #6 had blood on his/her face after being hit by Resident #7. During an interview on 6/29/26 at 3:35 P.M. Certified Medication Technician (CMT) A and Licensed Practical Nurse (LPN) A said:-There were no staff witnesses to the altercation.-They were both at the facility at the time of the altercation but had not been involved in the incident.-They had been told that Resident #6 and Resident #7 had been arguing which escalated into a physical altercation.-Resident #6 had been injured during the altercation.-Hitting someone would be considered physical abuse.-They would consider the altercation that occurred on 5/28/26 between Resident #6 and Resident #7 as abuse. During an interview on 6/29/26 at 3:52 P.M. the Director of Nursing (DON) said:-He/She had completed the investigation related to the altercation that occurred on 5/28/26.-He/She was not present at the facility when the altercation occurred.-He/She had been (continued on next page)

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	06/29/2026

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	called about an altercation that had occurred and came up to the facility.-To his/her knowledge, the following occurred:--Resident #6 was upset about dinner.--Resident #6 called Resident #7 a derogatory name.--Resident #6 then swung at Resident #7 but missed.--In response, Resident #7 swung at Resident #6 and struck Resident #6 in the face.--Resident #6 had a skin tear to his/her right eyebrow.--Resident #6 refused treatment until he/she came up to the facility.--He/She applied steri-strips to Resident #6's skin tear which was the only intervention that was needed.-The root cause of the altercation was as follows: --Resident #6 was upset about dinner, then when Resident #6 could not go out to smoke this caused increased agitation.--Resident #6 then used derogatory language towards Resident #7 which then caused the physical altercation.-He/She had educated Resident #6 on the use of derogatory language.-He/She did not think that abuse had occurred at first.-He/She thought physical abuse was harming another person knowing that they were causing harm.-He/She did not think that Resident #6 or Resident #7 was in the right state of mind to understand what they were doing.-Once told that Resident #7 intended to hit Resident #6, he/she had changed his/her mind and stated that the incident would be considered as abuse. 3052940