STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265597	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop at Blue River, The	10425 Chestnut Dr Kansas City, MO 64137

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 prevent physical abuse for one sampled resident (Resident #1) out of four sampled residents. On 4/26/26 at approximately 11:00 A.M. Resident #2 who has a history of being physically aggressive to residents and staff, struck Resident #1 on the head with a chair resulting in a red and raised area on his/her head and a small scratch on the bridge of his/her nose which required first aid. The facility census was 143 residents.The Administrator was notified on 5/1/26 of Past Non-Compliance which occurred on 4/26/26. An all-staff in-service on Abuse and Neglect and Resident's Rights. Both residents were also set up for additional psychiatric services and therapy. The deficiency was corrected by 4/27/26. Review of the facility policy for Abuse and Neglect revised 8/2020 showed:-The purpose of the policy was to establish a program to prevent resident mistreatment and abuse.-The facility was committed to keeping all residents safe from abuse while in the facility including safe from resident-to-resident abuse.-The residents had the right to be free from abuse by others including other residents.-Physical abuse was the willful infliction of bodily injury causing injury. 1. Review of Resident #1's Facility admission Record showed he/she was admitted [DATE] with the following diagnoses:-Psychotic Disorder with Delusions (a type of serious mental illness (psychotic disorder) characterized by the presence of one or more fixed, false beliefs (delusions) that persist for at least one month).-Paranoid Schizophrenia (a chronic mental health condition characterized by intense, irrational suspicion and distrust of others (paranoia), accompanied by delusions and auditory hallucinations).-Anxiety Disorder (mental health conditions characterized by persistence, excessive fear or worry that interferes with daily life, functioning, and relationships).-Right Below the Knee Amputation. Review of Resident #1's Nursing Care Plan dated 2/10/26 showed:-The resident had been involved in a physical altercation months prior when he/she inserted himself/herself into an altercation between two other residents.-The facility staff was to give the resident as many choices in cares and activities as possible.-The staff was to encourage the resident to verbalize distress.-The staff was to respond to the resident with empathy and respect.-The resident was seeing behavioral health services in order to provide appropriate assessment and treatments. Review of Resident #1's quarterly Minimum Data Set-(MDS-a federally mandated assessment tool completed by facility staff and used for care planning) dated 3/26/26 showed:-Was cognitively intact.-Had issues focusing his/her attention, was easily distracted, had disorganized thinking, had rambling talk with unclear thoughts and ideas, and irrelevant conversation.-Had delusions.-Rejected cares daily. Review of Resident #2's Facility admission Record showed he/she was admitted on [DATE] with the following diagnoses:-Chronic Pulmonary Edema (one-term, gradual buildup of fluid in the lung's air sacs (alveoli), usually caused by ongoing conditions like congestive heart failure or kidney disease).-Dementia (a progressive decline in mental ability-including memory, thinking, and reasoning-severe enough to interfere with daily life).-Diabetes (a chronic metabolic disease characterized by high blood glucose (sugar) levels, occurring when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it makes). Review of Resident #2's Nursing Care Plan dated 11/6/25 showed:-He/she (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had the potential to demonstrate physical behaviors as he/she had hit other residents and been verbally aggressive towards facility staff and other residents.-The staff was to analyze key times, places, circumstances, triggers and what de-escalates the resident's behaviors and document them.-The staff was to give the resident as many choices as possible about cares and activities.-When the resident became agitated, the staff was to intervene before he/she escalated by guiding him/her away from the source of distress, engage him/her calmly in conversation and if the resident's response was aggressive, staff was to walk calmly away and approach the resident later. Review of Resident #2's annual MDS dated [DATE] showed:-He/she had moderate cognitive impairment.-He/she showed physical behaviors such as hitting, kicking, scratching and/or grabbing one to three days were week during the look-back period.-He/she showed verbal behaviors such as swearing, threatening, screaming, and yelling one to three days per week during the look-back period. Review of the Facility Resident Altercation Investigation dated 4/26/26 at 11:00 A.M., showed:-While in the Dining Room Resident #2 approached Resident #1 about talking to the opposite sex and informed the opposite sex that he/she was married and was committing adultery.-Resident #2 stated Resident #1 did not appreciate this.-Resident #2 then proceeded to pick up a Dining Room chair and hit Resident #1 on the top of head with the chair.-Resident #1 stood up when Resident #2 picked up the chair and upon having been hit, both residents fell to the floor due to both residents primarily ambulating via wheelchair due to poor gait.-Staff promptly attended to the residents separating them and returning them to their respective areas for safety.-Resident #2 was temporarily placed on one-to-one staff observation during the investigation and until he/she showed stability.-The residents involved were interviewed as well as staff who were involved.-The resident's medications were reviewed with physicians.-The root cause analysis was completed.-Resident #1 refused to go to the hospital so was treated in house.-Resident #2 received same day hospital psychiatric evaluation and returned the same day without new orders.-An emergency care plan meeting was conducted with Resident #2's Durable Power of Attorney (DPOA). Review of Resident #1's Nursing Progress Note dated 4/26/26 at 12:11 P.M., showed:-He/she states he/she was in the Dining Room when he/she saw Resident #2 talking to a person of the opposite sex.-Resident #1 stated to Resident #2 that he/she shouldn't talk to people of the opposite sex in that way as it was considered adultery.--Resident #1 then said that Resident #2 went and got a dining room chair, dragged it to him/her and after they conversed, hit him/her on top of the head with the chair.-They then wrestled on the ground for a short time and staff separated them.-A skin assessment was completed, and the resident had a knot on the top of his/her head and a red spot on the bridge of his/her nose.-The resident did not want to go to the hospital saying he/she was okay. Review of Resident #2's Nursing Progress Notes dated 4/26/26 at 11:52 A.M., showed:-He/she got into an altercation with another resident.-Resident #2 stated that Resident #1 was yelling that he/she was cheating on his/her spouse and stated Resident #1 came up and pushed him/her down.-He/she stated that he/she was defending himself/herself, picked up a dining room chair and threatened to throw the chair at Resident #1.-The staff immediately separated the two residents.-The staff did a skin assessment and sent him/her out to the hospital for evaluation and treatment.-The resident showed no bumps, bruises or injuries. Review of Resident #1's Weekly Skin Check dated 4/26/26 at 12:30 P.M., showed:-He/she had a half-dollar sized knot on the top of his/her scalp.-He/she had redness across the bridge of his/her nose. -He/she showed a pain level of three on a scale of one-10 on his/her head.-He/she stated the pain was dull.-A cold compress was applied and the resident received two 500 milligrams (mgs) Tylenol (an analgesic medication used for minimal to moderate pain) by mouth at 12:30 P.M. Review of Resident #1's Medication Administration Record (MAR) dated 4/26/26 showed he/she received 500 mgs of Tylenol by mouth at 12:30 P.M. During an interview on 5/1/26 at 1:40 P.M., Certified Nursing Assistant/Central Supply CNA/CS A said:-He/she was standing outside CS door facing directly into the Dining Room at the coffee set up and in view of both tables. -Resident #1 and Resident #2's tables were next to each other. -He/she saw Resident #2 turn around and say (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	something to Resident #1.-Neither resident appeared to be yelling at that point.-The next thing he/she knew Resident #1 turned around and both stood up from their wheelchairs.-When he/she saw the residents rise, he/she began getting closer and heard Resident #2 say, I'll hit you with this chair, however there was no chair in the resident's hands yet.-CNA/CS A then began running towards the residents as Resident #1 eagled spread his/her arms and lunged at Resident #2.-At that point, Resident #2 picked up a dining room chair and hit Resident #1 on top of the head. During an interview on 5/1/26 at 1:55 P.M., Licensed Practical Nurse LPN A said:-By the time he/she got involved, the altercation was over as he/she came to the Dining Room after they paged the nurses overhead. -He/she performed the assessment on Resident #1 and noted a small, reddened bump on the top of the resident's head that dissipated as well as a small red mark on the bridge of the nose.-He/she believed the resident got one dose of Tylenol for some minor head pain. Observation and interview on 5/1/26 at 2:30 P.M., Resident #1 showed a small spot on the bridge of his/her nose which appeared to be completely healed and a small slightly raised area on the top of his/her head near middle/right with no redness noted.-The resident said:--He/she was in the dining room getting coffee and Resident #2 was talking to a staff member of the opposite sex.--As he/she rolled his/her wheelchair past Resident #2, he/she said, That's adultery because he/she was a Chistian and believed that's a sin.--He/she also said that when you sin, demons come to get you, and Jesus has to deliver you. --He/she shouldn't have said that though, because it made Resident #2 mad.--Resident #2 started yelling that he/she was going to hit him/her with a chair, so he/she lunged at him/her.--They both went to the ground, and were wrestling, when Resident #2 picked up the chair and hit him/her on the head with the chair. --Resident #2 also scratched his/her face and messed my face all up.--He/she didn't want it to happen again. --He/she sees these demons and angels and the demons sometimes make him/her say the wrong things to people. During an interview on 5/1/26 at 2:45 P.M., Resident #2 said:- It was just two patients fighting, that's all.- I don't have anything else to say about it.- It was self-defense because he/she was saying things to me that he/she had no business saying.- He/she was just staying away from him/her. Review of Resident #3's quarterly MDS dated [DATE] showed he/she was cognitively intact. During an interview on 5/1/26 at 3:15 P.M., Resident #3 said:-Resident #1 was always walking around saying crazy things to people and sticking his/her nose in where it didn't belong.-He/she doesn't know why they let people like Resident #1 in the facility as all they do is cause trouble.-Resident #1 says things just to make people mad.-He/she wants Resident #1 and anyone else like him/her out of the facility. During an interview on 5/1/26 at 4:00 P.M., the Director of Nursing (DON) and Administrator said:-The resident-to-resident abuse happened.-Resident #1 has schizophrenia and some delusions which caused him/her to talk continually saying some non-sensical things and other things that made sense.-Resident #1 also talked to things or people who weren't there which could make residents believe he/she was saying things to them that could be upsetting. During an interview on 5/6/26 at 3:45 P.M., Dietary Aide A said:-On 4/26/26 at around 11:00 A.M., he/she saw Resident #1 and Resident #2 exchanging words after Resident #1 got his/her coffee.-Once Resident #1 rolled his/her wheelchair over towards the tables after getting coffee and more words were exchanged, he/she heard Resident #2 say to Resident #1, I'm going to hit you with the chair.-Resident #2 then proceeded to pick up a dining room chair and hit Resident #1 on top of the head with it.-Both residents ended up on the floor and staff separated them and called for help. 2994390