STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265721	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gregory Ridge Health Care Center	7001 Cleveland Avenue Kansas City, MO 64132

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** 46890 Based on observation, interview and record review, the facility failed to keep one sampled resident (Resident #5) free from physical abuse when on 6/26/24 the facility Dietary Manager (DM) hit the resident in the head out of 9 sampled residents. The facility census was 110 residents. On 6/27/24, the facility Administration was notified of the past noncompliance which occurred on 6/26/24. Facility staff were educated on abuse and neglect protocols and customer service. The deficiency was corrected on 6/26/24. Review of the facility policy titled, Behavioral Emergency Policy, revised 1/5/23 showed: - Provide safe treatment and humane care to the resident in a behavioral crisis to outline steps to follow to correctly care for the resident in a behavioral crisis, to ensure that the resident is not being coerced, punished or disciplined for staff convenience. Review of the facility policy titled, Abuse and Neglect Policy, revised 4/30/24 showed: -Mistreatment, neglect, or abuse of residents is prohibited by the facility. This includes physical abuse, sexual abuse, verbal abuse, mental abuse and involuntary seclusion. -This Facility is committed to protecting our residents from abuse by anyone. 1. Review of Resident #5's facility face sheet showed he/she was admitted to the facility on [DATE] with the following diagnosis: - Alcohol dependence with alcohol induced mood disorder. -Major depressive disorder. Review of the resident's Annual Minimum Data Set (MDS-a federally mandated assessment instrument completed by the facility staff for care planning), dated 5/5/24, showed: -He/She was cognitively intact. -He/She had no behaviors during the look back period. (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	Review of the resident's undated care plan showed: -He/She had potential to be physically aggressive towards others. -Staff were to intervene before resident agitation escalates. -Staff were to provide protective oversight. -Staff were to intervene as necessary to protect the rights and safety of others. Approach and speak to resident in a calm manner. Remove the resident from the situation and take to alternate location as needed. Observation of the facility camera footage on 6/27/24 at 11:14 A.M., showed: -The footage took place in the dining room. -The DM was standing on the right side of the resident who was seated in a wheelchair. -Certified Nursing Assistant (CNA) A was standing in front of the resident. -Medical Records Manager was standing behind the resident. -The resident swung and hit the DM. -The DM swung at the resident hitting him/her at least once on the left side of his/her face/head. Review of the Medical Records Manager written Statement, dated 6/26/24 showed: -A Code [NAME] (a behavioral emergency and/or incident needing physical support and presence when an individual poses a threat to himself/herself or others) was called to 3 E. -The resident was verbally arguing with the pastor in the dining area about scripture. -He/She had asked the resident to come with him/her and he/she did. -The resident then turned around in the hall and went back to the dining area. -The DM had arrived and then the resident hit the DM. -The DM then punched the resident. During an interview 6/27/24 at 11:50 A.M., the Medical Records Manager said: -A Code [NAME] was called to 3 E on 6/26/24 at approximately 10:30 A.M. -The resident was in the dining room yelling at the pastor about scriptures. -He/She asked the resident to come with him/her to try and deescalate the situation. (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 did follow him/her out of the dining room but then turned around and started back to the dining room yelling statements I pay to live here I can go wherever I want. -The resident return to the dining room where the DM had arrived. -The DM was talking to the resident and was trying to calm the resident down. The resident continued to argue with the DM and said I pay rent to live fucking here and can go where I want. I feel like hitting you get the fuck out of my way! - The resident then swung and the DM. The DM swung with closed fists at the resident and hit him/her on the left and right side of the head. -The DM and resident were separated and the DM was escorted out of the building and told to leave the premises immediately. Review of the DM written Statement, dated 6/26/24 showed: -He/She heard the Code [NAME] over walkie talkie. -He/She responded to 3 N and when he/she got there, the resident was yelling and cussing at the Medical Records Manager. -He/She tried talking to the resident and tried to moving him/her but the resident refused and had come back cussing and yelling. -He/She had calmly asked the resident to calm down and to sit down and talk. -The resident had made statement of feeling like he/she wanted to hit something and to get of his/her way. -He/She had told resident to go ahead that he/she was not in residents way. The resident then hit him/her, and he/she reacted back. During an interview 6/27/24 at 2:12 P.M., the DM said: -He/She had responded to a Code [NAME] in the dining room. -The resident was yelling and cussing. -He/She had tried to calm the resident down. -The resident swung and hit him/her in face. -He/She reacted and swung his/her fists at the resident hitting him/her in head. -He/She had abuse/neglect training (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- I hit the resident because I was trying to help him/her, and he/she was being disrespectful to me. Review of the resident's electronic medical record progress note 6/26/24 at 11:09 A.M., showed he/she had rolled over to staff and hit staff, staff hit resident on top of his head with a closed fist. Staff was told to leave the building immediately and was escorted from the facility. The resident was placed on one on one. Review of the police report dated 6/26/24 showed on 6/26/24 at approximately 12:03 P.M., the Police Officer and Investigator were dispatched to facility in regards to an assault. During an interview and observation 6/27/24 at 11:30 A.M., the resident said he/she had hit an employee and the employee hit him/her back. The resident had pointed at the left side of his/her head above the left ear. During an interview 6/27/24 at 12:36 P.M., the DON said: -He/She had started abuse and neglect in-services to all employees 6/26/24. -Residents should never be hit by an employee. -He/She reports to his/her Administrator with all abuse and neglect allegations. During an interview 6/27/24 at 12:40 P.M., the Regional Registered Nurse said he/she would expect residents are not abused/neglected by an employee. MO 00328198