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	08/30/2024

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 - 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** 42984 Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident #9) out of seven sampled residents, was free from abuse when on 8/6/24 Licensed Practical Nurse (LPN) G was verbally and physically abusive. LPN G called the resident names, pulled the resident's hair and kicked the resident while the resident was laying on a mattress on the floor which resulted in a contusion to the resident's right hip and pain to his/her left knee. The resident was heard yelling and crying during the altercation and needed an injection to calm his/her agitation after the incident. Multiple staff witnessed the altercation and did not intervene. The facility census was 109 residents. The Administrator was notified on 8/29/24 at 11:29 A.M. of an Immediate Jeopardy (IJ) which began on 8/6/24. The IJ was removed on 8/30/24, as confirmed by surveyor onsite verification. Review of the facility's Abuse and Neglect Policy, reviewed and revised on 6/12/24, showed: -Abuse was defined as a willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. -Physical abuse included handling a resident with any more force than was reasonable for a resident's proper control, treatment, or management. -Mistreatment was inappropriate treatment or exploitation of a resident. 1. Review of Resident #9's undated Face Sheet, showed the resident admitted to the facility on [DATE] with the following diagnoses: -Major depressive disorder (a mental health condition that caused a persistently low or depressed mood and a loss of interest in activities that once brought joy). -Anxiety disorder (a condition in which a person had excessive worry and feelings of fear, dread, and uneasiness). -Post-traumatic stress disorder (PTSD-a mental health disorder that can develop after a person is exposed to a traumatic event). (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	-Bipolar disorder (a mental health condition characterized by extreme mood swings that include emotional highs and lows). -Schizophrenia (a chronic and severe mental health disorder that affects how a person thinks, feels and behaves). -Intermittent explosive disorder (a mental health condition characterized by sudden, intense outbursts of anger or aggression). -Moderate intellectual ability. Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning), dated 5/20/24, showed he/she was cognitively intact. Review of the resident's care plan, dated 6/28/24, showed: -He/she had a history of being abused as a child and PTSD with no known triggers. -The environment should be free from actual or perceived judgement and physical or perceived danger. -He/She was at risk for displaying signs and symptoms of bipolar disorder, displaying high and low emotions. Interventions included: helping him/her to stay on task; calm redirection; decreasing stimulation; using a firm and calm approach; avoiding getting in a power struggle; keeping his/her routine consistent. -He/She was at risk for displaying signs and symptoms of schizophrenia. Interventions included avoiding arguing or getting defensive with him/her; being respectful, non-judgmental and honest with him/her; respecting his/her personal space. -He/She had a history of behavioral challenges requiring protective oversight, such as being physically aggressive toward staff and peers, frequent elopements, obsessing about things, impulsive thoughts and actions, disordered thoughts. Interventions included: CALM (a communication strategy often used to de-escalate tense or potentially volatile situations) technique if needed; plans to change inappropriate behavior; 1:1 observation; pharmaceutical interventions as needed. -He/She had a long history of mental illness. He/She had a low tolerance for restrictions, becoming physically assaultive and physical and verbal aggressions. Interventions included: psychiatric management and counseling if needed; behavior modification programs as needed; interdisciplinary team and guardian involvement. -He/She had a long history of PTSD and functional impairment from symptoms, including aggressiveness and self-destructive behavior. Interventions included: encouraging the resident to express emotions in a safe environment, assessing the resident for suicidal or homicidal ideation's and ensuring the safety of the resident and others; administering medications as appropriate; assessing for anxiety. (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 Medication Administration Record (MAR), dated 8/6/24, showed: -At 2:15 A.M., he/she was given an injection of Olanzapine (a medication used to treat conditions such as schizophrenia and bipolar disorder) as ordered 10 milligrams intramuscularly as needed (PRN) for three times a day for increased agitation. Review of the resident's progress note, dated 8/6/24 at 3:45 A.M., showed: -LPN F notified by staff the resident was having a behavior. Upon arrival, he/she noted the resident throwing papers and picking up trash cans to throw at staff. -LPN F notified Certified Medication Technician (CMT) C (who was the house supervisor) for assistance with getting a PRN (as needed) medication and syringe. -While preparing the PRN medication, the resident was approached by LPN G and was told to go to his/her room. -The resident entered his/her room and LPN G followed him/her into the room. -LPN F heard the resident say stop kicking me, and stop pulling my hair. -LPN F entered the resident's room with other staff and observed the resident sitting on the bed with LPN G standing over him/her. -LPN F asked what was going on and neither LPN G or the resident answered. -LPN F asked the resident for permission to administer the PRN injection and the resident was cooperative. The PRN medication was not effective. -The resident then threw a trash can at staff into the hallway and started kicking the wall, kicking the staff, and using racial slurs. -Staff entered the room to initiate a Code [NAME] (a facility wide alert that there is a situation involving a resident who was exhibiting violent or potentially dangerous behavior), and a CALM hold and LPN G stated, No, don't call it. I got this. I got him/her by myself. -LPN F then observed LPN G kick the resident. -LPN F intervened, separated the resident, made sure he/she was safe and asked LPN G to leave the unit. -LPN G did not leave the unit immediately. -LPN F then notified the administrator and Director of Nursing (DON) and was instructed to call the Police Department (PD). -The resident's range of motion and vital signs were at baseline and the resident denied pain or discomfort. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-PD was notified twice before arriving at the facility. Review of the resident's hospital visit summary, dated 8/6/24, showed he/she was seen related to contusion (bruise) of his/her right hip and left knee pain related to a physical assault. Review of the resident's progress note, dated 8/6/24 at 10:05 A.M., showed: -Resident returned from the hospital and escorted by staff 1:1 to the social worker's office. -He/she had a pleasant attitude and stated he/she was feeling better. -When asked how he/she was feeling about the incident, he/she stated he/she was not affected unless the nurse (LPN G) returned. -He/She did not want that nurse on his/her unit. Administrator was notified. Review of the facility investigation, dated 8/6/24, showed: -The incident was alleged abuse. -There was one resident witness, Resident #32, the resident's roommate. -The incident involved Resident #9 and one other staff member. -The resident was unable to identify the staff person, just that it was a staff person with black hair. -Initially he/she stated the staff person slapped him/her and he/she fell to the bed; he/she then stated he/she was pushed and dragged by his/her arms out of the bed onto his/her knees. -Staff reported to the DON the resident had been kicked and hair pulled by LPN G. -Two employees reported they witnessed the resident being abused by kicking and hair pulling. -The DON instructed the staff to call Kansas City Police Department (KCPD). -An assessment of the resident was completed by the DON when he/she arrived at the facility. -A skin assessment was done by staff and no discoloration or injury was noted to face or knees. -The resident was sent to the hospital for evaluation due to increased behaviors, destruction of property, and increased physical aggression toward staff and peers. -LPN G was detained by KCPD and taken to jail. -LPN G was suspended pending investigation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident stated he/she was kicked, hair pulled, and dragged over the floor by LPN G, but his/her story was convoluted. He/She remained on 1:1 observation. Review of the resident's Psychosocial Post-Incident Impact Questionnaire, dated 8/6/24, showed: -The resident said he/she was not trying to hurt him/herself or anyone; the nurse was trying to hurt him/her. -He/She was only biting him/herself so staff would not come near him/her and he/she only hit the nurse's hand. -Walking down the hallway, pacing back and forth, and walking around the dining area helps him/her to calm and it worked if the staff would leave him/her alone. -He/She did not feel like he/she could have done anything differently, because the nurse wouldn't listen to him/her or let him/her out of his/her room and made him/her cry really hard. -He/She felt safe and was ok as long as she (the nurse) was gone. -He/She wanted to press charges against the staff member who assaulted him/her. Review of the resident's skin evaluation, dated 8/6/24 at 10:49 A.M., showed: -The resident had a new skin issue located on his/her right lateral thigh, which was bruising. Review of the resident's undated written statement showed: -This bitch pulled him/her to the ground off his/her bed and put his/her foot on his/her back, even though he/she told him/her to get his/her foot off of him/her. -Then he/she (the staff person) said he/she would bitch-slap him/her and he/she would fuck me up. Review of Agency Certified Nursing Assistant (CNA) J's written witness statement, dated 8/6/24, showed: -He/She saw LPN G kicking, hitting, and being verbally abusive toward Resident #9. LPN G also pulled the resident's hair. -The resident started crying and was yelling to the staff to stop beating on him/her. -When Agency LPN F heard what was going on, he/she immediately told LPN G to leave the unit. -LPN G refused to leave the unit and made the statement, I love fucking with him/her. During an interview on 8/7/24 at 10:00 A.M., Agency CNA J said: -He/She had never worked with LPN G before. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-When the incident took place, LPN G was not suppose to be working on that unit. -The resident was calling LPN G names. -The resident was having a behavior and getting agitated. He/She has the mentality of a five-year old. -The staff put on gloves in case they had to do a safety hold to give the resident a injection. -LPN G came over from another unit, but did not offer to help the staff with the resident, just started calling the resident names. -The resident was only combative with LPN G and tried to kick him/her. The resident was on a mattress on the floor. -LPN G was standing over the resident kicking him/her. He/She would walk up on the resident, kick him/her and back up, and kept doing it. -The staff were going to put the resident in a safety hold and LPN G said, No, I got it, get out! -As soon as the staff walked out, he/she heard the resident shouting at LPN G to stop hitting me and stop pulling my hair and start crying. He/She did not see LPN G pulling the resident's hair. All of the staff heard this. -Agency LPN F told the staff what to say about this incident so he/she would not get in trouble, but he/she was the resident's nurse and should have stood up to LPN G. He/She sat there and listened to LPN G abuse the resident and did nothing. -LPN G was going to do what he/she was going to do with the resident, even if the staff had stepped between them. -The corporate staffing agency did not offer any deescalation or CALM training. A lot of staff do not know how to work with mental health patients. -The staff could not touch LPN G to stop him/her or it would have been assault. All they could do was be the eyes and ears of the situation. Review of LPN G's written employee statement, dated 8/8/24, showed: -The resident was standing in the hallway talking and he/she told the resident to come on and go to his/her room. The resident then went to his/her room. -He/She told the resident he/she was going to sit with him/her for a little while to give everyone else a break because they had been dealing with him/her for a while. -The resident told him/her to get the fuck out and he/she said no, that he/she was going to be with him/her for a while. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident said, I'm getting out of here and you can't stop me and acted like he/she was going to go past him/her, but didn't and went to the wall where the head of the bed was. -The resident started slapping and kicking the wall. -He/She asked the resident to stop and the resident said no. -He/She asked him/her again to stop because everyone was going to sleep. -The resident said, Fuck you, bitch, no! -He/She said this was the last time he/she was going to ask and he/she was going to count to three and assist the resident to stop his/her actions. -The resident continued to kick the wall, which made a hole in the wall. -He/She went to the resident and put his/her hands on the resident's shoulders and pulled him/her from the wall. -The resident pulled away and flopped down on his/her mattress and said, Don't you push me again! -He/She said he/she didn't push him/her, that the resident broke from him/her. -The resident said, Get the fuck away, bitch, I'll kill you! He/She leaned back on the mattress and raised his/her legs and started kicking the wall where he/she had already been kicking it. -He/She put his/her hand on the resident's head and said to stop it and go to bed. -The resident laid down on his/her bed and grabbed the top of his/her head and said, You bitch, you pulled my hair. -He/She told the resident he/she did not pull his/her hair and the resident then said he/she didn't care and began kicking the wall again. -He/She asked the aides to come in the room and move the mattress and while waiting for them, the resident called him/her racial epithets. -The aides came in the room and helped him/her move the mattress. -The resident then began to kick him/her several times, as well as kick the night stand and the wall -He/She told the resident to quit kicking him/her and the resident continued to attempt to kick him/her. -He/She used his/her foot to block the kicks. -The resident continued to call him/her a bitch and yelled, You are abusing me! (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 said, How am I abusing you? I am blocking you from kicking me! -The other staff were outside the room. The resident was still kicking at him/her. -The other nurse came in the room with a PRN injection and an oral medication. -The resident was given the injection and the resident was swatting at the staff and initially refused. Staff checked the resident's mouth to make sure he/she swallowed. -The resident flopped back down on the mattress and the staff left the room. -The resident continued to kick at the wall and yelled for him/her to give her the blankets. -He/She got the blanket for the resident and the resident threw it right back at him/her. -Nobody came into the room after that. He/She gave the resident the blanket back and turned off the light, at the resident's request. -He/She did not see anyone come in the room when the resident was yelling that he/she was being abused. -The resident also called him/her a pussy, and he/she replied, If I am a pussy, then you are a pussy. -He/She was in no way trying to hurt the resident, just trying to prevent him/her from hurting him/herself and prevent him/her from damaging property. During an interview on 8/7/24 at 10:30 A.M., LPN G said: -That night, the resident had just gotten back from being sent out to the hospital for behaviors. -When the resident was brought back, he/she walked him/her back to the unit. A skin assessment was not done on the resident at that time. -Two hours later, the resident was having a behavior and the staff were at their wits end from dealing with him/her. -He/She thought he/she would try to help out and give the other staff some relief, since the resident can wear out the 1:1 observation staff; the resident had a 1:1 at the time. -He/She said, 'I'll give you guys a break. -He/She was dealing with the resident and the resident was calling him/her names and racial names. The resident said, Fuck you, you stupid (racial slur), I'm going to fucking kill you. -He/She told the resident to go to his/her mattress and the resident said no. -The resident went to the wall and started hitting it with his/her hand and kicking it. (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 told the resident to stop it, that it was too early in the morning and people were trying to sleep. -The resident said no and kept calling him/her names and saying, fuck you and calling him/her the N word. -He/She grabbed the resident's upper arms to turn him/her away from the wall so he/she could stop kicking and punching the wall. -When he/she turned the resident, the resident flopped down on the mattress and said, Don't you ever push me again. -He/She told the resident he/she didn't push him/her. -The resident continued kicking, so the staff moved the mattress. -Before they moved the mattress, he/she put his/her hand on the top of the resident's head and told him/her to stop again. -The resident then said, Don't you ever fucking pull my hair! That is when he/she had the staff help him/her move the mattress. -They didn't call a Code [NAME] because anyone who would have responded were already there. -The staff were in and out and moved the mattress to the center of the room, so the resident could not kick the walls anymore, so the resident started kicking at him/her. -The resident's kicking made contact with him/her and also with the nightstand. He/She used his/her feet to block the resident's kicks from him/her and the nightstand. He/She never made any contact with the resident's hip or thigh. -The resident kept saying, You're abusing me, and he/she said, How can I be abusing you when you are kicking me? -He/She moved the nightstand. -Nobody intervened to help him/her or stop the kicking. -Agency LPN F gave the resident a injection and an oral medication and the resident stood against the wall. -The resident stopped trying to kick him/her and asked for a cover, because he/she was going to go to bed, and asked for the light to be turned off. -He/She turned the light off and stayed for a few more minutes and then left. -He/She 100% thought the staff misconstrued what they saw. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident was calm and they talked about correcting behaviors and forgiveness, and happy memories he/she had. -Around 12:30 A.M., he/she noticed a change in the resident's behavior, he/she starting pacing and getting agitated, and he/she notified the other CNA. -Around 1:00 A.M., he/she let the other CNA take over so he/she could help on 3 North. He/She told the nurse he/she was there to help and take a break from the resident, so he/she could be with a familiar face for a while. -He/She came back to 3 South at 2:00 A.M. and the resident was still pacing. -Around 3:00 A.M., LPN G came up and told Agency LPN F he/she had this. They discussed calling a Code [NAME] and LPN G said the resident did this all the time, he/she had this. -LPN G made the resident go in his/her room and he/she started hearing the resident screaming, You are pulling my hair! Stop kicking me! -He/She saw LPN G kick the resident. -He/She asked if this was protocol and LPN G said, He/She always does this. -They then had a kicking match. -The nurse came in and said he/she had the resident's medication. -He/She did not know whether to help hold the resident or not, because he/she was shocked. -After the resident got his/her injection, LPN G was cool and he/she left and asked what to do. -He/She was told when the resident woke up, ask him/her if he/she was ok. -The staff stated this situation was not ok and he/she needed to report what he/she had seen and heard. -He/She did not confront LPN G because he/she was scared. -He/She told the resident, when he/she awakened at 4:30 A.M. if he/she was not ok to let him/her know. -The resident said the nurse hurt him/her and he/she asked a staff person to call 911. During an interview on 8/9/24 at 11:30 A.M., Agency CNA G said: -He/She was not a regular employee at the facility and had only worked there 3 or 4 times previously. -He/She had done 1:1 observation of the resident when he/she worked. (continued on next page)

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Gregory Ridge Health Care Center	7001 Cleveland Avenue Kansas City, MO 64132

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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 did not know the other staff's names. -He/She was in the room when the incident happened for some of the time. Other staff were in and out of the room. -The resident had been pacing around and was agitated and said the staff were going to beat him/her if he/she did not go to sleep. -He/She heard a lot of banging in the room. The resident was kicking the wall and the dresser and kicked LPN G in the knee. -The resident took off his/her shoes and threw one at the wall and one at LPN G, who threw the shoe back. -The resident was calling LPN G the N word. -LPN G called the resident a pussy. -He/She did not see LPN G pull the resident's hair. He/She saw the resident kick LPN G and LPN G kick the resident back. -Agency LPN F told LPN G he/she had it from there and LPN G refused to leave. -The resident had not been combative before or when he/she came back from the hospital. -Nobody stepped in between LPN G and the resident. Everyone was afraid. He/She was afraid he/she would get beat up. -When LPN G threw the shoe, he/she covered his/her eyes, but told him/her he/she was going to call the police. -When the incident happened, he/she was by the door of the room, about two feet away. -When he/she saw LPN G and the resident's physical aggression, he/she put his/her hand over his/her mouth and slid down the wall and asked, Is this protocol? One of the other staff said no, this wasn't supposed to be happening. LPN F also said no. -Agency LPN F coached everyone that they should write down what they witnessed and heard; if they felt like something was wrong, it was wrong. -Agency LPN F said he/she was not going to put his/her license on the line, because he/she told LPN G to stop and he/she didn't. -The police were called, and while they were waiting for the police to arrive, he/she told LPN G the police had been called, because the resident did not feel he/she had protected him/her. -LPN G said, Ain't nobody can protect him/her from me; not even his/her family wants him/her. (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 felt the other staff knew protocol, so they should have stepped in, but did not because they were afraid of LPN G. Review of CNA I's written witness statement, dated 8/6/24, showed: -At about 2:15 A.M., the resident began to have a behavior. -They called the nurse to come to 3 South, and he/came, but did not have his/her medication key, so he/she called LPN G to come over with a medication. -While Agency LPN F was preparing the medication, LPN G told the resident to go to his/her room. -The resident did not want to go to his/her room, but he/she did. -Other staff came with Agency LPN F to go in the room. -He/She was standing outside the door. Agency LPN F wanted to call a Code Green, but LPN G said he/she had it. -He/She heard the resident say to stop kicking him/her and also to stop pulling his/her hair. -He/She went in to see what happened. LPN G was pushing the nightstand out of the room, so he/she took the nightstand, because the resident was kicking it. The resident was given his/her medication and the nurses left, and then the resident went to sleep. Review of CMT C's written witness statement, dated 8/6/24, showed: -He/She was called to bring medication to the unit. -The nurse on 3 South (Agency LPN F) needed needles for an injection. -The resident was having a behavior. -He/She asked the nurse on 3 North (LPN G) to unlock the cart and hand him/her a needle. -LPN G asked why he/she needed the needle and he/she replied that the resident was having a behavior. -LPN G stated he/she was going to go over there and be nosey, and left. -He/She was getting pain medications for other residents at the time. -He/She arrived on 3 South and the resident was in his/her room with LPN G. -He/She heard the resident saying to leave him/her alone and the nurse calling him/her a pussy and said, shut up, pussy bitch, kick me! (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-LPN G kept antagonizing the resident. -The resident kicked the LPN G by this time. -Other people started coming in the room. -Agency LPN F asked LPN G to leave the unit. -LPN G said, No, I got this. -He/She was in shock and tried to intervene, but LPN G grabbed the resident by his/her hair and kicked him/her several times. Every time the resident kicked him/her, LPN G kicked him/her back. -He/She was confused and had never experienced something like this before. During a interview on 8/12/24 at 10:00 A.M., CMT C said: -He/She got a call from Agency LPN F on 3 South that he/she needed a medication, but did not have any needles. -He/She asked LPN G if he/she had any needles on his/her cart. -LPN G asked who the injection was for, and he/she told him/her. -LPN G said he/she was about to go be nosy and started to head over to that unit. -By the time he/she got to the unit, LPN G was already in the room. -Agency LPN F was sitting down and he/she handed him/her the medication. -Only LPN G and the resident were in the resident's room. -Everyone else was standing around and looking around. -LPN G was not the nurse caring for the resident. -There was not a Code [NAME] called. He/She could not see what was going on, but heard the resident yelling at LPN G to leave him/her alone. -If the resident was having a behavior, he/she was known to tell staff to leave him/her alone. -LPN G called the resident a punk bitch, which was going to escalate the situation and make it worse. -When Agency LPN F was trying to give the resident his/her injection, the resident was saying to leave him/her alone. -The staff told the resident the medication was going to help him/her to try to calm down. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-LPN G told the resident he/she was going to take the shot and the resident said he/she was going to call the administrator. LPN G told him/her nobody was going to save him/her. -Before he/she was given the injection, the resident had said to stop kicking him/her. The resident had also picked up the trash can and thrown it at staff, and was kicking his/her foot and saying he/she did not want the medication. -LPN G said, I dare you to kick me, and the resident kicked him/her and he/she kicked back, two to three times. These were actual kicks, not blocks. -He/She heard the resident said LPN G had pulled his/her hair, and he/she saw and it was definitely a pull. -He/She then let Agency LPN F know, because he/she had already left the room. -He/She did not know the procedure that he/she could touch a staff person to stop the situation. He/She did not want to start a fight in the room. During an interview on 8/7/24 at 11:35 A.M., the Social Worker said: -The resident had the mind of an 8-year-old and had trouble processing information. During an interview on 8/7/24 at 11:40 A.M., the resident said: -He/She kicked LPN G because he/she kicking him/her. -He/She told all the staff about it. He/She was unable state which staff he/she told. -He/She had scratches on his/her knee, because all of the staff pulled him/her on the ground. -He/She thought LPN G was very rude to him/her and nicer to other residents, which made him/her feel uncomfortable and sad. -LPN G pulled his/her hair and made him/her cry. -He/She didn't know why LPN G pulled his/her hair. -His/Her mattress was on the floor because he/she broke the footboard. -He/She called LPN G a bitch, bullshit and the N word and LPN cursed back at him/her. -LPN G called him/her names and said, Get your fat pussy up! -LPN G dragged him/her on the floor and pulled his/her arms. He/She did that all the time. -He/She tried to go tell someone and LPN G blocked him/her from going out the door. -There were some other staff members involved. He/She didn't know the names. (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 said when he/she had a behavior, the staff were not supposed to stop it, they were supposed to call the social worker or the Administrator, but they never did. -He/She said he/she had two bruises from this incident and pointed at his/her hip. -He/She wanted to press charges on LPN G. He/She told the police he/she didn't know why LPN G would act that way. Observation of the resident on 8/7/24 at 11:40 A.M. showed the resident had a quarter-sized discolored green, yellow and purple area on his/her right hip that he/she said that it was from this incident with LPN G. The skin was not broken. Review of Resident #32's MDS, dated [DATE], showed he/she was cognitively intact. During an interview on 8/9/24 at 12:20 P.M., Resident #32 said: -He/She was the resident's current roommate. -He/She kept his/her privacy curtain open. -He/She heard someone call Resident #9 a pussy. During an interview on 8/29/24 at 11:00 A.M., Agency LPN F said: -The resident was having a behavior. -LPN G came over. He/She was not sure why LPN G came over. -LPN G told the resident to go in his/her room. The resident was already agitated. -He/She was the resident's nurse that shift. -He/She was waiting for CMT C, who was the night supervisor, to bring him/her intermuscular (IM) medication for the resident, since they did not have it on the unit. -He/She could hear the LPN G call the resident a pussy, so he/she went to look in the ro

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469 Based on interview and record review, the facility failed to ensure Resident #29's belongings were sent to the resident's current facility after discharging from the facility on 2/8/24. This affected one out of 34 sampled residents. The facility census was 109 residents. Review of the facility's policy, Resident Transfer/Discharge, Immediate Discharge, and Therapeutic Leave Policy, dated 5/14/24, showed: -Transfer and Discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. -Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility was not expected. -The facility should provide sufficient preparation and orientation to ensure that the resident has a safe and orderly transfer or discharge. -This includes informing the resident where he or she was going and taking steps to minimize anxiety. 1. Review of Resident #29's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning), dated 11/29/23, showed the resident assessed as cognitively intact. Review of the resident's care plan, dated 6/13/23, showed: -He/She had coping issues. -The desired outcome was the resident would be without fear or anxiety. Review of the resident's medical record showed no inventory of the resident's belongings. Review of the resident's discharge and entry MDS, dated [DATE], showed: -He/She was discharged from the facility on 2/8/24. -He/She was admitted to a different facility approximately 80 miles from the former facility on 2/8/24. Review of an email from the Social Service Director (SSD) at the resident's new facility to the Social Service Director at this facility, dated 2/16/24 showed: -The resident had come to him/her today and stated he/she had left several things behind at his/her former facility. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident said he/she had several totes of clothes and a tote of shoes that was left at the former facility. -He/She said there was a white nightstand that contained crocheting items in it. -The facility had coffee, tea, and Kool aid packets that the former facility had stored for him/her in the medication room that nobody would get out for him/her when he/she left the facility. -He/She was told by the driver from the former facility that delivered him/her to the new facility, that they would bring him/her the rest of his/her belongings the next day and that did not happen. -Please let him/her know if you were able to find the items. Review of an email from the SSD at the former facility to the SSD at the new facility, dated 2/18/24, showed: -Yes, that was correct. -He/She had spoken with his/her Administrator and he/she stated they were going to set up a time and date for our transportation driver to meet half way with your transportation driver to transfer the rest of the resident's items. Review of an email from the SSD at the former facility to the SSD at the new facility, dated 2/20/24, showed: -Please let us know when the best time and date is to meet, and we will check our availability and try to make it work. Further review showed no response email from the receiving facility. Review of the SSD Progress Notes in this facility, dated 8/2/24, showed: -On 8/2/24 he/she called the resident's new facility to try to set up a time and date to transport the resident's personal items. -The receptionist/transportation/staffing coordinator said they currently only have one driver available, and they don't usually go out of town. -They may not be able to meet us, but he/she would check with the appropriate people in the resident's new facility and get back with me. During an interview on 8/2/24 at 12:05 P.M., the Environmental Services Manager said: -When a resident leaves the facility and leaves their belongings, they put the belongings in storage. -The facility's driver would take it to them. -The driver should have taken the belongings to the resident within 72 hours. (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was responsible for ensuring the resident had all of his/her belongings. -He/She had not received a call from the resident requesting the rest of his/her belongings. -There was not enough room in the van for all the belongings when they took this resident to the new facility as they were dropping off another resident at the same time. During an interview on 8/2/24 at 1:30 P.M., the SSD said: -Environmental Services was responsible for documenting the belongings that were sent with a resident when they leave the facility. -The resident went to another facility. -He/She should have documented where the resident went when he/she discharged from the facility. -Environmental Services should have documented that the belongings went with the resident or the disposition of the belongings. This was not done. -He/She emailed the other facility stating that they would have meet up with the other facility to transfer the remainder of belongings. -He/She had not had contact with the other facility since February and it got missed. -He/She was responsible to ensure a resident's belongings went with them when they left the facility. During an interview on 8/2/24 at 1:45 P.M., the Administrator said: -The resident left the faciity on [DATE]. -The resident still had 7 to 10 boxes and four black trash bags of belongings at the facility. -There was not enough room to send all of the resident's belongings with him/her when he/she discharged to the other facility. -For a while they did not have a van driver. -He/She would have expected the resident to have received the rest of his/her belongings within 30 days of discharge. -He/She was ultimately responsible for ensuring the resident's belongings go with them when they discharge from the facility or it was sent to them later. -The Environmental Services manager did an inventory of the residents belongings still at the facility on 8/1/24. The list had more than 100 items still at the facility. During an interview on 8/2/24 at 2:00 P.M. the Director of Nursing said: (continued on next page)

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F 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Environmental Services should have boxed up the resident's belongings that did not accompany him/her to the new facility and sent them to the new facility within two weeks. -It has been several months and it has not been done. -The Administrator was ultimately responsible for ensuring that residents received all of their belongings when they left the facility. MO 00239730

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42984 Based on interview and record review, the facility failed to appropriately de-escalate one sampled resident with known triggers and mental health needs (Resident #9). On 8/6/24, the resident displayed behaviors of agitation, yelling, throwing items, kicking, hitting the wall, nightstand and mattress. Staff failed to provide calm redirection; decrease stimulation; use a firm and calm approach; and avoid getting into a power struggle with the resident. Staff argued with the resident, became defensive, called the resident derogatory names, and failed to respect his/her personal space. Staff failed to utilize de-escalation techniques appropriately and to involve the interdisciplinary team and guardian per the resident's care plan. The resident was not encouraged to express emotions in a safe environment. Rather, facility staff left the resident alone with Licensed Practical Nurse (LPN) G in his/her room after LPN G called off a Code [NAME] and said he/she would handle it him/herself- and proceeded to kick, slap and verbally abuse the resident instead of following the resident's care plan for de-escalating behavior or walking away. Certified Nurse Aide G was on duty and had not been trained on de-escalation techniques utilized by the facility. Agency CNA J was also on duty and reported his/her corporate staffing agency did not offer any deescalation or CALM training. This effected one out of 7 sampled residents. The census was 109 residents. Review of the facility policy titled, CALM (Crisis Alleviation Lessons and Methods) Certification, dated 2/26/21, showed: -To set guidelines for employees of the facility to become CALM certified. -To provide safe treatment and humane care to the resident in a behavioral crisis. -After time of hire, all employees working with behavioral residents will become CALM certified. Review of the Facility Assessment Tool, dated 3/27/23 showed: -CALM training upon hire, before working the behavioral unit. -The facility accepts residents with Psychiatric/Mood Disorders, including: --Psychosis, Impaired Cognition, Mental Disorder, Depression, Bipolar Disorder, Schizophrenia, Post-Traumatic Stress Disorder, Anxiety Disorder, Behavior that needs interventions, Personality disorder, Schizoaffective Disorder, Explosive Disorder. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Mental health and behavior: Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety (a condition in which a person had excessive worry and feelings of fear, dread, and uneasiness), care of someone with cognitive impairment, care of individuals with depression (a mental health condition that caused a persistently low or depressed mood and a loss of interest in activities that once brought joy), post-traumatic stress disorder (PTSD) (a mental health condition that was triggered by a terrifying event, either experiencing it or witnessing it), schizoaffective disorders (a mental health condition characterized by a combination of schizophrenia and a mood disorder), schizophrenia (a chronic and severe mental health disorder that affects how a person thinks, feels and behaves), bipolar disorder (a mental health condition characterized by extreme mood swings that include emotional highs and lows), personality disorder, other psychiatric diagnoses, intellectual or development disabilities. Review of the facility Behavioral Emergency policy, dated 1/5/24, showed: -To 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. -The licensed nursing staff will assess the resident who is exhibiting behaviors, ensuring that safety of the resident and others is the first priority. -Behavioral emergency which is classified as a Code [NAME] is called when a resident exhibits extreme behaviors such as suicidal, homicidal, self-mutilation, elopement, or resident to resident altercations. -A one to one monitoring of resident will be initiated immediately. 1. Review of Resident #9's undated Face Sheet showed the resident was admitted to the facility on [DATE] with the following diagnoses: -Major depressive disorder. -Anxiety disorder. -Post-traumatic stress disorder (PTSD). -Bipolar disorder. -Schizophrenia. -Intermittent explosive disorder (a mental health condition characterized by sudden, intense outbursts of anger or aggression). Review of the resident's admission Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning), dated 5/20/24, showed he/she was cognitively intact. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's care plan, dated 6/28/24, showed: -He/She was at risk for displaying signs and symptoms of bipolar disorder, displaying high and low emotions. Interventions included: helping him/her to stay on task; calm redirection; decreasing stimulation; using a firm and calm approach; avoiding getting in a power struggle; keeping his/her routine consistent. -He/She was at risk for displaying signs and symptoms of schizophrenia. Interventions included avoiding arguing or getting defensive with him/her; being respectful, non-judgmental and honest with him/her; respecting his/her personal space. -He/She had a history of behavioral challenges requiring protective oversight, such as being physically aggressive toward staff and peers, frequent elopements, obsessing about things, impulsive thoughts and actions, disordered thoughts. Interventions included: CALM technique if needed; plans to change inappropriate behavior; 1:1 observation; pharmaceutical interventions as needed. -He/She had a long history of mental illness. He/She had a low tolerance for restrictions, becoming physically assaultive and physical and verbal aggressions. Interventions included: psychiatric management and counseling if needed; behavior modification programs as needed; interdisciplinary team and guardian involvement. -He/She had a long history of PTSD and functional impairment from symptoms, including aggressiveness and self-destructive behavior. Interventions included: encouraging the resident to express emotions in a safe environment, assessing the resident for suicidal or homicidal ideations and ensuring the safety of the resident and others; administering medications as appropriate; assessing for anxiety. Review of the resident's progress note, dated 8/5/24 at 1:06 P.M., showed: -He/She was heard through the walls as he/she was kicking the walls and yelling obscenities at staff and throwing chairs. -The social worker went into the resident's room and the resident was on the floor. He/She told the social worker he/she was on the floor because he/she did not want the staff to touch him/her and started yelling for staff not to touch him/her. -He/She stated he/she put herself on the floor and staff did not touch him/her. -The social worker tried to redirect his/her verbal and physical aggression and also attempted to remove him/her from the unit. -He/She refused and stated, I hate you, you are rude, and I don't want to talk to you or the administrator. -He/She also stated he/she was going to start hurting his/her peers and the staff when he/she got the chance. -The administrator and director of nursing (DON) were notified. (continued on next page)

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Gregory Ridge Health Care Center	7001 Cleveland Avenue Kansas City, MO 64132

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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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's progress note, dated 8/5/24 at 4:50 P.M., showed: -A Code [NAME] (a facility wide alert that there is a situation involving a resident who was exhibiting violent or potentially dangerous behavior) was called due to the resident's physical and verbal aggression with the staff. He/She continued to kick walls and put a large hole in the wall. -He/She then began throwing pieces of the wall at the staff. -Staff removed the resident, without physical contact, from the unit to the administrator's office. -He/She refused to calm down and stated he/she was going to slap the social worker in the face and kick him/her. -The administrator and DON were notified. Review of the resident's progress note, dated 8/5/24 at 6:04 P.M., showed: -The resident reported to to the administrator that staff had hit him/her in the face a few days previously. He/She was unable to identify the staff, but stated it was a black lady with black hair. -His/Her version of the events changed while he/she was recounting the events -Initially he/she said he/she was slapped and fell to the bed, then stated he/she was pushed and dragged by his/her arms out of the bed onto his/her knees and stated he/she was bruised on his/her knees. -A skin assessment of the resident at the time showed no injury or discoloration on face or knees. -He/She was sent to the emergency department (ED) for evaluation due to increased behaviors, destruction of property and increased physical aggression. His/her psychiatric team, doctor and guardian were notified. Review of the resident's progress note dated 8/5/24 at 8:30 P.M. showed: -A skin assessment was done; skin was clear with no sign or symptom of injury. Review of the resident's progress note dated 8/6/24 at 2:15 A.M. showed: -He/She had been agitated and aggressive with staff, throwing trash cans and kicking the wall. Review of the resident's progress note, dated 8/6/24 at 3:45 A.M., showed: -LPN F was notified by staff the resident was having a behavior. Upon arrival, he/she noted the resident was throwing papers and picking up trash cans to throw at staff. -LPN F notified CMT C (who was house supervisor) for assistance with getting a PRN (as needed) medication and syringe. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-While preparing the PRN medication, the resident was approached by LPN G and was told to go to his/her room. -The resident entered his/her room and LPN G followed him/her into the room. -LPN F heard the resident say stop kicking me and stop pulling my hair. -LPN F entered the resident's room with other staff and observed the resident sitting on the bed with LPN G standing over him/her. -LPN F asked what was going on and neither LPN G or the resident answered. -LPN F asked the resident for permission to administer the PRN injection and the resident was cooperative. The PRN medication was not effective. -The resident then threw a trash can at staff into the hallway and started kicking the wall, kicking the staff and calling the staff racial slurs. -Staff entered the room to initiate a Code [NAME] and a CALM hold and LPN G stated, No, don't call it. I got this. I got him/her by myself. -LPN F then observed LPN G kick the resident. -LPN G intervened, separated the resident, made sure he/she was safe and asked LPN G to leave the unit. -LPN G did not leave the unit immediately. -LPN F then notified the administrator and DON and was instructed to call the Kansas City Police Department (KCPD) of the situation. Review of the facility Investigation, dated 8/6/24, showed: -The incident was alleged abuse. -There was one resident witness, Resident #32, the resident's roommate. -The incident involved Resident #9 and one other staff member. -The resident was unable to identify the staff person, just that it was a staff person with black hair. -Initially he/she stated the staff person slapped him/her and he/she fell to the bed; he/she then stated he/she was pushed and dragged by his/her arms out of the bed onto his/her knees. -Staff reported to the DON the resident had been kicked and hair pulled by LPN G. -Two employees reported they witnessed the resident being abused by kicking and hair pulling. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The DON instructed the staff to call KCPD. -An assessment of the resident was completed by the DON when he/she arrived at the facility. -A skin assessment was done by staff and no discoloration or injury was noted to face or knees. -The resident was sent to the hospital for evaluation due to increased behaviors, destruction of property, and increased physical aggression toward staff and peers. -LPN G was detained by KCPD and taken to jail. LPN G was suspended pending investigation. -The resident stated he/she was kicked, hair pulled and dragged over the floor by the staff person, but his/her story was convoluted. He/She remained on 1:1 observation. -There was a suspicious injury. Review of Agency CNA J's written witness statement, dated 8/6/24, showed: -He/She saw LPN G kicking, hitting and being verbally abusive toward a patient. LPN G also pulled the patient's hair. -The patient started crying and was yelling to stop beating on him/her. -When the unit nurse (LPN F) heard what was going on, he/she immediately told LPN G to leave the unit. -It was reported that the resident was having a behavior and he/she was to come up and help with him/her because he/she had a good rapport with him/her and was able to talk him/her down. -A Code [NAME] was never called because staff had it under control; the nurse had given the resident his/her medications. -LPN G refused to leave the unit and made the statement, I love fucking with her. -All of the staff were shocked and caught off guard by what they witnessed. During an interview on 8/7/24 at 10:00 A.M., Agency CNA J said: -He/She had never worked with LPN G before. -Resident #9 has made false accusations against people in the past. He/She was mentally like a child. -The resident had kicked at times. -When the incident took place, LPN G was not supposed to be working on that unit. -The resident was calling LPN G names. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The the other nurse (LPN F) gave the resident a shot and an oral medication and the resident stood against the wall after the medications. Then he/she laid down and went to sleep. -He/She 100% thought the staff misconstrued what they saw. -He/She typically worked at another facility and sometimes would pick up shifts at this facility. He/She probably worked 6 shifts at the facility. -He/She could have walked away. Review of Certified Nursing Assistant (CNA) G's written witness statement, dated 8/6/24, showed: -On 8/5/24 at around 10:30 P.M., he/she was told to do 1:1 observation with the resident which he/she had previously done in the past. -The resident was calm and they talked about correcting behaviors and forgiveness, and happy memories he/she had. -The resident stated other staff members had abused him/her. He/She asked the resident which staff. -He/She stated CNA H did it in the morning and a nurse at night did it, and asked if he/she knew them. -He/She told the resident he/she would help him/her file a grievance if he/she behaved till the boss came in. -Around 12:30 A.M., he/she noticed a change in the resident's behavior, he/she starting pacing and getting agitated, and he/she notified the other CNA. -Around 1:00 A.M., he/she let the other CNA take over so he/she could help on 3 North. He/She told the nurse he/she was there to help and take a break from the resident, so he/she could be with a familiar face for a while. -He/She came back to 3 South at 2:00 A.M. and the resident was still pacing. -Around 3:00 A.M., LPN G came up and told LPN F he/she had this. They discussed calling a code and LPN G said the resident did this all the time, he/she had this. -LPN G made the resident go in his/her room and he/she started hearing the resident screaming, You are pulling my hair! Stop kicking me! -He/She saw LPN G kick the resident. -He/She asked if this was protocol, and LPN G said, He/She always does this. -They then had a kicking match. -The nurse came in and said he/she had the resident's medication. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She did not know whether to help hold the resident. -After the resident got his/her injection, LPN G was cool and he/she left and asked what to do. -He/She was told when the resident woke up, ask him/her if he/she was ok. -The staff stated this situation was not ok and he/she needed to report what he/she had seen and heard. -He/She did not confront LPN G because he/she was scared. -He/She told the resident, when he/she awakened at 4:30 A.M. if he/she was not ok to let him/her know. -The resident said the nurse hurt him/her and he/she asked a staff person to call 911. During an interview on 8/9/24 at 11:30 A.M., CNA G said: -He/She was not a regular employee at the facility and had only worked there 3 or 4 times previously. -He/She did 1:1 observation with the resident when he/she worked. -He/She did not know the other staff's names. -He/She heard a lot of banging in the room. The resident was kicking the wall and the dresser and kicked LPN G in the knee. -The resident took off his/her shoes and threw one at the wall and one at LPN G, who threw the shoe back. -The resident was calling LPN G the N word. -LPN G called the resident a pussy. -He/She did not see LPN G pull the resident's hair. He/She saw the resident kick LPN G and LPN G kick the resident back. -The nurse (LPN F) told LPN G he/she had it from there and LPN G refused to leave. -The resident had not been combative before or when he/she came back from the hospital. -Nobody stepped in between LPN G and the resident. Everyone was afraid. CNA G was afraid he/she would get beat up. -When LPN G threw the shoe, he/she covered his/her eyes, but told him/her he/she was going to call the police. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She then let LPN F know, because he/she had already left the room. -If he/she could have done anything differently, he/she would have removed LPN G, but he/she did not know the procedure. He/She did not think he/she could touch a staff person to stop a situation like this. They did not want to start a fight in the room. During an interview on 8/29/24 at 11:00 A.M., LPN F said: -The resident was having a behavior and LPN G came over and he/she was not sure why. -LPN G told the resident to go in his/her room. The resident was already agitated. -He/She was the resident's nurse that shift. -He/She was waiting for CMT C, who was the night supervisor, to bring him/her intermuscular (IM) medication for the resident, since they did not have it on the unit. -He/She could hear the LPN G call the resident a pussy, so he/she went to look in the room -He/she could see LPN G's back against the wall and the resident on the floor on his/her mattress. -The two were verbally going back and forth. -He/She went in the room to give the resident the medication and the resident kicked at LPN G and LPN G kicked him/her back on the shin. -When he/she saw LPN G kick the resident, he/she told him/her to get off his/her unit. -He/She did not know if LPN G heard him/her or not, but he/she did not leave. -The resident was still kicking and spitting and could not be calmed down, so the staff put the resident in a CALM hold. -At first the resident did not want to take the medication, but then agreed to take it. -He/She did not see LPN G pull the resident's hair. -The resident continued to kick at LPN G, but then calmed and they left the room and LPN G left the unit. -Nobody tried to step in between them. -LPN G had been the resident's nurse before. -He/She never talked to any of the aides about their story. He/She gave the aides paper to write what they saw, though some of the aides did not want to do it. (continued on next page)

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	08/30/2024

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

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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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She did not feel like LPN G was intentionally trying to harm the resident, but was trying to set a boundary. -The nurses had access to resident care plans so should know how to deal with individual residents. -He/She felt like things went the way they should have, though it was not appropriate for LPN G to call the resident names, which made things worse. -He/She felt he/she was intervening by telling LPN G to leave the unit. -He/She thought if he/she touched LPN G in any way, he/she could get in trou