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	11/12/2025

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 - 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. (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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(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 - Actual harm Residents Affected - Few	**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 #2) out of 16 sampled residents was free from abuse; when on 10/27/25 at approximately 12:00 P.M., Resident #1 approached Resident #2 from behind and struck Resident #2 in the head and neck areas. Resident #2 was knocked to the floor from the hit when Resident #1 then kicked Resident #2 multiple times in the head and body; resulting in bruising on his/her forehead and minor swelling on the back of his/her head and neck and a small scratch on his/her left cheek. The facility census was 106 residents.Review of the facility's Abuse and Neglect Policy dated 6/12/24 showed:-Abuse was the willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm, pain or mental anguish, which could include staff to resident abuse and certain resident to resident altercations.-Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish.-Purposefully beating, striking, wounding or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner.-Physical abuse included, but was not limited to, hitting, slapping, punching, biting and kicking. 1. Review of Resident #1's admission Record face sheet showed the resident was admitted to the facility on [DATE] with the following diagnoses:-Disorganized schizophrenia (a mental disorder characterized by disorganized thinking, speech and behavior).-Major depressive disorder, recurrent, (a mood disorder characterized by persistent feelings of sadness). Review of Resident #1's Level II Pre-admission Screening/Resident Review ((PASRR, a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care), dated 11/21/22 showed:-He/she had a history of disorganized schizophrenia; psychotic disorder, (a severe mental health condition that affects the mind causing the person to have a distorted sense of reality); generalized anxiety disorder, (a mental health disorder characterized by excessive, persistent and uncontrollable worry about everyday things); methamphetamine (meth) abuse; marijuana abuse.-He/She had a history of disorganized thoughts, thought blocking, responding to internal stimuli, being withdrawn and depressed, being suspicious, paranoid (feeling suspicious and distrustful), wandering, hallucinations and delusions, and abnormal thought processes. Review of Resident #1's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by staff and used for care planning), dated 6/20/25, showed he/she was cognitively intact. Review of Resident #1's Care Plan Report dated 4/1025 showed the resident had a history of behavioral challenges that required protective oversight. Interventions included: pharmaceutical interventions as needed; 1:1 observation intervention as needed. Review of Resident #2's admission Record face sheet showed the resident was admitted to the facility on [DATE] with the following diagnoses:-Paranoid schizophrenia, (a type of schizophrenia with paranoia and delusions being prominent symptoms). -Anxiety disorder.-Alcohol dependence.-schizoaffective disorder (a chronic mental health disorder that combines symptoms of schizophrenia with symptoms of a mood disorder). Review of Resident #2's Level II PASSR dated 11/21/22 showed he/she was not able to care for him/herself due to chronic illness and inability to distinguish real from not real. Review of Resident #2's MDS dated [DATE], showed the resident was cognitively impaired. Review of Resident #2's Care Plan Report dated 4/12/25 showed:-He/she was at risk for the following signs/symptoms related to anxiety disorder: cursing, hollering, leg shaking, moving around in or frequently getting up and down from the chair, nail biting, nervousness, pacing on the unit, restlessness, shaky voice, toe tapping, sweating. -Interventions included: being aware of body and facial expressions when approaching the resident; watching for signs of anxiety and acting before he/she lost control; do not argue or tell him/her was wrong while he/she was upset; do not getting a power struggle with the resident; offer medication before he/she had a behavioral outburst; do not get close and remember personal space; offer non-invasive coping mechanisms to reduce anxiety; assist with finding the cause of the anxiety. Review of Resident #1's Progress Notes dated 10/27/25 at 2:32 P.M. showed:-The resident became angry at another resident and hit him/her in the back of his/her head and kicked the resident in the head several times.-A Code Green, (a behavioral emergency or aggressive incident) was called.-The resident went to his/her room when the nurse arrived.-911 was called to have the resident arrested related to assault.-The resident did not have a guardian. Review of Resident #2's Progress Notes dated 10/27/25 at 1:27 P.M. showed:-He/She went to the dining area and was sitting in a chair when Resident #1, came from the back and hit him/her in his/her head and stomped his/her head several times.-A Code [NAME] was called; upon assessment, the

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report to the State Agency (SA) physical abuse for one sampled resident (Resident #2); when on 10/27/25 at approximately 12:00 P.M., Resident #1 approached Resident #2 from behind and struck him/her in the head and neck areas. Resident #2 was knocked to the floor and Resident #1 kicked him/her multiple times in the head and body out of 16 sampled residents. The facility census was 106 residents.Review of the facility's Abuse and Neglect Policy dated 6/12/24 showed:-Any owner, operator, employee, manager, agent or contractor of the facility can report an allegation of abuse/neglect/exploitation to the abuse agency without fear of retaliation.-Refer to the State Operations Manual (SOM) for reporting and utilize the Abuse-Neglect Reporting Decision Tree to assess the particular incident. Best practice was to include the SOM and Decision Tree with the investigation.-Should the incident be a reportable event, notify the appropriate agencies immediately; as soon as possible, but no later than 24 hours after. 1. Review of Resident #1's admission Record face sheet showed the resident was admitted to the facility on [DATE] with the following diagnoses:-Disorganized schizophrenia (a mental disorder characterized by disorganized thinking, speech and behavior).-Major depressive disorder, recurrent, (a mood disorder characterized by persistent feelings of sadness). Review of Resident #2's admission Record face sheet showed the resident was admitted to the facility on [DATE] with the following diagnoses:-Paranoid schizophrenia, (a type of schizophrenia with paranoia and delusions being prominent symptoms). -Anxiety disorder.-Alcohol dependence.-Schizoaffective disorder (a chronic mental health disorder that combines symptoms of schizophrenia with symptoms of a mood disorder). Review of Resident #2's Progress Notes dated 10/27/25 at 1:27 P.M. showed:-Resident refused to let another resident in the room.-He/She went to the dining area and was sitting in a chair when his/her roommate, Resident #1, came from the back and hit Resident #2 in the head and stomped Resident #2's head several times. Review of the Resident #1's Progress Notes dated 10/27/25 at 2:32 P.M. showed he/she became angry at Resident #2 and hit Resident #2 in the back of the head and kicked Resident #2 in the head several times. Review of the Facility Admin/RN Investigation dated 10/27/25 showed:-The incident occurred on 10/27/25.-It was physical aggression involving the head.-Persons involved were Resident #1 and Resident #2.-Local law enforcement was notified. Resident #1 was in police custody.-At approximately 12:05 P.M., shortly before lunch was served on the men's unit, Resident #1 was seated in a chair by him/herself.-Resident #1 stood over Resident #2 and with his/her foot and began hitting Resident #2's head. Review of the local Police Department report dated 10/27/25 at 1:08 P.M. showed:-Resident #1 was arrested; suspect charged.-Resident #2 was the victim.-Business Office Manager (BOM) A was a witness.-The facility reporter was the Assistant Manager of the facility.-Upon arrival, Police Officer A contacted the Assistant Manager at the facility, who stated he/she was advised by staff that a physical altercation occurred which saw Resident #1 assault Resident #2.-The assault occurred in the downstairs common area.-The Assistant Manager contacted Resident #1 who told him/her, If I see him/her again, I'll stomp on him/her until I kill him/her.-Resident #1 was apparently angry at Resident #2 for coming into his/her room sometime prior to their physical altercation.-The Assistant Manager advised that Resident #2 was under guardianship of Guardian A, who was an employee with a County Public Administrator.-Guardian A advised he/she would press charges on behalf of Resident #2.-Resident #1 was self-responsible, meaning he/she was not under any guardianship.-BOM A was contacted and stated the assault occurred in the downstairs locked unit in the common room.-Resident #2 was sitting in a chair minding his/her own business when Resident #1 came up to him/her from behind and struck him/her with a closed fist two times to the face/head area.-This caused Resident #2 to fall to the floor where Resident #1 proceeded to stomp on Resident #1's head three times with his/her right foot before he/she was finally separated by staff.-Nurses employed by the facility administered aid to Resident #2 who did not have any major injuries.-Officer A observed Resident #2's injuries. Resident #2 had bruising on his/her forehead and minor swelling on the back of his/her head and neck and a small scratch on his/her left cheek.-Resident #1 was taken into custody without incident and transported to detention for booking.-Resident #1 was issued a summons for assault. During an interview on 11/7/25 at 1:00 P.M. Nurse Practitioner A said:-Resident #1 assaulted Resident #2. -He/She would personally not consider being high as an excuse for hitting and kicking residents. During an interview on 11/7/25 at 1:20 P.M, the Director of Nursing (DON) said:-He/She did not consider hitting someone in the head or kicking them as abuse. -He/She considered abuse to be