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	03/09/2026

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** Based on observation, interview and record review, the facility failed to ensure two sampled residents (Residents #14 and #18) were free from abuse when on 2/26/26 Resident #8 struck Resident #14 on the back of the head and on 3/1/26 Resident #17 struck Resident #18 with a chair out of 22 sampled residents. The facility census was 104 residents. Review of the facility Abuse and Neglect Policy dated 6/12/24 showed:-It is the policy of the facility to report all allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes. -Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. -Physical abuse is 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 also includes, but is not limited to, hitting, slapping, punching, biting, and kicking. -This facility is committed to protecting our residents from abuse by anyone including, but not limited to, Facility staff, other residents, consultants, volunteers, and staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals.-The facility will identify events, patterns and trends that may constitute abuse and investigate thoroughly, notifying the Administrator and the proper authorities. 1. Review of Resident #8's Preadmission Screening and Resident Review (PASRR, DA-124C, a required form to be submitted for any client who requests admission to a Medicaid certified bed regardless of the client's payment source; this includes dually certified beds both Medicare and Medicaid), dated 5/8/2020 showed: -Diagnoses including schizoaffective disorder (a mental condition that causes loss of contact with reality and mood problems), bipolar disorder (mood disorders characterized usually by alternating episodes of depression and mania), and vascular dementia (a decline in thinking skills caused by conditions that block or reduce blood flow to the brain, robbing brain cells of oxygen) without behavioral disturbances. -He/She had to be given medications, told to shower, change clothes, etcetera.-Significant memory issues are the main problem, with a retention time of 10-15 minutes, each day is a new day. -History of mood swings, depression, and trouble with sleep. -Tended to stay away from others, not much interaction and verbal responses were slow. Review of Resident #8's Referral Packet dated 1/12/26 showed the resident displayed exit-seeking behaviors and aggressive behaviors with staff and peers at a prior placement. Review of Resident #8's Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 2/10/26 showed the resident was severely cognitively impaired. Review of Resident #14's PASARR dated 5/31/16 showed:-Diagnoses including Post-Traumatic Stress Disorder (PTSD is a mental health condition triggered by witnessing or experiencing terrifying, life-threatening events, such as abuse, war, or natural disasters), depression (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living), (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265721	A. Building B. Wing	03/09/2026

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	anxiety (anticipation of impending danger and dread accompanied by restlessness, tension, fast heart rate, and breathing difficulty not associated with an apparent stimulus), adjustment disorder (a mental health condition where an extreme emotional or behavioral reaction to a stressor, such as divorce, job loss, or illness, disrupts daily life), and panic attacks.-He/She had poor impulse control, poor insight, poor judgement, and irritability. -Needed medical, behavioral, medication and safety provided within the nursing facility.-Required more supervision due to poor decision making, behaviors and would be considered an elopement risk in a less restrictive setting. Review of Resident 14's MDS dated [DATE] showed he/she was cognitively intact. Review of the facility Incident Report dated 2/27/26 showed:-On 2/26/26 an incident of physical aggression occurred involving Resident #14 and Resident #8.-Resident #8 walked up to staff and stated he/she wanted to smoke, staff advised it was not time to smoke. -Resident #14 also said it was not time for smoke break.-As Resident #14 was walking away from the table outside of the dining room, Resident #8 hit Resident #14 in the back of the head.-Resident #8 backed away on his/her own and walked towards his/her room.-Resident #14 expressed having a headache and was offered pain relief medication. -According to Resident #8, Resident #14 hit him/her on the cheek, so he/she hit Resident #14 back in the stomach while inside the smoke room. During an interview on 3/9/26 at 1:30 P.M. Certified Nurses Aide (CNA) G said: -One of the resident's called out and Resident #8 was in Resident #14's room beating him/her head. -When he/she got in the room Resident #14 was in bed and Resident #8 was standing. -He/She got Resident #14 out of the bed and behind him/her, Resident #8 was coming towards them. -He/She told Resident #14 to count to 3, then they backed up and ran out of the room to get away from Resident #8. During an interview on 2/26/26 at 11:00 A.M. the Administrator said:-The facility had an incident of abuse. Resident #8 struck Resident #14 in the back of the head. During an interview on 2/26/26 at 12:33 P.M. Resident #14 said: -Resident #8 hit him/her several times on his/her head, face and arm. -He/She was trying to help Resident #8 out, trying to help explain smoke breaks since Resident #8 couldn't quite get it.-He/She complained of pain to the back of head and forearm. -He/She screamed for help and would tell Resident #8 this wasn't his/her room and redirected him/her out of the room. -He/She was glad Resident #8 was gone and didn't want to deal with him/her again. -He/She felt scared when around Resident #8. 2. Review of Resident #17's PASARR dated 12/17/24 showed:-No known family support, under court ordered guardianship.-Diagnoses included schizophrenia, psychosis, bipolar with psychotic features, and borderline personality disorder.-History of mood lability, paranoid delusions, easily agitated, grandiosity, flight ideations, increased psychosis, and refusal of compliance with medications. -History of polysubstance abuse, including hallucinogenic.-History of delusions and talking to unseen persons. -Significant and ongoing fixed delusional ideation of grandiose, religious and persecutory nature leading to functional impairment and disability. -Preoccupied with idea that he/she is being continuously raped. -Other symptoms include labile mood, agitation, intrusiveness, rapid pressured speech, paranoia, internally preoccupied, history of medication non-compliance, and denial of illness.-Nursing Facility services recommended for a period of psychiatric stabilization following a period of medication non-compliance and elopement from previous RCF placing self in a dangerous situation in the community.-Requires ongoing cueing for ADLs as needed, diabetes management due to denial of illness, medication administration and monitoring. -Needs mental health and behavioral services, medication therapy and monitoring, structured environment, and crisis intervention services. Review of Resident #17's MDS dated [DATE] showed he/she was severely cognitively impaired. Review of Resident #18's PASARR dated 1/9/13 showed:-Diagnoses including schizophrenia, chronic paranoid schizoaffective disorder, alcohol dependence and polysubstance abuse.-Suffers from a chronic psychiatric condition, has had multiple in-patient psychiatric treatment episodes and multiple placements in long-term care facilities beginning in the early 1980's.-Significant history of legal problems usually associated with substance use/abuse.-History of homicidal ideation, of threatening behaviors.-History of lability of mood, mild agitation at times and some depression.-History of polysubstance abuse and alcohol use with treatment. -He/She tends to (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	03/09/2026

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	respond almost continually to unseen or unheard others.-Mental status exam was difficult due to paranoia and delusion system.-Suspicious of others, believes he/she is being watched, that others can read or hear his/her thoughts.-Conversation was disorganized, a word salad and interspersed with neologisms. -Continual auditory and visual hallucinations, many of which appear to be command. -Required verbal direction for personal care, monitor what the voices are telling him/her to do, and needed supervision due to disorganization.-Unable to take care of him/herself due to chronic illness, inability to distinguish real from not real, and not treatment compliant without structure. -Was his/her own guardian and needed to be placed under public administration.-Needed guardianship, monitoring for how he/she manages in an unlocked setting very closely. Review of Resident #18's Brief Interview for Mental Status dated 3/2/26 showed the resident was severely cognitively impaired. Review of Resident #17's Progress Note dated 3/01/26 at 2:00 A.M. showed:- It was reported the resident walked into the dining room, picked up a chair, and hit Resident #18 with it, causing Resident #18 to have a small pen-sized scratch on the right side of his/her eye. Review of Resident #17's Incident Report dated 3/1/26 showed:-On 3/1/26 at 2:02 A.M. there was an incident involving Resident #17 and Resident #18.-Resident #18 was sitting in the dining room with other staff nearby. -Resident #17 was observed pacing in the dining room with no clear evidence of anticipated aggression.-Without provocation, Resident #17 quickly picked up a dining room chair and threw it at Resident #18.-Resident #18 raised his/her arm to block the chair while staff verbally directed Resident #17 to stop .-Resident #18 had a scratch on the right eyebrow about the size of a pinhole and difficult to determine if it came from the chair or his/her hand when blocking. -The bleeding stopped after being cleaned, some swelling was noted by the charge nurse.-Pain relief administered, and ice pack offered. Observation of Resident #18 on 3/2/26 at 12:00 P.M. showed: -He/she had a laceration above his/her right eye. -No dressing noted, laceration was well approximated with redness and swelling noted. -He/she was alert to self and unable to interview. Observation of Resident #17 on 3/2/26 at 12:15 P.M. showed:-The resident was displaying behaviors and was unable to be interviewed.-The resident believed the state agency oniste was the feds coming after him/her. -The Assistant Administrator did not feel it was safe to be around the resident at that time due to the resident's behaviors. During an interview on 3/9/26 at 12:04 P.M. the Regional Care Plan Coordinator said:-Resident #17 throwing chairs is a new behavior. -He/She believed Resident #17 hitting Resident #18 was classified as abuse. During an interview on 3/9/26 at 2:30 P.M., the psychiatric Nurse Practitioner:-He/She expected the staff to keep the residents safe.-He/She felt the incident met the criteria for abuse. 3. During an interview on 3/6/26 at 1:00 P.M. the Director of Nursing (DON) said:-Resident #17 struck Resident #18 with a chair. -Resident #18 had a small cut above his/her eye.-The incident met the criteria for abuse. During an interview on 3/2/26 at 3:01 P.M. the Assistant Administrator said:-Resident #17 did not release the chair and kept it in his/her hand when striking Resident #18. -The incident met the criteria for abuse. 2789854, 2791189

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	03/09/2026

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, and record review, the facility failed to ensure residents were provided with activities to meet the residents' psychosocial well-being for two sampled residents (Resident #2 and Resident #16 out of 22 sampled residents. The facility census was 104 residents.Review of the facility's policy, Activities, dated 7/19/23 showed:-The purpose of this policy was to ensure that all residents in the facility were provided an ongoing program of activities designed to meet, in accordance with comprehensive assessment, their interests and their physical, mental and psychosocial well-being.-The Life Enhancement Director coordinates the comprehensive assessment and ensures that activities were designed to promote and enhance the emotional health, self-esteem, pleasure, comfort, education, creativity, success and independence for all residents, based on interview and assessing the resident's likes and dislikes. -The activity calendar would have been posted on each unit.-Under the direction of the Life Enhancement Director/Activities Director documentation would have been completed on each resident's activity within the facility daily. -Documentation would note participation in activities. 1. Review of Resident #2's face sheet showed he/she was admitted to the facility with the following diagnoses:-Schizophrenia (a severe mental disorder characterized by loss of touch with reality).-Anxiety.-Bipolar (a mental health condition characterized by intense mood swings, ranging from extreme highs to lows).-He/She had a legal guardian. Review of the resident's progress notes dated 1/7/26 showed he/she was cognitively intact. Review of the resident's undated care plan showed:-He/She had a behavior problem related to Schizophrenia, dated 7/16/24.-Staff was to provide a program of activities that was of interest and accommodates the resident. No documentation of which activities.-He/She had a behavior problem and went out to the hospital for Suicide Ideation (SI- wanting to end one's life) and upon return stated he/she went to the hospital because he/she was bored.-Staff was to assist the resident to develop more appropriate methods of coping and interacting, offer different activities and resident choice with staff, dated 2/26/26. -He/She was at risk for Anxiety.-Staff was to offer activities to keep him/her from getting bored and provide an opportunity to release energy in a healthy way, dated 6/4/24.-No documentation of which activities the resident enjoyed. Review of the resident's Physician's Order Sheet (POS) dated February 2026 showed an order to send him/her to the emergency room (ER) for evaluation related to suicidal and self-harm threats and refusal to take as needed (PRN) medication, dated 2/16/26. Review of the facility's investigation dated 2/16/26 showed:-The resident overheard staff asking another resident if they were trying to kill themselves.-The resident raised his/her hand and said yes. -The resident was assessed by the nurse and redirected for suicide ideation.-The resident said he/she was hearing voices.-The Nurse Practitioner (NP) was contacted, and an order was received to send the resident to the hospital for evaluation.-The resident was sent out to a nearby hospital.-The resident told the staff that he/she was just bored and wanted to get out of the building. -Conclusion: The resident was not engaged in meaningful activities. Review of the resident's Social Service notes dated 2/18/26 showed:-The Social Service Director (SSD) spoke with the resident about his/her suicidal ideations.-The residents need something to do as this is there home and many of them cannot leave the facility.-They need to interact with each other and maybe make some friends. During an interview on 2/25/26 at 2:10 P.M. the resident said:-He/She had heard voices which told him/her to do something bad to him/herself.-He/she would have liked to do something besides coloring or BINGO.-He/she would like to do something outside of the building. During an interview on 2/25/26 at 2:40 P.M. Certified Nurse's Aide (CNA) F said:--There were not many activities for the residents to do. -They have a social hour in the dining room where the Activity Director plays music or a movie on the TV. -He/She did not remember seeing an Activity Calander. -He/She would not know where to look to find which activities a resident would like to do. -He/she was not educated on the resident's preferred activities. During an interview on 2/26/26 at 2:30 P.M. Licensed Practical Nurse (LPN) D said:-There was not much for the residents to do at night only (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	03/09/2026

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	watch TV.-If the resident did not smoke, they don't go outside the building.-Some of the residents can't leave the building for safety reasons.-A lot of the residents are young and need to go outside to play basketball or do something to get fresh air.-There was nothing for the residents to do on the weekends. -He/she may have seen an activity calendar in the past but not recently.-The Activity Director should ask the residents what kind of activities would interest them, and that interest should be on their care plans. -Residents say they would have liked to do something on the weekend, but they did not know what was available.-He/She was busy with other duties, and it was the Activity Director's job to find things the resident's liked to do to keep them busy and out of trouble. Review of the facility's Action Plan dated 2/26/26 showed:-Staff was to monitor behaviors and attempt to determine underlying cause.-Staff was to provide a program of activities that was of interest and accommodated the resident's status.-Staff was to provide activities that promote exercise and strength building where possible.-There was no documentation of any activities set up. During an interview on 3/2/26 at 2:00 P.M. CNA A said:-If the resident starts to act out, he/she gave them a snack.-He/She did not know where to look for which activities any of the residents would like to go to. -A lot of the residents were in their 30's and need something more than TV or BINGO to do especially on the weekends. During an interview on 3/9/26 at 1:30 P.M. CNA G said:-The residents need more activities to do. -He/She did not know where to look to see which activities the residents would be interested in.-He/She had not seen any Activity Calanders on the walls for a while.-If the residents had more to do then maybe there would have been less problems with the residents. During an interview on 3/9/26 at 9:00 A.M. the SSD said:-The resident told him/her when he/she came back from the hospital that he/she wanted to go to an all-female facility. -There was not much for the residents to do at night.-He/She has seen the resident color as an activity. -There should have been some activities where the residents could have interacted with each other. During an interview on 3/9/26 at 9:44 A.M. the Activity Director said:-The resident went to all the scheduled activities. -The resident was in his/her mid 20's and liked to color and play BINGO. -The resident was not specifically asked what type of activities he/she would have liked. 2. Review of Resident #16's face sheet showed he/she was admitted to the facility with the following diagnoses:-Psychosis (a loss of contact with reality, characterized by symptoms like hallucinations (seeing or hearing things not there), delusions (false, firm beliefs) and disorganized thinking).-Bipolar.-The resident had a legal guardian. Review of the resident's undated care plan showed:-The resident was at risk for signs and symptoms of anxiety disorder.-Staff was to offer activities to keep him/her from getting bored and provide an opportunity to release energy in a healthy way, dated 7/25/24.-Staff was to ensure that the activities the resident attended were compatible with physical and mental capabilities, compatible with known interests and preferences.-Adapt as needed (such as large print, holders if resident lacks hand strength and were age appropriate. -Invite the resident to scheduled activities. -The care plan did not address which activities that were of interest to the resident. Review of the resident's Pre admission Screening and Resident Review PASRR (a comprehensive, person-centered assessment triggered by a positive Level 1 screening, determining if an individual with suspected serious mental illness, intellectual disability, or related conditions needed specialized services) Level II evaluation dated 5/16/25 showed:-Provision of a structured environment.-Staff was to provide schedule of daily tasks or activities. Review of the resident's progress notes showed his/her BIMS score was 12 indicating he/she was moderately cognitively impaired. During an interview on 3/2/26 at 2:00 P.M. the resident said:-There was nothing to do here and he/she went to his/her family's home over the weekend. -He/She would go home whenever it was possible to get out of the facility and do something different.-The staff had never asked him/her what kind of activities he/she would like to participate in.-He/She would have like to do something 1:1 not in a large noisy group, more than BINGO and more activities on the weekends. -He/She said that he/she spends a lot of time sitting in his/her room and would have liked to had someone to talk to or do an activity together. Review of the resident's Action Plan dated 3/9/26 showed staff was to provide him/her with diversional activities. (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	03/09/2026

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Activity Sheet from 1/1/26 to 3/9/26 showed the resident attended activities on the following dates:-1/5/26 and 2/1/26. -There was no documentation of the resident attending any activities after 2/1/26. During an interview on 3/9/26 at 9:44 A.M. the Activity Director said:-He/She did not know what kind of things the resident liked to do.-He/She tried to write down who attended activities but did not always do that. 3. During an interview on 3/9/26 at 9:44 A.M. the Activity Director said:-He/She would go around to the residents and ask them what they would like to do. -They put up Activities Calendars and sometimes the residents tear it down.-There was no current Activity Calendar on the wall. -He/She did not fill out a form for each individual resident showing what kind of activities they were interested in. -The residents were not specifically asked what type of activities they would like to attend. -He/She had a sheet that was filled out for attendance to the activities. -The residents have board games available to play at night. -There was a Church service the residents watched on TV on Sundays. -They did not have many activities on the weekends. Residents usually watched TV. -During the week there was a social hour. -Recently the residents had ice cream. During an interview on 3/9/26 at 2:30 P.M. the Administrator said:-A lot of the resident were younger and needed something to occupy their time.-Many of the residents were not able to leave the facility as they have guardians and did not have permission to leave. -They did not have many outside activities for the residents to do.-His/Her expectation was the Activity Director should have interviewed each of the residents when they first came into the facility and documented on their care plan which type of activities were of interest to them. -The Activity Director should have provided activities to meet the needs of the residents whether the resident was in a group or 1:1.-There should have been activities scheduled in the evening and on the weekends. -Residents become bored then they start to act out. -The Activity Director should have had documentation daily of which residents attended the activities and did not think that had been done. During an interview on 3/9/26 at 3:00 P.M. the Director of Nursing (DON) said:-The Activity Director should ask each resident which activities would be of interest to them, and it should have been documented on an assessment.-The assessment should have been completed when they first came into the facility. -There were activities on the weekends like cards, board games, bowling, crosswords, and watching movies on the TV.-A resident's choice of activities should have been documented in their care plan. During an interview on 3/9/26 at 2:28 P.M. the Psych Nurse Practitioner said:-It was important to have activities as they decrease resident behaviors. -The residents should have been evaluated for the things they liked to do as this was their home.-It was important to have activities in the evenings and on the weekends.