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	04/02/2026

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 - 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 protect three sampled residents (Resident #1, Resident #2, and Resident #9) from physical abuse out of ten sampled residents. On 3/25/26 Resident #2 punched Resident #1, Resident #1 then punched Resident #2 which resulted in bruise to Resident #1's left eye. On 3/31/26 Resident #10 picked up an ashtray, threw it across the room and hit Resident #9 on the left eye which resulted in a bruise to the left eye and a swollen left check for Resident #9. The facility census was 106 residents.Review of the facility Abuse and Neglect Policy, dated 11/28/16 revised on 6/12/24, showed:-Abuse was 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 was purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner. 1. Review of Resident #1's Preadmission Screening and Resident Review (PASRR - A preadmission screening used to help ensure individuals with serious mental disorder and/or developmental disabilities are not inappropriately placed in nursing homes for long term care and receive the services they need in their residential setting), dated 2/26/23, showed the following diagnosis:--Schizophrenia Paranoid Type (a chronic mental disorder characterized by intense, irrational paranoia (distrust and suspicion of others), delusions (false beliefs), and auditory hallucinations (hearing voices).--Schizoaffective Disorder (a chronic mental health condition combining schizophrenia symptoms (hallucinations, delusions) with mood disorder symptoms (mania or depression).--Psychotic Disorder (severe mental health condition that cause a loss of touch with reality, characterized by hallucinations, delusions, and disorganized speech/behavior).--Dependent Personality Disorder (a chronic, excessive need to be cared for, leading to submissive, clingy behavior and intense fear of abandonment).--Adjustment Disorder, with mixed Disturbance of emotions and conduct.--Bipolar II Disorder (a mental health condition characterized by alternating patterns of major depressive episodes and hypomania, a less severe form of mania).--Anxiety Disorder.--Major Depressive Disorder (MDD) (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), recurrent severe without psychotic features.--Traumatic Brain Injury (TBI) (damage caused by an external force that disrupts brain function, ranging from temporary concussion to permanent disability).-The resident's symptoms include stealing from other residents, withdrawn, depressed, suicidal ideations, poor insight and judgement, attention seeking, paranoid, poor hygiene, sexually inappropriate, and refusing medications.-He/She had a history of verbal and physical threats to staff and other residents.-He/She hallucinated (tell him/her to hurt him/herself, hearing voices telling him/her to kill his/her spouse).-The resident had a history of multiple psychiatric admissions and had attempted suicide multiple times. Review of Resident #1's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff and used for care planning), dated 1/21/26, showed he/she was cognitively intact and had no behaviors. Review of Resident #2's undated admission (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 - Actual harm Residents Affected - Few	Record showed he/she was admitted to the facility on [DATE] with the following diagnosis:-Bipolar Disorder.-Anxiety.-Major Depressive Disorder.-Dementia with behaviors (a decline in mental ability such as memory, reasoning, and communication which can cause confusion and negative behaviors such as anxiety, aggression, agitation, and delusions). Review of Resident #2's quarterly MDS, dated [DATE], showed he/she was cognitively intact and had no behaviors. Review of the facility Administrator/Registered Nurse Investigation (RNI), dated 3/25/26, showed:-Physical aggression involving the head between Resident #1 and Resident #2.-Witnessed by Certified Nursing Aide (CNA) A.-At approximately 8:00 A.M., the Administrator was notified that residents were lining up at the smoke room door for smoke break.-Resident #2 walked in front of Resident #1 and Resident #1 told Resident #2 you cannot cut the line.-Resident #2 hit Resident #1 in the eye and Resident #1 hit Resident #2 back on top of the head according to Resident #1.-Resident #1's eye noted to be watery, with mild redness at the time.-Resident#1's left eye had slight bruising on the under-eye area.-Resident #2 had no bruising, red marks or swelling Review of Resident #1's Skin Check, dated 3/25/26 at 8:00 A.M., showed the resident: -Had a new skin issue to the left eye with redness, the eye was watery and had bruising. -Acquired in-house on 3/25/26. Review of Resident #2's incident note, dated 3/25/26 at 9:48 A.M., showed:-A code was called, upon arrival staff informed Licensed Practical Nurse (LPN) A.-Resident #2 had cut the line and Resident #1 told Resident #2 he/she can't do that.-LPN A observed Resident #2 get up off the ground.-Resident #2 stated that he/she was hit on top of his/her head and kicked in his/her left leg.-Resident #2 had no visible injury. Review of Resident #2's Social Service Progress Note, dated 3/25/26 at 10:50 A.M., showed:-Resident #2 was escorted to Social Services office due to a resident to resident this morning.-Per the resident's own admittance, It was all my fault, but Resident #1 should not have hit me.-He/she should not have gotten ahead of the line, if he/she had gone to the back of the line then they would not have this problem.-Resident #1 asked resident #2 to get out of the line and when Resident #2 did not move Resident #1 hit Resident #2 in the head and Resident #2 hit Resident #1 back. Review of Resident #1's social Service Progress Note, dated 3/25/26 at 10:02 A.M., showed:-Per the resident he/she noticed at smoke break Resident #2 had cut the smoke line.-CNA A had asked Resident #2 to get in front of other residents as they walked into the smoke room. -Resident #2 refused to move per Resident #1.-Resident #1 told Resident #2 that he/she cut the line and needed to move.-Resident #2 proceeded to move toward the smoke room.-When Resident #1 nudged Resident #2. Then Resident #2 turned around and punched Resident #1 in the eye.-Per Resident #1 he/she hit Resident #2 back. Review of Resident #2's written statement, dated 3/25/26, showed:-He/She cut in line.-Resident #1 hit him/her and he/she hit Resident #1.-He/She should not have cut the line.-Resident #1 said sorry to the staff but not to him/her. During an interview on 3/31/26 at 3:32 P.M., Resident #2 said:-He/She had cut in line.-Resident #1 hit him/her, because he/she did not go to the end of the line.-He/she was angry and hit Resident #1 on the head. -He/she had no injuries to the head. Review of Resident #1's written statement, dated 3/25/26, showed:-He/She was in line to smoke.-Resident #2 butted in front of him/her and everyone else.-He/she told CNA A about it.-Resident #2 said he/she was up in front of Resident #1.-He/She bumped Resident #2, Resident #2 turned around and hit Resident #1 in the eye, so Resident #1 hit Resident #2 back. Observation and interview on 3/31/26 at 3:38 P.M., with Resident #1 showed:-Resident #1 had a bruise under his/her left eye by the nose.-Resident #1 said Resident #2 cut in line at smoke break time.-Resident #1 told staff but Resident #2 said he/she did not cut in line to the staff.-Resident #1 bumped into Resident #2 and Resident #2 turned around and punched Resident #1 in the left eye.-Resident #1 hit Resident #2 back because Resident #1 was upset. -Resident #1 tried to stay away from Resident #2. Review of CNA A's written statement, dated 3/25/26, showed:-Resident #2 jumped the line.-Resident #1 told Resident #2 to go back.-He/She did as well, but Resident #2 just looked at Resident #1 and said F you.-He/she was not sure who hit who first.-Resident #2 fell and Resident #1 kicked Resident #2.-He/she called a code green, and it was over. During an interview on 3/31/26 at 3:57 P.M., CNA A said:-He/she does not remember what (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	happened for sure.-Resident #2 cut line said F you.-It happened so fast.-He/she called for a code to get help.-He/she tried to separate the residents.-He/she stayed with Resident #2.-Resident #2 had no injuries. During an interview on 4/1/26 at 1:26 P.M., Medical Nurse Practitioner (MNP) said he/she:-Was notified of the incident between Resident #1 and Resident #2 on 3/25/26 due to Resident #1 being punched in the left eye by Resident #2, no new orders were given. During an interview on 4/1/26 at 1:32 P.M., Psychiatric Nurse Practitioner (PNP) said he/she:-Was notified of the incident between Resident #1 and Resident #2 on 3/25/26. During an interview on 4/2/26 at 4:36 P.M., the Administrator said:-The resident-to-resident incident on 3/25/26 between Resident #1 and Resident #2 happened because Resident #1 was to smoke before the other residents due to behaviors in the smoke room with other residents.-Resident #2 walked faster to get in front of Resident #1 to get into the smoke room sooner.-When Resident #1 brought this to CNA As attention and no corrective measures were taken to move Resident #2 to the back of Resident #1 who was not scheduled to smoke at that time.-Resident #1 got upset and bumped into Resident #2 per Resident #1, Resident #2 turned around and punched Resident #1 in the left eye.-CNA A tried to get in-between the residents to separate them and called for a code green for more staff to help.-No one saw Resident #1 push or hit Resident #2. 2. Review of Resident #9's PASRR, dated 5/31/16, showed the following diagnosis:--PTSD.--Depression.--Anxiety.--Adjustment Disorder.--Panic Attacks (a sudden, intense episodes of fear or discomfort, often peaking within 5 to 20 minutes, featuring symptoms like a racing heart, chest pain, dizziness, and feelings of doom).--Histrionic Personality Disorder (a mental health condition marked by a pervasive pattern of excessive emotionality and an overwhelming desire to be the center of attention).--Anti-Social Behavior (a mental health condition defined by a long-term pattern of manipulating, exploiting, or violating the rights of others).--Low Intellectual Functioning.--Mild Intellectual Disability. -The resident's symptoms included poor impulse control, poor insight, poor judgement, irritability, boundary issues, difficulty with appropriate interactions, problems with authority, manipulative, excessive emotionality and attention seeking behaviors.-The resident had a history of multiple psychiatric admissions. Review of Resident #9's undated admission Record showed he/she was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnosis:-Major Depressive Disorder.-Adult Antisocial Behavior.-Bipolar Disorder.-PTSD. Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact with no behaviors. Review of Resident #10's PASRR, dated 9/2/24, showed the following diagnosis:--Schizophrenia.--Psychotic disorder.--Anxiety.--Bipolar Disorder.--Mood Disorder.--Developmental Disability.--Psychosis.--Schizoaffective Disorder.-The resident symptoms included feelings of sadness and agitation with aggressive behaviors with hitting head against.-The resident had a history of multiple psychiatric admissions, and 16 emergency room visits in two and a half months. Review of Resident #10's undated admission Record showed he/she was admitted to the facility on [DATE] and readmitted [DATE] with the following diagnosis:-Restlessness and agitation.-Intellectual Disabilities. Review of Resident #10's quarterly MDS, dated [DATE], showed he/she was cognitively intact with no behaviors. Review of the facility RNI, dated 3/31/26 at 10:10 P.M., showed:-At 8:12 P.M., the Administrator was notified of an incident involving Resident #10 and Resident #9, where Resident #10 was the aggressor.-Resident #10 was receiving a white (personal) cigarette from another peer when Resident #9 interjected and told the peer he/she was not supposed to do that, it was against the rules.-CNA B already made this clear to Resident #10 before Resident #9 interjected.-CNA B told Resident #10 if he/she was going to be aggressive he/she would have to leave.-Resident #10 ignored redirection and threw the ashtray and hit Resident #9.-This upset Resident #10 because Resident #10 because she feels the Resident #9 was bossy in nature.-Resident #10 told Resident #9 to shut up and threw the ashtray across the room hitting Resident #9's left cheek.-Initial skin assessment on Resident #9 noted swelling then about an hour or more later, bruising was observed. Review of Resident #9's Incident Note dated 3/31/26 at 7:50 P.M., showed:-Late Entry.-The Director of Nursing (DON) responded immediately to code green.-Upon (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	arrival CNA B reported Resident #10 threw an ashtray at Resident #9, striking him/her in the face.-Resident #9 was assessed and noted to have a small abrasion under the left eye.-Resident #9 stated At smoke break, I was talking to a peer about not giving out his/her cigarettes to Resident #10. Resident #10 yelled at me in my face; I told CNA B to come here because Resident #10 was going to hit me. Then Resident #10 was yelling some more about me being bossy when I was cleaning the dining room earlier. After Resident #10 sat down in the chair, Resident #10 picked up a black ashtray and threw, and it hit me on the left side of my face. Review of Resident #10's Incident Note, dated 3/31/26 at 7:50 P.M., showed: -upon arrival CNA B reported Resident #10 threw an ashtray at Resident #9, striking him/her in the face. Review of Resident #9's Neurologic Focused Evaluation, dated 3/31/26 at 7:49 P.M., showed: - the resident's left eye pain rated a 9 on a scale of zero being the lowest pain to 10 being the highest pain and was aching, intermitted cool compresses applied, and as needed pain (PRN) medication was given per physician's order. Review of Resident #9's written statement, dated 3/31/26, showed he/she:-At 7:30 P.M. smoke break talking to a peer about not giving out his/her cigarettes to Resident #10.-Resident #10 yelled at Resident #9 in his/her face.-Told CNA B to come in the smoke room because Resident #10 was going to hit Resident #9.-Then Resident #10 yelled at Resident #9 being bossy when he/she cleaned the dining room.-Resident #10 picked up a black ashtray and threw it across the room and hit Resident #9 in the left face real hard.-Resident #9 wants to press charges against Resident #10 for assault. Review of Resident #9's Social Service Progress Note, dated 4/1/26 at 10:00 A.M., showed:-Resident #9 was escorted to the Social Service Office due to the resident to resident overnight.-Per Resident #9 he/she was conversing but (whispering) with one of his/her peers at the evening smoke break. -Resident #9 stated Resident #10 got in his/her face calling him/her a tattle tale.-Resident #9 yelled for staff.-Resident #10 threw an object and hit Resident #9 in the face. Review of Resident #9's Skin Issue, dated 4/1/26 at 4:59 P.M., showed:-Left face had bruising.-Stable; previously deteriorating wound characteristics plateaued, was acquired in-house.-Wound pain medication as needed; ice pack applied relief from interventions. Observation and interview on 4/1/26 at 3:36 P.M., Resident #9 had a bruise under his/her left eye and swelling to the left side of his/her face and temple and said:-He/She told another resident to not share cigarettes.-He/She did not pay attention to Resident #10 when talking to other residents.-Resident #10 yelled Resident #9 that he/she needed to stay out of his/her F business.-Resident #10 got close to his/her face when yelling.-Called for CNA B and LPN B came in the smoke room and told Resident #10 to give the cigarette back to peer.-Resident #10 said, that bitch always wants to be bossy.-CNA B told Resident #10 to leave the smoke room if not going to calm down.-Resident #10 picked up the ashtray and threw it hitting him/her on the left side of the face.-His/Her pain was rated a 9 out of 10 being the highest pain level.-CNA B was in the hallway at that time.-No staff were in the smoke room monitoring the residents.-During the day staff monitor the residents when smoking.-At night some staff stay in the hallway, and some will stay in the smoke room monitoring the residents smoking.-He/She had dreamt about the incident thinking someone was coming in the room, the incident had scared him/her.-Feels safe around others except Resident #10. Review of Resident #10's written statement, dated 3/31/26, showed he/she wrote he/she refused to give a statement for the investigation. During an interview on 4/1/26 at 1:54 P.M., Resident #10 said:-Resident #9 was bossy and a tattle tale.-He/She could only have two of the facility cigarettes and he/she wanted a white cigarette to smoke during the smoke break.-He/She was out of his/her own cigarettes and had no money to buy some.-He/She had enough of Resident #9 being in his/her business.-First, he/she stomped his/her foot to get Resident #9 to stop talking about him/her.-He/She picked up the ashtray and threw it at Resident #9.-Resident #9 had pissed him/her off.-He/She aimed for Resident #9's left eye. Review of CNA B's written statement, dated 3/31/26, showed:-Resident #10 called Resident #9 some names.-CNA B told Resident #10 to give the cigarette back to their peers.-Resident #10 resisted for a little bit then gave the cigarette back to the peer.-Resident #10 was calm and went to the far-right window seat while CNA B was in the doorway (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	monitoring.-Resident #10 then turned around and threw the metal ashtray across the room hitting Resident #9 in the face. During an interview on 4/2/26 at 3:21 P.M., CNA B said he/she:-Was in charge of the 7:30 P.M. smoke break.-Resident #10 did not have any of her own cigarettes.-Offered Resident #10 a house cigarette, but he/she refused did not want a house cigarette wanted a white cigarette.-Explained to Resident #10 he/she was out of his/her own white cigarettes.-While passing out cigarettes to the other residents, Resident #10 borrowed a white cigarette from another resident behind CNA B's back.-Resident #9 told the other unidentified resident that they were not to borrow cigarettes from each other, it was against the rules.-Resident #10 started yelling at Resident #9 calling him/her names.-He/She made Resident #10 give the white cigarette back.-Resident #10 was told to calm down or leave the smoke room.-Resident #10 went to the other side of the smoke room and sat down and did not say anything.-He/She stepped out of the smoke room doorway for a second and Resident #10 threw an ashtray at Resident #9 hitting Resident #9 in the face. During an interview on 4/1/26 at 1:26 P.M., Medical Nurse Practitioner (MNP) said he/she:-Was notified of the incident between Resident #9 and Resident #10 on 3/31/26 due to Resident #9 being hit in the face with an ashtray. -A order was given to apply ice pack to Resident #9's left eye and side of face as needed for swelling. During an interview on 4/1/26 at 1:32 P.M., Psychiatric Nurse Practitioner (PNP) said he/she:-Was notified of the incident between Resident #9 and Resident #10 on 3/31/26.-Staff need to follow facility policies and procedures. During an interview on 4/1/26 at 2:31 P.M., ADON said:-Residents buy their own cigarette with the money they receive monthly, families buy them, or the residents earn points at the facility to buy them.-A white cigarette was the resident's own personal cigarette and are not allowed to give to another resident at any time.-The facility (house) cigarette was brown in color and was flavored,-Residents who do not have any can have a house cigarette during smoke breaks.-Some residents just want their own cigarettes or do not like the house cigarettes due to them being flavored.-Resident #10 was out of his/her own cigarettes and refused a house cigarette.-Resident #10 was caught borrowing a white cigarette from another resident during the 7:30 P.M. smoke break.-Resident #9 chimed in saying Resident #10 cannot borrow a cigarette from another resident.-This upset Resident #10 because Resident #9 was in his/her business.-Resident #10 picked up the ashtray and threw it at Resident #9 hitting him/her in the face.-Resident #9 was assessed for injuries to the left eye and face was puffy and starting to bruise under the left eye.-Would have expected the staff to have separated Resident #9 and Resident #10 incident before the residents escalated to physical abuse per facility policy and procedures. During an interview on 4/2/26 at 4:36 P.M., the Administrator said:-On the resident-to-resident incident between Resident #9 and Resident #10. CNA B should have called a code green when the residents started yelling at each other per facility policy.-LPN B should have made Resident #10 leave the smoke room due to aggression towards Resident #9 before the ashtray was thrown.-Resident #10 threw an ashtray at Resident #9 while in the smoke unattended by staff, hitting Resident #9 in the face.-MNP was notified of the injury, and order was given to place an ice pack to the injured area as needed for swelling, monitor resident for a change in condition and call back if needed.-Resident #9's left eye and cheek changed condition overnight and the MNP was notified of the change, and an order was given for mobile x-ray to come to the facility and take x-rays of Resident #9's left side of his/her face. 2963701, 2970175

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide appropriate, necessary behavioral health services for two sampled residents (Resident #2 and Resident #10) out of 10 sampled residents to maintain the highest practicable physical, mental and psychosocial wellbeing of each resident with supervision and the use of Crisis Prevention Intervention (CPI- behavioral techniques for de-escalation). On 3/25/26, Certified Nurse Aide (CNA) A failed to implement Resident #1's care plan for behavioral interventions on the smoke deck including supervision and the use of CPI with Resident #1 and Resident #2 which resulted in a resident to resident altercation where Resident #1 received a black eye. On 3/31/26, CNA B failed to utilize CPI and provide supervision, when CNA B left the smoke room unattended after Resident #10 had already become agitated with verbal outbursts and Resident #10 threw an ashtray and hit Resident #9 in the face,. which resulted in a bruise to the left eye and a swollen left check for Resident #9. The facility census was 106. Review of the facility's Behavioral Health Services Policy, revised 10/31/24, showed:-The purpose of the policy was to ensure all residents received necessary behavioral health services to assist them in reaching and maintain their highest level of mental and psychosocial functioning.-The facility staff were to ensure the residents were receiving necessary behavioral health care which were person-centered and reflect the resident's goals for care while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.-Behavioral health care and services were to be provided in an environment that was conducive to mental and psychosocial well-being. -The facility staff were to monitor the resident closely for expressions or indications of distress.-If the resident showed signs of distress, the staff were to evaluate if those changes in behavior were unavoidable.-The facility staff were to develop person-centered care for any concerns identified with the resident.-The staff were to maximize the resident's dignity, autonomy, privacy, socialization, independence, and safety.-The facility staff were to have interventions that were person-centered, evidence-based, culturally competent, trauma-informed, and in accordance with professional standards of practice. Review of the CPI Facility Training, dated 2023, showed the goal of CPI training is to equip employees with the necessary skills to prevent and safely manage crisis situations, ensuring a safe and supportive environment for everyone. Review of the facility's undated handbook for CPI showed: -Safety interventions range from verbal and environmental non-restrictive interventions to non-restrictive disengagements and restrictive interventions. The goal is to choose the safety intervention that is a last resort, reasonable, and proportionate. -Disengagements and restrictive interventions are not risk-free and are highly traumatic for everyone involved. It can affect a person physically and mentally. These effects can be long-lasting or even life-threatening. -Many individuals in your care might have already been through traumatic experiences. A disengagement or restrictive intervention can trigger previous traumatic experiences. -Holding. A restrictive safety intervention necessary to restrict a person's range of movement to prevent the infliction of harm to self or others. -Standing Hold: Medium Level Restriction - Staff begin in the low-level restriction. Apply the Outside Principle by placing the palm of your furthest hand at the resident elbow. Apply the Inside Principle, bringing your nearest arm underneath and resting your arm over the person's forearm. Cup your hand to avoid gripping and squeezing. Stand close, adjusting your furthest leg so you remain balanced and stable. Use your body to maintain contact at the shoulder, hip, and thigh. Encourage the person to keep their arms in front of their body. Review of the facility Smoking Safety Regulations, dated 4/6/17 and revised on 6/29/23, showed:-The purpose of this policy was to ensure that all staff and residents were following the safety regulations for smoking.-The facility would provide direct supervision for smoking residents classified as not responsible. Review of the employee training records showed:-Licensed Practical Nurse (LPN) A was trained in CPI on 3/12/26. -LPN B was (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	trained in CPI on 2/1/26.-Director of Nursing (DON) was trained in CPI on 6/24/25. -Assistant Director of Nursing (ADON) was trained in CPI on 6/30/25.-Certified Nursing Aide (CNA) A was trained in CPI on 2/19/26.-CNA B was trained in CPI on 5/20/25. 1. Review of Resident #1's Preadmission Screening and Resident Review (PASARR - A preadmission screening used to help ensure individuals with serious mental disorder and/or developmental disabilities are not inappropriately placed in nursing homes for long term care and receive the services they need in their residential setting), dated 2/26/23, showed the following diagnosis:--Schizophrenia Paranoid Type (a chronic mental disorder characterized by intense, irrational paranoia (distrust and suspicion of others), delusions (false beliefs), and auditory hallucinations (hearing voices).--Schizoaffective Disorder (a chronic mental health condition combining schizophrenia symptoms (hallucinations, delusions) with mood disorder symptoms (mania or depression).--Psychotic Disorder (severe mental health condition that cause a loss of touch with reality, characterized by hallucinations, delusions, and disorganized speech/behavior).--Dependent Personality Disorder (a chronic, excessive need to be cared for, leading to submissive, clingy behavior and intense fear of abandonment).--Adjustment Disorder, with mixed Disturbance of emotions and conduct.--Bipolar II Disorder (a mental health condition characterized by alternating patterns of major depressive episodes and hypomania, a less severe form of mania).--Anxiety Disorder.--Major Depressive Disorder (MDD) (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), recurrent severe without psychotic features.--Traumatic Brain Injury (TBI) (damage caused by an external force that disrupts brain function, ranging from temporary concussion to permanent disability).-The resident's symptoms include stealing from other residents, withdrawn, depressed, suicidal ideations, poor insight and judgement, attention seeking, paranoid, poor hygiene, sexually inappropriate, and refusing medications.-He/She had a history of verbal and physical threats to staff and other residents.-He/She hallucinated (tell him/her to hurt himself/herself, hearing voices telling him/her to kill his/her spouse).-The resident had a history of multiple psychiatric admissions and had attempted suicide multiple times. Review of Resident #1's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff and used for care planning), dated 1/21/26, showed he/she was cognitively intact and had no behaviors. Review of Resident #1's undated Care Plan showed he/she:-Will have decreased signs and symptoms of the diagnosis of traumatic Brain Injury (TBI), Schizophrenia, Suicidal Ideations (SI), Anxiety, Dependent Personality Disorder, and Bipolar Disorder. -Avoid confrontation.-Do not argue or get defensive with him/her.-Keep a routine as much as possible.-Provide a comforting and homelike environment.-Remember his/her personal space.-Watch him/her closely for signs of agitation and work with the residents to reduce impulse feelings of anger.-Decrease stimulation around him/her when displaying signs of anxiety.-Implement plans to change inappropriate behavior.-Was taught the importance of not lining up at the door and waiting to let staff members take other residents when assigned out to smoke. Review of Resident #2's PASARR showed the resident did not have a Level II screening, but did have a Level I screening, dated 6/20/25, showed he/she: -Had Major Depressive Disorder.-Experienced one psychiatric treatment episode that was more intensive than routine follow-up care.-Had a substance related disorder.-Diagnosis of dementia with behaviors, Major Depressive Disorder, and Bipolar Disorder.-Behavioral symptoms were withdrawn/depressed controlled with medications.-Received in patient treatment at psychiatric hospital. Review of Resident #2's undated admission Record showed he/she was admitted to the facility on [DATE] with the following diagnosis:-Bipolar Disorder.-Anxiety.-Major Depressive Disorder.-Dementia with behaviors (a decline in mental ability such as memory, reasoning, and communication which can cause confusion and negative behaviors such as anxiety, aggression, agitation, and delusions). Review of Resident #2's quarterly MDS, dated [DATE], showed he/she was cognitively intact and had no behaviors. Review of Resident #2's undated Care Plan showed he/she:-If resident was disturbing others, encourage him/her to go to a more private area to voice concerns/feelings to assist in decreased episodes of disturbing (continued on next page)

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	265721	A. Building B. Wing	04/02/2026

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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F 0740 Level of Harm - Actual harm Residents Affected - Few	others.-Had potential to be physically aggressive related to poor impulse control.-When the resident becomes agitated, intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, if response was aggressive, staff to walk calmly away, and approach later. -Provide physical and verbal cues to alleviate anxiety.-Keep the resident's routine consistent and try to provide consistent care givers as much as possible to decrease confusion.-Do not get into a power struggle with him/her.-He/She would be assessed per smoking policy to smoke in the designated areas and clothing checks. Review of the facility Administrator/Registered Nurse Investigation (RNI), dated 3/25/26, showed:-Physical aggression involving the head between Resident #1 and Resident #2 witnessed by CNA A.-At approximately 8:00 A.M. on 3/25/26, the Administrator was notified when residents were lining up at the smoke room door for smoke break, Resident #2 walked in front of Resident #1 and Resident #1 told Resident #2 you cannot cut the line. Resident #2 hit Resident #1 in the eye and Resident #1 hit Resident #2 back on top of the head. -LPN A re-educated CNA A, Resident #1 was to have solo smoke breaks before the scheduled time as of 3/22/26. -Resident #1's left eye was noted to be watery, with mild redness and slight bruising on the under-eye area.-Staff shall not permit residents to line up to smoke door; this creates anticipation and could increase anxiety for some residents. During an interview on 3/31/26 at 4:11 P.M., LPN A said:-He/She was the charge nurse working the day the intervention was put in place for Resident #1 to smoke alone before the other residents.-The intervention was a result of prior resident to resident altercation, when Resident #1 had placed his/her hands on another resident's neck.-The care plan was not updated at the time of the incident.-3/22/26 was the date the intervention started.-He/She did not know CNA A was not told about Resident 1's smoking at a different time. Just figured CNA A knew.-The Director of Nurses (DON) and Assistant Director of Nurses (ADON) were responsible for training the staff on any new changes with the residents or policy/procedures including Resident #1 being permitted to smoke prior to smoking times alone. Review of Resident #1's Incident Note, dated 3/25/26 at 9:01 A.M., showed:-A code green was called, upon arrival LPN A observed Resident #1 near the smoke door.-Resident #1 said Resident #2 cut the line.-Resident #1 told Resident #2 he/she could not cut in line and that was when Resident #2 hit Resident #1 in his/her left eye.-Resident #1 then hit Resident #2 in his/her jaw.-Resident #1's right eye was slightly watery no redness noted and the resident denied any pain.-Resident #1 and Resident #2 were reminded ofn the importance of not lining up at the door and to wait to let staff members smoke him/her. Review of Resident #2's incident note, dated 3/25/26 at 9:48 A.M., showed:-Resident #2 had cut the line and Resident #1 told him/her he/she can't do that.-Resident #2 was hit on top of his/her head and kicked in his/her left leg.-Resident #2 was educated to not hit other residents/staff. Review of Resident #1's social Service Progress Note, dated 3/25/26 at 10:02 A.M., showed:-He/she was escorted to the Social Service Office in regards of a resident to resident this morning.-Resident #1 told Resident #2 that he/she cut the line and needed to move.-Resident #1 nudged Resident #2. Resident #2 turned around and punched Resident #1 in the eye and Resident #1 hit Resident #2 back.-Resident #1 was not trying to harm Resident #2.-Resident #1 was just trying to help staff direct Resident #2 to smoke break, because it was Resident #1's turn to smoke. Review of Resident #2's Social Service Progress Note, dated 3/25/26 at 10:50 A.M., showed:-Resident #2 said, It was all my fault, but Resident #1 should not have hit me.-He/She should not have gotten ahead of the line, had he/she gone to the back of the line then they would not have this problem.-Resident #1 asked Rresident #2 to get out of the line and when Resident #2 did not move Resident #1 hit Resident #2 in the head and Resident #2 hit Resident #1 back.-Resident #2 fell because he/she was wearing slippers and lost balance.-Resident #2 was not hurt and feels fine. During an interview on 3/31/26 at 3:32 P.M., Resident #2 said:-He/she had cut in line and did not go to the back of the line.-Resident #1 hit him/her. -He/she was angry and hit Resident #1 on the head. Observation and interview on 3/31/26 at 3:38 P.M. showed Resident #1 had a bruise under his/her left eye by the nose and he/she said: -Resident #2 cut in line at smoke break time.-Resident #1 told staff but Resident #2 told staff he/she did not cut in line.-Resident #1 bumped into Resident #2 and (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	Resident #2 turned around and punched him/her in the left eye.-Resident #1 said he/she hit Resident #2 back.-The incident upset him/her and that was why he/she punched Resident #2 back.-He/she felt safe with no problems and tried to stay away from Resident #2. During an interview on 3/31/26 at 3:57 P.M., CNA A said:-Did not know the interventions Resident #1's smoke breaks had changed since he/she had been off work for a couple of days.-Interventions can be found on the resident's care plan and CPI.-CPI was kept in a notebook at the Nurse's Station.-He/She did not remember what happened for sure.-Resident #2 cut line said F you.-He/she told Resident #2 to get into line. -It happened so fast.-He/she had not separated Resident #1 from the group when Resident #1 had complained Resident #2 had cut in line. -He/She called for a code to get help.-He/She tried to separate the residents.-He/She stayed with Resident #2.-Resident #2 had no injuries. During an interview on 4/1/26 at 1:26 P.M., Medical Nurse Practitioner (MNP) said he/she:-Was notified of the incident between Resident #1 and Resident #2 on 3/25/26 due to Resident #1 being punched in the left eye by Resident #2, no new orders were given.-Would have expected CNA A to separate Resident #1 and Resident #2 when Resident #1 told resident #2 he/she could not cut in line instead of just telling Resident #2, he/she cannot cut in line and left Resident #2 there. -Would expect facility staff to follow the facility policies and separate the residents when residents started to escalate with residents. During an interview on 4/1/26 at 1:32 P.M., Psychiatric Nurse Practitioner (PNP) said he/she:-Was notified of the incident between Resident #1 and Resident #2 on 3/25/26.-Staff did not follow Resident #1's care plan and smoke Resident #1 before the other resident due to several incidents with peers in or around the smoke room. -Would have expected staff to separate the residents when Resident #1 told staff about resident #2 cutting in line.-Staff need to follow facility policies and procedures; staff are to intervene before the residents get physical with each other. -It was reported to them by the DON that CNA A just told Resident 2 to get in line and did not redirect Resident 2 to the end of the line to respond to Resident #1's concern of Resident #2 cutting the line. During an interview on 4/1/26 at 2:31 P.M., ADON said:-Would have expected the staff to have separated Resident #1 and Resident #2 prior to the incident before the residents escalated to physical abuse per facility policy and procedures for Behavior Management.-CNA A reported that he/she just told Resident 2 to get in line and did not redirect Resident 2 to the end of the line. During an interview on 4/2/26 at 4:36 P.M., the Administrator and the DON said:-The altercation was inside the smoke room. -The residents know the smoke break times as they were posted around the facility.-The residents see the staff go to the closet on the other end of the hallway to get out the smoke box and walk by the residents going to the smoke room on each unit.-The staff do not line up the residents; they know when it was time to smoke and start to gather outside the smoke room, getting the residents to enter the smoke room.-Residents can come in late and go out early during the smoke breaks.-The resident to residentincident on 3/25/26 between Resident #1 and Resident #2 happened because Resident #1 was to smoke before the other residents due to behaviors in the smoke room with other residents.-This was put in place for Resident #1 on 3/22/26 due to another resident-to-resident in the smoke room.-Resident #1 must be reminded of this intervention at smoke break times.-CNA A did not know of this intervention and thought Resident #1 was to smoke with the other resident. They forgot to educate him/her.-Not all the staff members were not educated about this intervention at the time of the incident, CNA A was off. -Resident #2 walked faster to get in front of Resident #1 to get into the smoke room sooner.-When Resident #1 brought this to CNA As attention and no corrective measures were taken to move Resident #2 to the back of Resident #1 who was not scheduled to smoke at that time.-Resident #1 got upset and bumped into Resident #2 per Resident #1, Resident #2 turned around and punched Resident #1 in the left eye.-Staff should read the person-centered care plans of each resident involved in incidents or be informed by the charge nurse before or during the shift. The prior shift should have told CNA A on report of the changes to Resident #1's smoke plan; but CNA A was off for a couple of shifts and the staff were no longer giving the Resident #1's change for smoking in report.-Staff knew where to find the resident care plans but only if they had time to (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	read it. Changes were given off in report to the next shift per discipline. -CNA A did not utilize CPI when he/she did not separate Resident #1 from the group and acknowledge Resident #2 had cut in line. CPI provided instruction for verbal de-escalation. 2. Review of Resident #9's PASARR dated 5/31/16, showed the following diagnosis:--PTSD.--Depression.--Anxiety.--Adjustment Disorder.--Panic Attacks (a sudden, intense episodes of fear or discomfort, often peaking within 5 to 20 minutes, featuring symptoms like a racing heart, chest pain, dizziness, and feelings of doom).--Histrionic Personality Disorder (a mental health condition marked by a pervasive pattern of excessive emotionality and an overwhelming desire to be the center of attention).--Anti-Social Behavior (a mental health condition defined by a long-term pattern of manipulating, exploiting, or violating the rights of others).--Low Intellectual Functioning.--Mild Intellectual Disability. -The resident's symptoms included poor impulse control, poor insight, poor judgement, irritability, boundary issues, difficulty with appropriate interactions, problems with authority, manipulative, excessive emotionality and attention seeking behaviors.-The resident had a history of multiple psychiatric admissions. Review of Resident #9's undated admission Record showed he/she was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnosis:-Major Depressive Disorder.-Adult Antisocial Behavior.-Bipolar Disorder. Review of Resident #9's quarterly MDS, dated [DATE], showed the resident was cognitively intact with no behaviors. Review of Resident #9's undated Care Plan showed he/she:-Will have decreased signs and symptoms of the diagnosis of PTSD, depression, anxiety, Adjustment Disorder, Intellectual Disabilities, Antisocial Behavior, and Impulse Disorder.-Administer medications and monitor for side effects.-Providing a calm, relaxing environment can help lessen or relieve anxiety and promote a feeling of safety.-Was at risk for peer-to-peer conflict and psychosocial distress related to a lack of social nuance and boundary awareness associated with Mild Intellectual Disabilities and Adult Antisocial Behavior.-Tends to assume helper or staff-like roles (managing trash in the dining room), which creates negative power dynamics and triggers aggressive responses from cognitively impaired peers.-The resident will defer questions regarding facility rules/schedules to staff rather than attempting to enforce them with peers.-Educate and gently remind the resident of appropriate peer-to-peer boundaries.-Instruct him/her that if a peer asks him/her a question about the schedule, he/she should reply, Let's go ask the nurse/staff.-Staff to check in with the resident daily to ensure he/she continued to feel safe on the unit and allow him/her to verbalize any lingering anxiety regarding the incident. -Staff to monitor the resident's proximity to peers with known episodes of impulse control.-Ensure the residents were seated away from high-traffic areas where peer friction was likely to occur.-Had a behavior problem where he/she attempts to be helpful with staff maintaining environment and helping peers, will try to tell peers what to do, can trigger peers at times resulting in conflicts will hurt the resident's feelings as he/she only wants to help.-Assist the resident to develop more appropriate methods of coping and interacting with his/her peers.-Encourage the resident to express feelings appropriately.-Educate resident on not involving his/herself in other people's affairs.-Intervene as necessary to protect the rights and safety of others.-Approach/speak in a calm manner, divert attention, remove from situation and take to alternate location as needed.-Decrease stimulation around him/her when displaying signs of anxiety.-Educate the residents on boundary setting; redirect away from performing staff-oriented tasks in common areas. Review of Resident #10's PASRR, dated 9/2/24, showed the following diagnosis:--Schizophrenia.--Psychotic disorder.--Anxiety.--Bipolar Disorder.--Mood Disorder.--Developmental Disability.--Psychosis.--Schizoaffective Disorder.-The resident's symptoms included feelings of sadness and agitation with aggressive behaviors with hitting head against.-Place on a 96 hour hold due to attempts to elope and hitting head against the wall.-The resident had a history of multiple psychiatric admissions, and 16 emergency room visits in two and a half months.-The resident had difficulty understanding and following directions, memory was impaired, and thought process was circumstantial and nearly totally focused.-Affective development such as interest and skills involved with expressing emotions, making judgments, and making independent (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	decisions were poor judgement, poor response to redirection, becomes easily agitated, uncooperative and defiant, concrete, judgement quite impaired, and unable to make informed decisions regarding his/her care.-The resident had a history of disorganized behavior worsening psychosis, inability to care for his/herself.-Reports paranoid delusions like having a rat in his/her stomach that needs to be removed, staff poising him/her with red meat. States a dangerous man had control of me. The voice will not leave him/her alone. Review of Resident #10's undated admission Record showed he/she was admitted to the facility on [DATE] and readmitted [DATE] with the following diagnosis:-Restlessness and agitation.-Mood Disorder.-Bipolar Disorder. Review Resident #10's quarterly MDS, dated [DATE], showed he/she was cognitively intact with no behavior. Review of Resident #10's undated Care Plan showed he/she:-Will have decreased signs and symptoms of the diagnosis of Anxiety, Schizophrenia, Psychotic Disorder, Bipolar Disorder, Mood Disorder, Suicidal Ideations (SI) and Intellectual Disabilities.-Administer medications as ordered by physicians.-Closely watch him/her for signs of anxiety and act before he/she loses control.-Will work on coping skills on how to walk away from someone's aggression.-Had aggression with Resident #9. Resident #9 had intervened when the resident requested a cigarette from a peer. -Educated staff and residents on smoking policy. -Give residents five minutes to understand processes with activities. -Offer rewards program to assist with buying personal cigarettes. -Triggers are being yelled at, not smoking, and voices in his/her head.-Staff must actively monitor the residents during smoke breaks and intervene immediately at the first sign of peer conflict or rule disputes. -Staff will consistently and calmly remind the resident of the facility's strict no sharing, trading, or borrowing cigarette policy, ensuring enforcement comes from staff, not peers. Review of the facility RNI, dated 3/31/26 at 10:10 P.M., showed:-At 8:12 P.M., the Administrator was notified of an incident involving Resident #10 and Resident #9, where Resident #10 was the aggressor.-Resident #10 was receiving a white (personal) cigarette from another peer when Resident #9 interjected and told the peer he/she was not supposed to do that, it was against the rules.-CNA B already made this clear to Resident #10 before Resident #9 interjected.-CNA B told Resident #10 if he/she was going to be aggressive he/she would have to leave.-Resident #10 ignored redirection and threw the ashtray hitting Resident #9.- Resident #9 telling the peer to not give Resident #10 a cigarette upset Resident #10 because Resident #10 felt Resident #9 was bossy in nature.-Resident #10 told Resident #9 to shut up and threw the ashtray across the room hitting Resident #9's left cheek.-According to Resident #9, he/she was not paying attention to move out of the way.-Nothing more than first aide administered. -Initial skin assessment of Resident #9 noted swelling then about an hour or more later, bruising was observed.-Resident #10 had been moved and placed on continuous monitoring for the rest of the shift.-CNA B was expected to call the code green at the first sign of verbal aggression and Resident #10s refusal to leave area prior to Resident #9s interjection, to potentially prevent occurrence. This behavioral emergency required corrective action for CNA B. Review of Resident #9's Incident Note, dated 3/31/26 at 7:50 P.M., showed:- CNA B reported Resident #10 threw an ashtray at Resident #9, striking Resident #9 in the face.-Resident #9 was assessed and noted to have a small abrasion under the left eye.-Resident #9 stated At smoke break, I was talking to a peer about not giving out his/her cigarettes to Resident #10. Resident #10 yelled at him/her in my face; I told CNA B to come here because Resident #10 was going to hit me. Then Resident #10 yelled some more about me being bossy when I was cleaning the dining room earlier. After Resident #10 sat down in the chair, Resident #10 picked up a black ashtray and threw, and it hit me on the left side of my face. Review of Resident #10's Incident Note, dated 3/31/26 at 7:50 P.M., showed:-CNA B reported Resident #10 threw an ashtray at Resident #9, striking him/her in the face.-Multiple de-escalation interventions were attempted, including verbal redirection and environmental modification; however, these interventions were unsuccessful. Review of Resident #10's Behavior Note, dated 3/31/26 at 7:35 P.M., showed: - Resident #10 and Resident #9 had what started as a verbal altercation in the smoke room that lead to Resident #10 throwing an ashtray at Resident #9 hitting Resident #9 in the face. Observation and interview on 4/1/26 at 3:36 P.M., (continued on next page)

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