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	04/14/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **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 #9) right to maintain his/her personal property out of 16 sampled residents. The facility census was 105 residents.Review of the facility's Resident Rights policy, revised 9/21/25 showed:-Residents have the right to voice grievances without discrimination or reprisal. -Prompt efforts will be made by facility to resolve grievances residents may have, including those with respect to the behavior of other residents. 1. Review of Resident #16's admission Record showed the resident was admitted to the facility on [DATE] with the following diagnoses:-Bipolar disorder (Mood disorder that can cause intense mood swings).-Psychosis (Mental disorder involving loss of contact with reality) not due to substance or known physiological condition.-Paranoid Schizophrenia (Serious mental illness that affects how a person thinks, feels, and behaves characterized by intense delusions (false beliefs), hallucinations (sensory perceptions that are not real), and distrust of others). Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 2/10/26 showed the resident was moderately cognitively intact. Review of the resident's progress note, dated 4/6/26 at 2:05 P.M. showed a Code [NAME] (behavioral emergency response) was called for the resident at approximately 11:00 A.M. The resident threw another resident's cell phone and broke it and then paced through the medical unit. Review of the resident's internal incident investigation for behavioral events that took place on 4/6/26 and 4/7/26 showed Resident #9 turned in a grievance on 4/6/26 about his/her phone being broken by Resident #16. Review of Resident #9's admission Record showed the resident was admitted to the facility on [DATE] with a primary diagnosis of a stroke. Review of the resident's Inventory Form, signed and dated by the resident on 2/7/26, showed:-The resident had an Apple i-pad.-The resident had a Samsung Galaxy phone. Review of the resident's admission MDS, dated [DATE] showed the resident was cognitively intact. Review of the Resident Grievance Form, dated 4/6/26 and signed by the resident, showed: -His/her phone was broken by Resident #16. -The facility is responsible for the actions of the other resident and needs to replace or pay for his/her phone As Soon As Possible (ASAP). During an interview on 4/9/26 at 11:20 A.M. Resident #9 said:-On 4/6/26 Resident #16, who was his/her roommate, was throwing his/her phone at the window along with throwing other stuff at the window while trying to break the window. -He/She left the room to tell staff what Resident #16 was doing. Resident #16 broke his/her phone at around 10:00 A.M. on 4/6/26 and it was unable to be used. Resident #16 cracked the screen of his/her i-pad as well, but the device could still be used. -The window ended up getting broken by Resident #16 the evening of 4/6/26.-His/Her family member gave him/her the phone that had been broken for Christmas, 2025 and gave him/her another cell phone to use temporarily.-The Administrator told him/her the facility wasn't responsible for his/her phone. Observation on 4/9/26 at 11:40 A.M. showed: -The resident had two phones, one of which the resident was observed using. The other phone had a shattered screen which the resident said was broken by Resident #16. The phone that was shattered was not a Samsung Galaxy.-An i-pad was observed with a crack running from the top left of the screen to the bottom (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right. During an interview on 4/9/26 at 2:05 P.M. the Activities Director said he/she learned from Resident #9 about his/her broken phone and tablet when he/she came to work on 4/7/26. The resident said Resident #16 had smacked his/her phone out of his/her hand on 4/6/26 causing it to shatter. During an interview on 4/10/26 at 2:05 P.M. Certified Medications Technician (CMT) A said: -On 4/6/26 Resident #9 said Resident #16 broke his/her phone.-He/She had seen the resident using two different phones recently and knew both phones worked.-He/She didn't notice the brand of either phone. During an interview on 4/10/26 at 2:57 P.M. CMT B said on 4/6/26 Resident #9 said Resident #16 busted his/her smart phone and broke their room window. During an interview on 4/10/26 at 4:35 P.M. the Social Services Director (SSD) said Resident #9 told him/her Resident #16 broke his/her phone and filled out a grievance form related to his/her complaint. During an interview on 4/14/26 at 9:15 A.M. Receptionist A said:-He/She and the other receptionist were responsible for doing resident inventories when residents are new to the facility. They use an electronic form to document the resident's possessions. -He/She wasn't working the day Resident #9 came into the facility so the other receptionist would have filled it out.-The receptionists were supposed to indicate on the inventory form if a device like an i-pad screen is cracked and the form didn't show the i-pad to have been cracked at the time. -The receptionist always makes a copy of the inventory they fill out and has the resident sign it. During an interview on 4/14/26 at 11:46 A.M. with the Administrator, Regional Nurse Coordinator (RNC) A and RNC B:-RNC A said:--On 4/6/26 a Code [NAME] was called at 11:00 A.M. because Resident #16 was restless and pacing the halls and pacing around the dining room tables.--Around 2:00 P.M. on 4/6/26 Resident #9 said Resident #16 had broken his/her phone earlier in the day.-The Administrator said:--The resident filled out a grievance with the SSD related to a broken phone. --Staff have mentioned the resident has been seen with multiple phones, so he/she didn't know why all the resident's devices weren't on his/her inventory sheet.--He/She notified the corporate office of the resident's grievance but didn't know what the office did about property that might have been broken by another resident. 2975515

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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 interview and record review, the facility failed to prevent physical abuse for three sampled residents (Resident #6, #7 and #8) out of 16 sampled residents. On [DATE] Resident #6 hit Resident #7 and he/she fell to the ground. Resident #6 hit Resident #7 two more times while he/she was on the ground. Resident #7 was sent to the hospital and received a dissolvable suture to his/her bruised lip and swelling to the forehead. On [DATE] Resident #8 was standing in the hallway when Resident #6 approached Resident #8. Resident #6 then threw multiple closed fist punches at Resident #8's face then Resident #8 hit Resident #6. Resident #8's left cheek had swelling and redness. The facility census was 105 residents. Review of the facility's Abuse policy, revised [DATE] showed:-Physical abuse was purposefully striking, wounding, or injuring any resident in any manner whatsoever, including hitting, slapping, punching, biting, and kicking.-On a regular basis the supervisors will monitor the ability of the staff to meet the needs of the residents. 1. Review of Resident #6's admission Record showed the resident was admitted to the facility on [DATE] with the following diagnoses:-Schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves.-Paranoid personality disorder (a mental health condition characterized by a long-term pattern of pervasive distrust and suspicion causing misinterpretations).-Restlessness and agitation. Review of Resident #6's Pre-admission Screening and Resident Review (PASARR), Level II (an in-depth evaluation triggered when a Level I screen indicates a potential serious mental illness or intellectual disability (ID) or related condition. The Level II determines if a nursing facility is appropriate and identifies needed specialized services), dated [DATE], showed:-The resident had a history of mental illness beginning in his/her late teens to early 20's which required inpatient psychiatric treatment. The resident heard voices, thought he/she was being poisoned, thought he/she received personal messages from the TV, and thought he/she had special powers to control others or make things happen. He/She also has a history of crystal meth substance abuse (a highly addictive, illegal central nervous system stimulant). -The resident could be guarded, suspicious, irritable, and easily frustrated and agitated. He/She avoided interpersonal interactions and had difficulty adapting and concentrating.-If admitted to a nursing facility the resident could benefit from medication management and a structured environment and plans for changing inappropriate behaviors and crisis intervention. Review of Resident #6's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated [DATE], showed the resident:-Was moderately cognitively impaired.-Had no verbal or physical behaviors with others during the review period. Review of Resident #7's admission Record showed the resident was admitted to the facility on [DATE] with the following diagnoses:-Traumatic Brain Injury (TBI - damage to the brain resulting from external mechanical force).-Mild cognitive impairment.-Mood disorder (a mental health condition characterized by long-term emotional disturbances that disrupt daily life).-Anxiety disorder (a psychiatric disorder causing feelings of persistent anxiety). Review of Resident #7's Care Plan Report showed the following individual care plans: -The resident's Schizophrenia care plan, initiated [DATE], showed the resident required medications for anxiety and hallucinations. Interventions were for staff to monitor closely for signs of anxiety and help the resident reduce anxiety by offering opportunities to listen to music and relax in bed.-The resident's TBI care plan, initiated [DATE] showed the resident had deficits in attention and inability to manage time and get things done. Interventions were for keeping routine consistent and watch closely for signs of agitation, impulsivity, and/or anger.-The resident's Negative Behaviors care plan, initiated [DATE], showed the resident sometimes slammed doors. Triggers were identified as people being rude. Interventions included counseling, a structured environment, and coping skills training. Review of Resident #7's quarterly MDS dated [DATE] showed the resident: -Was cognitively intact.-Had no verbal or physical behaviors (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	involving others during the review period. Review of the facility's internal investigation, dated [DATE], showed:-On [DATE] at 7:40 P.M. an incident of physical aggression occurred involving the head between Residents #6 and #7. -On [DATE] at approximately 7:40 P.M during a smoke break Resident #6 came into the smoke room and got into line behind Resident #7. Resident #6 didn't like being behind another resident who he/she believed would steal money so he/she went in front of Resident #7 and Resident #7 said he/she couldn't cut in front of him/her. Resident #6 told Resident #7 not to touch him/her and then hit Resident #7 which caused Resident #7 to fall to the ground. Resident #6 proceeded to hit Resident #7 two more times. Staff redirected Resident #6 to walk to his/her own room. Staff provided medical care to Resident #7 who had a busted lip and slight bruising to the forehead. Due to Resident #7's past history of a TBI, he/she was sent to the hospital. Resident #6 received a Telehealth visit with the Psychiatric Nurse Practitioner (Psych NP) who recommended Resident #6 be sent to the hospital for an evaluation. Education was started for resident rights. Interventions were for the Interdisciplinary Team to review the smoke policy and procedures. Abuse was defined as the purposeful infliction of physical, sexual, or emotional injury or harm. Review of the Resident #7's hospital record, dated [DATE], showed:-The resident presented from his/her nursing facility after he/she was punched in the face causing an inner lip laceration and facial abrasions.-The resident has a one centimeter (cm) internal lip laceration. One dissolvable suture placed to keep together. Educated on suture care. Review of the Police Report, dated [DATE], showed:-On [DATE] at 10:35 P.M. officers were dispatched to the facility regarding a call.-Upon arrival they met with the nurse who had not witnessed the physical altercation but was able to look at video footage which showed Resident #6 punch Resident #7 multiple times. From what the nurse gathered the altercation occurred because Resident #7 cut Resident #6 in line.-Officers were unable to gather information on the extent of Resident #7's injury due to the party not being on location. -The nurse said his/her supervisor stated the police incident needed to be documented due to their policy.-The police incident status was closed. The report was inactivated pending further development. Review of Resident #6's incident and progress notes, dated from [DATE] to [DATE], showed:-On [DATE] at 7:35 P.M., a Code [NAME] (it is used to designate a secure, rapid response to an aggressive or combative person) was called and Resident #7 sat on the smoke room floor with active bleeding from his/her mouth. An assessment was completed with the resident found alert and responsive. The resident said he/she had been struck by Resident #6. Resident #6 became agitated and struck Resident #7 in the face because he/she believed the other resident cut in line during the smoke break. The residents were immediately separated and Resident #6 was placed on 1:1 monitoring for safety. The Administrator, medical provider, psychiatric provider, and guardians were notified.-On [DATE] at 12:50 A.M., Resident #6 completed a Telehealth evaluation visit with Psych NP A who ordered a transfer to the hospital for a comprehensive psychological evaluation and x-ray of the resident's right hand due to complaints of pain and visible swelling to the right knuckles. -On [DATE] at 3:33 A.M., following hospital evaluation Resident #6 was provided with a splint with instructions to not remove it. Review of Resident #6's Psychosocial Post-Incident notes, dated [DATE], showed:-A note written at 7:00 P.M. showed: Resident #6 was involved in an incident. He/She didn't want to talk to staff about any incident and stated he/she wanted to smoke. -A note written at 7:01 P.M. showed: Staff observed the resident's right outer ear bleeding. Provider and legal representative notified. Resident refused skin check. -A note written at 8:16 P.M. showed: A Code [NAME] was called. Upon arrival observed Resident #6 in hallway. Staff informed the nurse that Resident #6 was involved in a fight. Resident #6 said he/she asked another resident to stay out of his/her room from getting water and stated the other resident hit him/her. The resident refused to talk further and walked into the dining room. Observed Resident #6's right ear was bleeding. The resident was taken off the unit, and his/her right ear was cleaned. The resident said he/she was okay. Vital signs (heart rate, respirations, and blood pressure) were stable. The NP, Director of Nursing (DON), and Administrator were notified. Observation and interview on [DATE] at 3:25 P.M. showed Resident #7 had a visible cut (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	approximately one-third to one-half inch long and his/her right ear was slightly reddish tented. Resident #7 said:-On [DATE] Resident #6 hit him/her at smoke break time. -He/She was in line to smoke and Resident #6 cut in front of him/her and two other residents. -He/She told Resident #6 he/she couldn't do that. Resident #6 cussed him/her out and he/she cussed Resident #6 out. Resident #6 called him/her a stupid white cracker derogatory name bitch. -He/She told Resident #6 he/she couldn't talk to him/her like that, and Resident #6 hit him/her on his/her lip.-Resident #6 punched him/her two or three times in the mouth and also on the right side of his/her stomach. -Resident #6 hit his/her right ear.-He/She never before had problems with Resident #6 so he/she didn't expect to be attacked by him/her. Review of Certified Nurse Assistant (CNA) F's written statement, dated [DATE], showed:-He/She had residents in the smoke room for the 7:00 P.M. smoke break.-While waiting in line to receive their cigarette he/she heard Residents #6 and #7 get into a disagreement over who was in line first the conversation escalated very quickly into a loud back and forth over who was going to be first.-Resident #6 began to elevate his/her voice and CNA F told the resident to relax and reminded him/her everyone gets to smoke. After that statement Resident #7 said, yeah, that's right. Resident #6 immediately hit Resident #7 twice in the face so hard the blows knocked Resident #7 backwards into the soda machine which caused the resident to fall onto the floor.-Residents #6 and #7 were surrounded by at least five other residents.-He/She moved as fast as he/she could to get Resident #6 off of Resident #7. Before he/she could position himself/herself to do so, Resident #6 threw two more quick punches to the face of Resident #7.--The charge nurse arrived to the unit to assess Resident #7.--He/She explained to the nurse that Resident #7 should remain on the floor because Resident #7 had tried to get up on his/her own and fell hard once again to the floor.--Resident #6 kept hitting Resident #7 in his/her head and temple and his/her nose was bleeding. During an interview on [DATE] at 4:15 P.M., CNA F said:-On [DATE] he/she was passing out cigarettes in the smoke room and saw Resident #6 cut in line. He/She got there late but told Resident #6 all residents would get to smoke. Resident #7 then said yeah, all residents will get a cigarette. -Resident #6 didn't like that and hit Resident #7 in the face. Then Resident #6 hit Resident #7 a second time in the face by Resident #6's cheek and mouth, but he/she didn't remember which side.-Resident #7 fell down and Resident #6 got on top of him/her and hit Resident #7 a couple more times in the face.-Resident #6 was in another world. It looked like the resident would hit CNA F as well so he/she put his/her hands up with palms toward the resident and the resident stopped. -He/She grabbed Resident #6 off Resident #7. -Resident #6 was definitely the aggressor. Resident #7 was too dazed to do anything. Review of Resident #1's quarterly MDS, dated [DATE], showed the resident was moderately cognitively impaired. During an interview on [DATE] at 4:25 P.M., Resident #1 said:-He/She was in the smoke room when Resident #6 attacked Resident #7, who didn't deserve it. -Resident #7 turned around and Resident #6 just clocked him/her and knocked Resident #7 down in two hits to the face.-CNA F looked very concerned and staff called a Code Green. -Resident #7 got hit bad. Review of Resident #10's quarterly MDS, dated [DATE], showed the resident was cognitively intact. During an interview on [DATE] at 4:35 P.M., Resident # 10 said:-He/She turned around and #6 was punching Resident #7 while he/she was standing and Resident #7 landed on the ground.-It happened in the smoke room. -He/She only knew Resident #6 was trying to get his/her cigarette and get out of the smoke room. During an interview on [DATE] at 11:46 A.M., with the Administrator, Regional Nurse Coordinator (RNC) A and RNC B -The Administrator said video coverage of the incident between Resident #6 and #7 was no longer available. After a certain number of hours the video gets taped back over.-RNC A said physical abuse included hitting, punching, slapping, spitting, kicking, and grabbing. -Resident #6 abused Resident #7.-RNC B said Resident #6 abused Resident #7. 2. Review of Resident #8's admission Record showed the resident was admitted to the facility on [DATE] with the following diagnoses:-Mild intellectual disabilities.-Oppositional defiant disorder (a behavioral conditions most common in children and teens characterized by a persistent pattern of angry and irritable moods, argumentative behaviors, and defiance towards authority figures).-Persistent mood (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	disorder.-Autism spectrum disorder (a neurodevelopmental condition affecting brain development, characterized by social and communication challenges, restricted interests, and repetitive behaviors). Review of Resident #8's PASARR Level II Evaluation, dated [DATE] showed the resident:-Had a history of significant psychomotor agitation, opposition to all cares, verbal and physical aggression directed toward staff, cursing and threatening to harm others, and refusing to speak to staff or take medications as scheduled. -Was impatient/demanding, intrusive/invasive with others, and was suspicious of others.-Required 24 hour nursing supervision and oversight to assure he/she and others are safe and he/she had consistent access to psychiatric follow-up and psychotropic medications (drugs that affect mood, perception, and/or behaviors).-Required a plan to address physical aggression directed toward others to include how to firmly redirect while maintaining dignity. Include steps to reduce agitation and anger by use of quiet time in room, 1:1 interactions, distraction through activity, and use of medications as needed.-Required ongoing assessment of mood, thought processes, and behaviors to identify signs of worsening anxiety, fear, depression, and anger that could precipitate harm to self/others.-The resident's plan should include clear steps to take to support the individual during a crisis situation, specify who to contact for assistance, how staff will work together during a crisis and identify when the physician, EMS, and/or law enforcement should be contacted. Review of Resident #8's annual MDS, dated [DATE], showed the resident: -Was cognitively intact.-Had no verbal or physical behaviors involving others during the review period. Review of Resident #8's progress notes, dated [DATE], showed:-Resident #8 was the aggressor in an incident.-New skin issue. Front left earlobe abrasion one cm wide.-Left side of face apparent swelling at cheek, left ear small pen sized scratch. Review of the facility's internal Investigation, dated [DATE] showed:-There was an incident on [DATE] of physical aggression involving the head.-At approximately 6:50 P.M. on [DATE] the DON was notified that according to Resident #6 he/she told Resident #8 to stay out of his/her room and Resident #8 asked what he/she was going to do about it. Resident #6 said Resident #8 hit him/her first, but Resident #8 said he/she did not.-Because the incident happened inside Resident #6's room there was no camera footage to confirm the allegation. -Resident #8 had a bloody nose that was cleaned up with first aid and a scratch on his/her ear.-Resident #6 refused to be evaluated by the nurse.Resident #6 left the facility with the police to a local hospital at 10:46 P.M. for a 96 hour hold after Resident #8 pressed charges. Review of the Police Report, for the [DATE] incident, showed:-Upon arrival the police officer made contact with the Assistant Manager who stated two residents got into a fight and there was video coverage of the incident. -He/She observed Resident #6 assault Resident #8. The video showed Resident #8 stood in the hallway when Resident #6 came into the frame. Resident #6 shoulder checked Resident #8 and proceeded to throw multiple closed fist punches to Resident #8's face. Staff broke up the fight shortly thereafter.-Resident #8 said he/she was going down the hallway to get water when he/she saw Resident #6 walking down the hallway towards him/her. Resident #6 then pushed Resident #8 with his/her shoulder and proceeded to throw punches. -He/She observed swelling and redness to Resident #8's left cheek. Resident #8 said he/she wanted to press charges.-Resident #8's statement was consistent with what he/she observed on the video.-Resident #6 had a previous encounter with Emergency Medical Systems (EMS) a few days prior and proceeded to fight EMS. Resident #6 was a danger to others due to his/her violent behavior and mental health diagnoses.-Resident #6 was taken into custody without incident and transported to the hospital to be placed on a 96-hour hold for a mental evaluation. Resident #6 was issued an assault charge. Due to city level charges Resident #6 was booked and released at the hospital and an affidavit was completed. Review of Certified Medication Technician (CMT) C's written statement dated [DATE] showed:--He/She sat at the table charting medications when he/she heard the noise. --When he/she went to see what was going on he/she saw Residents #8 and #6 fighting. --He/she called a Code [NAME] and tried to break up the fight along with CNA F and CNA G. Review of CNA G's written statement, dated [DATE], showed:--Residents #6 and #8 were fighting in the hallway near the dining area.--He/she saw (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Residents #6 and #8 throwing punches. Then they fell down which caused Resident #6 to hit his/her head.--He/She and the other CNAs held the residents' hands until we were able to get them apart. During an interview on [DATE] at 3:45 P.M., CMT C said:-He/She was working when Resident #6 bloodied Resident #8's nose.-He/She didn't know until later that Resident #8 kept going into Resident #6's room to get water. Resident #6 never told staff until later.-Resident #8 told Resident #6 he/she was going into Resident #6's room whether Resident #6 wanted him/her to or not.-CMT C was charting his/her medications and heard a commotion. Resident #8 grabbed Resident #6 around the body like he/she was going to take him/her down. -He/She called a Code [NAME] and he/she and two other staff tried to break it up. It happened around 6:30 P.M. or so.-He/She and another CNA put Resident #8 in the dining room, and another aide took Resident #6 to the other end.-Resident #8 bullied his/her way into Resident #6's room according to Resident #6.-He/She thought Resident #6 hit Resident #8 because Resident #6 was frustrated. Resident #6 said he/she was just tired of Resident #8 coming into his/her room. Review of Resident #8's written statement, dated [DATE], showed:-He/She went to get water from Resident #7's room because that room had good water. Resident #7 was in the bathroom, so he/she went to the other resident room who had the second-best water.-Resident #6 rushed him/her and stopped and looked and then hit him/her in the face. Resident #6 hit him/her in the head a couple of times.-He/she took Resident #6 down. -By the time he/she had Resident #6 on the ground CMT C and CNA F tried to pull him/her off of Resident #6, but it was kind of a struggle. because for one, when I'm mad and I get ahold of you, trust that my strength is very strong. It usually takes four to five people just to get me off that person. During an interview on [DATE] at 4:00 P.M., Resident #8 said:-He/She had tried to go to another resident's bathroom to get water, but someone was in there. His/Her room didn't have cold water.-He/She walked into Resident #6's room without knocking and went to the bathroom to get water. He/She drank the water and went back into Resident #6's room to get more water. Resident #6 told him/her not to come in.-He/She told Resident #6 he/she didn't have cold water at his/her sink and Resident #6 punched him/her on the left cheek with a closed fist.-He/She thought about hitting Resident #6, but then Resident #6 punched him/her on his/her nose with a closed fist.-Resident #6 tried to hit him/her in the head and he/she grabbed Resident #6 around his/her body, but he/she might have ended up grabbing Resident #6's head instead.-He/She thought Resident #6 hit his/her head on the floor. He/She got on top of Resident #6 and tried to punch him/her, but the aides stopped him/her from hitting Resident #6. Review of CNA F's written statement, dated [DATE], showed:--He/she was coming out of the supply room when he/she heard CMT C screaming you all stop!--When he/she made it to the doorway of the dining area, he/she saw Residents #6 and #8 fighting.--He/she immediately went to assist CMT C and CNA F to separate the two residents.--The time of the Code [NAME] was around 6:48 P.M. During an interview on [DATE] at 4:15 P.M., CNA F said:-He/She came out of the supply closet room around 6:50 P.M. to get ready to start his/her shift and saw an alarmed look on CMT C's face. CMT C said oh, my God! You guys stop!-Residents #8 and #6 were both swinging and fighting.-Resident #6 grabbed Resident #8's hoodie and pulled it over his/her face and swung Resident #8 around while Resident #8 was trying to get out of his/her grip.-They were entangled and went down together. -He/She couldn't tell if either had made contact before they were on the ground. -Once they were exhausted, he/she talked Residents #6 and #8 into letting go and told them OK, you all are tired. Let each other go and they did. -He/She saw the Administrator taking pictures of Resident #8's face.-Resident #6 was taken out of the facility to the hospital a couple of hours after the incident. -Resident #8 pressed charges. -Resident #6 had handcuffs on when he/she left the faciity on [DATE]. During an interview on 4/14 at 10:10 A.M., Psych NP A said:-He/She didn't think Resident #8 struck back until the end of the altercation.-On [DATE] Resident #6 said he/she told Resident #8 not to go into his/her room. -Resident #8 said Resident #6 bumped into him/her hard in the hallway.-Resident #8 said he/she had been going in there because he/she had no cold water and said Resident #6 told him/her not to go into his/her room, but Resident #8 went into Resident #6's room anyway and then Resident #6 (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	04/14/2026

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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(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	purposely bumped into him.-He/She thought Resident #8's nose looked swollen on [DATE], but Resident #8 didn't want to go to the hospital and denied he/she had a swollen nose.-Staff said the water faucet in Resident #8's room worked. -He/She did a Telehealth visit with Resident #8 the night of [DATE] and learned Resident #8 bit Resident #6's ear. During an interview on [DATE] at 9:56 A.M., CNA G said:-On [DATE] he/she heard a noise and turned around and saw Residents #6 and #8 fighting. It was after supper around shift change and staff were meeting in the dining room.-When he/she first saw the altercation Residents #6 and #8 were swinging at each other and they hit each other, but he/she couldn't tell where because they were swinging so fast.-They both slipped and were holding and grabbing each other by the clothes and hitting each other.-They moved so fast she couldn't tell where they hit each other.-Staff had to physically grab them to separate them. They wouldn't stop.-Someone took Resident #8 and someone took Resident #6 to be checked by the nurse. -He/She checked them one at a time. Resident #8 was bleeding from his/her nose.-Resident #6 had a little blood on the outside of his/her ear. He/She left soon after that. During an interview on [DATE] at 10:26 A.M. Licensed Practical Nurse (LPN) A said:-Resident #6 said he/she was upset because Resident #8 kept going into his/her room and getting water and he/she doesn't want anyone in there.-Resident #6 said Resident #8 called him/her a curse word. He/She told Resident #6 he/she needed to tell the staff.-He/She told Resident #8 to stay out of Resident #6's room and leave him/her alone after the incident happened.-He/She could have gotten water from his/her own room. They keep an ice chest on the unit for cold water and he/she can get it there.-What set Resident #6 off was the intrusion. Resident #8 told Resident #6 what you gonna do about it. Resident #6 had told Resident #8 for a couple of nights not to come into his/her room. During an interview on [DATE] at 11:46 A.M., with the Administrator, RNC A and RNC B:-The Administrator said: --The facility goes over all types of abuse during abuse trainings, no matter the type of abuse that has occurred for a refresher. -Video footage of the altercation between Resident #6 and #8 was no longer available. It lasts a certain number of hours and then gets taped back over.Resident #8 said he/she kept going into Resident #6's room because his/her faucet didn't come on full-stream. -RNC B said he/she encouraged Resident #8 to get water from the kitchen water dispenser. What Resident #8 was doing was a boundary issue which is an ongoing behavior of his/hers. What happened between Residents #6 and #8 was abuse.-RNC A said physical abuse included hitting, punching, slapping, spitting, kicking, and grabbing. -What happened between Residents #6 and #8 was abuse. 2978191, 2973781