STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265721	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2026

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, #5 and #8) from physical abuse out of 15 sampled residents. On 4/18/26 Resident #6 choked Resident #5 around his/her neck which left scratch marks to Resident #5's neck. On 4/22/26 Resident #7 hit Resident #8 in the face that caused bruising to Resident #8's left eye. On 4/24/26 Resident #2 hit Resident #1 in the face that caused bruising to Resident #1's left eyebrow/forehead area and nose. The facility census was 104 residents.Review of the facility's policy titled Abuse and Neglect Policy, dated 6/12/2024, showed:-Abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which could include staff to resident abuse and certain resident to resident altercations.-It included verbal abuse, sexual abuse, physical abuse, and mental abuse including facilitated or enabled through the use of technology.-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.-Physical abuse also included, but was not limited to, hitting, slapping, punching, biting, and kicking.-The facility would identify, correct, and intervene in situations in which abuse was more likely to occur.-Prevention would also include assessment care planning and monitoring of residents with needs or behaviors which may lead to conflict or neglect. 1.Review of Resident #5's admission Record showed he/she admitted to the facility with a diagnosis of paranoid schizophrenia (a chronic mental health condition characterized by a combination of schizophrenia symptoms such as hallucinations or delusions) and mood disorder symptoms (mania or depression). Review of Resident #5's quarterly Minimum Data Set (MDS- a federally mandated assessment completed by facility staff), dated 3/5/26, showed:-The resident was cognitively intact.- The resident had no behavioral symptoms within the seven day look back period. Review of an Incident Note, dated 4/18/26 at 9:05 A.M., from Resident #5's showed:-The resident was observed in his/her wheelchair and Resident #6 was standing over Resident #5 hitting Resident #5 several times in the chest and face.-Resident #5 reported that he/she was turning the channel on the TV and then he/she was hit by Resident #6.-Resident #5 had redness on the left side of his/her face and chest area with a scratch under his/her neck.-Resident #5 was sent to a local hospital upon request. Review of Resident #6's admission Record showed he/she was admitted to the facility with a diagnosis of schizoaffective disorder. Review of an Incident Note, dated 4/18/26 at 9:05 A.M., from Resident #6s EMR showed:-The resident was observed to be standing over Resident #5 and hit Resident 35 several times.-Resident #6 reported that Resident #5 took the TV remote from him/her.-Resident #6 was educated on not hitting people.-Resident #6 began to cuss out the staff member and attempted to charge Resident 5 who was sitting at the nurse's station. Review of an Admin/RN (Administrator/ Registered Nurse) Investigation, dated 4/18/26 at 9:10 A.M., showed:-The incident occurred on 4/18/26 at 9:10 A.M.-The type of incident was physical aggression involving the head.-Resident #5 and Resident #6 were involved in an incident.-Resident #9 was a witness to the incident.-The Assistant Director of Nurses (ADON) was on the phone with the Director of Nursing (DON) when (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	he/she heard commotion at the far-left table in front of the TV in the main dining room.-The ADON saw Resident #6 standing over Resident #5 and appeared to be hitting Resident #5 but was not sure due to the angle he/she was looking from.-Resident #9 said the following:--Resident #5 and Resident #6 were fighting/arguing over the TV remote.--Resident #6 wanted to put on a movie while Resident #5 was asking for the TV remote back.--Resident #6 declined to give the TV remote back, stood up, and hit Resident #5.--He/She was certain that Resident #5 had been hit, but he/she could not tell if it had been with an open or closed hand.-Resident #5 and Resident #6 were interviewed by the police before being transported to the hospital.-The facility concluded the following:--Resident #6 made physical contact with Resident #5 during a dispute over the TV remote in the main dining room.--A staff member observed Resident #6 standing over and appeared to strike Resident #5.--Based on staff observations and assessment findings, the physical interaction between Resident #5 and Resident #6 did occur, so the allegation was substantiated.-The incident was a result of abuse. Review of Resident #5's care plan, dated 4/18/26, showed the resident was involved in a physical altercation with a peer on 4/18/26 with a noted minor injury. Review of Resident #6's care plan, dated 4/18/26, showed:-Do not argue or get defensive with the resident.-Watch the resident closely for signs of agitation and work with the resident to reduce impulsive feelings of anger.-The resident had been involved in a physical altercation with a peer on 4/18/26 which resulted in a minor injury to the peer. Review of a Skin Check dated 4/18/26 at 9:05 A.M. from Resident #5's EMR showed the resident had redness on the left side of his/her face and a scratch on his/her neck. Review of a Skin Check dated 4/18/26 at 9:05 A.M. from Resident #6's EMR showed no skin issues were found. Review of Police Report, dated 4/18/26 at 3:37 P.M., showed:-The incident was a non-aggravated assault.-They were dispatched to the facility at 9:15 A.M.-The call notes stated that one resident had assaulted another resident.-Resident #6 was the suspect and was charged with the assault.-Resident #5 was the victim.-The police officer made contact with Resident #5 first.-Resident #5 said:--He/She had been sitting in the cafeteria in his/her electric wheelchair watching TV.--Resident #6 handed him/her the TV remote to control the TV.--He/She told Resident #6 that he/she was going to put on a movie.--Resident #6 then became angry and came to the right side of his/her wheelchair.--Resident #6 put two hands around his/her neck and began to choke him/her.--He/She tried to grab Resident #6's hands to get Resident #6 to stop.--Staff then responded to the incident and separated Resident #6 from him/her.--He/She did not lose consciousness from being choked.-The officer then made contact with Resident #6.-Resident #6 said:--He/She had the TV remote when Resident #5 ripped the remote out of his/her hands.--He/She tried to get the TV remote back from Resident #5 when Resident #5 started to pull at his/her hair.--He/She then hit with an open hand Resident #5 in the chest.--Staff came and separated them.--He/She denied choking Resident #5.-The officer then made contact with the ADON.-The ADON said:--Resident #5 and Resident #6 were in the cafeteria watching tv with their backs to him/her.--He/She looked up and saw arms moving in a hitting motion.--He/She went over to see what was going on.--He/She saw Resident #6 standing over the side of Resident #5's wheelchair with two hands around Resident #5's neck.--Staff broke up and separated the residents before calling the police.--He/She thought Resident #6's behavior had been escalating towards employees and other residents over the past few days.-The officer observed scratches to Resident #5's neck.-The officer did not observe any marks to Resident #6's body. Review of Resident #5's witness statement, dated 4/18/26, showed:-He/She was watching TV.-Resident #6 then gave him/her the TV remote to find a movie to watch.-Resident #6 then stood over him/her.-Resident #6 then went to hit him/her. During an interview on 4/27/26 at 4:00 P.M., Resident #5 said:-Resident #6 stood over him/her.-Resident #6 then started to hit him/her.-Resident #5 then ended the interview. During an interview on 4/27/26 at 3:38 P.M., Resident #6 said:-He/She had been using the TV remote.-Resident #5 wanted to use the TV remote, so he/she handed the remote to Resident #5.-Resident #5 yanked it out of his/her hands and changed the channel.-He/She questioned Resident #5 and asked for the TV remote back.-He/She reached out his/her hand to get the TV remote back.-Resident #5 must have thought that he/she was (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	trying to do something because Resident #5 then started pulling his/her hair.-Resident #5 also hit him/her in the neck.-Resident #5 pulled out a handful of his/her hair.-He/She denied choking Resident #5, but he/she did strike Resident #5 in the chest to get Resident #5 to let go of his/her hair. Review of Resident #9's quarterly MDS, dated [DATE], showed he/she was cognitively intact. Review of Resident #9's written statement, dated 4/18/26, showed:-Resident #5 and Resident #6 were fighting over a TV remote.-Resident #5 was trying to change the TV to a movie.-Resident #6 asked for the TV remote back and Resident #5 told Resident #6 no.-Resident #6 then stood up and hit Resident #5 in the face.-He/She could not tell if Resident #6 hit Resident #5 with an open or closed hand. During an interview on 4/28/26 at 11:56 A.M., Resident #9 did not want to say anything. During an interview on 4/28/26 at 12:03 P.M., the ADON said:-He/She had been at the nurse's station when the altercation occurred.-He/She was unsure of what led to the incident.-He/She saw Resident #5's hands waving and Resident #6 leaned over Resident #5.-He/She couldn't really tell at first if Resident #5 and Resident #6 were having a physical altercation.-Resident #6 hit Resident #5 in the chest area and face.-He/She did observe Resident #6's hands around Resident #5's neck, but not in a choking manner.-Resident #6 did try to hit Resident #5 again while at the nurse's station.-He/She observed redness to Resident #5's face and chest. During an interview on 4/28/26 at 1:14 P.M., Nurse Practitioner (NP) B said:-He/She had been notified after the altercation.-He/She had not observed or heard of any behavior that Resident #6 exhibited before this altercation occurred.-He/She had not been really told what happened.-He/She thought that the staff didn't really know what happened either.-If Resident #6 had hit Resident # 5 then the altercation would be considered abuse. During an interview on 4/28/26 at 2:37 P.M., the Director of Nurses (DON) and Regional Nurse Consultant (RNC) said:-The TV remote was the root cause of the altercation.-There was no outcome related to the altercation.-The DON thought the altercation was a behavioral incident.-They did not think that the altercation could have been prevented and that staff responded appropriately. 2. Review of Resident #8's admission Record showed he/she admitted to the facility with a diagnosis of schizoaffective disorder (a mental health condition that includes features of both schizophrenia and mood disorder), bipolar (a mood disorder that can cause intense mood swings) type. Review of Resident #7's admission Record showed he/she was admitted to the facility with a diagnosis of schizoaffective disorder, bipolar type. Review of Resident #7's quarterly MDS, dated [DATE], showed:-The resident was cognitively intact.-The resident did not have any hallucinations or delusions within the seven day look back period.-The resident had no behavioral symptoms within the seven day look back period. Review of Resident #8's quarterly MDS, dated [DATE], showed:-The resident was cognitively intact.-The resident had no behavioral symptoms within the seven-day look back period. Review of an Admin/RN Investigation, dated 4/23/26 at 3:20 P.M., showed:-The incident occurred on 4/22/26 at 7:30 P.M.-The type of incident was physical aggression invColving head.-Resident #7 was the aggressor in the incident.-Resident #8 was the victim in the incident.-A code green was called at 7:30 P.M. regarding a physical altercation in the hallway.-Upon arrival, staff separated Resident #7 and Resident #8.-Resident #7 was found sitting in a chair in the dining area and stated that another resident had poured something on him/her. -A skin check was performed on Resident #7 and no injuries were found.-Resident #8 was found standing in the doorway of another resident's room.-Resident #8 reported that another resident became angry about not getting some noodles that Resident #8 had had in his/her hands.-Resident #7 then proceeded to call Resident #8 names and hit him/her near his/her left eye several times before falling to the ground.-The nurse had observed a bruise over Resident 8's left upper eye. -Resident #8 was given some pain medication and an ice pack was applied. -The residents had not been sent to the hospital.-The facility concluded that a peer-to-peer physical altercation had occurred.-The residents had been immediately separated, assessed, and treated. Review of a Skin Check dated 4/22/26 at 7:30 P.M., showed Resident #8 had a hematoma (a collection of blood beneath the skin) to his/her left temporal area close to his/her left eye. Review of an Incident Note, dated 4/22/26 at 7:49 P.M., from Resident #7's EMR showed:-Upon (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	arrival, Resident #7 was found in the dining area sitting in a chair with no physical injuries noted.-When asked what happened, Resident #7 stated another resident had poured something on him/her. Review of an Incident Note, dated 4/22/26 at 8:35 P.M., from Resident #8's EMR showed:-Upon arrival, Resident #8 was standing in the doorway of another resident's room.-The nurse observed a knot over the resident's left upper eye.-When asked what happened, Resident #8 stated that another resident became angry related to some noodles that Resident #8 had in his/her hands.-Resident #8 then said that the other resident had called him/her several names and attacked him/her by hitting him/her by his/her eye several times. -Both residents then fell to the floor. Review of Resident #8's care plan, dated 4/23/26, showed the resident had been involved in a physical altercation with a peer on 4/22/26 and had an injury to the left eye. Review of Resident #7's written statement, dated 4/23/26, showed:-Resident #8 threw tomato sauce on him/her at lunch time.-He/She felt Resident #8 took it too far after he/she flipped him/her off.-He/She had given Resident #8 a dirty look and that was why Resident #8 flipped him/her off.-He/She hit Resident #8 and then Resident #8 pinned him/her to the ground. During an interview on 4/27/26 at 2:35 P.M., Resident #7 said:-He/She had flipped off Resident #8.-Resident #8 then flipped him/her off back.-Resident #8 had Vienna sausages with him/her.-Resident #8 then threw the contents of the container at him/her.-This prompted him/her to hit Resident #8 really hard in the eye.-He/She intended to hurt Resident #8 and would have killed Resident #8 if staff had not held him/her back.-He/She felt that the altercation was self-defense.-Staff told him/her afterwards to not get into fights and to avoid Resident #8.-He/She had bad hallucinations recently. Review Resident #8's written statement, dated 4/23/26, showed:-Resident #7 wanted some coffee.-Resident #7 was unable to get coffee.-Resident #7 then started flipping him/her off.-Resident #7 was cussing at him/her.-He/She went back to the hallway and Resident #7 started threatening him/her.-He/She told Resident #7 off.-Resident #7 then proceeded to hit him/her four times above his/her eye.-He/She and Resident #7 went down to the ground and some of his/her Vienna sausages ended up on Resident #7 and him/her.-Resident #7 said that he/she had thrown the Vienna sausages at him/her.-He/She ended up putting Resident #7 in a chokehold.-He/She did not hit Resident #7 back. Observation and interview on 4/27/26 at 3:09 P.M., showed Resident #8 had had purple and red bruising to his/her left eye; and had yellow bruising around his/her left eye, eyebrow, and forehead. He/She said: -Resident #7 wanted coffee.-He/She had been given coffee and Resident #7 was not given any.-Resident #7 then got upset and took it out on him/her.-He/She felt like he/she had just been a convenient target for Resident #7's aggression.-Vienna sausage juice had gotten on Resident #7 during the altercation, but he/she had not thrown anything on Resident #7 prior to the altercation.-His/Her eye had started to heal up by the time SA interviewed him/her and was no longer in pain.-He/She did not feel safe at the facility because of the altercation.-He/She had not reported his/her safety concerns to any of the staff members prior to the interview. Review of Certified Nursing Assistant (CNA) D's witness statement, dated 4/22/26, showed:-He/She had been conducting the 7:30 P.M. smoke break.-He/She overheard residents arguing.-He/She then opened the door and saw Resident #7 and Resident #8 on the floor fighting.-He/She then separated the residents and called a Code green (response to a behavioral incident). During an interview on 4/28/26 at 8:58 A.M., CNA D said:-He/She was in the smoke room when he/she heard loud yelling.-He/She exited the smoke room and saw Resident #7 and Resident #8 fighting.-He/She saw Resident #7 hitting Resident #8. Review of CNA F's witness statement, dated 4/22/26, showed:-He/She was sitting in the common area.-Resident #7 and Resident #8 were in a physical altercation in the hallway around 7:20 P.M.-He/She yelled for CNA D. During an interview on 4/28/26 at 9:04 A.M., CNA F said:-He/She had been looking through a resident's chart when the altercation occurred.-He/She looked up and saw Resident #7 and Resident #8 fighting in the hallway.-Resident #7 was hitting Resident #8. During an interview on 4/28/26 at 12:32 P.M. ADON said the altercation between Resident #7 and Resident #8 would be considered abuse. During an interview on 4/28/26 at 1:14 P.M., NP B said:-He/She thought the altercation (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	occurred because of coffee.-Resident #7 had hallucinations and delusions as part of his/her baseline.-He/She felt the altercation would be considered as abuse.-He/She did not think that the incident could have been prevented due to Resident #7's impulsiveness. During an interview on 4/28/26 at 2:37 P.M., the DON and RNC said:-The root cause of the altercation was related to an unmet need. Resident #7 wanted coffee and Resident #8 had the coffee that Resident #7 wanted.-The DON did not think that Resident #7 had actual intent to harm Resident #8. 3. Review of Resident #1's admission Record showed he/she admitted to the facility with the diagnosis of disorder of brain, unspecified. Review of Resident #1's annual MDS, dated [DATE], showed:-The resident was cognitively intact.-The resident had no behavioral symptoms within the seven day look back period. Review of a Social Services Progress Note, dated 4/24/26 at 5:00 P.M., from Resident #1's EMR showed:-The resident was the aggressor in the resident-to-resident altercation.-Resident #1 and Resident #2 were sitting in the dining area and having a conversation.-Resident #1 felt that Resident #2 was talking down to him/her.-Resident #2 had been telling Resident #1 that he/she wasn't a good parent because Resident #1 would rather smoke cigarettes and eat all day long rather than do good by his/her children.-Resident #1 did not like that so he/she threw a cup of juice at Resident #2's face.-Resident #2 responded by hitting Resident #1 in the face. Review of Resident #2's admission Record showed he/she admitted to the facility with a diagnosis of other schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves). Review of Resident #2's quarterly MDS, dated [DATE], showed:-The resident was cognitively intact.-The resident had no behavioral symptoms within the seven day look back period. Review of a Social Services Progress Note, dated 4/24/26 at 5:00 P.M., from Resident #2's EMR showed:-The resident was the victim in the resident-to-resident altercation.-Resident #2 said he/she and Resident #1 were having a conversation about getting out of the facility.-Resident #2 told Resident #1 that as a parent he/she should be doing everything so he/she could get to his/her kids.-Resident #2 also told Resident #1 that Resident #1 was less of a parent because all Resident #1 ever thought about was eating and smoking.-Resident #1 then threw a cup of Kool-Aid in Resident #2's face.-Resident #2 lost his/her composure after Resident #1 threw the Kool-Aid. Review of an Admin/RN Investigation, dated 4/24/26, showed:-The incident occurred on 4/24/26 at 4:50 P.M.-The type of incident was physical aggression involving the head.-Resident #1 and Resident #2 were involved in the incident.-Resident #2 struck Resident #1 in the face.-Upon arrival, Resident #2 was observed in his/her room sitting on the side of the bed breathing heavily and appearing anxious.-Resident #2 stated, We were talking, and he/she got upset about me telling him/her the fact of life. Resident #1 picked up his/her cup. I told Resident #1 three times not to throw the drink on me. He/She did it anyway, so I hit him/her.-Resident #2 had superficial scratches to his/her upper chest area.-The facility concluded that Resident #1 and Resident #2 had been in a physical altercation initiated by a drink being thrown.-The incident was determined not to be a result of abuse. Review of a Police Report, dated 4/25/26 at 1:41 A.M., showed:-The incident was a non-aggravated assault.-The officers had been dispatched to the facility at 11:43 P.M.-Resident #1 and Resident #2 were considered victims.-When the police officers arrived at the facility, the head nurse had reported that there had been a physical altercation between Resident #1 and Resident #2.-The officer made contact with Resident #2 first.-Resident #2 said:--He/She had been sitting with Resident #1 in the lunchroom.--He/She had gotten into a verbal altercation over family matters with Resident #1.--Resident #1 picked up a drink to throw at him/her.--Resident #2 stated If you throw your juice on me, I am going to beat your ass.--Resident #1 proceeded to throw juice on him/her.--He/She then got up and punched Resident #1 in the face multiple times with a closed fist.--At that point, staff had separated the residents.-The officer then made contact with Resident #1.-Resident #1 said:--Resident #2 was sitting with Resident #1 in the lunchroom.--He/She had gotten into a verbal altercation with Resident #2 over family matters.--He/She picked up a drink to throw at Resident #2.--Resident #2 stated If you throw your juice on me, I am going to beat your ass.--He/She then proceeded to throw juice on Resident (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	#2.--Resident #2 then got up and punched Resident #1 in the face multiple times with a closed fist.--At that point, staff had separated the residents.-Resident #1 appeared to have minor injuries to his/her nose and forehead. Review of Resident #1's care plan, dated 4/25/26, showed the resident had been involved in a physical altercation with a peer related social conflict with noted emotional distress and bruising to nose. Review of Resident #2's care plan, dated 4/25/26, showed the resident had been involved in a physical altercation with a peer related to social conflict with noted anxiety, labored breathing, and superficial scratches to chest. Review of Resident #1's written statement, dated 4/27/26, showed:-Resident #2 hit him/her because he/she had thrown a cupcake when talking about his/her daughter.-Resident #2 called him/her dumb.-He/She had pain to his/her nose and above his/her eyes. Observation and interview on 4/27/26 at 12:58 P.M., showed Resident #1 had yellow and purple bruising to his/her nose and left eyebrow/forehead area. He/she said: -Resident #2 had been talking bad about him/her.-He/She threw a cup of juice at Resident #2.-Resident #2 responded by hitting him/her.-If he/she had known that Resident #2 was going to hit him/her then he/she would not have thrown the juice at Resident #2.-He/She talked with staff afterwards about using coping skills and kind words.-He/She would not throw juice at anyone else. Review of Resident #2's witness statement, dated 4/24/26, showed:-Resident #1 had asked what's for dinner.-Resident #2 told Resident #1 what was for dinner.-Resident #1 then asked again, so in response Resident #2 said he/she needed to try to remember.-Resident #1 then said that he/she wasn't talking to Resident #2. During an interview on 4/27/26 at 1:16 P.M., Resident #2 said:-He/She had been sitting at a table with Resident #1.-They were sitting across from each other.-Resident #1 rolled his/her eyes and got hateful.-He/She told Resident #1 he/she didn't need to be a smartass.-Resident #1 then called him/her a dumbass.-He/She was talking to Resident #1 about the different things that he/she could do to be able to get back with his/her daughter.-Resident #1 looked like he/she was going to throw water at him/her.-He/She told Resident #1 not to do that and had reminded him/her three different times.-He/She told Resident #1 that he/she would whoop his/her ass if he/she threw the water.-Resident #1 then threw the juice at him/her.-He/She then responded by hitting Resident #1 in the face.-He/She then blacked out and when he/she came to, he/she was still punching Resident #1 in the face and staff were pulling him/her off of Resident #1.-He/She cared about Resident #1, and his/her impulse got the better of him/her.-He/She was ashamed and remorseful of his/her actions. Review of CNA G's witness statement, dated 4/24/26, showed:-He/She witnessed punching Resident #2 punching Resident #1 in the face.-A conversation led to the altercation.-Resident #2 had been talking about Resident #1's child.-Resident #2 wanted Resident #1 not to throw juice at him/her or else he/she would whoop Resident #1's ass. During an interview on 4/28/26 at 9:18 A.M., CNA G said:-Resident #1 and Resident #2 were sitting at a table.-Resident #2 was talking to Resident #1 about how Resident #1 was going to take care of his/her daughter if Resident #1 could not take care of himself/herself.-At some point before the altercation he/she did remember Resident #2 saying if you throw it, I will whoop your ass.-This triggered Resident #1 and Resident #1 then threw water at Resident #2.-Everything happened so quickly and there was no time to respond to the threat.-Resident #1 told him/her that Resident #1's daughter caused Resident #1 to throw water at Resident #2. Review of CNA B's witness statement, dated 4/24/26, showed:-Resident #1 and Resident #2 were arguing about something.-He/She overheard Resident #2 say if you throw that water at me, I am going to whoop your ass.-He/She then told Resident #1 not to throw water on Resident #2.-Resident #1 initially did not throw the water at Resident #2 after the reminder.-All of the sudden Resident #1 threw water at Resident # #2. During an interview on 4/28/26 at 9:51 A.M., CNA B said:-Resident #1 and Resident #2 were having a conversation.-The conversation turned into an argument.-He/She checked-in with Resident #2 to see if everything was okay.-Everything went quiet after that.-He/She then heard Resident #1 tell Resident #2 that he/she would throw water at Resident #2.-Staff told Resident #1 not to do that and everything went quiet again and he/she went back to charting.-All of a sudden, he/she saw juice flying and Resident #2 hit Resident 1.-He/She did not think that the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265721	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2026

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	resident's would get into a physical altercation because Resident #1 and Resident #2 were close.-The altercation would be considered abuse. Review of CMT B's witness statement, dated 4/24/26, showed:-Around 4:37 P.M. he/she had been at his/her medication cart.-He/She heard a voice from one of the staff members.-The staff member was shouting and telling the residents to stop it.-He/She then ran to the altercation and saw Resident #2 hitting Resident #1 in the face.-He/She then separated the residents. During an interview on 4/28/26 at 10:13 A.M., CMT B said:-He/She wasn't in the best position to see what had happened.-He/She had been looking for his/her keys when he/she heard a staff member say, stop it.-He/She then ran to the incident and saw Resident #2 hitting Resident #1 in the face.-He/She was unsure of what triggered the altercation.-He/She saw redness to Resident #1's ears and face and some bruising after the altercation ended. -He/She reminded Resident #1 to use self-defense when a resident becomes physical.-He/She felt the incident could have been prevented.-The altercation would be considered abuse. Review of Resident #12's quarterly MDS, dated [DATE], showed the resident was cognitively intact. Review of Resident #12's witness statement, dated 4/24/26, showed:-Resident #1 threw Kool-Aid on Resident #2.-Resident #2 responded by punching Resident #1 about two to three times. During an interview on 4/28/26 at 11:25 A.M., Resident #12 said:-Resident #1 and Resident #2 were talking about kids.-Resident #1 then threw juice at Resident #2.-Resident #2 then started punching Resident #1.-The altercation happened in the dining room. Review of Resident #13's annual MDS, dated [DATE], showed the resident had mildly impaired cognition. Review of Resident #13's witness statement, dated 4/24/26, showed:-Resident #2 was putting Resident #1 down and saying mean things.-Resident #1 then threw the juice at Resident #2.-Resident #2 then started hitting Resident #1.-A Code [NAME] was then called. During an interview on 4/28/26 at 11:51 A.M., Resident #13 said:-Resident #2 put Resident #1 down and then started wailing on Resident #1.-Resident #1 had thrown Kool-Aid at Resident #2 during the altercation. During an interview on 4/28/26 at 12:23 P.M., the ADON said:-The altercation could have been prevented.-Staff heard the situation going on and they all knew that Resident #2 escalated things quickly.-When staff overheard Resident #2 warn Resident #1 multiple times that would have been the opportunity for intervention.-Staff only intervened verbally when they should have intervened by walking over to the residents to figure out how to best respond.-Staff could have taken Resident #2 off the unit or could have taken the juice away from Resident #1.-The altercation would be considered as abuse. During an interview on 4/28/26 at 1:14 P.M., NP B said:-He/She had been notified of the altercation and did telehealth appointments that night with Resident #1 and Resident #2.-Resident #1 reported to him/her the following:--Resident #2 had been talking to Resident #1 about not being a good parent.--Resident #1 then picked up a drink and told Resident #2 that he/she would throw it at Resident #2.--Resident #2 told Resident #1 that he/she would beat Resident #1's ass if Resident #1 threw the drink at Resident #2.--Resident #1 then set the drink down.--Staff had also told Resident #1 not to throw the drink at Resident #2.--Resident #1 ended up throwing the cup at Resident #2 anyway.--Resident #2 then struck Resident #1 in the face.-Resident #2 told him/her the following:--He/She had been talking to Resident #1.--Resident #2 had told Resident #1 that Resident #1 needed to worry about more things like getting out of the facility to be with his/her daughter instead of focusing on food, drinks, and cigarettes.--Resident #1 interpreted that as Resident #2 calling Resident #1 a bad parent.--He/She responded in self-defense to Resident #1's actions.-The altercation would be considered abuse. During an interview on 4/28/26 at 2:37 P.M., the DON and RNC said:-If staff thought the altercation could have been prevented, then it probably could have been prevented.-The altercation would be considered as abuse. 2994292, 2991969, 2987506, and 2987549

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure professional standards were met related to the documentation of blood glucose (sugar) checks (measures the amount of sugar in blood) and insulin (a hormone produced by the pancreas that regulates blood sugar levels) for three sampled residents (Resident #10, Resident #14, and Resident #15) out of 15 sampled residents. The facility census was 104 residents.Review of the facility's policy titled Administration of Insulin Policy dated 5/14/24 showed:-All insulin would be administered in accordance with physician orders.-Insulin administration will be coordinated with mealtimes and bedtime snacks unless otherwise specified in the physician order.-Staff were to review the insulin order which included:--Resident name.--Medication name.--Medication dosage.- Time to be administered.--Route of administration.-Staff were also to administer insulin at appropriate times.-After administering the insulin staff were to document the dosage, site, and time in the medication along with nurse signature. Review of Transcription Orders/Following Physician's Orders dated 5/18/24 showed:-The licensed nurse would review electronic Medication Administration Records (MARs) and electronic Treatment Administration Records (TARs) on a routine basis to monitor for medications that were not administered to the resident due to unavailability, refusal, omission, etcetera.-If a medication was marked as not given, the reasoning for not being given should be explained in the progress notes, and the Director of Nursing (DON)/Assistant Director of Nursing (ADON)/Registered Nurse (RN), and Administrator should all be notified.-The Physician and legal guardian (if applicable) must also be notified.-The nurse's progress notes must document the plan/solution because of the medication not being administered and any adverse reactions that the resident may have.-For electronic MARs/TARs, the medication would be documented as not given by selecting the corresponding chart code for the reason why it was not given, and a progress note would be written.-The nurse or Certified Medication Technician (CMT) in charge of medication administration must review all their designated MARs and TARs prior to the end of their shift to ensure that all medications/treatments scheduled to be given on their shift were administered according to the physician's order and that all necessary interventions were taken in the event of an omission. 1. Review of Resident #15's admission Record showed he/she admitted to the facility with a diagnosis of Diabetes Mellitus (DM II- a metabolic disease). Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff) dated 2/23/26 showed:-The resident was cognitively intact.-The resident received no injections within the seven day look back period. Review of the resident's Order Summary Report dated April 2026 showed:-An order for Humalog (Insulin Lispro- a fast-acting insulin) Injection Solution, inject as per sliding scale.-An order for Insulin Glargine (a long-acting insulin) Solostar Subcutaneous Solution Pen-Injector 100 unit/milliliter (ml), inject 25 units subcutaneously at bedtime, hold for blood glucose level less than 70 milligrams (mg)/deciliters (dL).-An order for blood sugars to be checked before meals and at bedtime. Review of the resident's MAR/TAR dated April 2026 showed:-The resident missed six out of 27 opportunities of administration related to his/her insulin glargine injection.-The resident missed seven out of 81 opportunities of administration related to his/her insulin lispro injection.-The resident missed 11 out of 108 opportunities related to his/her blood sugar checks. During an interview on 4/28/26 at 11:30 A.M. the resident said:-Sometimes the staff would forget to check his/her blood sugar and give him/her insulin.-Sometimes he/she would need to ask staff to do his/her blood sugar checks or insulin administration if he/she was not checked as ordered.-He/She thought that the staff could be doing the checks and administration outside of the scheduled time, so maybe that was why they were not documenting the blood sugar checks or insulin administration. 2. Review of Resident #10's admission Record showed he/she was admitted to the facility with a diagnosis of DM II. Review of the resident's quarterly MDS dated [DATE] showed the resident received insulin injections seven (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	days out of the seven day look back period. Review of the resident's Order Summary Report dated April 2026 showed:-An order for blood sugars to be checked before meals and at bedtime.-An order for Lantus (Insulin Glargine) Solostar Subcutaneous Solution Pen-Injector 100 unit/ml, inject 12 units subcutaneously two times a day. Review of the resident's MAR/TAR dated April 2026 showed:-The resident had an order for Insulin Lispro Injection Solution 100 units/ml, inject per sliding scale from 4/1/26 which was discontinued on 4/21/26.-The resident had an order for Lantus Solostar Sub cutaneous Pen-Injector 100 unit/ml, inject 13 units subcutaneously two times a day from 4/1/26 that was discontinued on 4/21/26.-The resident had an order for Lantus Solostar Subcutaneous Pen-Injector 100 unit/ml, inject 10 units subcutaneously two times a day, which was ordered on 4/21/26 and discontinued on 4/24/26.-The resident missed nine out of 36 opportunities of administration related to his/her insulin lispro injection.-The resident missed one out of seven opportunities of administration related to his/her insulin glargine inject 10 units subcutaneously two times a day injection.-The resident missed seven out of 18 opportunities of administration related to his/her insulin glargine inject 13 units subcutaneously two times a day injection.-The resident missed 10 out of 66 opportunities related to his/her blood sugar checks. 3. Review of Resident #14's admission Record showed he/she admitted to the facility with a diagnosis of DM II. Review of the resident's quarterly MDS dated [DATE] showed received insulin injections seven days out of the seven day look back period. Review of the resident's MAR/TAR dated April 2026 showed:-An order for blood sugar to be checked before meals and at bedtime.-An order for Insulin Aspart (a fast-acting insulin) Subcutaneous Solution Pen-Injector 100 unit/ml, inject per sliding scale.-An order for Insulin Aspart-szjj (a fast-acting insulin) Subcutaneous Solution Pen-Injector 100 unit/ml, inject eight units subcutaneously before mealtimes and at bedtime.-An order for Insulin Degludec (a long-acting insulin) Subcutaneous Solution Pen-Injector 100 unit/ml, inject four units subcutaneously at bedtime. Review of the resident's MAR/TAR dated April 2026 showed:-The resident missed nine out of 109 opportunities of administration related to his/her insulin aspart injection.-The resident missed 10 out of 109 opportunities of administration related to his/her insulin aspart-szjj injection.-The resident missed four out of 27 opportunities of administration related to his/her insulin degludec injection.-The resident did not have any documentation records related to his/her blood sugar checks. 4. During an interview on 4/28/26 at 12:21 P.M. the ADON said:-He/She had not noticed any issues with documentation related to blood sugar checks and insulin administration.-He/She has had residents inform him/her that they didn't have their blood sugars checked at times.-All CMTs were able to check resident's blood sugars.-Some of the CMTs were certified to be able to administer insulin.-The majority of the time nurses were responsible for blood sugar checks and insulin administration.-He/She felt like staff were not very good about documenting refusals of blood sugar checks and insulin administration.-He/She had been doing daily audits of medication administration but had been assigned to work on the floor and was unable to perform the audits.-He/She had been assigned to work the floor for about three to four weeks.-He/She thought that documentation could also be getting missed if staff had to respond to behavioral emergencies.-Staff should be documenting all blood sugar checks and insulin administration regardless of issues that may occur on the shift.-If a resident refused for their blood sugar to be checked or have insulin administered then the staff were responsible for documenting the refusal and progress note.-Staff should also be communicating with nurse management if there were issues during the shift that prevented documentation to be completed. During an interview on 4/28/26 at 1:08 P.M. Nurse Practitioner (NP) A said:-He/She expected staff to follow all physician orders.-If a resident refused to have their blood sugar checked or their insulin administered then it needed to be documented.-He/She expected the staff to follow the facility's policy related to blood suage checks and insulin administration.-He/She expected staff to notify the provider if the order indicated to do so.-He/She had not heard residents complain to him/her about blood sugar checks or insulin administration. During an interview on 4/28/26 at 2:37 P.M. the DON and Regional Nurse Consultant (RNC) said:-All staff were expected to chart in real (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time.-There was no excuse for staff not to document blood sugar checks or insulin administration.-The ADON had been performing medication administration audits but had been assigned to work on the floor more frequently and had been unable to perform the audits.-There was no other person assigned to perform the medication administration audits since the ADON had been working on the floor.-He/She expected the staff to follow all physician orders.-He/She felt that staff were doing the blood sugar checks and insulin administration but were not documenting it.-Id residents refused their blood sugar checks and insulin administration then it needed to be documented too. 2986541

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F 0740 Level of Harm - Minimal harm or potential for 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 observation, interview, and record review, the facility failed to utilize the facility practices and procedures to call a Code [NAME] (behavioral health response) at the start of a verbal escalation per facility policy for one sampled resident (Resident #2) resulting on 4/24/26 Resident #2 hit Resident #1 in the face causing bruising to Resident #1's left eyebrow/forehead area and nose out of 15 sampled residents. The facility census was 104 residents.Review of the facility's policy titled Behavior Health Services Policy dated 10/31/24 showed:-It was the policy of the facility to ensure all residents received necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning.-The facility utilized the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care.-All facility staff, including staff and volunteers, should receive education to ensure appropriate competencies and skill sets for meeting behavioral health needs of residents.-Education should be based on the role of the staff member and resident needs identified through the facility assessment.-The facility staff would implement person-centered approaches designed to meet the individual goals and needs of each resident, which included non-pharmacological interventions (refers to approaches to care that do not involve medications, generally directed towards stabilizing and/or improving a resident's mental, physical, and psychosocial well-being).-Examples of individualized, non-pharmacological interventions to help meet behavioral needs of all ages could include, but were not limited to:--Assisting residents with access to therapies, such as psychotherapy, behavior modification, cognitive behavioral therapy, and problem-solving therapy.--Providing support with skills related to verbal de-escalation, coping skills, and stress management. 1. Review of Resident #2's admission Record showed he/she admitted to the facility with the following diagnoses:-Other schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves).-Anxiety disorder (a group of mental health conditions characterized by persistent, excessive, and uncontrollable fear, worry, or dread that interferes with daily life).-Major depressive disorder (MDD- a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), recurrent, unspecified. Review of Resident #2's quarterly Minimum Data Set (MDS- a federally mandated assessment completed by facility staff), dated 3/5/26 3/5/26 showed:-The resident was cognitively intact.-The resident had no behavioral symptoms within the seven day look back period. Review of Resident #2's undated care plan showed:-The resident had been involved in a physical altercation with a peer related to social conflict with noted anxiety, labored breathing, and superficial scratches to chest.-The resident is at risk for the following signs and symptoms r/t the diagnosisanxiety disorder: Cursing, hollering, moving around in or frequently getting upand down from the chair, nervousness, pacing on the unit, and restlessness. -The following interventions were in place:--Closely watch me for signs of anxiety and act before I lose control.--Do not get into a power struggle with the resident.--Don't get to close and remember personal space.--Offer activities to keep me from getting bored and provide an opportunity torelease energy in a healthy way.--Offer non-invasive coping mechanisms first to try to reduce my anxiety level. Assistwith finding the cause of the anxiety.The resident was at risk for the following signs/symptoms related to their diagnosis ofSchizophrenia: Aggression, anxiety, inability to make decisions, delusions, fearful, hallucinations, hard time focusing or showing no interest in activities/projects, and irritability.-The following interventions were in place:--Avoid arguing or getting defensive with the resident.--Be respectful, honest, and nonjudgmental with the resident at all times.--Please notify charge nurse if staff observed the resident experiencing any of the signs and symptoms of schizophrenia.--Please respect the resident's personal space.--Residents that hallucinate are often fearful of people coming near them, be (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	carefulwhen using reassuring touch.--Use simple, clear language with me.- The resident had negative behaviors including: yelling, screaming, slamming doors, threatening to hurt people, head banging, and throwing objects. -The following interventions were in place:--Coping skills including reading and writing, music and tv, cleaning and staying busy.--The resident needed supports including counseling, structured environment, outside support network, and coping skills training.--Preferred interventions including talking to staff when upset and feeling heardby staff, cleaning, keeping busy with staff around the facility.--The resident's support system included his/her mom and sister.--The resident had triggers including rude people, dirt and filth, yelling and cursing, people not listening to him/her. Review of Resident #1's admission Record showed he/she was admitted to the facility with the diagnosis of disorder of brain, unspecified. Review of Resident #1's annual MDS dated [DATE] showed:-The resident was cognitively intact.-The resident had no behavioral symptoms within the seven day look back period. Review of Resident #1's care plan dated 4/25/26 showed the resident had been involved in a physical altercation with a peer related social conflict with noted emotional distress and bruising to nose. Review of an Admin/Registered Nurse (RN) Investigation dated 4/24/26 showed:-The incident occurred on 4/24/26 at 4:50 P.M.-The type of incident was physical aggression involving the head.-Resident #1 and Resident #2 were involved in the incident.-Resident #2 struck Resident #1 in the face.-Upon arrival, Resident #2 was observed in his/her room sitting on the side of the bed breathing heavily and appearing anxious.-Resident #2 stated, We were talking, and he/she got upset about me telling him/her the fact of life. Resident #1 picked up his/her cup. I told Resident #1 three times not to throw the drink on me. She did it anyway, so I hit him/her.-Resident #2 had superficial scratches to his/her upper chest area.-The facility concluded that Resident #1 and Resident #2 had been in a physical altercation initiated by a drink being thrown. Review of Resident #1's witness statement dated 4/27/26 showed:-Resident #2 hit him/her because he/she had thrown a cupcake for talking about his/her daughter.-Resident #2 called him/her dumb.-He/She had pain to his/her nose and above his/her eyes. Observation and interview on 4/27/26 at 12:58 P.M. showed Resident #1 had yellow and purple bruising to his/her nose and left eyebrow/forehead area. He/she said: -Resident #2 had been talking bad about him/her.-He/She threw a cup of juice at Resident #2.-Resident #2 responded by hitting him/her.-If he/she had known that Resident #2 was going to hit him/her then he/she would not have thrown the juice at Resident #2.-He/She had talked with staff afterwards about using coping skills and kind words.-He/She would not throw juice at anyone else. Review of Resident #2's witness statement dated 4/24/26 showed:-Resident #1 had asked what's for dinner.-Resident #2 told Resident #1 what was for dinner.-Resident #1 then asked again, so in response Resident #2 said she needed to try to remember.-Resident #1 then said that he/she wasn't talking to Resident #2. During an interview on 4/27/26 at 1:16 P.M. Resident #2 said:-He/She had been sitting at a table with Resident #1.-They were sitting across from each other.-Resident #1 rolled his/her eyes and got hateful.-He/She told Resident #1 that Resident #1 didn't need to be a smartass.-Resident #1 then called him/her a dumbass.-He/She was talking to Resident #1 about the different things that Resident #1 could do to be able to get back with his/her daughter.-Resident #1 looked like he/she was going to throw water at him/her.-He/She told Resident #1 not to do that and had reminded her three different times.-He/She told Resident #1 that he/she would whoop his/her ass if he/she threw the water.-Resident #1 then threw the juice at him/her.-He/She then responded by hitting Resident #1 in the face.-He/She then blacked out and when he/she came to, he/she was still punching Resident #1 in the face and staff were pulling him/her off of Resident #1.-He/She cared about Resident #1, and his/her impulse got the better of him/her.-He/She was ashamed and remorseful of his/her actions. Review of Certified Nurse's Aide (CNA) G's undated witness statement dated 4/24/26 statement:-He/She witnessed punching Resident #2 punching Resident #1 in the face.-A conversation led to the altercation.-Resident #2 had been talking about Resident #1's child.-Resident #2 wanted Resident #1 not to throw juice at him/her or else he/she would whoop Resident #1's ass.-A Code [NAME] was then called.-He/She intervened and took Resident #2 back to (continued on next page)

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his/her room.-He/She remained with Resident #2 until Code [NAME] was determined to be all clear. During an interview on 4/28/26 at 9:18 A.M. CNA G said:-The conversation that Resident #1 and Resident #2 was the trigger to Resident #2's behavior.-Resident #2's main triggers were dirtiness and mouthy people.-He/She felt that Resident #2 was probably bored which also trigged his/her behavior.-He/She felt that if staff had intervened when the argument first started and helped Resident #2 with his/her learned coping skills that the incident could have been prevented. Review of CNA B' s witness statement dated 4/24/26 showed:-Resident #1 and Resident #2 were arguing about something.-He/She overheard Resident #2 say if you throw that water at me, I am going to whoop your ass.-He/She then told Resident #1 not to throw water on Resident #2.-Resident #1 initially did not throw the water at Resident #2 after the reminder.-All of the sudden Resident #1 threw water at Resident # #2.-He/She called a Code [NAME] when he/she saw Resident #2 get out of his/her seat. During an interview on 4/28/26 at 9:51 A.M. CNA B said:-He/She had checked in with Resident #2 when the argument started but did not really intervene.-He/She had told Resident #1 not to throw the water at Resident #2.-He/She did not think that the altercation was going to escalate at that point, so he/she felt like the reminder was an appropriate response.-There was an opportunity for staff to intervene directly and help Resident #2 with coping skills.-Resident #2 throws tantrums when he/she did not get his/her way.-Resident #2's behaviors mainly involve Resident #1 only and is not directed towards staff or other residents.-Resident #2 liked to talk to staff, take a walk, or get a soda as part of Resident #2's coping skills.-Resident #2's mom had recently passed away and felt that his/her anger could have been related to that. Review of Certified Medication Technician (CMT) B's witness statement dated 4/24/26 showed:-Around 4:37 P.M. he/she had been at his/her medication cart.-He/She heard a voice from one of the staff members.-The staff member was shouting and telling the residents to stop it.-He/She then ran to the altercation and saw Resident #2 hitting Resident #1 in the face.-He/She then separated the residents. During an interview on 4/28/26 at 10:13 A.M. CMT B said:-He/She had overheard a staff person say stop it to Resident #1 and Resident #2 before the altercation became physical. -The altercation could probably have been prevented if staff had intervened differently.-He/She was unsure of the specific trigger that started the altercation.-Resident #2 was always coming up with issues.-Resident #2 would get angry if his/her past was brought up.-He/She felt that in general if more staff were in the building, then resident behaviors could be managed easier. During an interview on 4/28/26 at 12:23 P.M. the Assistant of Director of Nursing (ADON) said:-The altercation could possibly have been prevented.-The staff should have done more than just remind Resident #1 not to throw the liquid at Resident #2.-Resident #2 escalated to anger quickly, which the staff were aware of.-It could be hard to keep Resident #2 calm at times.-Resident #2 had a lot of triggers for behaviors.-Resident #2 being bored is one of his/her main triggers.-Resident #2 needed meaningful activities to prevent behaviors.-Staff could have gone on a walk with Resident #2 or taken the cup away from Resident #1 to prevent the altercation. During an interview on 4/28/26 at 1:14 P.M. Nurse Practitioner (NP) B said:-Resident #2 had told him/her that he/she acted in self-defense to the situation.-He/She felt that if staff thought the altercation could have been prevented by managing Resident #2's behaviors better, then he/she agreed with staff.-Staff should always err on the side of resident safety. During an interview on 4/28/26 at 2:37 P.M. the Director of Nursing (DON) and Regional Nurse Consultant (RNC) said:-Resident #1's and Resident #2's altercation was triggered behavior.-Staff did not report to them that they felt like the altercation could have been prevented with better intervention.-The staff should have been more active in the situation.-If staff felt that the altercation could have been prevented with better behavioral management, then it probably could have been prevented.-Resident #2 was very self-aware and they thought the resident would be a good candidate for an anger management behavior contract.-Resident #2 liked to be involved in activities and was assigned to help the Activities Assistant to help manage his/her behaviors. 2991969