| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265721 | A. Building<br>B. Wing | 05/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Gregory Ridge Health Care Center | 7001 Cleveland Avenue<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to keep one sampled resident (Resident #4) safe from abuse out of 11 sampled residents when on 5/11/26 at approximately 9:55 P.M., Resident #4 was hit by another resident with his/her fist while sleeping which caused a large bruise on Resident #4's right bicep area and a cut under his/her left eye. The facility census was 103 residents.Review of the facility Abuse and Neglect Policy, dated 11/28/16 and revised on 06/12/24, showed Physical Abuse is purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal of inhumane manner. Handling a resident with any more force than is reasonable for a resident's proper control, treatment or management. It can include, but not limited to hitting, slapping, punching, biting, kicking, and corporal punishment.1. Review of Resident #2's Preadmission Screening and Resident Review (PASRR, DA-124C, a required form to be submitted for any client who requests admission to a Medicaid certified bed regardless of the client's payment source; this includes dually certified beds both Medicare and Medicaid), dated 7/29/15, showed he/she had the following diagnoses:-Schizophrenia (a chronic, severe mental disorder characterized by disruptions in thought processes, perceptions, and behaviors, often causing a disconnection from reality).-He/She endorsed audible hallucinations (sensory perceptions of hearing sounds such as voices, music, or noises, without any corresponding external stimulus) and was frequently seen talking to himself/herself. Review of Resident #2's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff and used for care planning), dated 4/8/26, showed he/she was cognitively intact. Review of Resident #2's Individualized Care and Services Plan (ICSP), taken from the resident's care plan and used by the facility staff dated 4/21/26, showed:-His/Her triggers were hostile people, fidgeting, people stealing from him/her, being touched and invasions of his/her boundaries.-His/Her coping skills were to be left alone.-The staff were to intervene before the resident escalated if he/she became agitated, guide him/her away from the source of distress and engage him/her calmly in conversation. -The staff were to notify the Charge Nurse if the resident voiced any delusions or hallucinations. Review of Resident #2's progress note, dated 5/12/26 at 12:00 A.M., showed:-Resident #2 was seen outside his/her room showing a fighting stance.-Upon entering the residents', who were roommates, room, Resident #4 was still in bed with blood on his/her face.-Resident #4 stated Resident #2 hit him/her while he/she was sleeping.-The incident occurred in the residents room and was not witnessed by staff.-Resident #2 told staff he/she was told by God to attack his/her roommate, so he/she did.-Resident #2 stated Resident #4 was cussing at him/her prior to the incident.-Resident #2 later stated Resident #4 said, fuck my mother and fuck my hood and talked shit for two hours.-Resident #2 stated he/she asked the Lord if he/she could fight Resident #4.-Resident #2 stated that Resident #4 went to his/her hood on 29th street and told the people his/her hood was better and the people wanted to get him/her before Resident #2 did, so Resident #2 fought him/her.-Resident #2 also explained that he/she was blind at the time so couldn't see the people on 29th street so didn't know who they were.-Resident #4 stated that he/she was asleep and there had been no discussion between the two residents prior to the<br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | incident and Resident #2 didn't say anything after the incident, he/she just walked away and stood outside the door.-Resident #2 had no injuries and was moved to a different room and Resident #4 agreed to counseling. -Resident #2 was placed on one-to-one staff observation in a private room.-Resident #2 had a recent Gradual Drug Reduction of his/her Risperidone which was put back at the original dosage. Review of Resident #2's Facility Skin Assessment, dated 5/11/26 at 12:00 A.M., showed no injuries were noted. 2. Review of Resident #4's PASRR, dated 10/10/24, showed the resident had the following diagnoses:-Schizophrenia.-Bi-polar Disorder (a chronic, severe mental health condition characterized by at least one, often hospitalized , manic episode lasting at least 7 days or requiring immediate care, usually alternating with intense depressive episodes). Review of Resident #4's admission MDS, dated [DATE], showed he/she was cognitively intact. Review of Resident #4's ICSP, dated 4/14/26, showed:-The staff were to monitor the resident for signs of depression, labile mood or agitation, whether the resident felt threatened by others, resistance to care and withdrawal from others.-The staff were to converse with the resident, assist with staying on task, be aware of their body stance and facial expressions.-The staff was to closely watch the resident for signs of anxiety and act before the resident lost control.-The staff was to set limits that the resident needed to follow. Review of Resident #4's progress note dated 5/12/26 at 12:00 A.M., showed:-Resident #2 was seen outside his/her room showing a fighting stance.-Upon entering the residents', who were roommates, room, Resident #4 was still in bed with blood on his/her face.-Resident #4 stated Resident #2 hit him/her while he/she was sleeping.-The incident occurred in the resident' room and was not witnessed by staff.-Resident #2 told staff he/she was told by God to attack his/her roommate, so he/she did.-Resident #2 stated Resident #4 was cussing at him/her prior to the incident.-Resident #2 later stated Resident #4 said, fuck my mother and fuck my hood and talked shit for two hours.-Resident #2 stated he/she asked the Lord if he/she could fight Resident #4.-Resident #2 stated that Resident #4 went to his/her hood on 29th street and told the people his/her hood was better and the people wanted to get him/her before Resident #2 did, so Resident #2 fought him/her.-Resident #2 also explained that he/she was blind at the time so couldn't see the people on 29th street so didn't know who they were.-Resident #4 stated that he/she was asleep and there had been no discussion between the two residents prior to the incident and Resident #2 didn't say anything after the incident, he/she just walked away and stood outside the door.-Resident #2 had no injuries and was moved to a different room and Resident #4 agreed to counseling. -Resident #2 was placed on one-to-one staff observation in a private room.-Resident #2 had a recent Gradual Drug Reduction of his/her Risperidone which was put back at the original dosage. Review of Resident #4's Facility Skin Assessment, dated 5/12/26 at 12:00 A.M., showed:-He/She had a small 2 centimeter (cm) scratch under his/her left eye.-He/She had a small 1 cm scratch on the bridge of his/her nose. 3. Review of the facility Registered Nurse Investigation (RNI), dated 5/11/26 at 12:00 A.M., showed:-The incident involved physical aggression involving the head.-The incident was not witnessed but Resident #2 was noted outside his/her room in a fighting stance and was taken off the unit to de-escalate.-Resident #2 told staff he/she was told by God to attack his/her roommate, so he/she did.-Resident #2 stated Resident #4 was cussing at him/her prior to the incident.-Resident #2 later stated Resident #4 said, fuck my mother and fuck my hood and talked shit for two hours.-Resident #2 stated he/she asked the Lord if he/she could fight Resident #4.-Resident #2 stated that Resident #4 went to his/her hood on 29th street and told the people his/her hood was better and the people wanted to get him/her before Resident #2 did, so Resident #2 fought him/her.-Resident #2 also explained that he/she was blind at the time so couldn't see the people on 29th street so didn't know who they were.-Resident #4 stated that he/she was asleep and there had been no discussion between the two residents prior to the incident and Resident #2 didn't say anything after the incident, he/she just walked away and stood outside the door.-Resident #2 was placed on one-to-one staff observation in a private room.-Resident #2 had a recent Gradual Drug Reduction of his/her Risperidone which was put back at the original dosage.-Resident #2 showed no<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | recent hallucinations, however, review of the prior 30 days did show some pattern of hallucinations.-Resident #2 also had two prior reported incidents of aggression in April 2026 where he/she was the aggressor. -The action taken post-incident was to educate the staff to review the communication dashboard and/or the ICSP for each resident in their care prior to their shift.-Resident #4 had a small scratch under his/her left eye and a small scratch on his/her nose.-Resident #4 said he/she got the injuries from Resident #2 hitting him/her while he/she was sleeping. Review of Resident #2's written statement, dated 5/11/26 and 5/12/26, showed:-He/She stated Resident #4 was cussing at him/her prior to the incident.-Resident #4 said, fuck my mother and fuck my hood and talked shit for two hours.-He/She asked the Lord if he/she could fight Resident #4.-Resident #4 went to his/her hood on 29th street and told the people his/her hood was better and the people wanted to get him/her before Resident #2 did, so Resident #2 fought him/her.-He/She was blind at the time so couldn't see the people on 29th street so didn't know who they were.-Resident #2 was asleep and there had been no discussion with Resident #4 prior to the incident and Resident #2 didn't say anything after the incident, Resident #2 just walked away and stood outside the door.-He/She was not trying to hurt Resident #4, he/she was just obeying God. During an interview on 5/18/26 at 2:30 P.M., Resident #2 said:-Resident #4 was his/her old roommate.-The Lord told him/her to fight Resident #4.-He/She hit Resident #4 a few times and left the room.-Resident #4 never hit back.-He/She had to do what the Lord told him/her to do.-He/She wasn't trying to hurt anyone, just trying to obey the Lord. Review of Resident #4's written statement, dated 5/11/26, showed he/she was just sleeping and his/her roommate started hitting him/her. Observation and interview on 5/18/26 at 2:42 P.M., showed:-Resident #4 had a two millimeter (mm) in circumference scab below his/her left eye and had a three-inch oval shaped bruise which had colors of blue, purple, green and yellow showing varying stages of healing, on his/her right bicep area. The resident said: -He/She just woke up with Resident #2 on top of him/her hitting him/her in the face and arm.-Resident #2 hits a lot of people.-He/She said the bruise and scab came from the incident with Resident #2. During an interview on 5/20/2026 at 2:53 P.M., Registered Nurse (RN) A said:-The residents were both assessed and Resident #4 was found to have two small scratches under Resident #4's his/her left eye and on the resident's chin. -Simple first aid was provided. During an interview on 5/20/26 at 1:45 P.M., the Director of Nursing (DON) said:-Resident #2 had a Gradual Drug Review (GDR) of his/her Risperidone (an antipsychotic medication used to treat schizophrenia) and soon after that he/she began having increased hallucinations. -They had contacted the psychiatric Nurse Practitioner (NP) and he/she had increased the resident's Risperidone back to where it was prior to the increase in hallucinations.-This incident was related to the GDR and not abuse. During an interview on 5/20/26 at 2:00 P.M., the Administrator said:-He/She did not believe this was abuse as it was different than the prior incidents with other residents.-In the prior incidents Resident #2 had a noted escalation in behavior before lashing at a resident.-In this case, there was no noted escalation, and it seemed to be totally caused by the GDR causing the resident to have hallucinations that he/she was acting on.-They realize they have to do the GDR's but frequently they end up causing an increase in behaviors with the residents soon after.-Since they had restored his/her medication dosage, he/she has leveled out in his/her behaviors. 3010863 |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision to ensure Resident #1's physical, mental, and psychosocial well-being in accordance with the resident's identified needs related to mental health care needs and substance use disorders. The facility failed to implement interventions to reduce known hazards and risks to the resident. Facility staff were aware of the resident's family's concern the resident needed a legal guardian to assist them in making health care decisions in September 2025. The facility was aware of behaviors that were escalating and becoming dangerous with the resident leaving the facility all day, taking illicit drugs and drinking alcohol. In February 2026, the resident received a new Preadmission Screening and Resident Review (PASRR) II ( Level II - an in-depth assessment of resident's serious mental illness or related condition which evaluates the need for facility services, specialized services and confirms if nursing facility care is appropriate). The PASRR identified the resident had ongoing use of illicit drugs and alcohol with poor insight and compromised safety judgment. Due to the resident's severe psychiatric condition, ongoing substance use, significant behavioral dysregulation, and complex medical needs, the resident was identified to need 24-hour care in a highly structured setting. Illicit drug use was identified to undermine psychiatric stability and posed serious safety concerns. The resident demonstrated inability to remain safely within the facility, nonadherence to medication and treatment when unsupervised, and vulnerability in the community. The facility failed to implement interventions in the PASRR including assistance to the family to facilitate guardianship proceedings and coordinate communication with legal and community resources, in order for the resident to receive services in setting that could better address high-risk behaviors, ongoing risk for substance use, and enhance safety. Local police were called to manage resident's behavior on multiple occasions, with the resident having been jailed on at least two occasions. The resident had a history of leaving the facility and returning back with signs of having consumed large amounts of alcohol and illicit drugs. On 4/24/26, the resident showed signs of an overdose after being in the community and was sent to the hospital, testing positive for alcohol, fentanyl (a highly potent synthetic opioid used medically for severe pain an anesthesia), PCP (a potent illegal street drug with hallucinogenic and dissociative effects), and marijuana- resulting in the physician ordering the resident on a 72 hour facility hold for safety and detox. The census was 103 residents. The Administrator was notified on 5/15/26 at 2:00 P.M. of the Immediate Jeopardy (IJ) which began on 2/26/26. The IJ was removed on 5/15/26, as confirmed by surveyor onsite verification.Review of the facility's Care Assessment Summary and Individualized Care Plan policy, revised 11/6/23, showed:-The Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) would be completed by Interdisciplinary Team members (Nursing, Activities, Social Services, Dietary) to address the needs of the individual resident.-After completing the MDS the Care Area Assessment (CAA) would be used to further assess triggered areas of concern. The care area triggered alerts to the assessor that interventions must be put in place to address care concerns in the plan of care for the individual resident.-The care plan should address:--Improvement where possible.--Maintenance and prevention of avoidable declines in all care area triggers. Review of the facility policy for Discharge, Immediate Discharge, Transfer and Therapeutic Leave, revised on 6/12/25, showed:-The purpose of the policy was to establish a policy and procedure regarding the transfer/discharge of residents to ensure no inappropriate discharges were made and that no discharges were made in an unsafe manner.-Reasons for discharge/transfer was when a resident's welfare and needs could not be met by the facility, and/or the resident's safety in the facility was in danger, the health of the resident could be in danger.-Reasons for Immediate Discharge included actual harm to self or others, non-compliance with medications which lead to severe behaviors, repeated disregard or destruction of facility property<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | and/or sexual acting out with potential harm to self or others. 1. Review of Resident #1's admission Record showed he/she 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).-Schizoaffective disorder (a mental condition that causes loss of contact with reality and mood problems).-Psychoactive substance abuse with psychoactive substance-induced disorder - a disconnection from reality characterized by hallucinations (sensory experiences which aren't related to reality) and delusions (false beliefs) attributed to substance intoxication.-Depression - a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living.-Acquired absence of right leg below knee and left leg below knee. Review of the resident's undated care plan showed problem identified as: -He/She had a psychosocial well-being problem with anxiety and ineffective coping revised on 4/5/24:--Staff were to provide opportunities for the resident and family to participate in care.--When conflict arose, staff were to remove the resident to a calm, safe environment and allow to vent feelings.-He/She was at risk for signs and symptoms of his/her schizophrenia, revised 6/4/24:--When speaking about the resident's hallucinations, the staff were to focus on how those hallucinations made the resident feel rather than the hallucinations themselves.-He/She was to reside in the least restrictive environment revised 4/5/24--The staff were to define for the resident his/her roles and expectations for being a resident in the facility.-He/She was to have resided in the facility of his/her choice revised 9/18/24:--The staff were to have sent our referrals for new placement at the resident's request.-The resident was to have had a decrease in behaviors during the next review period revised 12/24/24.--The resident was to have been offered PRN (as needed) medication to assist with outbursts and kept in a calm environment.-He/She had increased outbursts, initiated 12/24/24, showed: --The resident yelled and cussed at two little girls on his/her shoulders and frightened other residents.--Staff were to offer medications as needed to assist with outbursts and allow the resident to have outbursts in a private area. Review of an email sent by the facility Social Services Designee (SSD), dated 9/3/25, showed to the Director of Nursing (DON) as well as other former administrative staff the SSD got a phone call from the resident's primary family member requesting a letter with the resident's diagnoses as he/she attempted to obtain guardianship for the resident. Review of an email sent by the facility SSD, dated 9/17/25, to the facility DON requested a referral be sent to a sister facility for the resident as soon as possible, as his/her behaviors were escalating and becoming dangerous with the resident leaving the facility all day, taking illicit drugs and drinking alcohol. Review of an email received by the DON, dated 9/23/25, from a Health and Wellness Facility showed:-After receiving the resident's behavior notes the Health and Wellness Facility replied that the resident's notes showed he/she had been found outside of the facility, had aggressive behaviors towards others, took illicit drugs from the street when he/she was outside the facility.-Due to these behaviors, they would not accept the resident into their community. Review of an email received by the DON, dated 10/28/25, sent from Assistant Director of Nursing (ADON) B showed the physician wanted to know if the DON wanted him/her to write a letter recommending the facility to get legal guardianship in light of the resident's poor impulse control and drug use. Record review of the resident's Electronic Medical Record, from October 2025 until May 2026, showed no documentation of any follow-up completed having the physician write a letter recommending the facility obtain guardianship. Review of the resident's undated care plan showed problem identified as: -He/She had depression related to schizophrenia revised on 1/20/26: --The resident had the following signs and symptoms related to schizophrenia:aggression, anxiety, inability to make decisions, delusions (fixed beliefs that can't be reasoned with), eyes that dart back and forth, fearfulness, hallucinations (hearing, seeing, feeling, and/or smelling things that aren't there), difficulty focusing, no interest in activities, irritability, making hand gestures as if having a conversation, mumbling, poor hygiene, isolation, and talking to self.--The resident states there are multiple little girls living on his/her shoulders who gang up on him/her and are mean.--Interventions included:---Administering medications (continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | for anxiety or hallucination according to physician orders.---Avoid arguing.---Notify charge nurse if observing resident experiencing signs/symptoms of schizophrenia.---Be careful when using reassuring touch.---Focus the resident on how the hallucination makes them feel rather than the content of the hallucination. Review of an email received by the DON and SSD, dated 2/10/26, sent by the facility Administrator said:-He/She had spoken to Regional Director of Operations (RDO) A regarding the most effective way for the facility to deal with Resident #1 in order to mitigate the resident's aggressive behaviors.-The resident was currently self-responsible and was suspected to have been a trigger for other residents in the facility.-On 2/6/26, the Administrator informed RDO A that he/she urgently needed to discharge the resident in order to prevent potential harm to the other residents.-On 2/9/26 he/she informed RDO A that he/she needed to either do an immediate discharge on the resident or need RDO A's assistance on placement to initiate a 30-day notice. -RDO A suggested sending a request to the corporate legal team, however the Administrator thought it best to reach out to the Ombudsman to learn of any resources that the team may not have tried before initiating an immediate discharge.-There was also a suggestion that the physician write an order to remove access for therapeutic leaves since it was not safe for the resident regardless of his/her status. -On 2/10 he/she informed RDO A the resident had been banned from the corner store and had received multiple police citations in the past 24 hours. -He/She then stated that he/she had left a message for the Ombudsman.-He/She also asked the SSD to send out a mass referral on behalf of the resident, stating that in the case of safety, the resident did not have to give consent reinforcing that day one started when the facility accepted the resident. -He/She was hoping to hear from the Ombudsman by day's end of business 2/10/26.-He/She also asked the DON to reach out to the provider to ask that they write an order for the resident to not be able to sign themselves out due to safety, which he/she hoped would cover their bases for oversight. Record review of the resident's Electronic Medical Record, from February 2026 until May 2026, showed there was no documentation of any follow-up with the Ombudsman resources for the resident or follow-up with the resident's physician to remove the therapeutic leave. Review of the resident Level II PASRR, dated 2/26/26 showed: -Besides the diagnoses mentioned on the admission Record the resident was also diagnosed with:--Bipolar disorder - Mood disorder that can cause intense mood swings.--Disruptive behavior disorder.--Conduct disorder, adolescent onset - a serious mental health condition, usually seen in children and adolescents, characterized by a consistent pattern of aggression, theft, vandalism, and rule violations that violate the rights of others.--Borderline Personality Disorder - a serious mental illness characterized by pervasive instability of moods, self-image, interpersonal relationships, and marked impulsivity.-The resident had a chronic pattern of severe psychiatric decompensation characterized by persistent auditory and visual hallucinations involving an imaginary little girl, fixed delusional content, and frequent responding to internal stimuli. He/She had recurrent verbal aggression, intimidation of peers, and escalation toward physical altercations, including lunging from his/her wheelchair, striking walls, damaging facility property and engaging in threatening behaviors that required staff intervention. He/She demonstrated repeated smoking and contraband violations and elopement to the adjacent gas station despite prior warnings and law enforcement involvement. He/She continued to go outside in his/her wheelchair most days and sit at the gas station next door.-The resident had been observed spending time outside at the corner store using recreational drugs; however, the specific substance type was not reported. -Progress notes reflected a pattern of behavioral dysregulation occurring in the context of active psychosis, poor impulse control, and suspected substance use. -The resident required 24-hour protective oversight due to the severity of behaviors or mental illness symptoms and medication management.-Mental health care needs exceeded what could be managed in previous/current living situation due to aggression, substance use, or medication non-compliance leading to exacerbation of symptoms.-Documentation indicated no active discharge planning and no referrals initiated. This appeared to contradict current nursing facility reports describing active efforts toward rehabilitation placement and guardianship<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | pursuit.-The resident had ongoing use of illicit drugs and alcohol with poor insight and compromised safety judgment. -Due to the resident's severe and treatment-refractory psychiatric condition, ongoing substance use, significant behavioral dysregulation, and complex medical needs, the resident continued to require 24-hour care in a highly structured setting. His/Her chronic psychosis is characterized by persistent auditory and visual hallucinations, paranoid ideation, gross disorganization, and frequent response to internal stimuli which significantly impair his/her reality testing and behavioral regulation. He/She had been involved in multiple episodes of verbal and physical aggression, often in the context of responding to internal stimuli or perceived threats. In the nursing home setting the resident's symptoms remained only moderately controlled. His/Her illicit drug use continued to undermine psychiatric stability and posed serious safety concerns. The resident had a history of bilateral below knee amputations due to frostbite, resulting in mobility limitations and the need for continued assistance with activities of daily living (ADLs, feeding, dressing, grooming) and medical oversight. His/Her demonstrated inability to remain safely within the facility, nonadherence to medication and treatment when unsupervised, and vulnerability in the community highlight the necessity of a structured and secure environment. Placement in a nursing facility with a locked behavioral unit should be considered for the resident to address his/her ongoing elopement, enhance safety, and provide the containment necessary to support adherence, minimize risk of harm, and reduce access to illicit substances.-Given the resident's persistent substance use and repeated elopement for the purpose of obtaining drugs and alcohol, integrated dual-diagnosis therapy was strongly recommended to target both his/her psychiatric illness and substance use disorder.-The resident needed among other supports: medication set up and administration by staff monitoring for medication compliance, supports to prevent elopement, and assessment of supervision required to prevent harm to self or others. -Plan for crisis intervention that promoted emotional support, education, safety planning and case management to handle immediate crisis. A crisis plan should be developed to create clear steps that are to be taken to support the resident during a behavioral health crisis including who to contact for assistance, how to work together with the client during a crisis, and how to determine when the crisis is over. The plan should identify a physician and emergency medical services that should be contacted. The facility may also utilize Department of Mental (DMH) Health Behavioral Crisis hotline. Assault precautions and elopement precautions should be part of the crisis intervention plan. -At this time priority should be given to supporting the resident's family member in pursuing guardianship as the resident's poor insight, current psychosis, substance related behaviors, and documented refusal of previously arranged rehabilitation significantly limit his/her ability to participate meaningfully in discharge planning or adhere to treatment recommendations independently. The facility should provide assistance to the family to facilitate guardianship proceedings and coordinate communication with legal and community resources. If guardianship was achieved and sustained clinical stabilization occurred the primary recommendation would be residential or intensive substance use treatment and rehabilitation services given the resident's high-risk behaviors, ongoing risk for substance use, and prior refusal of rehabilitation placement. Review of the resident's Electronic Medical Record from February 2026 through May 2026 showed there was no safety plan created or implemented for the resident while he/she was outside of the building. Review of the resident's undated care plan showed problem identified as: -The resident continued to have increased behaviors including refusal of cares, along with verbal and physical aggression towards staff and peers revised 2/26/26. --The staff were to attempt to anticipate the resident's needs, attempt to discuss the resident's behaviors including why they were inappropriate and attempt to determine the cause for those behaviors, intervening as necessary while protecting the resident's rights. Further review of the resident's care plan showed recommendations from the 2/26/26 PASRR such as, providing support to the resident's family to obtain guardianship, providing 24/7 protective oversight on a locked unit, or providing outside counseling and drug/alcohol rehabilitation. Review of the resident's progress notes, from February<br>(continued on next page) |

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| | 265721 | A. Building<br>B. Wing | 05/20/2026 |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | 2026 - May 2026, showed no documentation of follow up regarding assisting the resident's family member to pursue guardianship of the resident as directed by the PASRR or to find alternate placement for the resident. Review of the resident's undated Individual Care Service Report (ICSP) showed: -The resident's crisis intervention plan showed triggers were hallucinations and stupid actions. --Staff were to monitor behaviors and attempt to determine underlying cause, monitor, document, and report any adverse psychotropic medication reactions, risk of harm to self or others, and or risky actions by the resident and any signs and symptoms of depression.-- They were to monitor, record and report depression and increased anger that could cause him/her to lash out at others.--They show that he/she was self-responsible and able to leave on pass without supervision of staff. -Mental health interventions/de-escalation steps were to:--Avoid arguing, respect personal space, and use simple clear language.--Notify charge nurse if observing the resident experiencing signs and symptoms of schizophrenia (hallucinations, delusions, difficulty focusing, inability to make decisions, poor hygiene, isolation, irritability, talking to self, mumbling, making hand gestures as if having a conversation, eyes darting, anxiety, and aggression) or if resident is suspected of violating the smoking policy.--Focus the resident on how the hallucination makes them feel rather than the content of the hallucination. During an interview on 5/12/26 at 2:15 P.M., the Administrator and DON said:-They were not aware that a new PASRR had been completed in February 2026. -They did not know who had requested a new PASRR, nor were they aware of recommendations for obtaining a guardian for the resident nor that the resident had been deemed no longer appropriate for residence in the facility due to his/her behaviors. -They were not aware of the recommendations that the resident be placed on a locked unit so he/she could not leave unaccompanied by staff.-Once a new PASRR was recommended, the facility SSD should have been made aware and should have notified the Administrator, DON, MDS Coordinator and Care Plan Coordinator (CPC). -Those individuals should then incorporate the new recommendations into the resident's care plan after doing a Change of Condition MDS. -Without the knowledge that a new PASRR had even been completed, none of those procedures were followed.-They did share their concerns for the resident's safety earlier in the year with former RDO A asking for assistance in getting the resident out of the facility and/or emergency guardianship completed. -RDO A had reached out to the Ombudsman back in February 2026, but RDO A had not followed up. -They had also reached out in attempt to get corporate legal assistance in assisting the resident's primary family member in obtaining guardianship but were told there was no longer anyone on the corporate legal team who assisted with guardianship. -Their concern was that while the resident was still his/her own person, as a facility, they could not physically keep the resident inside the building, nor could they force him/her to take his/her medication every day as he/she had a right to refuse and they feared getting in trouble for limiting the resident's freedoms. During an interview on 5/5/26 at 11:10 A.M., the SSD said:-He/She didn't know who was responsible for following up on PASRR recommendations but thought the Care Plan Coordinator did that.-He/She didn't know the PASRR had recommended guardianship.-The resident's family member was going to pursue guardianship and then said he/she wouldn't. -On 4/24/26 the resident's family member asked if the facility could pursue the guardianship.-He/She had not initiated the guardianship process and didn't know if the Administrator had done so.-He/She didn't know if the IDT ever discussed a safety plan for when the resident was outside. During an interview on 5/5/26 at 11:54 A.M., the Care Plan Coordinator said:-The expectation was he/she was to review the PASRR recommendations and add them to the care plan. -He/She didn't realize the family member had asked the facility to pursue the guardianship and didn't know if the facility tried to pursue an emergency guardianship.-Recently the resident said he/she wanted his/her family member to pursue guardianship, and he/she assumed the family member was doing that.-The resident wasn't safe inside or outside the building because he/she was using drugs at the corner store and he/she needed a guardian.-He/She didn't know if the facility ever discussed the resident's need for a guardian. -He/She was not aware of the PASRR update from 2/26 or the new interventions that were recommended so he/she did not incorporate<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | those interventions into the residents care plan. Review of the resident's March Medication Administration Record (MAR) showed the resident refused the following ordered psychotropic medications: -Benztropine Mesylate 0.5 milligrams (mg) (a medication used to manage drug-induced movement disorders extrapyramidal symptoms caused by antipsychotic medications) at 8:A.M., daily for paranoid schizophrenia was refused on 3/13/26, 3/23/26, and 3/24/26. -Cymbalta capsule delayed release particles 30 mg, (commonly prescribed to treat depression), two capsules by mouth in the morning were refused on 3/2/26, 3/3/26, 3/4/26, 3/7/26, 3/13/26, 3/23/26 and 3/24/26. -Trazadone HCl tablet 100 mg, one tablet by mouth at bedtime (a prescription antidepressant of the [NAME] class (Serotonin Antagonist and Reuptake Inhibitor) is primarily used to treat major depressive disorder) was refused on 3/4/26, 3/5/26, 3/10/26, 3/15/26, 3/18/26, 3/19/26 3/23/26, 3/24/26, 3/27/26 3/28/26 and 3/29/26. -Haloperidol tablet 10 mg, one tablet by mouth two times a day (a first-generation typical antipsychotic medication used primarily to treat schizophrenia, acute psychotic episodes, and Tourette's syndrome) for paranoid schizophrenia was refused on 3/2/26, 3/3/26, 3/4/26, 3/7/26, 3/13/26, 3/23/26, and 3/24/26. -Depakote tablet delayed release 500 mg (an FDA-approved prescription medication primarily used to treat epilepsy (seizures), stabilize mood in bipolar disorder (specifically manic episodes) by mouth three times per day was refused on 3/2/26, 3/3/26, 3/4/26, 3/7/26, 3/13/26, 3/23/26, and 3/24/26. Review of the resident's March 2026 progress notes showed no documentation regarding the resident's missing his/her medications or notifying the physician of the resident's missing medications. Review of the resident's most recent Mental Status Exam (MSE), dated 3/4/26, showed:-The resident continued to go outside in his/her wheelchair most days and sit at the gas station next door. The resident was on six psychotropic medications (drugs that affect brain function, altering mood, thoughts or behaviors). -The psychoactive substance abuse was worsening. Encourage the resident to refrain from outside drugs.-Insight and judgment were at baseline and were impaired as evidenced by decisions of recent past. -Multiple refusals for labs.-Care plan goals:--To continue haloperidol (Haldol - antipsychotic medication used to treat mental illness, such as schizophrenia, behavior problems, agitation, and symptoms of Tourette's syndrome (a neurodevelopmental disorder). --Demonstrate improved reality through medication compliance and therapeutic interactions. -The MSE did not show what staff were to do when the resident refused medication. Review of the resident's undated care plan showed problem identified as: -He/She had physical altercation incident initiated 3/5/26:--The resident was involved in a physical altercation with another resident.--Staff escorted the resident out of the building and educated the resident on side effects of drugs.--Staff were looking into new placement.-The resident had altered social interactions related to psychosis revised 3/10/26.-He/She had behaviors related to mental illness revised on 3/10/26:--His/her behaviors might disturb others and involve conversing with self and imaginary people.--Staff were to administer medications, address root cause of behavioral changes or mood as needed, and if disturbing others encourage the resident to go to a more private area to decrease episodes of disturbing others.-He/She had impaired social interaction psychotic disorder initiated 3/10/26:--The resident could be verbally loud and aggressive, yelling and cursing at staff and other residents.--Interventions showed:---Encourage recreational activities.---Monitor for negative thoughts and feelings.---Redirect to a private area if resident is verbally aggressive. Review of the resident's quarterly MDS, dated [DATE], showed the resident:-Was cognitively intact.-Felt down and depressed seven to 11 days out of the past 14.-Had verbal behaviors directed toward others.-Had other behaviors (e.g. - self harm, property destruction, disruptive behaviors).-Was diagnosed with schizophrenia/schizoaffective disorder and depression.-Within the past seven days routinely took an antipsychotic medication and an antidepressant. Review of the resident's Alert Note, dated 3/26/26 at 1:12 A.M., showed:-The resident returned to the facility at approximately 1:00 A.M. smelling strongly of alcohol with very bloodshot eyes. -His/her speech was slow and deliberate with an inability to focus. Review of the resident's care plan showed staff did not update the care plan with interventions after the resident<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | came back on 3/26/26 with a strong smell of alcohol and signs of being intoxicated. Review of the resident's April 2026 MAR showed the resident refused the following ordered psychotropic medications:-Benztropine Mesylate 0.5 mg at 8:A.M., daily for paranoid schizophrenia was refused on 4/1/26, 4/2/26, 4/6/26, 4/7/26, 4/11/26, 4/12/26, 4/17/26, 4/20/26, and 4/24/26. -Cymbalta capsule delayed release particles 30 mg, two capsules by mouth in the morning for Major Depressive Disorder (MDD) was refused on 4/1/26, 4/2/26, 4/6/26, 4/7/26, 4/11/26, 4/12/26, 4/17/26, and 4/24/26.-Trazadone HCl tablet 100 mg, one tablet by mouth at bedtime for insomnia secondary to depression was refused on 4/1/26, 4/2/26, 4/5/26, 4/6/26, 4/7/26, 4/10/26, 4/11/26, 4/15/26, 4/16/26, 4/17/26, 4/20/26, 4/21/26, and 4/24/26.-Haloperidol tablet 10 mg, one tablet by mouth two times a day for paranoid schizophrenia was refused at 8:00 A.M. and 4:00 P.M. on 4/1/26, 4/2/26, 4/6/26, 4/7/26, 4/11/26, 4/12/26, 4/17/26, 4/20/26, and 4/24/26.-Depakote tablet delayed release 500 mg by mouth three times a day for paranoid schizophrenia and schizoaffective disorder was refused at 8:00 A.M., 2:00 P.M., and 8:00 P.M. on 4/1/26, 4/2/26, 4/6/26, 4/7/26, 4/11/26, 4/12/26, 4/17/26, 4/20/26 and 4/24/26. Review of the resident's April 2026 progress notes showed no documentation regarding the resident's missing his/her medications or notifying the physician of the resident's missing medications. Review of the resident's Behavioral Note, dated 4/8/26 at 5:15 A.M., showed:-The resident had verbal and threatening physical behaviors toward staff and had to be redirected three times.-He/She believed the staff had stolen drinks from his/her bathroom, which caused him/her to accuse the staff and led to the behaviors. -The Administrator, DON and ADON were notified of behaviors.-911 was called and the police officers arrived. No report to note. Advised the resident to not fight with the staff and to wait in the other room and the resident agreed. Review of the resident's undated care plan showed problem identified as: -The resident had a history of negative behaviors such as screaming, yelling and hallucinating revised 4/9/26.--The staff were to have provided counseling, outside support networks and a structured environment.-He/She was at risk for adverse reaction related to a history of having illicit drug on his/her person revised 4/9/26:--The physician would be notified if the resident was in possession of illicit drugs to review and evaluate medication for any changes to be made. --Review pharmacy consult recommendations and follow up as needed. Review of the resident's Behavior Note, dated 4/12/26 at 7:45 P.M., showed:-The resident was noted coming into the facility upset while in the lobby area.-The resident began to slam the facility phone during his/her outburst.-The nurse came in to try to de-escalate the situation when the resident grabbed the nurse by the hair and struck him/her in the eye. The resident also noted hitting and cracking the front door entrance to the facility.-The resident was still upset which prompted assistance from Emergency Medical Technicians (EMT) and the local police department.-The resident was taken to Hospital A for altered mental status. Review of the Resident's Physical Aggression Involving the Head investigation, dated 4/13/26, showed:-The Investigative Narrative showed:--On 4/12/26 Around 7:30 P.M. the resident was seen coming into the lobby verbally aggressive. --The ADON told the resident he/she would have to get off the phone when the resident slammed the desk phone. This upset the resident and he/she became extremely aggressive toward the ADON, eventually reaching the ADON to strike his/her eye and pull his/her hair. --Police were called, charges were pressed, and the resident was sent to the hospital. The hospital indicated the resident was aggressive there as well. --At 9:00 A.M. on 4/13/26 the Administrator asked the resident what happened, and he/she stated the ADON was talking crazy telling him/her to get off the phone and stuff like that. The ADON was all in his/her business. When asked if the resident hit the ADON the resident said not for real.--The Administrator discussed recent behaviors and the |

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| F 0740<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure each resident must receive and the facility must provide necessary behavioral health care and services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary behavioral health care and services to attain the highest practicable physical, mental, and psychosocial well-being in accordance with the resident's identified needs related to mental health care needs and substance use disorders. The facility failed to review, collaborate with the resident's interdisciplinary team (IDT), and create a plan of care after the resident receive an updated Preadmission Screening and Resident Review (PASRR) II (Level II - an in-depth assessment of resident's serious mental illness or related condition which evaluates the need for facility services, specialized services and confirms if nursing facility care is appropriate) to aid in preventing or relieving the residents behaviors, and help maintain the resident's safety. The facility failed to review and revise behavioral health care plans that had not been effective. The resident had multiple verbal and physical outbursts. Local police were called to manage resident's behavior on multiple occasions, with the resident having been jailed on at least two occasions. The resident had a history of leaving the facility and returning back with signs of having consumed large amounts of alcohol and illicit drugs, including an overdose which required the physician to order the resident on a 72 hour facility hold for safety and detox. The census was 103 residents.Review of the facility's Care Assessment Summary and Individualized Care Plan policy, revised 11/6/23, showed:-The Minimum Data Set (MDS-a federally mandated assessment instrument completed by facility staff for care planning) would be completed by Interdisciplinary Team members (Nursing, Activities, Social Services, Dietary) to address the needs of the individual resident.-After completing the MDS the Care Area Assessment (CAA) would be used to further assess triggered areas of concern. The care area triggered alerts to the assessor that interventions must be put in place to address care concerns in the plan of care for the individual resident.-The care plan should address:--Improvement where possible.--Maintenance and prevention of avoidable declines in all care area triggers. Review of the facility policy for Discharge, Immediate Discharge, Transfer and Therapeutic Leave, revised on 6/12/25, showed:-The purpose of the policy was to establish a policy and procedure regarding the transfer/discharge of residents to ensure no inappropriate discharges were made and that no discharges were made in an unsafe manner.-Reasons for discharge/transfer was when a resident's welfare and needs could not be met by the facility, and/or the resident's safety in the facility was in danger, the health of the resident could be in danger.-Reasons for Immediate Discharge included actual harm to self or others, non-compliance with medications which lead to severe behaviors, repeated disregard or destruction of facility property and/or sexual acting out with potential harm to self or others. 1. Review of Resident #1's admission Record showed he/she 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).-Schizoaffective disorder (a mental condition that causes loss of contact with reality and mood problems).-Psychoactive substance abuse with psychoactive substance-induced disorder - a disconnection from reality characterized by hallucinations (sensory experiences which aren't related to reality) and delusions (false beliefs) attributed to substance intoxication.-Depression - a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living.-Acquired absence of right leg below knee and left leg below knee. Review of the resident's undated care plan showed problem identified as: -He/She had a psychosocial well-being problem with anxiety and ineffective coping revised on 4/5/24:--Staff were to provide opportunities for the resident and family to participate in care.--When conflict arose, staff were to remove the resident to a calm, safe environment and allow to vent feelings.-He/She was at risk for signs and symptoms of his/her schizophrenia, revised 6/4/24:--When speaking about the resident's hallucinations, the staff were to focus on how those hallucinations made the resident feel rather than the hallucinations<br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | themselves.-He/She was to reside in the least restrictive environment revised 4/5/24--The staff were to define for the resident his/her roles and expectations for being a resident in the facility.-He/She was to have resided in the facility of his/her choice revised 9/18/24:--The staff were to have sent our referrals for new placement at the resident's request.-The resident was to have had a decrease in behaviors during the next review period revised 12/24/24.--The resident was to have been offered PRN (as needed) medication to assist with outbursts and kept in a calm environment.-He/She had increased outbursts, initiated 12/24/24, showed: --The resident yelled and cussed at two little girls on his/her shoulders and frightened other residents.--Staff were to offer medications as needed to assist with outbursts and allow the resident to have outbursts in a private area. Review of an email sent by the facility Social Services Designee (SSD), dated 9/3/25, showed to the Director of Nursing (DON) as well as other former administrative staff that the SSD got a phone call from the resident's primary family member requested a letter with the resident's diagnoses as he/she attempted to obtain guardianship for the resident. Review of an email sent by the facility SSD, dated 9/17/25, to the facility DON requested a referral be sent to a sister facility for the resident as soon as possible, as his/her behaviors were escalating and becoming dangerous with the resident leaving the facility all day, taking illicit drugs and drinking alcohol. Review of an email received by the DON, dated 9/23/25, from a Health and Wellness Facility showed:-After receiving the resident's behavior notes the Health and Wellness Facility replied the resident's notes showed he/she had been found outside of the facility, had aggressive behaviors towards others, took illicit drugs from the street when he/she was outside the facility.-Due to these behaviors, they would not accept the resident into their community. Review of an email received by the DON, dated 10/28/25, sent from Assistant Director of Nursing (ADON) B showed the physician wanted to know if the DON wanted him/her to write a letter recommending the facility to get legal guardianship in light of the resident's poor impulse control and drug use. Record review of the resident's Electronic Medical Record, from October 2025 until May 2026, showed no documentation of any follow-up completed having the physician write a letter recommending the facility obtain guardianship. Review of the resident's undated care plan showed problem identified as: -He/She had depression related to schizophrenia revised on 1/20/26: --The resident had the following signs and symptoms related to schizophrenia:aggression, anxiety, inability to make decisions, delusions (fixed beliefs that can't be reasoned with), eyes that dart back and forth, fearfulness, hallucinations (hearing, seeing, feeling, and/or smelling things that aren't there), difficulty focusing, no interest in activities, irritability, making hand gestures as if having a conversation, mumbling, poor hygiene, isolation, and talking to self.--The resident states there are multiple little girls living on his/her shoulders who gain up on him/her and are mean.--Interventions included:---Administering medications for anxiety or hallucination according to physician orders.---Avoid arguing.---Notify charge nurse if observing resident experiencing signs/symptoms of schizophrenia.---Be careful when using reassuring touch.---Focus the resident on how the hallucination makes them feel rather than the content of the hallucination. Review of an email received by the DON and SSD, dated 2/10/26, sent by the facility Administrator said:-He/She had spoken to Regional Director of Operations (RDO) A regarding the most effective way for the facility to deal with Resident #1 in order to mitigate the resident's aggressive behaviors.-The resident was currently self-responsible and was suspected to have been a trigger for other residents in the facility.-On 2/6/26, the Administrator informed RDO A that he/she urgently needed to discharge the resident in order to prevent potential harm to the other residents.-On 2/9/26 he/she informed RDO A that he/she needed to either do an immediate discharge on the resident or need RDO A's assistance on placement to initiate a 30-day notice. -RDO A suggested sending a request to the corporate legal team, however the Administrator thought it best to reach out to the Ombudsman to learn of any resources that the team may not have tried before initiating an immediate discharge.-There was also a suggestion that the physician write an order to remove access for therapeutic leaves since it was not safe for the resident regardless of his/her status. -On 2/10<br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | he/she informed RDO A that the resident had been banned from the corner store and had received multiple police citations in the past 24 hours. -He/She then stated that he/she had left a message for the Ombudsman.-He/She also asked the SSD to send out a mass referral on behalf of the resident, stating that in the case of safety, the resident did not have to give consent reinforcing that day one started when the facility accepted the resident. -He/She was hoping to hear from the Ombudsman by day's end of business 2/10/26.-He/She also asked the DON to reach out to the provider to ask that they write an order for the resident to not be able to sign themselves out due to safety, which he/she hoped would cover their bases for oversight. Record review of the resident's Electronic Medical Record, from February 2026 until May 2026, showed there was no documentation of any follow-up with the Ombudsman resources for the resident or follow up with the resident's physician to remove the therapeutic leave. Review of the resident Level II PASRR, dated 2/26/26 showed: -Besides the diagnoses mentioned on the admission Record the resident was also diagnosed with:--Bipolar disorder - Mood disorder that can cause intense mood swings.--Disruptive behavior disorder.--Conduct disorder, adolescent onset - a serious mental health condition, usually seen in children and adolescents, characterized by a consistent pattern of aggression, theft, vandalism, and rule violations that violate the rights of others.--Borderline Personality Disorder - a serious mental illness characterized by pervasive instability of moods, self-image, interpersonal relationships, and marked impulsivity.-The resident had a chronic pattern of severe psychiatric decompensation characterized by persistent auditory and visual hallucinations involving an imaginary little girl, fixed delusional content, and frequent responding to internal stimuli. He/She had recurrent verbal aggression, intimidation of peers, and escalation toward physical altercations, including lunging from his/her wheelchair, striking walls, damaging facility property and engaging in threatening behaviors that required staff intervention. He/She demonstrated repeated smoking and contraband violations and elopement to the adjacent gas station despite prior warnings and law enforcement involvement. He/She continued to go outside in his/her wheelchair most days and sit at the gas station next door.-The resident had been observed spending time outside at the corner store using recreational drugs; however, the specific substance type was not reported. -Progress notes reflected a pattern of behavioral dysregulation occurring in the context of active psychosis, poor impulse control, and suspected substance use. -The resident required 24-hour protective oversight due to the severity of behaviors or mental illness symptoms and medication management.-Mental health care needs exceeded what could be managed in previous/current living situation due to aggression, substance use, or medication non-compliance leading to exacerbation of symptoms.-Documentation indicated no active discharge planning and no referrals initiated. This appeared to contradict current nursing facility reports describing active efforts toward rehabilitation placement and guardianship pursuit.-The resident had ongoing use of illicit drugs and alcohol with poor insight and compromised safety judgment. -Due to the resident's severe and treatment-refractory psychiatric condition, ongoing substance use, significant behavioral dysregulation, and complex medical needs, the resident continued to require 24-hour care in a highly structured setting. His/Her chronic psychosis is characterized by persistent auditory and visual hallucinations, paranoid ideation, gross disorganization, and frequent response to internal stimuli which significantly impair his/her reality testing and behavioral regulation. He/She had been involved in multiple episodes of verbal and physical aggression, often in the context of responding to internal stimuli or perceived threats. In the nursing home setting the resident's symptoms remained only moderately controlled. His/Her illicit drug use continued to undermine psychiatric stability and posed serious safety concerns. The resident had a history of bilateral below knee amputations due to frostbite, resulting in mobility limitations and the need for continued assistance with activities of daily living (ADLs, feeding, dressing, grooming) and medical oversight. His/Her demonstrated inability to remain safely within the facility, nonadherence to medication and treatment when unsupervised, and vulnerability in the community highlight the necessity of a structured and secure environment. Placement in a nursing<br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | facility with a locked behavioral unit should be considered for the resident to address his/her ongoing elopement, enhance safety, and provide the containment necessary to support adherence, minimize risk of harm, and reduce access to illicit substances.-Given the resident's persistent substance use and repeated elopement for the purpose of obtaining drugs and alcohol, integrated dual-diagnosis therapy was strongly recommended to target both his/her psychiatric illness and substance use disorder.-The resident needed among other supports: medication set up and administration by staff monitoring for medication compliance, supports to prevent elopement, and assessment of supervision required to prevent harm to self or others. -Plan for crisis intervention that promoted emotional support, education, safety planning and case management to handle immediate crisis. A crisis plan should be developed to create clear steps that are to be taken to support the resident during a behavioral health crisis including who to contact for assistance, how to work together with the client during a crisis, and how to determine when the crisis is over. The plan should identify a physician and emergency medical services that should be contacted. The facility may also utilize Department of Mental (DMH) Health Behavioral Crisis hotline. Assault precautions and elopement precautions should be part of the crisis intervention plan. -At this time priority should be given to supporting the resident's family member in pursuing guardianship as the resident's poor insight, current psychosis, substance related behaviors, and documented refusal of previously arranged rehabilitation significantly limit his/her ability to participate meaningfully in discharge planning or adhere to treatment recommendations independently. The facility should provide assistance to the family to facilitate guardianship proceedings and coordinate communication with legal and community resources. If guardianship was achieved and sustained clinical stabilization occurred the primary recommendation would be residential or intensive substance use treatment and rehabilitation services given the resident's high-risk behaviors, ongoing risk for substance use, and prior refusal of rehabilitation placement. Review of the resident's Electronic Medical Record from February 2026 through May 2026 showed there was no safety plan created or implemented for the resident while he/she was outside of the building. Review of the resident's undated care plan showed problem identified as: -The resident continued to have increased behaviors including refusal of cares, along with verbal and physical aggression towards staff and peers revised 2/26/26. --The staff were to attempt to anticipate the resident's needs, attempt to discuss the resident's behaviors including why they were inappropriate and attempt to determine the cause for those behaviors, intervening as necessary while protecting the resident's rights. Further review of the resident's care plan showed recommendations from the 2/26/26 PASRR such as, providing support to the resident's family to obtain guardianship, providing 24/7 protective oversight on a locked unit, or providing outside counseling and drug/alcohol rehabilitation. Review of the resident's progress notes, from February 2026 - May 2026, showed no documentation of follow up regarding assisting the resident's family member to pursue guardianship of the resident as directed by the PASRR or to find alternate placement for the resident. Review of the resident's undated Individual Care Service Report (ICSP) showed: -The resident's crisis intervention plan showed triggers were hallucinations and stupid actions. --Staff were to monitor behaviors and attempt to determine underlying cause, monitor, document, and report any adverse psychotropic medication reactions, risk of harm to self or others, and or risky actions by the resident and any signs and symptoms of depression.-- They were to monitor, record and report depression and increased anger that could cause him/her to lash out at others.--They show that he/she was self-responsible and able to leave on pass without supervision of staff. -Mental health interventions/de-escalation steps were to:--Avoid arguing, respect personal space, and use simple clear language.--Notify charge nurse if observing the resident experiencing signs and symptoms of schizophrenia (hallucinations, delusions, difficulty focusing, inability to make decisions, poor hygiene, isolation, irritability, talking to self, mumbling, making hand gestures as if having a conversation, eyes darting, anxiety, and aggression) or if resident is suspected of violating the smoking policy.--Focus the resident on how the hallucination makes them feel rather than the<br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | content of the hallucination. During an interview on 5/12/26 at 2:15 P.M., the Administrator and DON said:-They were not aware that a new PASRR had been completed in February 2026. -They did not know who had requested a new PASRR nor were they aware of recommendations for obtaining a guardian for the resident nor that the resident had been deemed no longer appropriate for residence in the facility due to his/her behaviors. -They were not aware of the recommendations that the resident be placed on a locked unit so he/she could not leave unaccompanied by staff.-Once a new PASRR was recommended, the facility SSD should have been made aware and should have notified the Administrator, DON, MDS Coordinator and Care Plan Coordinator (CPC). -Those individuals should then incorporate the new recommendations into the resident's care plan after doing a Change of Condition MDS. -Without the knowledge that a new PASRR had even been completed, none of those procedures were followed.-They did share their concerns for the resident's safety earlier in the year with former RDO A asking for assistance in getting the resident out of the facility and/or emergency guardianship completed. -RDO A had reached out to the Ombudsman back in February 2026, but RDO A had not followed up. -They had also reached out in attempt to get corporate legal assistance in assisting the resident's primary family member in obtaining guardianship but were told there was no longer anyone on the corporate legal team who assisted with guardianship. -Their concern was that while the resident was still his/her own person, as a facility, they could not physically keep the resident inside the building, nor could they force him/her to take his/her medication every day as he/she had a right to refuse and they feared getting in trouble for limiting the resident's freedoms. During an interview on 5/5/26 at 11:10 A.M., the SSD said:-He/She didn't know who was responsible for following up on PASRR recommendations but thought the Care Plan Coordinator did that.-He/She didn't know the PASRR had recommended guardianship.-The resident's family member was going to pursue guardianship and then said he/she wouldn't. -On 4/24/26 the resident's family member asked if the facility could pursue the guardianship.-He/She had not initiated the guardianship process and didn't know if the Administrator had done so.-He/She didn't know if the IDT ever discussed a safety plan for when the resident was outside. During an interview on 5/5/26 at 11:54 A.M., the Care Plan Coordinator said:-The expectation was he/she was to review the PASRR recommendations and add them to the care plan. -He/She didn't realize the family member had asked the facility to pursue the guardianship and didn't know if the facility tried to pursue an emergency guardianship.-Recently the resident said he/she wanted his/her family member to pursue guardianship, and he/she assumed the family member was doing that.-The resident wasn't safe inside or outside the building because he/she was using drugs at the corner store and he/she needed a guardian.-He/She didn't know if the facility ever discussed the resident's need for a guardian. -He/She was not aware of the PASRR update from 2/26 or the new interventions that were recommended so he/she did not incorporate those interventions into the residents care plan. Review of the resident's March Medication Administration Record (MAR) showed the resident refused the following ordered psychotropic medications: -Benztropine Mesylate 0.5 milligrams (mg) (a medication used to manage drug-induced movement disorders extrapyramidal symptoms caused by antipsychotic medications) at 8:A.M., daily for paranoid schizophrenia was refused on 3/13/26, 3/23/26, and 3/24/26. -Cymbalta capsule delayed release particles 30 mg, (commonly prescribed to treat depression), two capsules by mouth in the morning were refused on 3/2/26, 3/3/26, 3/4/26, 3/7/26, 3/13/26, 3/23/26 and 3/24/26. -Trazadone HCl tablet 100 mg, one tablet by mouth at bedtime (a prescription antidepressant of the [NAME] class (Serotonin Antagonist and Reuptake Inhibitor) is primarily used to treat major depressive disorder) was refused on 3/4/26, 3/5/26, 3/10/26, 3/15/26, 3/18/26, 3/19/26 3/23/26, 3/24/26, 3/27/26 3/28/26 and 3/29/26. -Haloperidol tablet 10 mg, one tablet by mouth two times a day (a first-generation typical antipsychotic medication used primarily to treat schizophrenia, acute psychotic episodes, and Tourette's syndrome) for paranoid schizophrenia was refused on 3/2/26, 3/3/26, 3/4/26, 3/7/26, 3/13/26, 3/23/26, and 3/24/26. -Depakote tablet delayed release 500 mg (an FDA-approved prescription medication primarily used to treat epilepsy (seizures), stabilize mood<br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | in bipolar disorder (specifically manic episodes) by mouth three times per day was refused on 3/2/26, 3/3/26, 3/4/26, 3/7/26, 3/13/26, 3/23/26, and 3/24/26. Review of the resident's March 2026 progress notes showed no documentation regarding the resident's missing his/her medications or notifying the physician of the resident's missing medications. Review of the resident's most recent Mental Status Exam (MSE), dated 3/4/26, showed:-The resident continued to go outside in his/her wheelchair most days and sit at the gas station next door. The resident was on six psychotropic medications (drugs that affect brain function, altering mood, thoughts or behaviors). -The psychoactive substance abuse was worsening. Encourage the resident to refrain from outside drugs.-Insight and judgment were at baseline and were impaired as evidenced by decisions of recent past. -Multiple refusals for labs.-Care plan goals:--To continue haloperidol (Haldol - antipsychotic medication used to treat mental illness, such as schizophrenia, behavior problems, agitation, and symptoms of Tourette's syndrome (a neurodevelopmental disorder). --Demonstrate improved reality through medication compliance and therapeutic interactions. -The MSE did not show what staff were to do when the resident refused medication. Review of the resident's undated care plan showed problem identified as: -He/She had physical altercation incident initiated 3/5/26:--The resident was involved in a physical altercation with another resident.--Staff escorted the resident out of the building and educated the resident on side effects of drugs.--Staff were looking into new placement.-The resident had altered social interactions related to psychosis revised 3/10/26.-He/She had behaviors related to mental illness revised on 3/10/26:--His/her behaviors might disturb others and involve conversing with self and imaginary people.--Staff were to administer medications, address root cause of behavioral changes or mood as needed, and if disturbing others encourage the resident to go to a more private area to decrease episodes of disturbing others.-He/She had impaired social interaction psychotic disorder initiated 3/10/26:--The resident could be verbally loud and aggressive, yelling and cursing at staff and other residents.--Interventions showed:---Encourage recreational activities.---Monitor for negative thoughts and feelings.---Redirect to a private area if resident is verbally aggressive. Review of the resident's quarterly MDS, dated [DATE], showed the resident:-Was cognitively intact.-Felt down and depressed seven to 11 days out of the past 14.-Had verbal behaviors directed toward others.-Had other behaviors (e.g. - self harm, property destruction, disruptive behaviors).-Was diagnosed with schizophrenia/schizoaffective disorder and depression.-Within the past seven days routinely took an antipsychotic medication and an antidepressant. Review of the resident's Alert Note, dated 3/26/26 at 1:12 A.M., showed:-The resident returned to the facility at approximately 1:00 A.M. smelling strongly of alcohol with very bloodshot eyes. -His/her speech was slow and deliberate with an inability to focus. Review of the resident's care plan showed staff did not update the care plan with interventions after the resident came back on 3/26/26 with a strong smell of alcohol and signs of being intoxicated. Review of the resident's April 2026 MAR showed the resident refused the following ordered psychotropic medications:-Benztropine Mesylate 0.5 mg at 8:A.M., daily for paranoid schizophrenia was refused on 4/1/26, 4/2/26, 4/6/26, 4/7/26, 4/11/26, 4/12/26, 4/17/26, 4/20/26, and 4/24/26. -Cymbalta capsule delayed release particles 30 mg, two capsules by mouth in the morning for Major Depressive Disorder (MDD) was refused on 4/1/26, 4/2/26, 4/6/26, 4/7/26, 4/11/26, 4/12/26, 4/17/26, and 4/24/26.-Trazadone HCl tablet 100 mg, one tablet by mouth at bedtime for insomnia secondary to depression was refused on 4/1/26, 4/2/26, 4/5/26, 4/6/26, 4/7/26, 4/10/26, 4/11/26, 4/15/26, 4/16/26, 4/17/26, 4/20/26, 4/21/26, and 4/24/26.-Haloperidol tablet 10 mg, one tablet by mouth two times a day for paranoid schizophrenia was refused at 8:00 A.M. and 4:00 P.M. on 4/1/26, 4/2/26, 4/6/26, 4/7/26, 4/11/26, 4/12/26, 4/17/26, 4/20/26, and 4/24/26.-Depakote tablet delayed release 500 mg by mouth three times a day for paranoid schizophrenia and schizoaffective disorder was refused at 8:00 A.M., 2:00 P.M., and 8:00 P.M. on 4/1/26, 4/2/26, 4/6/26, 4/7/26, 4/11/26, 4/12/26, 4/17/26, 4/20/26 and 4/24/26. Review of the resident's April 2026 progress notes showed no documentation regarding the resident's missing his/her medications or notifying the physician of the<br>(continued on next page) |

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| F 0740<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | resident's missing medications. Review of the resident's Behavioral Note, dated 4/8/26 at 5:15 A.M., showed:-The resident had verbal and threatening physical behaviors toward staff and had to be redirected three times.-He/She believed the staff had stolen drinks from his/her bathroom, which caused him/her to accuse the staff and led to the behaviors. -The Administrator, DON and ADON were notified of behaviors.-911 was called and the police officers arrived. No report to note. Advised the resident to not fight with the staff and to wait in the other room and the resident agreed. Review of the resident's undated care plan showed problem identified as: -The resident had a history of negative behaviors such as screaming, yelling and hallucinating revised 4/9/26.--The staff were to have provided counseling, outside support networks and a structured environment.-He/She was at risk for adverse reaction related to a history of having illicit drug on his/her person revised 4/9/26:--The physician would be notified if the resident was in possession of illicit drugs to review and evaluate medication for any changes to be made. --Review pharmacy consult recommendations and follow up as needed. Review of the resident's Behavior Note, dated 4/12/26 at 7:45 P.M., showed:-The resident was noted coming into the facility upset while in the lobby area.-The resident began to slam the facility phone during his/her outburst.-The nurse came in to try to de-escalate the situation when the resident grabbed the nurse by the hair and struck him/her in the eye. The resident also noted hitting and cracking the front door entrance to the facility.-The resident was still upset which prompted assistance from Emergency Medical Technicians (EMT) and the local police department.-The resident was taken to Hospital A for altered mental status. Review of the Resident's Physical Aggression Involving the Head investigation, dated 4/13/26, showed:-The Investigative Narrative showed:--On 4/12/26 Around 7:30 P.M. the resident was seen coming into the lobby verbally aggressive. --The ADON told the resident he/she would have to get off the phone when the resident slammed the desk phone. This upset the resident and he/she became extremely aggressive toward the ADON, eventually reaching the ADON to strike his/her eye and pull his/her hair. --Police were called, charges were pressed, and the resident was sent to the hospital. The hospital indicated the resident was aggressive there as well. --At 9:00 A.M. on 4/13/26 the Administrator asked the resident what happened, and he/she stated the ADON was talking crazy telling him/her to get off the phone and stuff like that. The ADON was all in his/her business. When asked if the resident hit the ADON the resident said not for real.--The Administrator discussed recent behaviors and the resident interrupted saying, you are supposed to be the head person and now you are talking to me crazy. Bitch The interview could not be continued due to escalating speech. The resident went to his/her room. --On 4/17/26 the resident apologized to the ADON and did not believe he/she hit the ADON. The resident refused to cooperate.-The conclusion showed:-The resident had been educated numerous times. -The facility was coordinating with facility Activities to find a group to host Alcohol Anonymous (AA) meetings inside the facility and/or other alternates to be a resource to all residents. -The resident was still unwilling to go to AA meetings. Review of ADON's Witness Statement showed:-On 4/12/26 around 7:45 P.M. he/she was in his/her office getting ready to go home when he/she heard the resident shouting and yelling. -The resident came into the facility angry at someone on the outside. The resident went straight to the phone and made a call.-He/She noticed the resident's eyes were blood red and he/she was slurring his/her words. The resident was hollering in the phone then the resident slammed the phone down twice really hard. -Staff asked the resident to calm down and told him/her lets go smoke. The resident refused and started charging the staff and flipped over the chair.-He/She informed the staff we needed to get the resident outside, but the resident started swinging and hitting at everyone. -The resident then caught ahold of his/her top and pulled him/her in and hit |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide medically-related social services to help each resident achieve the highest possible quality of life.<br><br>Based on record review and interview, the facility failed to provide sufficient and appropriate social services to meet one resident's needs (Resident #1). The facility failed to provide or obtain services from outside entities to determine if the resident needed a legal representative or guardian to assist in making health care decisions. Family, physicians, administrative staff, and a PASRR assessment identified the need for the facility to facilitate guardianship proceedings and coordinate communication with legal and community resources, however, steps were not taken to begin the process. The facility census was 103 residents. 1. Review of Resident #1's undated care plan showed problem identified as: -He/She had depression related to schizophrenia revised on 1/20/26: --The resident had the following signs and symptoms related to schizophrenia:aggression, anxiety, inability to make decisions, delusions (fixed beliefs that can't be reasoned with), eyes that dart back and forth, fearfulness, hallucinations (hearing, seeing, feeling, and/or smelling things that aren't there), difficulty focusing, no interest in activities, irritability, making hand gestures as if having a conversation, mumbling, poor hygiene, isolation, and talking to self.--The resident states there are multiple little girls living on his/her shoulders who gain up on him/her and are mean.--Interventions included:---Administering medications for anxiety or hallucination according to physician orders.---Avoid arguing.---Notify charge nurse if observing resident experiencing signs/symptoms of schizophrenia.---Be careful when using reassuring touch.---Focus the resident on how the hallucination makes them feel rather than the content of the hallucination. Review of an email sent by the facility Social Services Designee (SSD), dated 9/3/25, showed to the Director of Nursing (DON) as well as other former administrative staff that the SSD got a phone call from the resident's primary family member requesting a letter with the resident's diagnoses as he/she attempted to obtain guardianship for the resident. Review of an email sent by the facility SSD, dated 9/17/25, to the facility DON requested a referral be sent to a sister facility for the resident as soon as possible, as his/her behaviors were escalating and becoming dangerous with the resident leaving the facility all day, taking illicit drugs, and drinking alcohol. Review of an email received by the DON, dated 10/28/25, sent from Assistant Director of Nursing (ADON) B showed the physician wanted to know if the DON wanted him/her to write a letter recommending the facility to get legal guardianship in light of the resident's poor impulse control and drug use. Review of the resident's Electronic Medical Record, from October 2025 until May 2026, showed no documentation of any follow-up completed having the physician write a letter recommending the facility obtain guardianship. Review of an email received by the DON and SSD, dated 2/10/26, sent by the facility Administrator said:-He/She had spoken to Regional Director of Operations (RDO) A regarding the most effective way for the facility to deal with Resident #1 in order to mitigate the resident's aggressive behaviors.-The resident was currently self-responsible and was suspected to have been a trigger for other residents in the facility.-On 2/6/26, the Administrator informed RDO A that he/she urgently needed to discharge the resident in order to prevent potential harm to the other residents.-On 2/9/26, he/she informed RDO A that he/she needed to either do an immediate discharge on the resident or need RDO A's assistance on placement to initiate a 30-day notice. -RDO A suggested sending a request to the corporate legal team, however the Administrator thought it best to reach out to the Ombudsman to learn of any resources that the team may not have tried before initiating an immediate discharge.-On 2/10/26, he/she informed RDO A the resident had been banned from the corner store and had received multiple police citations in the past 24 hours. Review of the resident Level II PASRR, dated 2/26/26 showed: -Besides the diagnoses mentioned on the admission Record the resident was also diagnosed with:--Bipolar disorder - Mood disorder that can cause intense mood swings.--Disruptive behavior disorder.--Conduct disorder, adolescent onset - a serious mental health condition, usually seen in children and adolescents, characterized by a consistent pattern of aggression, theft, vandalism, and<br>(continued on next page) |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | rule violations that violate the rights of others.--Borderline Personality Disorder - a serious mental illness characterized by pervasive instability of moods, self-image, interpersonal relationships, and marked impulsivity.-The resident had a chronic pattern of severe psychiatric decompensation characterized by persistent auditory and visual hallucinations involving an imaginary little girl, fixed delusional content, and frequent responding to internal stimuli. He/She had recurrent verbal aggression, intimidation of peers, and escalation toward physical altercations, including lunging from his/her wheelchair, striking walls, damaging facility property and engaging in threatening behaviors that required staff intervention. He/She demonstrated repeated smoking and contraband violations and elopement to the adjacent gas station despite prior warnings and law enforcement involvement. He/She continued to go outside in his/her wheelchair most days and sit at the gas station next door.-The resident had been observed spending time outside at the corner store using recreational drugs; however, the specific substance type was not reported. -Progress notes reflected a pattern of behavioral dysregulation occurring in the context of active psychosis, poor impulse control, and suspected substance use. -The resident required 24-hour protective oversight due to the severity of behaviors or mental illness symptoms and medication management.-Mental health care needs exceeded what could be managed in previous/current living situation due to aggression, substance use, or medication non-compliance leading to exacerbation of symptoms.-Documentation indicated no active discharge planning and no referrals initiated. This appeared to contradict current nursing facility reports describing active efforts toward rehabilitation placement and guardianship pursuit.-The resident had ongoing use of illicit drugs and alcohol with poor insight and compromised safety judgment. -Due to the resident's severe and treatment-refractory psychiatric condition, ongoing substance use, significant behavioral dysregulation, and complex medical needs, the resident continued to require 24-hour care in a highly structured setting. His/Her chronic psychosis is characterized by persistent auditory and visual hallucinations, paranoid ideation, gross disorganization, and frequent response to internal stimuli which significantly impair his/her reality testing and behavioral regulation. He/She had been involved in multiple episodes of verbal and physical aggression, often in the context of responding to internal stimuli or perceived threats. In the nursing home setting, the resident's symptoms remained only moderately controlled. His/Her illicit drug use continued to undermine psychiatric stability and posed serious safety concerns. The resident had a history of bilateral below knee amputations due to frostbite, resulting in mobility limitations and the need for continued assistance with activities of daily living (ADLs, feeding, dressing, grooming) and medical oversight. His/Her demonstrated inability to remain safely within the facility, nonadherence to medication and treatment when unsupervised, and vulnerability in the community highlight the necessity of a structured and secure environment. Placement in a nursing facility with a locked behavioral unit should be considered for the resident to address his/her ongoing elopement, enhance safety, and provide the containment necessary to support adherence, minimize risk of harm, and reduce access to illicit substances.-Given the resident's persistent substance use and repeated elopement for the purpose of obtaining drugs and alcohol, integrated dual-diagnosis therapy was strongly recommended to target both his/her psychiatric illness and substance use disorder.-The resident needed among other supports: medication set up and administration by staff monitoring for medication compliance, supports to prevent elopement, and assessment of supervision required to prevent harm to self or others. -Plan for crisis intervention that promoted emotional support, education, safety planning and case management to handle immediate crisis. A crisis plan should be developed to create clear steps that are to be taken to support the resident during a behavioral health crisis including who to contact for assistance, how to work together with the client during a crisis, and how to determine when the crisis is over. The plan should identify a physician and emergency medical services that should be contacted. The facility may also utilize Department of Mental (DMH) Health Behavioral Crisis hotline. Assault precautions and elopement precautions should be part of the crisis intervention plan. -At this time priority should be given to supporting the<br>(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<br>B. Wing | 05/20/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Gregory Ridge Health Care Center | 7001 Cleveland Avenue<br>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.

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resident's family member in pursuing guardianship as the resident's poor insight, current psychosis, substance related behaviors, and documented refusal of previously arranged rehabilitation significantly limit his/her ability to participate meaningfully in discharge planning or adhere to treatment recommendations independently. The facility should provide assistance to the family to facilitate guardianship proceedings and coordinate communication with legal and community resources. If guardianship was achieved and sustained clinical stabilization occurred the primary recommendation would be residential or intensive substance use treatment and rehabilitation services given the resident's high-risk behaviors, ongoing risk for substance use, and prior refusal of rehabilitation placement. Review of the resident's undated care plan showed problem identified as: -The resident continued to have increased behaviors including refusal of cares, along with verbal and physical aggression towards staff and peers, revised 2/26/26. Review of the resident's care plan showed recommendations from the 2/26/26 PASRR assessment not included in the resident's care plan including supporting the resident's family to obtain guardianship, need for 24/7 protective oversight on secured unit, and outside counseling and drug/alcohol rehabilitation. Review of the resident's progress notes, from February 2026 - May 2026, showed no documentation of follow up regarding assisting the resident's family member to pursue guardianship of the resident as directed by the PASRR or to find alternate placement for the resident. During an interview on 5/12/26 at 2:15 P.M., the Administrator and DON said:-They were not aware a new PASRR had been completed in February 2026. -They did not know who had requested a new PASRR, nor were they aware of recommendations for obtaining a guardian for the resident nor that the resident had been deemed no longer appropriate for residence in the facility due to his/her behaviors. -They did share their concerns for the resident's safety earlier in the year with former RDO A asking for assistance in getting the resident out of the facility and/or emergency guardianship completed. -They had also reached out in attempt to get corporate legal assistance in assisting the resident's primary family member in obtaining guardianship, but were told there was no longer anyone on the corporate legal team who assisted with guardianship. -Their concern was that while the resident was still his/her own person, as a facility, they could not physically keep the resident inside the building, nor could they force him/her to take his/her medication every day as he/she had a right to refuse and they feared getting in trouble for limiting the resident's freedoms. During an interview on 5/5/26 at 11:10 A.M., the SSD said:-He/She didn't know who was responsible for following up on PASRR recommendations, but thought the Care Plan Coordinator did that.-He/She didn't know the PASRR had recommended guardianship.-The resident's family member was going to pursue guardianship and then said he/she wouldn't.-On 4/24/26 the resident's family member asked if the facility could pursue the guardianship.-He/She had not initiated the guardianship process and didn't know if the Administrator had done so. During an interview on 5/5/26 at 11:54 A.M., the Care Plan Coordinator said:-The expectation was he/she was to review the PASRR recommendations and add them to the care plan. -He/She didn't realize the family member had asked the facility to pursue the guardianship and didn't know if the facility tried to pursue an emergency guardianship.-Recently the resident said he/she wanted his/her family member to pursue guardianship, and he/she assumed the family member was doing that.-The resident wasn't safe inside or outside the building because he/she was using drugs at the corner store and he/she needed a guardian.-He/She didn't know if the facility ever discussed the resident's need for a guardian. During an interview on 5/14 /26 at 11:00 A.M., Resident #1's primary family member said:-He/She felt that he/she had gotten no real assistance from the facility SSD. -He/She felt the facility didn't watch the resident close enough or keep the resident in the facility as they should.-The facility staff told him/her they couldn't keep the resident in the facility against the resident's will as long as the resident was self-responsible. |