| 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 | 06/04/2026 |

| 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.

| (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 protect two sampled residents Resident #1and Resident #9 out of 10 sampled residents. On 5/23/26 Resident #2 had pulled Resident #1's hair and hit Resident #1 in the face resulting in bruising. On 5/29/26 Resident #2 hit Resident #9 in the face resulting in a small mark to the lower lip. The facility census was 101 residents.Review of the facility's policy titled Abuse and Neglect Policy dated 6/12/2024 showed:-Abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which could include staff to resident abuse and certain resident to resident altercations.-It included verbal abuse, sexual abuse, physical abuse, and mental abuse including facilitated or enabled through the use of technology.-Physical abuse was purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner.-Physical abuse also included, but was not limited to, hitting, slapping, punching, biting, and kicking.-The facility would identify, correct, and intervene in situations in which abuse was more likely to occur.-Prevention would also include assessment care planning and monitoring of residents with needs or behaviors which may lead to conflict or neglect. 1. Review of Resident #1's admission Record showed he/she admitted to the facility with a diagnosis of schizoaffective disorder (a mental health condition that includes features of both schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves) and a mood disorder). Review of Resident #1's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff) dated 4/16/26 showed the resident was cognitively intact. Review of Resident #2's admission Record showed he/she was diagnosed with schizophrenia on 2/10/2024. Review of Resident #2's quarterly MDS dated [DATE] showed:-The resident had severely impaired cognition.-The resident did not have any hallucinations (perceptual experiences in the absence of real external sensory stimuli) within the seven-day look back period.-The resident did not have any delusions (misconceptions or beliefs that are firmly held, contrary to reality) within the seven-day look back period.-The resident did not have physical behavioral symptoms within the seven-day look back period.-The resident did not have verbal behavioral symptoms within the seven-day look back period.-The resident experienced other behavioral symptoms not directed towards others one to three days within the seven-day look back period. Review of an Admin/RN Investigation dated 5/23/26 showed:-The incident occurred on 5/23/26 at 6:00 P.M.-The incident type was physical aggression involving the head.-Resident #1 and Resident #2 were involved in the incident.-Certified Nursing Assistant (CNA) A was a witness to the altercation.-Resident #6 was a witness to the altercation.-Resident #1 was standing in the hallway and talking to CNA A.-Resident #2 came down the hall behind Resident #1.-Resident #2 then pulled Resident #1's hair and started to hit Resident #1 in the face and chest.-Staff separated Resident #1 and Resident #2.-Resident #2 was removed from the unit for the safety of the other residents on the unit.-Resident #1 stated that he/she did not have any interaction with Resident #2 leading up to the incident.-Resident #1 stated that he/she didn't do anything wrong and that he/she did not hit<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 | Resident #2 back.-CNA A reported that there were no warning signs that Resident #2 showed prior to the altercation.-No injuries were reported at that time of the incident.-It was noted that on 5/24/26 that Resident #1's left eye may have bruising as the hyperpigmentation appeared darker.-Resident #2 had no recollection of the altercation.-The root cause of the incident was behavioral related due to poor impulse control.-The incident was not the result of abuse. Review of Resident #1's Skin Check dated 5/23/26 showed:-The resident had a new skin issue to his/her face.-The resident had bruising to his/her face.-The bruising was painful and aching. Review of Resident #2's Incident Note dated 5/23/26 at 5:55 P.M. showed:-Around 6:00 P.M. Resident #2 was walking in the hallway and turned to Resident #1 and hit him/her in the face.-A code green (a behavioral emergency and/or incident needing physical support and presence when an individual poses a threat to himself/herself or others) was called.-Resident #2 was unable to say what happened.-Staff informed the writer that Resident #2 had walked down the hall and started pulling Resident #1's hair and hit Resident 1 in the face with a closed fist. During an interview and observation on 6/1/26 at 1:07 P.M. Resident #1 said:-Resident #2 attacked him/her out of nowhere.-He/She was talking with staff when Resident #2 came up to him/her and hit him/her in the face and chest.-Resident #2 did not say anything to him/her before he/she was hit.-He/She reported no injuries.-Observation of Resident #1 showed bruising to Resident #1's face.-The staff separated him/her from Resident #2, and nothing happened after that.-Resident #2 had been physical with other residents before this altercation.-He/She had been avoiding Resident #2 since the incident occurred.-He/She did not feel safe at the facility. During an interview on 6/1/26 at 1:30 P.M. Resident #2 said:-He/She did not remember the incident.-He/She was unable to answer any questions related to the altercation. During an interview on 6/1/26 at 3:21 P.M. CNA A said:-Resident #1 was standing in the hall.-Resident #2 walked up to Resident #1 and pulled Resident #1's hair.-Resident #2 then turned Resident #1 around and started to hit Resident #1.-Resident #1 did not hit Resident #2 back.-The staff then called a code green and separated the residents.-Resident #1 had redness to the face and chest after the altercation.-He/She felt that staff responded appropriately to the incident. During an interview on 6/2/26 at 1:48 P.M. Assistant Director of Nursing (ADON) A said:-The incident between Resident #1 and Resident #2 would be considered as abuse.-Resident #2 didn't know any better in either situation because of his/her delusions and hallucinations. During an interview on 6/2/26 at 3:27 P.M. the Director of Nursing (DON) said:-He/She understood that Resident #2 struck Resident #1.-The incident between Resident #1 and Resident #2 would be considered as abuse.-Resident #2 was unpredictable, but hitting another resident still counted as physical abuse.-He/She felt that the reported root cause of the incident between Resident #1 and Resident #2 was not related to poor impulse control because Resident #2 was unable to control any of his/her impulses. 2. Review of Resident #9's admission Record showed he/she admitted to the facility with a diagnosis of borderline personality disorder (a mental health condition characterized by severe difficulties in regulating emotions). Review of Resident #9's comprehensive MDS dated [DATE] showed:-The resident was cognitively intact.-The resident had verbal behavioral symptoms directed toward others one to three times within the seven-day look back period.-The resident had other behavioral symptoms not directed toward others one to three times within the seven-day look back period. Review of an Admin/RN Investigation dated 5/29/26 showed:-The incident occurred on 5/29/26 at 6:30 P.M. -The incident type was physical aggression involving the head.-Resident #2 and Resident #9 were involved in the incident.-Certified Medication Technician (CMT) A was a witness to the incident.-Resident #9 was in the hallway stating that he/she wanted medication and began getting loud.-Resident #2 passed Resident #9 and hit the resident in the face.-The root cause of the altercation was behavioral related due to poor impulse control. Review of Resident #9's care plan dated 5/30/26 showed the resident was involved in a physical altercation with a peer, the peer was reacting to Resident #9's loud voice. Review of Resident #2's Incident Note dated 5/29/26 showed Resident #2 was walking in the hallway when Resident #2 turned to Resident #9 and hit Resident #9 in the face. Review of Resident #9's Incident Note dated 5/29/26<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 | showed:-Resident #9 was in the hallway and had been asking for medication.-Resident #9 began getting loud when Resident #2 was walking passed Resident #2.-Resident #2 then hit Resident #9 in the face. During an interview on 6/2/26 at 12:30 P.M. the Assistant Administrator said:-He/She had been notified of the altercation between Resident #2 and Resident #9.-He/She informed the Regional Nurse Consultant (RNC) of the incident between Resident #2 and Resident #9.-He/She had been told that Resident #2 swatted at Resident #9 in more of a startled response to the commotion that Resident #9 was causing.-There were no injuries to Resident #2 or Resident #9 related to the incident. During an interview on 6/2/26 t 12:42 P.M. Licensed Practical Nurse (LPN) A said:-Resident #2 was walking by Resident #9 when Resident #2 started hitting Resident #9.-It was more of a swat than an actual hit.-He/She thought Resident #2 might have been surprised by Resident #9 based off of Resident #9's location which may have caused the started response.-He/She felt the altercation did not count as abuse because Resident #2 did not intentionally hit Resident #9. During an interview and observation on 6/2/26 at 1:40 P.M. Resident #9 said:-Resident #2 came up to him/her, pulled his/her hair, and started to hit him/her.-He/She defended himself/herself and hit Resident #2 back.-He/She scratched Resident #2 in the face.-His/Her left side of the face still hurt related to the incident.-He/She had been hit in the lip, and it left a mark on his/her lower lip.-Nothing happened after the incident.-He/She felt like the facility didn't really do anything for him/her after the altercation occurred.-He/She felt that he/she had been abused by Resident #2. -Observation of Resident #9's face showed no bruising, swelling, or redness to any part of Resident #9's face.-Observation of Resident #9's mouth showed a quarter to half inch white mark to the inside of the lower lip, though the mark appeared older than 4 days-old. During an interview on 6/2/26 at 1:48 P.M. ADON A said:-The incident between Resident #2 and Resident #9 would not be considered as abuse.-He/She had been told that Resident #2 unintentionally swatted at Resident #9.-Loud noise and commotion were one of Resident #2's triggers, which could have Resident #2's response. During an interview on 6/2/26 at 3:23 P.M. CMT A said:-Resident #2 came behind Resident #9 and started hitting Resident #9 in the face using his/her fists.-In response, Resident #9 hit Resident #2 back and scratched Resident #2's face.-Staff immediately separated the residents.-Nothing happened after the incident.-He/She was unsure if there was a specific trigger that caused Resident #2 to hit Resident #9.-He/She felt that the staff intervened appropriately.-He/She would consider Resident #2's and Resident #9's altercation as abuse.-Resident #2 intentionally hit Resident #9 and in response Resident #9 hit and scratched Resident #2. During an interview on 6/2/26 at 3:27 P.M. the DON said:-He/She felt that the investigation related to Resident #2's and Resident #9's altercation was incomplete after discussing the investigation during the interview.-Resident #2's and Resident #9's altercation would be considered abuse.-He/She was unsure of how/why the staff who completed the investigations determined that abuse had not occurred. During an interview on 6/5/26 at 11:45 A.M. the Regional Nurse Consultant (RNC) said:-He/She was not in the building to complete the investigation related to Resident #2's and Resident #9's altercation.-The investigation was incomplete.-He/She thought the Assistant Administrator and/or ADON A had interviewed all of the parties involved in the incident between Resident #2 and Resident #9.-The root cause of Resident #2's and Resident #9's altercation was not related to poor impulse control.-The root cause of Resident #2's and Resident #9's altercation was overstimulation.-He/She felt that the incident between Resident #2 and Resident #9 would not be considered as abuse because the altercation was not an intentional act. 3022671 |