STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265721	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gregory Ridge Health Care Center	7001 Cleveland Avenue Kansas City, MO 64132

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure proper notification to the resident's guardian for one sampled resident (Resident #2) when on 6/8/26 the resident was transferred to the hospital for behavior type issues out of eleven sampled residents. The facility census was 101 residents.Review of the facility's undated Resident Rights Policy showed:-The facility must immediately inform the resident, consult with the resident's physician, and, if known, notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental, or psychosocial status.-The facility must immediately inform the resident, consult with the resident's physician, and, if known, notify the resident's legal representative or an interested family member when there is a decision to transfer or discharge the resident from the facility.-The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. 1. Review of Resident #2's admission Record face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:- Schizoaffective disorder (a mental health disorder characterized by symptoms of schizophrenia, such as hallucinations or delusions, occurring along with mood disorder symptoms, including depression or mania).- Anxiety disorder (a mental health disorder characterized by excessive fear, worry, or anxiety that interferes with daily functioning).- Bipolar disorder (a mental health disorder characterized by alternating episodes of depression and mania or hypomania that affect mood, energy, and behavior). - Major depressive disorder (a mood disorder characterized by persistent feelings of sadness, loss of interest, and impaired daily functioning).- Asperger's syndrome (a neurodevelopmental disorder characterized by persistent difficulties with social interaction, communication, and restricted or repetitive patterns of behavior, without significant language or cognitive delay). - Unspecified intellectual disability (a disorder characterized by limitations in intellectual functioning and adaptive behavior when the severity cannot be fully specified because of insufficient information or the individual's condition). - Schizophrenia (a chronic mental health disorder characterized by disturbances in thought processes, perception, emotions, and behavior, often including hallucinations, delusions, or disorganized thinking).- Catatonic schizophrenia (a form of schizophrenia characterized by significant disturbances in movement and behavior, including immobility, rigidity, excessive or purposeless movement, or diminished responsiveness). Review of the County Public Administrator Emergency Call Information dated 3/31/26 showed:-The Public Administrator (PA)'s name who was assigned to the resident.-The PA's email address.-A list of examples of expected uses of the on-call phone vs. using the direct line and/or email.-The on-call phone number was to be used for consent to send a ward to the hospital.-This document was signed by the facility Social Worker. Review of the Resident's Progress Notes dated 6/8/26 at 9:33 P.M. showed:-The physician was notified of the incident, and an order was given to send to the emergency room for evaluation and treatment.-The patient's guardian was notified of transfer to the hospital.-This was a late entry. Review of the Resident's Progress Notes dated 6/8/26 at 9:39 P.M. showed:-He/she attempted to gain access to peer's room in an aggressive manner.-He/she attempted (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to push through this writer and was unsuccessful.-He/she was redirected to his/her room to calm down.-He/she then reported he/she wanted to cause harm to himself/herself.-The Nurse Practitioner was notified, and an order was given to send the patient to the hospital for evaluation and treatment for thoughts of self-harm. Review of the Resident's Progress Notes dated 6/9/26 at 2:20 A.M. showed:-The patient returned to the facility at 1:45 A.M. from this hospital via Z-trip.-The patient had been sent out for suicidal ideations between 9:30 P.M and 9:45 P.M. on 6/8/26 via ambulance. During an interview on 6/17/26 at 1:00 P.M., Certified Medication Technician (CMT) A said:-The facility left a message for the resident's guardian regarding the resident but did not speak directly with the guardian. The call occurred during the night shift.-To the best of his/her knowledge, if staff were unable to reach the guardian, follow-up calls were not required until the resident returned to the facility.-When calling the guardian, the system prompted staff to call only the emergency contact number.-He/She did not consider the resident's behavior to be an emergency.-Based on his/her nursing judgment, he/she did not use the emergency contact number unless there was a true emergency, such as a physical problem like a heart attack.-He/She may have been mistaken regarding the notification process, may require additional education, and was open to the possibility that his/her understanding was incorrect.-The resident was sent to the hospital because the resident made statements about self-harm.-The transfer was necessary because of the statements made, not because the resident had engaged in self-harm. -There had been no attempts at self-harm.-The resident was evaluated at the hospital and returned to the facility quickly without receiving treatment. -The guardians did not have on-call staff except for emergencies. -The emergency contact number was intended for actual health emergencies and not for providing updates.-The resident had made verbal statements only and had not acted on those statements. -The resident did not do anything with the fork and did not reach the other resident.-The incident was entirely verbal. During an interview on 6/27/26 at 1:15 P.M., the Psychiatric Nurse Practitioner said:-Leaving voicemail constituted as notification.-If staff could not send a resident to the hospital because they had to wait for the guardian's approval, it could result in a negative outcome for the resident.-If someone agreed to serve as a resident's guardian, he/she needed to be available. During an interview on 6/17/26 at 2:15 P.M. Guardian A said:-The resident was at the hospital for approximately three hours.-There was someone on call 24 hours a day, seven days a week for the guardian's office.-An email was sent to the facility with the guardian's information.-There was a notice identifying the deputy assigned to the resident.-The emergency on-call number was listed, along with the reasons it should be used, and facility staff could speak with the deputy on call.-A specific form was provided to the facility identifying which telephone number to call and the reasons for calling.-The information should also have been included on the facility face sheet.-The facility should have called when the resident was sent to the hospital. During an interview on 6/18/26 at 10:30 A.M., the Interim Director of Nursing (DON) and Regional Nurse Consultant said:-The guardian or responsible party would be contacted when a resident was sent to the hospital.-If it were an emergency, the resident would be sent to the hospital, and the guardian would be notified of the circumstances when he/she returned the call.-If it was the middle of the night and a voicemail was left, staff could follow up later.-Staff should attempt to follow up but do not always reach the guardian.-The resident face sheets were created through a team effort.-As updated information was obtained during the resident's stay, it should be added to the face sheet.-Not every PA had a back-up telephone number.-Some PA's had back-up telephone numbers that were the same as the primary number and rolled over after hours.-Every PA had different preferences and needs.-When updated information was received, it should have been added to the resident contact information.-Whoever received the updated information was responsible for updating the contact information on the face sheet. During an interview on 6/18/26 at 10:45 A.M., the Social Worker said:-Some guardians provided information regarding who should be contacted, but not every guardian did so.-Nursing staff would have to look at the resident face sheet for guardian contact information.-The information on the resident face sheet was the same information that was (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	uploaded into Point Click Care (PCC), an electronic medical record system.-When a resident was admitted with a guardian, the guardian's telephone numbers were provided by the guardian.-Many guardians did not want residents to have access to those telephone numbers.-The resident had been assigned a new PA, possibly in March.-If nursing staff did not review the documents in PCC, they would not know the emergency telephone number.-The emergency telephone number document was uploaded into PCC under the documents tab.-He/She signed the document and acknowledged he/she should have added the information to the resident face sheet. During an interview on 6/19/26 at 3:00 P.M., the Assistant Administrator said:-The CNA should not have called the emergency telephone number.-The resident was sent to the hospital due to behavioral concerns.-If it had been a true emergency, the resident would not have returned to the facility within a couple of hours.-Examples of a true emergency included cardiac issues, respiratory distress, or unresponsiveness.-A behavioral situation could constitute an emergency.-The resident was sitting in a chair when emergency medical services (EMS) arrived.-The resident got onto the gurney independently.-The resident stated he/she was going to harm him/herself with a fork but never had possession of a fork.-The resident stated he/she wanted to harm him/herself.-The behavior was for attention.-He/She did not consider it a true medical emergency.-The resident's vital signs were within normal limits and the resident was stable.-The resident returned to the facility within two hours.-Some notification was better than no notification. During an interview on 6/19/26 at 3:30 P.M., the Administrator said:-The secondary guardian phone number should have been added to the face sheet. -The nurse should have known there was an emergency. -He/She understood the nurse's viewpoint that it was not emergent.-He/She would have expected the Social Worker to put the complete information on the face sheet.-The face sheet was a working document and should be as complete as possible.-The resident's circumstance was enough to contact the emergency number. 3039092

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent resident-to-resident physical abuse for four sampled residents (resident #3, #5, #10, and #11) out of seven sampled residents. On 6/10/26 Resident #6 hit Resident #5 which caused the resident to land on the floor by the elevator. Resident #6 repeatedly hit Resident #5 in the head and stomped on his/her arm. Resident #5 was sent to the hospital for evaluation and remained afraid of Resident #6. On 6/13/26 Resident #3 lunged at Resident #4 and Resident #4 hit Resident #3. Resident #4 picked up Resident #3 and slammed Resident #3 to the floor and continued to hit and kick Resident #3 in the abdomen, chest and hand. Resident #3 had bruising on his/her abdomen and left hand which caused Resident #3 to be upset and angry. On 6/19/26 Resident #11 slapped/backhanded Resident #10 on the right side of his/her face. Resident #10 then struck Resident #11 in the face three times and Resident #11 fell on the floor. Resident #10 then struck Resident #11 three more times in the face which resulted in Resident #11 having a swollen and bruised eye. The facility census was 101 residents. Review of the facility Abuse and Neglect Policy, dated 6/12/24, showed:-Abuse is the willful infliction of injury, intimidation or punishment with resulting physical harm, pain or mental anguish.-Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish.-Physical abuse is 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 is not limited to, hitting, slapping, punching, biting, and kicking. 1. Review of Resident #6's admission Record face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:-Schizophrenia.-Post-traumatic stress disorder (PTSD), (a mental health condition triggered by experiencing or witnessing a life-threatening or deeply traumatic event).-Obsessive-compulsive disorder (a mental health disorder characterized by unwanted, intrusive thoughts (obsessions) and repetitive behaviors or mental acts (compulsions) performed to reduce anxiety).-Mild intellectual disability (a disorder characterized by mild limitations in intellectual functioning and adaptive behavior that affect conceptual, social, and practical skills).-Anxiety disorder.- Major depressive disorder (a mood disorder characterized by persistent feelings of sadness, loss of interest, and impaired daily functioning). Review of the resident's Care Plan report, dated 2/12/26, showed:-He/She had manifestations of behaviors including ineffective coping skills. Interventions included positive feedback for good behaviors, addressing root causes of changes in behavior or mood.-He/She had a history of intellectual disability and inability to connect actions and consequences. Interventions included making sure his/her environment was safe, providing with diversional activities, limiting changes to routines, and using a calm and gentle approach.-He/She had potential for verbal aggression. Interventions included de-escalation by removing him/her to a quiet environment and medications.-He/She had a history of PTSD which could flare up without any known trigger, and cause reactivity including aggressiveness and self-destructive behavior. Intervention was counseling services when needed. Review of Resident #6's MDS, dated [DATE], showed he/she was cognitively intact. Review of Resident #5's admission Record face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:-Schizoaffective disorder (a mental health disorder characterized by symptoms of schizophrenia, such as hallucinations or delusions, occurring along with mood disorder symptoms, including depression or mania).-Schizophrenia (a chronic mental health disorder characterized by disturbances in thought processes, perception, emotions, and behavior, often including hallucinations, delusions, or disorganized thinking).-Anxiety disorder (a mental health disorder characterized by excessive fear, worry, or anxiety that interferes with daily functioning).-Impulse disorder (a mental health disorder characterized by difficulty resisting urges or impulses that may be harmful to oneself or others.-Paranoid schizophrenia (a form of (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	schizophrenia characterized primarily by delusions of persecution or grandeur and auditory hallucinations, while cognitive function and emotional responsiveness are relatively preserved). Review of Resident #5's Quarterly Minimum data set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 5/27/26, showed he/she was cognitively intact. Review of the facility's Admin/Registered Nurse Investigation (RNI), dated 6/10/26 at 7:10 P.M., showed:-The incident was physical aggression involving the head.-The residents involved were Resident #5 and Resident #6.-At or about 7:10 P.M., a Code [NAME] (a facility response to a behavioral health event) was called.-Licensed Practical Nurse (LPN) A responded and was talking to both residents.-Resident #6 was very upset.-As the nurse was exiting the unit, Resident #5 approached him/her.-Resident #6 began to walk up to Resident #5, argued and repeatedly hit him/her in the head.-Resident #5 did not retaliate.-Resident #5 was on the floor wedged by the elevator door.-Staff attempted to pull them apart and were unsuccessful for a while.-Staff continued to intervene and Resident #6 was successfully pulled off or Resident #5.-Both residents were separated into different areas of the unit.-This incident resulted in abuse.-The altercation was not preventable. Review of Resident #6's Progress Note, dated 6/10/26 at 7:10 P.M., showed:-The residents involved were Resident #5 and Resident #6.-At or about 7:10 P.M., a Code [NAME] was called.-LPN A responded and was talking to both residents.-Resident #6 was very upset.-As the nurse was exiting the unit, Resident #5 approached him/her.-Resident #6 began to walk up to Resident #5, argued and repeatedly hit him/her in the head.-Resident #5 did not retaliate.-Resident #5 was on the floor wedged by the elevator door.-Staff attempted to pull them apart and were unsuccessful for a while.-Staff continued to intervene and Resident #6 was successfully pulled off or Resident #5.-Both residents were separated into different areas of the unit.-Resident #6 refused to get vitals done or have his/her hand assessed-Resident #6 refused tele health with nurse practitioner.-Resident #6's guardian had him/her sent to the hospital in attempt to get a citation while at the hospital. Review of Resident #5's written Witness Statement, dated 6/10/26, showed:-I don't even say anything, and he/she said I'm harassing him/her. He/She then came to me and beat the shit out of me.-Resident #6 had become more aggressive. Review of the local law enforcement police summons, dated 6/10/26 at 8:32 P.M., showed: -Resident #6 did by intentional, overt act inflict bodily injury or cause an unlawful offensive contact upon Resident #5 by hitting him/her in the head repeatedly. Review of Resident #5's Progress Note, dated 6/10/26 at 9:00 P.M., showed:- Pain Issue: No Change. Location: Head. Pain score: 10. Aching. Radiating. -Indicators of pain: Vocal complaints of pain. -Pain Note: Generalized pain all over and on the top of his head. Review of Resident #5's Progress Note, dated 6/10/26 at 9:40 P.M., showed:-Skin Issues: New skin Issue. Location: Rear head. Additional location information: Rear head ---Issue type: Bruising. Progress: New: new wound. -Wound acquired in-house. -Exact date: 06/10/2026-Signs and symptoms of infection: None. -Painful: Yes. Wound pain (Frequency): Continuous. -Wound pain interventions: Distraction techniques. Wound pain interventions: Relaxation techniques. Relief from interventions: Review of Resident #5's Progress Note, dated 6/11/26 at 10:35 A.M. as a late entry, showed:-Per staff a Code [NAME] was called.-At or about 6:10pm staff were talking to both parties.-He/She was very upset and as the staff were leaving the unit, the resident approached the staff. -Per staff, resident's peer (Resident #6) also walked up to the nurse but started arguing with Resident #5 and knocked him/her down hitting him/her repeatedly.-Staff immediately intervened to separate the two. -Both parties were moved to different areas of the unit. The psychiatric nurse practitioner was notified.-Tele health was done; an order was given to send Resident #5 out to hospital to be checked. Review of Resident #5's Progress Note, dated 6/12/26 at 1:52 P.M., showed:-He/She returned from the hospital with no new orders. -He/She returned back to the facility around 3:35 A.M. Review of Resident #5's nurse practitioner's Progress Note, dated 6/12/26 at 2:40 P.M., showed a physical altercation with another resident resulted in hospital visit, headaches and migraines, feeling unsafe in current living environment. During an interview on 6/16/26 at 11:30 A.M., Resident #5 said:-He/She was speaking with a nurse and asking to speak with (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	him/her privately.-Resident #6 approached and wanted an as needed (PRN) injection.-Resident #6 became upset and struck him/her approximately 20 to 25 times on the back and top of the head.-Resident #6 stomped on his/her right arm.-He/She could barely lift his/her right arm.-Staff attempted to remove Resident #6 but were unsuccessful until a Code [NAME] was called.-Resident #6 struck him/her with a closed fist.-The incident occurred near the elevator on the unit.-He/She had argued with Resident #6 previously but had never been involved in a physical altercation with him/her.- Staff separated the residents and the resident was sent to the hospital for evaluation. -He/She was scared when Resident #6 began hitting him/her.-His/Her right arm remained sore and stiff from the neck down.-Resident #6 also kicked and stomped him/her on the side. -He/She stated there was no visible bruising.-He/She still felt somewhat afraid. During an interview on 6/16/26 at 11:55 A.M., Resident #6 said:-There had been an altercation with Resident #5.-He/She struck Resident #5 and Resident #5 did not strike him/her.-He/She was speaking with a nurse when Resident #5 interrupted the conversation.-He/She then put his/her hands on Resident #5.-He/She became upset when Resident #5 interrupted him/her.-Resident #5 repeatedly stated, I won't do it no more, I promise.-He/She struck Resident #5 with a closed fist, kicked him/her, and stomped on him/her.-Staff attempted to stop the altercation. Review of Certified Nursing Assistant (CNA) A's written Witness Statement, dated 6/10/26, showed:-Resident #5 said something to Resident #6, and Resident #6 began head-butting, punching, and kicking Resident #5.-Staff separated the residents. During an interview on 6/18/26 at 1:15 P.M., CNA A said:-He/She was present when Resident #5 and Resident #6 became involved in a physical altercation.-Resident #6 head-butted Resident #5, causing Resident #5 to fall to the floor against the elevator.-Resident #6 then kicked Resident #5.-He/She was holding a drink and only had one available hand to assist with separating Resident #6 from Resident #5.-He/She was afraid of being struck and stated it took three staff members to separate Resident #5 and Resident #6.-Another staff person pulled Resident #6 away from Resident #5.-Resident #5 stated he/she was afraid of Resident #6 and believed Resident #6 knew he/she would not fight back. During an interview on 6/18/26 at 2:45 P.M., Licensed Practical Nurse (LPN) A said:-He/She responded to the Code Green, which was called at about 7:10 P.M.-He/She was talking to Resident #6, who was upset.- Resident #6 attempted to ask for PRN medication or to leave the unit to calm down.-As he/she exited the unit, Resident #5 approached him/her.-Resident #5 said Resident #6 only wanted medication to get high.-This caused Resident #6 to be more agitated.-Resident #6 walked up to Resident #5, arguing, and knocked him/her down, and struck him/her repeatedly in the head.-Resident #5 did not retaliate. He/She was on the floor wedged between the medication cart and the elevator door.-Staff intervened and Resident #6 was successfully pulled off Resident #5.-Both residents were taken to separate areas of the unit. During an interview on 6/17/26 at 11:00 A.M., the Psychiatric Nurse Practitioner said:-Resident #5 commented that Resident #6 did not need the PRN medication and only wanted to get high.-Resident #6 reacted by striking Resident #5.-Resident #6 recognized he/she should not have struck Resident #5.-Resident #5 was sent to the hospital following the incident.-Resident #5's actions did not give Resident #6 the right to put his/her hands on Resident #5.-Hitting another resident constituted abuse. During an interview on 6/17/26 at 2:00 P.M., the Licensed Clinical Social Worker (LCSW) with Therapy Company A said:-He/She met with Resident #5 and Resident #6 following the altercation.-Resident #6 admitted being the instigator.-Resident #6 reported becoming frustrated because Resident #5 interrupted him/her.-There had been a prior disagreement between the residents involving Resident #6's belongings.-Hitting another resident constituted abuse.-All residents knew fighting was wrong. During an interview on 6/18/26 at 10:30 A.M., the Interim Director of Nursing (DON) and Regional Nurse Consultant said:-Resident #6 requested a PRN medication.-Resident #5 was not present when Resident #6 initially requested the PRN medication.-Resident #5 interjected into the conversation and stated Resident #6 wanted to get high.-He/She stated Resident #6 appropriately requested a PRN medication when becoming upset.-He/She stated Resident #5 inserted him/herself into the interaction between Resident #6 and (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	a nurse.-Hitting and kicking was abuse. 2. Review of Resident #3's admission Record face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:-Unspecified dementia (a disorder characterized by a decline in memory, thinking, and reasoning abilities that interferes with daily functioning, without a more specific type of dementia identified).-Schizoaffective disorder.-Bipolar disorder.-Major depressive disorder.-Diffuse traumatic brain injury with loss of consciousness (a traumatic injury affecting multiple areas of the brain that resulted in a period of unconsciousness and may impair cognitive, physical, emotional, or behavioral functioning). Review of Resident #3's MDS, dated [DATE], showed he/she was cognitively impaired. Review of Resident #4's admission Record face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:-Schizophrenia.-Anxiety disorder.-Major depressive disorder.-Autistic disorder (a neurodevelopmental disorder characterized by persistent differences in social communication and interaction, along with restricted or repetitive patterns of behavior, interests, or activities). Review of Resident #4's MDS, dated [DATE], showed he/she was cognitively intact. Review of the facility's RNI for this event, dated 6/13/26, showed:-The incident involved physical aggressions not involving the head.-The residents involved were Resident #3 and Resident #4.-Resident #4 was very upset that a peer gave another resident some food and did not give him/her any.-Resident #4 became irate and started throwing chairs and hitting the tables in the dining room.-Staff was trying to redirect Resident #4 and calm him/her down but Resident #3 got upset and went up to Resident #4 and told him/her to stop and sit down.-Resident #4 angrily said, Who is going to make me?-Resident #3 responded by lunging at Resident #4 but did not hit him.-Resident #4 started hitting Resident #3.-A Code [NAME] was called.-Staff tried to intervene and Resident #4 picked up Resident #3 and slammed him/her to the floor and continued to hit him/her in the abdomen, chest and hand.-Staff intervened and separated both parties.-Staff were unable to get Resident #4 to move to a different area, but he/she was still irate, hitting walls and screaming and yelling.-Resident #4 was upset and unable to be redirected even with staff offering other choices.-Resident #3 approached Resident #4 while he/she was already upset and lunged at Resident #4 causing him/her to feel threatened.-This incident resulted in abuse.-The altercation was not preventable. Review of Resident #3's MAR, dated June 2026, showed he/she received Tylenol 325 mg, 2 tablets by mouth PRN for pain on 6/13/26 at 2:53 P.M. Review of Resident #3's progress note, dated 6/13/26 at 3:36 P.M., showed:-He/She was very upset that another peer, Resident #4, was throwing chairs, hitting the tables and screaming and hollering.-He/She went up to peer Resident #4 and told him/her to stop and sit down.-Resident #4 angrily said, Who's going to make me?-He/She responded by lunging at Resident #4 but did not hit him/her.-Resident #4 started punching Resident #3.-A Code [NAME] was called.-Staff tried to intervene, then Resident #4 picked Resident #3 up and slammed him/her to the floor and continued to hit him/her in his/her abdomen, chest, and hand. -Staff intervened and separated both parties. -Staff were able to get him/her to move to a different area. -He/She was evaluated and had bruises on his/her abdomen and left hand.-He/She did not complain of pain and refused to go to the hospital. Review of Resident #4's Progress Note, dated 6/13/26 at 5:25 P.M., showed:-The resident was very upset that a peer gave another resident some food and did not give him/her any. -He/She became irate and started throwing chairs and hitting the tables in the dining room. -A staff member was talking to the resident, trying to redirect him/her and calm him/her down but Resident #3 got upset and went up to Resident #4 and told him/her to stop and sit down.-Resident #4 angrily said who's going to make me.-Resident #3 responded by lunging at Resident #4 but did not hit him/her.-Resident #4 started punching Resident #3.-A Code [NAME] was called.-Staff tried to intervene and Resident #4 then picked Resident #3 up and slammed him/her to the floor and continued to hit him/her in his/her abdomen, chest, and hand. -Staff intervened and separated both parties. -Staff were able to get Resident #4 to move to a different area, but he/she was still irate, hitting walls and screaming and yelling.- Resident #4 refused to take a PRN medication. -The nurse practitioner gave orders to send Resident #4 out to the hospital if he/she was not able to be redirected. -Resident #4 was sent out to (continued on next page)

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	265721	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gregory Ridge Health Care Center	7001 Cleveland Avenue Kansas City, MO 64132

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F 0600 Level of Harm - Actual harm Residents Affected - Few	the hospital for a psychiatric evaluation. Review of Resident #3's Progress Note, dated 6/13/26 at 7:44 P.M., showed:-New skin issue, abdomen. Issue type: bruising.-New skin issue, left hand. Issue type, bruising and abrasion. Observation on 6/18/26 at 11:45 A.M., showed Resident #3 had a large, approximately apple sized area of dark purple discoloration on his/her abdomen that appeared to be a bruise and a small, discolored area on his/her left hand. During an interview on 6/18/26 at 11:45 A.M., Resident #3 said:-Resident #4 became upset because he/she did not get the lunch he/she wanted.-Resident #4 was kicking the water cooler.-He/She was sitting near the television and stood up and told Resident #4 to knock it off.-The residents approached each other.-He/She did not intend to hit Resident #4.-Resident #4 struck him/her in the neck, knocked him/her to the floor, and began kicking him/her.-He/She had a large bruise on his/her abdomen and hand.-Police responded to the facility, and he/she pressed charges for assault.-Two staff members attempted to separate the residents.-After he/she got up, Resident #4 stated, Stay down or I'll hit you again.-The incident upset him/her and made him/her angry.-He/She had been taking Tylenol for pain. Observation of Resident #4 on 6/18/26 at 12:48 P.M. showed no visible injury or bruising. During an interview on 6/18/26 at 12:48 P.M., Resident #4 said:-He/She became angry because the kitchen did not provide a deli sandwich in a timely manner after he/she declined the regular meal.-He/She initially wanted food from a restaurant across the street and became upset when staff could not immediately obtain it.-He/She kicked an ice bucket to express his/her anger.-Resident #3 approached while both residents were upset.-He/She told Resident #3 not to approach, but Resident #3 continued toward him/her.-He/She stated Resident #3 struck him/her twice in the chest with a closed fist. -He/She placed his/her leg behind Resident #3's legs, causing Resident #3 to fall to the floor.-He/She pinned Resident #3's arms behind his/her back and then released him/her.-He/She did not kick or strike Resident #3 and did not know how Resident #3 sustained bruising.-He/She was transported to the hospital following the altercation.-Police responded to the facility, and no arrests were made. During an interview on 6/17/26 at 3:30 P.M., Certified Medication Technician (CMT) B said:-He/She was preparing to begin passing medications around lunchtime.-Resident #4 became upset after seeing another resident eating food from outside the facility and stated he/she also wanted food from outside the facility.-Resident #4 began yelling and kicking an ice bucket.-He/She attempted to calm Resident #4, but Resident #4 did not calm down.-Resident #4 threw the nurses' station telephone and punched a window without breaking it.-He/She asked the front desk staff member to call Code Green.-Resident #3 approached Resident #4 and told him/her to shut up.-Resident #4 responded, Come make me shut up.-Resident #3 stated, I'll come make you shut up.-Resident #4 struck Resident #3 several times with a closed fist and threw Resident #3 to the floor.-He/She stated Resident #3 struck a table and chairs when thrown to the floor, causing the bruising. Review of the undated Activities Director's written Witness Statement showed:-He/She was assisting residents on the medical unit when he/she heard Resident #3 and Resident #4 arguing.-He/She immediately called Code [NAME] and separated the residents.-Resident #3 attempted to lunge at Resident #4, and he/she immediately separated the two residents. During an interview on 6/17/26 at 1:30 P.M., the Activities Director said:-He/She heard witness the physical altercation but heard the verbal argument between Resident #3 and Resident #4.-He/She would have arrived at the scene sooner but was dealing with another resident.-Resident #4 was upset about food and having an alternative.-He/She constantly reminded Resident #4 of his/her coping skills. -Resident #4 got involved because Resident #4 was yelling and he/she got frustrated.-Resident #3 only liked certain people near him/her and liked to control the TV remote.-He/She immediately positioned him/herself between the residents to separate them.-Resident #3 appeared to lunge toward Resident #4. -Resident #4 threw him/her on the floor.-He/She made Resident #3 go to his/her room and Resident #4 go to the nurse's station. During an interview on 6/18/26 at 10:30 A.M., the Interim DON and Regional Nurse Consultant said:-Staff were attempting to redirect Resident #4 before the altercation.- A Code [NAME] had already been initiated before Resident #3 became involved.- Resident #3 became upset because Resident #4 was (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	creating a disturbance while Resident #3 was trying to watch television.-He/She stated staff were focused on calming Resident #4 when Resident #3 became involved in the situation.-Hitting and kicking is abuse. During an interview on 6/18/26 at 3:00 P.M., the Assistant Administrator said:-Resident #4 wanted Resident #3's food.-Resident #4 hitting and kicking Resident #3 constituted as abuse. During an interview on 6/18/26 at 3:20 P.M., the Administrator said hitting and kicking was abuse. 3. Review of Resident #11's Preadmission Screening and Resident Review (PASARR), dated 3/2/09, showed the resident:-Had a substantiated dementia or related condition. -Diagnoses including schizophrenia, mild mental retardation and autism.-History of becoming involved with drugs, alcohol and prostitution. -Was placed in long-term care as the family discovered they could no longer safely care for the resident. -Had a history of having temper tantrums, exposing his/herself, eloping from unlocked facilities, and been aggressive with staff. -Had problematic behaviors including being suspicious of others.-Asked the same questions repeatedly and childlike. Review of Resident #11's MDS, dated [DATE], showed the resident was mildly cognitively impaired. Review of Resident #10's PASARR, dated 3/24/2019, showed the resident:-Services were recommended to be provided at the nursing facility.-Implementation of systemic plans to change inappropriate behavior.-Medication therapy and monitoring to change inappropriate behavior or alter manifestations of psychiatric illness. -Provisions of a structured environment.-Development of person support networks.-Diagnoses including schizophrenia.-Started hearing voices at around age [AGE] years old. -Bizarre behavior, disorganized thoughts, poor insight and judgement, delusions and psychosis. -Multiple psychiatric hospitalizations. -History of illicit substance use/abuse and possible sex trafficking victim.-Typically stays to him/herself.-Had difficulty interacting appropriately with others and a history of altercations, eviction or fear or strangers. -Determined to have a serious mental illness as defined by PASARR.-Needed psychiatric rehabilitative services of lesser intensity which can be provided by the nursing facility. -Recommended services include implementing plans to change behavior, drug therapy and monitoring, provisions of structured environment, and develop a personal support network. -Secured placement was recommended. Review of Resident #10's MDS, dated [DATE], showed the resident was cognitively intact. Review of the facility investigation, dated 6/18/26, showed:-The type of incident was physical aggression involving the head. -The incident was unwitnessed.-Notifications were made to the guardian, physician, administrator, and director of nursing. -Resident #11 was yelling at Resident #10 about a watch Resident #11 planned to get.-Resident #10 said he/she tried to walk away.-Resident #10 stated Resident #11 slapped/backhanded him/her on the right side of his/her face. -Resident #10 struck Resident #11 in the face three times and Resident #11 fell on the floor.-Resident #10 then struck Resident #11 three more times in the face.-Resident #10 then informed staff of what happened in their room.-Resident #10 said he/she was just defending him/herself from Resident #11. -Resident #11 was upset about not being able to find a smart watch that he/she wanted. Review of Resident #10's Progress Note, dated 6/18/26 at 7:00 P.M., showed:-The resident notified staff he/she was slapped by Resident #11. -He/She hit Resident #11 back. Review of Resident #11's Progress Note, dated 6/18/26 at 7:08 P.M., showed:-Per staff unwitnessed resident to resident incident.-The resident was escorted to social services office.-The resident stated he/she fell and staff were getting him/her a new watch.-The resident's left eye was bruised. Review of Resident #11's Progress Note, dated 6/18/26 at 7:18 P.M., showed:-The resident came out the room with a swollen eye.-When asked what happened, Resident #11 said another resident had hit/smacked him/her. -Residents #10 and #11 were separated, an assessment was done and neurological checks performed.-Observed Resident #11's left upper cheek was swollen. Observation and interview on 6/24/26 at 12:10 P.M., showed Resident #11's left eye socket was dark purple and swollen.-He/She got hurt and lost his/her watch.-He/She did not disclose by who but did point towards the unit.-He/She said his/her eye hurt. During an interview on 6/24/26 at 12:14 P.M., Resident #10 said:-Resident #11 came in the room and he/she was in the bathroom. -Resident #11 slammed the door shut and when Resident #10 came out he/she asked why Resident #11 shut the door.-Resident (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	#10 was on his/her side of the room.-Resident #11 was upset about a watch and then slapped him/her in the face.-Resident #10 punched Resident #11 three times in the face, Resident #11 fell to the floor and he/she slapped Resident #11 three more times in the face.-He/She then went and told LPN A. During an interview on 6/24/26 at 2:20 P.M., LPN A said:-Resident #10 came and told him/her Resident #11 had hit him/her. -Resident #10 did not say right away that he/she hit Resident #11. -He/She told Resident #10 to go to the dining area. -He/She didn't see any bruises on Resident #10 and asked where he/she was hit. -Resident #10 reported Resident #11 had pushed him/her at that time. -He/She got an assessment on Resident #11 next, and his/her eye was swollen. During an interview on 6/24/26 at 10:57 A.M. the Assistant Administrator said:-Resident #10 and #11 got into an altercation. -Resident #11 struck Resident #10 with the intent to harm due to thinking Resident #10 stole Resident #11's watch. -Resident #10 hit Resident #11 in defense, although it was a total of six times. During an interview on 6/24/26 at 3:10 P.M., the Director of Nursing (DON) said: -Resident #10 reported he/she was in the bathroom when Resident #11 came in the room and shut the door.-When Resident #10 came out of the bathroom Resident #11 mentioned a watch and then hit Resident #10. -Resident #10 then hit Resident #11 and reported the incident immediately. -He/She defined abuse as willful intent to take action with injury. 3043153, 3040578, 3049110

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the Ombudsman with a copy of one sampled resident's (Resident #1) 30-day discharge notice at the time the notice was issued, limiting the resident's opportunity to exercise his/her appeal rights out of eleven sampled residents. The facility census was 101 residents.1. Review of Resident #1's admission Record face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:-Hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side (paralysis and weakness affecting the right dominant side of the body following a stroke).-Anxiety disorder (a mental health disorder characterized by excessive fear, worry, or anxiety that interferes with daily functioning).-Post-traumatic stress disorder (a mental health disorder that may develop after exposure to a traumatic event and is characterized by persistent distress, intrusive memories, avoidance behaviors, and heightened arousal). Review of the resident's Progress Notes, dated 6/8/26 at 3:37 P.M. showed:-The resident verbalized he/she was not happy at the facility and wanted referrals sent to all local facilities in Kansas City.-Later that day, the resident stated he/she did not want to move and, if asked to move, would appeal the discharge. During an interview on 6/17/26 at 2:05 P.M., the facility Social Worker said:-As of 6/9/26, to the best of his/her knowledge, the resident had been accepted for admission at another sister facility.-The resident contacted the sister facility and made threatening statements.-The resident had been told the facility had 30 days to issue discharge referrals, and the resident initially stated he/she understood.-After receiving the 30-day discharge notice, that night the resident stated he/she was ready to leave and demanded to be discharged immediately.-The resident's sister later informed facility staff that the resident no longer wanted to leave.-He/She spoke with the Ombudsman about the discharge but did not provide a copy of the discharge notice to the Ombudsman because he/she did not believe it was required until the resident was officially discharged . During an interview on 6/17/26 at 2:30 P.M., Resident #1 said:-He/She stated that nobody in [NAME] City knew about the 30-day discharge notice, so he/she could not appeal the discharge.-He/She stated the sister facility did not agree to accept him/her. During an interview on 6/18/26 at 10:30 A.M., the Interim Director of Nursing (DON) and Regional Nurse Consultant said:-The facility Social Worker was responsible for notifying the Ombudsman regarding 30-day discharges.-He/She was not sure of the notification process.-The facility was redacting the previous 30-day discharge notice, amending the discharge date , and issuing the resident a new notice.-He/She was not sure why the facility was taking that action. During an interview on 6/17/26 at 1 P.M., the Ombudsman said:-The resident had contacted the office and wanted to appeal the discharge. -The facility had not provided a copy of the letter to the Ombudsman office. -The facility should have sent a copy of the discharge letter to enable the resident to advocate for him/herself in appeal rights. During an interview on 6/18/26 at 3:00 P.M., the Assistant Administrator said:- The Ombudsman should be notified before or at the time the 30-day discharge notice was issued.- If the Ombudsman was not notified until the time of discharge, the resident would not have the opportunity to appeal the discharge.- There was definitely training that needed to be completed. During an interview on 6/18/26 at 3:30 P.M., the Administrator said:-The Ombudsman should have been notified of the 30-day discharge on the same day the notice was issued.-The facility Social Worker was responsible for sending the notification to the Ombudsman.-The Ombudsman should have been sent the same copy of the discharge notice that was provided to the resident. 3049601, 3040425