STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265758	A. Building B. Wing	06/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehab of Kansas City South	8033 Holmes Kansas City, MO 64131

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one sampled resident (Resident #2) was free from abuse when on 6/3/26 Resident #1 hit Resident #2 causing a bloody lip out of 13 sampled residents. The facility census was 87 residents.On 6/12/26, the Administrator was notified of past non-compliance which occurred on 6/3/26. Immediate interventions were put into place for both Resident #1 and Resident #2. All staff received education prior to working their next shift. The deficiency was corrected on 6/4/26. Review of the facility's policy titled Abuse Prevention and Prohibition Program dated 10/24/22 showed:-Each resident had the right to be from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property.-The policy provided did not define physical abuse or resident-to-resident altercations. 1.Review of Resident #1's admission Record showed he/she was admitted to the facility with a diagnosis of Crohn's disease (intestinal disorder) of both small and large intestine with unspecified complications. Resident #1 did not have any Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff) in IQIES completed by the facility or at the prior facility from which the resident had transferred. Review of Resident #2's admission Record showed he/she admitted to the facility with a diagnosis of acute infarction of spinal cord (a stroke in the spinal cord). Review of Resident #2's comprehensive admission MDS dated [DATE] showed:-The resident was cognitively intact.-The resident did not exhibit any behavioral symptoms within the seven day look back period. Review of an Incident Report dated 6/3/26 showed:-The incident occurred on 6/3/26.-The incident involved Resident #1 and Resident #2.-Description of the altercation:--At approximately 6:30 P.M. Resident #2 was outside of Resident #1's doorway.--Resident #1 asked Resident #2 if he/she could move down the hall because Resident #2 was being too loud and he/she was trying to sleep.--Resident #2 then responded to Resident #1 by calling him/her a racial slur.--Resident #2 also stated, if you don't want to hear it then close the door.--Resident #2 was also rolling his/her wheelchair towards Resident #1.--Resident #1 then hit Resident #2.-A skin assessment was completed on both Resident #1 and Resident #2, and it was noted that Resident #2 had an abrasion on his/her bottom lip.-In conclusion, the facility determined that abuse occurred because Resident #1 had intentionally caused harm to Resident #2. Review of Resident #1 and Resident #2's Progress Note dated 6/3/26 showed:-Resident #2 was outside Resident #1's doorway when Resident #1 asked Resident #2 to go down the hall because Resident #2 was too loud and Resident #1 was trying to sleep Review Resident #2's Weekly Skin Check dated 6/3/26 at 7:16 P.M. showed the resident had a small abrasion to the inner bottom lip. Review of Resident #2's care plan dated 6/4/26 showed:-The resident had manipulative behaviors towards his/her peers including:--Argumentative towards peers.--Loud behaviors.--Provoking peers.--The resident had an altercation with another resident on 6/3/26.-The resident had a psychosocial well-being problem related to ineffective coping with peers which included making racial slurs towards others. Review of Resident #1's care plan dated 6/4/26 showed the resident had a psychosocial well-being problem related to an altercation with another peer on 6/3/26. Review of Resident #2's witness statement dated 6/3/26 showed:-He/She was speaking with another (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident.-Resident #1 was disturbed by the fact that he/she was able to hear the conversation.-Resident #1 came out and started yelling at Resident #2.-Resident #2 told Resident #1 that if he/she didn't like the conversation, then Resident #1 could shut his/her door.-Resident #1 then got mad and stated that he/she was going to fuck me up.-Resident #2 then responded by saying Okay, I am not afraid of you.-That was when Resident #1 started hitting Resident #2 in the face. During an interview on 6/12/26 at 10:35 A.M. Resident #2 said:-He/She was having a conversation in the hallway.-Resident #1 was upset because the conversation woke him/her up.-Resident #1 then hit him/her in the face twice.-He/She had a bloody lip from the incident. Review of Resident #1's witness statement dated 6/3/26 showed:-He/She had been asleep when he/she woke up to someone loud outside of his/her doorway.-He/She got up and nicely asked Resident #2 to move away from his/her door or to keep it down.-Resident #2 responded by stating, I'm not talking to you.-Resident #2 then got even louder.-He/She asked Resident #2 again to move, and Resident #2 refused.-He/She put his/her hand up trying to scare Resident #2 away.-Resident #2 responded by grabbing his/her arm.-That was when he/she smacked Resident #2 twice in the mouth.-Resident #2 then hit him/her in the arm and chest in defense. During an interview on 6/12/26 at 10:56 A.M. Resident #1 said:-He/She was asleep, and Resident #2 was in the hallway by his/her doorway.-Resident #2 was talking loudly and it woke him/her up.-He/She nicely asked Resident #2 to lower his/her voice or move away from the doorway.-Resident #2 then responded by saying I'm not talking to you, you don't tell me what to do.-Resident #2 also called him/her a racial slur.-He/She then put up his/her hand, but Resident #2 grabbed it.-He/She then smacked Resident #2 in the jaw. Review of an undated witness statement completed by the MDS Coordinator showed:-Resident #2 was outside Resident #1's doorway when Resident #1 asked Resident #2 if he/she could go down the hall because Resident #2 was being too loud.-Resident #2 responded to Resident #1 by calling Resident #1 a racial slur.-Resident #2 also stated, if you don't want to hear it, then close the door.-Resident #2 then rolled his/her wheelchair towards Resident #1 getting into Resident #1's space.-Resident #1 responded by hitting Resident #2. During an interview on 6/12/26 at 12:40 P.M. the MDS Coordinator said:-Resident #2 was talking loudly in front of Resident #1's room.-Resident #1 asked Resident #2 to get away from his/her room.-Resident #2 then rolled his/her wheelchair towards Resident #1 and called him/her a racial slur.-Resident #1 responded to Resident #2 by hitting Resident #2 near his/her jaw. During an interview on 6/12/26 at 9:30 A.M. the Administrator said:-He/She had completed the investigation related to Resident #1 and Resident #2.-He/She determined that abuse had occurred. -Resident #1 admitted to Intentional hitting Resident #2. During an interview on 6/12/26 at 1:40 P.M. Licensed Practical Nurse (LPN) B said:-Physical abuse occurred when someone laid hands on a resident.-A resident-to-resident altercation may not be physical abuse depending on the situation.-If a resident intentionally hits slaps or hits a resident then it would be considered as physical abuse. During an interview on 6/12/26 at 1:49 P.M. LPN A said:-Physical abuse occurred when someone laid hands on another person.-Physical abuse included hitting and slapping.-He/She would consider the incident between Resident #1 and Resident #2 as physical abuse. During an interview on 6/12/26 at 2:20 P.M. the Director of Nursing (DON) said:-On 6/3/26 Resident #2 was talking and being loud.-Resident #1 told Resident #1 to be quiet.-An exchange of words had occurred, and Resident #2 got into Resident #1's face.-Resident #2 called Resident #1 a racial slur and Resident #1 responded to this by slapping Resident #2 in the face.-An injury occurred during the altercation.-Resident #2 had an open area to the inside of his/her lower lip.3033246