STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265786	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Rehab and Healthcare Center	1415 West White Oak Independence, MO 64050

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to keep one sampled resident (Resident #17) out of 23 sampled residents safe from physical abuse. On 3/5/26 Resident #18 struck Resident #17 multiple times in the face, resulting in bruising and cut above Resident #17's left eye. The facility census was 251 residents.The Administrator was notified on 3/19/26 of Past Non-Compliance which occurred on 3/5/26. An all-staff in-service on Abuse and Neglect was completed by 3/6/26. The deficiency was corrected by 3/6/26. Review of the facility's Abuse Prevention and Prohibition Program revised 10/24/22 showed each resident had the right to remain free from abuse and neglect, including abuse from other residents. 1. Review of Resident #17's facility admission Record showed the resident was admitted on [DATE] with the following diagnoses:-Unspecified Dementia without behaviors- (a diagnosis used when a patient shows clear symptoms of cognitive decline-such as memory loss or impaired reasoning-but the specific cause or the precise severity has not yet been determined).-Auditory Hallucinations- (the false perception of sounds, such as hearing voices, music, or noises in the absence of an external stimulus).-Psychotic disorder with hallucinations- (a severe mental health condition where a person loses touch with reality, experiencing false sensory perceptions-such as hearing voices, seeing, or feeling things that are not present). Review of Resident #17's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff and used for care planning) dated 2/5/26 showed he/she:-Was not cognitively intact.-Had moderate issues with mood.-Inattention and disorganized thinking were continuously without fluctuation.-Was independently ambulatory. Review of Resident #18's facility admission Record showed the resident was admitted on [DATE] with the following diagnoses:-Unspecified Dementia with Agitation.-Anxiety.-Psychotic Mood Disorder- (a severe mental health condition where a primary mood disturbance-such as extreme depression or bipolar disorder-is accompanied by symptoms of psychosis, including hallucinations, delusions, or paranoia).-Stroke. Review of Resident #18's admission MDS dated [DATE] showed he/she:-Was not cognitively intact.-Had moderate issues with mood.-Showed physical behaviors one to three days per week such as hitting, kicking, pushing, scratching, and/or grabbing others. Review of Resident #18's Behavior Note dated 3/5/26 at 5:40 P.M., showed:-Occupational Therapy Assistant (OTA) A walked into the resident's room and observed Resident #18 kneeling over Resident #17 and hitting him/her in the face.-Licensed Practical Nurse (LPN) A ran into the room and assisted in separating the residents and ensure their safety.-Resident #18 said a man/woman came into his/her room and said he/she owed him/her money. He/she was confused because he/she didn't know he/she owed any money. Then he/she hit him/her on his/her shoulder, and he/she let him/her have it.-Blood was noted on both residents and the floor. Review of Resident #17's Nurse's Notes dated 3/5/26 at 11:50 P.M., showed:-Resident #17 wandered into Resident #18's room.-OTA A walked by the room and noted the residents were on the floor and Resident #18 was hitting Resident #17 in the face.-OTA A yelled for help and Certified Nurse's Aide (CNA) A ran to the room and summoned LPN A who came and helped CNA A and OTA A separate the residents.-Blood was noted on both residents and on the floor.-Resident #17 stated, I was beat (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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NAME OF PROVIDER OR SUPPLIER Rosewood Rehab and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 West White Oak Independence, MO 64050	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	up.-Bruising and bleeding were noted above and below Resident #17's left eye and a laceration was noted to the resident's left thumb. Review of the facility's Abuse Investigation dated 3/5/26 showed:-On 3/5/26 at approximately 11:30 A.M., (OTA) A walked by Resident #18's room.-Resident #17 was in Resident #18's room and the residents were having an altercation in the room.-OTA A immediately called for help and CNA A came to help.-OTA A and CNA A separated the two residents and CNA A called the Assistant Director of Nursing (ADON) and the facility Administrator who both responded.-The ADON assessed both residents and found that Resident #17 had a small cut on his/her left eyebrow and a small red area on the left side of his/her face.-A small amount of first aid was required for Resident #17 and the resident complained of no pain.-Resident #18 had a small cut below his/her lip, requiring no first aid.-The majority of the incident was not witnessed by any staff or residents.-Both residents resided on the locked dementia unit, and both had a history of dementia.-Resident #18 was unable to recall the incident. Review of Resident #17's Skin assessment dated [DATE] at 12:00 P.M., showed:-The resident had a skin tear on his/her left thumb.-He/she had bruising/hematoma (a localized collection of clotted or partially clotted blood trapped in an organ, tissue, or space, usually caused by a broken blood vessel) under his/her left eye.-He/she had a laceration (cut) on his/her left eyebrow. Review of Resident #17's Medication Administration Record (MAR) dated 3/5/26 at 12:30 P.M., showed the resident received 500 milligrams (mgs) of Tylenol (a medication used to treat mild pain). Review of Resident #17's Nurse Practitioner (NP) note dated 3/5/26 at 7:39 P.M., showed:-He/she was seeing Resident #17 for a follow-up after an altercation with Resident #18 that occurred when the resident wandered into another resident's room.-The resident sustained multiple facial injuries during the incident, including a contusion (to his/her left cheekbone and right temple area, a small cut above the left eyebrow lateral to the outer canthus (and a small cut to his/her right thumb.-The altercation began when Resident #17 wandered into another resident's room and that resident apparently started hitting him/her. Review of Resident #17's NP progress note dated 3/6/26 at 8:35 P.M., showed:-Resident #17 was seen for a follow-up after a recent altercation with Resident #18.-The resident continued to have bruising and contusions (to his/her face in multiple areas following the incident. During an interview on 3/7/26 at 2:15 P.M., Resident #18 said he/she did not recall any altercation between him/her and any other resident. Observation and interview of Resident #17 on 3/7/26 at 2:30 P.M., showed:-He/she was unable to answer any questions about the altercation due to his/her dementia diagnosis.-The resident had an approximately five centimeter (cm) long purple/blue bruise under his/her left eye where the lower portion of the resident's glasses were.-He/she had a small, two cm cut in his/her left eyebrow where the upper portion of his/her glasses were. During an interview on 3/18/26 at 9:40 A.M., OTA A said:-He/she was coming onto the unit and heard what sounded like yelling coming from Resident #18's room.-He/she went to Resident #18's room and found Resident #18 on top of Resident #17 and both residents were punching on each other.-He/she yelled for help and CNA A came running into the room and assisted in separating the residents.-He/she saw blood on both residents. During an interview on 3/19/26 at 10:56 A.M., CNA A said:-When he/she heard the call for help, he/she ran to Resident #18's room and found Resident #17 and Resident #18 fighting with each other, both of them throwing punches.-He/she and OTA A intervened to separate the two residents. During an interview on 3/19/26 at 11:06 A.M., the ADON said:-He/she responded to the incident and the residents had been separated.-Resident #17 had some bleeding above his/her left eye and the beginning of a bruise under his/her left eye. During an interview on 3/19/26 at 12:30 P.M., the Administrator said:-He/she responded to the incident right after it happened.-Resident #17 had a history of wandering but was unaware of any violent behavior.-He/she felt the altercation was more territorial in nature instead of an abusive situation and neither resident was cognitively intact.-He/she believed that since Resident #17 wandered and Resident #18 was newer to the dementia unit, it likely startled Resident #18 and he/she was just defending his/her room and territory.-He/she felt that since Resident #18 was new, the incident could not have been predicted by the staff.-He/she did not believe that either resident meant to harm the other. 2797635

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The Administrator was notified on 3/19/26 of Past Non-Compliance which occurred on 3/5/26. An all-staff in-service on Abuse and Neglect, as well corporate administrative staff completed education with the facility Administrator on 3/6/26. The deficiency was corrected by 3/6/26. Review of the facility's Abuse Prevention and Prohibition Program revised 10/24/22 showed:-The purpose of the policy was to protect residents and ensure a standardized methodology for addressing abuse and neglect.-Each resident had the right to remain free from abuse and neglect, including abuse from other residents.-The facility Administrator was responsible for coordinating the facility's abuse and neglect programs and systems.-The facility was responsible for reporting any incident of abuse that resulted in significant resident injury within two hours of the injury, to all required entities including the Department of Health and Senior Services (DHSS). 1. Review of Resident #17's facility admission Record showed the resident was admitted on [DATE] with the following diagnoses:-Unspecified Dementia without behaviors- (a diagnosis used when a patient shows clear symptoms of cognitive decline-such as memory loss or impaired reasoning-but the specific cause or the precise severity has not yet been determined).-Auditory Hallucinations- (the false perception of sounds, such as hearing voices, music, or noises in the absence of an external stimulus).-Psychotic disorder with hallucinations- (a severe mental health condition where a person loses touch with reality, experiencing false sensory perceptions-such as hearing voices, seeing, or feeling things that are not present). Review of Resident #18's facility admission Record showed the resident was admitted on [DATE] with the following diagnoses:-Unspecified Dementia with Agitation.-Anxiety.-Psychotic Mood Disorder-(a severe mental health condition where a primary mood disturbance-such as extreme depression or bipolar disorder-is accompanied by symptoms of psychosis, including hallucinations, delusions, or paranoia).-Stroke. Review of the facility's Abuse Investigation dated 3/5/26 showed:-On 3/5/26 at approximately 11:30 A.M., Occupational Therapy Assistant (OTA) A walked by Resident #18's room.-Resident #17 was in Resident #18's room and the residents were having an altercation in the room.-OTA A immediately called for help and Certified Nursing Assistant (CNA) A came to help.-OTA A and CNA A separated the two residents and CNA A called the Assistant Director of Nursing (ADON) and the facility Administrator who both responded.-The ADON assessed both residents and found that Resident #17 had a small cut on his/her left eyebrow and a small red area on the left side of his/her face.-A small amount of first aide was required for Resident #17 and the resident complained of no pain.-Resident #18 had a small cut below his/her lip, requiring no first aide. During an interview on 3/18/26 at 9:40 A.M., OTA A said:-He/she was coming onto the unit and heard what sounded like yelling coming from Resident #18's room.-He/she went to Resident #18's room and found Resident #18 on top of Resident #17 and both residents were punching on each other.-He/she yelled for help and CNA A came running into the room and assisted in separating the residents.-He/she did see blood on both residents.-CNA A reported what was happening to Licensed Practical Nurse (LPN) A and the Assistant Director of Nursing (ADON). During an interview on 3/19/26 at 10:56 A.M., CNA A said:-When he/she heard the call for help, he/she ran to Resident #18's room and found Resident #17 and Resident #18 fighting with each other, both of them throwing punches.-He/she and OTA A intervened to separate the two residents.-The two residents had never had an issue with each other in the past, but Resident #17 wandered a lot and Resident #18 was newer to the unit, so probably didn't like Resident #17 coming into his/her room.-He/she immediately reported the incident to LPN A and the ADON. During an interview on 3/19/26 at 11:06 A.M., the ADON said:-He/she responded to the incident and the residents had been separated.-Resident #17 had some bleeding above his/her left eye and the beginning of a bruise under his/her left eye.-He/she told the Administrator. The Administrator was the abuse coordinator and responsible for reporting. During an (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 3/19/26 at 12:30 P.M., the Administrator said:-He/she responded to the incident right after it happened.-Resident #17 had a history of wandering but was unaware of any violent behavior.-He/she felt the altercation was more territorial in nature instead of an abusive situation and neither resident was cognitively intact.-He/she believed that since Resident #17 wandered and Resident #18 was newer to the dementia unit, it likely startled Resident #18 and he/she was just defending his/her room and territory.-He/she felt that since Resident #18 was new, the incident could not have been predicted by the staff.-He/she did not believe that either resident meant to harm the other.-He/she did not think the event was abuse and did not report. 2797635