| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 26A293 | A. Building<br>B. Wing | 06/27/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Clara Manor Nursing Home | 3621 Warwick Boulevard<br>Kansas City, MO 64111 |

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 - Immediate jeopardy to resident health or safety<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>(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 - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect one out of six sampled residents (Resident # 1) from physical abuse. On 6/22/25, around 1:30 A.M., Certified Nurse Aide A became aware of Resident #1 and #2 getting into an altercation at the 2nd floor nursing station. Resident #1 wanted to get some ice and Resident #2 blocked the area with his/her wheelchair and would not let him enter. Resident #1 stated he cursed and threw a small amount of the remaining water in his water pitcher on Resident #2. Resident #2 yelled at Resident #1 and stated Resident #1 had called him/her racial names and threw water at him/her. Resident #1 went back to his own room. After Resident #1 left, Resident #2 told CNA A he/she was going to call his/her cousin and put a wood under his/her ass. The nurse aide advised Resident #2 to calm down and return to his/her room for the night. The facility failed to provide intervention and monitoring after the verbal incident per policy. Resident #2 went to the smoking area on the 2nd floor. Around 2:24 A.M., Resident #2 entered Resident #1's room. Resident #1 was awakened by Resident #2 striking him with a folding chair. Resident #2 then grabbed Resident #1's cell phone and placed it in his/her waistband and then forcefully grabbed Resident #1's scrotum, holding onto it while Resident #2 tried to wheel himself out of the room his/her room- which was next door. Resident #1 had bruising on his bilateral forearms and his right upper leg. Resident #1 said he was in excruciating pain from his scrotum being squeezed and was very angry that it occurred. The facility census was 86.The Administrator was notified on 6/25/25 at 2:40 P.M. of Immediate Jeopardy (IJ) which began on 6/22/25. The IJ was removed on 6/25/25.Review of the facility's undated Abuse and Neglect Policy showed:-Abuse was the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.-Physical abuse was the use of physical force that may result in bodily injury, physical pain or impairment and could include: punishing, slapping, hitting, shoving, striking with or without an object, pinching, kicking, burning. -All residents would be protected from abuse, neglect or mistreatment. Review of the facility's undated Behavior Management Program policy showed:-Behavior symptoms in this policy was defined as an indication or characteristic of a negative physical or psychosocial out come which could indicate negative interactions or negative attitude that resulted in unpleasant atmosphere that disturbed others.-Resident who exhibited behavior symptom concerns would be monitored and/or treated to prevent incidents per the Quality Assurance (QA) decision on how often, what and where, and when the behavior was to be monitored.-Residents who often had outburst behaviors, aggression, verbal and/or physical abusive behavior should be monitored for safety. (The process of monitoring was decided individually per case by the QA committee or safety committee.)1. Review of Resident #1's admission Record Face Sheet showed the resident admitted to the facility on [DATE]. Review of Resident #1's quarterly Minimum Data Set (MDS-a standardized assessment tool that measured health status in nursing home residents), dated 4/16/25, showed the resident assessed as cognitively intact.Review of Resident #2's admission Record Face Sheet showed the resident admitted to the facility on [DATE], with the following diagnoses:-Schizophrenia, unspecified (a disorder that affected a person's ability to think, feel and behave clearly).-Major depressive disorder (a mental disorder characterized by persistently sad mood or loss of interest in activities, causing significant impairment of daily life).-Persistent mood affective disorder (a chronic low-grade depressed mood that lasts at least two years in adults).-Psychoactive substance abuse (abuse of substances that affect the brain).-Cannabis abuse.-Suicidal ideations (thinking or planning to kill one's self).-Insomnia (a disorder that makes it difficult to sleep).Review of Resident #2's quarterly MDS, dated [DATE], showed the resident assessed as cognitively intact.Review of Resident #1's Nurse's Notes, dated 6/22/25 at 2:24 A.M., showed: -Certified Nursing Assistant (CNA) B heard Resident #2 in Resident #1's room on the same hall, fighting, screaming, and throwing objects.-Resident #3 came to the nurses' station saying Resident #2 was in Resident #1's room and hit him with a chair.-CNA B went to the scene and called Licensed Practical Nurse (LPN) A to tell LPN A he/she was down the hall, two residents were fighting, and he/she needed help.-LPN A arrived immediately to Resident #2 in the hallway in his/her wheelchair, holding Resident #1's cell phone and refusing to get it out of his/her waistband and give it back.-CNA B stated after Resident #2 hit Resident #1 with the chair, he/she snatched the phone and when Resident #1 attempted to retrieve the phone, Resident #2 grabbed Resident #1's genitals. -Resident #1 began hitting Resident #2 on the head. -Resident #2 would not give back the phone.-Resident #1 was pushing Resident #2's wheelchair out of his room and hitting Resident #2 on the head.-Staff asked Resident #1 to stop and let |