STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A293	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clara Manor Nursing Home	3621 Warwick Boulevard 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 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #1) was free from physical abuse when Certified Medication Technician (CMT) A put the palm of his/her hand over the resident's mouth and squeezed really hard, resulting in a scratch on the resident's right cheek, a circular bruise on the resident's left cheek, and the resident stating he/she was scared to death. The resident told two staff members and the facility failed to protect the resident by allowing CMT A to continue working his/her shift until 9:00 P.M. Twelve residents were selected for review. The facility census was 89 residents. The Administrator was notified on 11/18/25 at 1:20 P.M. of Immediate Jeopardy (IJ) which began on 11/12/25. The IJ was removed on 11/19/25. Review of the facility's undated policy titled, Policy Regarding Abuse and Neglect of Facility Residents, showed:-All suspicious crime including abuse shall be reported to the Administrator immediately. -Follow chain of command in the absence of the Administrator for reporting.-All suspected incidents must be investigated immediately.-The suspected victim must be protected immediately. -Employees who were involved with the suspects shall be suspended or terminated immediately.-Employees who were involved with the incident shall be suspended upon investigation.-All suspicious crime including abuse must be reported to law enforcement and/or the state surveyor agency in a timely manner.-Anything that appears even remotely suspicious should be reported immediately including all unexplained incidents of physical and/or verbal abuse.-Report to the charge nurse on duty, which in turn will report to the Administrator and/or Director of Nursing (DON), and physician.-The definition of abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.-The definition of physical abuse was the use of physical force that may result in bodily injury, physical pain, or impairment. 1. Review of the facility's in-services showed CMT A attended an abuse in-service on 6/25/25. Review of Resident #1's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning), dated 10/14/25, showed the resident was cognitively intact. Review of the resident's undated face sheet showed he/she admitted on [DATE] his/her diagnosis included: cerebral infarction (blood flow to the brain is blocked resulting in brain tissue death), anxiety (anticipation of impending danger and dread accompanied by restlessness, tension, fast heart rate, and breathing difficulty not associated with an apparent stimulus), and depression (a mood disorder that consists of intense sadness and a loss of interest or loss of pleasure in activities and/or life). Review of the facility's investigation completed by the Administrator dated 11/17/25 at 6:45 P.M. showed: -Resident #1 stated CMT A grabbed his/her face after he/she was attempting to steal cigarettes off the medication cart. -Resident #1 was alert and oriented to person, place, and time.-Resident #1 was able to answer questions appropriately.-Resident #1 used a wheelchair for ambulation throughout the facility.-On 11/12/25 at 7:30 P.M. ,--The Administrator received a message from the AIT stating Resident #1 stated he/she was assaulted by CMT A.--The Administrator instructed staff to give written/verbal statements and give them to the AIT.--The Administrator contacted CMT A and stated that he/she needed to leave and time out due to a reported accusation of abuse.--CMT denied abusing Resident #1-On 11/13/25:--Resident #1 was noted to have two areas of red/dark red ecchymosis (medical term for a bruise) on his/her jawline and neck approximately 2 centimeters (cm) x 3 cm and a scratch on his/her right side of his/her face.--The DON called the Administrator to inform him/her of the bruises he/she saw on Resident #1. Review of the resident's undated care plan showed:-He/She received an anti-depressant medication for depression.-He/She required extensive assistance with locomotion using a wheelchair.-An update, dated 11/12/25, bruising was present on his/her left side of his/her face and a scratch was on his/her right side of his/her face with bruising. Review of CMT A's timecard report showed he/she worked 2:55 P.M. to 9:06 P.M. on 11/12/25. During an interview on 11/17/25 10:10 A.M., Resident #1 said:-On 11/12/25, CMT A left the medication cart unlocked, so he/she looked for cigarettes on the cart.-CMT A took ahold of the resident's face by putting the palm of his/her hand over the resident's mouth with his/her thumb on the right side of the resident's face and his/her four fingers on the left side of the resident's face and squeezed really hard.-CMT A scared him/her to death when it happened.-CMT A was talking to him/her, but he/she doesn't remember what CMT A said to him/her. -He/She tried to get CMT A's hand off his/her face. He/She used his/her hand to try to pull CMT A's hand off his/her face.-CMT A sent him/her back toward his/her room by pushing him/her in his/her wheelchair nine million miles an hour down the hall:-There were some other residents around when it happened, but he/she

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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 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. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report to local law enforcement an allegation of abuse of Resident #1 by Certified Medication Technician (CMT) A. Twelve residents were selected for review. The facility census was 89 residents. Review of the facility's undated policy titled, Abuse and Neglect showed the definition of abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Review of the facility's undated policy titled, Policy Regarding Abuse and Neglect of Facility Residents, showed:-Instructions to coordinate with local law enforcement entities to determine what actions are considered crimes in the political subdivision.-The suspected victim must be protected immediately.-Employees who were involved with the suspects shall be suspended or terminated immediately.-Employees who were involved with the incident shall be suspended upon investigation.-All suspicious crime including abuse must be reported to law enforcement in a timely manner. Review of the facility's undated policy titled, Policy for Investigating and Reporting of Abuse and Neglect showed instructions to report abuse after investigation to law enforcement. 1. Review of Resident #1's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning), dated 10/14/25, showed the resident was cognitively intact. Review of the resident's undated face sheet (dated as printed on 11/17/25) showed he/she was admitted to the facility on [DATE] with the following diagnoses: cerebral infarction (blood flow to the brain is blocked resulting in brain tissue death), anxiety (anticipation of impending danger and dread accompanied by restlessness, tension, fast heart rate, and breathing difficulty not associated with an apparent stimulus), and depression (a mood disorder that consists of intense sadness and a loss of interest or loss of pleasure in activities and/or life). During an interview on 11/17/25 at 10:10 A.M., the resident said:-On 11/12/25, CMT A left the medication cart unlocked, so he/she was looking for cigarettes on the cart.-CMT A took ahold of the resident's face by putting the palm of his/her hand over the resident's mouth with his/her thumb on the right side of the resident's face and his/her four fingers on the left side of the resident's face and squeezed really hard.-CMT A scared him/her to death when it happened.-CMT A was talking to him/her, but he/she doesn't remember what CMT A said to him/her.-He/She tried to get CMT A's hand off his/her face. He/She used his/her hand to try to pull CMT A's hand off his/her face.-CMT A sent him/her back toward his/her room by pushing him/her nine million miles an hour down the hall.-He/She didn't want to tell anyone what happened, because he/she didn't want CMT A to get even madder at him/her.-Licensed Practical Nurse (LPN) A noticed the bruise and scratch on his/her face and asked him/her what happened. -He/She started crying and told LPN A what happened. -He/She also told the Administer in Training (AIT) and the Administrator.-He/She felt safe now that CMT A was no longer at the facility.-The Administrator told him/her CMT A would not be coming back and he/she responded, good, I don't want to be around him/her. Review of the facility's investigation completed by the Administrator, dated 11/17/25 at 6:45 P.M., showed:-Resident #1 stated CMT A grabbed his/her face after he/she was attempting to steal cigarettes off the medication cart.-Resident #1 was alert and oriented to person, place, and time.-Resident #1 was able to answer questions appropriately.-Resident #1 used a wheelchair for ambulation throughout the facility.-On 11/12/25 at 7:30 P.M.,--The Administrator received a message from the AIT stating Resident #1 stated he/she was assaulted by CMT A.--The Administrator contacted CMT A and stated that he/she needed to leave and time out due to a reported accusation of abuse. --CMT A denied abusing Resident #1-On 11/13/25:--Resident #1 was noted to have two areas of red/dark red ecchymosis on his/her jawline and neck approximately 2 centimeters (cm) x 3 cm and a scratch on his/her right side of his/her face.--The Director of Nursing (DON) called the Administrator to inform him/her of the bruises he/she saw on Resident #1. Review of CMT A's timecard report dated 11/6/25-11/19/25 showed he/she worked 2:55 P.M. to 9:06 P.M. on 11/12/25. Observation on 11/17/25 at 10:10 A.M., showed the resident had a red scratch on his/her right cheek that was about a 3 cm long and a circular bruise on the left side of his/her face that was 2 cm in length and 2 cm in width and demonstrated how CMT A placed his/her right hand over his/her face. During an interview on 11/17/25 at 11:23 A.M., the Administrator said:-He/She knew CMT A abused Resident #1.-They did not notify the police of CMT A abusing Resident #1.-Resident #1 told Resident #2 on 11/12/25 about the incident with CMT A and they both went to the AIT the evening of 11/12/25 to report it. -The AIT reported the incident with CMT A to him/her by text on 11/12/25 around 6:00 P.M. and he/she read the text around 7:30 P.M.-He/She called CMT A soon after 7:30 P.M. and told CMT A