STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26E084	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Myers Nursing & Convalescent Center	2315 Walrond Avenue Kansas City, MO 64127

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 observation, interview and record review, the facility failed to prevent physical abuse for two sampled residents (Resident #1 and Resident #2) out of four sampled residents. On 5/25/26 Resident #1 hit Resident #2 on the head. Resident #2 struck Resident #1 with an aluminum cane, the cane broke and resulted in Resident #2 having an approximately 2-inch pink, unbroken area on his/her left upper thigh. The facility census was 84 residents.The Administrator was notified on 6/2/26 of the past noncompliance which began on 5/25/26. The facility immediately completed education for staff for Abuse and Neglect. Resident care plans were updated. Both residents had medical and psychological evaluations. Resident #2's anxiety medication was increased. Resident #1 moved to a new facility. The deficiency was corrected on 5/26/26. Review of the facility's undated Abuse and Neglect Policy showed:-Abuse was the willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm, pain or mental anguish.-Physical abuse was the use of physical force that might result in bodily injury, physical pain or impairment.-Physical abuse included punishing, slapping, hitting, shoving, striking with or without an object, pinching, kicking or burning.-Emotional or psychological abuse included verbal or nonverbal infliction of anguish, pain or distress that resulted in mental or emotional suffering, including demeaning statements, harassment, threats, insults, humiliation and intimidation. 1. Review of Resident #1's admission Record face sheet showed the resident was admitted to the facility on [DATE] with the following diagnoses:-Major depressive disorder (a serious mood disorder characterized by a persistent feeling of profound sadness, hopelessness and loss of interest in activities).-Generalized anxiety disorde(intense, excessive and persistent worry and fear about every day activities).-Schizophrenia (a serious mental health condition that affects how people think, feel and behave). Review of Resident #1's quarterly Minimum Data Set (MDS- a federally mandated assessment completed by facility staff), dated 4/11/26, showed the resident was assessed as cognitively intact. Review of Resident #1's Care Plan dated 4/9/26 showed:-He/She had limited mobility and was able to walk with a cane.-He/She had impaired thought processes and cognitive function.-He/She did not have any documentation of physical aggression or behaviors prior to this incident, or related interventions. Review of Resident #2's admission Record face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:-Paranoid schizophrenia (a severe type of schizophrenia characterized by delusions of persecution and unwarranted suspicion).-Schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms and mood disorder symptoms).-Post-traumatic stress disorder (persistent mental and emotional stress occurring as a result of injury or severe psychological shock).-Depression.-Anxiety disorder. Review of Resident #2's quarterly MDS dated [DATE], showed the resident was assessed as cognitively intact. Review of Resident #2's Care Plan dated 4/2/26 showed he/she did not have any documentation of physical aggression or behaviors prior to this incident, or related interventions. Review of the facility's investigation dated 5/25/26 showed:-An altercation between Resident #1 and Resident #2 occurred on 5/25/26 at approximately 6:33 A.M.-The incident was witnessed by Resident #3 who reported the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26E084	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Myers Nursing & Convalescent Center	2315 Walrond Avenue Kansas City, MO 64127

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	incident to the charge nurse.-Licensed Practical Nurse (LPN) A, the charge nurse, responded and observed Resident #1 being struck twice with an aluminum mobility cane by Resident #2. -The residents were immediately separated and 911 was contacted.-Law enforcement responded to the facility and interviewed Resident #1.-Resident #1 declined to press charges and reported he/she was physically ok.-Both the night shift nurse and the day shift nurse attempted to complete skin assessments on Resident #1; however, he/she refused both assessments at the time. -The Administrator met with Resident #1 alongside the day shift nurse. The resident then agreed to be transferred to the Veteran's Administration (VA) for further evaluation and treatment if deemed necessary.-The Administrator also met with Resident #2 to obtain his/her account of the incident.-Resident #2 reported he/she was in the smoking room, and asked Resident #1 for a cigarette.-According to Resident #2, Resident #1 became verbally aggressive, cursed at him/her and struck him/her in the face. -Resident #2 said he/she defended him/herself and struck Resident #1 twice.-Resident #2 further stated that Resident #1 had used the aluminum mobility cane during the altercation and the cane broke during the incident.-Resident #1 confirmed he/she had only been struck twice and reported pain/discomfort to the upper portion of his/her left thigh. Review of Resident #1's Progress Notes dated 5/25/26 at 6:54 A.M. showed:-He/She was in the smoke room smoking a cigarette when he/she was assaulted by another resident.-He/She was witnessed being beat with a cane by another resident.-The nurse was able to stop the resident from being assaulted and separated the two residents.-The resident was told 911/police would be called.-The resident was told a skin assessment needed to be performed.-The resident stated, I'm ok for now, I think. I don't feel any pain or anything except for my leg, but I have had leg problems for a long time.-The resident also stated, Just leave me alone for a second so I can calm down.-No apparent injury noted to head, arms, chest or back at that time.-Unable to assess the resident's legs, hips and buttocks as the resident declined. Review of Resident #1's hospital Progress Notes dated 5/25/26 showed the radiology report of his/her thigh showed no fracture or misalignment. Review of a photograph taken on 5/26/26 of the resident's upper thigh showed an approximately 2-inch pink oval shaped area with a small darker center. There was no break in the skin. Observation and interview on 6/2/26 at 10:45 A.M. showed the Resident #2's had no marks, bruises or injuries to his/her head. He/she said: -Resident #1 hit him/her on the head twice. -The two residents were inside the smoking room. -He/She was standing, and Resident #1 was sitting. -Resident #1 called him/her a motherfucker. -He/She doesn't know why Resident #1 hit him/her. -Resident #1 hit him/her first. -Then he/she kicked their ass. -He/She held Resident #1 down with his/her foot.-He/She told Resident #1 he/she did not want to fight him/her. -He/She then walked away from the situation. -Nobody separated them. -He/She was defending him/herself. During an interview on 6/2/26 at 11:40B A.M., LPN B said:-He/She was working when the two residents got into the altercation. -That morning, he/she was at the nurses station and he/she was informed by another resident that this person is getting assaulted in the smoking room. -He/She went over there, and she saw Resident #2 hitting Resident #1 with the cane. -The cane snapped. -Resident #2 did not have a cane and did not use an assistive device. -The cane was not heavy like a wooden cane; it was light weight. -He/ She was able to get Resident #2 to stop. -Resident #2 said, he/she hit me first. -He /She asked Resident #2 why he/she didn't come tell him/her that. - Resident #2 left out of the smoking room. -He/She saw Resident #2 hit Resident #1 on his/her leg. -He/ She got Resident #1 up. -Resident #1 said Resident #2 started hitting him/her for no reason. -He/She asked Resident #1 if it was about cigarettes.-He/She has never seen these two residents being aggressive. It was a total shock to him/her. -He/She had never known either resident to have behaviors-He/She did not remember who else was in the smoke area at the time. -Resident #3 was the resident who told him/her what was going on. -Resident #1 would not allow a skin assessment; he/she said he/she was ok. -He/She did not see anything on Resident #1s face or his/her head, arms or hands. -Resident #2 did not have any visible injuries. During a telephone interview on 6/2/26 at 1:00 P.M, the Psychiatric Nurse Practitioner said hitting was considered (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26E084	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Myers Nursing & Convalescent Center	2315 Walrond Avenue Kansas City, MO 64127

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	abuse, but he/she did not feel like it was abuse in this case. Review of Resident #3's admission Record face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's quarterly MDS dated [DATE], showed the resident was assessed as cognitively intact. During an interview on 6/2/26 at 1:30 P.M, Resident #3 said:-He/She did not see what happened before he/she arrived at the smoke room. -He/She went to smoke and saw Resident #2 standing over Resident #1 and the cane was broken. -He/She went right away to get the nurse. During an interview on 6/2/26 at 2:40 P.M., the Administrator said:-He/She did not feel this incident was preventable or predictable. -He did not feel that it was intention of either resident to harm the other as far as abuse. -He/She did not save the cane because it was broken. It was thrown out.-Resident #2 had no injuries or marks. -Resident #1 just had the red mark on his/her leg. The photograph of the mark was taken the day after the altercation, when the resident allowed staff to assess him/her. -Resident #1 transferred to a new facility on 5/28/26 per guardian's wish to have him/her out of the neighborhood. During a telephone interview on 6/5/26 at 1:30 P.M., the resident and LPN D said:- The resident did not have any marks on his body during his/her admission assessment, and he/she did not appear to have any injuries.-The resident said he/she did not want to get anyone in trouble. -The resident got agitated and did not want to discuss it further and said to hang up the phone. Incident 3022707