STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265339	A. BUILDING _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPINE BREEZE HEALTH AND WELLNESS	6124 RAYTOWN ROAD RAYTOWN, MO 64133

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one sampled resident (Resident #2) was free from physical abuse out of 8 sampled residents when on 4/17/25 Resident #1 struck Resident #2 on the head with rock resulting in an approximately 3 centimeter (cm) laceration and a hospital visit. The facility census was 138 residents. The Administrator was notified on 4/23/25 of the past noncompliance which began on 4/17/25. The facility immediately completed education for staff on the facility's Abuse and Neglect policy, the facility's Behavior Management police and de-escalation techniques. Resident #1 was placed on 1:1 supervision until his/her transport to the hospital on 4/18/25. Resident #2 was treated. The deficiency was corrected on 4/18/25. Review of the facility's Abuse, Neglect and	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE ADMINISTRATOR (X6) DATE 5-2-25

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265339	A. BUILDING _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPINE BREEZE HEALTH AND WELLNESS	**6124 RAYTOWN ROAD RAYTOWN, MO 64133**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 1	F 600		

Exploitation Policy, dated 8/22/22, showed:
-It was the policy of the facility to provide protections for the health, welfare and rights of each resident by implementing policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.
-Abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which could include staff to resident abuse and certain resident to resident altercations.
-Instances of abuse of all residents, irrespective of any mental or physical condition, caused physical harm, pain or mental anguish.
-Willful meant the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.
-Physical abuse included, but was not limited to hitting, slapping, punching, biting, and kicking. It also included controlling behavior by corporal punishment

1. Review of Resident #1's facility Admission Record Face sheet showed he/she was admitted to the facility on 9/27/24 with the following diagnoses:
-Homelessness.
-Anxiety disorder (a mental condition characterized by excessive fear, worry or nervousness), uncomplicated.
-Mood disorder due to known physiological condition.
-Major depressive disorder (persistent sadness, loss of interest or pleasure in activities) recurrent.
-Hemiplegia (a condition characterized by paralysis on one side of the body) and hemiparesis (a condition involving weakness on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265339	A. BUILDING _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPINE BREEZE HEALTH AND WELLNESS	6124 RAYTOWN ROAD RAYTOWN, MO 64133

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 2	F 600		

one side of the body) following cerebral infarction (stroke) affecting left dominant side.

Review of Resident #1's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff and used for care planning), dated 4/18/25, showed he/she was cognitively intact.

Review of of Resident #1's Level One Facility Pre-Admission Screening for Mental Illness, Intellectual Disability or Related Condition, dated 9/27/24, showed:
-The person completing the document was the hospital case manager.
-The resident did not show any signs of a major mental disorder.
-He/She did have a current, suspected or history of a major mental illness.
-The resident did not have any area of impairment due to serious mental illness.
-The resident did not have a diagnoses of a major neurocognitive disorder.
-The resident did not show behavioral symptoms.
-The resident had a stable mental condition monitored by a physician or licensed mental health professional at least monthly or behavior symptoms exhibited in the past, but not currently present or psychiatric conditions exhibited in the past but not recently present.
-The resident had impaired situational memory.
-The resident displayed difficulty making decisions in new situations or occasionally required supervision with decision making and had issues with memory, mental function or ability to be understood/understand others.

Review of Resident #1's Trauma Informed Care assessment, dated 4/13/25, showed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265339	A. BUILDING _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPINE BREEZE HEALTH AND WELLNESS	**6124 RAYTOWN ROAD RAYTOWN, MO 64133**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 3	F 600		

-He/She had an altercation with another resident on that date.
-He/She was glad to be separated from the other resident, because he/she had a temper.
-He/She stated he/she would stay to him/herself to prevent further incidents.

Review of Resident #1's Care Plan Report, updated 4/17/25, showed:
-He/She had a history of a traumatic event; no known triggers. Interventions included: medications as ordered to relieve anxiety or known stressors.
-He/She had an altercation with a resident on 11/6/24 and was found to be the instigator in a dispute regarding a wheelchair. Interventions included: administering medications as ordered; color coding wheelchairs for easy identification.
-He/She had an altercation with another resident on 4/13/25. Interventions included placing the resident on 15-minute checks for 72 hours; scheduled for team health; smoking times alternated for 48 hours; trauma informed assessment completed; determining what might lead to altercations; monitoring the resident's behavior and progress to assess effectiveness of care plan
-He/She had an altercation with another resident on 4/17/25. Interventions included maintaining a calm, respectful tone of voice; listening attentively to the resident's thoughts and feelings, validating his/her emotions; use clear and simple language so the resident could understand; he/she was placed on 1:1 oversight.

Review of Resident #2's facility Admission Record Face sheet showed he/she was admitted to the facility on 4/11/25 with the following diagnoses:
-Difficulty in walking.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265339	A. BUILDING _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPINE BREEZE HEALTH AND WELLNESS	6124 RAYTOWN ROAD RAYTOWN, MO 64133

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 4	F 600		

-Muscle weakness.
-Long term drug therapy.

Review of Resident #2's quarterly MDS, dated 4/18/25, showed he/she was cognitively intact.

Review of Resident #3's facility Admission Record Face sheet showed he/she was admitted to the facility on 1/14/25 with the following diagnoses:
-Displaced fracture of left femur; closed fracture with routine healing.
-Encounter for orthopedic aftercare.

Review of Resident #3's quarterly MDS, dated 4/17/25, showed he/she was cognitively intact

Review of Resident #3's Care Plan, report updated 4/13/25, showed:
-He/She had an altercation with another resident. Interventions included: monitoring for behavioral changed such as mood swings, irritability, changes in sleep patterns or decreased productivity and report changes to physician; encouraging positive coping skills; increasing social interaction with peers.

Review of Resident #1's progress note, dated 4/17/25 at 5:01 P.M., showed:
-It was reported the resident was outside and threw a rock.
-The nurse immediately went outside.
-The resident was yelling and cursing stating, "I didn't do shit! I didn't even mean to hit that man!"
-The Administrator attempted to deescalate the situation; resident struck the Administrator's phone out of his/her hand.
-Police were called to assist.
-The resident (Resident #2) who was hit with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265339	A. BUILDING _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPINE BREEZE HEALTH AND WELLNESS	6124 RAYTOWN ROAD RAYTOWN, MO 64133

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 5	F 600		

rock pressed charges.
-Police stated they were unable to take the resident.
-The resident was immediately placed on 1:1 observation.
-The physician and the resident's family member were made aware.
-He/She was calm, resting in bed at that time with 1:1 observation at bedside; he/she apologized to the Administrator.

Review of Resident #2's Progress Note, dated 4/17/25 at 2:55 P.M., showed:
-It was reported the resident was injured with a rock by another resident.
-Resident had a laceration of approximately 3 cm long to the back of his/her head and complained of pain.
-Physician notified and ordered to send resident to the hospital as he/she was on blood thinners.

Review of Resident #2's Care Plan Report, updated 4/18/25, showed:
-He/She had a risk of trauma related to injury with a rock by another resident. Interventions included: assessment for trauma on 4/17/25; no new triggers identified with trauma assessment; referral to in-house psychological services.

Review of Resident #2's Progress Note, dated 4/18/25 at 1:50 P.M., showed:
-He/She had been self-propelling manual wheelchair outside by the front entrance.
-Another resident threw a rock, not intending to hit this resident.
-The rock did hit him/her on the back of the head.
-He/She had no loss of consciousness; remained alert and oriented to baseline.
-A 3 cm x 0.1 cm x < 0.1 cm laceration was noted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265339	A. BUILDING _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPINE BREEZE HEALTH AND WELLNESS	**6124 RAYTOWN ROAD RAYTOWN, MO 64133**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 6	F 600		

to the back of the head; the area was cleansed, ice was applied.
-He/She remained with the nurse until the ambulance arrived for transport.
-Emergency Department (ED) evaluation was required per the resident's physician due to his/her use of blood thinner.
-The Director of Nursing (DON), facility Administrator, physician and the resident's sister were notified.
-His/her care plan was updated.

Review of Resident #2's hospital Patient Visit Information, dated 4/17/25, showed:
-He/She was seen for a scalp laceration.
-He/She received the head injury on 4/17/25.
-It did not appear serious at the time.
-He/She received a head computed tomography (CT - a detailed imaging procedure that uses x-ray and computer technology to create cross-sectional pictures) which was negative.

Review of the facility's Resident to Resident Investigation Summary, dated 4/18/25, showed:
-On 4/17/25 Resident #1 had a resident-to-resident altercation with Resident #2.
-Resident #1 was on the patio having a supervised smoke break.
-Resident #1 became agitated at Resident #3 who Resident #1 felt was "looking at him/her funny."
-The Administrator attempted to intervene and deescalate.
-Resident #1 struck the Administrator's hand, smacking his/her phone out of his/her hand.
-Resident #1 got angry and threw a rock at Resident #3 and missed striking Resident #2.

During an interview on 4/21/25 at 12:40 P.M.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265339	A. BUILDING _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPINE BREEZE HEALTH AND WELLNESS	6124 RAYTOWN ROAD RAYTOWN, MO 64133

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 7	F 600		

Resident #3 said:
-On the day of the incident, he/she went outside and Resident #1 was already out there.
-Resident #1 told him/her that he/she could not come out there and said, "Get on out of here!"
-He/She was nowhere near Resident #1 who was sitting in the smoking area.
-Resident #1 wheeled his/her chair over toward him/her, stopped at the fountain and picked up a rock.
-He/She began backing away from Resident #1, who kept coming toward him/her.
-He/She did not say anything to Resident #1. He/She did not think he/she could hit him/her with the rock, because he/she only had one good arm.
-Resident #1 threw the rock and it hit the other resident, Resident #2, whose back was toward him/her.
-He/She did not see anything else because the Administrator told him/her to go inside.
-Resident #1 could get verbally aggressive with people. Resident #1 had his/her own room because he/she could not get along with anyone.

During and observation and interview on 4/21/25 at 1:00 P.M., Resident #2 said:
-Resident #1 threw the rock at someone and it hit him/her.
-He/She was minding his/her business and Resident #1 was behind him/her and threw the rock at Resident #3.
-He/She went to the hospital.
-Resident #1 had a fight before with Resident #3 earlier in the week.
-The place where the rock hit him/her was painful, but he/she had not asked for any pain medication.
-He/She had an approximately inch long closed laceration on the back of his head. There was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265339	A. BUILDING _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPINE BREEZE HEALTH AND WELLNESS	6124 RAYTOWN ROAD RAYTOWN, MO 64133

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 8	F 600		

discoloration or visible swelling.
-He/she was angry and wanted to press charges.

During an interview on 4/22/25 at 11:00 A.M., Resident #1 said:
-He/She threw a rock at Resident #3, because Resident #3 had previously punched him/her in the face.
-He/She was outside on a smoke break and Resident #3 was making fists at him/her.
-He/She did not want to keep seeing the other resident when he/she was outside, so he/she picked up a rock and threw it, but it hit the other resident (Resident #2).
-He/She and Resident #3 got along sometimes, but he/she did not like him/her.

During an interview on 4/23/25 at 1:30 P.M., Resident #1's physician said:
-He/She was aware of the rock throwing incident.
-Medication adjustments were reviewed and the resident was put on 1:1 observation.
-The staff were concerned about the safety of the other residents.
-Resident #1 had dementia that was progressing.
-Resident #1 had to be sent out for evaluation, because the facility was not able to manage his/her signs and symptoms.
-It was never justified for a resident to throw a rock at another resident.

During an interview on 4/23/25 at 2:00 P.M., the DON said:
-He/She was at the facility on 4/17/25. Someone said help was needed outside, so he/she went running.
-He/She took Resident #2 into his/her office. His/her laceration was very superficial and they were not originally going to send him/her to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265339	A. BUILDING _____ B. WING _____	C 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPINE BREEZE HEALTH AND WELLNESS	6124 RAYTOWN ROAD RAYTOWN, MO 64133

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 9 hospital. It was cleansed and ice was applied. He/She was sent to the hospital due to being on a blood thinning medication. -Resident #1 should not have thrown a rock at Resident #3. During an interview on 4/23/25 at 2:00 P.M., the Administrator said: -It was never appropriate for a resident to throw a rock at another resident. -He/She did not feel the incident was predictable because prior to 4/13/25 the resident did not have behaviors. -When Resident #1 threw the rock, he/she had just gone outside. MO00252926	F 600		