STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265758	A. BUILDING _____ B. WING _____	C 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB OF KANSAS CITY SOUTH	8033 HOLMES KANSAS CITY, MO 64131

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F 600 SS=D	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 interview and record review, the facility failed to prevent physical abuse for two sampled residents (Resident #3 and #4) out of nine sampled residents. The facility census was 94 residents. On 5/7/25, the Administrator was notified of the past non-compliance which occurred on 4/25/25. Facility staff were educated on the root-cause of the abuse and keeping the back patio doorway/area clear. Interventions were put into place to mitigate future occurrences. The deficiency was corrected on 4/26/25. Review of the facility's policy titled "Abuse Prevention and Prohibition Program" dated August 2020 showed each resident had the right to be free from mistreatment, neglect, abuse, involuntary seclusion, and misappropriation of property.	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
S Hamir	Administrator	5/21/25

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.

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Review of the facility's policy titled "Reporting Abuse" showed:
-Abuse meant the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.
-Physical abuse meant assault, battery, assault with a deadly weapon or force likely to produce great bodily injury, unreasonable physical constraint or prolonged or continual deprivation of food or water, sexual assault, use of a physical or chemical restraint or psychotropic medication for punishment or for beyond a period of time that was ordered by a licensed physician, or for any purpose not authorized by the physician.

1. Review of Resident #5's admission record showed he/she admitted to the facility 2/7/24 with the following diagnosis of bilateral amputations of his/her legs.

Review of Resident #5's quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 3/21/25 showed:
-The resident had moderately impaired cognition.
-The resident exhibited verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) one to three times within the seven days look back period.

Review of Resident #4's Pre-Admission Screening and Resident Review (PASRR- a federally mandated screening process for individuals with serious mental illness and/or intellectual disability/developmental disability related diagnosis who apply or reside in Medicaid

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Certified beds in a nursing facility regardless of source of payment) dated 9/15/23 showed:
-The resident had a diagnosis of Schizophrenia. (a disorder that affects a person's ability to think, feel, and behave clearly).
-The resident had an Anxiety Disorder (any group of mental conditions characterized by excessive fear of or apprehension about real or perceived threats).
-The resident had a Traumatic Brain Injury (TBI- brain dysfunction caused by an outside source).
-The resident had minimal behavioral symptoms related to being withdrawn or depressed.

Review of Resident #4's admission record showed he/she re-admitted to the facility 1/16/24 with the following diagnoses:
-Paraplegia (the inability to voluntarily move the lower parts of the body).
-Major Depressive Disorder (MDD- a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).
-Schizophrenia .

Review of Resident #4's quarterly dated 2/03/25 showed the resident was cognitively intact.

Review of video footage of the altercation dated 4/25/25 at 8:21 A.M. showed:
-The footage had no sound.
-The video footage was two minutes and eight seconds long.
-Both residents can be seen outside on the patio.
-Resident #4 wheeled up close to the back entrance door of the facility smoking a cigarette.
-Resident #5 could be seen in the back area away from the door.
-Approximately 20 seconds into the video,

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Resident #5 could be seen starting to propel his/her wheelchair towards the same door that Resident #4 was in proximity of.
-Resident #5 continued towards the door and then became within arms distance of Resident #4 and appeared words were exchanged.
-After possible words exchanged Resident #5 pushed Resident #4 out of the way to continue to try to get into the building.
-That action caused Resident #4 to become visibly upset and Resident #4 wheeled his/her wheelchair back towards Resident #5.
-Resident #5 responded to this by reaching out and grabbing Resident #4's sleeve.
-Resident #5 continued to hold Resident #4's sleeve and started to shake Resident #4's arm around.
-Resident #4 and Resident #5 also appeared to be exchanging words with each other.
-Certified Medication Technician (CMT) A and Activity Assistant A could then be seen exiting the facility to respond to the incident.
-At that same time Resident #5 continued to hold Resident #4's sleeve and punched Resident #4 twice in the face.
-CMT A then separated the residents.
-Resident #4 and Resident #5 continued to communicate with each other even though they had been physically separated.
-CMT A then pulled Resident #4's wheelchair back, so Resident #5 could enter the building.
-As Resident #5 entered the building he/she could be seen visibly upset by the altercation.
-The video footage concluded once Resident #5 entered the building.

Review of the facility Investigation Summary for the altercation dated 4/25/25 showed:
-Resident #4 and Resident #5 were involved in an

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altercation.
-Both residents had been outside in the back patio area.
-Resident #5 had been attempting to get back into the facility and Resident #4 was blocking Resident #5's path.
-Both residents became agitated and were bumping wheelchairs against each other.
-Both residents were flinging their arms at each other.

During an interview on 5/5/25 at 10:45 A.M. Resident #4 said:
-He/She had been hit in the head and neck during the altercation.
-He/She felt safe at the facility and was not afraid of Resident #5.
-He/She had been outside in the smoking area.
-Resident #5 hit him/her because he/she had been in the way and he/she needed to go back inside to use the bathroom.

During an interview on 5/5/25 at 10:50 A.M. Resident #5 said:
-Resident #4 had thrown a cigarette on him/her.
-Resident #4 was not supposed to be smoking by the door.

During an interview on 5/7/25 at 12:05 P.M. Resident #4 said he/she felt like he/she had not deserved to be hit.

Review of a witness statement dated 4/25/25 completed by Activity Assistant A showed:
-Resident #4 had been sitting in his/her wheelchair in the walkway area.
-Resident #5 had been trying to get through.
-Resident #4 continued to smoke his/her cigarette.

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-Resident #4 and Resident #5 began to argue and were bumping into each other.

During an interview on 5/7/25 at 1:06 P.M. Activity Assistant A said:
-He/She had been standing by the door to the back patio area.
-Resident #4 and Resident #5 started bickering with each other about Resident #4 being in Resident #5's way.
-He/She had seen Resident #5 punch Resident #4.

During an interview on 5/7/25 at 4:12 P.M. the Assistant Director of Nursing (ADON) said:
-He/She was aware that Resident #4 and Resident #5 had been in an altercation but had not seen the video footage.
-He/She was unsure of what happened during Resident #4's and Resident #5's altercation.
-The staff had been educated after the altercation about keeping the back patio doorway and area clear to prevent further issues.
-That intervention seemed to be effective since being put in place.
-Staff were responsible for intervening and attempting to re-direct residents when exhibiting verbal behaviors.
-If a resident hits another resident it counted as physical abuse.

During an interview on 5/7/25 at 4:55 P.M. the Director of Nursing (DON) and Regional Corporate Nurse A said:
-Abuse had occurred during the altercation.
-The abuse occurred when Resident #5 punched Resident #4.

2. Review of Resident #2's Pre-Admission

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Screening and Resident Review dated 1/7/25 showed:
-The resident had Schizophrenia.
-The resident had Schizoaffective Disorder (a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania or depression).
-The resident had an Anxiety Disorder (any group of mental conditions characterized by excessive fear of or apprehension about real or perceived threats).
-The resident had Major Depressive Disorder (MDD- a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life.
-The resident had Post-Traumatic Stress Disorder (PTSD- a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event).
-The resident had difficulty in adapting to change.

Review of Resident #2's quarterly MDS dated 3/21/25 showed he/she was cognitively intact.

Review of Resident #3's quarterly MDS dated 3/10/25 showed he/she was cognitively intact.

Review of the facility's Investigation Summary dated 5/8/25 showed:
-On 5/3/25 Resident #2 and Resident #3 were involved in an altercation with each other.
-Resident #3 was sitting in the dining room in his/her wheelchair when Resident #2 approached Resident #3 and stated the resident owed him/her 20.00.
-Resident #3 denied owing Resident #2 anything.
-This caused Resident #2 to become agitated

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and allegedly pushed Resident #3 to the ground.
-Staff then entered the dining room and noted that Resident #3 was on the ground.
-Resident #2 and Resident #3 were separated at that time and told to stay away from each other.
-Resident #3 then called the police and the police came to the facility to file a report.
-Resident #2 and Resident #3 were also placed on 1:1 monitoring.
-Skin assessments were completed for Resident #2 and Resident #3.
-Resident #3 had noted injuries to his/her nose and left knee.

During an interview on 5/5/25 at approximately 9:30 A.M. Resident #2 said:
-He/She thought that Resident #3 was going to hit him/her with his/her cane and was defending himself/herself by deflecting the cane from hitting him/her which caused him/her fall to the ground.
-The altercation had occurred in the dining room.
-The altercation had started as an argument about money.

During an interview on 5/5/25 at 11:50 A.M. Resident #3 said:
-Resident #2 had owed him/her money.
-He/She went into the dining room to confront Resident #2 about the money.
-He/She had been trying to walk away from the incident with his/her cane when Resident #2 had swiped his/her legs from underneath him/her which caused him/her to fall on a table then to the floor.
-He/She thought Resident #2 was going to hit him/her.

During an interview on 5/7/25 at 4:12 P.M. the ADON said:

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F 600	Continued From page 8 -Resident #2 mostly exhibited verbal behaviors. -Resident #3 was not known for exhibiting any behaviors. -He/She was unsure of what happened in the altercation between Resident #2 and Resident #3. -He/She knew that the altercation occurred in the dining room and that there had been an argument. During an interview on 5/7/25 at 4:55 P.M. the DON and Regional Nurse Consultant A said: -Resident #2 "liked to be noisy" with other staff and residents. -Resident #2 should have behavioral monitoring in place prior to 5/7/25. -He/She was unsure why behavioral monitoring was not in place for Resident #2 prior to 5/7/25 and it was possible the incident could have been avoided. MO00253302 & MO00253688	F 600		