

Missouri Department of Health and Senior Services

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>23774</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>10/14/2025</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>GARDENS AT BARRY ROAD, THE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8300 NW BARRY ROAD<br/>KANSAS CITY, MO 64153</b> |
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| (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) COMPLETE DATE |
|--------------------|---|---------------|---|--------------------|
| A8023              | <p>19 CSR 30-88.010(23) Develop/Implement A/N Policies</p> <p>The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III</p> <p>This regulation is not met as evidenced by:<br/>Class II*</p> <p>Based on interview and record review the facility failed to develop and implement written abuse policies and procedures when Resident #2's emergency contact was not notified when Resident #1 smacked Resident #2's arm with the back of his/her hand. This deficient practice affected one of two sampled residents. The facility census was 31 residents.</p> <p>Review of the facility's Abuse and Neglect policy revised on 10/17/19, showed that as part of the facility's investigation into any abuse or neglect allegation, notification to the resident's emergency contact was required.</p> <p>Review of the facility's Abuse and Neglect investigation dated 10/06/25 showed:<br/>-Resident #1 entered Resident #2's room through the open door, and when Resident #2 told Resident #1 to leave his/her room, he/she refused, and then smacked Resident #2's arm with the back of his/her hand;<br/>-Residents were immediately separated by Level</p> | A8023         |   |                    |

Missouri Department of Health and Senior Services

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

8699

OPI011

If continuation sheet 1 of 4

Missouri Department of Health and Senior Services

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Missouri Department of Health and Senior Services  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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| A8023              | <p>Continued From page 1</p> <p>One Medication Aide (L1MA) A who was already in the room assisting Resident #2's roommate;<br/>-Both residents were assessed for injuries, no injuries were noted, physicians and responsible parties were notified.</p> <p>1. Review of Resident #1's face sheet showed:<br/>- Diagnoses included: Major neurocognitive disorder (mental health disorders that primarily affect cognitive abilities including learning, memory, perception, and problem-solving), vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain) with delusions, behavioral disturbance, impulse control disorder (difficulties in controlling impulsive behaviors, often leading to harmful or disruptive consequences), and anxiety.</p> <p>2. Review of Resident #2's face sheet showed:<br/>- Diagnoses included: Dementia (a general term for a group of brain disorders that cause a gradual decline in cognitive abilities, such as memory, thinking, problem-solving, and language) and anxiety.</p> <p>Review of Resident #2's progress note entered by L1MA A, dated 10/06/25 at 8:20 P.M. showed:<br/>-At around 3:35 P.M. Resident #1 walked into Resident #2's room, when Resident #2 told Resident #1 to leave, Resident #1 refused to leave and then hit Resident #2 in the arm, with the back of his/her hand;<br/>-Staff separated the two residents immediately, vitals were obtained, and no complaints of pain or injuries noted;<br/>-All parties were notified.</p> <p>During an interview on 10/14/25 at 12:12 P.M. Resident #2's Emergency Contact said:<br/>-He/She was not aware of any altercation</p> | A8023         |   |                    |

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| A8023              | <p>Continued From page 2</p> <p>involving his/her mother that took place on 10/06/25;</p> <p>-He/She was at the facility on 10/08/25 and was still never made aware of the incident;</p> <p>-He/She would have expected to be notified of this incident immediately.</p> <p>During an interview on 10/14/25 at 12:20 P.M. L1MA A said:</p> <p>-This was the first time completing an incident report, so L1MA B was helping him/her complete the report and he/she thought L1MA B was going to make the phone call to Resident #2's family;</p> <p>-He/She did not call Resident #2's family after the incident on 10/06/25.</p> <p>During an interview on 10/14/25 at 12:26 P.M. L1MA B said:</p> <p>-He/She did not call Resident #2's family after the incident on 10/06/25, but thought other staff said they did;</p> <p>-L1MA's were responsible for notifying families of incidents that occurred.</p> <p>During an interview on 10/14/25 at 1:02 P.M. the Administrator said:</p> <p>-He/She was not aware that Resident #2's family was not notified of the 10/06/25 incident;</p> <p>-He/She contacted all staff that were working on 10/06/25 all of whom advised they did not call the family because they thought someone else was;</p> <p>-He/She expected whomever wrote the incident report to notify the resident's family;</p> <p>-In this incident, L1MA A was new and still being trained by L1MA B, there appeared to be a break down in the procedure as each staff thought the other was notifying the resident's family;</p> <p>-He/She expected families to be notified after any allegation or incident of abuse or neglect.</p> | A8023         |   |                    |

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| A8023              | Continued From page 3<br><br>*The higher classification merited due to the extent of the violation.<br><br>MO258714    | A8023         |   |                    |

## PLAN OF CORRECTION

|   |   |                        |
|---|---|------------------------|
| <b>Provider/Supplier Name:</b>                      | The Gardens at Barry Road   |                        |
| <b>Street Address, City, Zip:</b>                   | 8300 NW Barry Road<br>Kansas City, MO 64153   |                        |
| <b>Date of Survey:</b>                              | 10/14/2025  |                        |
| <b>PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER</b> |   | 23774                  |
| <b>ID PREFIX TAG</b>                                | <b>PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</b>   | <b>COMPLETION DATE</b> |
|   | <p>This plan of correction is submitted as required under State Law to correct noted deficient practices that could affect all residents. The submission of this plan shall not constitute or be construed as an admission by The Gardens of Barry Road of the allegations found by the surveyor(s) nor the conclusions drawn there from. This plan of correction shall serve as our credible letter alleging compliance, which will be effective on or before 10/14/25. Compliance will be maintained as provided in the plan of correction.</p>   |                        |
| A8023   | <p><i>19 CSR 30-88.010(23) Develop/Implement A/N Policies.</i></p> <p><i>The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has reasonable cause to believe has been abused or neglected. II/III.</i></p> <p>The Gardens at Barry Road maintains written policies and procedures that strictly prohibit the mistreatment, neglect, or abuse of any resident, as well as the misappropriation of resident property or funds. These policies require notification to the resident's designated emergency contact or resident representative in the event of any incident involving potential harm, injury, or risk.</p> <p>During this recent incident, a new staff member was being trained on the procedure by another staff member. Implementation failed because it was unclear whether the trainer or the trainee was responsible for notifying the resident's emergency contact.</p> <p>The Executive Director (ED), Health Services Director (HSD), and Memory Care Director (MCD) have clarified and redefined responsibilities to eliminate any ambiguity regarding notification</p> | 10/17/25               |

