STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265355	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Grandview	6301 East 125th St Grandview, MO 64030

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 - 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 ensure three sampled residents (Resident #2, Resident #4, and Resident #11) were free from abuse when on 10/10/25 Resident #1 slapped Resident #2 in the back of the head; on 10/16/25 when Resident #3 punched Resident #4 in the face multiple times which caused Resident #4 to have a small laceration to his/her right eyebrow, bruising to his/her right orbital area of his/her face, and multiple small cuts to the back of his/her head, and on 10/23/25 when Resident #3 poured hot sauce on Resident #11's face. 13 residents were selected for sample. The facility census was 106 residents.Review of the facility's policy titled Abuse-Identification of Types dated 5/6/25 showed:-Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain, or mental anguish.-Physical abuse included but was not limited to:--Hitting.--Slapping.--Punching.--Biting.--Kicking. -Verbal abuse was considered a type of mental abuse (the use of verbal or non-verbal conduct which causes or has potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation).-Verbal abuse included the use of oral, written, gestured communication, or sounds, to residents within hearing distance regardless of age, ability to comprehend, or disability.-Examples of mental and verbal abuses included, but was not limited to:--Harassing a resident.--Mocking, insulting, ridiculing.--Yelling or hovering over a resident, with the intent to intimidate. 1. Review of Resident #1's admission Record showed he/she was admitted to the facility with a diagnosis of Hemiplegia (paralysis of one side of the body) Following Cerebral Infarction (ischemic stroke-occurs as a result of disrupted blood flow and restricted oxygen to the brain) Affecting Left Non-Dominant Side.Review of Resident #1's undated care plan showed the resident had potential to be verbally aggressive and would cuss at staff/residents and concoct situations related to ineffective coping skills and poor impulse control.Review of Resident #1's Annual Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 8/11/25 showed:-The resident was cognitively intact.-The resident had not exhibited any physical behavioral symptoms directed towards others during the look back period.Review of Resident #2's admission Record showed he/she was admitted to the facility with the following diagnoses:-Anxiety Disorder (any group of mental conditions characterized by excessive fear or apprehension about real or perceived threats), Unspecified. -Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), Unspecified.-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).-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.-Anoxic Brain Injury (occurs when the brain is deprived of oxygen for an extended period.Review of Resident #2's undated care plan showed:-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
	265355	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Grandview	6301 East 125th St Grandview, MO 64030

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 - Actual harm Residents Affected - Few	resident had potential for a behavioral problem related to accusatory behaviors and was easily agitated when he/she could not fully express himself/herself. -The resident had impaired cognitive ability/impaired thought processes related to Anoxic Brain Injury.Review of Resident #2's Quarterly MDS dated [DATE] showed:-The resident was cognitively intact.-The resident did not exhibit any verbal behavioral symptoms within the look back period.Review of the facility's investigation summary completed on 10/11/25 showed:-There were no witnesses to the altercation.-On 10/10/25 around 12:00 P.M. Resident #2 stated he/she was struck in the back of the head by Resident #1. -Resident #2 stated that he/she and Resident #1 were passing each other in the hallway and Resident #1 swung his/her purse at him/her striking him/her in the back of the head.-Resident #2 initially stated that nothing happened prior to Resident #1 swinging his/her purse at him/her. -Resident #2 then stated that he/she had called Resident #1 a witch, not a bitch. -Resident #2 was upset because Resident #1 would always get what he/she wanted, and he/she had to wait. -Resident #2 also said, I really didn't mean to upset Resident #1, but it just burns me that he/she is getting her way all the time. -No injury was noted. -Resident #2 denied pain or psychosocial distress. -Resident #2 was educated on boundaries, conflict resolution, and therapeutic communication.-Resident #2 was also moved to a different side of the facility. -Resident #1 stated that he/she was passing the resident in the hall in his/her wheelchair and Resident #2 called him/her a bitch. -Resident #1 stated that he/she was upset and frustrated that he/she had called him/her a name and turned around and swung at him/her with his/her hand. -Resident #1 made contact with the back of Resident #2's head. -Resident #1 also told Resident #2 that he/she should not use words like that. -No injuries were noted. -Resident #1 was educated on therapeutic communication, conflict resolution, and notifying staff with concerns. -The facility did not think that the situation was counted as abuse because they believe that Resident #1 had reacted to being called a derogatory name by a peer.During an interview on 10/21/25 at 9:48 A.M. Resident #2 said: -He/She had passed Resident #1 in the hallway. -He/She didn't do anything and didn't call him/her any names. -It really hurt at the time of the altercation-He/She would consider the situation as abuse.-He/She was always having issues with Resident #1. -Resident #1 stared him/her down in the lunchroom and he/she was always banging on the kitchen door demanding food.During an interview on 10/21/25 at 9:59 A.M. Resident #1 said: -The situation happened about a week and a half ago. -He/She had passed Resident #2 in the hallway. -He/She told Resident #2 he/she was trying to get to the business office. -Resident #2 then called him/her a bitch. -The facility's receptionist heard Resident #2 call him/her a bitch. -Resident #2 had said it three times. -He/she told Resident #2 that he/she would give Resident #2 one more chance not to call him/her a bitch again or that he/she would slap Resident #2. -The following day he/she had passed Resident #2 in the hallway again. -Resident #2 called him/her a bitch again. -The next morning it happened again. -He/she told Resident #2 to not call people that. -He/she hit Resident #2 in the back of the head with an open hand, like a slap. -He/she had a temper. During an interview on 10/21/25 at 10:21 A.M. the facility's receptionist said:-Resident #2 did call Resident #1 a bitch three times.-He/She had de-escalated the situation by trying to separate the residents. -Resident #2 kept rumbling and rumbling on. -He/She did not hear Resident #1 say that he/she would hit Resident #2 if he/she called Resident #1 a bitch one more time.-The Administrator was aware of the first incident.During an interview on 10/21/25 at 11:04 A.M. the Administrator said:-To his/her own knowledge Resident #1 and Resident #2 had never been involved in an altercation before.-He/She was unaware that Resident #1 had threatened to hit Resident #2 the day before the incident.-He/She was aware that Resident #1 and Resident #2 had been involved in a verbal altercation the day before the incident and educated both residents on therapeutic communication and calling for staff (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265355	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Grandview	6301 East 125th St Grandview, MO 64030

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 - Actual harm Residents Affected - Few	if needed.During an interview on 10/21/25 at 1:58 P.M. Resident #2 said:-Around 1:00 P.M. today, Resident #1 came and sat in front of his/her door. -He/she didn't do anything but was just sitting there. -He/She told Resident #1 something along the lines of go away you witch and then Resident #1 left. -He/She just wanted Resident #1 to leave him/her alone.During an interview on 10/21/25 at 3:26 P.M. Resident #1 said:-He/She was passing Resident #2's room earlier on his/her way to speak with a nurse.-When he/she passed Resident #2's room, Resident #2 told him/her to go away witch. -He/She didn't stop at Resident #2's room; he/she just ignored it and minded his/her own business. During an interview on 10/23/25 at 8:58 A.M. Dietary Aide A said:-Both Resident #1 and Resident #2 were prone to name calling.-Resident #1 and Resident #2 had no history of physical altercations with each other or other residents.During an interview on 10/23/25 at 9:49 A.M. Facility Physician A said:-He/She did not think Resident #1 had a history of physical altercations with Resident #2 or any other residents.-He/She thought Resident #2 had been in verbal altercations with previous roommates, but not with Resident #1.-He/She did not believe that the incident was preventable.-Resident #2's cognition was worsening and seemed more paranoid recently.During an interview on 10/23/25 at 10:36 A.M. the Activities Assistant said he/she had worked with Resident #1 before, and he/she could be snappy at times but had never gotten into a physical altercation before.During an interview on 10/23/25 at 10:54 A.M. the Director of Nursing (DON) said:-He/She was unaware of the verbal altercation that Resident #1 and Resident #2 had the day prior to the incident. -Abuse occurred when Resident #1 hit Resident #2 in the back of the head.-Resident #2 had behaviors of just being playful at times, and sometimes he/she would make a joke, and no one would find it funny. -He/She had aphasia (a language disorder that affects a person's ability to communicate) and sometimes couldn't get the words that he/she wanted out.-Resident #2 had gotten into verbal altercations with staff before, like cussing, he/she hasn't had any with other residents until the incident with Resident #1. -Resident#1 had been called names by Resident #2 before. -Resident #1 was just tired of Resident #2 calling him/her that word. -Resident #2 could have said witch but with his/her aphasia it might have sounded like bitch. -Resident #1 could make sound decisions and was just tired of being called names. -He/She would have expected Resident #1 to roll away and try to ignore it.-If he/she had known about the verbal altercation the day prior the situation could have been addressed differently, and interventions may have already been put into place to prevent the physical altercation.2. Review of Resident #3's admission Record showed he/she was admitted to the facility with the following diagnoses:-Unspecified Dementia (a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement, and impulses), Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety.-Anxiety Disorder, Unspecified.-Depression, Unspecified.Review of Resident #3's undated care plan showed Resident #3 had a psychosocial well-being problem r/t ineffective coping after the sudden death of his/her brother, lack of acceptance to current condition, depressed over being here in nursing home.Review of Resident #3's Quarterly MDS dated [DATE] showed:-The resident had moderately impaired cognition.-The resident had not exhibited any behaviors within the look back period.Review of Resident #4's admission Record showed he/she was admitted to the facility with a diagnosis of Anxiety Disorder, Unspecified.Review of Resident #4's undated care plan showed he/she had the potential to be verbally aggressive related to ineffective coping skills and poor impulse control.Review of Resident #4's Quarterly MDS dated [DATE] showed:-The resident was cognitively intact.-The resident did not exhibit any type of behaviors within the look back period.Review of Resident #5's admission Record showed he/she was admitted to the facility with the following (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265355	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Grandview	6301 East 125th St Grandview, MO 64030

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 - Actual harm Residents Affected - Few	diagnoses:-Chronic Obstructive Pulmonary Disease (COPD- a disease process that decreases the ability of the lungs to perform ventilation).-Cognitive Communication Deficit (an impairment in organization/thought organization, sequencing, attention, memory, planning, problem-solving, and safety awareness).Review of Resident #5's undated care plan showed the resident had a behavior problem related to making false and/or fabricating accusations towards staff and residents.Review of Resident #5's Quarterly MDS dated [DATE] showed:-The resident was cognitively intact.-The resident had not exhibited any type of behaviors within the look back period.Review of the facility's investigation summary dated 10/17/25 showed:-On 10/16/25 the Administrator/Executive Director (ED) was notified that Resident #3 and Resident #4 were involved in physical aggression toward each other. -Resident #5 stated that Resident #4 was at his/her lunch table and that Resident #4 told Resident #5 that it was his/her lunch table and Resident #5 needed to move.-Resident #4 grabbed Resident #5's arm and his/her shirt; Resident #3 came over to the table to intervene. -Resident #3 was just trying to help Resident #5. -No evidence of contact was found on Resident #5. Resident #4 stated that he/she did not touch Resident #5. -Resident #4 was only eating lunch and did not do anything to Resident #5. -Resident #4 stated that he/she struck Resident #3 but could not remember if it was before or after he/she was struck by Resident #3. -Resident #4 had an abrasion under his/her right eye and left side back of his/her head.-Resident #3 stated that Resident #4 was being rude to Resident #5 and went over to speak with Resident #4.-He/She bent over to get eye level with Resident #4 while speaking to him/her, then Resident #4 grabbed his/her shirt and pulled him/her forward.-Resident #4 then pushed Resident #3 back and then started to swing at Resident #4. -Staff immediately separated the residents.-Resident #3 was then placed on one-to-one (1:1) monitoring (a term used by healthcare support workers whose role is to provide one-to-one nursing or observation care to an individual patient/resident for a period of time). -The Administrator spoke with multiple residents that were present in the dining room at the time of the incident. -Some resident accounts state that Resident #5 called Resident #3 over to the table and that Resident #4 did not hit or grab Resident #5's clothing. -They heard Resident #5 call Resident #3 over to the table and Resident #3 started to speak with Resident #4. -Resident #4 grabbed Resident #3's shirt and physical aggression occurred. -Some residents have stated that Resident #4 pulled at Resident #5's clothing which prompted Resident #3 to go over to the table. -Resident #3 then started to speak with Resident #4 and then Resident #4 struck Resident #3 and then Resident #3 struck Resident #4. -Resident #3 remained on 1:1 observation until 10/20/25. -A medication review was also completed, and it was found [NAME] Resident #3 had a Gradual Dose Reduction (GDR- the stepwise process of decreasing the dosage of medication over s specific period of time) completed of his/her Buspar (Buspirone- used to treat Anxiety) on 8/12/25 in which his/her Buspar was discontinued at that time. -There was no physical aggression noted prior to altercation and when GDR was completed.During an interview on 10/21/25 at 12:25 P.M. Resident #5 said:-Resident #4 told him/her to get up from the table. -Resident #4 reached over grabbed his/her shirt and arm. -Resident #4 slapped him/her in the face. Resident #3 then came over to the table.-Resident #3 was just protecting him/her.-He/She didn't want to further discuss the incident.During an interview on 10/21/25 at 12:29 P.M. Resident #3 said:-He/She was just sitting in the dining room. -He/She saw Resident #4 and Resident #5 and heard Resident #5 saying to Resident #4 leave me alone. -He/She then went over to the table. -He/She asked Resident #4 what was wrong. -Resident #4 ignored him/her at first. -He/She told Resident #4 to not mess with Resident #5. -He/She then turned to Resident #5 to make sure he/she was okay. -That was when Resident #3 was punched in the chest by Resident #4. -He/She then proceeded to punch Resident #4 in the face and then he/she was punched in the face by Resident #4. -Staff separated them after (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265355	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Grandview	6301 East 125th St Grandview, MO 64030

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 - Actual harm Residents Affected - Few	that. -He/She was not injured during the altercation.During an interview on 10/21/25 at 1:39 P.M. Resident #8 said:-Resident #3 went over to Resident #5's table. -Resident #3 didn't go over there for any particular reason. -Resident #3 hit Resident #4 and then Resident #4 hit back. -The staff separated them after that and nothing else happened.NOTE: Review of the resident's Quarterly MDS dated [DATE] showed the resident had moderately impaired cognition.During an interview on 10/21/25 at 1:46 P.M. Resident #10 said:-Resident #3 was whispering in Resident #4's ear. -All of the sudden Resident #4 started hitting Resident #3. -Resident #4 hit Resident #3 in the face. -Resident #3 then slammed Resident #4 to the ground. -Resident #5 was not involved in the incident.During an interview on 10/21/25 at 1:53 P.M. Resident #9 said: -He/She only saw the end of it. -He/She saw Resident #4 on the ground and Resident #3 was standing over Resident #4.-He/She didn't see them hitting each other. -Resident #3 went over to the table because Resident #4 was terrorizing Resident #5.-Staff separated the residents after that.-Nothing happened afterwards.NOTE: Review of Resident #9's Significant Change MDS dated [DATE] showed the resident was cognitively intact.Review of a witness statement dated 10/16/25 completed by Licensed Practical Nurse (LPN) A showed:-Certified Medication Technician (CMT) A had told him/her that Resident #5 did not Resident #4 to sit at his/her table.-LPN A then went to the dining room and observed Resident #4 eating lunch and Resident #5 was sitting in his/her wheelchair with his/her back towards Resident #4.-LPN A was going to move Resident #4 to a different table but Resident #5 stated that Resident #4 could sit at his/her table.-LPN A then left the dining room to assist a different resident.During an interview on 10/21/25 at 2:16 P.M. LPN A said:-Resident #5 was in the dining room eating. -CMT A came and told him/her to check on Resident #5. -Resident #5 didn't want Resident #4 to sit with him/her. -He/She was really only there for the beginning part because he/she was pulled to a different dining room to check on a different resident. -When he/she was with the other resident a staff member had told him/her that something was going on in the dining room. -A nurse and CMT A were in the dining room already, so he/she didn't go back.Observation and interview on 10/21/25 at 3:06 P.M. Resident #4 showed:-A yellowing bruise and scabbed cut near his/her right eyebrow. -On the back of Resident #4's head, he/she has a grouping of scabs about the size of a tennis ball-He/She did not remember getting into a fight with Resident #3 in the dining room. -He/She had no idea how he got the marks on his/her face or the back of his/her head. During an interview on 10/21/25 at 3:26 P.M. Resident #1 said:-Resident #5 and Resident #4 were arguing at the table. -Resident #5 called Resident #3 over to the table because Resident #4 wouldn't leave the table. -He/She heard something along the lines of get away from the motherfucking table.-Resident #3 went over to the table to talk to Resident #4. -Resident #4 grabbed Resident #3's shirt when he got to the table. -He/She didn't see anything after that.During an interview on 10/23/25 at 9:32 A.M. Resident #6 said:-He/She mainly just saw Resident #3 hitting Resident #4. -He/She wasn't really sure what was going on. -Physical contact was made between both of them. -They hadn't been physical with each other before.NOTE: Review of Resident #6's Quarterly MDS dated [DATE] showed the resident was cognitively intact.During an interview on 10/21/25 at 2:31 P.M. the Maintenance Assistant said:-He/She was walking through the dining room. -Resident #3 was standing over Resident #4 when he/she was walking through. -He/She now assumed that Resident #4 was probably getting smart with Resident #5 and that was why Resident #3 was standing over Resident #4. -It seemed like they were just whispering to each other. -He/She was told afterwards that Resident #4 told Resident #5 to move because Resident #5 was sitting at Resident #4's table. -He/She had stopped by the break room because he/she saw cake and then he/she heard Dietary Aide A yell for help. He/She looked back into the dining room and saw Resident #4's wheelchair pushed over with Resident #4 still sitting in it and Resident #3 was punching (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265355	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Grandview	6301 East 125th St Grandview, MO 64030

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 - Actual harm Residents Affected - Few	Resident #4. -He/She pulled Resident #3 away from Resident #4 and then more staff arrived. -Resident #4 had bruises to his/her upper right eye/forehead area and some bruising to the back of his/her head. -Resident #3 was normally very quiet. Resident #3 and Resident #4 had never had any issues before that day. During an interview on 10/21/25 at 2:50 P.M. Certified Nursing Assistant (CNA) B said:-He/She heard someone calling for help and responded. -Once he/she was in the dining room Resident #3 and Resident #4 were already separated. -Resident #4 was on the ground still. -He/She was the one who brought Resident #4 to the nurse's station. -Resident #4 had a cut to his/her right eyebrow and some marks on the back of his/her head.During an interview on 10/23/25 at 8:58 A.M. Dietary Aide A said:-He/She had finished passing out trays and saw Resident #3 and Resident #4 talking. -Their tones weren't elevated. -He/She didn't see anything alarming at first. -Then he/she turned around and saw Resident #3 on top of Resident #4 and Resident #4's wheelchair was on the floor. -Resident #3 was punching Resident #4. -He/She assumed Resident #4 was getting hit in the face. -He/She was not sure if Resident #4 hit Resident #3 at all. -Staff responded after calling for help and the Maintenance Assistant separated Resident #3 from Resident #4. -He/She was not involved in the aftermath. -Resident #3 and Resident #4 had gotten into it with each other before, but it has been months ago. -Resident #3 and Resident #4 never escalated to physical aggression though. -Both Resident #3 and Resident #4 were prone to name calling but had no physical aggression history to his/her knowledge.During an interview on 10/23/25 at 9:14 A.M. Nurse Practitioner (NP) A said:-Resident #4 does have a behavioral history but was not sure of specifics because he/she didn't have the resident's chart in front of him/her. -He/She did not think that there has been any physical aggression in Resident #4's past.-The facility had a standing order to send out residents after altercations, so the facility's interventions were appropriate.During an interview on 10/23/25 at 9:49 A.M. Facility Physician A said:-He/She was unsure of the specifics of any behaviors. -He/She hadn't had to interact with Resident #3 much recently and had not seen him/her post incident yet. -He/She understood that NP B put him/her back on the Buspar as the main intervention. -The medication change wouldn't be enough time since the incident to know if it had been effective yet. -There were no known previous altercations between Resident #3 and Resident #4 or other residents to his/her knowledge.-Resident #3 probably didn't need to be sent out because the emergency rooms typically send residents right back for that kind of situation. -To his/her knowledge staff have done everything post-incident correctly. -He/She did not think the altercation could have been prevented.During an interview on 10/23/25 at 10:36 A.M. the Activities Assistant said:-He/She was in his/her office. -He/She heard a boom and residents yelling. -He/She initially thought someone fell. -He/She ran into the dining room. -He/She saw Resident #4's wheelchair was tipped over. -Resident #3 was punching Resident #4's face. -He/she was yelling at them to stop and then tried to grab Resident #3. -He/She was not strong enough, so the Maintenance Assistant ended up separating them.-Resident #4 appeared very scared and had a cut on his/her eyebrow bruising was already forming. -He/She helped Resident #4 up with another staff person. -Resident #3 and Resident #4 had no history of altercations with each other.During an interview on 10/23/25 at 11:03 A.M. the DON said:-The altercation that occurred counted as abuse.-He/She was told that Resident #4 was sitting next to Resident #5. -No staff member or resident could confirm what was said outside of a conversation happening. -Resident #5 looked like he/she was in distress and Resident #3 went to help. -When Resident #3 arrived at the table he/she asked Resident #5 what happened, and Resident #5 said that Resident #4 was bothering him/her. -Resident #3 told the DON that he/she was standing in front of Resident #4. Resident #3 bent over to be eye level with Resident #4. -Resident #3 told Resident #4 that Resident #4 needed to pick on someone his/her own size. -Resident #4 then grabbed Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265355	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Grandview	6301 East 125th St Grandview, MO 64030

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 - Actual harm Residents Affected - Few	#3's shirt, pulled Resident #3 forward, and chest bumped Resident #3 with his/her fist. -Resident #3 took that as a threat and proceeded to strike Resident #4. -Resident #3 hit Resident #4 three to four times. -Resident #4 did end up on the floor. -Staff then separated the residents. -He/She made it down to the dining room and took Resident #3 back to his room. -He/She did 1:1 monitoring until EMS arrived. -He/She also got Resident #3's statement and performed an assessment. -Resident #3 voiced that he/she was doing his/her appropriate duties. -Resident #3 understood that he/she could have responded differently.-Resident #3 did show remorse after incident.-Resident #4 claimed that he didn't know anything. -Staff did not respond appropriately to the situation. -He/She would have expected staff to stay in dining room during the whole meal and jumped in sooner. During an interview on 10/24/25 at 12:29 P.M. CNA A said: -Resident #3 and Resident #4 had been separated in the past because Resident #4 threatened Resident #3. -Resident #3 liked helping the women in the facility and would go out of his/her way to do so which was the reason Resident #3 was involved in the first incident.3. Review of Resident #11's admission Record showed that he/she was admitted to the facility with a diagnosis of Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety.Review of the resident's Annual MDS dated [DATE] showed the resident had severely impaired cognition.Review of the facility's initial self-report on 10/24/25 showed:-On 10/23/25 at approximately 1:00 P.M. a staff member heard Resident #3 with a raised voice. -Upon turning around to see what was going on, the staff member noted Resident #11 with hot sauce on his/her face. -Resident #3 refused to give complete statement. -Resident #3 stated you just going to be blame me anyway. -Resident #3 was immediately placed on 1:1 monitoring. -Resident #11 stated that Resident #3 threw the hot sauce at him/her. -Upon investigation, Resident #3 and Resident #11 were at the table in the dining room speaking to each other. -Resident #3 said they were joking with each other and then Resident #3 told Resident #11 if he/she were to throw at himself/herself, then he/she was going to throw it back at Resident #11. -Resident #11 threw juice at Resident #3 and Resident #3 threw hot sauce at Resident #11. -Hot sauce got on Resident #11's face. -Staff immediately separated the residents. -Resident #11's eyes were washed out with no injury noted. -Resident #3 continued to have aggressive behaviors which included yelling at staff and stomping in hallways. -Orders were received to send resident to the emergency room for eval due to his/her behavior. -EMS and police on site, as resident was going with EMS, he/she stated to the Administrator, you started so I am going to finish it!During an interview on 10/24/25 at the local hospital at 8:45 A.M. Resident #3 said:-He/She felt that they just want him out of the facility.-They are treating him/her like he/she was the bad guy in this situation. -He/She was always joking around with Resident #11. They are pretty close to each other. -He/She was just trying to be funny and went overboard. -Resident #11 was always playfully hitting, kicking, and throwing water at him/her.-Normally everything was fine, and he/she didn't realize that he/she wasn't in the mood yesterday for joking around.During an interview on 10/24/25 at 10:08 A.M. Resident #12 said:-Resident #3 and Resident #11 were always joking with each other. -Resident #3 told Resident #11 to throw the coffee at Resident #3 and Resident #3 did.-He/She was not sure if coffee was hot. -Resident #3 knew better, but Resident #11 did not know any better. -He/She thought it was coffee that was thrown on Resident #3. -He/She is a dining room table mate of Resident #3 and Resident #11. -Resident #11 must not have been in a good mood. NOTE: Review of the resident's Quarterly MDS dated [DATE] showed the resident had severely impaired cognition.During an interview on 10/24/25 at 10:16 A.M. Resident #6 said:-Resident #3 threw hot sauce at Resident #11's face. -They were just playing at first and then it got serious. -Usually, they play around with each other. -Resident #3 had been out of control lately. -Resident #3 needed to work on his behavior.During an (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265355	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Grandview	6301 East 125th St Grandview, MO 64030

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 - Actual harm Residents Affected - Few	interview on 10/24/25 at 10:20 A.M. the facility's van driver said:-Resident #3 and Resident #11 were usually friendly teasing each other. -Sometimes Resident #11 was not up to it.-Resident #3 was normally really mellow. -Resident #3 did not have behaviors normally.Observation and interview on 10/24/25 at 11:25 A.M. Resident #11 showed:-His/her eyes were free from injury, and no redness was noted.-He/She thought she remembered the incident, but when SA started questioning him/her about it he/she had not remembered. -He/She thought he/she normally got along well with Resident #3. -He/She could not confirm that they always were playing around with each other. -He/She was worried that Resident #3 had done it on purpose. During an interview on 10/24/25 at 11:42 A.M. the Social Services Designee said:-A staff member informed him/her that Resident #3 threw hot sauce in Resident #11's face. -He/She went with the Administrator to Resident #3's room. -They asked Resident #3 how he/she was doing. -Resident #3 responded poorly, he/she started pacing and saying that they wouldn't believe him/her anyway. -When asked when they could come back to chat and Resident #3 said, try two fucking days. -Then they went to check on Resident #11.During an interview on 10/24/25 at 12:55 P.M. LPN C said: -Resident #3 was very protective of Resident #11.-To his/her knowledge Resident #3 did not have any known triggers that would have caused the altercations.During an interview on 10/24/25 at 2:48 P.M. LPN D said:-Resident #3 and Resident #11 were sitting in the dining room.-He/She heard a noise and came over to the table that Resident #3 and Resident #11 were sitting at. -The table had juice and hot sauce all over it. -Resident #3 looked like he/she was going to hit Resident #11, but staff intervened in time and separated the residents. -When he/she looked at Resident #3, he/she had hot sauce all over his/her face and was afraid that it was in his/her eyes.-Resident #11 and Resident #3 normally got along just fine, but he/she never noticed them playing around or teasing each other.During an interview on 10/27/25 at 10:47 A.M. the DON said:-He/She was not at the facility during the altercation. -It was playful teasing until it wasn't. -Resident #3 and Resident #11 were tablemates in the dining room and had no issues with each other prior to the incident.-He/She would consider the situation abuse because Resident #3 showed intent to harm Resident #11. -The altercation could not have been prevented. 2645298, 2640530, and 2551465

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265355	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Grandview	6301 East 125th St Grandview, MO 64030

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one sampled resident (Resident #3) was allowed back to the facility when the facility completed an Immediate Notice of Involuntary Discharge when they sent the resident to a local hospital on [DATE] out of 13 sampled residents. The facility census was 106 residents.Review of the facility's policy titled Notices of Transfers and Discharges dated 8/5/25 showed no policy related to immediate notice of involuntary discharges.1. Review of Resident #3's admission Record showed that he/she was admitted to the facility with a diagnosis of Diabetes Mellitus (DM II- a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin).Review of the resident's Quarterly Minimum Data Set (MDS)(a federally mandated assessment instrument completed by facility staff) dated 8/7/25 showed:-The resident had moderately impaired cognition.-The resident had not exhibited any behaviors within the look back period.Review of the resident's Immediate Notice of Involuntary discharge date d 10/23/25 showed:-The resident would be forced to discharge from the facility.-The resident was being sent to a local hospital.-The safety of individuals in the facility was endangered.-The health of individuals in the facility would be otherwise endangered.-The resident was involved in a resident-to-resident altercation on 10/16/25.-The resident was involved in a resident-to-resident altercation on 10/23/25.-The resident was threatening residents and staff.Review of an emergency room Note dated 10/23/25 showed the resident was being admitted to the hospital with a primary diagnosis of Social admission Secondary to Facility Refusal for Taking Patient Back.During an interview on 10/24/25 at 8:45 A.M. the resident said:-He/She didn't know what is going on. -No one has updated him/her on anything. -He/She felt that the Administrator just want him/her out of the facility. -He/She was really upset because he/she wanted to go back to the facility because that was his/her home.During an interview on 10/24/25 at 11:04 A.M. the Administrator said:-The resident would not be allowed back to the facility.-He/She did not feel the facility was adequately equipped to take care of the resident.During an interview of 10/24/25 at 11:42 A.M. the Social Services Designee (SSD) said:-He/She had sent multiple referrals to other facilities in the area after the second resident-to-resident altercation that the resident was involved in. -The facility was not equipped to handle the resident's behaviors.-He/She had sent the Ombudsman (resident advocate) the Immediate Notice of Involuntary Discharge letter on 10/23/25.During an interview on 10/27/25 at 10:35 A.M. the Director of Nursing (DON) said:-The resident had to go. -He/She was sent to the hospital for increased behaviors and now couldn't come back to the facility. -He/She understood that the facility was not meeting regulation by not accepting the resident back, and by not providing a reevaluation after he/she received the necessary treatment. 2651315