STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265822	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2023
NAME OF PROVIDER OR SUPPLIER: Bridgewood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 11515 Troost, Kansas City, MO 64131	

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 - Immediate jeopardy to resident health or safety 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** 37608 Based on observation, interview and record review, the facility failed to ensure six sampled residents (Resident #29, #35, #26, #25, #33, and #44) were free from abuse. On 12/14/23 Resident #1 with known aggressive behaviors struck Resident #29 multiple times on the top of his/her head and torso with a metal chair causing multiple contusions to the right side of his/her head and above the hairline. He/she also sustained bilateral rib fractures to ribs 2 through 8, deep defensive wounds to both hands and a left hip red contusion with indentation. Also, on 12/1/23, Resident #36 punched Resident #35 in the mouth resulting in Resident #35 needing two stitches in his/her lower right lip. On 12/10/23, Resident #31 punched Resident #26 in the mouth resulting in Resident #26's lip to be split. On 12/10/23, Utility Aide A placed his/her hands on both of Resident #33's shoulders from behind and pushed the resident down the hall towards the resident's room. On 12/16/23, Resident #30 hit Resident #25 in the right jaw resulting in breaking Resident #25's jaw and on 12/16/23, Utility Aide B struck Resident #44 in the back of his/her head. This effected six out of 26 sampled residents. The facility census was 163 residents. The Administrator was notified on 12/14/23 at 4:30 P.M., of the Immediate Jeopardy (IJ) which began on 12/14/23. The IJ was removed on 12/18/23, as confirmed by surveyor onsite verified. Review of the facility's Abuse and Neglect policy, updated 1/5/23, showed: -Physical abuse was defined as purposely beating, striking, wounding, or injuring another resident or mistreating or maltreating a resident in a brutal of inhumane manner. Physical abuse included hitting, slapping, punching, biting and kicking, and also included corporal punishment. -The facility was committed to protecting residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members, legal representatives, friends or any other individual. -Prevention will include assessment, care planning, and monitoring of residents with needs or behaviors which may lead to conflict. 1. Review of Resident #1's Level One Nursing Facility Pre-Admission Screening for Mental Illness, Intellectual Disability or Related Condition (PASRR), date 6/24/16, showed: -Mood swings of manic behavior and depression. (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: 265822	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewood Health Care Center	11515 Troost Kansas City, MO 64131

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	-Paranoid and visual hallucinations. -Delusional. -Flight of Ideas. -Difficulty interacting appropriately/communicating effectively with others. -Difficulty in adapting to typical changes associated with social interactions. -Manifests agitation, exacerbated signs and symptoms associated with the illness. -History of altercations, evictions, firing, and fear of strangers. -Poor insight and judgement. -Mild Intellectual Disability. -Mood swings of manic behavior and depression. -Paranoid and visual hallucinations, delusions. Review of Resident #1's facility face sheet showed the resident admitted to the facility on [DATE] with the following diagnoses: -Paranoid Schizophrenia (characterized by predominantly positive symptoms of schizophrenia, including delusions and hallucinations). -Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). -Anxiety Disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). -Depression (a depressed mood or loss of pleasure or interest in activities for long periods of time). -Borderline Personality disorder (BPD - a mental illness marked by an ongoing pattern of varying moods, self-image, and behavior). -Schizophrenia (A disorder that affects a persons ability to think, feel and behave clearly). -Impulse Disorder. Review of the resident's care plan, dated 7/28/23, showed: -The resident had a Guardian that will assist in decision making due to mental illness. (continued on next page)

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	-Monitor behavior episodes and attempted to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. -The resident uses psychotropic medications related to paranoid schizophrenia. -The resident uses antidepressant medication related to depression. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool used by the facility for care planning purposes), dated 11/9/23, showed: -He/she was severely cognitively impaired. -He/she had physical behaviors directed toward others one to three days a week. Review of Resident #29's facility face sheet showed the resident admitted to the facility on [DATE] with the following diagnoses: -Stroke. Review of Resident #29's admission MDS, dated [DATE], showed the resident was severely cognitively impaired. Review of Resident #29's care plan, dated 12/4/23, showed: -He/she was at risk for impaired communication. -Allow adequate time for resident's response. -Provide clear, simple instructions. Review of Resident#29's Incident Note, dated 12/14/23 at 2:35 A.M., showed: -The resident was on the medical unit in COVID isolation and was verbally and physically assaulted by Resident #1. Resident #29 was transferred to the hospital and Resident #1 was transferred to a different hospital. Licensed Practical Nurse (LPN) C notified the on call medical provider and spouse. Review of Resident #1's Incident Note, dated 12/14/23 at 2:49 A.M., showed: -The resident was on the medical unit in COVID isolation and verbally and physically assaulted Resident #29. Resident #29 was transported to the hospital and Resident #1 was transferred to a different hospital. LPN C notified the on-call medical provider and Power of Attorney (POA) for Resident #1. When Resident #1 was asked, he/she stated that he/she beat Resident #29 up and told him/her that he/she was not gay and that he/she had a spouse. Resident #1 did not specify what caused him/her to beat up Resident #29. A Code [NAME] (additional assistance needed from staff) was called and Resident #1 was taken out of the room. Resident #1 displayed disorganized thinking and looseness of association. A skin assessment was performed on Resident #1 with no redness, bruising, or open areas noted at the time of the assessment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #29's Incident Note, dated 12/14/23 at 10:55 A.M., showed: -When LPN C entered Resident #1 and Resident #29's room, Resident #29 was laying on the floor. LPN C saw blood and instructed a staff to get the crash cart. LPN C instructed another staff member to call 911 and Certified Nurses Aide (CNA) B to wait at the front door to let EMS in when they arrived. Upon accessing Resident #29, he/she was alert and oriented and did not communicate that he/she was in any pain when asked. Resident #29 had blood coming from his/her head area on the side that he/she was laying on. Resident #29 also had blood on his/her hand toward the wrist and the area was exposed. Review of the facility's Registered Nurse (RN) Investigation, dated 12/14/23, showed: -The Director of Nursing (DON) completed the investigation. -This incident was not witnessed. -About 1:00 A.M. on 12/14/23, a Code [NAME] was called on the medical unit involving Resident #1 and Resident #29. LPN C was at his/her medication cart and heard loud thumping noises. CNA D went to respond to the sound and saw Resident #29 laying on the floor. LPN C instructed staff to get the crash cart, CNA B to call 911 and wait at the front door to let EMS in when they arrived. Resident #29 was alert and oriented and did not communicate that he/she was in any pain when asked. Resident #29 had blood coming from his/her head area on the side that he/she was laying on. Resident #29 also had blood on his/her hand toward the wrist and area was exposed. A pillow was placed under Resident #29's head. The pillow was placed to make sure Resident #29 was getting oxygen from his/her nasal cannula. A chair was noted flipped over, sitting next to Resident #29. Resident #1 was removed from the room and was being monitored by another staff. EMS arrived and transported Resident #29 to the hospital. Resident #1 was transported by EMS to a different hospital. -CNA B's written statement, dated 12/13/23, showed he/she was sitting at the nurse's station when CNA D called him/her to the COVID unit. Resident #29 was laying face down with a chair over his/her back. Resident #1 said Resident #29 was trying to come on to him/her, so he/she beat Resident #29. After LPN C came into the room, he/she was instructed to get another nurse and call 911 and wait for EMS to arrive. -CNA D's written statement, dated 12/13/23, showed he/she heard a loud crash. He/she went to the COVID unit and saw Resident #29 laying on the floor with a chair on top of him/her. Resident #29 had bone exposed on his/her wrist and bruising to his/her head. Resident #1 was laying in his/her bed. He/she asked Resident #1 if he/she hit Resident #29. Resident #1 said he/she did, because Resident #29 was a homosexual. He/she notified LPN C and stayed with Resident #29 until more help arrived to assist. -CNA C's written statement, dated 12/13/23, showed he/she was sitting at the Nurse's station with CNA B when he/she was called to come to Resident #29's room. Resident #29 was face down on the floor bleeding, with a chair on his/her back. Resident #1 said he/she beat Resident #29 because he/she was not gay, he/she had a spouse. LPN C arrived and told staff to call 911. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-LPN C's written statement, dated 12/14/23, showed he/she was standing at his/her cart and heard loud thumping noises. CNA D went down the hall and checked the rooms. He/she went down the hall behind CNA D after locking his/her cart. CNA D said hurry up it is pretty bad. Resident #29 was on the floor. He/she called a Code Blue (medical emergency) and assistance came. When he/she entered the room Resident #29 was laying on the floor. He/she got his/her vital signs, put a pillow under his/her head, to make sure he/she was getting oxygen via nasal cannula. He/she called 911 and waited with Resident #29 until EMS arrived. When EMS arrived Resident #29 was transported to the hospital. -Conclusion of the investigation read: A loud thumping noise was heard and a staff member went to check in the room. CNA D saw Resident #29 laying on the floor while Resident #1 was laying on his/her bed calmly. CNA D called for LPN C's attention. LPN C saw Resident #29 on the floor and noted blood on the floor and a open area on the right hand with blood on it. EMS was contacted and Resident #29 was sent to the hospital for evaluation. Resident #1 was sent to a different hospital for psych evaluation related to physical aggression. -The incident was identified as abuse. Review of Resident #1 and Resident #29's police report, dated 12/14/23, showed: -On 12/41/23 at 1:13 A.M. police responded to the facility in regard to an assault. -Upon arrival Resident #1 was sitting on the floor outside of his/her room. -Resident #29 was lying flat with his/her face downward, motionless on his/her room floor with apparent blood on his/her lower left arm and around his/her head. -EMS took custody of Resident #29 and advised that he/she was unable to speak due to his/her medical nature. -Resident #1 stated Resident #29 shot him/her with a revolver handgun once in the stomach and once in the head. -Resident #1 advised that Resident #29 began making sexual advances towards him/her by Resident #29 coming close and by Resident #29 shoving his/her foot in Resident #1's face. -Resident #1 advised he/she broke two of Resident #29's toes. -Resident #1 advised that Resident #29 was laying on the ground in their room and that he/she informed staff that Resident #29 was on the floor. -Facility staff gave diagnoses for Resident #1 as Paranoid Schizophrenia, Borderline Personality disorder, Anxiety disorder, Bipolar disorder, and Impulse disorder. -The officer was told Resident #1's Schizophrenia specifically includes sexual assault ideations to where he/she believes others are trying to engage in unwanted sexual acts with him/her. During an interview on 12/14/23 at 10:30 A.M., Hospital Registered Nurse (RN) A said: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/she was the charge nurse for the medical intensive care unit (ICU). -The emergency room (ER) reported Resident #29 was brought in sometime after 1:00 A.M., and had allegedly been assaulted by his/her roommate with a chair. -The hospital placed Resident #29 was on trauma protection status, because he/she was assaulted. During an interview on 12/14/23 at 10:45 A.M., Resident #29's Family Members A, B, and C said: -Family Member A was called by hospital staff and was told the resident was transferred to the hospital after an assault by another resident. -Family Member B said Resident #29 had 6 broken ribs on each side. The resident had only been in the facility for 2 weeks and had been transferred there from the hospital after 3 strokes. During an interview on 12/14/23 at 11:00 A.M., Hospital RN B said Resident #29 was intubated and had 6 fractured ribs bilaterally 2 through 8. Observation on 12/14/23 at 11:00 A.M., of Resident #29 while in the ICU at the hospital showed: -He/she had 3 cuts on the right above his/her hairline all approximately 3-4 centimeters (cm) in length. -He/she had a 6 cm cut at his/her right eyebrow. -He/she had 2 1-2 cm cuts on his/her right eyelid. His/her right eyebrow area was reddened and very swollen. -He/she had a ping pong ball sized contusion and with an indentation to his/her left hip bony prominence which was where the chair was reportedly resting. -Both of the resident's wrists were wrapped as they had reported defensive cuts on both wrists. There was blood seeping through both wrist bandages. The left bandage appeared to be a compression dressing. During an interview on 12/14/23 at 1:46 P.M., Agency CNA B said: -He/she had heard Resident #1 could be aggressive. -He/she last checked on Resident #1 and Resident #29 about 8:00 P.M. It was about 1:00 A.M. when he/she was at the nurse's station with Agency CNA C and CNA D said, come here now, hurry up. -Resident #1 was on the bed with his/her eyes open and following all staff with his/her eyes that entered the room. -Resident #29 was on the floor, face down with a chair on top of his/her back. -Resident #1 said, I beat [him/her] because [he/she] tried to come on to me and I am not gay. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident #29 said nothing and was barely breathing. -The nurse came in with the Assistant Administrator and instructed him/her to leave. -He/she worked on the medical unit and had not had any facility training for resident triggers and or behaviors. -He/she was given report on the residents to care for, but not their triggers. During an interview on 12/14/23 at 1:59 P.M., Agency CNA C said: -CNA D called to him/her and Agency CNA B and said come, come, come with urgency. -Resident #29 was on the floor face down with a padded chair with metal legs on top of his/her back. -Resident #1 said he/she had beat Resident #29. -Resident #1 said he/she was not gay. -Resident #29 was bloody, face down with blood around his/her head, the floor and blood on his/her hands. -Resident #29 was sent to the hospital. -Prior to the incident he/she last checked on the residents about 12:00 A.M. and they were both in bed. -He/she had some training, it was not his/her first time working at the facility, but he/she did not know all of the resident triggers. During an interview on 12/14/23 at 1:17 P.M., Agency LPN C said: -He/she had been working at the facility for about three weeks. -Was told by staff that Resident #1 was not to be approached due to aggression and to call a Code [NAME] when having behaviors. -About 1:30 A.M. on 12/14/23 he/she was at his/her medication cart when he/she heard three loud banging noises and asked CNA B if he/she heard the noise and CNA B said it was the television up front. -CNA D started checking the resident's rooms to see where the noise came from. -CNA D asked this nurse for help in Resident #1 and Resident # 29's room and described the scene as bad. -Resident #29 was on the floor with blood on the floor by his/her head. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/she told other staff to get the crash cart, call 911 and a Code Blue (medical emergency extra staff needed). -Resident #29 was laying twisted on the floor with his/her left arm turned upward and the right arm and hand had blood and a open area. -There was an upside down chair to the left side of Resident #29 on the floor. -He/she assessed Resident #29 for other injuries, took vital signs, and placed a pillow under the resident's head to make sure the resident was getting oxygen through his/her nasal cannula due to low oxygen saturation. -Resident #29 did not respond to any questions he/she asked, eyes were open. -Resident #1 was sitting on his/her bed with knees pulled up and arms raped around his/her legs. -Resident #1 stated he/she was not gay. -He/she called 911 again to see when EMS was going to arrive at the facility. -He/she stayed with Resident #29 until EMS arrived. During an interview on 12/14/23 on 1:35 P.M., the Assistant Administrator said: -About 1:30 A.M., on 12/14/23 staff on the medical unit contacted him/her after they heard banging in a resident room and found Resident #1 agitated and Resident #29 on the floor. -He/she entered the room with the nurse. -Resident #29 was on the ground, he/she looked bruised. -A crash cart was called for. -Resident #1 was isolated. -Resident #29 had blood on or near his/her wrist, it looked like it may have been cut. -Resident #29 said nothing. Resident #1 was rambling. -The police were called. -He/she told the police not to interview Resident #1, because of his/her mental health. -It looked like Resident #1 was aggressive with Resident #29, but no one knows what happened as there was no one in the room at the time but Resident #1 and Resident #29. During an interview on 12/14/23 12:30 P.M., Resident #1 said: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident #29 was touching his/her arm and leg and he/she tried to be nice, but Resident #29 wouldn't stop so that's when he/she hit Resident #29. -He/she hit Resident #29 with a chair. During an interview on 12/15/23 at 12:34 P.M. Nurse Practitioner (NP) said: -There was no level of predictability this incident would happen between Resident #1 and Resident #29. -Did not think putting Resident #1 and Resident #29 would be a problem. -He/she was notified of the incident on 12/14/23. During an interview on 12/15/23 at 1:52 P.M., Hospital RN C said: -Resident #29 had sutures to his/her right wrist from defensive wounds. -He/she had tendon exposure to his/her right wrist. -The assault had most definitely exacerbated Resident #29's underlying co-morbidities and he/she will not live due to this assault. -Resident #29 has not come off the ventilator. During an interview on 12/18/23 at 2:30 P.M., Hospital RN C said Resident #29 passed away on 12/16/23 after family consultation and the resident going into multi-system organ failure. 2. Review of Resident #35's facility face sheet showed the resident admitted to the facility on [DATE] with diagnoses that included: -Autistic Disorder (a developmental disability caused by differences in the brain). -Attention-Deficit Hyperactivity Disorder (a chronic condition including attention difficulty, hyperactivity and impulsiveness). -Major depression. Review of Resident #35's Annual MDS, dated [DATE], showed: -The resident was cognitively intact. -No behaviors towards others exhibited during the assessment period. Review of the Resident #36's PASRR, dated 9/22/23, showed: -Suspicious of others. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Paranoia and delusions. -Alcohol and drug use. -Elopes/leaves the facility. -Auditory hallucinations. -Ongoing delusions that some one is trying to kill him/her. Review of Resident #36's facility face sheet showed the resident admitted to the facility on [DATE] with diagnoses that included: -Paranoid Schizophrenia (characterized by predominantly positive symptoms of schizophrenia, including delusions and hallucinations). -Post Traumatic Stress Disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). -Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). -Anti social personality disorder (person tends to lie, break laws, act impulsively, and lack regard for their own safety or the safety of others). -Schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms). -Major depression. Review of Resident #36's Admission MDS, dated [DATE], showed: -The resident was cognitively intact. -No behaviors towards others exhibited during the assessment period. Review of Resident #36's care plan, dated 10/10/23, showed: -CALM technique employed if needed. -Resident often talks to unseen others and is delusional and paranoid. -Elopement assessment upon admission, readmission and quarterly. -Provide calming and reassuring environment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident may often have difficulty communicating due to racing thoughts or inability to concentrate, avoid rushing the resident and allow him/her more time to answer or respond to promote security and still a sense of value. Review of the facility's Registered Nurse (RN) Investigation, dated 12/1/23, showed: -Type of incident showed physical aggression involving head. -Persons involved in the incident were Resident #35 and Resident #36. -Statements were received from one witness and the affected resident. -The guardian and the physician were notified by the charge nurse for both residents. -Code [NAME] was called on Resident #36 for physical aggression. -Resident #36 was in the hangout smoking, sitting next to Resident #35. -Resident #36 hit Resident #35 in the mouth. -Residents were immediately separated. -Physician orders received to send both residents for for psychological evaluation and medical evaluation respectively. -Resident #36 reports that he/she hit the resident, because he/she raped somebody and that God told him/her to hit Resident #35. -The incident was not preventable as Resident #36 did not exhibit any agitation or anxiety prior to hitting Resident #35. -Resident #36 has a diagnosis of Paranoid schizophrenia (a part of a spectrum of related conditions that involve psychosis) and auditory hallucinations. Review of Resident #35 and Resident #36's police report, dated 12/1/23, showed: -On 12/1/23 at 4:25 P.M. police responded to the facility in regard to a disturbance. -Resident #36 stated he/she punched Resident #35 outside while smoking, because Resident #35 raped resident. -Resident #36 stated he/she did not say anything to staff, because the female did not say anything about the rape. -Resident #35 stated he/she was outside and Resident #36 walked up to him/her and punched him/her in the lip. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bridgewood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11515 Troost Kansas City, MO 64131	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Activities Aide B stated he/she was outside when he/she saw Resident #36 walk up to Resident #35 while outside smoking and punch Resident #35 in the face. -Resident #35 was observed to have a busted lip and Resident #36 had a small scar on the left knuckle. -Staff requested Resident #35 to be sent to one hospital for evaluation and treatment and Resident #36 be sent to a different hospital due to aggression. During an interview on 12/6/23 at 1:43 P.M., Activity Aide B said: -Resident #36 asked for two cigarettes and went to sit on a bench. -Resident #35 was already sitting on a different bench. -Resident #36 got up and walked over to Resident #35 and hit Resident #35 in the mouth. -Resident #36 sat back down just as calmly, but you could see anger in his/her face after the incident. During an interview on 12/6/23 at 1143 A.M., Resident #35 said: -He/she had two stitches in his/her bottom left lip. -He/she had only been on the men's unit and did not interact with female residents. -He/she did not know why Resident #36 hit him/her in the mouth. -He/she feels safe living at the facility. -His/her guardian was looking to transfer him/her to a different facility. -He/she wants assault charges pressed on Resident #36. -He/she was doing good, will be glad when the stitches come out, he/she had very little to no pain. During an interview on 12/14/23 at 3:00 P.M., Deputy Case Manager A said: -Resident #36's explanation for hitting Resident #35 was not based in reality. -Resident #36 lacked basic reasoning skills. -It had been a common issue for Resident #36 to attack unprovoked, others around him/her at prior placements. -Resident #36 was increasingly agitated and there was nothing the facility staff would have been able to do to know or prevent Resident #36 from attacking another resident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Review of Resident #26's facility face sheet showed the resident admitted to the facility 8/22/23 with diagnoses that included: -Paranoid Schizophrenia. -Schizoaffective Disorder. -Antisocial Personality Disorder. -Major Depression. -Attention Deficit Hyperactivity Disorder. -Malingerer (to pretend or exaggerate incapacity of illness). Review of Resident #26's Quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment. -No untoward behaviors exhibited during the assessment period. Review of Resident #31's PASSR, dated 4/27/23, showed: -Delusional thoughts and behaviors. -Traumatic brain injury. -Disturbance in thought process, reality testing and paranoia. -Reports that he/she was Jesus. -Expansive mood, racing thoughts, risk taking behavior, grandiosity, distractibility, mood liability. -Wandering and agitation. Record review of Resident #31's facility face sheet showed the resident admitted to the facility on [DATE] with diagnoses that included: -Paranoid Schizophrenia. -Schizoaffective Disorder. -Post Traumatic Stress Disorder. -Bipolar Disorder. -Attention Deficit Hyperactivity Disorder. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Major Depression. Review of Resident #31's care plan, dated 6/19/23, showed: -Assessment and implementation of behavioral support plan. -Monitoring of behavioral symptoms. -Provide for individual personal space. -Establish consistent routines. -Provide schedule of daily tasks and activities. -Crisis plan should identify clear steps that will be taken to support individual during a crisis situation, specify who to contact for assistance, how staff should work together with individual during the crisis, as well as identify when the physician, emergency medical services and/or law enforcement should be contacted. Review of Resident #31's Quarterly MDS, dated [DATE], showed: -The resident was cognitively intact. -Delusions, behavioral symptoms not directed toward others and wandering occurred during the assessment period. Review of the facility's RN investigation, dated 12/10/23, showed: -Type of incident showed physical aggression involving head. -Persons involved in the incident were Resident #26 and Resident #31. -Statements were received from one witness and the affected residents. -The guardian and physician were notified by the charge nurse for both residents. -Code [NAME] was called for physical aggression involving Resident #31. -Resident #31 was informed by another resident that one of his/her peers, Resident #26, had his/her phone charger. -Resident #31 confronted Resident #26 and was told that he/she did not have his/her phone charger. -Resident #31 swung at Resident #26 hitting him/her on the left side of the mouth. -Residents were immediately separated. -Resident #26 was noted to have a small cut on both the upper and lower lips. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Resident #31 was moved to the front hall and placed on 1:1 observation. During an interview on 12/11/23 at 2:31 P.M., Administrator in Training (AIT) H said: -When he/she passed Resident #31 and Resident #26 in the hallway they were just talking in normal voices about a phone charger. Then he/she heard something hit the floor and turned around and went to separate the two residents. -It was a Bible that hit the floor. -A Code [NAME] was called on the unit. -Resident #31 accused Resident #26 of stealing his/her phone charger. -When Resident #26 denied having the phone charger that was when Resident #31 hit Resident #26 in the mouth. During an interview on 12/11/23 at 2:11 P.M., Resident #26 said: -How do I keep walking away from other residents when they keep hitting me? -He/she was frustrated, because he/she is getting hit. During an interview on 12/11/23 at 2:46 P.M., Resident #31 said: -He/she was tired of being at the facility and wants out. -Was told he/she would only be at the facility for 90 days for medication adjustment. -His/her phone charger was stolen by another resident. -He/she was told that Resident #26 had taken his/her phone charger. -He/she was very angry during the interview and was yelling that he/she wanted out of the facility and he/she was about to fight. 34927 4. Review of Resident #25's face sheet showed he/she admitted on [DATE] with the following diagnosis: -Schizophrenia. -Anxiety. -Depression. Review of the resident Quarterly MDS, dated [DATE], showed he/she was cognitively intact. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #30's PASRR, dated 12/27/21, showed: -He/she had the following diagnosis: Schizoaffective Disorder and Bi-polar Disorder. -He/she was verbally abuse, verbally threatening, cursed and swore, disturbed others, and was physically threatening. -He/she had difficulty staying on track of conversation and would jump from one topic to another. -He/she used a wheelchair unassisted. Review of Resident #30's face sheet showed he/she admitted on [DATE] with the following diagnosis: -Depression. Chronic Obstructive Pulmonary Disorder (COPD). -Headaches. Review of the resident's Annual MDS, dated [DATE], showed he/she was cognitively intact. Review of the facility investigation, dated 12/16/23, showed: -There was incident was physical aggression involving the head. -Resident #25 was sent to the hospital for evaluation. -Resident #30 had asked Resident #45 for chocolates. Resident #25 had brought a teddy bear for Resident #45. Resident #25 asked Resident #30 if he/she wanted to see the bear. Resident #30 said Resident #25 touched him/her and then Resident #30 hit Resident #25. -Resident #25 returned from the hospital with a displaced mandibular condyle inferiorly (upper jaw bone) and flattening; -Resident #25's new orders indicated medication for pain management, a soft food diet and follow-up with the maxillofacial surgical team. Review of Resident #25's hospital clinical summary, dated 12/16/23, showed: -He/she received received a CT Scan (imaging test to detect internal injuries) of the maxillofacial bones (bones of the face) without contrast. -He/she had a minimal inferior displacement of the left mandibular condyle without significant dislocation and chronic flattening of the left mandibular condyle. -He/she was provided Naproxen at 500 milligrams (mg) for pain management. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #45's Quarterly MDS, dated [DATE], showed he/she was mildly cognitively impaired. During an interview on 12/18/23 at 9:41 A.M., Resident #45 said: -Resident #30 had come to get candy from him/her and Resident #25 had come to give him/her a gift. -Resident #30 and Resident #25 got into a fight, Resident #30 hit Resident #25 and Resident #25 hit Resident #30. -Resident #30 and Resident #25 were cussing loudly. Review of the police report, date

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34927 Based on interview and record review, the facility failed to provide a discharge notice for one sampled resident (Resident #36) out of 26 sampled residents. The facility census was 163 residents. Review of the facility's Resident Transfer/Discharge, Immediate Discharge, and Therapeutic Leave Policy, dated 7/12/22, showed: -A facility-initiated transfer or discharge was a transfer or discharge which the resident objected to, which did not originate through a resident's verbal or written request, and/or was not in alignment with the resident's stated goals for care and preferences. -Discharge referred to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community when return to the original facility was not expected. -The facility could discharge or transfer a resident as a facility-initiated transfer or discharge for the following reasons: the resident's needs or welfare could not be met by the facility; the safety of individuals in the facility was endangered. -With the exception of ceasing to operate, the resident's medical record must be documented with the reason(s) for any facility initiated discharge. -Residents who were sent emergently to the hospital were considered facility-initiated transfers, because the resident's return was generally expected. -Residents who were sent to the emergency room must be permitted to return to the facility, unless the resident met one of the criteria under which a facility could initiate a discharge. -The facility should work with the hospital to determine if the resident's condition and needs upon discharge from the hospital were within the scope of care. -Any decision to immediately discharge a resident should be approved by the administrator or his/her designee. Immediate discharge may be appropriate in the following circumstances: suicide attempt, actual harm to self or others, leaving against medical advice, and repeat and total destruction of property of the facility or others. -When the facility transferred or discharged the resident to another facility or provider, the following information, (at a minimum), should be provided to the new facility or provider: contact information for the physician responsible for the care of the resident; the resident's representative; advance directive information; all special instructions or precautions for ongoing care, as appropriate; comprehensive care plan goals; all other necessary information, including a copy of the resident's discharge summary, to ensure a safe and effective transition of care. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident #36's Level One Nursing Facility Pre-Admission Screening for Mental Illness, Intellectual Disability or Related Condition (PASRR), dated 9/22/23 showed: -Suspicious of others. -Paranoia and delusions. -Alcohol and drug use. -Elopes/leaves the facility. -Auditory hallucinations. -Ongoing delusions that some one is trying to kill him/her. Review of the resident's facility face sheet showed the resident admitted to the facility on [DATE] with the following diagnoses: -Paranoid Schizophrenia (characterized by predominantly positive symptoms of schizophrenia, including delusions and hallucinations). -Post Traumatic Stress Disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). -Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). -Anti social personality disorder (person tends to lie, break laws, act impulsively, and lack regard for their own safety or the safety of others). -Schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms). -Major depression. Review of the resident's care plan, dated 10/10/23, showed: -Resident often talks to unseen others and was delusional and paranoid. -Elopement assessment upon admission, readmission, and quarterly. -Provide calming and reassuring environment. -Resident may often have difficulty communicating due to racing thoughts or inability to concentrate, avoid rushing the resident and allow him/her more time to answer or respond to promote security and still a sense of value. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Admission Minimum Data Set (MDS- a federally mandated assessment tool used by the facility for care planning purposes), dated 10/5/23, showed he/she was cognitively intact. Review of the facility's Registered Nurse (RN) Investigation, dated 12/1/23, showed the resident was sent to the hospital for psychiatric evaluation. During an interview on 12/29/23 at 2:21 P.M., Hospital Social Worker A said: -The facility had not provided a letter of discharge, only refusal to take back. During an interview on 1/2/24 at 10:24 A.M., Hospital Social Worker A said: -On 12/5/23, the facility's Customer Service Consultant said they had not provided discharge to the resident, but they would probably move the resident to another sister facility. -The facility provided no 30 day discharge notice, no letter at all. During an interview on 1/2/24 at 10:54 A.M., Ombudsman A said: -On 12/18/23, the hospital social worker had reached out regarding the facility responsibility regarding discharge planning. -The facility had not provided a letter of notice or intent to discharge the resident and was failing to allow the resident to return. During an interview on 1/2/24 at 10:13 A.M., the Administrator said the resident was never given a notice of discharge. MO00229590

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34927 Based on interview and record review, the facility failed to allow one sampled resident (Resident #36) to return to the facility after a hospital admission out of 26 sampled residents. The facility census was 163 residents. Review of the facility's Resident Transfer/Discharge, Immediate Discharge, and Therapeutic Leave Policy, dated 7/12/22, showed: -A facility-initiated transfer or discharge was a transfer or discharge which the resident objected to, which did not originate through a resident's verbal or written request, and/or was not in alignment with the resident's stated goals for care and preferences. -Discharge referred to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community when return to the original facility was not expected. -The facility could discharge or transfer a resident as a facility-initiated transfer or discharge for the following reasons: the resident's needs or welfare could not be met by the facility; the safety of individuals in the facility was endangered. -With the exception of ceasing to operate, the resident's medical record must be documented with the reason(s) for any facility initiated discharge. -Residents who were sent emergently to the hospital were considered facility-initiated transfers, because the resident's return was generally expected. -Residents who were sent to the emergency room must be permitted to return to the facility, unless the resident met one of the criteria under which a facility could initiate a discharge. -The facility should work with the hospital to determine if the resident's condition and needs upon discharge from the hospital were within the scope of care. -Any decision to immediately discharge a resident should be approved by the administrator or his/her designee. Immediate discharge may be appropriate in the following circumstances: suicide attempt, actual harm to self or others, leaving against medical advice, and repeat and total destruction of property of the facility or others. -When the facility transferred or discharged the resident to another facility or provider, the following information, (at a minimum), should be provided to the new facility or provider: contact information for the physician responsible for the care of the resident; the resident's representative; advance directive information; all special instructions or precautions for ongoing care, as appropriate; comprehensive care plan goals; all other necessary information, including a copy of the resident's discharge summary, to ensure a safe and effective transition of care. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident #36's Level One Nursing Facility Pre-Admission Screening for Mental Illness, Intellectual Disability or Related Condition (PASRR), dated 9/22/23 showed: -Suspicious of others. -Paranoia and delusions. -Alcohol and drug use. -Elopes/leaves the facility. -Auditory hallucinations. -Ongoing delusions that some one is trying to kill him/her. Review of the resident's facility face sheet showed the resident admitted to the facility on [DATE] with the following diagnoses: -Paranoid Schizophrenia (characterized by predominantly positive symptoms of schizophrenia, including delusions and hallucinations). -Post Traumatic Stress Disorder (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). -Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). -Anti social personality disorder (person tends to lie, break laws, act impulsively, and lack regard for their own safety or the safety of others). -Schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms). -Major depression. Review of the resident's care plan, dated 10/10/23, showed: -Resident often talks to unseen others and is delusional and paranoid. -Elopement assessment upon admission, readmission and quarterly. -Provide calming and reassuring environment. -Resident may often have difficulty communicating due to racing thoughts or inability to concentrate, avoid rushing the resident and allow him/her more time to answer or respond to promote security and still a sense of value. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Admission Minimum Data Set (MDS- a federally mandated assessment tool used by the facility for care planning purposes), dated 10/5/23, showed he/she was cognitively intact. Review of the facility's Registered Nurse (RN) Investigation, dated 12/1/23 showed the resident was sent to the hospital for psychiatric evaluation. During an interview on 12/29/23 at 2:21 P.M., Hospital Social Worker A said: -The resident was ready for discharge and to return to his/her original placement on 12/18/23. -The facility had not provided a letter of discharge, only refusal to take back. -The facility had abandoned the resident at the hospital. During an interview on 1/2/24 at 10:24 A.M., Hospital Social Worker A said: -On 12/5/23, the facility's Customer Service Consultant said they had not provided discharge to the resident, but they would probably move the resident to another sister facility. -On 12/8/23, the Customer Service Consultant said he/she would have to talk to the Administrator regarding the readmission. -On 12/12/23, the Customer Service Consultant was left a message for a return call. -On 12/13/23, the Director of Nursing (DON) said he/she would need to talk to the Customer Service Consultant regarding the placement of the resident to another facility. -On 12/14/23, the Customer Service Consultant was left a message for a return call. -On 12/15/23, the Customer Service Consultant was notified of intent to discharge early the next week in which he/she replied a need to talk with the facility Administrator. -On 12/18/23, the Customer Service Consultant said DMH would have to come out and see if the resident had change of condition. When asked what that meant the Customer Service Consultant said they would have to talk to the Administrator -On 12/19/23, the Customer Service Consultant was spoken to about discharge back to the facility on [DATE]. -On 12/20/23, the Customer Service Consultant was called to coordinate a discharge and reminded the facility they had not gone through the process of a discharge. -On 12/20/23, the Administrator emailed for an update of information on the resident. The Administrator was emailed back asking what was needed and there was no further reply. -On 12/26/23, the Customer Service Consultant said he/she had not heard what the plan was and that he/she needed to talk to the Administrator. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Ombudsman was contacted and said to contact the hotline. During an interview on 1/2/24 at 10:37 A.M., the Customer Service Consultant said: -He/she was in charge for the admission referrals for the Kansas City area for the corporation and this facility was one of the homes. -The hospital called and left several messages and he/she told them DMH would be doing a reevaluation on change of condition. -It was the facility Administrator and admission team's decision to admit or not readmit for all residents. -He/she told the facility Administration the hospital had called or left messages regarding the resident readmission. During an interview on 1/2/24 at 10:54 A.M., Ombudsman A said: -On 12/18/23, the hospital social worker had reached out regarding the facility responsibility regarding discharge planning. -The facility had not provided a letter of notice or intent to discharge the resident and was failing to allow the resident to return. -The Administrator's direct email was provided. -He/she instructed the hospital to make a call to the hotline. During an interview on 1/2/24 at 10:13 A.M., Administrator said: -He/she had received emails regarding the return of the resident and was aware the hospital wanted to return the resident. -He/she had requested follow up information regarding the resident's medications and behaviors and never heard a response back. -Department of Mental Health (DMH) had been contacted to do a change of condition with the resident PASRR while he/she was in the hospital, the hospital was notified of this. -The guardian said the resident had assaulted two people while in the hospital. -The resident was never given a notice of discharge. -He/she would not allow the resident to return because of his/her behaviors. -He/she understood this was not following the facility policy or the regulatory requirement and had to think about the safety of all residents in his/her building. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewood Health Care Center	11515 Troost Kansas City, MO 64131

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO00229590

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37608 Based on interview and record review, the facility failed to make a referral to the state mental health authority for a Level II Preadmission Screening and Resident Review (PASRR) evaluation when Resident #1 experienced a significant change in behavioral health needs requiring a 38-day stay in inpatient psychiatric treatment and when the resident did not respond to current care plan/treatment measures, requiring physical and chemical interventions and multiple hospitalization s related to behaviors. The facility policy did not include when a referral should be made for a Level II evaluation. This deficient practice effected one out of 25 sampled residents. The facility census was 163 residents. Review of the facility PASRR Assessment & DA 124 A & B policy, dated 4/6/17 and reviewed on 7/9/21, showed: -The purpose of the policy is to utilize the PASRR assessment to develop a plan of care that shows continuity from previous history of behaviors and placement. -The policy is to ensure that a procedure is set up that communicates to the Social Services Director, MDS Minimum Data Set (MDS-a federally mandated assessment tool used by the facility for care planning purposes)/Care Plan Coordinator/Case Manager and Director of Nursing (DON) issues and concerns that need to be addressed in the plan of care for the resident to reach and maintain the resident's highest level of mental and psychosocial functioning. -The Customer Service Consultant will give a copy of the PASRR to the DON, MDS/Care Plan Coordinator and Social Services Director. -The DON, MDS/Care Plan Coordinator and Social Services Director will meet and develop a plan of care that shows continuity from previous history of behaviors and placement. -The PASRR will be utilized as an instrument to assist the facility in maintaining as much as possible, previous treatment modalities that were effective in the resident's life prior to placement at the facility. -The MDS Coordinator will ensure that all recommendations made in the PASRR are address in the care plan. -The DA-124 A,B, & C forms will be completed by the MDS Coordinator as needed. -In the event the facility is without an MDS Coordinator, the DON/Assistant Director of Nursing (ADON) will complete. -The policy did not include when a referral should be made to the state mental health authority for a significant change in status. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Comprehensive Care Plans and Baseline Care Plans, dated 1/19/22 showed: -The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. -Review PASRR when applicable, to include any past history into the resident's current plan of care. -The care plan will be oriented toward: --Preventing avoidable declines in functioning or functional levels. --Managing risk factors. --Addressing resident strengths. --Involving resident/family/responsible party. --Assessing and planning for care sufficient to meet the care needs of new admissions. --Involving the direct care staff with the care planning process relating to the resident's expected outcomes, and addressing additional care planning areas that could be considered in the facility setting. Review of Resident #1's Level II Nursing Facility Pre-Admission Screening for Mental Illness, Intellectual Disability or Related Condition (PASRR), dated 6/24/16, showed: -Diagnoses of chronic paranoid schizophrenia and mild intellectual disability. -Potential problem was he/she is paranoid/suspicious of being around people of color. -Mood swings of manic behavior and depression. -Paranoid and visual hallucinations. -Delusional. -Flight of Ideas. -Difficulty interacting appropriately/communicating effectively with others. -Difficulty in adapting to typical changes associated with social interactions. -Manifests agitation, exacerbated signs and symptoms associated with the illness. -Minimal level of combativeness. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Maximum level at causing management problems -Poor for rehabilitation. -History of altercations, evictions, firing, and fear of strangers. -Poor insight and judgement. -Mild Intellectual Disability. -Mood swings of manic behavior and depression. -Paranoid and visual hallucinations, delusions. -Functional limitations in adaptation in last six months. -Precautions were close supervision, assault, fall, and seizure. Review of the resident's hospital discharge summary, dated 7/28/23, showed: -Transferred to hospital on 6/20/23 from a sister facility with chief complaint of violent behavior, -Due to mood instability and psychosis after throwing chairs, a microwave, struck a staff member, became very aggressive towards others, and non-compliance of medications. -Was admitted to the geriatric psychiatric unit. -On 6/21/23, he/she began to become very aggressive against other peers for no reason and threatening harm to others. -He/she pushed a nurse and then was transferred to a more higher acuity unit at the hospital. -Discharge Diagnoses was Schizoaffective disorder. -Other medical problems were: --Schizophrenia (a disorder that affects a persons ability to think, feel and behave clearly). --Paranoid delusion (reflect profound fear and anxiety along with the loss of the ability to tell what is real and what is not real). --Aggressive behaviors. --Acute psychosis (a brief period of delusion, hallucination, disorganized thoughts and/or speech with reduced motivation and/or initiative-taking compared to baseline state). (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--Catatonic schizophrenia (rare severe mental disorder characterized by striking motor behavior, typically involving either significant reductions in voluntary movement or hyperactivity and agitation). --Acute exacerbation of chronic paranoid schizophrenia. -discharged to the facility on [DATE] after 38 days of in-patient psychiatric treatment. Review of the resident's Admission Record showed the resident admitted to the facility on [DATE] with the following diagnoses: -Paranoid Schizophrenia (characterized by predominantly positive symptoms of schizophrenia, including delusions and hallucinations). -Bipolar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). -Anxiety Disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). -Depression (a depressed mood or loss of pleasure or interest in activities for long periods of time). -Borderline Personality (BPD - a mental illness marked by an ongoing pattern of varying moods, self-image, and behavior). -Schizophrenia. -Impulse Disorder. Review of the resident's care plan, dated 7/28/23, showed: -He/she had a PASRR from 6/24/16. -The resident had a Guardian that will assist in decision making due to mental illness. -Monitor behavior episodes and attempted to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. -The resident uses psychotropic medications related to paranoid schizophrenia. -The resident uses antidepressant medication related to depression. -New problem was initiated on 10/13/23, he/she was leaning over a peer and the peer struck him/her and received a laceration below eye and nasal bone fracture. --Intervention was to send him/her to the hospital for evaluation and treatment and redirected. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-New problem was initiated on 10/13/23, he/she had a behavior problem related to paranoid schizophrenia, bipolar and anxiety. --Desired outcome was to ensure protective oversight is provided through next review. --Interventions were: ---8/10/23, resident urinated on the floor and unable to redirect. He/she became agitated and attempted to swing at staff. Five man C.A.L.M. (Crisis Alleviation Lessons and Methods) was done for protection. ---As needed (PRN) medication was administered and effective. ---8/11/23, Code [NAME] (call for additional staff) called due to staff directed him/her to empty his/her trash and he/she kicked the staff member in the stomach. ---He/she calmed down after Code [NAME] called. ---Education was given to him/her and he/she states understanding. ---8/13/23, Code [NAME] due to him/her exhibiting physical aggression towards a staff member. ---He/she attempted to swing at staff however no contact was made. ---He/she was redirected but was very anxious. ---PRN medication was administered. ---He/she was monitored and was able to calm down after PRN medication and sitting on couch. ---8/14/23, he/she was having verbal outbursts, hitting on the table and attempting to throw chairs. ---PRN medications administered. ---9/18/23, he/she refused to take last nights medications. ---Now he/she was exhibiting aggressive and physical behavior as well as verbal. ---New order obtained and administered. ---9/23/23, behavior of cussing at peers and staff, attempting to intimidate peers and staff by striking a Ninja pose and swinging hands, aiming at staff and peers as if he/she was shooting a gun at them, and hit staff member open handed and dug his/her fingernails into the staff members hand. ---PRN medication shot was administered and escorted to his/her room. ---9/24/23, Code [NAME] called, he/she was kicking wheelchairs as he/she walked past them. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	---Removed from situation and escorted to room. ---9/24/23, Code [NAME] called because he/she was exposing him/herself in the common area. ---He/she said his/her friend wanted to see it. ---Was escorted back to his/her room. -Initiated the following interventions on 10/13/23: --Administer medications as ordered. --Monitor/document for side effects and effectiveness. --Caregivers to provide opportunity for positive interaction and attention. --Stop and talk with him/her as passing by. --Intervene as necessary to protect the rights and safety of others. --Approach/speaking a calm manner, divert attention, remove from the situation and take to alternate location as needed. --Monitor behavior episodes and attempt to determine underlying cause. --Consider location, time of day, persons involved, and situations. --Document behavior and potential causes. --Provide a program of activities that is of interest and accommodate his/her status. --Likes to put him/herself on the floor, sit on the floor and sleep on the floor. --He/she had auditory and visual hallucinations, will place him/herself on the floor and scoot, verbal and physical outbursts, likes to intimidate staff by posing in a Ninja stance, will urinate on the floor, kicks wheelchairs as he/she walks by, and runs in hallway. -New problem was initiated on 11/10/23, new problem was added that he/she was having increased aggression, grabbed the arm of a staff and bent it behind him/her, grabbed him/her by the neck/hair and ended up scratching him/her on the chest. --Desired outcome he/she will have fewer delusions and not cause harm. --The interventions were psych to review his/her medications and redirect him/her to his/her room where he/she laid down. --Intervention dated 11/13/23, he/she was making statements about demons breaking his/her bones. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--He/she also states that he/she will rape all the people due to they are dirty. --He/she did request PRN medication. Review of the resident's Behavior Note, dated 9/6/23, showed: -He/she was noted with outburst yelling, hitting on the tables, and throwing chairs. -PRN shot was given and effective. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool used by the facility for care planning purposes), dated 11/9/23, showed: -He/she was severely cognitively impaired. -He/she had physical behaviors directed toward others one to three days a week. Review of the resident's Behavior Note, dated 11/11/23, showed: -He/she was on Medical unit in the hall when this writer walked onto the unit, resident walked up to this writer. -He/she stated, Let me out on the streets, I don't want to be here. -When asked why, he/she pulled his/her pants down and stated they are sticking pencils in my penis and rectum. I am not gay. -When asked who, he/she had no answer. Can you send me to a heterosexual place? -Explained to resident that if his/her Guardian wanted different placement the facility could look for a place for him/her. -He/she then pulled his/her pants down again in front of the nurse, MDS, and Administrator. -The resident was asked to pull clothes up and we could go to his/her room to look at his/his body, he/she agreed. -While in room he/she lifted his/her shirt, chest revealed no issues, his/her lower back had scratches and older abraded area to right side. -He/she pulled pants down to look at legs no new areas, old scabbed areas to right shin, buttocks noted to have chaffing, and superficial scratches. -He/she was incontinent of bladder at times and at times was resistive to being assisted with pericare. -He/she was encouraged to toilet frequently, but not always compliant. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Received a call from the Administration to send him/her to the hospital for evaluation and treatment due to increased physical/aggressive and disruptive behavior. -Physician was notified order received and the resident was sent to hospital. -A voice mail was left for the guardian. Review of the resident's Behavior Note, dated 11/17/23, showed: -At around 9:30 A.M., resident was noted with increased verbal, physical, disruptive, and threatening behavior throwing things, chairs, and blocking other residents room. -Unable to redirect resident had a PRN order Olanzapine (antipsychotic to treat schizophrenia) 10 mg intramuscularly injection (IM) and was given as directed, with no effect. -He/she continued threatening unable to redirect Administrations aware. -At around 12:30 P.M., resident threatened that he/she would kill somebody before he/she gets out of here and started yelling get me out of here, get me out of here -Physician was notified about resident's behavior, order received to send to hospital for evaluation and treatment. -Voice mail left for the guardian. Review of the resident's Incident Note, dated 12/2/23, showed: -At 3:20 A.M., he/she had a verbal outburst and physical aggression behavior talking to television banging the window behind the nursing station going to double exit and said he/she was leaving. -Physician notified and gave a one time order for PRN medication. -At 8:51 A.M., he/she was in the dining room yelling at staff and being verbally and physically aggressive. -Redirection attempted and was unsuccessful. -Code [NAME] called proper staff responded. -Physician notified of incident and for PRN order for medication. -Order was given to send out for evaluation and medication review would be completed. -Administration notified. -Resident sent to the hospital. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/3/23 at 1:10 P.M., the Administrator said; -Resident #1 did get sent to the hospital for significant change in behaviors several times and a PASRR change in status evaluation was never requested for him/her. 37841 During an interview on 1/3/23 at 1:00 P.M., MDS Coordinator said: -He/she was the one who should request a new PASRR evaluation for residents who need one. -He/she was behind due to working the floor. During an interview on 1/3/23 at 1:10 P.M., the Administrator said; -All staff are to monitor residents for behaviors and follow the chain of command for reporting. -The nurse was to report to the Administrator and DON who then reports to the MDS Coordinator to be put on the residents Care Plan and if needed a Significant Change MDS and/or PASRR. -All interventions tried to redirect the resident should be charted in the resident's medical record at the time of the incident. During an interview on 1/3/24 at 1:35 P.M., the DON said: -The MDS Coordinator was pulled to the floor constantly and that is why care plan updates, MDS updates, and requests for updated PASRR were not done. -The DON was ultimately responsible for all nursing processes and so he/she was responsible to ensure the resident medical records including the resident care plans, requests for updated PASRR related to resident baseline changes were completed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35013 Based on interview and record review, the facility staff failed to ensure the resident environment remains as free of accident hazards as is possible. The facility failed to maintain proper storage of medication for one sampled resident (Resident #32) when on 12/8/23, a bottle of Melatonin (a medication used to help induce sleep) 3 milligrams (mg) was left on top of the medication cart and the resident took the bottle and ingested 5 tablets. The facility census was 163 residents. Review of the facility policy for Medication Storage and Destruction, revised 10/20/22, showed: -The purpose of the policy was to ensure that all medication were properly stored. -All medications used for residents were to be kept locked in the medication cart. Review of Resident #32's Preadmission Screening and Resident Review (PASRR-a federal requirement to help ensure that individuals are not inappropriately placed into nursing homes for long term care), dated 8/12/19, showed he/she had the following diagnoses: -Schizophrenia (a mental problem that causes loss of contact with reality and mood problems),Vascular dementia-(a common form of dementia caused by a lack of oxygen to the brain), Borderline personality disorder-(a mental illness marked by an ongoing pattern of varying moods, self-image and behaviors), Cocaine abuse with intoxication, Hallucinogen abuse. -He/she had a long history of substance abuse, having used multiple types of substances such as alcohol, PCP, amphetamines, cannabis, and cocaine. -He/she had a history of making poor decisions. -He/she required medication monitoring -He/she showed a history of risky behavior, poor insight and judgement. -He/she required long term medication education, counseling, set-up and administration. Review of the resident's Nursing Care Plan, dated 11/14/23, showed: -He/she had cognitive impairment/function with dementia including impaired decision making. -The facility staff was to administer medications as ordered and watch for any negative side effects and effectiveness. -The facility staff was to review medications and record possible causes of cognitive deficit including any new medications, dosage increases, drug interactions, or drug toxicity. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's annual Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff and used for care planning), dated 11/25/23, showed he/she: -Was mildly cognitively impaired. -Had issues with mood including having little interest in doing things nearly every day, trouble falling asleep or sleeping too much nearly half the days, and tired or low energy nearly every day. -Had shown no behaviors. Review of the resident's Nurse's Notes, dated 12/9/23 at 10:15 P.M., showed: -During staff rounds, the resident was noted to have an opened bottle of Melatonin labeled 3 milligrams (mg) tablets with him/her. -He/she stated he had the medication with him/her since 12/8/23 when he/she took it from the top of the medication cart. -When asked if he/she took any of the medication, he/she stated yes, but did not remember how many he/she took. -His/her vital signs were obtained and were all within normal limits. -Neurological assessments were begun showing no alteration in his/her baseline mental status. -The physician was notified and the resident was sent to the hospital for evaluation. -The resident's guardian was notified as was facility Administration. -He/she returned from the hospital at 12:30 A.M., with no issues and no new orders. -He/she remained on neurological assessments. -He/she was educated about notifying the staff whenever he/she had issues or concerns pertaining to his/her care. Record review of the resident's Physician's Order Sheet (POS), dated 12/11/23, showed he/she had no physician's order for Melatonin. During an interview on 12/11/23 at 12:00 P.M., the facility Administrator said: -The resident reported to the hospital emergency room (ER) that he/she took five tablets. -The hospital reported back to the facility that the resident took five tablets of Melatonin 3 mg tablets as his/her Melatonin levels showed 15 to 30 mgs present in his/her system. -Optimal levels of Melatonin are from 10-85 mgs. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/23 at 1:12 P.M., Agency LPN A said: -He/she was not caring for the resident, but happened to answer the phone when the hospital called the report on the resident. -The hospital reported to him/her the resident had ingested ten 3 mg tablets of Melatonin per the resident's Melatonin levels in the ER. During an interview on 12/11/23 at 12:30 P.M., LPN C said: -He/she was assigned to the unit where the resident resided on 12/8/23 and 12/9/23, but he/she was not working on the medication cart that had contained the Melatonin. -An agency Certified Medication Technician (CMT) was working on the unit with him/her and was not familiar with the residents. -The agency CMT appeared to be overwhelmed, so LPN C offered and administered the medications for a portion of the unit both the morning and bedtime medications in attempt to take some of the burden off the agency CMT. -He/he did not see any medication bottles on top of any of the medication carts while he/she worked. -He/she never observed any medications left out on any medication carts. -Medications were not to be left out on the medication cart. During an interview on 12/11/23 at 1:43 P.M., the resident said: -He/she saw someone had left the medication out on top of the medication cart on 12/8/23. -He/she wanted to get some sleep and the staff refused to give him/her his/her Trazadone (a medication used for depression that is also a sedative) so he/she just took the bottle from the top of the medication cart. -He/she thought he/she ingested about five tablets of the Melatonin. During an interview on 12/11/23 at 2:30 P.M., the Nurse Practitioner (NP) said: -He/she did not believe the ingestion of Melatonin by the resident would cause any medical complications. -He/she believed the medication should have been properly locked inside the medication cart so residents could not obtain the medication inappropriately. During an interview on 12/12/23 at 4:15 P.M., the Director of Nursing (DON) said: -All medications were to be locked up and kept away from the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265822	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewood Health Care Center	11515 Troost Kansas City, MO 64131

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she expected medication to be locked at all times it was not attended to by facility nursing staff and that no medications ever be left on top of the cart. During an interview on 12/12/23 at 4:20 P.M., the facility Administrator said: -He/she expected the staff to keep the medication cart locked with no medications ever sitting out on top of the cart. -He/she expected staff to notice if a medication was sitting out and alert a nurse so the medication could be locked up prior to any resident ingesting the medication. MO00228575