

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 05/03/2024
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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35013</p> <p>Based on observation, interview and record review, the facility failed to protect one sampled resident (Resident #6) from physical abuse when on 4/23/24 about 8:30 P.M., Certified Nursing Assistant (CNA) A grabbed, shoved, and pushed the resident down the hall and then up against the wall. Hall Monitor (HM) A and CNA C watched the physical abuse and did not intervene. CNA A continued to work his/her shift until 7:00 A.M., on 4/24/24. The sample was 16 residents. The facility census was 163 residents.</p> <p>The Administrator was notified on 4/29/24 at 4:45 P.M. of the past noncompliance Immediate Jeopardy (IJ) which began on 4/23/24. The facility completed education for all staff on the Abuse, Neglect policy. Involved staff were suspended and terminated. The IJ was corrected on 4/26/24.</p> <p>Record review of the facility's Abuse and Neglect policy, updated 1/5/23, showed:</p> <ul style="list-style-type: none"> -Physical abuse was defined as purposely beating, striking, wounding, or injuring another resident or mistreating or maltreating a resident in a brutal or inhumane manner. Physical abuse included hitting, slapping, punching, biting and kicking, and also included corporal punishment. -Mental abuse was the use of verbal or nonverbal conduct which causes or has the potential to cause the resident humiliation, intimidation, fear, shame, agitation or degradation. -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. <p>1. Review of Resident #6's Preadmission Screening and Resident Review (PASRR, DA-124C, a required form to be submitted for any client who requests admission to a Medicaid certified bed regardless of the client's payment source; this includes dually certified beds both Medicare and Medicaid), dated 10/25/23, showed he/she had the following diagnoses:</p> <ul style="list-style-type: none"> --Schizophrenia (a severe psychiatric disorder with symptoms of emotional instability, detachment from reality, and withdrawal into the self). --Bi-Polar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). <p>(continued on next page)</p>

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
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>--Psychotic Disorder (a mental disorder in which there is a severe loss of contact with reality)</p> <p>--Dissociative Identity Disorder (a mental health condition that involves experiencing a loss of connection between thoughts, memories, feelings, surroundings, behaviors and identity).</p> <p>--PTSD (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event).</p> <p>--Personality Disorder (a condition characterized by repetitive behavioral patterns that are contrary to usual moral and ethical standards and cause a person to experience continuous conflict with society).</p> <p>--Obsessive Compulsive Disorder (OCD-is an anxiety disorder characterized by intrusive thoughts that produce uneasiness, apprehension, fear, or worry; by repetitive behaviors aimed at reducing the associated anxiety; or by a combination of such obsessions and compulsions).</p> <p>Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff and used for care planning), dated 2/1/24, showed he/she was cognitively intact.</p> <p>Review of resident's Counseling Services, dated 4/8/24, showed he/she:</p> <ul style="list-style-type: none"> -Had impulsive behaviors. -Had increase in anxiety. -Had an excellent ability to recognize his/her triggers and a willingness to work on using his/her coping skills. <p>Review of the resident's Nursing Care Plan, dated 4/21/24, showed:</p> <ul style="list-style-type: none"> -The facility staff was to provide specific services to assist the resident with managing his/her behaviors and mental illness. -The behavioral health plan was indicated due to his/her history of risk-taking behavior, aggression and inappropriate behaviors. -Facility staff were to have been aware of his/her triggers which were people who were ignorant or stupid and being lied to. -The facility staff were to have known his/her coping skills which were smoking, listening to music, exercising, talking to specific staff members, and quiet time where he/she was by himself/herself. -The resident had behaviors related to his/her mental illness that created disturbances which affected others such as yelling, cursing and name calling directed at staff. <p>Observation of the facility's undated and untimed video footage of the incident that occurred on 4/23/24 at 8:30 P.M., showed:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-CNA A was behind the snack cart in the hallway.</p> <p>-HM A was standing in the middle of the hallway observing the incident as it happened.</p> <p>-CNA C was standing up against the wall next to the snack cart observing the incident as it happened.</p> <p>-Resident #11 was standing in the middle of the hallway near CNA B, who was in the snack room, and watched the incident.</p> <p>-No other staff or residents were present.</p> <p>-Resident #6 approached the snack cart and appeared to exchange words with CNA A.</p> <p>-Resident #6 then snatched a small bag of chips off the snack cart.</p> <p>-CNA A snatched the chips back as more words appeared to be exchanged between the two.</p> <p>-Resident #6 then snatched the chips back and CNA A came around the snack cart, shoved the resident, grabbed the resident, shoving him/her down the hallway backwards and then slammed the resident into the wall several feet down the hallway before the resident pushed CNA A off of him/her.</p> <p>-HM A and CNA C stood watching the exchange as CNA B ran out of the snack room, down the hallway and stepped in between CNA A and Resident #6.</p> <p>Review of the Facility Registered Nurse Investigation, dated 4/25/24, showed:</p> <p>-On 4/23/24, an incident of alleged abuse occurred and involved: Resident #6 and CNA A, witnessed by Resident #11, HM A, CNA B, and CNA C.</p> <p>-Resident #6 snatched the bag of chips off the snack cart that CNA A was monitoring.</p> <p>-CNA A then snatched the bag back, so the resident pushed at CNA A.</p> <p>-CNA A then grabbed the resident and pushed him/her down the hall.</p> <p>-Resident #6 stated he/she was not hurt and didn't think of it as a big deal.</p> <p>-Resident #6 said that he/she didn't tell anyone about the incident that night.</p> <p>-CNA A said the resident snatched the chips away to which he/she told the resident not to do that, because he/she was still passing out chips to other residents.</p> <p>-CNA A stated the resident then called him/her a faggot and a bitch, so he/she pushed the resident away and grabbed his/her wrists to restrain the resident.</p> <p>-Resident #6 stated that he/she felt safe and was not threatened by what happened.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-It all happened so fast, he/she didn't even get a chance to intervene.</p> <p>-Night Shift Supervisor A was far down the hall so when he/she was told what happened, Night Shift Supervisor A kept HM A on the hall and moved CNA A to another part of the hall for the resident of the night.</p> <p>During an interview on 4/29/24 at 1:40 P.M., HM A said:</p> <p>-He/she was in the snack room eating.</p> <p>-CNA A was passing out chips and was rationing them by having the residents get a paper towel an putting some chips on the paper towel.</p> <p>-He/she was not there to see the whole incident as he/she came into the hallway later.</p> <p>-He/she just saw the resident grab CNA A's wrists so CNA A pushed him/her.</p> <p>-CNA B then came into the hall and showed CNA A out of the way.</p> <p>-He/She did not intervene, because he/she did not see the altercation until the end.</p> <p>During an interview on 4/29/24 at 12:05 P.M., CNA B said:</p> <p>-It looked like CNA A was fighting with the resident.</p> <p>-He/she came out of the snack room as CNA A shoved the resident up against the wall.</p> <p>-He/she ran and got in between them to stop the altercation.</p> <p>Review of Resident #11's quarterly MDS, dated [DATE], showed he/she was cognitively intact.</p> <p>Review of Resident #11's written witness statement dated 4/25/24 showed:</p> <p>-Resident #6 grabbed the chips and threw them down.</p> <p>-CNA A started pushing Resident #6 down the hallway and kept pushing him/her.</p> <p>-CNA B then stepped in front of the resident and the resident started cussing at CNA A.</p> <p>During an interview on 4/29/24 at 3:02 P.M., Resident #11 said:</p> <p>-Resident #6 came up to the snack cart.</p> <p>-No one else was in line, but CNA A told the resident to get a paper towel to put some chips on because there wasn't enough chips for everyone.</p> <p>-The resident grabbed the chip bag and CNA A grabbed it back.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The resident grabbed the bag again and threw it down, shoving CNA A.</p> <p>-CNA A got upset and pushed the resident back, pushed him/her down the hall and into the wall.</p> <p>-CNA B then came and separated them.</p> <p>-CNA B then gave the resident the bag of chips and sent him/her to his/her room.</p> <p>-Resident #6 looked like he/she was going to fight CNA A.</p> <p>Review of Night Shift Supervisor A's written statement, dated 4/25/24, showed:</p> <p>-After the incident with CNA A, Resident #6 and the Night Shift Supervisor went outside, so the resident could smoke and calm down.</p> <p>-He/she asked the resident what happened between him/her and CNA A and the resident told him/her that CNA A grabbed him/her.</p> <p>-The Night Shift Supervisor asked the resident if CNA A hit the resident and the resident said he/she was not hit.</p> <p>-The Night Shift Supervisor asked the resident to show him/her how the resident was grabbed to which the resident said he/she did not feel comfortable grabbing the Night Shift Supervisor.</p> <p>-He/she spoke with HM A and asked the resident to show him/her on HM A how CNA A grabbed the resident.</p> <p>-The resident asked if HM A could show the Night Shift Supervisor on him/her so HM A grabbed a hold of the resident's hand to demonstrate having been grabbed.</p> <p>-The Night Shift Supervisor then left HM A with the resident outside and he/she went and texted administration.</p> <p>During an interview on 4/29/24 at 1:01 P.M., Night Shift Supervisor A said:</p> <p>-He/she spoke with CNA B and Resident #6 who told him/her what happened.</p> <p>-The resident stated CNA A grabbed him/her.</p> <p>-When Night Shift Supervisor A asked the resident to show him/her how CNA A grabbed, the resident did not feel comfortable doing that.</p> <p>-He/she then spoke with CNA B with the resident present and CNA B then showed Night Shift Supervisor A how the resident was grabbed.</p> <p>-He/she did not know the resident was pushed.</p> <p>-He/she had not seen the video, so had no idea the extent of the abuse.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The resident and CNA B made it sound like the incident was no big deal.</p> <p>Review of CNA A's Facility Employment Education showed he/she was educated and tested on the Abuse and Neglect policy as well as dignity and resident's rights on 2/13/24.</p> <p>During an interview on 5/3/24 at 1:00 P.M., the Director of Nursing (DON) said:</p> <p>-He/she had no idea why CNA A would have reacted the way he/she did.</p> <p>-He/she would have expected CNA A to recognize the resident was escalating and use the resident's coping skills.</p> <p>-He/she would have expected CNA A to negotiate with the resident and if that did not work, to allow the resident to have the bag of chips.</p> <p>-CNA A had been well educated as to how to handle residents with behaviors prior to working at the facility.</p> <p>-He/she would have expected the staff who were witnessing the abuse to immediately intervene to attempt to stop it from occurring.</p> <p>During an interview on 5/3/24 at 1:15 P.M., the Facility Administrator said:</p> <p>-He/she was extremely disappointed in how the staff acted in this situation.</p> <p>-All staff were fully educated prior to caring for any residents in the facility.</p> <p>-The education had a strong focus on caring for residents with mental health diagnoses and how to de-escalate those residents.</p> <p>-Those doing the interviews make it a point to emphasize the type of resident cared for at the facility so those prospective staff know the facility is not a traditional nursing home.</p> <p>-He/she would have expected CNA A to negotiate with the resident, attempt to de-escalate the situation and not argue or do anything to make the situation more volatile.</p> <p>-There was never a time that laying hands on a resident in anger, shoving a resident, or pushing a resident up against the wall, was acceptable behavior on the part of a staff member.</p> <p>-Resident #6 was not a resident who caused a lot of trouble, had any resident to resident altercations, or fought with staff.</p> <p>-The resident could annoy others from time to time, but his/her triggers and interventions were easily accessed by the staff, so CNA A should have well known how to handle the resident once he/she began to escalate and intervene appropriately.</p> <p>During an interview on 5/7/24 at 2:00 P.M., Nurse Practitioner (NP) A said:</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>35013</p> <p>Based on observation, interview, and record review, facility staff (Certified Nursing Assistant (CNA) A, CNA B, CNA C, Hall Monitor (HM) A, and the Night Shift Supervisor A) failed to report allegations of abuse to the facility Administrator as instructed by the facility policy resulting in a delay of an investigation. On 4/23/24 about 8:30 P.M., CNA A grabbed Resident #6, shoved and pushed him/her down the hall and then up against the wall. Hall Monitor A and CNA C watched the abuse occur. CNA B came around the corner intervened and separated the resident from CNA A and then reported the incident to the evening administration. The facility census was 163 residents.</p> <p>The Administrator was notified on 5/3/24 of the past noncompliance which began on 4/23/24. The facility inserviced all staff on the reporting policy and made notifications to appropriate agencies. The deficiency was corrected 4/25/24.</p> <p>Record review of the facility's Abuse and Neglect policy, updated 1/5/23, showed:</p> <ul style="list-style-type: none"> -Physical abuse was defined as purposely beating, striking, wounding, or injuring another resident or mistreating or maltreating a resident in a brutal or 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. -Facility staff was to immediately report abuse to a Supervisor or and Facility Administrator. <p>1. Review of Resident #6's Preadmission Screening and Resident Review (PASRR, DA-124C, a required form to be submitted for any client who requests admission to a Medicaid certified bed regardless of the client's payment source; this includes dually certified beds both Medicare and Medicaid) dated 10/25/23 showed he/she had the following diagnoses:</p> <ul style="list-style-type: none"> --Schizophrenia (a severe psychiatric disorder with symptoms of emotional instability, detachment from reality, and withdrawal into the self). --Bi-Polar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). --Psychotic Disorder (a mental disorder in which there is a severe loss of contact with reality) --Dissociative Identity Disorder (a mental health condition that involves experiencing a loss of connection between thoughts, memories, feelings, surroundings, behaviors and identity). --PTSD (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event). <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>--Personality Disorder (a condition characterized by repetitive behavioral patterns that are contrary to usual moral and ethical standards and cause a person to experience continuous conflict with society).</p> <p>--Obsessive Compulsive Disorder (OCD-is an anxiety disorder characterized by intrusive thoughts that produce uneasiness, apprehension, fear, or worry; by repetitive behaviors aimed at reducing the associated anxiety; or by a combination of such obsessions and compulsions a severe psychiatric disorder with symptoms of emotional instability, detachment from reality, and withdrawal into the self).</p> <p>Observation of the facility's undated and untimed video of the incident that occurred on 4/23/24 at 8:30 P.M., showed:</p> <p>-CNA A was behind the snack cart in the hallway.</p> <p>-HM A was standing in the middle of the hallway observing the incident as it happened.</p> <p>-CNA C was standing up against the wall next to the snack cart observing the incident as it happened.</p> <p>-Resident #11 was standing in the middle of the hallway near CNA B, who was in the snack room, and watched the incident.</p> <p>-No other staff or residents were present during the incident.</p> <p>-Resident #6 approached the snack cart and appeared to exchange words with CNA A.</p> <p>-Resident #6 then snatched a small bag of chips off the snack cart.</p> <p>-CNA A snatched the chips back as more words appeared to be exchanged between the two.</p> <p>-Resident #6 then snatched the chips back and CNA came around the snack cart, shoved the resident, grabbed the resident, shoving him/her down the hallway backwards and then slammed the resident into the wall several feet down the hallway before the resident pushed CNA A off of him/her.</p> <p>-HM A and CNA C stood watching the exchange as CNA B ran out of the snack room, down the hallway and stepped in between CNA A and Resident #6.</p> <p>During an interview on 4/29/24 at 1:08 P.M., CNA A said:</p> <p>-The whole incident was in his/her statement.</p> <p>-When asked if he/she would like to tell his/her side of the story or add anything he/she responded, Resident #6 was up in my face calling me names and I needed to get him/her away from me and the snack tray.</p> <p>-He/she further stated, I have nothing else to say.</p> <p>-CNA A then hung up the phone.</p> <p>(continued on next page)</p>		

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 05/03/2024
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.			
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/29/24 at 2:07 P.M., CNA C said:</p> <ul style="list-style-type: none"> -It was his/her first time on that hall and he/she was training with CNA A. -CNA A was passing out sandwiches and chips. -Resident #6 cut into the line and grabbed a bag of chips off the snack tray. -There weren't enough chips for everyone to have a bag, so CNA A was having the residents place some chips on a paper towel a few at a time. -When the resident snatch the chips, CNA A snatched them back. -The resident then pushed CNA A and CNA A pushed the resident back. -Another worker separated the two. -It all happened so fast, he/she didn't even get a chance to intervene. -Night Shift Supervisor A was far down the hall, so when he/she was told what happened, Night Shift Supervisor A kept HM A on the hall and moved CNA A to another part of the hall for the resident of the night. -He/she had been educated to notify the Administrator, but thought Night Shift Supervisor A knew about it so he/she would call the Administrator. <p>During an interview on 4/29/24 at 12:05 P.M., CNA B said:</p> <ul style="list-style-type: none"> -It looked like CNA A was fighting with the resident. -He/she came out of the snack room as CNA A shoved the resident up against the wall. -He/she ran and got in between them to stop the altercation. -He/she texted Staffing Coordinator A around 1:30 A.M., on 4/24/24 stating there had been an altercation between Resident #6 and CNA A and telling Staffing Coordinator A to look at the video at around 8:30 P.M., on 4/23/24. -He/she had been educated to notify a supervisor or the Administrator. -He/she was sure Night Shift Supervisor A was there when the incident took place so he/she didn't think he/she needed to call the Administrator. <p>During an interview on 4/29/24 at 1:01 P.M., Night Shift Supervisor A said:</p> <ul style="list-style-type: none"> -He/she spoke with CNA B and Resident #6 who told him/her what happened. -The resident stated that CNA A grabbed him/her. <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-When Night Shift Supervisor A asked the resident to show him/her how CNA A grabbed, the resident did not feel comfortable doing that.</p> <p>-He/she then spoke with CNA B with the resident present and CNA B then showed Night Shift Supervisor A how the resident was grabbed.</p> <p>-He/she did not know the resident was pushed.</p> <p>-He/she had not seen the video, so had no idea the extent of the abuse.</p> <p>-The resident and CNA B made it sound like the incident was no big deal.</p> <p>-He/she did not call the Administrator as the event didn't seem to warrant it.</p> <p>During an interview on 4/29/24 at 1:40 P.M., HM A said:</p> <p>-He/she was in the snack room eating.</p> <p>-CNA A was passing out chips and was rationing them by having the residents get a paper towel and putting some chips on the paper towel.</p> <p>-He/she was not there to see the whole incident as he/she came into the hallway later.</p> <p>-He/she just saw the resident grab CNA A's wrists so CNA A pushed him/her.</p> <p>-CNA B then came into the hall and showed CNA A out of the way.</p> <p>-He/she was sure Night Shift Supervisor A was there for the incident, so he/she would notify the Administrator.</p> <p>During an interview on 5/3/24 at 1:00 P.M., the Director of Nursing (DON) said:</p> <p>-He/she would have expected that the staff members who witnessed the altercation to notified the Administrator per the policy.</p> <p>During an interview on 5/3/24 at 1:15 P.M., the Facility Administrator said:</p> <p>-He/she was extremely disappointed in how the staff acted in this situation.</p> <p>-He/she had educated all staff that they were to notify him/her every time an incident that could have been abuse occurred no matter what time the incident happened.</p>