

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  05/30/2024
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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>35013</p> <p>Based on interview and record review, the facility failed to maintain one sampled resident's (Resident #1) dignity, when staff made light of the resident being upset, not using appropriate de-escalation techniques, touching the resident on the back while following the resident into the unit, causing the resident to further escalate his/her behaviors out of six sampled residents. The facility census was 162 residents.</p> <p>Review of the facility policy for Dignity and Respect revised 6/29/23 showed:</p> <ul style="list-style-type: none"> <li>-The policy was created to ensure that all residents were treated with dignity and respect.</li> <li>-Every resident had the right to be treated with dignity and respect.</li> </ul> <p>Review of the facility policy for Customer Service revised 7/31/23 showed:</p> <ul style="list-style-type: none"> <li>-The purpose of the policy was to set expectations for customer service and professional behavior expected of all facility staff.</li> <li>-Appropriate conduct was required while in person, by telephone or written correspondence.</li> <li>-Courtesy and respect for residents was required by staff at all times.</li> </ul> <p>1. Review of Resident #1'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 6/7/22, showed he/she had the following diagnoses:</p> <ul style="list-style-type: none"> <li>-Schizophrenia (a severe psychiatric disorder with symptoms of emotional instability, detachment from reality, and withdrawal into the self).</li> <li>-Psychotic Disorder (a mental disorder in which there is a severe loss of contact with reality).</li> <li>-Delusional Disorder (a mental disorder characterized by fixed, false beliefs).</li> </ul> <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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Chronic schizophrenic stimulant disorder due to methamphetamine and cocaine usage(schizophrenia caused by the use of illicit drugs such as stimulants and methamphetamines).</p> <p>-Panic disorder (an anxiety disorder characterized by unexpected and repeated episodes of intense fear accompanied by physical symptoms that may include chest pain, heart palpitations, shortness of air, dizziness or abdominal distress).</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 2/28/24 showed he/she was cognitively intact.</p> <p>Review of the resident's Nursing Care Plan dated 3/6/24 showed:</p> <p>-He/she had ongoing paranoid delusional behaviors.</p> <p>-He/she had a history of refusing medications, activities and nursing/medical care.</p> <p>-The facility staff was to allow the resident to call the Administrator or go to the Administrator's office to where he/she could vent his/her feelings.</p> <p>-The facility staff was to redirect him/her without arguing, asking him/her to use his/her coping skills.</p> <p>-The facility staff was to allow him/her to a call his/her family guardian to vent feelings and get direction.</p> <p>-The facility staff was to use a calm voice and patience to de-escalate the resident.</p> <p>Observation of the facility video footage of the incident dated 5/23/24 showed:</p> <p>--4:16 P.M., the Administrator and the resident came through the first set of unit doors.</p> <p>--4:17 P.M., the resident came through the door toward the open unit door with the Administrator following behind him/her.</p> <p>--4:17 02 P.M., The resident got through the open unit door with the Administrator behind him/her.</p> <p>--16 03 P.M., The Administrator lightly pushed on the resident's back with his/her left hand.</p> <p>--4:17 04 P.M., the resident tried to shut the door on the Administrator but the Administrator was in the way.</p> <p>--4:17 07 P.M., the resident charges through the door coming at the Administrator pushing the Administrator appearing to attempt to strike the Administrator, but the Administrator blocks the resident's left hand.</p> <p>--4:17 10 P.M., the resident ran out the door.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-It was also noted the Administrator did not use two hands as stated by the resident but rather was touching him/her on his/her shoulder and the resident had an issue with that interaction as he/she was already upset.</p> <p>Review of Staffing Coordinator A's written statement dated 5/25/24 showed he/she did not know what the resident was talking about as he/she never gave the resident any money.</p> <p>During an interview on 5/25/24 at 11:45 A.M., Staffing Coordinator A said:</p> <p>-He/she never gave the resident any money.</p> <p>-He/she was not present during the alleged incident but he/she had never known the Administrator to ever be abusive or inappropriate with any residents.</p> <p>-The Administrator and the resident always had a great relationship.</p> <p>Review of the written statement provided by Certified Medication Technician (CMT) A showed:</p> <p>-He/she was down the hall and only saw the resident.</p> <p>-He/she did not see the resident get pushed.</p> <p>-He/she just saw the resident swing at the Administrator.</p> <p>-He/she did not know anything about the Staffing Coordinator allegedly giving the resident money.</p> <p>-He/she had heard before the incident that the Administrator offered to buy the resident fast food the following day.</p> <p>Review of the resident's written statement dated 5/24/24 showed:</p> <p>-He/she left the room after MDS Coordinator A stole his/her lighter and eyebrow shaver.</p> <p>-He/she confronted the Administrator about it and was told to go back to his/her hall.</p> <p>-When he/she went to the hall, the Administrator pushed him/her and shut the door on him/her.</p> <p>-CMT A saw the incident.</p> <p>-The incident was all over him/her spraying some perfume and having the lighter and eyebrow shaver.</p> <p>-Staffing Coordinator A gave him/her 12 dollars and the Administrator bought him/her fast food so he/she wouldn't snitch.</p> <p>Review of the resident's second written statement dated 5/25/24 showed the Administrator pushed him/her and shut the door.</p> <p>During an interview on 5/25/24 at 12:30 P.M., the resident said:</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she had taken a lighter and MDS Coordinator A took it back.</p> <p>-He/she went to talk to the Administrator to ask him/her where the lighter was.</p> <p>-The Administrator told him/her that it was in the office and that he/she couldn't have it.</p> <p>-The Administrator then walked the resident back to his/her unit and when they got to the door, the Administrator said, You know you can't have a lightand then pushed his/her back.</p> <p>-He/she then pushed the Administrator back before the Administrator closed the door to the unit.</p> <p>-The Administrator then bought him/her fast food and Staffing Coordinator A gave him/her 12 dollars so he/she wouldn't snitch.</p> <p>Review of the written stated completed by the Administrator on 5/24/24 showed:</p> <p>-On 5/23/24 at about 1:00 P.M., the resident came to the door in from of the dining room doors.</p> <p>-The Administrator asked the resident what he/she was doing, and he/she stated that his/her family member/Guardian had blocked all of his/her phone calls and stating that his/her Guardian was not going to bring him/her any food on Friday.</p> <p>-The Administrator discussed the issue with the resident and told the resident if he/she did not have any behaviors through the night, he/she would get him/her fast food.</p> <p>-The resident agreed and asked if the Administrator would call his/her Guardian to which the Administrator said no as the Guardian had blocked his/her calls for a good reason.</p> <p>-At around 4:10 P.M., the resident came to the Administrator's office demanding to know who had taken his/her lighter.</p> <p>-The Administrator explained to him/her that the lighter was in the office that it was not allowed on the unit for safety reasons.</p> <p>-The Administrator escorted the resident away from other residents back to his/her unit.</p> <p>-The two were talking as they walked back to the unit and the Administrator touched the resident on his/her back stating that the resident knew he/she couldn't have a lighter.</p> <p>-At that point the resident turned around to come back through the door.</p> <p>-The Administrator attempted to close the door, backing up through the door.</p> <p>-The resident then went back through to the unit and the Administrator closed the door.</p> <p>-The Administrator later went to speak with the resident and the resident stated that the Administrator had pushed him/her.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The Administrator told him/her that he/she was not pushed, that the Administrator was just trying to reiterate that he/she was not allowed to have a lighter on the unit.</p> <p>-The resident stated that he/she understood and told the Administrator, I love you.</p> <p>-The Administrator said that he/she loved the resident, too as the resident hugged the Administrator.</p> <p>-The resident then stated that they were good.</p> <p>-On 5/24/24 while rounding, the resident asked the Administrator if he/she was going to get his/her fast food.</p> <p>-The Administrator stated that he/she would, and asked the resident what he/she wanted to eat.</p> <p>-Around noon, the Administrator went back to the resident's room to ask him/her again what he/she wanted to eat.</p> <p>-The resident showed him/her what food he/she wanted and the Administrator ordered the food before leaving the resident's room.</p> <p>-The resident came to the Administrator's office around 12:15 P.M., to get his/her food and the Administrator escorted the resident to the front lobby to eat.</p> <p>-The resident thanked the Administrator and walked away.</p> <p>During an interview on 5/25/24 at 12:05 P.M., the Administrator said:</p> <p>-It was never his/her intent to ever harm the resident.</p> <p>-Earlier in the day around lunch time the resident was standing in the doorway leading into the front lobby.</p> <p>-He/she asked the resident what was going on and the resident asked the Administrator if he/she could call the resident's family/Guardian, as he/she had been blocked from making any calls to them.</p> <p>-The Administrator knew that the resident always escalated if he/she could not speak with his/her family/Guardian, so the Administrator told the resident that if he/she had no behaviors throughout the day and night, he/she would buy him/her fast food the following day.</p> <p>-The resident agreed but asked if the Administrator could call his/her family/Guardian for him/her.</p> <p>-The Administrator said no as he/she had been blocked from calling them for a reason and would un-block him/her as soon as he/she was ready.</p> <p>-Later on in the day a little after 4:00 P.M., the resident came to the Administrator's office asking who had his/her lighter.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The Administrator told him/her that the light was in the office as he/she knew he/she wasn't allowed to have lighters.</p> <p>-The Administrator then escorted the resident back to his/her unit.</p> <p>-The two were talking and laughing on the way to the unit and as they got to the door, the Administrator lightly pushed the resident on his/her shoulder and chuckling said, You know you can't have lighters and razors in your room, in a playful way as they had been talking earlier playfully.</p> <p>-The resident then turned around and came at the Administrator shoving at him/her before the Administrator could get the door closed.</p> <p>-If he/she would have thought about the fact that the resident was having behaviors because he/she wanted to leave and could not get his/her family/Guardian on the phone, the Administrator would never have handled the situation so lightly and playfully.</p> <p>Review of the written statement of MDS Coordinator A dated 5/24/24 showed:</p> <p>-On 5/23/24, while on the unit, two residents told him/her that the resident had a vape pen and was offering it to residents.</p> <p>-The resident left the room and MDS Coordinator A saw a lighter on his/her table along with two razors.</p> <p>-The lighter and razors were removed and given to Staffing Coordinator A to place in the Administrator's office for safety.</p> <p>-Later, while out by the Administrator's office, the resident came up yelling at him/her wanting the lighter.</p> <p>-The resident was told he/she could not yell and could not have lighters in his/her room.</p> <p>-The resident continued to yell.</p> <p>-The Administrator placed his/her hand on the resident's shoulder to walk him/her back to the unit.</p> <p>-The MDS Coordinator stepped away after the two walked through the doorway past the elevator.</p> <p>-He/she did not see the Administrator push the resident at any time.</p> <p>-He/she did not take the lighter from the resident, rather finding it in the resident's room.</p> <p>During an interview on 5/25/24 at 11:00 A.M., MDS Coordinator A said:</p> <p>-The resident's family/Guardian blocked his/her calls upsetting the resident as he/she wanted to discuss going to a different facility.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35013</p> <p>Based on observation, interviews and record review, the facility failed to ensure temperatures inside Resident #6 and 7's room were maintained between 71 and 81 degrees Fahrenheit ( F) when the outside temperature rose to 82.1 degrees F, and to follow its policy for maintaining room temperatures at a comfortable level while the air conditioning system in the resident's room was not appropriately functioning affecting two sampled residents out of seven sampled residents. The facility census was 162 residents.</p> <p>Review of the facility's undated policy for Utility Failure showed:</p> <p>-The policy was in place to ensure that resident comfort remained paramount in the operation of the facility and that plans for utility failure were in place to ensure equipment was maintained.</p> <p>-It was the responsibility of the facility staff to maintain room temperatures housing residents between 71 degrees F, and 81 degrees F.</p> <p>-If the room temperature rose above 81 degrees F, fans were to have been provided and hourly temperature checks were to have been done by facility staff until the temperature remained below 81 degrees F.</p> <p>1. Review of Resident #6's Facility Admission Record showed he/she was admitted on [DATE] with the following diagnoses:</p> <p>-Acute pulmonary edema (fluid build-up in the lungs).</p> <p>-Chronic congestive heart failure (disorder that impairs the ability of the heart to fill with or pump a sufficient amount of blood throughout the body).</p> <p>-Acute respiratory failure (a sudden onset of an inability to get enough oxygen to the lungs making it difficult or impossible to breath on one's own).</p> <p>-Morbid obesity with a body mass index (BMI) of 70 or greater (a complex, chronic disease in which a person's BMI is 40 or higher).</p> <p>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 3/10/24 showed the resident was cognitively intact.</p> <p>Review of the resident's Nursing Care Plan dated 3/20/24 showed:</p> <p>-He/she had shortness of breath and decreased cardiac output due to heart failure.</p> <p>-Facility staff was to monitor for increased restlessness, anxiety and air hunger</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Facility staff was to evaluate the resident's lung sounds, skin color and temperature.</p> <p>-The resident had a behavior of placing items on his/her air conditioner unit causing the air to not be as cold.</p> <p>-The facility staff was to encourage the resident to not use the air conditioner unit as a table.</p> <p>2. Record review of Resident #7's Facility Admission Record showed he/she was admitted on [DATE] with the following diagnoses:</p> <p>-Atherosclerotic heart disease (thickening of the artery walls).</p> <p>-High blood pressure.</p> <p>Review of the resident's annual MDS dated [DATE] showed he/she was minimally cognitively intact.</p> <p>3. Observation of the temperatures within the residents' room (Resident #6 and Resident #7 are roommates) on 5/29/24 at 3:11 P.M., showed:</p> <p>-A temperature of 82.1 degrees F.</p> <p>-A box fan was sitting on the sink facing the resident but was not blowing hard enough to help.</p> <p>-No other fans were in the room.</p> <p>-The air conditioning (a/c) unit in the room was set to on instead of auto which caused room temperature air to come out instead of cold air.</p> <p>-The a/c unit in the room's setting was changed to auto in attempt to allow cold air to come out.</p> <p>During an interview on 5/29/24 at 3:11 P.M., Resident #6 said:</p> <p>-He/she told Social Worker A and some unknown Certified Nurses Aide (CNA)'s the previous Monday on 5/27/24 that it was too warm in his/her room.</p> <p>-Nothing had been done about it.</p> <p>-He/she had his/her own thermometer in the room on his/her table and at one point it had been 84 degrees F.</p> <p>-He/she also had his/her own fan and somehow, it got broken.</p> <p>-He/she had mentioned the broken fan to the same staff on the same day as the heat and nothing had been done about that either.</p> <p>-He/she would just like it to be cooler in his/her room and to have his/her broken fan replaced.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation of the temperature in the residents' room at 4:40 P.M., showed a temperature of 79.9 degrees F.</p> <p>During an interview on 5/29/24 at 4:45 P.M., the Administrator said:</p> <ul style="list-style-type: none"> <li>-The air conditioner repair company was on site in another area of the building.</li> <li>-They came and looked at the a/c unit and at first, thought it just needed to be charged.</li> <li>-After further examination of the a/c unit, the compressor was broken and would need to be replaced.</li> <li>-The compressor could not be acquired until the following Monday 6/3/24.</li> <li>-He/she sent a worker to purchase a window air conditioning unit for the resident's room as well as a new fan to replace the resident's broken fan.</li> <li>-He/she was having the staff check the temperature in the resident's room throughout the night and until the temperature remained well under the mandated temperature.</li> </ul> <p>During an interview on 5/30/24 at 10:00 A.M., Social Worker A said:</p> <ul style="list-style-type: none"> <li>-Resident #6 had told him/her that it was hot in his/her room on either 5/27/24 or 5/28/24.</li> <li>-He/she went to the residents' room and it was warm, however, the resident had the window open and the a/c unit was not on the correct setting.</li> <li>-He/she shut the window, educated the resident to keep the window closed, and set the a/c unit to the correct setting.</li> <li>-Before he/she left the room, cooler air was blowing out of the a/c unit.</li> <li>-He/she then told Maintenance Worker A about the residents' a/c unit so it could be checked again later in the day.</li> </ul> <p>During an interview on 5/30/24 at 10:30 A.M., Maintenance Worker A said:</p> <ul style="list-style-type: none"> <li>-Social Worker A did come to him/her regarding Resident #6's a/c unit and the warm temperature in the room.</li> <li>-The resident's window was once again open.</li> <li>-He/she re-educated the resident about keeping his/her window closed.</li> <li>-After being notified, he/she went to the room and checked the a/c unit and the setting was wrong and the a/c unit appeared to be dirty.</li> <li>-He/she set the a/c unit to the correct setting and cleaned it.</li> </ul> <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  05/30/2024
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-By the time he/she left, it appeared to be blowing out colder air.</p> <p>-He/she did not recall checking any temperatures in the residents' room.</p> <p>Observation of the residents' room on 5/30/24 at 10:40 A.M., showed:</p> <p>-The temperature in the room was 76.1 degrees F.</p> <p>-A window a/c unit was in place blowing toward Resident #6 and a new fan with a remote control was sitting next to his/her bed and was on.</p> <p>During an interview with Resident #6 on 5/30/24 at 10:40 A.M., showed:</p> <p>-He/she was now comfortable.</p> <p>-The facility brought in a window a/c unit on 5/29/24 around 5:30 P.M.</p> <p>-The new fan with remote was brought to him/her at the same time as the window a/c unit and he/she was very pleased they replaced his/her broken fan.</p> <p>During an interview on 5/30/24 at 2:36 P.M., Maintenance Worker A said:</p> <p>-Social Worker A did come to him/her earlier in the week, regarding Resident #6's a/c unit and the warm temperature in the room.</p> <p>-After being notified, he/she went to the room and checked the a/c unit appeared to be dirty.</p> <p>-He/she took the a/c unit apart and cleaned it.</p> <p>-The room temperature went from 82.0 degrees F to 77 degrees F and appeared to be working much better.</p> <p>-Resident #6 gets very hot and Resident #7 gets cold, so there is a bit of a roommate temperature discrepancy.</p> <p>-He/she does not recall taking any follow up room temperatures as the a/c unit appeared to be functioning well again.</p> <p>MO00236776</p>		