STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265822	A. Building B. Wing	07/31/2024

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42984 Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident #1) was free from abuse when on [DATE], the resident was struck in the face by Resident #2 which resulted in Resident #1 having a broken nose. The facility census was 165 residents. The Administrator was notified on [DATE] of Past Non-Compliance which occurred on [DATE]. An all staff in-service was completed on resident abuse and neglect by [DATE]. The deficiency was corrected [DATE]. Review of the facility's Abuse and Neglect policy, updated [DATE], 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. -Mental abuse was the use of verbal or nonverbal conduct with causes or has the potential to cause the resident experience 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. 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 [DATE], showed: -He/She had a history of mood disorder due to traumatic brain injury, auditory hallucinations, (a perception, in the absence of external stimulus, that appears real to the person experiencing it, which can involve any of the senses), poor concentration, poor judgement, forgetfulness at times, communication problems, and suicidal ideation. -He/She had a history of polysubstance abuse, episodes of agitation, memory impairment and problems with aggression, cognitive disturbance. (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Multiple ED visits due to homicidal threats with agitation. Review of Resident #1's Admission Record showed the resident was admitted on [DATE] with the diagnoses: -Intracranial injury with loss of consciousness greater than 24 hours (traumatic brain injury). -Unspecified dementia (significant cognitive decline affecting daily life). -Major depressive disorder (a serious mood disorder that negatively affects how a person feels, thinks and handles daily activities). -Bipolar disorder (a mental health condition characterized by extreme mood swings including emotional highs and lows). -Anxiety disorder (a mental health condition characterized by chronic excessive worry about various aspects of life). -Schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels and behaves). -Paranoid schizophrenia (a mental disorder characterized by prominent delusions and auditor hallucinations). -Mood disorder (a mental health condition that involves significant disturbances in a person's mood). Review of Resident #1's Care Plan, dated [DATE], showed: -He/She had a history of behavioral challenges that required protective oversight. -He/She had a history of polysubstance abuse, personality disorder, auditory hallucinations, suicidal ideations, and expressing homicidal threats in his/her past as well as becoming physical threatening. Interventions included pharmaceutical interventions and 1:1 observation as needed. -He/she had a long history of mental illness and frequent psychiatric hospital admissions. -He/She had impaired thought processes related to a head injury resulting in cognitive loss, and would make up stories of abuse, suicidal ideation and making threats in order to go to the hospital. Interventions included: simple, directive sentences, providing necessary cues; stopping and returning if he/she became agitated and reorienting and supervising as needed. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-He/She was at risk for signs/symptoms related to diagnosis of schizophrenia; aggression, anxiety, inability to make decisions, delusions, hallucinations, fearfulness, irritability, difficulty focusing, talking to self, making hand gestures as if having a conversation. Interventions included: as needed medications per the physician's order; avoiding arguing or getting defensive with him/her; focusing on how the hallucination made him/her feel rather than content of hallucination; being careful when using reassuring touch; being respectful and non-judgmental with him/her; notifying the charge nurse if he/she exhibited symptoms of schizophrenia. Review of Resident 1's Quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning), dated [DATE], showed the resident was cognitively intact. Review of Resident #2's PASRR, dated [DATE], showed: -The resident was unable to participate in Level II interview due to active psychosis. -He/She had diagnoses of: bipolar disorder, schizophrenia, and psychotic disorder. -He/She had a history of audio/visual hallucinations, persecutory delusions, inappropriate sexual behavior, comments and gestures toward nursing staff, frequent pacing, suspicious/paranoid behavior, depressed mood, wandering the unit, belief a family member had died , legal charges relating to burglary and a sexual offense. -He/She also had a history of walking around naked in public, displaying behaviors such as outing putting a cigarette out on a sofa, freezing when entering a grocery store, attempting to kick another person, inappropriate sexual displays, muttering conversation under his/her breath and inappropriate laughter on a frequent basis and disorganized thought processes. He/She was incarcerated for [AGE] years due to these behaviors. -He/She required frequent direction and redirection and firm limit setting. -He/She was not able to participate in group activities that required an average amount of concentration and focus. -He/She required 1:1 observation intermittently due to aggressive behaviors. Review of Resident #2's Admission Record showed the resident was admitted on [DATE] with the diagnoses: -Schizophrenia, unspecified. -Bipolar disorder. -Schizoaffective disorder (a chronic mental health condition that combines symptoms of schizophrenia and mood disorder). -Major depressive disorder. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Anxiety disorder. Review of Resident #2's Care Plan, dated [DATE], showed: -He/She had a history of behavioral challenges that required protective oversight. Interventions included pharmaceutical interventions as needed; 1:1 observation as needed; CALM technique (a therapeutic approach used in mental health care to help individuals manage emotional regulation), as needed. -He/she had a long history of mental illness and frequent psychiatric hospital admissions. -He/She was at risk for signs/symptoms related to diagnosis of schizophrenia; aggression, anxiety, inability to make decisions, delusions, hallucinations, fearfulness, irritability, difficulty focusing, talking to self, making hand gestures as if having a conversation. Interventions included: as needed medications per the physician's order; avoiding arguing or getting defensive with him/her; focusing on how the hallucination made him/her feel rather than content of hallucination; being careful when using reassuring touch; being respectful and non-judgmental with him/her; notifying the charge nurse if he/she exhibited symptoms of schizophrenia. -He/She was at risk for signs/symptoms of bipolar disorder and depression and might display high or low emotions. Interventions included: helping him/her stay on task; calm redirection for inappropriate behavior; short, clear explanations or directions; using a firm, calm approach; avoiding a power struggle with him/her; decreased stimulation if displaying anxiety. Review of Resident #2's Quarterly MDS, dated [DATE], showed the resident was cognitively intact. Review of Resident 1's Progress Notes, dated [DATE] at 7:27 A.M., showed he/she was standing in the hallway when a peer approached him/her and punched him/her in the face causing major bleeding and a large laceration on the upper part of his/her nose. The Medical doctor gave the order to send him/her to the hospital. Review of Resident 1's hospital Patient Visit Information, dated [DATE], the resident had bilateral nasal bone fractures and superficial laceration to nasal bridge. Review of the facility's Administrator/RN investigation, dated [DATE], showed: -The incident was one of physical aggression involving the head. -Involved parties were Resident #1, Resident #2 and Hall Monitor (HM) A. -On [DATE] at approximately 6:00 P.M., HM A heard a clapping noise while speaking to another resident. -Resident #2 had hit Resident #1 and Resident #1 had fallen to the floor. -A Code Blue, (an emergency code used to indicate a resident is experiencing a life-threatening condition), was called because Resident #1 had fallen to the floor. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Resident #2 calmly walked away and stated he/she was upset because his/her parents had not come to see him/her or called him/her. -Resident #1 said he/she didn't know what happened and asked who did it. -The residents were immediately separated and Resident #2 was taken off the unit by the staff. -Immediate assessment of Resident #1 was done by the charge nurse. -Resident #1 had a bloody nose and continued to try to blow his/her nose, which prevented the bleeding from stopping. -Orders were received to send Resident #1 to the Emergency Department (ED) for evaluation. -Orders were received to sent Resident #2 to the hospital for psychiatric evaluation. -Resident #2 returned from the hospital at 11:30 P.M. with no new orders and was placed on 1:1 observation for protective oversight and resident safety. -On [DATE] at 3:30 A.M., Resident #1 returned from the hospital with orders for antibiotics (a medication used to treat infection), and pain medication due to fractured nasal bones. He/She was moved to the medical unit. -The conclusion of the investigation was that the injury was not caused by abuse or neglect, was not preventable and was not a previous ongoing problem that the facility could have foreseen. Review of Resident 1's Progress Notes, dated [DATE] at 3:16 P.M., showed he/she returned from the hospital that day at 2:00 P.M. Per discharge information, the resident had a fractured nose. Review of Resident 1's Progress Notes, dated [DATE] at 3:38 P.M., showed he/she verbalized pain, burning, stiffness at nasal area. Observation on [DATE] at 3:10 P.M. showed Resident #1 had a small laceration on this bridge of his/her nose, but no swelling or discoloration present. During an interview on [DATE] at 3:10 P.M., Resident #1 said: -Resident #2 drop kicked him/her and he/she went up in the air and came back down and landed on his/her face. -The two residents had only had one previous interaction before, back when it was cold. -He/She did not say anything to Resident #2 before he/she hit him/her. -HM A was there and helped him/her up to his/her hands and knees. -He/She didn't want to see Resident #2 in the hallway. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Review of Resident #2's written statement, dated [DATE], showed: -He/She had never been to the hospital since he/she had been there. -He/She was tired of living at the facility and took matters into his/her own hands. During a interview on [DATE] at 10:00 A.M., Resident #2 said: -Resident #1 hit him/her first and he/she had to defend him/herself. -He/She was picking on him/her all day, running his/her mouth and talking. -He/She could not remember what he/she said. -He/She didn't know if anyone heard him/her. -He/She didn't remember if he/she used a fist or an open hand. -He/she was not trying to harm him/her. -His/Her hand was hurt and his/her jaw was sore where Resident #1 hit him/her. -He/She didn't know if anybody saw it. -He/She was sent to the hospital first. During an interview on [DATE] at 10:35 A.M., Resident #1 said: -He/She had never talked to Resident #2 before. -It was a lie that he/she hit Resident #2 first. -Resident #2 kicked him/her and he/she had a treadmark on his/her nose. Review of the HM A's written statement, dated [DATE], showed: -He/She was talking with another resident in the back hall. -He/She heard a slap and Resident #2 hit Resident #1 in the face. -Resident #1 hit the floor and he/she called a Code Blue, because he/she went down. -Resident #2 calmly walked away as if nothing had happened and said he/she was upset because his/her parents had not come or called. During an interview on [DATE] at 10:50 A.M., HM A said: -The incident between Residents #1 and #2 was completely unexpected. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-He/She was in the hall speaking with another resident. -He/She heard a slapping noise, turned and saw Resident #1 was on the ground. -Resident #2 then walked off; there was just one hit. -He/She called for a Code Blue because Resident #1 was down on the ground. -Resident #2 did not say anything and was not agitated at all. He/she gave no indication of anger, this happened out of the blue. -He/She asked Resident #2 why he/she did it and Resident #2 said his/her parents did not come to see him/her and was upset. -Resident #2 had been good all day, had not had issues. During an interview on [DATE] at 3:00 P.M., the Director of Nursing (DON) said: -There was no video of the incident between the two residents and the hit was unwitnessed. -It didn't take anything for Resident #2 to lash out. -Resident #1 had not been talking to Resident #2 that day, it was all in his/her mind. -Resident #2 had been moved to a different hallway and his/her medications were reevaluated. -There was no rhyme or reason for Resident #2's behavior; he/she could be smiling one moment and try to hit the next. -Resident #2's triggers could be triggered by family issues. -After the incident, Resident #2 was placed on 1:1 observation until his/her family picked him/her up for vacation and would be until further advised. During an interview on [DATE] at 3:30 P.M., the Administrator said: -Resident #1 had no history of old fractures in his/her nose. -A Code Blue (staff called to assist due to an emergency situation) was called because Resident #1 fell to the floor. -Both residents' stories about the incident were different. -Resident #1 makes up stories often. -Resident #1 did nothing to provoke Resident #2 to strike. -Resident #2 was angry because his/her family did not come. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-There had not been any interaction seen by the staff between the two residents that day, and Resident #2 had not shown any triggers that day. -The staff were present on the hall and where they should have been. MO00239265