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	08/15/2024

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 22727 Based on observation, interview and record review, the facility failed to maintain the dignity of one sampled resident (Resident #4) out of 10 sampled residents. The facility census was 162 residents. Review of the facility's policy titled Dignity and Respect, revised on 6/29/23 showed: -Every resident had the right to be treated with dignity and respect. -All staff would speak to and treat all residents with dignity and respect. 1. Review of Resident #4's care plan dated as revised on 3/20/24 showed: -The resident was at risk for: -Fatigue. --Activity intolerance due to Chronic Obstructive Pulmonary Disease (COPD - a disease process that decreases the ability of the lungs to perform ventilation). -The resident: --Refused to get out of bed. --Had bowel incontinence with instructions for staff to assist the resident as needed. --Had impairment to skin integrity related to the resident's refusal to get out of bed and/or reposition in bed. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 6/7/24 showed the following staff assessment of the resident: -Cognitively intact. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Understood others and others understood him/her. -No behaviors. -Had no range of motion impairment in his/her upper or lower extremities. -Required substantial/maximal assistance from staff in which the helper did more than half of the effort with toileting hygiene and personal hygiene. -Was totally dependent on staff for toileting transfer. -Was occasionally incontinent of bladder. -Was frequently incontinent of bowel. -Some of his/her diagnoses included anxiety disorder (psychiatric disorder that involve extreme fear, worry and nervousness), depression (a mood disorder that consists of intense sadness and a loss of interest or loss of pleasure in activities and/or life), lung disease, respiratory failure, severe obesity, and moisture associated skin damage (skin damage caused by excess moisture including incontinence). During an interview on 8/13/24 at 10:11 A.M.: -The resident said: --Certified Nursing Assistant (CNA) E was rough with him/her and was rude to him/her. --He/She felt belittled by CNA E. --CNA E did not talk to him/her like he/she was a human or an adult. --He/She did not have any pads for his/her bed when CNA E came into his/her room. --CNA E came in and asked the resident why he/she didn't ask the day shift to get him/her a pad for his/her bed. --He/She tried to tell CNA E that he/she tried to get the day shift to get him/her a new pad for his/her bed but they never did. --In the first recording, CNA E did not say what he/she was doing. --CNA E was providing incontinence care in the first recording when he/she started saying ow. --He/She told one employee about the way CNA E treated him/her and that employee suggested he/she record interactions with CNA E. --He/She was able to use a bed pan and he/she covered that up but he/she could not get pads for himself/herself and he/she could not wipe himself/herself when he/she's wet or soiled. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident played audio recordings of CNA E interacting with him/her. -An audio recording from 8/1/24 showed: --CNA E spoke to the resident in a gruff and disrespectful way throughout the recordings. --CNA E asked the resident why he/she didn't make the day shift give him/her a new pad. --The resident responded that he/she tried. --CNA E asked about why the resident did not have any wipes. --CNA E said, You ain't got nothing up under you, Lord, Jesus Christ, this is ridiculous! --CNA E did not say what he/she was doing after that. --The next thing heard was when the resident said ouch, repeatedly said ow! and told CNA E to stop being so rough. --CNA E said, I'm not being rough! You can ask them to do this. I'm the only one bothering to do this. --CNA E then said he/she was done, and the resident could roll back into position -The resident said on 8/7/24, he/she asked CNA E to wipe urine off him/her. -An audio recording from 8/7/24 showed: --The resident said ow! --CNA E said he/she was rubbing as soft as he/she could and asked the resident if he/she wanted to do it himself/herself. -An audio recording from 8/10/24 showed: --CNA E said he/she was going to give the resident the opportunity to wipe his/her own bottom and asked the resident what he/she wanted to do. --CNA E said he/she didn't have the time for somebody to say that he/she had been hurting him/her. --The resident said he/she could not wipe his/her own bottom. --CNA E said he/she was going to wipe the resident's bottom but if it hurt, he/she was leaving. During an observation and interview on 8/14/24 at 1:05 P.M., -The Administrator listened to the three audio tapes of the resident and CNA E. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Administrator asked the resident why he/she did not report this to anyone. -The resident said he/she felt like he/she could not trust anyone. -The Administrator asked the resident about calling him/her. -The resident got out his/her phone, the Administrator looked at it and the resident had the wrong phone number for him/her. -The resident corrected the Administrator's phone number in his/her phone. -The Administrator said CNA E needed to be educated on how to do and say things. -The Administrator said CNA E talked like that all the time. -The Administrator said CNA E was just brusk (abrupt, short, and rude in manner or speech). During an interview on 8/14/24 at 9:00 P.M., CNA E said: -The resident's skin on his/her bottom was damaged. -He/She asked the resident if he/she wanted to clean himself/herself up. -The resident probably could not clean himself/herself on his/her own, but maybe if he/she tried. -He/She thought he/she was just trying to help the resident. -He/She was not trying to hurt the resident. -He/She was trying to do the best he/she could. -He/She didn't think anything was wrong with anything he/she said to the resident or anything he/she did to the resident. During an interview on 8/15/24 at 11:40 A.M., the Administrator and the Director of Nursing said: -CNA E would be educated on tone of voice and how to explain what he/she was doing. -The resident could feel undignified by the way CNA E interacted with him/her. MO00239917

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 22727 Based on interview and record review, the facility failed to notify the resident's guardian (a person who looks after and is legally responsible for someone who is unable to manage their own affairs) of changes in the resident's condition for one sampled resident (Resident #6) out of 10 sampled residents. The facility census was 162 residents. Review of the facility's policy titled Residents' Rights dated as revised on 7/5/23 showed the facility must immediately inform the resident and notify the resident's legal representative when there was a change in the resident's condition. 1. Review of Resident #6's care plan dated 2/9/24 showed the resident had a guardian to assist in decision-making due to mental illness. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 5/30/24 showed one of the resident's diagnoses included schizophrenia (a chronic mental illness that interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others). Review of the resident's behavior note dated 8/12/24 at 7:00 P.M. showed Licensed Practical Nurse (LPN) C documented: -The resident was verbally aggressive towards the Certified Medication Technician (CMT) because he/she was upset about his/her medications being crushed. -The resident expressed increased pain due to his/her swollen right arm and stated that his/her current pain medications were not effective. -The resident spit in the face of a staff member and threatened to harm staff. -The resident was sent out to the hospital for medical attention as ordered by the nurse practitioner. -Administration, medical doctor, and the guardian were notified. Review of the hot rack note dated 8/12/24 showed LPN C documented: -The resident returned from the hospital at approximately 11:00 P.M. with new orders. -The resident had a wound incision on his/her right forearm to drain a pus abscess. -There was no documentation showing the resident's guardian was notified of the resident's return from the hospital, the abscess on the resident's forearm or the new order for antibiotics. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's order note dated 8/12/24 showed the resident was prescribed Clindamycin (an antibiotic) 300 milligrams (mg), give 600 mg every six hours for right forearm abscess for 10 days. Review of the resident's communication with guardian note dated 8/13/24 at 3:30 P.M. showed the Administrator and Social Services Director spoke to the guardian regarding the resident spitting in a staff member's face on 8/12/24. No documentation the resident's guardian was informed the resident was sent to the hospital, the resident's wound, or the change in the resident's medication. Review of the resident's Medication Administration Record dated August 2024 showed the resident started taking Clindamycin 300 mg, give 600 mg every six hours beginning 8/14/24. Review of the resident's admission record dated 8/15/24 showed the resident had a legal guardian. During an interview on 8/15/24 at 1:36 P.M., LPN C said: -He/She called the guardian once and got no answer. -He/She called the guardian a second time and left a voicemail regarding the resident going to the hospital. -He/She did not call the guardian to inform him/her that the resident returned from the hospital, that the resident had something done to his/her arm, or that the resident was prescribed antibiotics. -He/She does not know which phone number he/she called when he/she left the voicemail. During an interview on 8/15/24 at 11:40 A.M., the Administrator and Director of Nursing said notification of the guardian should be one of the first things that happen when there are changes like hospitalization status and medications. During an interview on 8/16/24 at 11:18 A.M., the resident's guardian said: -He/She provided the facility with all their phone numbers including their emergency phone number. -He/She provided the facility with a green sheet with all contact numbers on it. -He/She emailed the Administrator, Director of Nursing, Social Services all contact information on 4/10/24. -He/She was not notified of the resident being sent to the hospital on 8/12/24 and therefore, did not consent to treatment. -He/She did not receive a voicemail from anyone from the facility on 8/12/24. -He/She was not notified of the resident returning from the hospital. -He/She was not notified of the resident having something cut on his/her arm or that the resident was prescribed and administered antibiotics. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She didn't even know what hospital the resident was sent to. -The facility has not given him/her the documents from the resident's hospitalization he/she requested. MO00240549

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727 Based on interview and record review, the facility failed to follow their policy to maintain a secure environment for one sampled resident (Resident #1) out of six residents sampled for resident safety, who was allowed to leave the facility without guardian permission on 8/3/24 and as of 8/15/24 had not returned to the facility. The facility census was 162 residents. The Administrator was notified on 8/15/24 of Past Non-Compliance which occurred on 8/3/24. On 8/3/24 facility administration identified the resident left the facility without permission, began the facility investigation, made necessary notifications and facility staff were in-serviced on 8/3/24 and 8/4/24. On 8/3/24 the receptionist received corrective action and on 8/4/24 the receptionist received training. Review of the facility's Resident Outside Pass policy dated as revised on 6/29/23 showed: -The facility would obtain permission to go on an outside pass from the legal guardian, if applicable. -The facility would obtain specific information on: --Who the resident was allowed to be released with. --Where the resident was allowed to go. --How long the resident was allowed to be absent. --When the resident would be leaving. --Any additional information that was to be passed on to the responsible party. -24-hour advance notice of the resident's absence from the facility is requested for continuity purposes. -Orders would be obtained to allow the resident to go on outside pass with medications as determined by the primary care physician. -The charge nurse/designee would complete the outside pass form prior to the resident leaving the facility. Review of the facility's Elopements and Wandering Residents policy dated as revised on 6/12/24 showed: -An elopement was when a resident left the premises or a safe area without authorization and/or any necessary supervision to do so. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Residents would be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. -Adequate supervision would be provided to help prevent elopements. 1. Review of Resident #1's guardianship fee record dated 1/30/24 showed: -The resident was an incapacitated/disabled person. -The resident had a Public Administrator (PA-a county official with the responsibility to handle the affairs of someone who has no known or available relative, friend, guardian or executor) as a guardian. Review of the resident's hospital records dated 3/15/24 showed: -The resident had a PA as his/her legal guardian. -The resident attempted to manipulate staff into making additional phone calls by stating he/she had not used the phone when he/she had used the phone for quite some time. -The resident fled a residential care facility and his/her whereabouts were unknown until recently. -After the resident fled the residential care facility, he assaulted a family member and wrecked an individual's vehicle without a driver's license. Review of the resident's Level II Evaluation (confirms whether the applicant has a mental illness or intellectual/developmental disability, assesses the individual's need for nursing facility services and assesses whether the individual requires specialized services or specialized rehabilitative services) dated 4/7/24 showed: -The resident had significant mental illness. -The resident was in a long-term care facility since 2017. -The resident moved to a lower restrictive environment (residential care facility) in October 2023. -In November 2023, the resident ran from the facility and was brought back. -In January 2024, the resident had someone come and pick him/her up. -The guardian did not know where the resident was until his/her hospitalization in March 2024 and left against medical advice two weeks prior. -The resident had delusions (fixed false beliefs) about being married. (continued on next page)

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	265822	A. Building B. Wing	08/15/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's current interventions required elopement precautions due to the resident's previous elopement which resulted in the resident not having any housing, the resident not taking his/her medications and using Fentanyl (an opioid pain medication) and cannabis (Marijuana is a mind-altering (psychoactive) drug). Review of the resident's tracking form dated 4/10/24 showed the resident was admitted to the facility. Review of the resident's medical records showed no elopement assessment upon admission. Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment completed by facility staff for care planning) dated 4/16/24 showed the resident had a serious mental illness. Review of the resident's care plan dated 4/22/24 showed: -The resident had a guardian to assist in decision-making due to the resident's mental illness. -The problem identified was that the resident was a very high risk for elopement and had a history of multiple elopements from residential care facilities and now required more supervision. -The desired outcome was that the resident would be monitored closely and remain safe. -The interventions included: --Complete an elopement assessment on admission, readmission and quarterly. --The resident resided in a secure facility and would have supervision when out at the hangout area and while out of facility for appointments. --Face checks/intensive monitoring would be completed per facility protocol. --Resident's photo and information was kept in the elopement book. -The care plan was updated on 8/4/24 to include the resident's elopement on 8/3/24. Review of the facility's in-service dated 6/18/24 showed the receptionist attended education on resident outside passes and elopements. Review of the resident's quarterly MDS dated [DATE] showed the following staff assessment of the resident: -Was cognitively intact. -Had no behaviors and no mood indicators of depression. -Was independent with all self-cares. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Had a diagnosis of unspecified mood disorder (a mental health problem that affects a person's emotional state in which a person experiences long periods of extreme happiness, extreme sadness, or both). -Received antipsychotic medications (a group of psychoactive drugs (pertaining to a drug or other agent that affects such normal mental functioning as mood, behavior, or thinking processes) commonly but not exclusively used to treat psychosis) on a routine basis. -Did not use any mobility devices. Review of the resident's medical records showed no quarterly elopement assessment. Review of the resident's physician's progress note dated 7/28/24 showed the resident: -Had a diagnosis of schizophrenia (a chronic mental illness that interferes with a person's ability to think clearly, to distinguish reality from fantasy, to manage emotions, make decisions, and relate to others). -Overdosed on opioids three times and used methamphetamine (a stimulant that is highly addictive and affects the brain and body). -Resided on a locked unit due to his/her chronic medical and psychiatric conditions. Review of the resident's behavior note dated 8/3/24 showed Licensed Practical Nurse (LPN) A documented: -Around 10:05 A.M., the resident went to the lobby and asked to go hang out in the car with an individual the resident's alleged was his/her spouse. -The resident left the building and did not return. -The police, the resident's guardian, and the Administrator were informed of the resident's elopement. Review of the city's police department case number card showed the police were notified on 8/3/24. Review of the receptionist's written statement dated 8/3/24 showed: -He/She let the resident out of the building on 8/3/24 around 10:30 A.M. with his/her spouse because the resident said the Assistant Administrator said he/she could, and the resident did not return. -He/She called the Social Worker before letting the resident go out with the visitor but there was no answer. Review of the facility's resident sign in and out log dated 8/3/24 showed the resident did not sign out. Review of the resident's elopement evaluation dated 8/3/24 at 12:30 P.M. showed the resident: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Had a history of elopement at home. -Had a history of elopement at another facility. -Verbally expressed his/her desire to go home. Review of the resident's Administrator investigation dated 8/3/24 at 2:00 P.M. showed: -The Administrator received a phone call on 8/3/24 around 1:30 P.M. and was notified the resident was not in the facility. -The resident eloped from the facility. -The receptionist was the witness. -Disciplinary action was taken by suspension of the receptionist pending investigation. -The guardian and physician were notified on 8/3/24. -They initiated a search for the resident outside the facility and they were unable to locate the resident. -The receptionist said: --The resident had a visitor that identified as being the resident's spouse. --The resident said the Assistant Administrator told him/her he/she could go on an outside pass. --He/She attempted to call and verify the resident had permission to go out of the building with the Social Worker but did not get an answer. --He/She did not know the Assistant Administrator's phone number. --He/She did not call the Administrator. --He/She was told by the resident he/she was going out to sit in the car, which was supposed to be for an hour. --The resident did not have a resident outside pass form. --The resident went out around 10:15 A.M. -Certified Medication Technician (CMT) A said he/she looked for the resident to administer his/her medications and could not find him/her on the unit. -CMT A said he/she went to the receptionist to see if the resident was on outside pass around 12:45 P.M. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Assistant Administrator said he/she did not speak to the resident about an outside pass or give him/her permission to go on an outside pass with the person he/she identified as his/her spouse. -Camera footage showed the resident left the facility around 10:15 A.M. with another individual in a car. -The police department was notified of the resident's elopement. -The receptionist was suspended pending investigation. -The receptionist and all staff educated on resident outside policy, elopements and wandering residents. -All staff were educated to verify with the Administrator prior to letting any resident go for an outside pass or the Social Worker when the Administrator was unavailable. Review of an in-service dated 8/4/24 showed the receptionist was in-serviced on the resident out on pass procedure. Review of the communication with the resident's guardian note dated 8/5/24 documented as a late note by the Social Services Director showed the Social Services Director contacted the resident to encourage the resident to return and the resident stated he/she would not be returning, and no one could force him/her to. During an interview on 8/13/24 at 12:11 P.M., the Social Services Director said: -The resident did not tell him/her that he/she wanted to leave the facility. -The resident previously eloped from a residential care facility. -The resident was on a locked unit and the guardian had to give consent for the resident to leave the facility. -The resident had not left the facility since he/she came to the facility. -The guardian had not given consent for the resident to leave the facility. -The receptionist let the resident leave the facility with someone who had a car and he/she left in the car with that individual and the resident had not returned. -The receptionist knew not to let the resident leave the facility and should have called someone when the resident's visitor said he/she was there to take the resident out, when there was no paperwork confirming the approval of the resident going out of the facility with the visitor. -They notified the police and gave them information on the resident, the individual the resident left with and their car. (continued on next page)

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	08/15/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She called the individual the resident left with and spoke with the resident and educated the resident on the risks of him/her not being at the facility such as a lack of his/her medications and the lack of a controlled environment. -They in-serviced all staff after the incident. During an interview on 8/13/24 at 1:12 P.M., Hall Monitor A said: -He/She worked the resident's unit on the day the resident left. -He/She had not heard the resident talk about wanting to leave. -The resident went on smoke break around 9:30 A.M. -The resident told him/her that he/she was supposed to go out with his/her spouse. -He/She told the resident he/she could not let him/her out and that he/she had to wait for someone to call him/her up to the front of the building if the visit was approved. -The resident went to group hangout around 10:00 A.M., which lasted about two hours. -Lunch was right after group. -After lunch, they were checking on each individual resident and the CMT noticed the resident was not there. -He/She asked the nurse about it and the nurse was unaware of the resident leaving. -He/She was trained that the resident could not be let off the unit to leave the building without the resident being called up to the front of the building. During an interview on 8/13/24 at 1:30 P.M., the Medical Records employee said: -He/She had not heard the resident say anything about wanting to leave the building. -He/She did not think the resident had left the building since he/she admitted to the facility. -He/She was the Manager on Duty the day the resident left the building. -Around 1:15 P.M., the receptionist told him/her the resident was outside with a friend and they were supposed to be sitting in the car. -The receptionist went to look in the car and saw the car was no longer there. -He/She notified the Administrator the resident was gone. -The Administrator told him/her to call the police. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If a resident was leaving the facility for more than four hours, there was a packet of forms that needed to be completed. -If a resident was leaving the facility for less than four hours, they needed to call the Administrator to make sure the outside facility pass was approved. -The receptionist was responsible for looking for the pass and getting a copy of the driver's license and insurance of the individual he/she was going out with and to make sure they had their medication if needed. -The receptionists were trained on the process of residents going on an outside the facility pass. -The receptionist who let the resident out was not new to the facility. During an interview on 8/13/24 at 1:48 P.M., the Assistant Administrator said: -The resident asked him/her about the process of obtaining an outside the building pass about a month ago and he/she told the resident his/her guardian would have to approve it through the Social Worker. -The Administrator called him/her after the resident left the building to ask if he/she had given the resident permission to leave the facility. -He/She did not give the resident permission to leave the facility. -The resident told the receptionist he/she gave permission for the resident to leave the facility. -The receptionist did not call him/her to confirm the resident was given permission to leave the facility. -The resident had a guardian and the guardian had to give permission for the resident to leave the facility. -The Social Worker was the one who would have received permission from the guardian for the resident to leave the facility. -They utilize a shared calendar where all residents who had approval for outside passes were entered. -If the resident's outside pass was not the calendar, the receptionist should have called someone such as the Social Worker or the Administrator to confirm whether the resident was approved for an outside pass or not. During an interview on 8/13/24 at 2:35 P.M., LPN A said: -They learned the resident outside pass procedure in orientation and in additional in-services. -He/She was the charge nurse on the resident's unit the day the resident left. (continued on next page)

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	265822	A. Building B. Wing	08/15/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The process usually included notifying the nurse, having the outside the facility paperwork, and obtain guardian approval. -Usually, the Administrator or the Social Worker informed him/her of any approved passes. -No one told him/her the resident was going out of the facility that day. -He/She had never heard the resident say he/she wanted to go out of the facility. -He/She saw the resident after breakfast and then the resident was off the unit for group. -Normally the receptionist called him/her over the walkie talkie to tell him/her a resident needed to go up front for an outside pass. -When the staff were doing hourly checks on the residents, they could not find the resident. -He/She went to the receptionist to ask about the resident. -The receptionist told him/her that after group, the resident's (alleged) spouse arrived and said they were going out to smoke in his/her car in the parking lot. -He/She talked to the Administrator after they discovered the resident was gone. -The Administrator contacted the resident's guardian. -He/She called the resident and he/she did not answer his/her phone. -They went outside to look for the resident. -The Manager on Duty was there. -The Administrator came to the facility. -He/She drove around and looked for cars parked off the road. -The Administrator called all the department managers and they searched for the resident. During an interview on 8/13/24 at 2:54 P.M., CNA A said: -Usually, the receptionist called the unit and told them to bring the resident to the front of the building if they have been approved for a pass. -The resident told him/her the night before that his/her spouse was coming to visit. -The resident never talked to him/her about wanting to leave. -He/She did not see the resident the day he/she left. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The receptionist told him/her the resident left with someone in a car. -The Administrator and Director of Nursing (DON) were supposed to be informed of any approved passes. During an interview on 8/13/24 at 3:16 P.M., Hall Monitor B said: -He/She had never heard the resident say anything about wanting to leave. -The resident told him/her his/her spouse was coming to pick him/her up. -He/She saw the resident after breakfast and saw the resident in the hall. -Residents had to sign out and sign back in the facility when out on pass. -Other staff told him/her the resident was missing and he/she helped look for the resident in the building. During an interview on 8/14/24 at 9:04 A.M., the receptionist said he/she refused to answer any questions regarding the resident's elopement and that he/she no longer worked at the facility. During an interview on 8/14/24 at 9:27 A.M., the resident's Public Administrator's assistant said: -Their office was informed that the resident left the facility and had not returned. -They told facility staff from the beginning that the resident was a flight risk. -Facility staff told them that the resident told a staff member he/she was going outside to smoke and talk with his/her boyfriend/girlfriend. -The resident has mental illness and needed to be in a secure facility. -The resident was not supposed to leave the facility. -They did not give the resident consent to leave the facility. -The resident needed a locked unit and the facility staff let the resident leave without permission. During an interview on 8/15/24 at 11:30 A.M., the resident's physician said: -The resident was put in the facility for a reason. -The resident needed to be in a secure facility. During an interview on 8/15/24 at 11:40 A.M., the Administrator and Director of Nursing said: -The resident was a known elopement risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-They had a process in place for outside passes. -The receptionist failed to follow the resident outside pass policy. -They were supposed to do elopement risk assessments upon admission, quarterly and as needed. During an interview on 8/20/24 at 7:56 A.M., CMT A said: -He/She was working as a CMT on the resident's unit. -He/She was looking for the resident to give him/her his/her medications. -He/She asked the resident's roommate if he/she had seen him/her and he/she suggested looking in their room. -He/She looked in the resident's room, dining room, the outside area in the back of the facility and he/she was not in any of those places. -He/She asked the receptionist and he/she said the resident had stepped out up from and was supposed to be back. -He/She checked the resident sign-out log and the resident had not signed out. -That was when they started notifying everyone that the resident was missing. MO00240000

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22727 Based on observation, interview and record review, the facility failed implement interventions for dementia (a progressive mental disorder characterized by memory problems, impaired reasoning and personality changes) care to promote the highest possible level of well-being for one sampled resident (Resident #3) with dementia which negatively affected sampled Residents #2, #4, #9 and #10 out of 10 residents sampled. The facility census was 162 residents. Review of the facility's Elopements and Wandering Residents policy dated as revised 6/12/24 showed: -Wandering was defined as random or repetitive locomotion that may be goal-directed (such as searching for something like an exit) or non-goal directed, or aimless. -The facility should establish and utilize a systematic approach to monitoring and managing residents at risk for unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. -The interdisciplinary team would evaluate the unique factors contributing to risk to develop a person-centered care plan. -Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards would be added to the resident's care plan and communicated to appropriate staff. -Adequate supervision would be provided to help prevent accidents. -Charge nurses and unit managers would monitor the implementation of interventions, response to interventions, and document accordingly. -The effectiveness of interventions would be evaluated, and changes would be made as needed. -Any changes or new interventions would be communicated to relevant staff. 1. Review of Resident #3's admission record dated 7/22/24 showed the resident had diagnoses including Alzheimer's disease (a progressive loss of brain cells that leads to memory loss and the decline of other thinking skills) and dementia, cognitive communication deficit (trouble reasoning and making decisions while communicating), and insomnia (the inability to fall asleep or stay asleep). Review of the resident's health status note dated 7/23/24 at 6:48 P.M. showed: -The resident wandered about the unit often in other residents' rooms. -It was difficult to redirect the resident at times due to baseline cognition. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident's interactions with other residents was not positive due to the resident entering into other residents' rooms without their permission and trying to take others' belongings and the other residents were upset. Review of the resident's behavior note dated 7/24/24 at 8:59 A.M. showed: -A loud noise was heard from the resident's room. -The resident was grabbing at his/her roommate's (Resident #10 at the time) clothing. -The residents were separated. -There were no injuries. Review of the resident's hot rack note dated 7/24/24 showed the resident: -Was alert to self only. -Had a pattern of wandering. -Wandered in and out of other residents' rooms mistaking others' personal belongings as his/her own and was not easily directed. -Wandered at night. Review of the resident's hot rack note dated 7/25/24 showed the resident: -Was alert to self only. -Had a pattern of wandering. -Wandered in and out of other residents' rooms mistaking others' personal belongings as his/her own and was not easily directed. -Wandered at night. Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 7/28/24 showed the following staff assessment of the resident: -Severely cognitively impaired. -Had inattention such as difficulty focusing and/or was easily distracted. -Had disorganized thinking such as rambling, irrelevant conversation, unclear or illogical flow of ideas and/or unpredictable switching from subject to subject. -Had no behavioral symptoms. (continued on next page)

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	265822	A. Building B. Wing	08/15/2024

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Walked independently. -Some of his/her diagnoses include Alzheimer's Disease and dementia, cognitive communication deficit, and insomnia (inability to fall asleep or stay asleep). Review of the resident's care plan dated 8/2/24 showed: -The problem identified was the resident was at risk for wandering. -The desired outcome was the resident's safety would be maintained. -Interventions included: --Clearly identify the resident's room and bathroom. --Engage the resident in purposeful activity (no examples were included). --Identify if there is a certain time of day the resident wandered (none were included). --Identify if there is a pattern and purpose to the resident's wandering (none were included). --Identify wandering behaviors (none were included). Review of the resident's elopement evaluation dated 8/2/24 showed: -The resident's wandering behaviors were likely to affect the safety or well-being of himself/herself and/or others. -The resident's wandering behavior was likely to affect the privacy of others. Review of the resident's elopement evaluation dated 8/4/24 showed: -The resident wandered aimlessly. -The resident's wandering behaviors were likely to affect the safety or well-being of himself/herself and/or others. -The resident's wandering behavior was likely to affect the privacy of others. Review of the resident's respiratory evaluation dated 8/7/24 at 2:48 P.M. showed the resident slept intermittently and wandered at night. Review of the resident's interdisciplinary team note dated 8/7/24 at 8:30 P.M. showed: -The resident was physically aggressive with another resident. -There were no injuries and the resident denied being in pain. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident's physician and the department managers were notified. Review of the facility's investigation dated 8/7/24 of an incident between Resident #2 and Resident #3 showed: -The incident type was physical aggression. -Resident #2 said he/she was in his/her room in his/her wheelchair. -Resident #2 said Resident #3 came into his/her room and was going through his/her belongings. -Resident #2 said he/she started to take the items out of Resident #3's hands and told Resident #3 to leave. -Resident #2 said Resident #3 started putting his/her hands up towards his/her neck and he/she pushed Resident #2 away. -Resident #2 said Resident #3 did not choke him/her because he/she pushed Resident #3's hands away. -Resident #2 said he/she called out for help and staff came to assist. -Staff separated the residents and redirected Resident #3 from the room. -Notifications to the guardian, physician, psychiatrist, Administrator, Director of Nursing (DON) and regional staff were notified. -There were no injuries to either resident. -Resident #3 was unable to say what happened. -Resident #2 said he/she was not fearful. -The incident was not preventable and was not a previous, ongoing problem that the facility could have seen due to prior history. -They contacted the guardian regarding alternative placement. Review of the resident's communication note dated 8/8/24 showed the Administrator documented: -He/She spoke with the resident's responsible party regarding alternate placement due to the resident's diagnosis. -The alternate placement was another facility that was owned by the same company. -The resident's responsible party said he/she would tour the other facility. Review of the resident's care plan dated 8/8/24 showed: (continued on next page)

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	265822	A. Building B. Wing	08/15/2024

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident had impaired cognitive function and/or impaired thought processes related to dementia. -The problem identified was the resident had a behavior problem related to Alzheimer's and dementia and wandered into peers' rooms uninvited. -The desired outcome was to ensure protective oversight. -Interventions included: --Administer medications as ordered. --Caregivers to provide opportunity for positive interactions and attention. --Caregivers to stop and talk with the resident as passing by him/her. --If reasonable, discuss the resident's behavior. --Explain and /or reinforce why the resident's behavior is inappropriate and/or unacceptable to the resident. --Intervene as necessary to protect the rights and safety of others. --Speak to the resident in a calm manner. --Divert the resident's attention. --Remove the resident from the situation and take to alternate location as needed. --Provide a program of activities that is of interest and accommodates resident's status. -The problem identified was the resident wandered into a peer's room and the peer accused the resident of trying to choke him/her. -The desired outcome was the resident will be redirected by staff when wandering to prevent the resident from going into other resident's rooms. -Interventions included: --Assessed by staff. --Redirected to his/her room. --The resident's spouse, physician and the psychiatrist were notified of the incident. Review of the resident's health status note dated 8/11/24 showed the resident tried to take a shirt from another resident. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's communication note dated 8/12/24 showed the Administrator documented: -He/She spoke with the resident's responsible party. -The resident was noted to wander on the unit. -He/She discussed the referrals for a discharge to another facility that were sent on 8/8/24. -The resident's responsible party requested to meet on 8/14/24 to discuss options. During an interview on 8/13/24 at 9:54 A.M., Certified Medication Technician (CMT) B said: -The resident wandered a lot. -They just let him/her wander. During an interview on 8/13/24 at 10:00 A.M., Certified Nursing Assistant (CNA) B said: -They watch him/her for his/her wandering. -They were trained to: --Get the resident who was wandering away from the area and try to re-direct them. --Don't try to grab the resident. --Ways he/she has re-directed the resident included saying the resident's name and re-directing him/her to a chair in another area or taking him/her outside. Review of Resident #2's MDS dated [DATE] showed the resident was cognitively intact. During an interview on 8/13/24 at 11:13 A.M., Resident #2 said: -He/She was in his/her room in his/her wheelchair when Resident #3 wandered into his/her room and would not leave. -He/She was not happy about Resident #3 being in his/her room. -Resident #3 started picking up some of his/her stuff like his/her shoes. -He/She told Resident #3 loudly to please leave his/her room multiple times. -Resident #3 told him/her no. -He/She told the resident to get out of his/her room. -Resident #3 started pushing into him/her. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #3 tried to put his/her hands on his/her neck. -Resident #3 was growling. -He/She tried to use his/her elbow to get Resident #3 to move away from him/her. -He/She called out for help. -Staff came to his/her room and got Resident #3 out of his/her room. -He/She did not have any injuries. -Resident #3 wandered into his/her room again one day but he/she felt better prepared and just used his/her call light and someone (he/she did not know who) came and got Resident #3 out of his/her room. During an interview on 8/13/24 at 11:35 A.M., Resident #3 was unable to be understood and could not answer any questions about him/her going into Resident #2's room. During an interview on 8/13/24 at 12:02 P.M., the Social Services Director said: -Resident #3 was a wanderer. -There were no injuries from the incident with Resident #2 and Resident #3. -Resident #2 told him/her that he/she was not too upset and was not fearful. -There had been one previous incident when Resident #3 was going through someone's clothes, so they did a room move. -The employees were educated to monitor Resident #3's wandering but he/she did not know what exactly that entailed. -They didn't have anyone who could monitor Resident #3 one-on-one. -They talked to the resident's responsible party about what they could use to put on the resident's door to make it easily identifiable to the resident, but they had not come up with anything to put on the door. -After the incident with Residents #2 and Resident #3, he/she started trying to find alternate placement for Resident #3. -He/She explained to Resident #3's responsible party that there were residents on the unit who were cognizant and did not like Resident #3's wandering. -The resident's responsible party declined sending the resident to another facility owned by the same company. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/13/24 at 1:30 P.M., Medical Records said: -He/She did not see Resident #3 wander too much. -They were supposed to tell Resident #3 not to go in other residents' rooms and to re-direct him/her to watch television. During an interview on 8/13/24 at 1:48 P.M., the Assistant Administrator said: -He/She has seen Resident #3 wander often. -Resident #3 was very confused and difficult to re-direct. -He/She was not sure what staff were told to do about Resident #3's wandering. -He/She heard Resident #3 was being considered for a move to a different facility. During an interview on 8/13/24 at 2:35 P.M., Licensed Practical Nurse (LPN) A said he/she was trained to re-direct residents who were wandering. During an interview on 8/13/24 15 2:54 P.M., CNA A said: -Resident #3 was kind of new to the facility. -They just watch Resident #3 because he/she liked to go into other residents' rooms. -Resident #3 did like to help clean up like sweeping the floor or wiping things off with a washcloth. Review of Resident #4's quarterly MDS dated [DATE] showed the resident was cognitively intact. Review of Resident #10's MDS dated showed the resident was cognitively impaired. During an interview on 8/14/24 at 10:11 A.M., -Resident #4 said: --Resident #3 wandered into his/her room. --He/She had to run Resident #3 out of his/her room a couple of times. --Resident #3 got to his/her fan once. --Resident #3 had Resident #10's (Resident #4's roommate) trash in his/her arms once. --He/She felt like he/she could not sleep because he/she was worried Resident #3 would come into his/her room at night and take his/her things. (continued on next page)

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	08/15/2024

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--Resident #3 came into his/her room often, maybe two to three times a week, or maybe even more. --Resident #3 left when he/she told him/her to. --He/She had told the CNAs. --The CNAs know Resident #3 comes into their room. --The CNAs don't prevent Resident #3 from coming into his/her room, but they do come and get Resident #3 once he/she tells them he/she's in their room. -Resident #10 said Resident #3 wandered into their room lots of times. Observation on 8/14/24 at 11:00 A.M. showed there was nothing clearly identifying the resident's room or differentiating it from any other room. Review of Resident #9's annual MDS dated [DATE] showed the resident was moderately cognitively impaired. During an interview on 8/14/24 at 11:00 A.M., Resident #9 (Resident #3's current roommate) said: -Resident #3 goes around from room to room. -One time he/she told Resident #3 to leave his/her stuff alone and Resident #3 put up his/her fists, so he put up his/her fists, but nothing happened. -He/She locked up his/her stuff because Resident #3's goes through his/her things. -He/She did not have a way to lock up some of his/her drawers. -Resident #3 took three of his/her towels. -He/She was so mad when Resident #3 took his/her towels that he/she was shaking. -He/She didn't sleep for three nights because he/she was watching Resident #3 to make sure he/she didn't take anything else from him/her. -He/She does not like being Resident #3's roommate. Observation on 8/14/24 at 12:11 P.M. showed: -Resident #3 was walking one of the halls on his/her unit. -Resident #3 went to a medication cart and picked up a piece of paper. -LPN B removed the paper from the resident's hands and asked him/her to help fold some laundry. During an interview on 8/14/24 at 12:45 P.M., CNA C said: (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #3 wandered around the unit. -He/She was told to watch the resident to make sure he/she didn't put things in his/her mouth or do something to other residents so he/she just keeps an eye on Resident #3. -Some of the residents on the unit do not like Resident #3 going into their rooms and they have complained about it. -He/She did not see the incident between Resident #2 and Resident #3 but he/she knew there were no injuries. During an interview on 8/14/24 at 1:29 P.M., LPN B said: -Resident #3 walked around the unit all day. -They have been trained to re-direct the resident. -He/She tried to get Resident #3 to do things like folding or sitting by him/her. -Resident #3 goes into other resident rooms and he/she had to be re-directed. -The other residents come to the staff and let them know if Resident #3 is in somebody's room so they can take care of it. -Resident #3's roommate had not complained to him/her about Resident #3. -Resident #3 was not on one-on-one monitoring but someone was always around. During an interview on 8/14/24 at 8:35 P.M., CNA D said: -He/She was passing snacks around 8:30 P.M. when he/she heard Resident #2 yelling, Get out of my room! -Resident #3 was trying to get his/her hands on Resident #2's neck. -He/She was able to get Resident #3 out of Resident #2's room. -Residents #2 and #3 were not injured. -Resident #3 still goes into other residents' rooms and touches their stuff. -He/She did not receive training on how to handle residents who wander. -He/She just kept re-directing the resident the whole shift on every shift. -Resident #9 was usually very quiet and stayed in his/her room. -One time he/she heard Resident #9 cursing at Resident #3. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #9 said to Resident #3, I'm going to fuck you up! -Resident #9 stood up and said to Resident 3, I'm going to beat your ass! -He/She had never heard Resident #9 be like that before. -Resident #9 said Resident #3 was touching his things and took his/her remote. -He/She told Resident #3 to stop, but he/she didn't really understand. -He/She told Resident #9 they would help re-direct Resident #3 to the common area where the television was. -It's difficult to keep an eye on Resident #3 with 60 other residents on the unit. During an interview on 8/14/24 at 9:09 P.M., CNA E said: -He/She heard Resident #2 hollering. -He/She and the nurse went to Resident #2's room. -He/She left and let the nurse handle it. -Resident #3 did not usually go to bed. -Resident #3 usually wandered all night. -He/She tries to redirect Resident #3 but he/she tries to fight him/her. -Resident #3 frequently went into other residents' rooms. -They try to catch Resident #3 before he/she gets into other residents' rooms. During an interview on 8/15/24 at 11:30 A.M., the resident's physician said: -The staff could only do so much with what they had. -They couldn't put all the residents on one-on-one. -The resident would still wander if moved to a memory care unit. During an interview on 8/15/24 at 11:40 A.M., the DON and Administrator said: -The resident wandered and was re-directed by staff. -The staff could talk to the resident, re-directed the resident and he/she would follow the staff member. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident couldn't remember what he/she was told due to his/her disease process of Alzheimer's disease. -Agitation was also part of the disease process. -The staff were educated on how to keep the resident from wandering and keeping him/her busy. -They tried to keep the resident near the nurses' station. -They tried to provide the resident with fidget work. -They re-directed the resident to the television area. -Television distracted the resident. -The resident liked music. -Staff played music in the television area. -The resident had a previous incident with Resident #10 when they were roommates. -The resident attempted to take a basket from Resident #10 and Resident #10 attempted to take the basked back from the resident. -Then Resident #10 grabbed the resident and the resident grabbed Resident #10 back. -There were no injuries during the incident between Resident #3 and Resident #10. -They made a room change so the resident and Resident #10 were no longer roommates. -They were not aware of any issues between Resident #3 and Resident #9 (current roommate). -They were seeking a memory care unit for the resident. During an interview on 8/15/24 at 12:12 P.M., the resident's responsible party said: -The facility staff let him/her know about the incident with the resident and Resident #2. -The facility staff talked to him/her about touring another one of the facility's corporation's homes. -The facility told him/her the other facility owned by their corporation was the only facility that would accept the resident out of the facilities they sent referral information to. -He/She toured the other facility and found it depressing and told the facility he/she did not want the resident to be discharged to that facility. MO00240226