

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  09/12/2024
NAME OF PROVIDER OR SUPPLIER  Bridgewood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  11515 Troost Kansas City, MO 64131	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>43345</p> <p>Based on observation, interview, and record review, the facility failed to protect two residents (Resident #11 and Resident #12) from physical abuse. On 9/9/24 about 3:00 A.M., Certified Nurse Aide (CNA) F punched Resident #12. The resident and CNA F fell and rolled on the floor punching each other. CNA D and CNA G watched and did not attempt to separate Resident #12 and CNA F. A Code [NAME] (emergency response) was called and staff separated the resident and CNA F. Licensed Practical Nurse (LPN) D assessed Resident #12 and noted redness. CNA F pushed past the LPN D and other staff going toward Resident #12 and CNA F punched Resident #12 in the face three times. Resident #12 sustained a cut above the left eye, bruising under and around the left eye and brow, and a broken nose. On 9/8/24 about 7:00 P.M., Hall Monitor (HM) C hit and punched Resident #11. The facility census was 166.</p> <p>The Administrator was notified on 9/11/24 at 12:00 P.M., of the Immediate Jeopardy (IJ) which began on 9/8/24. The IJ was removed on 9/12/24, as confirmed by surveyor onsite verification.</p> <p>Record review of the facility's Abuse and Neglect policy, revised 6/12/24, showed:</p> <ul style="list-style-type: none"> <li>-Physical abuse was defined as purposely beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner.</li> <li>-Physical abuse included handling a resident with any more force that was reasonable for a resident's proper control, treatment, or management.</li> <li>-Physical abuse also included, but is not limited to, hitting, slapping, punching, biting, and kicking.</li> <li>-Physical abuse also included corporal punishment, which was physical punishment used as a means to correct or control behavior.</li> <li>-The facility was committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, and staff from other agencies that provided services to the individual, family members, legal representatives, friends or any other individuals.</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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>1. Review of Resident #12'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 8/13/19, 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>-- Schizoaffective Disorder (a mental condition that causes loss of contact with reality and mood problems).</li> </ul> <p>Review of the resident's Nursing Care Plan, dated 5/31/24, showed:</p> <ul style="list-style-type: none"> <li>-The facility staff was to provide specific services that assisted the resident with managing his/her behaviors and mental illness.</li> <li>-The behavioral health plan was indicated due to his/her history of poor impulse control, aggression, and inappropriate behaviors.</li> <li>-Facility staff were to have been aware of his/her triggers which were missing smoke breaks and coffee.</li> <li>-The facility staff were to have known his/her coping skills which were smoking, drinking coffee, talking to staff members, and quiet time where he/she was allowed to relax and calm down.</li> <li>-The resident had behaviors related to his/her mental illness that created disturbances which affected others such as yelling, cursing and name calling at staff.</li> </ul> <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 8/21/24, showed:</p> <ul style="list-style-type: none"> <li>-He/She was cognitively intact.</li> <li>-He/She had no behaviors.</li> </ul> <p>Observation of the facility's video footage, dated 9/9/24 at 2:50 A.M., of the incident that occurred showed:</p> <ul style="list-style-type: none"> <li>-The resident was standing in a doorway.</li> <li>-CNA F walked up to the resident and appeared to speak to the resident.</li> <li>-Then the resident pushed CNA F away from him/her.</li> <li>-CNA F walked over to the opposite wall and set his/her keys on a ledge and then bend down to tie his/her shoe.</li> <li>-The resident ran from the doorway towards CNA F.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-CNA F started to put his/her shoes back on.</p> <p>-CNA F was talking with staff member then broke away from the staff and ran back into the common area room out of view of the camera.</p> <p>-CNA F was forced out of the common area room by staff and walked out of view of the camera away from the common area room.</p> <p>-The resident was still off camera in common area room.</p> <p>Review of the Physician's Certification Statement for Non-Emergency Transportation, dated 9/9/24, showed Resident #12 had an altercation with staff and had a left eye hemoatoma (localized bleeding outside of blood vessels, due to either disease or trauma including injury or surgery and may involve blood continuing to seep from broken capillaries).</p> <p>Review of hospital discharge paperwork, dated 9/9/24, showed:</p> <p>-The resident had a corneal abrasion (scrape), Hyphema (bleeding on front part of the eye between the cornea and the iris), and a broken nose.</p> <p>-The hospital did not specify the reason of these injuries.</p> <p>Review of the Facility Registered Nurse Investigation, dated 9/9/24, showed:</p> <p>-The type of incident was physical aggression involving the head.</p> <p>--The resident was in the game room talking to CNA F.</p> <p>--The resident pushed CNA F.</p> <p>--CNA F put his/her belongings down on the floor.</p> <p>--CNA F began to swing at the resident.</p> <p>--The resident ran at CNA F and grabbed CNA F's hair.</p> <p>--Both the resident and CNA F fell to the floor.</p> <p>--Staff separated the resident and CNA F.</p> <p>--CNA D and CNA G walked CNA F off the unit.</p> <p>--Licensed Practical Nurse (LPN) D had assessed the resident and the resident had no injuries.</p> <p>--CNA F broke away from staff and went to the resident and stuck him.</p> <p>--LPN D saw CNA F strike the resident in the face three to four times.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>--CNA F separated from the resident and taken off the unit.</p> <p>--CNA F was immediately suspended.</p> <p>-The injury was the result of abuse.</p> <p>Review of Witness Statement, dated 9/9/24, from Night Supervisor A showed:</p> <p>-He/She was sitting in the front lobby when notified of the situation by agency CNA D over the radio.</p> <p>-He/She responded to the unit.</p> <p>-Agency CNA D and agency CNA G were with the resident.</p> <p>-CNA F was grabbing his/her shoes and hair.</p> <p>-He/She asked CNA F to leave the unit.</p> <p>-Agency CNA D and agency CNA G were escorting CNA F off the unit.</p> <p>-CNA F broke free from agency CNA D and agency CNA G.</p> <p>-CNA F charged at the resident and struck Resident #12 multiple times in the face.</p> <p>-Agency CNA D, agency CNA G, and LPN D were trying to get CNA F off the resident.</p> <p>-Staff were able to remove CNA F from the area.</p> <p>-The Administrator was called.</p> <p>-The resident left eye was blackened and swollen with a small cut above the eye.</p> <p>-Was advised by the Administrator to have the resident sent to the hospital for evaluation and to call the police.</p> <p>During an interview on 9/11/24 at 12:52 P.M., Night Supervisor A said:</p> <p>-He/She was at the front desk working on the midnight census report.</p> <p>-He/She was notified of the incident over the radio on 9/9/24 about 3:00 A.M.</p> <p>-He/She responded to the unit.</p> <p>-Two staff were with the resident and one was with CNA F.</p> <p>-CNA F appeared calm and then broke away from the staff.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-CNA F hit him/her in the left eye.</p> <p>-CNA F hit him/her 12-15 times.</p> <p>-He/She was not feeling any pain after the fight was over.</p> <p>-He/She had dark bruising below and above the left eye, and a small cut that was covered by tape to the corner of the left eye.</p> <p>-The tape was about one centimeter in length.</p> <p>Review of agency CNA D Witness Statement, dated 9/9/24, showed:</p> <p>-The resident wanted to be out of his/her room.</p> <p>-CNA F told the resident to go back to his/her room.</p> <p>-CNA F approached the resident and told the resident to calm down.</p> <p>-The resident then punched CNA F and slammed him/her to the floor.</p> <p>-CNA F tried to get the resident off him/her, but the resident continued to fight and pull CNA F's hair.</p> <p>-Agency CNA D notified everyone over the radio of the situation that was happening.</p> <p>-Agency CNA D and agency CNA G grabbed the resident to get the resident hands off CNA F's hair.</p> <p>During an interview on 9/10/24 at 1:30 P.M., Agency CNA D said:</p> <p>-His/Her shift started at 7:00 P.M.</p> <p>-The resident got in agency CNA D face and was cussing at him/her.</p> <p>-CNA F was trying to calm the resident down.</p> <p>-At 3:00 A.M. CNA F tried to redirect the resident and the resident pushed CNA F.</p> <p>-CNA F said so you are going to push me.</p> <p>-The resident tackled CNA F, grabbed CNA F's hair, and slammed CNA F to the ground.</p> <p>-Both Resident #12 and CNA F fell to the ground.</p> <p>-CNA F pushed the resident against the wall to hold the resident in place.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Agency staff were not allowed to intervene in these situations per their agency since the staff had not been trained on how to intervene with residents when the residents were physically attacking staff or other residents.</p> <p>-Agency staff have training on abuse and neglect through the agency, but are not trained on the extreme behaviors at the facility and how to handle them.</p> <p>During a phone interview on 9/10/24 at 1:04 P.M., CNA F said:</p> <ul style="list-style-type: none"> <li>-The incident occurred on 9/9/24 about 2:30 A.M.</li> <li>-The resident kept approaching the agency CNA D.</li> <li>-Agency CNA D became scared of Resident #12, because he/she kept approaching agency CNA D.</li> <li>-The resident kept going outside to the smoke area.</li> <li>-The resident was not listening to instructions that were given to him/her by CNA F.</li> <li>-The resident kept getting more and more agitated.</li> <li>-He/She was trying to get Resident #12 to return to his/her room and calm down.</li> <li>-The resident pushed him/her and tried to grab his/her hair.</li> <li>-The resident threw him/her around.</li> <li>-The resident pulled his/her hair out.</li> <li>-He/She did not strike the resident at any time.</li> </ul> <p>During an interview on 9/10/24 at 1:23 P.M., LPN D said:</p> <ul style="list-style-type: none"> <li>-He/She was notified of the altercation on 9/9/24 about 2:45 A.M. over the radio.</li> <li>-He/She responded to the men's unit.</li> <li>-He/She saw both the resident and CNA F in the common area room.</li> <li>-Both the resident and CNA F were on their knees and the resident had CNA F's hair in his/her hands.</li> <li>-Neither CNA F nor the resident had any visible injuries.</li> <li>-He/She could not recall which staff separated resident and CNA F.</li> <li>-CNA F was told to go home.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-This altercation may have been avoided had the staff called and received permission for unscheduled smoke break for the resident.</p> <p>During a phone interview on 9/16/24 at 11:30 A.M., Nurse Practitioner (NP) A said:</p> <p>-The on-call NP was notified of the situations that involved CNA F and the resident that occurred on 9/9/24.</p> <p>-CNA F should not have struck the resident under any situation,</p> <p>-Staff have been trained in the appropriate methods of how to handle residents in these type of situations without hitting them.</p> <p>-It was his/her expectation that once the incident was over that CNA F would not have gone back and struck the resident.</p> <p>2. Review of Resident #11's Preadmission Screening and Resident Review, dated 5/31/23, showed he/she had the following diagnoses:</p> <p>--Schizophrenia.</p> <p>--Psychotic Disorder (a mental disorder in which there is a severe loss of contact with reality).</p> <p>--PTSD (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event).</p> <p>--Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety).</p> <p>--Conduct Disorder (group of behavioral and emotional problems characterized by a disregard for others).</p> <p>-- Mixed receptive-expressive language disorder (a communication disorder in which both the receptive and expressive areas of communication may be affected in any degree, from mild to severe).</p> <p>--Moderate Mental Retardation (individuals with cognitive impairments that corresponded to an intelligence quotient (IQ) score between 35-40 and 50-55 and deficits in adaptive functioning that presented before the age of 18.</p> <p>--Cerebral Palsy (a disability resulting from damage to the brain before, during, or shortly after birth and outwardly manifested by muscular in coordination and speech disturbances).</p> <p>Review of the resident's Nursing Care Plan, dated 8/29/24, showed:</p> <p>-The facility staff was to provide specific services that assisted the resident with managing his/her behaviors and mental illness.</p> <p>-The behavioral health plan was indicated due to his/her history of poor impulse control, aggression, and inappropriate behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Facility staff were to have been aware of his/her triggers which were arguing with the resident, getting defensive, and not listening to the resident.</p> <p>-The facility staff were to have known his/her coping skills which were being respectful, being honest, nonjudgmental, and respect his/her personal.</p> <p>-The resident had behaviors related to his/her mental illness that created disturbances which affected others such as seeing things that are not there, becoming fearful and reactive verbally and physically.</p> <p>Review of the resident's admission Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff and used for care planning), dated 7/2/24, showed:</p> <p>-He/She was severely cognitively impaired.</p> <p>-He/She had no behaviors.</p> <p>Observation of the facility's video footage of the incident, dated 9/8/24 at 6:50 P.M., showed:</p> <p>-Hall Monitor (HM) C came on the unit with his/her backpack.</p> <p>-HM C said something to a resident on the hall.</p> <p>-HM C walked to a door and stopped.</p> <p>-The resident could be seen pacing and taking off his/her shirt on another camera view with HM B trying to calm the resident down.</p> <p>-The resident can be seen running towards HM B and HM B had his/her hands up and tried to stop the resident.</p> <p>-The resident ran past HM B and turned the corner of the hall.</p> <p>-The resident ran straight at HM C.</p> <p>-HM C turned and saw the resident almost on top of him/her.</p> <p>-The resident had his/her fist balled up and was ready to swing at HM C.</p> <p>-The resident threw a punch at HM C at the same time HM C also threw a closed handed punch at the resident.</p> <p>-The resident and HM C tangled up and fell to the floor.</p> <p>-The resident and HM C both got up and can be seen exchanging punches.</p> <p>-The resident threw HM C down the hall and HM C fell to the floor.</p> <p>(continued on next page)</p>

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

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The resident ran to HM C and got on top of HM C.</p> <p>-HM C got up again and can be seen exchanging punches with the resident.</p> <p>-Then HM C pushed the resident down the hall.</p> <p>-HM B then responded along with Resident #20 and Resident #12 to pull Resident #11 and HM C apart.</p> <p>-Both the resident and HM C were separated and HM C was taken off the hall.</p> <p>Review of Nurse's Progress Note dated 9/9/24 at 11:47 A.M. showed:</p> <p>-LPN E responded to the men's unit after the incident was over.</p> <p>-The resident and HM C were separated.</p> <p>-An unnamed resident told LPN E that the resident ran up on HM C and hit him.</p> <p>-HM C defended self while unnamed staff responded to the unit and separated the resident from HM C.</p> <p>-Administrator, DON, and NP notified.</p> <p>-The resident refused to say what HM C said to the resident that caused the incident.</p> <p>-Resident assessed for injuries and there were no injuries, swelling, or bruising at that time.</p> <p>-The resident said he/she was not hurt.</p> <p>Review of the Facility Registered Nurse Investigation, dated 9/8/24, showed:</p> <p>-Type of incident was physical aggression involving head.</p> <p>-Persons involved were the resident and HM C.</p> <p>-Statements were received from witnesses and affected persons.</p> <p>-Physician was notified at 9/8/24 at 7:10 P.M.</p> <p>-HM C was reported to have said to the resident let's have a good day and asked the resident what was wrong.</p> <p>-HM C reported to HM B that the resident took a fake swing at him/her.</p> <p>-The resident heard this and took off his/her shirt and started running down the hall.</p> <p>-HM B attempted to stop the resident.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-The resident struck HM C from behind and struck HM C on the left side of HM C's face.</p> <p>-HM C swung back at the resident.</p> <p>-The resident was placed on one-to-one observation and orders received to send the resident to the emergency room for evaluation.</p> <p>-This altercation was abuse even though there were no injuries.</p> <p>Review of HM C written statement, dated 9/8/24, statement showed:</p> <p>-He/She had just come on to the unit.</p> <p>-He/She asked the resident who was yelling to calm down.</p> <p>-He/She was talking to HM B.</p> <p>-The resident struck HM C in the mouth.</p> <p>-The resident was taken to the ground.</p> <p>-He/She then gathered all his/her items then went and gave his/her statement.</p> <p>During a phone interview on 9/10/24 at 2:30 P.M., HM C said:</p> <p>-That it was going to be a good night.</p> <p>-He/She did not threaten the resident.</p> <p>-He/She was getting ready to put things up and got jumped by the resident.</p> <p>-He/She did not hit the resident.</p> <p>-He/She was just trying to hold the resident.</p> <p>-The resident was pulled off him/her by HM B.</p> <p>-He/She gave a statement to the Administrator then went home.</p> <p>-That was all he/she remembered.</p> <p>Review of HM B's written statement, dated 9/9/24, showed:</p> <p>-After social time around 7:00 P.M. both the resident and HM C came on to the unit.</p> <p>-HM C told him/her that if the resident swung on him/her there would be a problem.</p> <p>-The resident overheard this and got agitated while HM C walked down the hall.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-He/She tried to calm the resident down and block the resident path, but the resident got around him/her.</p> <p>-The resident attacked HM C.</p> <p>-HM C defended himself/herself.</p> <p>-Resident #20 helped to break Resident #11 and HM C up along with himself/herself.</p> <p>During an interview on 9/10/24 at 2:01 P.M., HM B said:</p> <p>-He/She was on the unit when the resident and HM C came on the unit.</p> <p>-HM C said there would be a problem if the resident acted like he/she was going to hit HM C.</p> <p>-This was at around 7:00 P.M.</p> <p>-The resident heard the statement that HM C had said and turned and removed his/her shirt.</p> <p>-He/She tried to stop the resident.</p> <p>-The resident ran towards HM C and struck him/her with his/her fist.</p> <p>-HM C retaliated and struck the resident with his/her fist.</p> <p>-Both the resident and HM C fell to the floor and were exchanging blows.</p> <p>-He/She was able to separate the resident and HM C with the help of Resident #20.</p> <p>-He/She took the resident back to his/her room and calmed him/her down.</p> <p>-The resident had no visible injuries.</p> <p>Review of Resident #20's undated written statement showed:</p> <p>-He/She was lying in bed and heard the altercation.</p> <p>-He/She saw HM B trying to break up the resident and HM C.</p> <p>-He/She helped break up the altercation.</p> <p>-Staff came and separated the resident and HM C.</p> <p>During an interview on 9/10/24 at 12:55 P.M., Resident #20 said:</p> <p>-The incident happened during shift change.</p> <p>-The resident was walking another staff member off the unit.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-Then HM C came on the unit and said loudly it was going to be a good night tonight.</p> <p>-He/She then was walking back to his room and heard noise out in the hallway.</p> <p>-He/She went back out to the hall to see what was going on.</p> <p>-He/She saw the resident and HM C on the floor.</p> <p>-He/She saw the resident and HM C exchanging punches with each other on the ground.</p> <p>-He/She helped staff and separated the resident and HM C.</p> <p>-HM C was taken off the unit and the resident was taken to his/her room.</p> <p>During an interview on 9/10/24 at 12:43 P.M., Resident #26 said:</p> <p>-There was an argument between the resident and HM C.</p> <p>-The resident wanted to go to the front hall and HM C asked the resident to wait until after shift change.</p> <p>-The resident had gone back to his/her room and then came right back out and ran down the hall and punched HM C in the face and back of the head.</p> <p>-HM C gave the resident a bear hug from behind.</p> <p>-The resident and HM C lost their balance and fell to the floor.</p> <p>-The resident kicked and struck with his/her fists HM C.</p> <p>-Resident # 20 broke it up and pulled Resident #11 away from HM C.</p> <p>-HM B told the resident to stop and stood between the resident and HM C.</p> <p>During an interview on 9/10/24 at 12:59 P.M., Resident #12 said:</p> <p>-The resident attacked HM C and hit HM C a few times from behind.</p> <p>-HM C fought back and slugged the resident a few times.</p> <p>-He/She did not know what the resident was upset about.</p> <p>-Both the resident and HM C ended up on the floor.</p> <p>-The resident and HM C they were hitting each other while on the floor.</p> <p>During an interview on 9/12/24 at 1:50 P.M., Director of Nursing (DON) said:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-He/She had been notified of the abuse allegation between HM C and the resident.</p> <p>-All staff had been trained prior to the incident on abuse and neglect and that included HM C.</p> <p>-It was his/her expectation that if a HM C got into an altercation with a the resident the staff would have used what he/she had been taught and not hit the resident.</p> <p>-It was his/her expectation that no staff would hit a resident.</p> <p>-It was abuse anytime staff hit a resident.</p> <p>During an interview on 9/12/24 at 2:00 P.M., the Administrator said:</p> <p>-He/She had been notified of the incident on 9/8/24 between HM C and the resident.</p> <p>-All staff had been trained on abuse and neglect prior to the incident and that included HM C.</p> <p>-It was his/her expectation that if HM C got into an altercation with a the resident the staff would have used the training, he/she had received and not hit a resident.</p> <p>-It was his/her expectation that no staff would hit a resident.</p> <p>-Hitting a resident was abuse.</p> <p>During a phone interview on 9/16/24 at 11:30 A.M., NP A said:</p> <p>-The on-call NP was notified of the situation that involved HM C and the resident on 9/8/24.</p> <p>-Staff were not to hit or strike residents under any situation.</p> <p>-Staff had been trained in the appropriate methods of how to handle residents in these type of situations without hitting them.</p> <p>-It was his/her expectation that staff never hit a resident and use what he/she had been trained and that included HM C.</p> <p>NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements.</p> <p>At the time of exit, the severity of the deficiency was lowered to the G level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s).</p> <p>MO00241759 and MO00241753</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 35013</p> <p>Based on observation, interview, and record review, the facility failed to keep one resident, (Resident #19) free from self harm by not following the facility protocol for signing out disposable razors with the charge nurse, supervising the resident while he/she was shaving and then returning the disposable razor to the charge nurse for safe disposition, when on 9/1/24 the resident presented to staff with a superficial cut on his/her left forearm where he/she stated he/she had cut himself/herself with a broken disposable razor where the protective plastic covering had been broken off exposing the blade. 20 residents were sampled. The facility census was 166 residents.</p> <p>Review of the facility policy for Sharps and Hazardous Waste, revised 6/26/24, showed:</p> <ul style="list-style-type: none"> <li>-The purpose of the policy was to ensure that sharp objects and contaminated objects were disposed in a safe manner.</li> <li>-All sharp objects were to have been disposed of into a sharps container.</li> <li>-The sharps containers were to have been disposed of once they were 3/4 full.</li> <li>-Full sharps containers were to have been sealed and kept locked in a designated area until the responsible company came and picked up the container.</li> </ul> <p>During an interview on 9/12/24 at 2:30 P.M., the facility Administrator and DON said:</p> <ul style="list-style-type: none"> <li>-The facility put the new protocol in place six weeks prior in attempt to prevent incidents exactly like this one.</li> <li>-The new protocol had the disposable razors all located in the Central Supply room which only the charge nurse had a key.</li> <li>-The CNA was to request the disposable razor from the charge nurse and once the CNA got the razor, the CNA was to observe the resident while they shaved.</li> <li>-Once the resident was done shaving, the CNA was to return the razor to the charge nurse to dispose of in the sharps container.</li> </ul> <p>1. Review of Resident #19'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 4/22/16, showed he/she had the following diagnoses:</p> <ul style="list-style-type: none"> <li>--Schizoaffective disorder schizoaffective disorder (a mental condition that causes loss of contact with reality and mood problems).</li> </ul> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>--Bi-Polar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs).</p> <p>--Psychotic Disorder (a mental disorder in which there is a severe loss of contact with reality)</p> <p>--PTSD (a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event).</p> <p>--Anti-social Personality Disorder (a condition characterized by repetitive behavioral patterns that are contrary to usual moral and ethical standards and cause a person to experience continuous conflict with society).</p> <p>--Polysubstance Dependence (the use and dependence on more than one illicit drug).</p> <p>--Attention Deficit Hyperactivity Disorder (ADHD, a developmental disorder typically characterized by a persistent pattern of inattention and/or hyperactivity - a physical state in which a person is abnormally and easily excitable or exuberant, as well as forgetfulness, loss of control or impulsiveness, and distractibility).</p> <p>--Adjustment Disorder (a short-term condition that can affect a person's behavior, feelings, and thoughts after they experience a significant life change or stressor).</p> <p>--Major Depression Disorder (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living).</p> <p>--Mild Intellectual Disability (a developmental disorder that affects a person's ability to understand concepts and solve problems).</p> <p>-He/se presented with a flat affect, isolating behavior and anxiety.</p> <p>-He/she was described as withdrawn, with a history of suicidal ideation's but was not an imminent danger to himself/herself or others and had not showed any suicidal or aggressive behaviors for an extended period of time.</p> <p>-He/she was forgetful at times and made poor decisions.</p> <p>-He/she required long-term 24-hour nursing facility placement to monitor behaviors, manage medications, provide safety, and assist with daily decision making.</p> <p>Review of the resident's Nursing Care Plan, revised 7/4/23, showed:</p> <p>-He/she had a long history of mental illness with a history of expressing a desire to hang himself/herself or cut himself/herself as he/she like to go to the hospital frequently to get away.</p> <p>-The facility was to provide long term psychiatric management and counseling along with one-on-one staff interventions as needed.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-At the time he/she was admitted , he/she was deemed safe for admission to a skilled nursing facility.</p> <p>-He/she had voiced thoughts of self-hanging and self-cutting in the past, but had voiced doing so as he/she desired to get out of the facility, apologizing afterwards.</p> <p>-The resident was to remain safe during his/her long-term care stay.</p> <p>-The facility staff were to provide medication therapy as ordered by the physician and psychiatrist.</p> <p>-The facility staff were to provide the lowest restricted, structured environment while maintaining protective oversight.</p> <p>-He/she had poor judgement, impulsive behaviors, angry outbursts, and suicidal threats resulting in repeated hospital admissions.</p> <p>-The facility staff was to ensure that the resident was swallowing his/her medications as he/she had a history of holding his/her medications back and not swallowing them.</p> <p>-The facility staff was to have been aware of his/her triggers and if he/she escalated, they were to have allowed him/her to smoke an extra cigarette and allow him/her to talk to someone about his/her feelings.</p> <p>-The facility staff were to remind the resident of his/her coping skills which were talking to family, making sure he/she got his/her money on time making sure he/she got his/her medications on time and having someone available to advocate for him/her when he/she was struggling with depression and having anxious thoughts.</p> <p>-The facility staff were to assess him/her for potential suicidal or homicidal ideation's and provide protective oversight.</p> <p>-The facility staff were to encourage him/her to express his/her emotions in a safe environment allowing him/her the freedom to acknowledge his/her feeling and release any repressed emotions which could be exacerbating his/her distress and ideation's.</p> <p>-The facility staff were to listen calmly to the residents.</p> <p>-The facility staff were to ensure there were no items available to the resident which he/she could use to harm/cut himself/herself.</p> <p>-The facility staff was to observe the resident while he/she was having and collect the disposable razor afterwards, discarding the razor into the sharps container.</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 7/25/24, showed he/she was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's psychiatric Nurse Practitioner (NP) note, dated 8/25/24, showed:</p> <ul style="list-style-type: none"> <li>-The resident was seen at the facility for routine psychiatric support and follow-up.</li> <li>-He/she was advised by the NP after additional education regarding schizophrenia, to advise the facility staff any time he/she had feelings that were not his/her baseline.</li> <li>-He/she was educated on all diagnoses, triggers and coping skills which would assist the resident on a daily basis.</li> <li>-The resident showed no symptoms that were not at his/her baseline.</li> <li>-The resident reported no suicidal thoughts at the time of the psychiatric assessment.</li> </ul> <p>Review of the resident's Nurse's Notes, dated 9/1/24 at 2:00 P.M., showed:</p> <ul style="list-style-type: none"> <li>-The resident was upset that his/her Buspar (a medication commonly used to treat anxiety) had been stopped by the psychiatric NP.</li> <li>-The resident stated that he/she had pocketed disposable razors weeks ago, went into his/her room and cut his/her left forearm.</li> <li>-He/she stated that since they had taken his/her medication, he/she did not want to live anymore.</li> <li>-The resident's guardian and physician were notified and the resident was sent to the hospital for a psychiatric evaluation.</li> </ul> <p>Review of the facility's Registered Nurse Investigation (RNI), dated 9/1/24, showed:</p> <ul style="list-style-type: none"> <li>-The type of incident was self-harming involving Resident # 11.</li> <li>-There were no witnesses.</li> <li>-The resident had been asking about some of his/her medications.</li> <li>-He/she was upset the physician discontinued one of the medications he/she had been on previously.</li> <li>-It was explained to the resident that the medication had been discontinued due to his/her behaviors having been much better.</li> <li>-The resident went to his/her room and when he/she came out he/she was noted to have a fresh laceration where an old scar had been.</li> <li>-The resident first stated that he/she had the razor for over 30 days and had hid it in his/her room.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Prior to going to the hospital, he/she stated he/she obtained the razor from a nurse three to four days prior, but could not recall if it was day shift or night shift and could not provide a description of the nurse.</p> <p>-The physician was notified as well as the resident's guardian, facility Administrator and Regional representative.</p> <p>-The resident went to the hospital and was subsequently sent to the psychiatric center for a psychiatric evaluation and treatment for suicidal ideation's.</p> <p>-The facility was unable to determine how the resident obtained the razor and a full facility sweep was completed to ensure no more sharp objects were found with which residents could harm themselves.</p> <p>-He/she was placed on one to one staff observation.</p> <p>Review of the resident's Hospital Discharge Note, dated 9/4/24 at 8:15 A.M., showed:</p> <p>-He/she had been admitted through the emergency roiaqnom on [DATE] with potential suicidal ideation's (SI) with a superficial laceration to his/her left forearm.</p> <p>-The laceration required no intervention as there was no bleeding or swelling noted.</p> <p>-The resident was therefore transferred to the psychiatric center affiliated with the hospital for treatment of possible SI, laceration to arm and bi-polar disorder.</p> <p>-He/she was discharged back to the facility in a stable condition with outpatient psychiatric appointments scheduled for 9/6/24 and 9/13/24.</p> <p>-Recommendations were made for additional protective oversight upon discharge and until the resident had a follow-up psychiatric appointment.</p> <p>During an observation on 9/11/24 at 10:40 A.M., showed:</p> <p>-The resident had a 2 1/2 inch to three inch scar on his/her left arm going up and down between his/her wrist and elbow.</p> <p>-The scarred area appeared to have been recently picked at.</p> <p>-There were five additional scars on his/her left forearm and one on his/her right forearm which were all healed scars.</p> <p>During an interview on 9/11/24 at 10:40 A.M., Resident #11 said:</p> <p>-A staff member had given him/her a disposable razor. He/she could not remember who or when he/she was given the razor.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265822	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/12/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-When he/she finished using the razor, he/she pretended to give the razor back by acting like he/she wrapped it up in toilet paper and gave just the toilet paper to the staff member.</p> <p>-No staff watched him/her shave.</p> <p>-He/she was just upset at the time when he/she cut himself/herself, but would not say why he/she was upset.</p> <p>-He/she broke the plastic razor head and got the razor out which was what he/she use to cut himself/herself.</p> <p>-He/she went to the hospital to have the cut checked out.</p> <p>-The cut did not require stitches.</p> <p>-The hospital also wanted to make sure he/she was not suicidal.</p> <p>-He/she was in the hospital for three days.</p> <p>During an interview on 9/11/24 at 2:15 P.M., the Staffing Coordinator said:</p> <p>-He/she was the manager on duty on 9/1/24 when the incident occurred.</p> <p>-He/she was not aware of the resident showing any signs that he/she wanted to harm himself/herself.</p> <p>-He/she heard the Code Blue called overhead and immediately went to the unit where the resident resided.</p> <p>-The nursing staff had the resident sitting up in a chair and were attempting to stop the bleeding on the resident's left arm.</p> <p>-The resident had cut himself/herself over another old scar.</p> <p>-The nurses had the cut area covered with a gauze bandage and were applying pressure to the area to stop the bleeding.</p> <p>-The blood was coming through the bandage and blood was dripping on the floor.</p> <p>-He/she had never seen or known the resident to cut himself/herself before.</p> <p>-The resident did not say why he/she cut himself/herself at the time of the incident.</p> <p>-The resident handed the broken disposable razor where plastic had broken off to expose the blade over to the staff right after the incident.</p> <p>-The resident told the staff at the time that he/she did not remember when or where he/she got the razor.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The facility had a new protocol where the disposable razors were kept in Central Supply and only the charge nurse could check the razors out.</p> <p>-Once the charge nurse got the razor, the gave it to the CNA who was to the observe the resident while they shaved.</p> <p>-The CNA was to then return the razor to the charge nurse who was to safely dispose of the razor in the sharps container.</p> <p>-He/she had broken the plastic off of the razor leaving the razor portion which he/she used to cut himself/herself.</p> <p>-The resident had a habit of picking at his/her scars when he/she wanted attention or wanting something extra such as coffee or extra cigarettes.</p> <p>During an interview on 9/11/24 at 2:44 P.M., CNA J said:</p> <p>-The resident had a history of doing things like not swallowing his/her pills, picking at old scars, etc., to get staff's attention or when he/she wants something extra.</p> <p>-The resident had just taken his/her medications when his/her roommate yelled out the resident had cut himself/herself.</p> <p>-The resident then came out of his/her room with a broken razor in his/her hand and bleeding from his/her left arm.</p> <p>-The resident stated he/she had it for around for three days, but he/she would not say how he/she got the razor.</p> <p>-It looked like the resident had broken off the plastic from around the razor and left the handle and sharp portion of the blade.</p> <p>-The resident had not shaved during CNA J's shift and actually had several days of beard growth.</p> <p>-He/she had no idea how the resident got the razor or when he/she would have been able to get it.</p> <p>-He/she was aware of the new protocol regarding the charge nurses checking out the razors and the CNA observing residents while they shaved.</p> <p>-He/she had been educated on the new protocol and the resident had not shaved during his/her shifts.</p> <p>During an interview on 9/11/24 at 3:35 P.M., CNA K said:</p> <p>-He/she was standing near the medication cart and the resident had just come and gotten his/her medications.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-About five minutes after the resident went to his/her room, his/her roommate yelled that the resident had cut himself/herself.</p> <p>-The resident then came out of his/her room bleeding from his/her left arm.</p> <p>-He/she sat the resident into a chair while a Code Blue was called and the nurses came to attend to the resident to stop the bleeding.</p> <p>-The resident said he/she had gotten the razor three days prior to the incident, but would not say how he/she got it.</p> <p>-The resident had broken off the top plastic portion of the razor leaving the sharp part and stated that was what he/she used to cut himself/herself.</p> <p>-The resident had not shaved in at least three days as he/she had the same facial growth.</p> <p>-He/she had been educated on the new protocol where the CNAs could not get razors without the charge nurse checking out the razor.</p> <p>-He/she knew he/she was to observe the residents while they shaved, but the resident had not shaved on his/her shift.</p> <p>During an interview on 9/12/24 at 1:30 P.M., Resident #11 said:</p> <p>-He/she did not remember when he/she got the disposable razor.</p> <p>-He/she did not remember who gave him/her the disposable razor.</p> <p>-When asked why he/she cut himself/herself he/she said he/she did not know why.</p> <p>-When asked if he/she wanted to die and that was why he/she cut himself/herself, he/she said he did not want to die.</p> <p>-When asked if cutting himself/herself worked for his/her anxiety to calm him/her down, he/she said he/she did not know.</p> <p>During an interview on 9/12/24 at 2:30 P.M., the facility Administrator and DON said:</p> <p>-He/she had no idea how the resident got the disposable razor.</p> <p>-The facility put the new protocol in place several weeks prior in attempt to prevent incidents exactly like this one.</p> <p>-All facility staff had been educated on the new protocol.</p> <p>-It was unclear as to whether he/she had this razor hidden in his/her overnight bag for a long time (before the new procedure went into effect).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident had a history of cutting, however he/she had not cut for a few years as far as the Administrator was aware.</p> <p>-He/she was not aware of the resident showing any escalation or signs of being upset prior to the cutting.</p> <p>-He/she would have expected the facility staff follow the new protocol for checking out the razor and monitoring the residents while they shaved.</p> <p>MO00241537</p>