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	10/04/2024

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35013 Based on interview and record review, the facility failed to provide appropriate treatment and services for one out of 16 residents (Resident #19) with behavioral health needs and a history of post-traumatic stress disorder (PTSD), who displayed self-harming behaviors. On 9/1/2024, the resident was hospitalized due to his/her psychiatric needs after using a disposable razor blade to cut his/her forearm. The resident returned to the facility on [DATE], requiring one on one supervision. The resident was taken off one-on-one supervision and it was restarted again on 9/24/24 after he/she had an increase in behaviors. The facility did not have a system in place to ensure the interdisciplinary team was involved in assessing the resident's needs related to supervision and participating in decision making prior to implementing changes in the resident's care related to supervision. On 9/29/24, the resident was removed from one-on-one supervision, without input from the IDT team. The resident cut his/her right forearm- requiring six sutures at the emergency room - using a chewing tobacco can lid, bent to a sharp edge. Additionally, the facility staff failed to consistently implement the resident's plan of care related to behavioral services. The facility census was 164 residents. Review of the Facility Assessment, dated 10/1/24, showed: -The facility had the ability to treat Psychiatric/Mood Disorders such as psychosis (hallucinations and delusions), mental disorders, bi-polar disorder, schizophrenia, PTSD, anxiety disorder, behaviors that needed interventions, personality disorders, and schizoaffective disorder. -The facility used the Interdisciplinary Team (IDT) to discuss any changes in the residents' care and the changes in the residents' plan of care, providing education to staff that provide direct resident care to determine whether the facility could continue to provide appropriate care for a resident with changes in condition or a new diagnosis. -The facility was to reach out to the management team for assistance with education and finding the resources that could be needed to continue to manage a resident with a change of condition or new diagnosis. -The facility was to reach out to their corporate office to assist with resources or assistance in locating needed resources if there were resources needed for a resident that the facility did not currently have. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The facility staff was to provide person centered/directed care with psycho/social/spiritual support by- --Building relationships with residents, getting to know the residents and engaging the residents in conversations. --Finding out what each resident's preferences and routines were; what made a good day for them, and what upsets them, incorporating this information into the care planning process. --Making sure staff caring or the residents have the information needed. --Recording and discussing treatment and care preferences. --Supporting emotional and mental well-being, supporting helpful coping mechanisms. --Supporting residents having familiar belongings. --Providing culturally competent care, learning about residents' culture and religious references, staying open to requests and preferences as related to their culture and religion. --Providing or supporting access to religious preferences, using or encouraging prayer as appropriate/desired by the resident. --Providing opportunities for social activities/life enrichment including individual, small and community groups. --Identifying hazards and risks for residents. --Offering and assisting residents and family caregivers or other proxy as appropriate, to be involved in person-centered care planning and advance care planning. --Providing family/representative support. 1. Review of Resident 19'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. Review of the resident's change of condition Preadmission Screening and Resident Review (PASRR, a federal requirement to help ensure that individuals with serious mental disorder and/or intellectual disability are not inappropriately placed in nursing homes for long term care), dated 9/17/24, showed the following: -The resident was evaluated on 9/11/24. -Diagnoses including: --Schizoaffective disorder (a mental condition that causes loss of contact (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--provide one cigarette in the morning and then if he/she exhibits no behaviors, he/she could get another cigarette at the next smoke break. --not to argue with the resident. -Notify the facility charge nurse if the resident experiences hallucinations, delusions, has difficulty focusing, withdrawing from activities, inability to make decisions, poor hygiene, acting fearful, isolating, irritability, talking to himself/herself, mumbling, gesturing as if having a conversation, darting eye movements, anxiety and/or aggression. -The facility staff were directed to: --not to ignore the resident or his/her needs-as this caused escalation. --provide the resident with structure daily. -The resident voiced thoughts of self-hanging and self-cutting in the past, as he/she desired to get out of the facility, apologizing afterwards. -The resident was to remain safe during his/her long-term care stay. -The facility staff to provide the lowest restricted, structured environment while maintaining protective oversight. -The facility staff to assess the resident for potential suicidal or homicidal ideation's and provide protective oversight. -The facility staff to ensure no items were available to the resident which he/she could use to harm/cut himself/herself. Review of the resident's Telehealth visit, dated 9/20/24, showed: -The resident was upset over a change in his/her medication. The medication was administered per the physician's order. -The resident was educated to ask the facility staff to his/her questions about the ordered medications. -The resident denied any suicidal/homicidal thoughts, or any audio/visual hallucinations. -The resident was educated on schizophrenia and advised the resident to notify the staff of any negative feelings. Review of the resident's Telehealth visit, dated 9/23/24, showed: -The resident was seen for a follow-up regarding his/her anxiety, sleep, mood and medication reconciliation. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident was encouraged to attend activities and use his/her coping skills to reduce anxiety. -The staff were educated on safety precautions and the resident's medications were reviewed. Review of the resident's Behavior Note, dated 9/23/24 at 9:33 P.M., and written by the Administrator showed: -At approximately 7:30 P.M., the resident became physically aggressive, attacking the staff in front of the Administrator's office after having been redirected to wait for the Administrator who was occupied at the time. -He/she became upset, making verbal threats stating he/she was going to kick someone's ass. -The physician was notified who ordered a intramuscular (IM) PRN medication with facility staff safely holding the resident to prevent harm -No resident or staff injuries occurred. -The facility psychiatric NP as well as the Administrator were present at the time of the incident. During an interview on 10/4/24 at 2:25 P.M., the Administrator said: -The resident had been having an increase in behaviors especially over the past couple of weeks prior to his/her self-harm episode of 9/29/24. -The resident had been screaming at staff and other residents, threatening staff and being physically aggressive with staff which was why he/she was placed on one-on-one staff observations back on 9/24/24. Review of the resident's nurse's notes, dated 9/27/24 at 3:22 P.M., showed: -The resident remained in the facility Administrator's office and allowed to verbalize and vent his/her feelings and concerns. -He/she remained on one-on-one staff observation for an increase in escalation and general negative behaviors and was allowed to go outside and smoke as well as to spend time with his/her boyfriend/girlfriend. -The resident was apologetic for his/her recent behaviors of yelling, screaming, being combative with staff. -The discharge process as well as the process for finding alternate placement was discussed with the resident and he/she verbalized understanding. Review of the resident's nurse's note, dated 9/28/24 completed by LPN E at 7:14 A.M., showed: (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident came out of his/her room around 5:00 A.M., stating he/she was still having a problem with hearing voices. -When asked what the voices were telling him/her, the resident stated he/she was not suicidal and did not want to hurt anyone, just wanted to be sent out to the hospital. -The Administrator was notified and there appeared to be no valid reason to send him/her to the hospital. -This was explained to the resident. -Facility staff then followed the resident closely for monitoring. Review of the resident's nurse's note, dated 9/28/24 completed by LPN E at 1:42 P.M., showed: -The resident complained of hearing voices. -Licensed Practical Nurse (LPN) E encouraged him/her to call the suicide and crisis lifeline #988 with LPN E present. -When the resident spoke with the operator for #988, they asked the resident if he/she wanted to harm himself/herself or hurt someone else to which he/she said no. -The operator asked the resident if he/she had taken his/her medication and he/she got angry and hung up the phone. -LPN E followed the resident asking him/her what he/she wanted LPN E to do to which he/she stated he/she wanted the doctor called because his/her medication was not working. -LPN E placed a call to psychiatric NP A who gave an order for a medication change. During an interview on 10/4/24 at 1:34 P.M., LPN E said: -The resident had an increase in hearing voices as well as other behaviors which appeared to be attention seeking. - He/she last showed suicidal ideation the beginning of September 2024. -The resident was extremely attention seeking and demanded much of staff's time. -The resident's behaviors were very sporadic and at any moment could go from being good and calm to being angry and wanting to self-harm. -The resident had a history of doing whatever he/she could do to be sent to the hospital. -Most of the time, the resident did not need a hospital stay, he/she just liked the extra attention. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident had an episode a few days ago where he/she complained of hearing voices and he/she had been instructed by members of the IDT team to have the resident call the suicide and crisis lifeline hotline #988 when the resident escalated. -He/she had the resident call #988 and it seemed to escalate the resident more which he/she relayed to the IDT team. Review of the resident's medical record, dated from 9/24/24 through 9/28/24, showed: -No IDT meetings were held regarding the resident's increase in behaviors such as screaming at staff and peers, threatening staff, and being physically aggressive with staff. -The resident was placed on and taken off of one-on-one staff observations without documentation of an IDT meeting. Review of the facility staffing sheets, dated 9/24/24, showed the resident was on one- on-one (a facility staff member specifically assigned to keep the resident in constant view 24 hours per day to keep the resident safe from self-harm) staff observation. He/she was discontinued from the one-on-one monitoring the morning of 9/29/24. Review of the facility one-on-one staff observation sheets for 9/24/24 through 9/29/24, showed the resident was on one- on-one (a facility staff member specifically assigned to keep the resident in constant view 24 hours per day to keep the resident safe from self-harm) staff observation on 9/24/25. He/she was discontinued from the one to one the morning of 9/29/24. Review of the resident's hourly face checks sheets, dated 9/29/24, showed the resident's supervision level changed from one-on-one staff observations to hourly face checks (monitoring), which were completed by the CNA staff. Review of the resident's nurse's note, dated 9/29/24 at 2:33 P.M., showed: -The resident came out of his/her room with his/her right arm bleeding, stating he/she cut himself/herself with the lid from a can of chewing tobacco. -He/she had thrown the can over the balcony on the back hall smoke deck. -He/she stated that he/she found the can in his/her clothes in his/her closet but did not know how it got there. -The facility staff had completed environmental rounds the night previous to the incident on the night shift and the resident's closet was checked with no can found in his/her closet. -The bottom portion of the chewing tobacco can was found on the ground outside the smoking deck. -The resident stated the top of the can that he/she cut himself/herself with was flushed down the toilet. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-- encourage the resident to express emotions in a safe environment, allowing the freedom to acknowledge feelings and release any repressed emotions which could be exacerbating his/her distress and ideation's. --listen calmly to the resident. --give the resident his/her medications at the ordered time. --provide one cigarette in the morning and then if he/she exhibits no behaviors, he/she could get another cigarette at the next smoke break. -Notify the facility charge nurse if the resident experiences hallucinations, delusions, has difficulty focusing, withdrawing from activities, inability to make decisions, poor hygiene, acting fearful, isolating, irritability, talking to himself/herself, mumbling, gesturing as if having a conversation, darting eye movements, anxiety and/or aggression. -The facility staff were directed to: --not to ignore the resident or his/her needs-as this caused escalation. --provide the resident with structure daily. -The resident voiced thoughts of self-hanging and self-cutting in the past, as he/she desired to get out of the facility, apologizing afterwards. -The resident was to remain safe during his/her long-term care stay. -The facility staff to provide the lowest restricted, structured environment while maintaining protective oversight. Review of a hospital visit summary, dated 9/29/24 at 5:24 P.M., showed: -The hospital social worker called every psychiatric facility in the state with no psychiatric beds available for a new admission. -The hospital was unable to pursue psychiatric hospitals in another state as the legal guardian was not available by phone to provide formal consent. -Per the facility LPN A, the resident had been on one-on-one staff observation for months, had the recent medication change, and been seen by the facility psychiatric NP earlier on the day the resident self-harmed. -The recommendations from the hospital showed that the resident would have benefited from an inpatient psychiatric placement for the purposes of stabilization and medication re-evaluation. -The hospital recommendation was for the resident to return to the facility with one-on-one staff observations and medication adjustment. (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	10/04/2024

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Registered Nurse Investigation (RNI), dated 9/29/24, showed: -When the resident returned from the hospital, he/she was immediately place on one-to-one staff observation for safety and protective oversight. -The facility staff had an IDT meeting, speaking with the resident and encouraging him/her to use his/her coping skills when he/she got upset instead of self-harming. Review of the resident's IDT Meeting Notes, dated 9/30/24 at 2:47 P.M., showed: -The team met with the resident regarding his/her recent behaviors, asking why he/she continued to have increased types of behaviors, whether it was self-harming, physical/verbal aggression, or holding onto his/her medications in his/her mouth without swallowing them. -The resident stated he/she wanted to get into a facility closer to his/her family, which was the reason for his/her behaviors. -The team reviewed alternatives for the resident to utilize when he/she became agitated. -The resident agreed that he/she would attempt to use the skills discussed as opposed to letting his/her anxiety to overwhelm him/her. -The team reinforced with the resident that he/she could always come to the facility staff if he/she needed help and he/she voiced understanding. -The team reviewed alternatives for the resident to utilize when he/she became agitated. -The IDT team consisted of the Administrator, DON, Social Worker, MDS Coordinator, sometimes the NP and sometimes the charge nurse. During an interview on 10/4/24 at 2:01 P.M., the Director of Nursing (DON) said: -He/she expects the staff providing one-on-one staff observations to engage with the resident by talking, seeing what the resident would like to do, not just sitting or doing their own thing. -He/she expects the staff provide consistency for this resident. If they do not, he/she is more likely to pit staff against one another and have an increase in behaviors. -For instance, if a CMT gave him/her his/her medications at 1:30 P.M., instead of 2:00 P.M., the resident would get upset with any CMT who waited until the 2:00 P.M. administration time and act out. -He/she would have expected the charge nurse set the tone for the consistency of the resident's care by communicating with the staff regarding the resident's needs and how best to care for him/her. This was an expectation as nursing practice charge nurses give report to CNAs. -The CNAs were to always use their phone App to access the resident's care plan to assist in providing his/her care and keeping his/her behaviors controlled. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If the staff did not have a phone, there were tablets available for the staff to use to access the nursing care plans. During an interview on 10/1/24 at 9:50 A.M., Hall Monitor (HM) D said: -He/she had done one-on-one staff observations with the resident off and on for the past three weeks; where he/she was with the resident at all times never allowing the resident to get out of his/her sight. -During the one -on- one he/she and the resident get along well, talked and laughed a lot during the day. -The resident got upset easily if the resident did not get what was wanted it. -He/she usually gave into the resident- so the resident would not get upset. -He/she could use his/her phone App to access the resident care plan, but he/she knew the resident so well he/she did not use it. -He/she got report before the start of his/her shift, from the staff who was on one-on-one during the previous shift. -He/she did not recall getting any report from the charge nurse prior or during the shift regarding the resident or any resident. -He/she relied on his/her relationship with the residents in the building to know what they needed. During an interview on 10/1/24 at 11:45 A.M., Certified Medication Technician (CMT) E said: -He/she had done a lot of one-on-one observations with the resident over the past few weeks since the resident cut himself/herself back in the middle of September 2024. -He/she had to set boundaries with the resident, or the resident would take over the day. -He/she always made sure to follow all the rules and would not give in to the resident. He/she did not give the resident extra cigarettes or allowed the resident to get his/her medications early. -When he/she worked on the resident's unit the resident would take all his/her time and other residents needed attention, too. -During a regular day, if there were 10 incidents where a resident needed something, seven of those calls would be from this resident. -The resident was obsessed with his/her medication, coffee and cigarettes. -The resident got upset if he/she did not get his/her medications at a certain time, got upset over having to crush some of his/her medications. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If he/she did not get extra coffee and cigarettes, the resident would escalate. -He/she always got report from the person doing the previous one-on-one. -He/she usually did not have much communication with the charge nurse. During an interview on 10/1/24 at 12:55 P.M., psychiatric NP A said: -When the resident was having attention seeking behavior, he/she expected the staff to engage with the resident, remind the resident of their coping skills and meet the resident's needs at the time. -The resident was obsessed with his/her medications, smoking and co