Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/26/2025
Form Approved OMB
No. 0938-0391

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	01/03/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35013 Based on interview and record review, the facility failed to notify the resident legal guardian for one sampled resident (Resident #1) of a change in condition out of 15 sampled residents. The facility census was 157 residents. Review of the facility policy for Notification of Changes revised 5/14/24 showed: -The purpose of the policy was to ensure the facility staff promptly notified the resident or resident's representative when there was a change requiring such notification. -Examples of situations requiring the notification of the resident's representative was any time the resident had a significant change in condition and any time the resident was transferred out of the facility. -A resident who was incapable of making his/her own decisions and requiring a guardian, should have had that guardian notified of any transfers so those designated individuals could have assisted in making appropriate decisions on the resident's behalf. 1. Review of Resident #1's Facility Admission Record showed he/she was admitted on [DATE] with the following diagnoses: -Schizophrenia (a severe psychiatric disorder with symptoms of emotional instability, detachment from reality, and withdrawal into the self). -Narcissistic personality disorder (a mental health condition that is characterized -Unspecified dementia without behavioral disturbance (a mental disorder that causes a gradual decline in memory and other cognitive skills, which makes it difficult to perform daily activities but does not involve negative behaviors). Anxiety Disorder (a psychiatric disorder causing feelings of persistent anxiety). -Diabetes type II (a complex disorder of carbohydrate, fat, and protein metabolism that is primarily a result of a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin) (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Colostomy (an alternative exit from the colon created to divert waste through a hole in the colon and through the wall of the abdomen). Review of the resident's Nursing Care Plan dated 10/29/24 showed he/she had a guardian assigned to assist him/her in making decisions. 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 11/23/24 showed he/she was moderately cognitively intact. Review of the resident's Nursing Notes dated 12/30/24 at 6:30 P.M. showed: -The resident called 911. -He/she was transported to the hospital. -There was no documentation showing the guardian was notified. During an interview on 1/3/25 at 11:28 A.M. Public Administrator (PA) Deputy A said: -The PA was assigned guardian ship of the resident, the PA office was not notified of the resident's transfer to the hospital. -The facility staff had all the numbers available to them to have called and notified at least one of the PA deputies, none had been notified of the resident's transfer to the hospital and no messages had been left at the PA office. -The PA would have expected someone from the facility to have notified them of the resident's change of condition and transfer to the hospital each time the resident was transferred. During an interview on 1/3/25 at 12:08 P.M. Licensed Practical Nurse (LPN) E said: -He/she had not called the guardian to notify them that the resident had been transferred to the hospital. -He/she should have called. During an interview on 1/3/24 at 3:45 P.M. the Director of Nursing (DON) said: -He/she would have expected the Charge Nurse on duty when the resident was transferred to the hospital, to have notified the guardian. -Any time a resident had a change of condition and/or was transferred to the hospital, the guardian was to have always been notified of that transfer. During an interview on 1/3/24 at 4:00 P.M. the facility Administrator said he/she would have expected the Charge Nurse to have notified the guardian of the resident's change of condition and ultimate transfer to the hospital. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO00246876

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35013 Based on observation, interview and record review, the facility failed to protect one sampled resident (Resident #23) from restraint when on 12/22/24 Licensed Practical Nurse (LPN) E, Certified Medication Technician (CMT) D and Resident #29 held Resident #23 down on the floor by his/her arms and legs out of 15 sampled residents. The facility census was 157 residents. Review of the facility's undated Resident Rights information guide showed restraints were not to have been used for the purposes of discipline or staff convenience. 1. Review of Resident #23's Preadmission Screening and Resident Review (PASRR, a required assessment tool used to ensure individuals who have a mental disorder, or intellectual disabilities are not inappropriately placed in nursing homes for long term care), dated 12/10/20, showed: -He/She had the following diagnoses: --Psychotic Disorder (a group of symptoms that describe a severe mental disorder where a person loses touch with reality). -- Schizoaffective Disorder (a mental condition that causes loss of contact with reality and mood problems). --Unspecified Mood Disorder (a variety of conditions characterized by a disturbance in mood as the main feature). --Psychotic Disorder with delusions (a mental disorder in which there is a severe loss of contact with reality as well as fixed false beliefs). --Mild Cognitive Impairment-(subtle changes in thinking and memory). --Major Neurocognitive Disorder Due to a Surgical Ablation-(a minimally invasive surgical procedure that uses a laser to destroy abnormal brain tissue, sometimes used to treat seizure disorders). --Seizure Disorder- (uncontrolled periods of jerking of the body caused by abnormal electrical activity in the brain). -He/she made poor decisions with issues staying on task. -He/she displayed episodes of severely aggressive behaviors at his/her previous facility. Review of the resident 23's Nursing Care Plan dated 10/31/24 showed: -The resident was at risk for having delusions, aggression, fearful hallucinations and irritability. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The staff were to avoid arguing with the resident. -The staff should have been reassuring with the resident, to prevent escalation. -The staff were to have knowledge of the resident's behaviors, redirect when any negative behaviors were observed and observed for any changes in his/her behaviors. -He/she had behaviors due to both his/her psychiatric diagnoses as well as the brain ablation which caused a traumatic brain injury. -If he/she was having a behavior, the staff were to have taken him/her out to a more private area. -His/her safety plan included knowing his/her crisis moments including: --Having gotten held down because he/she did not want to take a shower. --Having gotten held down because he/she wanted his/her white yarn cut and wanted to get scissors. Review of the resident 23's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff and used for care planning) dated 12/19/24 showed he/she: -Was not cognitively intact. -Had delusions. -Had physical behaviors directed at others such as hitting, kicking, scratching, and inappropriate sexual behaviors occurring one to three days out of seven. -Had verbal behaviors directed at others such as threatening, screaming and cursing occurring one to three days out of seven. -Had other behaviors not directed towards others such as pacing, rummaging through other's belongings, scratching, or hitting self, public sexual acts and disruptive sounds four to six days out of seven. Review of Resident #29's quarterly MDS dated [DATE] showed he/she: -Was cognitively intact. -He/she had delusions. -He/she had physical behaviors directed towards others such as hitting, biting and kicking, one to three times over the previous seven days. -Had diagnoses of anxiety, Post Traumatic Stress Disorder (MDS-an anxiety that can develop after witnessing a traumatic event), psychotic disorder and schizophrenia. Observation of the facility's video dated 12/22/24 at 12:05 P.M. showed: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had his/her arm up and motioned toward Licensed Practical Nurse (LPN) E. -LPN E raised his/her right forearm in a blocking motion. -LPN E took hold of both of the resident's forearms in a push and pull motion. -Certified Nurses Aide (CNA) A's arm was over the back of LPN E as LPN E and Resident #29 pulled the Resident #23 to the floor. -LPN E was on his/her knees holding Resident #23's upper extremities while Resident #29 was holding Resident #23's legs. -Certified Medication Technician (CMT) D stepped over Resident #23 and Resident #29. -LPN E stands up, CMT D takes LPN E's place in holding Resident #23's upper extremity, Resident #29 continues to hold Resident #23's legs. -Resident #29 releases Resident #23's legs and stands up. -Resident #23 is flat on the floor on his/her belly, with his/her arms partially under his/her chest. CMT D is on his/her knees next to Resident #23's back with his/her arms on Resident #23's shoulder back area. -CMT D stands up, Resident #23 continues to lay on the floor on his/her belly and raises his/her head up. -Resident #23 stood up and walked off the unit with the Staffing Coordinator. Review of the Facility Registered Nurse Investigation (RNI) dated 12/23/24 at 1:28 P.M., showed: -On 12/22/24 after LPN E sent the resident's clothing to be laundered, the resident was seen arguing with LPN E. -The resident was heard swearing at LPN E stating LPN E was a bitch and was not to touch his/her things. -LPN E explained to the resident that his/her clothing had been removed from his/her room so they could be washed. -Once the resident was at the nurse's station, he/she continued to yell and swear at LPN E while LPN E attempted to explain that LPN E was trying to help him/her when the resident punched LPN E in the left eye. -The video was reviewed and showed LPN E attempting to grab the resident's hands to try and stop him/her from kicking. -The resident continued to kick and swing at LPN E, while trying to pull away causing their bodies to turn both losing their balance and landing on the floor. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-While LPN E and the resident were on the floor, CNA A tried to help LPN E to prevent injury to LPN E or the resident. -Resident #29 placed himself/herself in the situation and placed his/her hands on a Resident #23's legs trying to help the staff which occurred for less than one minute. -Once staff realized Resident #29 was holding Resident #23's legs, they asked him/her to remove himself/herself from the situation. -After speaking with involved staff and residents while also reviewing the video footage, the facility determined the incident was not abuse or neglect. -There were no injuries to any residents. During an interview on 1/3/25 at 1:00 P.M. the Staffing Coordinator said: -He/she was on the unit, on the phone with the Administrator and was walking away from LPN E and Resident #23. -When he/she turned around, Resident #23 an LPN E were on the floor and the resident was calm. -He/she got direction from the Administrator to bring the resident up to the lobby to await hospital transport. -He/she did not redirect any residents during the incident. -He/she did not believe that restraining a resident was ever appropriate. During an interview on 1/3/25 at 1:38 P.M., CNA A said: -He/she was cleaning another resident's room. -Every Sunday, LPN E and other staff assist in cleaning up resident rooms and collecting dirty laundry from residents who do not do a good job of keeping their rooms clean and laundry done. -Resident #23 was a resident who never cleaned his/her room as he/she should so LPN E always helped to clean it and gather dirty clothes. -As he/she was coming out of the other resident's room, he/she saw Resident #23 up in LPN E's face. -Resident #23 hit LPN E in the eye and began spitting at his/her face. -LPN E attempted to block Resident #23 from hitting him/her again and in the process, Resident #23 lost footing and they both went to the floor, so CNA A came to assist LPN E in getting Resident #23 under control. -He/she told the other residents around the incident to get back, but they did not listen and Resident #29 even held Resident #23's legs down. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA A got on the floor and placed his/her hand near the resident's mouth so LPN E would not get spit on again. -Resident #23 calmed down right after falling to the floor so other staff were able to take him/her off the unit to continue to de-escalate. During an interview on 1/9/25 AT 2:45 P.M., CMT D said: -He/she was in the medication room attached to the nurse's station when he/she heard something outside the nurse's station so he/she went to look out the nurse's station window. -He/she saw LPN E and Resident #23 on the floor so he/she went out to assist. -He/she took over for LPN E by holding the resident's arms down on the floor. -No residents should have been assisting to restrain Resident #23, and he/she did tell the residents to back away from Resident #23. -He/she did not recall telling Resident #29 to get up off Resident #23. During an interview on 1/2/25 at 3:03 P.M. LPN E said: -LPN E had observed Resident #23 going in and out of other resident's room and when he/she asked the resident why the resident was going into other resident's rooms, the resident stated, I am looking for clothes to wear. All of mine are dirty. -LPN E told Resident #23 that was why he/she needed to clean his/her room and gather his/her clothes. -Resident #23 did not want to clean is/her room, so LPN E gathered up the resident's dirty clothes bagged them to go to laundry and straightened up the room. -When Resident #23 found his/her room clean and laundry bagged, he/she became very angry. -Resident #23 confronted LPN E by yelling at him/her then proceeded to hit LPN E in the left eye. -He/she attempted to block the resident's hitting by blocking the resident to the wall. -LPN E took the resident by his/her forearms in attempt to turn him/her around and de-escalate the resident. -The resident began spitting in LPN E's face trying to kick LPN E, and during the attempt to get him/her under control, they both ended up on the floor. -Several residents were surrounding them while Resident #23 was on the floor and Resident #29 even went to the floor and held Resident #23's legs down. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No resident should have ever gotten held down due to a behavior or any other reason. -Resident #29 should have not helped in the deescalation of Resident #23. During an interview on 1/17/25 at 10:31 A.M. CPI Trainer said: -CPI has replaced the former intervention used for behavioral intervention. -Staff were to use the non-restrictive interventions for disengagement using holding skills depending on the the resident risk harm. -No staff has been taught to place a resident on the ground and use pressure to hold them in place. -Staff should be clearing the hall when a code is called and a resident should not hold another resident. MO00247086