

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 08/22/2025
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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to adhere to resident's rights by not providing a safe way for sexual interactions for three sampled residents (Resident #4, #5 and #7) out of nine sampled residents whom were sexually active. The facility census was 151 residents. Review of the facility's policy for Resident Rights revised on 7/5/23 showed:--The purpose of the policy was to ensure that resident's rights were protected.--The facility was to notify each resident of their rights both orally and in writing, in a language the resident could understand, prior or upon admission to the facility.--The resident had a right to reside and receive services with reasonable accommodation of the individual need and preferences, except with the health or safety of the individual or other residents would be endangered.--The resident had the right to participate in social activities that did not interfere with the rights of other residents in the facility.--The resident had the right to be treated with consideration, respect and in full recognition of his/her dignity and individuality, including privacy in treatment and care for his/her personal needs.--The resident was to have been permitted to associate and meet privately with the person/s of his/her choice whether on the resident's initiative or the other person's initiative, unless to do so would infringe upon the rights of other residents. 1 Review of Resident #4'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 6/11/20, showed he/she had the following diagnoses:--Schizophrenia (a severe psychiatric disorder with symptoms of emotional instability, detachment from reality, and withdrawal into the self).--Psychotic Disorder (a mental disorder in which there is a severe loss of contact with reality).--Anti-social Personality Disorder (ASPD-is a mental health condition characterized by a persistent pattern of disregard for and violation of the rights of others). --Delusional Disorder (a mental health condition characterized by the presence of one or more fixed, false beliefs (delusions) that persist for at least one month without other obvious symptoms of psychosis). Review of Resident #4's quarterly MDS dated [DATE] showed he/she-Was cognitively intact and had minimal issues with his/her mood.-Had physical behaviors of kicking, hitting, pushing, grabbing, and/or abusing others sexually one to three days during the look-back period.-Had verbal behaviors of threatening others screaming at others, and/or cursing at others one to three days during the look-back period.-Had other behaviors such as hitting or scratching himself/herself, pacing, and/or screaming or other disruptive sounds one to three days during the look-back period. Review of Resident #4's Capacity to Consent to Sexual Activity Form dated 8/2/25 showed:-He/she had a guardian.-He/she had the ability to communicate a yes or no decision.-He/she had the ability to understand relevant information such as who was initiating sexual contact, whether the resident was a spouse and, thus, acquiesces out of a delusional belief, or was cognizant of the other's identity and intent, and could state what level of sexual intimacy he/she was comfortable with.-He/she had the ability to appreciate the situation and its likely consequences including behavior consistent with formerly held beliefs/values, and a capacity to say no to uninvited sexual contact.-He/she had the ability to manipulate information rationally including awareness of potential risks such as a time limited relationship, and the ability to describe how he/she would react when the relationship ended.-The ability for the resident to consent to sexual activity required a yes answer to all questions. -Prior Sexual Consent Forms had been completed in the past and also showed the ability to consent. During an interview on 8/21/25 at 11:35 A.M. Resident #4 said:-He/she was not interested in sexual activity with anyone in the facility.-He/she was straight and was not interested in any of the residents.-He/she had not seen any condoms available in the event he/she changed his/her mind.-He/she was not sure if there was a private area for residents to spend time alone. 2 Review of Resident #5's PASRR dated 8/8/16 showed he/she had diagnoses of:-Bi-polar Disorder- (a chronic mental health condition characterized by extreme shifts in mood, energy, and behavior). -Attention Deficit Hyperactivity Disorder- (ADHD-includes a mix of ongoing problems. These can include having a hard time paying attention, being hyperactive and being impulsive).-Oppositional Defiance Disorder- (a mental health condition characterized by a persistent pattern of defiant, irritable, and aggressive behavior towards authority figures, such as parents, teachers, or caregivers).-Impulse Control Disorder- (a group of mental health conditions characterized by an inability to resist impulsive behaviors that can have negative consequences for the individual or others).-Mild Intellectual Disability- (a developmental disorder characterized by significant limitations in both intellectual functioning and adaptive behavior that</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>(continued on next page)</p>

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to promote and facilitate self-determination through support of the resident's choice for one sampled resident (Resident #8) out of three sampled residents by not providing the resident with clean clothes which caused the resident to wear the same soiled clothing for two consecutive days. The facility census was 152 residents. Review of the facility policy titled Dignity and Respect, revised 6/29/23, showed:-The purpose of policy was to ensure that every resident was treated with dignity and respect.-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.-All of the resident's possession, regardless of their apparent value to others, must be treated with respect.-Residents had the right to retain and use personal possessions to assist each resident in maintaining their independence, subject to reasonable limitations to protect the health and safety of residents and space limitations. Review of the facility policy titled Resident's Rights-Missouri, revised 7/5/23, showed:-The purpose of the policy was to ensure that residents rights were protected.-The resident had a right to a dignified existence, self-determination, communication with and access to persons and services inside and outside the facility.-The facility protected and promoted the rights of each resident.-The resident had the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.-The resident could retain and use his personal clothing and possessions as space permitted. 1. Review of Resident #8's admission record showed:-The resident was admitted to the facility on [DATE] with the diagnoses of: Epilepsy (also known as a seizure disorder - is a brain condition that causes recurring seizures), paranoid schizophrenia (a form 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] characterized by persistent preoccupation with illogical, absurd, and changeable delusions, usually of a persecutory, grandiose, or jealous nature, accompanied by related hallucinations), Hallucinations (a sensory perception that does not result from an external stimulus and that occurs in the waking state), personality disorder (a group of mental health conditions characterized by enduring patterns of thinking, feeling, and behaving that deviate significantly from cultural expectations and cause distress or impairment in various areas of life), anxiety disorder, delusional disorder (a type of mental health condition in which a person can't tell what's real from what's imagined), and very low level of personal hygiene. Review of the resident's Care Plan revised on 4/2/24, showed:-The resident required personal hygiene supervision and set up.-The resident was independent with activities of daily living but required supervision, cue, and assist as needed for completion. Review of the resident's Annual Minimum Data Set (MDS-A federally mandated assessment tool required to be completed by facility staff for care planning) dated 6/11/25 showed he/she had mild cognitive impairment. Observation on 8/20/25 at 5 P.M., showed: -The resident was wearing a purple pullover polo type shirt that had smudging and food on the front of it.-The resident was wearing jeans that were too big and kept falling down.-The resident had to keep pulling his/her jeans up. Observation and interview on 8/21/25 at 1:32 P.M. with the resident showed:-The resident had a purple pullover polo type shirt on. It had smudging and food on the front. This was the same purple pullover shirt that the resident was observed in on the previous day. -The resident had jeans on that kept falling down and the resident had to keep pulling them up. This was the same jeans that the resident was observed wearing on the previous day. -He/She had some clothes missing. Jeans, shorts and a pair of corduroy shorts.-His/Her clothes have been missing for a long time.-His/Her family member bought the clothes that were missing.-His/Her friend did his/her laundry.-He/She reported the missing clothes to the facility. Observation of the resident room including his/her closet and clothing storage on 8/21/25 at 1:40 P.M. showed:-No clothes in the resident's closet.-No clothes in the resident's drawers.-No clothes in the resident's clothing hamper. During an interview on 8/21/25 at 1:45 P.M. the Administrator said:-The resident had no clothes in the resident's room because the resident gave his/her clothes away to other residents.-The resident's friend did the resident's laundry and may have took all of the resident's clothes the last time the friend visited but he/she was unsure.-The resident's friend last visited the resident on 8/18/25.-He/She was unsure how long the resident had been without access to clean clothes. During an interview on 8/22/25 at 10:45 A.M. the Administrator said:-The staff went to the store and got the resident new clothes -The staff was putting the resident's name on the new clothes and then were putting the new</p>		

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<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.</p> <p>(continued on next page)</p>

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<p>F 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to allow one sampled resident (Resident #8) the right to receive visitors. The facility further failed to have written policies in place for resident rights and visitation for the facility out of three sampled residents. The facility census was 152 residents. Review of the facility policy titled Resident's Rights-Missouri, revised 7/5/23, showed:-The purpose of the policy was to ensure that residents rights were protected.-The resident had a right to a dignified existence, self-determination, communication with and access to persons and services inside and outside the facility.-The facility protected and promoted the rights of each resident.-The resident had the right, and the facility provided immediate access to any resident by subject to resident's rights to deny or withdraw consent at any time, immediate family or other relatives of the resident.-The resident had the right, and the facility must provide immediate access to any resident by the subject of reasonable restrictions and residents rights to deny a withdraw consent at any time others who are visiting with the consent of the resident.-A resident should be permitted to communicate, associate, and meet privately with persons of his or her choice rather on residents initiative or the other person's initiative. A policy for resident visitation was requested and not provided. 1 Review of Resident #8's admission record showed:-The resident was admitted to the facility on [DATE].-The resident had a guardian.-The resident's emergency contact#1 was the resident's brother.-The resident's sister was listed as a contact for the resident. Review of the resident's Physicians Order Sheet (POS) dated 3/2/21, showed the resident could participate in activities per care plan and as tolerated. Review of the resident's Care Plan, revised on 4/2/24, showed:-The resident was independent for meeting emotional, intellectual, physical, and social needs.-The resident would maintain involvement in cognitive stimulation and social activities as desired through review date. Review of the resident's Annual Minimum Data Set (MDS-A federally mandated assessment tool required to be completed by facility staff for care planning) dated 6/11/25 showed the resident had mild cognitive impairment. Review of the facility's Visitor Sign In Sheet dated 8/21/25, showed:-The resident's friend signed in to visit that resident at 4:50 P.M.-The resident's friend and the resident's sister signed in to visit the resident at 8:20 P.M. During an interview on 8/22/25 at 11:15 A. M. the resident's friend said:-He/She went to the facility on 8/21/25 after the Administrator called him/her about the resident's missing clothing being replaced and when he/she arrived at the facility, there were women's clothes in the resident's closet.-When he/she was visiting with the resident, he/she helped the staff give the resident a shower.-When he/she was giving the resident a shower, he/she noticed that the resident was bleeding from his/her mouth.-He/she was upset about the resident having women's clothing in the resident's closet and questioned the staff about it. -He/She went back to the facility with the resident's Family Member A on 8/22/25 at about 8:00 P.M. to check on the resident's mouth and clothing situation and was told by the Director of Nursing (DON) that they could not visit the resident. During an interview on 8/22/25 at 12:00 P.M. the DON said:-He/She got into a verbal altercation with the resident's friend on 8/21/25 at about 5:00 P.M.-The resident's friend and Family Member A returned to the facility about 8:00 P.M. to see the resident and he/she refused to allow them to see the resident.-He/She refused to allow the resident's visitors on the unit because he/she didn't want the unit to get worked up.-He/She did not allow the resident to come out in the lobby and visit the resident because the resident was in bed. During an interview on 8/22/25 at 2:30 P.M. the resident said: -He/She did not know that his/her family attempted to visit him/her the previous night on 8/21/25 around 8:00 P.M. -He/She went to bed about 10:30 P.M. on the previous night, 8/21/25. -He/She would have liked to have had a visit from Family Member A and his/her friend the night before on 8/21/25. During an interview on 8/22/25 at 3:15 P.M. resident's guardian said:-He/She has never had a negative interaction with the resident's friend.-He/She would expect that the resident's rights to visitors be granted.-He/She would expect that if staff did not allow a resident's visitors on the unit, then the staff would bring the resident out to the lobby to visit their friends and family. During an interview on 8/22/25 at 4:10 P.M. Certified Medication Technician (CMT) A said:-He/She was familiar with the resident and the resident's friend. -He/She has not had any negative encounters with the resident's friend.-The resident's friend visited the resident several times per week and was very involved in the resident's care. During an interview on 8/22/25 at 4:18 P.M. Certified Nurse Assistant (CNA) A, said:-He/She has worked on the medical unit for 3-4 months. -He/She was familiar with the resident and the resident's friend.-He/She never had a negative interaction with the resident's friend and the resident's friend was nice. During an interview on 8/22/25 at 4:25 P.M.</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to keep one sampled resident (Resident #3) free from physical abuse when on 8/1/25 Resident #4 then hit Resident #3 in the mouth and knocked out Resident #3's top two front teeth. Nine total residents were sampled. The facility census was 151 residents. The Administrator was notified on 8/22/25 of Past Non-Compliance which occurred on 8/1/25. An all-staff in-service on Abuse and Neglect was completed by 8/4/25. Resident # 3 and Resident #4 were separated. Resident #4 was placed on intensive monitoring with medication changes followed with psychiatric hospitalization. The deficiency was corrected by 8/4/25. Review of the facility Abuse and Neglect Policy, revised 6/12/24, showed:-Abuse was the willful infliction of injury, intimidation or punishment with resulting physical harm, pain or mental anguish.-Physical abuse is purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner. -Physical abuse also includes, but is not limited to, hitting, slapping, punching, biting, and kicking. 1. Review of Resident #3's Level One Nursing Facility admission Screening for Mental Illness, Intellectual Disability or Related Condition, dated 6/24/24, showed he/she was admitted with diagnoses of:-Sickle-Cell Disease Without Crisis (a chronic genetic condition where red blood cells are abnormally sickle-shaped, leading to anemia and potential organ damage, but without the acute pain episodes or severe symptoms of a sickle cell crisis). -Schizophrenia (a severe psychiatric disorder with symptoms of emotional instability, detachment from reality, and withdrawal into the self).-Sexual Dysfunction (a persistent or recurrent inability to experience or maintain satisfying sexual activity). **NOTE**The medical record had no additional Preadmission Screen Tool and Resident Review (PASRR) documentation. The resident had shown some dementia that was more prominent than the psychiatric diagnosis. Review of Resident #3's quarterly Minimum Data Set (MDS- a federally mandated assessment tool completed by staff and used for care planning), dated 7/8/25, showed he/she:-Was minimally cognitively intact-Had moderate issues with his/her mood.-Had no negative behaviors during the look-back period. Review of Resident #3's Individualized Care Service Plan (ICSP), dated 8/29/25, showed:-His/her triggers were arguing and disrespect.-His/her interventions were listening to music. -The staff were to avoid arguing or getting defensive with him/her.-The staff were to be respectful, honest and non-judgmental with him/her.-The staff were to be respectful of his/her space at all times. Review of Resident #4'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 6/11/20, showed he/she had the following diagnoses:--Schizophrenia (a severe psychiatric disorder with symptoms of emotional instability, detachment from reality, and withdrawal into the self).--Psychotic Disorder (a mental disorder in which there is a severe loss of contact with reality).--Anti-social Personality Disorder (ASPD-is a mental health condition characterized by a persistent pattern of disregard for and violation of the rights of others). --Delusional Disorder (a mental health condition characterized by the presence of one or more fixed, false beliefs (delusions) that persist for at least one month without other obvious symptoms of psychosis). --History of Severe Cannabis, Cocaine, methamphetamine, and PCP Use Disorder (these disorders are diagnosed when an individual meets six or more of the eleven diagnostic criteria within a 12-month period. The criteria are the same for all substance use disorders, with the specific symptoms tailored to each substance).-The resident grew up in locally and had been in treatment for many years.-The resident had a history of multiple inpatient as well as outpatient psychiatric treatment facilities and had been having behavioral health treatments since 2009.-He/she had a history of aggressive behaviors but was not having aggression during the date of the assessment.-He/she was usually able to be verbally redirected by staff but received medication if that was necessary.-He/she frequently paced, watched TV and spent time in his/her room.-The resident required ongoing behavioral monitoring and support to ensure safety due to wandering, disorientation, combative behaviors, hallucinations and delusions. Review of Resident #4's quarterly MDS, dated [DATE], showed he/she:-Was cognitively intact.-Had minimal issues with his/her mood.-Had physical behaviors of kicking, hitting, pushing, grabbing, and/or abusing others sexually one to three days during the look-back period.-Had verbal behaviors of threatening others screaming at others, and/or cursing at others one to three days during the look-back period.-Had other behaviors such as hitting or scratching himself/herself, pacing, and/or screaming or other disruptive sounds one to three days during the look-back</p>		

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<p>F 0850</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Hire a qualified full-time social worker in a facility with more than 120 beds.</p> <p>(continued on next page)</p>

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<p>F 0850</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain a full time qualified Licensed Social Worker (LSW) beginning 5/23/2525 affecting all residents who required services out of nine sampled residents. The facility census was 151 residents. Review of the facility Job Description for Licensed Social Worker (LSW) dated 2023 showed:-All facilities with more than 120 beds must employ a qualified social worker on a full-time basis.-The Social Services Department must be directed by a qualified professional LSW who had a minimum of a bachelor's degree in social work or another human services field to include but not limited to; sociology, gerontology, special education, rehabilitation, counseling or psychology. -The position also required one year of supervised social work experience in a health care setting working directly with individuals.-The LSW was to ensure that social services were provided in accordance with State and Federal regulations to assist the residents in maintaining their highest practicable well-being.-The LSW was to have completed the social work portion of the residents' comprehensive care plan ensuring goals and interventions were individualized to match the skills, abilities and interests/preferences of each resident in compliant with Federal and State regulations to include identifying and promoting individualized, non-pharmacological approaches to care that meet the mental and psychosocial needs of each resident.-The LSW was to contribute to the overseeing of preadmission services for inbound residents, participate in the interdisciplinary evaluation of residents' needs for care and completion of the PASARR Level I.-The LSW was to assist with transitioning residents back into the community or to another facility.-The LSW was to assist with coordination and implementation and oversight of procedures to ensure social services actions and interactions are adequately documented in each resident's medical record and that legal, ethical, and professional standards of social work practice are upheld in written recordings.-The LSW was to have assisted with Quality Assurance programs, Advanced Directives, including ensuring all staff members are aware of each resident's Code status.-The LSW was to have assisted residents with voicing and obtaining resolutions to grievances, making sure that residents were communicated with in a timely manner.-The LSW was to assist in policy development, in order to positively impact the quality of care delivered to residents. -The LSW was responsible for making sure staff members are knowledgeable about Resident's Rights and encourages staff to maintain and enhance each resident's dignity in recognition of each resident's individuality.-The LSW was to ensure that residents who display mental illness or psychosocial difficulties such as coping with grief and loss, will have access to appropriate treatment and resources. 1 Review of Resident #3's Level One Nursing Facility admission Screening for Mental Illness, Intellectual Disability or Related Condition dated 6/24/24 showed he/she was admitted with diagnoses of:-Sickle-Cell Disease Without Crisis- (a chronic genetic condition where red blood cells are abnormally sickle-shaped, leading to anemia and potential organ damage, but without the acute pain episodes or severe symptoms of a sickle cell crisis). -Schizophrenia- (a severe psychiatric disorder with symptoms of emotional instability, detachment from reality, and withdrawal into the self).-Sexual Dysfunction- (a persistent or recurrent inability to experience or maintain satisfying sexual activity). Review of Resident #3's medical record showed:-No progress notes related to the social worker written from 1/1/25 to present.-There was no evidence of any social services interventions or interviews since April 2025.-There was no evidence social services were involved in the Sexual Consent Forms completed in August 2025. 2 Review of Resident #4'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 6/11/20, showed he/she had the following diagnoses:-Schizophrenia.-Psychotic Disorder (a mental disorder in which there is a severe loss of contact with reality).-Anti-social Personality Disorder (ASPD-is a mental health condition characterized by a persistent pattern of disregard for and violation of the rights of others). -Delusional Disorder (a mental health condition characterized by the presence of one or more fixed, false beliefs (delusions) that persist for at least one month without other obvious symptoms of psychosis). Review of Resident #4's facility Progress Notes dating back to 5/1/25 showed:-The last progress note from the social worker was written 4/25/25. -There was no evidence of any social services assessments completed since April 2025.-There was no social service input noted in the resident's Sexual Consent Form completed in August 2025. 3 Review of Resident #5's PASRR dated 8/8/16 showed he/she had diagnoses of:-Bipolar Disorder- (a chronic mental health condition</p>		