

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 08/29/2025
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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <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 0557</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 provide dignity and respect for two sampled residents (Resident #1 and Resident #5) out of five sampled residents when on 8/26/25, [NAME] A failed to maintain professional boundaries by hugging and kissing Resident #1 on his/her cheek and taking possession of Resident #1's spending card and taking the spending card off the premises of the facility. In addition, [NAME] A failed to maintain professional boundaries by hugging Resident #5, which made Resident #5 feel uncomfortable. The facility census was 154 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. 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 facility established and maintained a system that assured a full, complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.-The facility precluded any commingling of resident funds with facility funds or with the funds of any person other than another resident.-The facility only accepted funds or personal possession from resident upon written authorization from the resident or the resident's designee or guardian. Review of the facility policy titled Customer Service, revised 7/31/23, showed:-The purpose of the policy was to set expectations for customer service and professional behavior.-Employees were required to treat all customers with dignity and respect.-Customers included residents.-Appropriate conduct was required in person, by telephone, fax or other written correspondence.-Courtesy and respect were required at all times. -Failure to comply with the policy resulted in disciplinary action up to and including termination for the first offense, depending upon the severity of the event 1. Review of Resident #1's admission record showed:-The resident was admitted to this facility on 4/25/2025.-The resident had a guardian.-The resident had the diagnoses of:--Schizoaffective Disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania).--Major Depressive Disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).--Post-Traumatic Stress Disorder (PTSD-a mental health condition that develops after experiencing or witnessing a traumatic event, such as a natural disaster, war, violent crime, or personal assault).--Borderline Personality Disorder (a mental health condition characterized by intense and unstable emotions, impulsive behaviors, and difficulty maintaining healthy relationships).--Obsessive Compulsive Personality Disorder (characterized by unreasonable thoughts and fears (obsessions) that lead to compulsive behaviors).--Agoraphobia with Panic Disorder (the fear of places and situations that might cause panic, helplessness, or embarrassment). Review of the resident's Care Plan dated 4/28/25, showed:-The resident had a history of PTSD.-The resident's PTSD affected the resident and flared up without any known triggers.-Intrusion or persistently re-experienced stressors in at least one of the following ways could cause a PTSD flare up.-- Recurrent memories.--Traumatic nightmares.--Flashbacks.--Prolonged distress following traumatic reminders.--Significant physical symptoms after exposure to stressors.--Negative alterations in mood and cognitions that began or got worse after the initial event. Review of the resident's Preadmission Screening and Resident Review (PASRR-a federally mandated program that requires individuals applying for admission to or currently residing in a Medicaid-certified nursing facility to be screened to determine if they have a serious mental illness) dated 5/30/25 showed:-The resident had a mental health disability.-The resident's limitations included: poor impulse control, poor judgment, and poor decision making.-The resident was alert and oriented.-The resident required encouragement and queuing for activities of daily living.-The resident required supervision for safety.-The resident required a structured environment with low stimulation and minimum visual auditory distractions.-The resident required individual personal space.-The resident required financial assistance and financial management services.-The resident required individual counseling and psychotherapy.-The resident required 24 hour protective oversight due to</p>		