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	11/25/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect Resident #1 from physical abuse when on the evening of 10/25/25, Certified Nurse Aide (CNA) A struck the resident with a closed hand and both fell to the floor. CNA A was on top of the resident with a closed fist swinging at the resident. The incident resulted in a fracture to the distal nasal bone. Seven residents were selected for sample. The facility had 139 residents. The Administrator was notified on 10/28/25 at 1:10 P.M., of an Immediate Jeopardy (IJ) which began on 10/25/25. The IJ was removed on 10/28/25, as confirmed by surveyor onsite verification. Review of the facility Abuse and Neglect Policy, dated 6/12/2024, showed:-Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations.-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 includes handling a resident with any more force than is reasonable for a resident's proper control, treatment or management. -Physical abuse also includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Review of the facility Behavioral Emergency Policy, dated 9/23/25, showed:-The purpose was to provide safe treatment and humane care to the resident in a behavioral crisis, to outline steps to follow to correctly care for the resident in a behavioral crisis, to ensure that the resident is not being coerced, punished, or disciplined for staff convenience. -It is the policy to provide a safe environment and provide humane care to all residents. -Non-physical interventions are the first choice as an intervention unless safety issues demand immediate physical intervention.-De-escalation techniques should be utilized as first resort. Review of Resident #1's admission record showed the resident was admitted on [DATE] with diagnoses including impulse disorder (a group of mental health conditions characterized by an inability to resist impulsive behaviors that can have harmful consequences), paranoid schizophrenia (a subtype of schizophrenia characterized by persistent delusions of persecution, being spied on, or having special powers) and obsessive-compulsive personality disorder (a mental condition in which a person experiences persistent, intrusive thoughts that cause distress and performs repetitive physical or mental acts in order to prevent or counteract the thoughts and relieve the distress). Review of the resident's Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 10/14/25, showed the resident was severely cognitively impaired. Review of the resident's undated Care Plan showed:-Per Preadmission Screening and Resident Review (PASRR) Behaviors include physically threatening strikes others provoked.-Has a history of physical aggression toward staff and peers at previous placement.-Staff should be aware of body stance and facial expressions when approaching the resident.-Staff should closely watch the resident for signs of anxiety and act before he/she loses control.-Staff should not get too close and remember the resident's personal space. Review of the resident progress note, dated 10/25/25 at 10:30 P.M., showed: -Licensed Practical Nurse (LPN) A had heard the Code [NAME] (a facility team response to behavioral health crisis) when coming back from the back hall and observed CNA A entangled with the resident on the floor. CNA A was on top of the resident. -LPN A and CNA B broke apart the entanglement and observed some blood from the resident's nose and a scratch under the resident's left eye. Review of the resident's progress note, dated 10/26/25 at 12:41 A.M., showed: -Evaluation of skin on the nose acquired in-house was a laceration. -Bleeding was stopped. -Left eye had a scratch with discoloration acquired in-house. Review of the resident's progress note, dated 10/26/25 at 5:12 A.M., showed the resident was sent to the hospital for further evaluation per x-ray report which was acute avulsion (a bone fracture where a small piece of bone is pulled away from the rest of the bone by a tendon or ligament) fracture distal nasal bone. Review of the resident's radiology results report, dated 10/26/25 at 11:58 P.M., showed:-He/she was hit in the face and had swelling with pain. -The test was an exam of the nasal bones. -Findings were acute avulsion fracture distal nasal bone. Plain films cannot evaluate intracranial pathology. CAT scan if concerned. Review of the resident's after visit hospital summary, dated 10/26/25, showed:-He/she was seen as an assault victim. -He/she had a nasal bone fracture and closed head injury. Review of local law enforcement police department report, dated 10/26/25, showed:-An incident of non-aggravated assault occurred on 10/25/25 at 10:00 P.M. and was reported to law enforcement on 10/26/25 at 9:30 A.M. Officers were dispatched to the facility on [DATE] at 10:00 A.M.-The Administrator reported on 10/25/25 at 10:00 A.M., the resident was acting out and causing problems. CNA A

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. (continued on next page)

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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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement and maintain an effective training program for all staff, which included training on behavioral health care and services as determined by staff need and the facility assessment. The facility identified 140 residents with behavioral health needs and 140 residents with long-term psychiatric management needs. Five out of 66 active employees did not have behavioral health training documented as completed. One previous employee, Certified Nurse Aide (CNA) A did not have training documented and was involved in an incident where he/she struck a resident with a closed hand. The facility had 139 residents.Review of the facility Behavioral Emergency Policy, dated [DATE], showed:-The purpose was to provide safe treatment and humane care to the resident in a behavioral crisis, to outline steps to follow to correctly care for the resident in a behavioral crisis, to ensure that the resident is not being coerced, punished, or disciplined for staff convenience. -It is the policy to provide a safe environment and provide humane care to all residents.-Non-Physical interventions are the first choice as an intervention unless safety issues demand immediate physical intervention. -The facility's approved early intervention crisis prevention techniques will be used to de-escalate conflict when possible.-Care will be guided by resident's plan of care and based on the strategies taught by Crisis Prevention Institute (CPI), or the current company guidance, and will help to respond to difficult behaviors in the safest and most effective way possible.-Proactive management for our residents is the best plan.-All staff should recognize when the resident has become or can become a danger to themselves or someone else.-De-escalation techniques should be utilized as first resort. Review of the Facility Assessment, dated [DATE], showed:-The facility had 166 licensed beds.-The facility accepted residents with psychiatric and mood disorders including psychosis (hallucinations, delusions), impaired cognition, mental disorder, depression, bipolar disorder (mania, depression), schizophrenia, post-traumatic stress disorder, anxiety disorder, behavior that needs interventions, personality disorder, schizoaffective disorder, explosive disorder.-The facility acuity over the past year, or during a typical month was 140 residents with behavioral symptoms and cognitive performance. -Residents with special treatments and conditions was:--Mental health:---140 residents with behavioral health needs.---140 residents with long-term psychiatric management.-Services and care offered based on resident needs included mental health and behavior.--Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma, PTSD, schizoaffective disorder, schizophrenia, bipolar disorder, personality disorder, other psychiatric diagnoses, intellectual or developmental disabilities.-Training required for new hires included abuse, resident rights, and caring for residents with Alzheimer's, dementia, mental illness, and specialized care. 1.Review of Active Employee List #1 hired between [DATE]-[DATE], dated [DATE], showed:-66 active employees for the facility.-Active employees who were not CPI trained included Certified Medication Technician (CMT) A; CNA E, CNA F, CNA G, and Licensed Practical Nurse (LPN) C. Review of Active Employee List #2, dated [DATE], showed:-124 active employees for the facility.-Nine employees had expired CPI Training.-There were 13 employees who were not CPI certified.-There was one employee with no indicator for CPI Training at all. During an interview on [DATE] at 12:35 P.M., CMT A said he/she:- has worked at the facility for about three months.- has not had any specialized training since he/she started.-has not had any training for behavioral or mental health residents.-is unsure what to do when a resident acts out. -was hired by a human resources person that no longer worked here.-had CPI mentioned to him/her, but he/she had not been set up for any training.-was not really sure what CPI was for.-felt CPI training would have allowed him/her to help in those situations.-has heard the term code green and has been told to go the code green. -does not understand codes in the facility.2. Review of Resident #1's admission record showed the resident admitted on [DATE] with diagnoses including impulse disorder (a group of mental health conditions characterized by an inability to resist impulsive behaviors that can have harmful consequences), paranoid schizophrenia (a subtype of schizophrenia characterized by persistent delusions of persecution, being spied on, or having special powers) and obsessive-compulsive personality disorder (a mental condition in which a person experiences persistent, intrusive thoughts that cause distress and performs repetitive physical or mental acts in order to prevent or counteract the thoughts and relieve the distress). Review of the resident's Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff