| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265822 | A. Building<br>B. Wing | 12/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bridgewood Health Care Center | 11515 Troost<br>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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident#21) out of 16 sampled residents was free from abuse. On 12/7/25 Resident #22 assaulted Resident #21 while Resident #21 was sleeping with fingernails and a broken pen resulting in the left side of Resident #21 having multiple facial lacerations to varying depths. The facility census was 135 residents.The Administrator was notified on 12/22/25 of the Past Non-Compliance which occurred on 12/7/25. The facility immediately completed education for all employees on Abuse and Neglect and Customer Service. The deficiency was corrected on 12/9/25. 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 #21's undated face sheet showed he/she admitted to the facility on [DATE] with readmission on [DATE] and had the following diagnoses: -Bipolar disorder (a disorder that causes extreme mood swings, shifting between highs (mania or hypomania) of intense energy, euphoria, or irritability, and lows (depression) of sadness and hopelessness, affecting sleep, energy, thinking, and daily function.)-Major Depressive disorder (a serious mood disorder causing persistent sadness, loss of interest (anhedonia), and significant impairment in daily life, stemming from complex genetic, biological (neurotransmitter imbalances), environmental, and psychological factors.)-Schizoaffective-bipolar (a serious mental illness blending symptoms of schizophrenia (hallucinations, delusions, disorganized thinking) with mood swings from bipolar disorder (manic highs and depressive lows.)-Anxiety disorder Review of Resident #21's Quarterly Minimum Data Set (MDS- a federally mandated assessment tool completed by staff and used for care planning) dated 12/6/25 showed he/she was cognitively intact. Review of Resident #22's undated face sheet showed he/she admitted to the facility on [DATE] with readmission on [DATE] and had the following diagnoses:-Schizoaffective disorder (a serious, chronic mental illness blending symptoms of schizophrenia (like hallucinations, delusions, disorganized thinking) with symptoms of a mood disorder (major depression or bipolar mania), causing significant distress and impairment. It's categorized as either bipolar type (with highs and lows) or depressive type (with lows only).)-Bipolar disorder-Unspecified psychosis (a temporary diagnosis used when someone has psychotic symptoms (like hallucinations or delusions) but there isn't enough information or clarity for a specific diagnosis like schizophrenia or bipolar disorder, often in emergencies or early stages.) -Anxiety disorder Review of Resident #22's Quarterly MDS dated [DATE] showed he/she was cognitively intact. Review of Resident #21's Progress Notes dated 12/7/25 showed: -A code green (facility team response for behavior) was called to the unit. Resident #21 complained Resident #22 hit him/her on the head and pulled his/her hair. -He/She had several abrasions on the side of his/her face. -He/She was lying in bed with no bleeding or redness in color and no swelling, with no complaint or discomfort. -Local law enforcement was called as the resident wanted to press charges.-He/She was sent to the hospital. Review of local law enforcement's report dated 12/7/25 at 8:10 P.M. showed: -At 8:33 P.M. officers were dispatched to the facility in regard to a disturbance. -Paramedics were on scene upon arrival and were taking Resident #21 to the hospital. -Resident #21 said he/she was in his/her room when Resident #22 had come into the room and attacked him/her with a plastic fork, scratching his/her face multiple times with the fork. -Resident #22 said Resident #21 had accused him/her of taking items and it had gone on for a month. He/she was angry about the accusations and then when he/she went to his/her room and found belongings thrown on the floor and lotion on his/her bed, he/she was fed up. Resident #22 attacked and scratched Resident #21 with his/her nails. -Resident #21 had multiple scratches to the left side of the face and scratches appeared clumped and red. There was a small amount of blood observed, but paramedics were already on scene and had begun cleaning the wound. -Resident #22 was not panicked and appeared calm and aware of his/her action toward Resident #21. -Resident #22's room was in disarray and specks of blood were seen on the bed and floor. -Resident #22 was issued a summons for assault of Resident #21. Review of Resident #21's Hospital discharge paperwork dated 12/7/25 showed:-He/She was seen in the emergency room for facial abrasions and assault that occurred on 12/7/25 about 9:17 P.M.-The affected area was to be kept clean and dry. -Bacitracin (antibiotic ointment to stop bacteria growth from growing in the wound) was to be applied a few |