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	01/08/2026

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect one sampled resident (Resident #4) from physical abuse. On 1/2/26 Resident # 3 punched Resident #4 twice in the face, staff intervened then later Resident #3 punched Resident #4 in the face two more times outside the nursing station. Resident #4 fell to the floor face down and Resident #3 then kicked Resident #4 in the head twice. Resident #4 had a bloody nose and a bruise under his/her left eye out of five sampled residents. The facility census was 138 residents.On 1/8/26 the Administrator and Director of Nursing (DON) were notified of past non-compliance which occurred on 1/2/26. All staff received education prior to working their next shift. The deficiency was corrected on 1/4/26. Review of the facility Abuse and Neglect Policy dated 6/12/24, 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 purposeful beating, striking, wounding, or injuring any resident of 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. 1. Review of Resident #3's admission record showed he/she was admitted on [DATE] with the following diagnoses:-Schizophrenia (a serious brain disorder causing a break from reality, leading to hallucinations, delusions, disorganized thinking, and reduced emotional expression).-Delusional disorder (a psychotic condition marked by persistent, fixed false beliefs lasting a month or more, but without prominent hallucinations or bizarre behavior seen in schizophrenia, allowing for relatively normal functioning outside the delusion.-Social exclusion and rejection (are painful experiences where individuals are shut out from groups or interactions). Review of Resident #3's Minimum data set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 1/6/26, showed he/she was moderately cognitively impaired and had no behaviors. Review of Resident #3's undated Care Plan showed:-Per Preadmission Screening and Resident Review (PASRR) he/she had behaviors including physical aggression.-Facility staff: --Should avoid arguing or getting defensive with the resident. --Be respectful, honest, and nonjudgemental with him/her at all times.--Residents that hallucinate are often fearful of people coming near them; be careful when using reassuring touch.--Intervene as necessary to protect the rights and safety of others.--Approach/Speak in a calm manner.--Divert attention.--Remove from situation and take to alternate location as needed.-He/She had poor impulse control. Review of Resident #4's admission record showed he/she was admitted on [DATE] with the following diagnosis:-Schizoaffective disorder Bipolar type (a serious mental illness combining symptoms of schizophrenia (hallucinations/delusions) with mood swings from bipolar disorder (mania/hypomania and depression) where psychosis occurs alongside mood episodes and for at (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

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 01/08/2026
NAME OF PROVIDER OR SUPPLIER Bridgewood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11515 Troost Kansas City, MO 64131	

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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 - Actual harm Residents Affected - Few	least two weeks without them, distinguishing if from bipolar disorder with psychosis).-Post-Traumatic Stress Disorder (PTSD - a mental health condition triggered by experiencing or witnessing a traumatic event, leading to persistent distressing memories, flashbacks, nightmares, avoidance of reminders, and heightened anxiety long after the danger has passed).-Anxiety (a mental health condition marked by intense, persistent, and excessive worry of fear about everyday situations, significantly interfering with daily life and often involving panic attacks, physical symptoms and avoidance behaviors).-Obsessive-Compulsive disorder (a mental condition in which a person experiences persistent, intrusive thoughts that cause distress and performs repetitive physical of mental acts to prevent or counteract the thoughts and relieve the distress).-Schizophrenia. Review of Resident #4's MDS dated [DATE], showed he/she was cognitively intact and had no behaviors. Review of Resident #4's undated Care Plan showed:-He/She would need a crisis intervention plan due to a history of violence, impulsivity and lack of judgement.-Facility staff should:--Monitor for any signs of agitation/aggression and report to immediate supervisor.--Decrease stimulation around him/her when he/she displays signs of anxiety.--Do not get into a power struggle with him/her.--Avoid arguing or getting defensive with him/her.--Residents that hallucinate are often fearful of people coming near them; be careful when using reassuring touch.--Assess anxiety level, determine severity of condition and course of treatment or therapy needed.--Leave the situation and reflect about how to handle the situation.--Intervene as necessary to protect the rights and safety of others.--Divert attention.--Remove from situation and take to alternate location as needed.-PTSD affects resident symptoms and may flare up without any known trigger.-His/Her triggers were when he/she feels threatened. Review of the Resident #3's progress note dated 1/2/26 at 9:00 P.M. showed:-Resident #3 was in the front hall and he/she had words with Resident #4.-Resident #3 hit Resident #4 in the head.-Resident #3 and Resident #4 were separated.-Resident #3 was walking back to his/her room in the back hall.-Resident #4 was in his/her room.-Assistant Director of Nursing (ADON) went to his/her office with the door cracked open and suddenly heard a commotion outside his/her office.-ADON went out to see what was going on and witnessed Resident #3 and Resident #4 fighting again.-Resident #3 punched Resident #4 in the face twice causing Resident #4 to drop to the floor.-Then Resident #3 kicked Resident #4 in the head twice.-Staff were finally able to get the residents separated again.-Resident #3 went back to his/her room on the back hall.-ADON assessed both residents and walked Resident #4 to the front lobby for ambulance to transport him/her to the hospital. Review of the Resident #4's progress note, dated 1/2/26 at 7:15 P.M., showed:-Resident #4 and Resident #3 got into an argument in the front hall outside Resident #4's room.-Resident #3 punched Resident #4 in his/her head twice.-Staff separated the residents.-A couple minutes later Resident #4 came around the corner by the front nurse's station and confronted Resident #3 again.-Resident #3 punched Resident #4 in the face twice and Resident #4 fell to the ground then Resident #3 kicked Resident #4 in the head two times.-This caused Resident #4 to have a bloody nose and to lose consciousness.-Staff separated the residents again and Resident #3 was taken to his/her room.-Resident #4 was sent to the hospital for evaluation and treatment per the Nurse Practitioner. Review of Resident #4's hospital Discharge summary dated [DATE] showed:-The resident was seen for assault, lip abrasion, contusion (bruising) to lip and nasal contusion.-Resident instructions reviewed for nasal contusion, and physical assault.-Follow up with primary care doctor in the next week for re-examination.-Return to the hospital for worsening symptoms. Review of Resident #3's written statement dated 1/2/26 showed:-He/She asked Resident #4 for money.-Resident #4 said NO.-Resident #4 got loud and tried to fight him/her.-Resident #4 ripped his/her shirt off so he/she hit Resident #4 and walked away. Observation and interview on 1/7/26 at 12:31 P.M. Resident #3 said:-The first time Resident #4 (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 0600 Level of Harm - Actual harm Residents Affected - Few	was trying to fight him/her was because Resident #4 stole $20.00 and he/she wanted to get his/her money back.-The second time Resident #4 grabbed his/her shirt so he/she fought Resident #4 off.-Resident #3 showed bruising to his/her right-hand knuckle area in the process of healing. Review of Resident #4's written statement dated 1/4/26 showed:-Resident #3 and Resident #4 had a disagreement.-Resident #4 lost his/her temper and squared up to Resident #3.-Staff was trying to stop him/her from going back to Resident #3.-He/She left and went to the hospital.-He/She was on the hospital bed for about 20 minutes.-Then the hospital sent him/her back to the facility. Review of second written statement from Resident #4 on 1/4/26 showed:-On 1/2/26 he/she was approached by Resident #3 several times if he/she had change for a twenty-dollar bill at the time.-Towards the end of the day he/she was at wits end and he/she was approached again.-At that time his/her anger and aggravation got the best of him/her.-He/She assertively addressed the situation and at that time Resident #3 assumed the stance position and dominantly asserted him/herself at him/her.-Resident #4 assumed the defense stance and received several blows knocking him/her out. Observation and interview on 1/7/26 at 11:53 A.M. showed Resident #4:-Had a bruise under his/her left eye in the corner by his/her nose in the healing process.-He/She had no swelling or bruising to the nose or lip was seen.-He/She was having a bad day and was tired of residents coming up to him/her asking for money, clothes or anything the residents could get out of him/her.-He/She had told the residents to stay out of his/her room he/she did not have anything to give them.-When Resident #3 asked for money, he/she blew up and started yelling at Resident #3.-Resident #3 put his/her hands up in front of him/her.-He/She thought Resident #3 was going to hit him/her, so he/she put his/her hands up to block the hit.-That was when Resident #3 punched him/her a few times in the face.-He/She told Resident #3 he/she was done and Resident #3 walked down the hall.-He/She does not remember if any staff or residents witnessed the incident.-He/She went to patch things up with Resident #3 and pulled on Resident #3's shirt and Resident #3 turned around and punched him/her in the face.-He/She does not remember anything after the first punch.-Staff told him/her to stay down on the floor when he/she came around.-This incident happened by the nurse's desk. During an interview on 1/7/26 at 1:05 P.M. Certified Medication Technician (CMT) A said:-He/She did not see the first incident between Resident #3 and Resident #4 because he/she was passing medications to residents.-He/She had heard loud voices.-After making sure the resident receiving his/her medications, he/she went to see what the loud voices were.-This first incident happened outside Resident #4's room on the front hall.-ADON had Resident #3 and Resident #4 separated before he/she got to the incident.-He/She was in the nurse's station at the time of the second incident which was a room with a glass enclosure with the door cracked open at the time of the incident.-He/She heard what sounded like a boom and came out of the nurse's station and yelled for Resident #3 and Resident #4 to stop until more help arrived.-Resident #4 was on the floor by the nurse's station when he/she arrived at the incident.-He/She did not see Resident #4 lose consciousness.-Resident #4 was sitting up right away.-The incident happened so fast; he/she did not have time to get to the residents and separate them. During an interview on 1/7/26 at 2:02 P.M. Assistant Administrator said:-Resident #4 has unsupervised outings and returned with items to sell to the other residents.-Resident #3 just had a visit from family and was given $20.00.-Resident #3 wanted to buy something from Resident #4.-Resident #4 said he/she didn't have anything to sale.-Resident #4 went into Resident #3's space.-The ADON saw the first punch and separated Resident #3 and Resident #4 the first time.-No staff escorted Resident #3 to the back hall.-He/She would have expected staff to keep Resident #3 and Resident #4 separated until Resident #3 was secured back on the back hall. During an interview on 1/8/26 at 12:47 P.M. Nurse Practitioner (NP) said:-He/She received a call from the ADON to report the incident between (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bridgewood Health Care Center	11515 Troost Kansas City, MO 64131

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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 - Actual harm Residents Affected - Few	Resident #3 and Resident #4.-He/She gave an order to send Resident #4 to the hospital for evaluation and treatment.-He/She was told by the ADON that Resident #4 had a bloody nose.-He/She would expect the facility staff to separate the residents after an altercation and move the residents to a safe area.-The staff should have made sure Resident #3 made it to the back hall without any further incidents before returning to tasks.-Staff were to follow facility's abuse/neglect policy. During an interview on 1/8/26 at 11:17 A.M. the ADON said:-The first incident he/she had separated Resident #3 and Resident #4.-Resident #4 went back into his/her room with the door shut and Resident #3 went back toward his//her room. -No staff were assigned to walk with Resident #3.-Then Resident #4 came out of his/her room looking for Resident #3.-Resident #4 saw Resident #3 around the corner. -The second incident, Resident #3 punched Resident #4 twice in the face causing him/her to fall to the floor. -Resident #4 was on his/her face and face down and he/she was making a gurgling sound. -Resident #4 did not respond right of way. -When Resident #4 came out of it, he/she wanted to stand. -Resident #4 didn't know where he/she was. -He/She thought Resident #3 kicked Resident #4 hard twice on the side of his/her left side of the head. -There were no red marks. During an interview on 1/8/26 at 3:38 P.M. the Director of Nursing (DON) said:-Resident #3 and Resident #4 got into a verbal confirmation about Resident #3 wanting to buy some stuff from Resident #4 and Resident #4 didn't have anything to sell. -Resident #3 went towards his/her room and Resident #4 went towards his/her room. -Somehow, they got back to each other.-According to Resident #4 he/she wanted to tell Resident #3 that he/she wasn't going to be punked.-ADON called him/her to report the first incident. -Then he/she heard that Resident #4 got hit.-He/she came to the facility and when he/she got to the facility the police and ambulance were there. -The staff should have ensured Resident #3, and Resident #4 had stayed separated. 2706764

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure sufficient and competent staff to meet the behavioral health needs for two sampled residents (Resident #3 and #4). On 1/2/26 Resident # 3 punched Resident #4 in the face twice, staff intervened, and then later Resident #3 punched Resident #4 in the face two more times outside the nursing station. Resident #4 fell to the floor face down, Resident #3 then kicked Resident #4 in the head twice. Resident #4 had a bloody nose and a bruise under his/her left eye out of five sampled residents. The facility censure was 138 residents.On 1/8/26 the Administrator and Director of Nursing (DON) were notified of past non-compliance which occurred on 1/2/26. All staff received education prior to working their next shift. The deficiency was corrected on 1/4/26. Review of the facility Behavioral Health Services Policy dated 10/31/24 showed:-It was the policy of the facility to ensure all resident receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning. -Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders, psychosocial adjustment difficulty, and trauma or post-traumatic stress disorders.-The facility will consider the acuity of the resident population, including residents with mental disorders, psychosocial disorders, or substance use disorders, and those with a history of trauma and/or post-traumatic stress disorder, as reflected in the facility assessment. -The assessment and care plan will include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice and safety.-The care plan will use pharmacological interventions on when non-pharmacological interventions are ineffective or clinically indicated. Review of the facility's Intensive Monitoring policy and procedure, dated 4/30/24, showed the purpose was to ensure a system was in place for residents who required increased monitoring for crisis, behavioral and psychiatric issues. -Intensive monitoring is defined as periodic (hourly, every two hours, or every shift) check by a facility staff member. One to one monitoring is a designated employee will monitor the resident at all times (within eyesight).-Residents who require intensive monitoring will have an assigned employee within eyesight until the resident has stabilized or returned to prior level of functioning. Educated on the reason for intensive monitoring, including triggers and interventions for that specific resident. The employee will interact with the resident throughout to receive therapeutic interventions.-The interdisciplinary team will address the resident's behavioral concerns and ensure interventions are in place to address the resident's needs. Once the resident has stabilized and returned to prior level of functioning, the facility's interdisciplinary team will meet to discuss determination of discontinuation of intensive monitoring.-The staff will document intensive monitoring in the resident's electronic medical record. 1. Review of Resident #3's admission record showed the resident was admitted on [DATE] with the following diagnoses:-Schizophrenia (a serious brain disorder causing a break from reality, leading to hallucinations, delusions, disorganized thinking, and reduced emotional expression).-Delusional disorder (a psychotic condition marked by persistent, fixed false beliefs lasting a month or more, but without prominent hallucinations or bizarre behavior seen in schizophrenia, allowing for relatively normal functioning outside the delusion.-Social exclusion and rejection (are painful experiences where individuals are shut out from groups or interactions). Review of Resident #3's Minimum data set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 1/6/26, showed he/she was moderately cognitively impaired and had no behaviors. Review of Resident #3's undated Care Plan (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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed:-Per Preadmission Screening and Resident Review (PASRR) he/she had behaviors including physical aggression.-Facility staff: --Should avoid arguing or getting defensive with the resident. --Be respectful, honest, and nonjudgemental with him/her at all times.--Residents that hallucinate are often fearful of people coming near them; be careful when using reassuring touch.--Intervene as necessary to protect the rights and safety of others.--Approach/Speak in a calm manner.--Divert attention.--Remove from situation and take to alternate location as needed.--Be careful when using reassuring touch.-He/She had poor impulse control.-His/Her triggers for behaviors were stealing.-His/Her behaviors were de-escalated by smoking and reading the Bible. Review of Resident #4's admission record showed he/she was admitted on [DATE] with the following diagnosis:-Schizoaffective disorder Bipolar type (a serious mental illness combining symptoms of schizophrenia (hallucinations/delusions) with mood swings from bipolar disorder (mania/hypomania and depression) where psychosis occurs alongside mood episodes and for at least two weeks without them, distinguishing if from bipolar disorder with psychosis).-Post-Traumatic Stress Disorder (PTSD - a mental health condition triggered by experiencing or witnessing a traumatic event, leading to persistent distressing memories, flashbacks, nightmares, avoidance of reminders, and heightened anxiety long after the danger has passed).-Anxiety (a mental health condition marked by intense, persistent, and excessive worry of fear about everyday situations, significantly interfering with daily life and often involving panic attacks, physical symptoms and avoidance behaviors).-Obsessive-Compulsive disorder (a mental condition in which a person experiences persistent, intrusive thoughts that cause distress and performs repetitive physical of mental acts to prevent or counteract the thoughts and relieve the distress).-Schizophrenia. Review of Resident #4's MDS dated [DATE], showed he/she was cognitively intact and had no behaviors. Review of Resident #4's undated Care Plan showed:-He/She would need a crisis intervention plan due to a history of violence and impulsivity and lack of judgement.-Facility staff should:--Monitor for any signs of agitation/aggression and report to immediate supervisor.--Decrease stimulation around him/her when he/she displays signs of anxiety.--Do not get into a power struggle with him/her.--Avoid arguing or getting defensive with him/her.--Residents that hallucinate are often fearful of people coming near them; be careful when using reassuring touch.--Assess anxiety level, determine severity of condition and course of treatment or therapy needed.--Leave the situation and reflect about how to handle the situation.--Intervene as necessary to protect the rights and safety of others.--Divert attention.--Remove from situation and take to alternate location as needed.-PTSD affects resident symptoms and may flare up without any known trigger.-His/Her triggers were when he/she feels threatened.*Note: No crisis intervention plan was found in the medical record. Review of the Resident #3's progress note dated 1/2/26 at 9:00 P.M. showed:-Resident #3 was in the front hall and he/she had words with Resident #4.-Resident #3 hit Resident #4 in the head.-Resident #3 and Resident #4 were separated.-Resident #3 was walking back to his/her room in the back hall.-Resident #4 was in his/her room.-Assistant Director of Nursing (ADON) went to his/her office with the door cracked open and suddenly heard a commotion outside his/her office.-ADON went out to see what was going on and witnessed Resident #3 and Resident #4 fighting again.-Resident #3 punched Resident #4 in the face twice causing Resident #4 to drop to the floor.-Then Resident #3 kicked Resident #4 in the head twice.-Staff were finally able to get the residents separated again.-Resident #3 went back to his/her room on the back hall.-ADON assessed both residents and walked Resident #4 to the front lobby for ambulance to transport to the hospital.*Note: No documentation of behavioral intensive monitoring was noted between the two incidents. Review of the Resident #4's progress note, dated 1/2/26 at 7:15 P.M., showed:-Resident #4 and Resident #3 got into an argument in the front hall outside Resident #4's room.-Resident #3 punched (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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4 in his/her head twice.-Staff separated the residents.-A couple minutes later Resident #4 came around the corner by the front nurse's station and confronted Resident #3 again.-Resident #3 punched Resident #4 in the face twice and Resident #4 fell to the ground then Resident #3 kicked Resident #4 in the head two times.-This caused Resident #4 to have a bloody nose and to lose consciousness.-Staff separated the residents again and Resident #3 was taken to his/her room.-Resident #4 was sent to the hospital for evaluation and treatment per the Nurse Practitioner.*Note: No documentation of behavioral intensive monitoring was between the two incidents. Observation and interview on 1/7/26 at 12:31 P.M. Resident #3 said:-The first time Resident #4 was trying to fight him/her was because Resident #4 stole $20.00 and he/she wanted to get his/her money back.-The second time Resident #4 grabbed his/her shirt so he/she fought Resident #4 off.-Resident #3 showed bruising to his/her right- hand knuckle area in the process of healing. Observation and interview on 1/7/26 at 11:53 A.M. showed Resident #4:-Had a bruise under his/her left eye in the corner by his/her nose in the healing process.-He/She had no swelling or bruising to the nose or lip was seen.-He/She was having a bad day and was tired of residents coming up to him/her asking for money, clothes or anything the residents could get out of him/her.-He/She had told the residents to stay out of his/her room, he/she did not have anything to give them.-When Resident #3 asked for money, he/she blew up and started yelling at Resident #3.-Resident #3 put his/her hands up in front of him/her.-He/She thought Resident #3 was going to hit him/her, so he/she put his/her hands up to block the hit.-That was when Resident #3 punched him/her a few times in the face.-He/She told Resident #3 he/she was done and Resident #3 walked down the hall.-He/She does not remember if any staff or residents witnessed the incident.-He/She went to patch things up with Resident #3 and pulled on Resident #3's shirt and Resident #3 turned around and punched him/her in the face.-He/She does not remember anything after the first punch.-Staff told him/her to stay down on the floor when he/she came around.-This incident happened by the nurse's desk. During an interview on 1/7/26 at 1:05 P.M. Certified Medication Technician (CMT) A said:-He/She did not see the first incident between Resident #3 and Resident #4 because he/she was passing medications to residents.-He/She had heard loud voices.-After making sure the residents received their medications, he/she went to see what the loud voices were.-This first incident happened outside Resident #4's room on the front hall.-ADON had Resident #3 and Resident #4 separated before he/she got to the incident. -He/She was in the nurse's station at the time of the second incident which was a room with a glass enclosure with the door cracked open at the time of the incident.-He/She heard what sounded like a boom and came out of the nurse's station and yelled for Resident #3 and Resident #4 to stop until more help arrived.-Resident #4 was on the floor by the nurse's station when he/she arrived at the incident. -He/She did not know what the ADON was doing on the unit at this time. -He/She did not see Resident #4 lose consciousness.-Resident #4 was sitting up right away.-The incident happened so fast; he/she did not have time to get to the residents and separate them.-Resident #4 was usually very calm and this was the first time he/she had seen this behavior.-Resident #3 ‘s room is on the back hall behind locked doors.-Residents from the back hall must walk through the front hall when going out to smoke. Residents were let out of the back hall by a staff member to walk to the locked door on the front hall where staff let the residents out the locked doors for the smoke break. Staff do not usually walk with the residents while walking from the back hall through the front hall.-No one had told him/her either Resident #3 or Resident #4 needed any extra monitoring. During an interview on 1/7/26 at 2:02 P.M. Assistant Administrator said:-Resident #4 has unsupervised outings and returned with items to sale to the other residents.-Resident #3 just had a visit from family and was given $20.00.-Resident #3 wanted to buy something from Resident #4.-Resident #4 said he/she (continued on next page)

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	didn't have anything to sale.-Resident #4 went into Resident #3's space.-The ADON saw the punch and separated Resident #3 and Resident #4 the first time.-No staff escorted Resident #3 to the back hall.-He/She would have expected staff to keep Resident #3 and Resident #4 separated until Resident #3 was securely on the back hall.-ADON was assigned a refresher class on behavioral monitoring training. During an interview on 1/8/26 at 12:47 P.M., Nurse Practitioner (NP) said:-He/She would expect the facility staff to separate the residents after an altercation and move the resident to a safe area.-The staff should have made sure Resident #3 made it to the back hall without any further incidents.-Staff were to follow facility's abuse/neglect policy. During an interview on 1/8/26 at 11:17 A.M. the ADON said:-The first incident he/she had separated Resident #3 and Resident #4.-Resident #4 went back into his/her room and shut his/her door then Resident #3 went back toward his//her room. -No staff were assigned to walk with Resident #3 back to his/her unit.-Resident #4 came out of his/her room looking for Resident #3.-Resident #4 saw Resident #3 coming around the corner. -The second incident, Resident #3 punched Resident #4 twice in the face causing him/her to fall to the floor. -There was a door between the two units, but the doors don't always lock, because the lock can be broken when residents kick the door. Nobody escorts the residents when they come back in from smoking. -He/She understands the fighting started over money. Resident #3 wanted Resident #4 to buy something when he/she went out, but Resident #4 didn't buy what Resident #3 wanted. As far as he/she knew Resident #3 never got the money in the first place. During an interview on 1/8/26 at 3:38 P.M. the Director of Nursing (DON) said:-Resident #3 and Resident #4 got into a verbal confirmation about Resident #3 wanting to buy some stuff off Resident #4 and Resident #4 didn't have anything to sell. -Resident #3 went towards his/her room and Resident #4 went towards his/her room. -Somehow, they got back to each other.-According to Resident #4 he/she wanted to tell Resident #3 that he/she wasn't going to be punked.-ADON called him/her to report the first incident. -Then he/she heard that Resident #4 got hit again.-The DON came to the facility and when he/she got to the facility the police and ambulance were there. -The staff should have ensured Resident #3, and Resident #4 stayed separated. -He/she had not told the staff to place Resident #3 or Resident #4 on intensive monitoring after the first incident. The incidents happened so quickly. 2706764