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	02/26/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain sufficient supplies of wash cloths, hand towels, bath towels, and sheets for five sampled residents (Residents #7, #22, #10, #23, and #14) out of 23 sampled residents. The facility census was 134 residents. The facility did not have a policy regarding maintaining sufficient supplies of washcloths, hand towels, bath towels, or sheets. 1. During an interview on 2/20/26 at 10:41 A.M., Resident #7 said (Review of his/her Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning showed the resident was cognitively intact) he/she started washing his/her own clothes, towels, and sheets so that he/she had some and that if he/she didn't wash them, he/she didn't get any. During an interview on 2/23/26 at 9:31 A.M., Licensed Practical Nurse (LPN) A said:-They don't have enough supplies such as sheets and towels.-There was a flood and a lot of the towels were used to clean up and they were thrown away. During a tour of facility on 2/23/26 beginning at 10:42 A.M. with the Director of Nursing (DON):-On the men's unit, there were 11 sheets, five blankets, five towels in the storage closet, and no washcloths.-On the women's unit, there were no sheets, no blankets, no towels, and no washcloths in the storage closet.-On the medical unit, there were three towels, five sheets, no blankets, and no washcloths in the laundry room.-On the laundry cart in the laundry room, there were two flat sheets, two fitted sheets, four blankets, 10 washcloths that had black stains and were tattered, eight incontinence pads, and three gowns.-There were no items in the washing machine.-There were two blankets, one incontinence pad, and two sheets in the dryer.-There were no additional linens, towels, or washcloths anywhere else in the laundry room.-The DON said they had a pipe burst recently and he/she thought they ordered more supplies after the pipe burst.-The laundry worker said:--The washers were empty.--Staff had not brought anything else down to launder.--He/She delivered the loads of laundry he/she had to the men's unit and the medical around 8:00 A.M. and 10:00 A.M.--They don't have any other supplies than what were on the units and in the laundry room. During a tour of the medical unit on 2/23/26 beginning at 1:17 P.M., with the Maintenance Assistant:-The Maintenance Assistant said:--He/She didn't know why they were low on sheets and towels.--He/She took over the supervision of the laundry department on 2/18/26 because they did not have a laundry supervisor.--The lead housekeeper/laundry worker was responsible for the laundry.--The storage closets on the units should have a full rack of towels, washcloths, and sheets.-Resident #22 had no hand towels or washcloths in his/her room.-Resident #22 said (Review of his/her annual MDS dated [DATE] showed resident was severely cognitively impaired) they frequently did not have supplies like washcloths and hand towels.-Resident #10's room had no hand towels or washcloths on the bars for Resident #10 and for Resident #10's roommate. -Resident #10's bed had no sheets.-Resident #10 said (Review of his/her quarterly MDS dated [DATE] showed the resident was cognitively intact) they often did not have towels, washcloths, or sheets. -The laundry room on medical had five sheets, three towels, no washcloths, and no blankets.-Resident #23's room had no hand towels.-Resident #23 said (Review of his/her annual MDS dated [DATE] showed the resident was moderately cognitively impaired) they didn't get any kind of towels in their room. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #14 said (Review of his/her quarterly MDS dated [DATE] showed the resident was moderately cognitively impaired) he/she has one fitted sheet and two towels that he/she keeps and washes himself/herself or otherwise he/she would not have any and that he used wipes for washing his/her face.-There were no hand towels in Resident #14's room. During an interview on 2/26/26 at 12:13 P.M., lead housekeeper/laundry worker A said:-They got an order in on 2/25/26.-He/She was not sure when they ordered the supplies.-They were low on fitted sheets and pillowcases.-He/She could put out enough towels and bedding for all of the residents and the majority of the time he/she doesn't get them back soon enough to get them washed and returned.-He/She washed whatever was sent down in the laundry. -They got flat sheets, wash cloths, and towels about a month ago.-It was common to have to replace these items monthly.-If there were items that he/she wouldn't use for himself/herself, he/she wouldn't send them up to have the residents use.-He/She worked 7:00 A.M. to 3:30 P.M. and went to each unit and stocked the closet. -The CNAs got what they need from the closets on the units. During an interview on 2/26/26 at 1:08 P.M., the Administrator said:-He/She and the Maintenance Assistant were responsible for ensuring there were enough supplies.-The Maintenance Assistant has been in that position for about a week and prior to that was just himself/herself.-They just made two big orders.-One of the orders came in on 2/25/26.-He/She would send the invoices (these were not received).-Lead housekeeper/laundry worker A had not reported any shortages of linens.-They should have had sufficient supplies on the units. Complaint #2739306

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F 0600 Level of Harm - Actual harm Residents Affected - Some	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 seven sampled residents (Resident #1, Resident #13, Resident #6, Resident #5, Resident #2, Resident #9 and Resident #16) from physical abuse. On 1/18/26 Resident #1 punched Resident #13 in the back of the head. On 1/27/26 Resident #1 hit Resident #6 on the head with a mop stick after Certified Nurses Aide (CNA) E had asked Resident #6 to help. Resident #6 then punched Resident #1 multiple times in the face and head. Resident #6 had a bruise and raised area on the left side if his/her forehead. Resident #1 had scratches and red marks on his/her face. Resident #6 was upset CNA E had asked for his/her assistance and wanted this to stop. On 1/31/26 Resident #1 punched Resident #5 in his/her head. Resident #5 then punched Resident #1 in the face and head. Resident #1 had a bleeding laceration to his/her lower lip. On 2/1/26 Resident #1 pushed Resident #2 down on the floor resulting in Resident #2 a right rib fracture. On 2/13/26 Resident #10 pushed Resident #9 out of his/her wheelchair onto the ground and then Resident #10 kicked Resident #9 on the shoulder and head, resulting in a contusion to Resident #9's left shoulder. On 2/19/26, Resident #15 punched Resident #16 in the face and body resulting in Resident #16 having a bruised and bloody nose and a rib contusion. On 2/22/26 Resident #18 took Resident #17 to the ground and held the resident there in a headlock which caused Resident #17 pain in the left rib area. The facility census was 134. 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 #1's admission record showed he/she was admitted on [DATE] with the following diagnoses:-Asperger's Syndrome (a neurodevelopmental condition characterized by difficulties with social interaction, nonverbal communication, and restricted, repetitive patterns of behavior).-Paranoid Schizophrenia (a chronic mental health disorder characterized by intense, irrational delusions and auditory hallucinations).-Major Depressive Disorder (a serious mental health condition characterized by persistent, intense feelings of sadness, worthlessness, and a loss of interest in activities).-Anxiety Disorder (a group of mental health conditions characterized by persistent, excessive, and uncontrollable fear or worry that interferes with daily life).-Mild Intellectual Disability (a neurodevelopmental condition characterized by mild limitations in learning, social, and practical life skills).-Impulse Disorder (a mental health condition characterized by an inability to resist urges or impulses that may harm oneself or others).-Obsessive Compulsive Personality Disorder (a chronic mental health condition characterized by a pervasive, rigid preoccupation with orderliness, extreme perfectionism, and mental/interpersonal control).-Schizoaffective Disorder (a chronic mental health condition combining schizophrenia symptoms-such as hallucinations, delusions, and disorganized thinking-with major mood disorder symptoms like mania or depression-Dissociative Identity Disorder (a complex mental health condition where a person's identity fragments into two or more distinct, alternating personality states). Review of Resident #1's Quarterly Minimum data set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 1/8/26, showed he/she was severely cognitively impaired and had behaviors. Review of Resident #13's admission record showed he/she was admitted on [DATE] with the following diagnoses:--Schizophrenia.--Anti-social personality disorder (characterized by persistent disregard of the rights of other people, failure to comply with laws and social customs, and irresponsible and (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	reckless behavior). Review of Resident #13's Quarterly MDS, dated [DATE], showed he/she was cognitively intact. Review of resident #1's Admin/Registered Nurse (RN) Investigation, dated 1/18/26 at 12:00 A.M., showed:-Resident #1 and Resident #13 were involved in an incident.-Resident #1 had a discolored right eye because of the incident.-Resident #1 stated that he/she was beat up by Resident #13 and was punched in the face by Resident #13.-Resident #13 stated that Resident #1 attacked and punched him/her and then Resident #1 fell to the ground and hit his/her head. -This incident was not marked as abuse. Review of resident #1's Psychosocial Post-Incident Impact Note (SPN), dated 1/19/26 at 2:18 P.M., showed:-He/She was the aggressor in the incident.-He/She had a bump on the right side of head. Review of resident #1's Incident note, dated 1/19/26 at 5:59 P.M., showed:-Resident #1 fell and hit face on handrail in hallway following pushing match with Resident #13. -Resident #1 received a bruise on his/her right eye. -An X ray was obtained. During an observation and interview on 2/23/26 at 2:00 P.M., Resident #13 said:-Resident #1 got mad at him/her because he/she wouldn't give Resident #1 a hug. -Resident #1 started yelling and screaming at him/her. -He/She started to walk away from Resident #1 when resident #1 started punching him/her from behind. -He/She then placed Resident #1 in a hold and when he/she let Resident #1 go, Resident #1 fell and hit his head. -Resident #1 was still trying to fight him/her while he/she was on the ground, and he/she had to place his/her foot on Resident #1's chest and belly and then Resident #1 finally calmed down and got up and walked away.-He/She noticed that Resident #1 had a black eye after the incident but could not recall how he/she received the black eye. During an interview on 2/27/26 at 2:00 P.M., Certified Nurse Assistant (CNA) D said:-He/She was the only witness to the incident. -Resident #13 was teasing Resident #1 and it made Resident #1 angry.-Resident #13 and Resident #1 started arguing and he/she told them to stop.-Resident #1 then attacked Resident #13 and Resident #13 tackled Resident #1 to the ground.-He/She attempted to break the residents up after the incident became physical. During an interview on 2/26/26 at 1:08 P.M., Director of Nursing (DON) said:- He/She had not done an abuse Registered Nurse Investigation to determine abuse yet. -The staff should be notifying the charge nurse and him/her immediately when behaviors happened.-Nursing staff should have implemented as needed medication and notified the doctor when behaviors were escalated before the behaviors escalated to abuse. -CNA D should have reported to the nurse Resident #13 was triggering Resident #1. During an interview on 2/26/26 at 1:08 P.M., Administrator said:-He/She and the Administrator Assistant have been doing the RNIs.-Abuse was defined as the willful infliction of harm. Example: someone who knowingly tried to harm someone else with or without an object, would be willful infliction of harm. -The incident that occurred on 1/18/26 between Resident #1 and Resident #13 should have been marked as abuse.-When a resident to resident incident occurred, staff should have intervened, deescalated, and followed the Crisis Prevention Institute (CPI-provides training in Nonviolent Crisis Intervention. It focuses on de-escalation strategies, verbal intervention, and safe, restrictive-conscious physical holding skills to manage agitated or aggressive residents while ensuring the safety of both staff and residents) guidelines.-In the incident that occurred between Resident #1and Resident # 13 on 1/18/26, CNA D did not call a code green until after the residents were fighting.-A code green should be called after residents become physical with each other during an incident. During an interview on 2/26/26 at 1:08 P.M., Chief Nursing Officer (CNO)-A code green should be called before the residents become physical to be proactive in preventing abuse.-CNA D should have called a code green prior to Resident #1 and Resident #13 escalating and becoming physical with each other. Review of Resident #6's admission record showed he/she was admitted on [DATE] with the following diagnoses:--Intermittent Explosive Disorder (a chronic mental health condition characterized by recurrent, sudden, and impulsive outbursts of verbal or physical aggression that are grossly disproportionate to the trigger).-- Mild Intellectual Disability.--Traumatic Brain Injury (a localized, mild brain injury caused by a direct blow, resulting in localized, non-diffuse, and sometimes, long-lasting symptoms). Review of Resident #6's Quarterly MDS, dated [DATE], showed he/she was cognitively intact. Review of Resident #1's (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Admin/RN Investigation, dated 1/27/26 at 10:00 P.M., showed:-Resident #1 and Resident #6 were involved in an incident.-Resident #6 along with staff attempted to get Resident #1 to comply with staff and go back to the unit. -Resident #1 picked up stick of mop or broom and struck Resident #6 on top of the head.-Resident #6 then pushed Resident #1 to the ground and began striking him/her several times in the face and head.-After several attempts staff were able to break up the altercation between Resident #6 and Resident #1.-Resident #6 had a small non discolored area to the top of his/her left forehead. -Resident #1 had scratches and red mark on his/her face, neck, and head. -This incident was not marked as abuse. Review of Resident #1's incident note, dated 1/27/26 at 10:00 P.M., showed:-Resident #1 stated that CNA E was being a bitch so he/she ran and kicked open door and ran out into dining room then attempted to go out into hangout.-CNA E followed Resident #1 into the dining room asked him/her to come back to the unit.-Resident #1 started cursing and yelling at CNA E then began to angrily run towards CNA E. -Resident #6 stepped in front of CNA E and asked Resident #1 to stop.-Resident #1 then went and kicked open the door to the hangout area.-CNA E and Resident #6 followed Resident #1 out to the hangout area. -Resident #1 then picked up a mop stick striking Resident #6 on top of the head. -Resident #6 in turn pushed Resident #1 to the floor then striking Resident #1 several times in the face and head. -Staff after several attempts were able to break up the altercation. -Resident #1 had superficial scratches and red marks on his/her face, neck, and head.-Resident #1 stated I'm not hurt, he/she tried to kill me, no one ever listens to me, I have all the power, and I can kill everybody. -Resident #1 refused neurological assessments stating nothing is wrong with me. I heal fast I told you I have all the power. Review of resident #1's skin assessment note, dated 1/27/26 at 10:14 P.M., showed that resident #1 had superficial scratches and red marks on his/her face. Review of resident #6's skin assessment note, dated 1/27/26 at 10:15 P.M., showed that Resident #6 had a small discolored raised area on top of his/her left forehead. Review of Licensed Practical Nurse (LPN) B written statement, dated 1/27/26 at 10:00 P.M., showed:-He/She observed CNA E and Resident #6 trying to deescalate and get Resident #1 to return to the unit. -He/She stated that resident #6 should not have been involved in deescalating a peer. Review of Resident #19's Annual MDS, dated [DATE], showed he/she was cognitively intact. During an interview on 2/23/26 at 10:48 A.M., Resident #19 said:-He/She witnessed Resident #1 have escalated behaviors and kicking walls and doors prior to the incident.-He/She witnessed Resident #6 attempting to help CNA E deescalate Resident #1.-He/She often saw Resident #6 protecting staff from other residents when they were being violent. -He/She saw Resident #6 directly after being hit in the head by Resident #1 with a stick.-Resident #6 had a bruise and large bump on his/her head.-Resident #6 stated that his/her head hurt after the incident and he/she weas in pain. -He/She asked Resident #6 how resident #6 got hit with a stick by Resident #1 and Resident #6 told him/her that resident #6 was protecting CNA E from getting hit by Resident #1 and that is how Resident #6 was struck in the head with the stick. -Resident #6 stated that CNA E asked Resident #6 to stay with him/her and protect him/her from Resident #1. During an interview on 2/23/26 at 1:49 P.M., Social Services Designee A said:-He/She was not involved in the incident. -After the incident Resident #6 told him/her that resident #1 was attempting to hit CNA E with the broom stick and resident #6 protected CNA E from getting hit with the stick and Resident #6 was hit instead. Review of Resident #8's Annual MDS, dated [DATE], showed he/she was cognitively intact. During an interview on 2/23/26 at 3:43 P.M., Resident #8 said:-He/she saw Resident #1 hit Resident #6 with a broom stick.-He/She saw Resident #6 grabbing his/her head after he/she was hit in the head with the broom stick.-Resident #6 told him/her that Resident #6 was in pain after being hit in the head by Resident #1 with a broom stick. -Resident #6 got hit in the head by resident #1 because resident #6 was protecting CNA E from getting hit by Resident #1. -None of the residents were cleared from the scene of the incident when it occurred. -Resident #6 was walking with CNA E and they were both trying to calm down Resident #1 when Resident #1 hit resident #6 in the head.-CNA E did not attempt to get resident #6 away from Resident #1.-CNA E wanted Resident #6 to protect CNA E from Resident #1 so that CNA E did not get (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	beat up by Resident #1. During an interview on 2/26/26 at 11:52 A.M. Resident #6 said:-He/She was hit in the head with a mop stick by Resident #1 and then him/her and Resident #1 began to fight and fell to the ground. -The fight occurred because he/she was attempting to help CNA E calm resident #1 down and it made Resident #1 mad at him/her. -CNA E asked him/her to help calm down Resident #1 because CNA E feared Resident #1. -He/She felt like staff asked him/her a lot to help calm other residents down and it put him/her in danger. -He/She has asked staff not to use him/her to calm other residents down because he/she felt like it made him/her a target with the other residents. -His/Her head hurt after being hit with the broom stick by Resident #1, but it felt better now. -He/She had a large bump on his/her head for several days after being hit with the broom stick. During an interview on 2/27/26 at 1:52 P.M., CNA E said:-He/She witnessed this incident and was the CNA directly involved in the incident.-Resident #1 was escalated and having angry behaviors his/her entire shift.-He/She reported Resident #1's behaviors to the charge nurse and informed the charge nurse that he/she was scared that Resident #1 was going to hurt themself or someone else if something was not done to calm him/her down.-He/she felt that his/her presence was making Resident #1 more angry so he/she attempted to walk away from Resident #1.-Resident #6 followed him/her as they walked away from Resident #1. -When he/she and Resident #6 started to walk away from Resident #1, Resident #1 became angrier and kicked the door to the hangout smoke deck area and entered the smoke deck.-He/She and Resident #6 then went out to the smoke deck to get resident #1 to return into the facility.-Upon entering the smoke deck resident #1 picked up what appeared to be a broken off mop stick and hit resident #6 in the head with the stick.-Resident #6 then defended himself/herself and started punching resident #1 numerous times in the face and head.-He/She then yelled out Code green.-The only person that responded to the code green to help him/her was another CNA and he/She could not recall who the other CNA that responded was. -By the time anyone else arrived at the code green, he/she already broke up the residents from fighting.-He/She knew that he/she should have told Resident #6 to not involve himself/herself in the attempt to deescalate Resident #1.-He/She did not tell Resident #6 to stop trying to help him/her deescalate Resident #1.-Resident #6 felt the need to protect him/her from resident #1 because there were no other staff protecting him/her.-She relied on the nursing staff to deescalate Resident #1 before the behaviors escalated to abuse.-He/She and other staff members were scared when Resident #1 was escalated because Resident #1 had violent behaviors and that was why Resident #6 felt the need to protect him/her. -This was not the first incident of resident #6 feeling the need and protecting staff from other residents when other residents are escalated and being violent toward them. -He/She never asked resident #6 to protect him/her but he/she also did not ask resident #6 to stop trying to protect him/her. During an interview on 2/26/26 at 1:08 P.M., Administrator said:-The incident that occurred on 1/27/26 between Resident #1 and Resident #6 should have been marked as abuse.-On 1/27/26 Resident #1 hit Resident #6 in the head with a broken mop stick and the hit in the head caused Resident #6 an injury.-Resident #6 got hit in the head by Resident #1 because resident #6 inserted himself/herself into the situation. -CNA E should have separated the two resident and not allowed Resident #6 to be involved with the incident. -He/She would not expect staff members to have been asking residents for help or protection from other residents. -CNA E should have reported to the nurse that they were triggering Resident #1and been removed from Resident #1's care. Review of Resident #5's admission record showed he/she was admitted on [DATE] with the following diagnoses:-Paranoid Schizophrenia.-Major Depressive Disorder.-Persistent Mood Disorder (a mental health condition characterized by significant, sustained, and disruptive disturbances in a person's emotional state, such as extreme sadness (depression), excessive elation (mania), or both).-Mild Intellectual Disability.-Generalized Anxiety Disorder.-Post Traumatic Stress Disorder (PTSD-a mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it. Symptoms may include flashbacks, nightmares, severe anxiety and uncontrollable thoughts about the event). Review of Resident #5's Quarterly MDS, dated [DATE], showed he/she (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	was cognitively intact. Review of Resident #1's Admin/RN Investigation, dated 1/31/26 at 4:50 P.M., showed:-Resident #1 struck Resident #5 in the head.-Resident #5 then struck Resident #1 back.-Resident #1 had a scant amount of blood on his/her left lower lip.-Resident #5 stated that a staff member was trying to enter the lobby area and resident #1 was in the staff members way.-Resident #5 told Resident #1 to come with them as Resident #5 was walking by.-Resident #1 then hit Resident #5 in the head and called Resident #5 the devil. -There may have been an intent to harm by both residents. -This incident was not marked as abuse. Review of Resident #1's behaviors note, dated 1/31/26 at 5:52 P.M., showed:-Resident #1 was running through the dining room and attempted to go into the administrator's office. -Resident #5 told Resident #1 to get away from there.-Resident #1 then punched Resident #5 in the right ear. -A code green was called, and the two residents were separated. -Resident #1 had an abrasion to his/her right eye and had a split lip on the bottom left side. Review of the resident #1's skin assessment note, dated 1/31/26 at 5:58 P.M., showed:-The resident had two new skin issues.-The resident had a laceration on his/her lower left lip that measured 1 centimeter (cm) in length. -The resident had an abrasion on his/her right eye. Review of resident #5's behaviors note, dated 1/31/26 at 6:18 P.M., showed:-He/she was trying to stop Resident #1 from going into the administrator's office when Resident #1 punched him/her in the right side of his/her face.-A code green was called, and the two residents were separated. Review of resident #1's Psychosocial Post-Incident Impact Note (SPN), dated 1/31/26 at 8:01 P.M., showed:-The resident was the aggressor in the incident. -The resident stated that everyone was trying to kill him/her. During an interview on 2/16/26 at 12:35 P.M., Resident # 5 said:-Resident #1 was blocking the door from a staff member being able to go through the door and he/she told resident #1 to move out of the way and walk with him/her.-Resident #1 got mad at what he/she said to him/her and punched him/her in the head.-He/She hit Resident #1 back in the face and head.-He/She was unsure how many times he/she hit Resident #1 in the face.-He/She wanted to hit Resident #1 more, but resident #1 started running from him/her and staff got in between them. During an interview on 2/20/26 at 10:45 A.M., with Certified Medication Technician (CMT) A said:-He/She witnessed Resident #1 and Resident #5 fighting toward the end of the incident. -When he/she arrived at the incident, Resident #5 had a grip on Resident #1's clothing and CNA F was attempting to separate the residents. -The residents both punched each other prior to him/her arriving to the incident. During an interview on 2/23/26 at 9:40 A.M., LPN A said: -He/She was the nurse on duty when the incident occurred. -Resident #1 went up and hit Resident #5 out of the blue and stated he/she was trying to protect the staff because Resident #5 was the devil.-Resident #5 then punched Resident #1 and started to chase Resident #1 around the dining room.-CNA F intervened and grabbed and hugged Resident #5 to deescalate the incident.-Resident #1 had a bloody lip after the incident from Resident #5 punching him/her in the lip. -Resident #1 had a black eye on the right side from resident #5 punching Resident #1 in the eye. During an interview on 2/23/26 at 10:48 A.M., Resident #19 said:-He/She witnessed Resident #1 punch Resident #5 in the head and then Resident #5 started punching Resident #1 back several times in the face. -Staff did not clear the residents from the dining area where the residents were fighting, and he/she witnessed the entire fight.-Resident #1 had a bloody lip after the fight. During an interview on 2/23/26 at 1:49 P.M. with Social Services Designee A said:-He/She was not aware of the incident until he/she looked at the reports and found out about the incident after the fact.-He/She was unaware if a psychosocial assessment was completed on the residents after this incident. -He/She was unaware if either resident had a negative psychosocial outcome from the incident.-He/She was unaware if any residents that witnessed the incident had any negative psychosocial outcome from the incident. During an interview on 2/23/26 at 2:13 P.M., CNA F said:-He/She witnessed Resident #1 punch Resident #5 in the head and then Resident #5 started punching Resident #1 back in the face.-He/She helped break up the residents fight and separate the residents. -He/She noticed that Resident #1 was bleeding from his/her lip and had a black eye from the fight. During an interview on 2/26/26 at 1:08 P.M., Administrator said the incident that occurred (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	on 1/31/26 between Resident #1 and Resident #5 was abuse. Review of Resident #2's admission record showed he/she was admitted on [DATE] with the following diagnoses:-Bipolar Disorder (a chronic mental health condition characterized by intense, extreme shifts in mood, energy, and activity levels, ranging from high-energy mania to deep, hopeless depression).-Paranoid Schizophrenia.-Schizophrenia.-Major Depressive.-Violent Behavior (any physical, verbal, or written action, including threats, intimidation, or property damage-intended to cause physical harm, fear, or injury to individuals or groups). Review of Resident #2's Quarterly MDS, dated [DATE], showed he/she was cognitively intact. Review of resident #1's Admin/RN Investigation, dated 2/2/26 at 3:45 P.M., showed:-Resident #1 and Resident #2 were in a resident to resident incident.-Resident #1was running down the men's unit front hall and unprovoked hit Resident #2 in his/her ribs. -Resident #2 complained of rib pain after the incident. -An Xray was completed on 2/4/26 and showed that Resident #2 had a rib fracture to the 11th rib. -Resident #2 was sent to the emergency room for evaluation of the rib fracture. -Resident #2 returned from the hospital with new orders for a lidocaine pain patch (a topical, local anesthetic adhesive patch that numbs a specific, localized area of skin to relieve pain) and Naproxen (a non-steroidal anti-inflammatory drug (NSAID) used to relieve pain, inflammation, swelling, stiffness, and fever) for pain.-The incident was a result of abuse. Review of resident #2's After Visit Hospital Summary, dated 2/4/26 at 12:15 P.M., showed:-The resident had a diagnosis of rib fracture.-The rib fracture injury was a result of a physical assault. -The resident was in pain.-The resident was given a lidocaine patch and naproxen for pain at 11:27 A.M. During an interview on 2/9/26 at 1:00 P.M., LPN A said:-He/She was not a witness to this incident, but it was reported to him/her by CNA A. -He/She was the charge nurse on duty the day of the incident.-He/She was outside on a break when the incident occurred.-The abuse incident was already over before he/she returned from his/her break. -He/She knew that Resident #1 was having increased behaviors on the day of the incident prior to the incident occurring.-Resident #2 reported to him/her that he/she had rib pain. -The Xray results showed that Resident #2 had a fractured rib on the right side.-He/She then send Resident #2 to the hospital for evaluation of his/her fractured rib.-The resident returned from the hospital with new orders for pain medication. During an interview on 2/9/26 at 1:30 P.M., Administrator Assistant said:-He/She was not a witness to the resident to resident altercation and was not in the building when it occurred.-It was reported to him/her that Resident #1 punched Resident #2 in the ribs and as a result, Resident #2 had a rib fracture.-It was reported to him/her that the incident was non provoked by Resident #2 and Resident #1 was the aggressor. -Resident #2 complained of rib pain after the incident occurred.-This incident was marked as abuse. During an interview on 2/9/26 at 2:30 P.M., Resident #2 said:-He/She remembered getting hit and pushed by Resident #1 and getting his/her ribs hurt. -He/She was standing in the hallway and Resident #1 ran up to him/her out of nowhere and punched him in the side of the stomach and then pushed him/her down on the floor.-He/She was not sure why Resident #1 punched him/her or pushed him/her down.-He/She was not a fighter and did not like to fight.-He/She was scared when Resident #1 punched and pushed him/her down.-He/She still had pain in his/ribs. During an interview on 2/9/26 at 4:00 P.M., Social Services Designee said:-He/She was at work the day the incident occurred but did not witness the incident. -It was reported to him/her that Resident #1 was having increased behaviors on this day but he/she did not here about the behaviors until after the altercation occurred.-Resident #2 sustained a fractured rib from the incident. -Resident #2 disclosed to him/her after the incident that he/she wanted an Xray and that he thought his ribs were broken. -Resident #2 reported to him/her after the incident that he/she was in pain. During an interview on 2/13/26 at 10:15 A.M., CNA C said:-He/She was here the day the incident occurred. -He/She was working on the front hall, which was where Resident #1 resided. -He/She left the unit to get some cereal for another resident when the incident occurred. -When he/she returned to the unit, Resident #2 reported to him/her that Resident #2 attacked him/her and he/she was in pain. -He/She notified the nurse what Resident #2 reported to him/her. During an interview on 2/13/26 at 3:30 P.M., resident #1's guardian (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	said:-Resident #1 had baseline delusions but has recently gotten worse.-He/She was notified with every incident that Resident #1 has been involved with. -He/She believed the incidents to be a result of abuse and escalated behaviors.-He/She would expect the residents to have a safe environment and effective protective oversight by the facility. During an interview on 2/13/16 at 3:40 P.M, Psychiatric Nurse Practitioner A said: -He/She considered all of these incidents to be abuse. -He/She expected all of the resident's to be free from abuse and live in a safe environment. During an interview on 2/26/26 at 1:08 P.M., Administrator said the incident that occurred on 2/1/26 between Resident #1 and Resident #2 was abuse. 2. Review of Resident #9's undated facesheet showed he/she admitted [DATE] with the following diagnosis: -Cerebral Infarction.-Bi-Polar Disorder.-Major Depressive Disorder.-Schizoaffective Disorder. Review of Resident #9's quarterly MDS, dated [DATE], showed he/she was cognitively intact. Review of Resident #10's undated facesheet showed he/she admitted [DATE] with the following diagnosis: -Schizoaffective Disorder.-Major Depressive Disorder. -Bipolar Disorder.-Hallucinations-Personal History of other Mental and Behavioral Disorders Review of Resident #10's quarterly MDS, dated [DATE], showed he/she was cognitively intact. Review of Resident #9's progress note, dated 2/13/26 at 6:40 P.M., showed: -He/She was in the hallway when Resident #10 had come up to Resident #9, punched Resident #9 and Resident #9's wheelchair fell over. -Staff intervened and separated when Resident #10 then kicked Resident #9 in the back of the head. -Resident #9 complained of pain to the left shoulder and was sent to the hospital. Review of Resident #10's progress notes, dated 2/13/26 at 6:59 P.M., showed:-He/She hit Resident #9 while Resident #9 was sitting in hallway. -Resident #10 hit and kicked Resident #9 in the back of Resident #9's head. Resident #9's wheelchair fell over. Review of the facility RNI, dated 2/13/26, showed: -Physical Aggression not involving the head between Resident #9 and Resident #10. -Responded to code green on medical unit. Resident #9 was lying on the floor in front of his/her wheelchair. Staff surrounded Resident #9 and completed an assessment. Resident #9 wanted off the floor and to press charges against Resident #10. -The event was a behavior based on Resident #10's poor impulse control, poor communication, and not being able to link consequences to actions. Resident #10 did not intend to harm Resident #9. Resident #10 said he/she pulled Resident #9 out of his/her wheelchair because Resident #10 was mad. -Resident #9 was sent to the hospital. -The incident was not the result of abuse and not reportable. Review of Resident #9's hospital after visit summary, dated 2/13/26, showed: -He/she was seen for neck pain. -He/she had a shoulder contusion. -He/she was provided a lidocaine (a fast acting pain relief) for pain. During an interview on 2/23/26 at 9 A.M., Resident #10 said: -Resident #9 had stolen from him/her and flipped him/her off. -He/She pushed Resident #9 from behind and knocked Resident #9 out of his/her wheelchair to the floor. -He/She did not remember who held him/her back. -He/She kicked Resident #9 once in the shoulder. During an interview on 2/23/26 at 10:24 A.M., Resident #9 said: -Resident #10 had run him/her down and tackled him/her. -He/she had left side paralysis which was why Resident #10 tackled him/her out of his/her wheelchair. Resident #10 kicked him/her in the shoulder and kicked him/her in the head. -He/she said the wheelchair flipped over on the side and bent the spokes on the foot pedal causing him/her to have a loaner wheelchair. -His/Her left shoulder hurt. -He/She went to the hospital. -He/She was mad his/her wheelchair was broke. During an interview on 2/23/26 at 10:58 A.M., LPN C said: -He/she was on the front hall and hall and heard commotion. When he/she responded Resident #9 was on the ground and Resident #10 had kicked Resident #9 in the head. During an interview on 2/23/26 at 11:15 A.M., CMT C said: -He/she was at the medication cart by the nursing station when he/she saw Resident #10 come from the [NAME] hall heading toward Resident #9. Resident

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F 0740 Level of Harm - 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 provide appropriate treatment and behavioral health services for one sampled resident (Resident #1) who had a known behavioral health history and mental health diagnosis. The facility staff failed to implement the resident's plan of care, administer psychotropic medications and tests as ordered by the physician, implement behavioral health techniques for de-escalation to reduce the resident's behavior and maintain residents safety. As a result, the resident was involved in multiple resident to resident altercations that resulted in physical injury. On 1/18/26 Resident #1 punched Resident #13 in the back of the head. On 1/27/26 Resident #1 hit Resident #6 on the head with a mop stick. Resident #6 then punched Resident #1 multiple times in the face and head. Resident #6 had a bruise and raised area on the left side if his/her forehead and was upset. Resident #1 had scratches and red marks on his/her face. On 1/31/26 Resident #1 punched Resident #5 in his/her head. Resident #5 then punched Resident #1 in the face and head. Resident #1 had a bleeding laceration to his/her lower lip. On 2/1/26 Resident #1 pushed Resident #2 down on the floor resulting in Resident #2 a right rib fracture. 13 residents were sampled. The facility census was 133 residents.Review of the facility's Intensive Monitoring Policy, dated 4/30/24, showed:-The purpose of the policy was to ensure a system was in place for residents who required increased monitoring for crisis, behavioral and psychiatric issues.-Residents who required more intensive monitoring due to crisis, behavioral, or psychiatric symptoms would be monitored by the facility staff.-Intensive monitoring was defined as periodic hourly, every two hours, or every shift check by a facility staff member.-One-on-one monitoring was a designated employee assigned by a facility supervisor.-Residents who required intensive monitoring of one to one would have a dedicated staff member within eyesight.-Residents may require more intensive monitoring based on their crisis, behavioral, and psychiatric issues.-The level of intensive monitoring required would be identified by the specific situation or the resident assessment.-Residents who were showing poor impulse control including crisis, behavioral, psychiatric issues, such as, verbal and or physical aggression, elopement ideation, suicidal and or homicidal ideation and decompensation mentally or crisis may be placed on intensive monitoring or one to one or two to one monitoring at the discretion of the administrative staff and or the facility supervisor. -The facility's interdisciplinary team would address the resident's behavioral concerns and ensure interventions were in place to address the residents needs such as psychiatry follow up, counseling, and medical needs.-Once the resident was stabilized and or returned to prior level of functioning, the facility's interdisciplinary team met to discuss determination of discontinuation of intensive monitoring. -The facility staff would document the intensive monitoring in the residents Electronical Medical Record (EMR). Review of the facility Behavioral Health Services Policy, dated 10/31/24, showed:-It was the policy of the facility to ensure all residents received necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning.-Behavioral health encompasses a residents whole emotional and mental well-being, which included, 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 would 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.-All facility staff, including contracted staff and volunteers, would receive education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents. -Education would be based on the role of the staff member and the residents needs identified through the facility assessment.-The social services director would serve as the facility's contact person for questions regarding behavioral services provided by the facility and outside (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	sources such as physician, psychiatrist, or neurologist.-The assessment and care plan would include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, privacy, socialization, independence, choice and safety.-Staff would monitor the resident closely for expressions or indication of distress.-Staff would accurately document the behaviors changes and potential triggers in the resident's record.-Staff would ensure appropriate follow up assessment, if needed.-Staff would evaluate resident and care plan routinely to ensure the approaches were meeting the needs of the resident. -Staff would share concerns with the Interdisciplinary Team (IDT) to determine underlying causes of mood and behaviors changes, including differential diagnosis. -Staff would use pharmacological interventions when non-pharmacological interventions were ineffective or clinically indicated. 1. Review of Resident #1's admission record showed he/she was admitted on [DATE] with the following diagnoses:-Asperger's Syndrome (a neurodevelopmental condition characterized by difficulties with social interaction, nonverbal communication, and restricted, repetitive patterns of behavior).-Paranoid Schizophrenia (a chronic mental health disorder characterized by intense, irrational delusions and auditory hallucinations).-Major Depressive Disorder (a serious mental health condition characterized by persistent, intense feelings of sadness, worthlessness, and a loss of interest in activities).-Anxiety Disorder (a group of mental health conditions characterized by persistent, excessive, and uncontrollable fear or worry that interferes with daily life).-Mild Intellectual Disability (a neurodevelopmental condition characterized by mild limitations in learning, social, and practical life skills).-Impulse Disorder (a mental health condition characterized by an inability to resist urges or impulses that may harm oneself or others).-Obsessive Compulsive Personality Disorder (a chronic mental health condition characterized by a pervasive, rigid preoccupation with orderliness, extreme perfectionism, and mental/interpersonal control).-Schizoaffective Disorder (a chronic mental health condition combining schizophrenia symptoms-such as hallucinations, delusions, and disorganized thinking-with major mood disorder symptoms like mania or depression-Dissociative Identity Disorder (a complex mental health condition where a person's identity fragments into two or more distinct, alternating personality states). Review of the resident's Preadmission Screening and Resident Review (PASARR- a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care), dated 1/30/24 showed:-The resident had behavioral difficulties and/or mental illness symptoms requiring 24 hr. monitoring/management.-The resident had the following diagnoses:--Aspergers Syndrome--Paranoid Schizophrenia--Impulse Control Disorder--Attention Deficit Hyperactivity Disorder (ADHD-a neurodevelopmental disorder characterized by a persistent pattern of inattention, hyperactivity, and/or impulsivity that interferes with daily functioning, school, or work).--Mood Disorder (a mental health condition characterized by significant, long-term disturbances in emotional state, extending far beyond typical mood swings).--Psychotic Disorder (a set of symptoms indicating a loss of contact with reality, characterized primarily by hallucinations (seeing/hearing things not there) and delusions (false, fixed beliefs)).--Bipolar 1 Disorder (a severe mental health condition characterized by at least one manic episode lasting at least 7 days or being severe enough to require hospitalization).--Major Depressive Disorder.--Oppositional Defiant Disorder (a frequent and ongoing pattern of anger, irritability, arguing and defiance toward parents and other authority figures).--Pervasive Developmental Disorder (an umbrella term for a group of neurodevelopmental conditions characterized by significant, early-onset delays in social interaction, communication skills, and restricted or repetitive behaviors).--Anxiety Disorder--Mild Intellectual Disability--Obsessive Compulsive Disorder--Schizoaffective Disorder-The resident required psychiatric follow up and consultation.-The resident required medication administration, management, and monitoring.-The resident required a secure behavioral unit.-The resident was impatient and demanding.-The resident destroyed property.-The resident disturbed other residents.-The resident physically threatened other residents.-The resident struck other residents unprovoked.-The resident required 24-hour oversight for safety and nursing care.-The resident (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	required medication administration and management.-The resident required psychiatric oversight.-The resident required monitoring of behavioral symptoms. -The resident required monitoring of medication therapeutic effects in managing mental health symptoms including labs. -The resident required assessment and planning for the level of supervision required to prevent harm to self and others. -A crisis plan was recommended due to the resident's history of aggression towards others. Review of the resident's Quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning), dated 1/8/26, showed he/she was severely cognitively impaired and had behaviors. Review of the resident's undated Care Plan showed:-The resident had behavioral challenges that required protective oversight in a secure setting.-Interventions included:--Counseling services to assist in developing coping skills.--1:1 intervention as needed.--Pharmaceutical Interventions as needed.-Per PASARR he/she had behaviors that included frequent and continuous telling, invading others space, verbal abuse, verbal threatening, physically threatening, striking others, and suspicion of others. -Triggers included:--When people were mean to him/her.--When people didn't understand him/her--When people yelled at him/her.--When he/she didn't get money on time.-Interventions included:--Smoking a cigarette.--Taking a shower.--People talking calmly to him/her.--Watching music videos.--Reading the Bible.--Listening to music. -Per PASARR, he/she needed provision of a structured environment.-Interventions included:--Provide instructions at his/her level of understanding.--Assess and plan for the level of supervision required to prevent harm to self/others.--Provide for individual personal space.--Establish consistent routines.--Provide schedule of daily tasks/activities.-The resident was at risk for the following signs/symptoms related to their diagnosis ofSchizophrenia: aggression, anxiety, inability to make decisions, delusions (fixedfalse beliefs that can't be reasoned with, fear, hallucinations (hearing, seeing, feeling, smelling things that are not there), hard time focusing, irritability, and staying to self. -Interventions included:-- Administering PRN (as needed) medication for anxiety or hallucinations per physician's order.--Avoiding arguing or getting defensive with him/her.--Being respectful, honest, and nonjudgmental with him/her at all times.--Notifying the charge nurse if the resident experienced any of the signs/symptoms of Schizophrenia.--Respecting his/her personal space.-The resident was at risk for the following signs and symptoms related to his/her diagnosis of Intellectual disability: difficulties talking or talking late, difficulty communicating or socializing with others, difficulty with problem-solving or logical thinking, Having problemsremembering things, Inability to connect actions with consequences, Inability to doeveryday tasks like getting dressed or using the restroom without help, Learning and developing more slowly than others, and had a lower-than-average scores on IQ test.-Interventions included:--Encouraging him/her to participate in social activities and groups.--Ensuring his/her environment is safe.--Offering behavior modification programs.--Providing him/her with diversional activities.--Providing positive reinforcement.--Use of calm and gentle approaches with him/her.-The resident was at risk of the following signs and symptoms related to the diagnosis Anxiety disorder such as cursing, hollering, leg shaking, moving around in or frequently getting up and down from the chair, nail biting, nervousness, pacing on the unit, restlessness, shaky voice, sweating, and toe tapping.--Interventions included:--Being aware of body stance and facial expressions when approaching him/her.--Closely watching him/her for signs of anxiety and act before he/she lost control.--Offering medication before he/she had a behavioral outburst.--Offering non-invasive coping mechanisms first to try to reduce his/her anxiety level. --Assisting with finding the cause of the anxiety. Review of the resident's Physician Order sheet (POS), dated January 2026, showed:-The resident had an active order for chlorpromazine HCl Injection Solution 25 MG/ML(Chlorpromazine HCl) Inject 50 mg intramuscularly every 12 hours as needed for Agitation: Anxiety. Review of the resident's Admin/Registered Nurse (RN) Investigation (RNI), dated 1/18/26 at 5:45 P.M., showed:-The resident kicked through the unit's front doors and entered the dining room. -The Activities Director/Staffing Coordinator was in the dining room when the resident entered. -The Activities Director/Staffing Coordinator sat the resident at a dining room table and gave the resident (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	something to eat. -While in the dining room eating, the resident was triggered by a commercial that came on the television in the dining room. -The resident threw a bottle of shampoo at the television.-The Activities Director/Staffing Coordinator left the dining room while the resident remained in the dining room tend to another issue.-While staff was tending to another incident, the resident picked up a chair, placed the chair back on the ground, and then charged at Maintenance Staff A. -The Activities Director/Staffing Coordinator and Maintenance Staff A placed the resident in a hold (a gripping, supporting or containing a person with hands, arms or capacity), and both fell to the ground with along with the resident. -New interventions included:--A urinalysis test would be ordered for the resident.--A compete blood count (CBC) lab test would be ordered for the resident. --The resident's care plan would be reviewed and updated interventions added. Review of the resident's medical record showed no urinalysis test or complete blood count lab completed after this incident on 1/18/26. Further review showed the care plan was not reviewed or interventions added. Review of Resident #1's RNI, dated 1/18/26 at 12:00 A.M., showed: -Resident #1 and Resident #13 were involved in a resident-to-resident incident with Resident #1 as the aggressor.-Resident #1 had discolored skin to his/her right eye because of the incident.-Resident #1 stated that he/she was beat up and punched in the face by Resident #13.-Resident #13 stated that Resident #1 attacked and punched him/her and then the resident fell to the ground and hit his/her head. --New interventions included:--Assessment.--Staff education.--Resident education During an interview on 2/9/26 at 1:00 P.M., Licensed Practical Nurse (LPN) A said:-He/She was familiar with the resident and was the main charge nurse.-He/She witnessed the resident's behaviors on numerous occasions.-He/She was not aware that a urinalysis and CBC tests were supposed to be drawn on 1/18/26 per the resident's RNI. -He/She could not recall the resident was administered an as needed medication due to his/her escalated behaviors on 1/18/26. -The resident had a standing as needed medication order that staff could administer for his/her escalated behaviors when needed. Review of Resident #1's Psychosocial Post-Incident Impact Note (SPN), dated 1/19/26 at 2:18 P.M., showed: -He/She was the aggressor in the incident.-He/She had a bump on the right side of his/her head. Review of Resident #1's incident note, dated 1/19/26 at 5:59 P.M., showed: -Resident #1 fell and hit his/her face on handrail in hallway following a pushing match with Resident #13. -Resident #1 received a bruise to his/her right eye. -An X ray was obtained. Review of the residents Medication Administration Record (MAR), dated January 2026, showed Chlorpromazine for the resident's agitation was not administered to the resident on the date of the incident, 1/18/26. Review of the resident's Electronic Medical Record (EMR), dated 1/18/26 through 1/23/26, showed:-No care plan updates, or new interventions were completed by staff after the behavior incident on 1/18.-No behavior monitoring was documented by staff. -No nonpharmacological interventions were documented by staff.-No pharmacological interventions were documented by staff. -PASARR recommendations were not implemented such as:-The resident required monitoring of medication therapeutic effects in managing mental health symptoms including labs. -The resident required assessment and planning for the level of supervision required to prevent harm to self and others. -A crisis plan was recommended due to the resident's history of aggression towards others.-Facility staff did not document offering counseling services to the resident per the care plan.-No documentation facility staff implemented the care plan interventions of 1:1, pharmaceutical interventions, to smoke or shower, music or music videos, to read the Bible, or calm talk for the increased behaviors. During an interview on 2/9/26 at 1:30 P.M., Administrator Assistant said:-He/She completed the investigation for the incident on 1/18/26.-He/She was not sure why the interventions for the resident behaviors were not completed. -He/She expected that all the interventions in an incident investigation were to be completed. -He/She was not sure why the resident's care plan was not updated after the incident.-He/She thought it was the Social Services (SS) that updated the resident's care plan but was not sure.-He/She expected care plans to be updated after incidents of escalated behaviors that required an investigation.-He/She expected a resident's care plan interventions to be used when a resident was having escalated (continued on next page)

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	265822	A. Building B. Wing	02/26/2026

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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F 0740 Level of Harm - Actual harm Residents Affected - Few	behaviors.-He/She was aware that the resident was care planned to have an as needed medication when his/her behaviors had escalated.-He/She was not sure why the nursing staff did not administer the resident's as needed medication when he/she needed it.-The facility was going to do some education on using interventions and as needed medications before the resident's behaviors got out of control. During an interview on 2/20/26 at 11:00 A.M., Maintenance Staff A said:-On 1/18/26, he/she heard a lot of commotion and witnessed the resident throwing something at the television in the dining area.-The resident then charged at him/her. -He/She and Activities Director/Staffing Coordinator placed a hold on the resident by each of them having one of the resident's arms placed above the resident's head.-Their hold on the resident was a Crisis Prevention Institute (CPI) approved hold. -During the hold, the resident and him/her fell to the floor.-There were no clinical staff or nurses monitoring the resident during his/her increased behaviors as was their protocol when the resident had behaviors. -Clinical staff arrived at the incident after a code green (facility wide call to ask for assistance) was called.-He/She witnessed the resident continue to have escalated behaviors for the rest of the day.-Staff were unable to handle the resident's behaviors. -He/She witnessed clinical staff allowing the resident to run around the facility and have escalated behaviors with no attempts to intervene on numerous occasions. -He/She witnessed the resident run around the facility hitting other residents, breaking things, doing what he/she wanted regardless of destructive behavior most days and nothing was done by staff to intervene or calm the resident down until he/she became physical with staff or other residents. -Most of the staff are female and they are fearful of the resident due to his/her violent behaviors. During an interview on 2/20/26 at 3:00 P.M., Activities Director/Staffing Coordinator said:-On 1/18/26, the resident busted through the door, and he/she sat the resident at a table in the dining room. -The resident had a shampoo bottle in his/her hand and threw the shampoo bottle at the television. -After the resident threw the shampoo bottle at the television, he/she got up and charged at Maintenance staff A.-Maintenance staff A performed a hold on the resident, and he/she stepped in to help get the resident under control.-The resident bit Maintenance staff A during the altercation.-The resident and Maintenance staff A both fell to the ground during the altercation. -There was no clinical or nursing staff present in the dining area at the time of the incident.-He/She called a code green.-Staff responded to the code green and helped get the resident and Maintenance staff A separated. -The resident continued to have increased behaviors and agitation after the incident.-He/She did not witness any clinical staff deescalating the resident before or after the incident. During an interview on 2/23/26 at 10:25 A.M., Certified Nurse Assistant (CNA) A said:-He/She did not directly witness the incident on 1/18/26 but responded when a code green was called.-He/She helped separate the resident and the staff members and took the resident outside on the smoke deck.-He/She was outside with the resident for 20 minutes. -A nurse did not come assess the resident after the incident while he/she had the resident on the smoke deck. -Once him/her and the resident returned into the facility, he/she brought the resident to see the nurse.-The resident continued to have escalated behaviors after the incident. -The nurse who responded to the incident did not attempt to deescalate the resident or give him/her an as needed medication for increased agitation. -The resident was not placed on any intense monitoring after the incident like their protocol after a resident behavior. -He/She was not given any interventions or special instructions to care for the resident after the incident.-He/She did not continue to sit with or monitor the resident. -He/She was not advised by the nurse to continue monitoring the resident. During an interview on 2/23/26 at 1:49 P.M., SS Designee A said:-He/She was here on 1/18/26 during the incident but did not see this incident when it occurred. -After the incident occurred, he/she made an attempt to talk to the resident, but he/she could not remember if he/she was able to do so.-Staff did not request him/her to help with the resident's escalated behaviors on 1/18/26. -He/She was unaware that the behavioral health policy stated SS served as the contact person for clinical staff to obtain behavioral health support. -He/She was rarely contacted by staff for behavioral health support when residents were having escalated behaviors.-He/She normally found out by his/her own record review if the incident (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	required staff to fill out an incident report.-Residents should have received psychosocial assessments after each incident of escalated behaviors per facility practice. -He/She could not remember if a psychosocial assessment was completed on the resident after the incident. Review of Resident #13's Quarterly MDS, dated [DATE], showed he/she was cognitively intact. During an observation and interview on 2/23/26 at 2:00 P.M., Resident #13 said:-Resident #1 got mad at him/her because he/she wouldn't give him/her a hug. -Resident #1 started yelling and screaming at him/her. -He/She started to walk away from the resident when he/she started punching him/her from behind. -He/She then placed Resident #1 in a hold and when he/she let him/her go, the resident fell and hit his/her head. -Resident #1 was still trying to fight him/her while Resident #1 was on the ground, and he/she had to place his/her foot on the resident #1's chest and belly and then Resident #1 finally calmed down and got up and walked away.-He/She noticed that Resident #1 had a black eye after the incident but could not recall how he/she received the black eye.-A code green was never called by staff until after the incident was over. -CNA D was present and witnessed Resident #1 attacking him/her. -CNA D just sat and watched it happen and never called a code or green or tried to stop the altercation between him/her and resident #1.-He/She looked at CNA D during the incident and said, why are you letting him/her attack other residents like this?-He/She reported to the Administrator that CNA D allowed Resident #1 to attack him/her and did nothing to intervene. During an interview on 2/27/26 at 2:00 P.M., CNA D said:-He/She was the only witness to the incident. -Resident #13 was teasing Resident #1 and it made Resident #1 angry.-Resident #1 was already having escalated behaviors and the teasing made the behaviors worse. -Resident #13 and Resident #1 started arguing and he/she told them to stop.-He/She did not call a code green during the argument. -Resident #1 then attacked Resident #13 and then Resident #13 tackled Resident #1 to the ground.-He/She attempted to break the residents up after the incident became physical.-He/She did not call a code green after the resident to resident became physical.-He/She called a code green after the resident's stopped fighting. -He/She was unsure what to do when the incident occurred.-He/She was unsure why he/she did not call a code green sooner. -He/She should have called a code green as soon as the residents started fighting. -Resident #1 continued to have escalated behaviors after the incident. -He/she asked for no other non-pharmacological interventions. -Resident #1 was not placed on intensive monitoring after the incident.-Resident #1 was not given any as needed medication after the incident. During an interview on 2/26/26 at 1:08 P.M., Director of Nursing (DON) said:-The staff should be notifying the charge nurse and him/her immediately when behaviors happen.-Nursing staff should have implemented the as needed medication and notified the doctor when behaviors were escalated before the behaviors escalated to abuse. -CNA D should have reported to the nurse that the resident was escalating. During an interview on 2/26/26 at 1:08 P.M., Administrator said:-He/She and the Administrator Assistant have been doing the RNIs.-When a resident-to-resident incident occurred, staff should have intervened, deescalated, and followed the CPI guidelines.-In the incident that occurred between Resident #1and Resident # 13 on 1/18/26, CNA D did not call a code green until after the residents were fighting.-A code green should be called before residents become physical with each other during an incident.-He/She would expect all staff to know how to deescalate and intervene with Resident #1.-He/She would expect nursing staff to be administering as needed medication to help prevent escalated behaviors from becoming physical. -He/She would expect staff who were working with Resident #1 to understand the resident's triggers and report any new behaviors to nursing staff. During an interview on 2/26/26 at 1:08 P.M., Chief Nursing Officer (CNO)-A code green should be called before the residents become physical to be proactive in preventing abuse.-CNA D should have called a code green prior to Resident #1 and Resident #13 escalating and becoming physical with each other. Review of Resident #1's Behavior Note, dated 1/23/26 at 2:02 A.M., showed:-The resident was having delusions.-The resident displayed physical aggression and was hitting towards others.-The resident displayed physical aggression and was pushing others.-The resident displayed physical aggression and was grabbing others.-The resident displayed verbal (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	behaviors and was screaming, threatening others, and making disruptive sounds. Review of Resident #1's Medication Administration Record (MAR), dated January 2026, showed Chlorpromazine was not administered to the resident for increased agitation documented 1/23/26. Review of Resident #1's Electronic Medical Record (EMR), dated 1/23/26 through 1/27/26, showed:-No care plan updates, or new interventions were completed by staff. -No behavior monitoring was documented by staff on 1/23.-No nonpharmacological intervention was documented by staff.-No pharmacological intervention was documented by staff. -PASARR recommendations were not implemented such as monitoring of medication therapeutic effects, assessment and planning for the level of supervision to prevent harm to self and others, or develop a crisis plan for aggression towards others.-Facility staff did not document offering counseling services to the resident per the care plan.-No documentation facility staff implemented the care plan interventions of 1:1, pharmaceutical interventions, to smoke or shower, music or music videos, to read the Bible, or calm talk for the increased behaviors. Review of Resident #1's Admin/RN Investigation, dated 1/27/26 at 10:00 P.M., showed:-Resident #1 and Resident #6 were involved in an incident.-Resident #6 along with staff attempted to get Resident #1 to comply with staff and go back to the unit. -Resident #1 picked up stick of mop or broom and struck Resident #6 on top of the head.-Resident #6 then pushed Resident #1 to the ground and began striking him/her several times in his/her face and head.-After several attempts staff was able to break up the altercation between Resident #6 and Resident #1.-Resident #6 had a small non discolored area to the top of his/her left forehead. -Resident #1 had scratches and red mark on his/her face, neck, and head. -Interventions included:--Intensive monitoring. Review showed staff did not document how the intensive monitoring was supposed to be done. --Interdisciplinary team meeting would be scheduled.--Care plan would be reviewed and updated.--Staff education would be provided to clear areas when residents are having escalated behaviors. Review of Resident #1's incident note, dated 1/27/26 at 10:00 P.M., showed:-Resident #1 stated that CNA E was being a bitch so he/she ran and kicked open door and ran out into dining room then attempted to go out into hangout.-CNA E followed Resident #1 into the dining room asked him/her to come back to the unit.-Resident #1 started cursing and yelling at CNA E then began to angrily run towards CNA E. -Resident #6 stepped in front of CNA E and asked Resident #1 to stop.-Resident #1 then went and kicked open the door to the hangout area.-CNA E and Resident #6 followed Resident #1 out to the hangout area. -Resident #1 then picked up a mop stick and struck Resident #6 on top of the head. -Resident #6 in turn pushed Resident #1 to the floor then struck him/her several times in the face and head. -Staff after several attempts were able to break up the altercation. -Resident #1 had superficial scratches and red marks on his/her face, neck, and head.-Resident #6 had a bruise and raised area on the left side if his/her forehead. Resident #1 had scratches and red marks on his/her face. Resident #6 was upset CNA E had asked for his/her assistance and wanted this to stop. Review of Resident #6's Quarterly MDS, dated [DATE], showed he/she was cognitively intact. During an interview on 2/26/26 at 11:52 A.M., Resident #6 said: -He/She was hit in the head with a mop stick by Resident #1 and then he/she and Resident #1 began to fight and fell to the ground. -The fight occurred because he/she attempted to help CNA E calm Resident #1 down and it made Resident #1 mad at him/her.-CNA E asked him/her to help calm down Resident #1 because CNA E feared the resident. -He/She felt like staff asked him/her a lot to help calm other residents down and it put him/her in danger. -He/She has asked staff not to use him/her to calm other residents down because he/she felt like it made him/her a target with the other residents. -He/She did not like being out in the middle of staff and Resident #1's problems.-There was not enough sta

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a safe, sanitary and functioning environment when the sink in rooms 215 had discolored water standing in the sink causing a bad odor, the bedroom and bathroom floors had brown grime built up, and the heating unit was pulled away from the wall which were both causing distress to one sampled resident (Resident #4), failed to have a sink installed in the 200 hall bathhouse #1 which resulted in two medal poles to protrude from the wall and create an unsafe environment for all residents who resided on the 200 hall, failed to maintain sanitation in the 200 hall bathhouse #2 by having a toilet that was filled with a dark brown substance, and failed to maintain a HVAC (heating, ventilation, and air conditioning) unit in the Main Dining room that had no cover on it exposing the metal edges around the opening's sides that were bent up causing a sharp edge out of 19 sampled residents. The facility census was 133 residents.Review of the facility Safe and Homelike Environment Policy date 6/5/2024 showed:-In accordance with resident's rights, the facility will provide a safe, clean, comfortable and homelike environment.-This included ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.-Environment refers to any environment in the facility that is frequented by residents, including the resident's rooms and bathrooms.-Housekeeping and maintenance services will be provided as necessary to maintain a sanitary and comfortable environment.-The facility would minimize odors by disposing of soiled linens and reporting lingering odors and bathrooms needing cleaned to the housekeeping department. Review of the Housekeeping-Deep Cleaning policy revised dated 12/27/24 showed all areas should be monitored on a daily basis and all resident living areas and non-living areas should be clean and odor free. Review of the facility Resident Rights-Missouri Policy dated 9/21/25 showed:-Residents had a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside facility.-Resident has the right to reside and receive services with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. 1.Review of Resident #4's admission Record showed he/she was admitted on [DATE] with diagnoses that include:-Schizoaffective Disorder, Bipolar type (is a mental illness that can affect your thoughts, mood and behavior).-Major Depressive Disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy). -Agoraphobia with Panic Disorder (recurrent, unexpected panic attacks and intense fear of situations where escape might be difficult or help unavailable, leading to avoidance of places like crowds, public transport, or being alone).-Post-traumatic stress disorder (PTSD-is a mental health condition that's caused by an extremely stressful or terrifying event, either being part of it or witnessing it).-Obsessive-compulsive personality Disorder (is a condition marked by an extensive preoccupation with perfectionism, organization and control). Observation on 2/9/26 at 9:15 A.M., of the resident's room showed:-The heating unit not attached and hanging from the wall.-The resident's bathroom sink was filled with standing brown water and had a bad odor.-The resident's bedroom floor was dirty and had brown grime built up on the floor and baseboards.-The resident's bathroom floor was dirty and had brown grime build up. During an interview on 2/9/26 at 9:20 A.M., Resident #4 said:-The heater has been unattached to his/her wall for over a month.-He/She reported the heater not being attached to the wall to the Director of Maintenance (DOM) and the Administrator.-He/She has not been able to use his/her sink for 2 weeks due to being plugged up.-He/she reported to the sink being plugged up and having an odor to the DOM and the Administrator. -His/Her room was always dirty and had grime on the floors.-Housekeepers never cleaned his/her room.-Both bathhouses on the unit were dirty and always had stopped up toilets.-The bathtub in bathhouse #1 was constantly running and was missing (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a sink.-He/She believed the unsanitary environment was making him/her sick. During an interview on 2/9/26 at 9:30 A.M., DOM said:-He/She was aware that the resident's heater was pulled from the wall.-The resident pulled the heater from the wall.-He/She was not aware that the resident's sink was plugged up. During an interview on 2/9/26 at 10:00 A.M., Administrator said:-The resident kept pulling his/her heater unit from the wall.-The resident kept putting items in his/her sink that causes the sink to get plugged up.-He/She was not aware that the heater unit was off the wall at that time.-He/She was not aware that the resident's sink was plugged up at that time.-Housekeeping cleaned the resident's rooms daily. 2. Observation of 200 hall bathhouse #1 on 2/9/26 at 2:00 P.M. showed:-No out of order sign was on the bathhouse door.-The bathhouse door was unlocked and able to be accessed.-The sink was missing, and poles were sticking out of the wall.-Tile was ripped from the wall behind the bathtub.-Bathtub plumbing was exposed behind the ripped out tile.-There was black substance on the back side of some of the broken tile.-The bathtub faucet was running. 3. Observation of 200 hall bathhouse #2 on 2/9/26 at 2:30 P.M., showed:-No out of order sign was on the bathhouse door.-The bathhouse door was unlocked and able to be accessed.-The toilet was filled with brown water and had a bad odor. During an interview on 2/9/26 at 11:30A.M., Certified Medication Technician (CMT) B said:-He/She is not aware of any bathtubs that were not properly working in the facility. -He/She was unaware of constant running bathtub water or toilets overflowing in the 200 bath houses. During an interview on 2/9/26 at 12:00 P.M., Certified Nurse Assistant (CNA) F said:-He/She has never witnessed continuous running of water in any bathtub, sink, or toilet.-It was the housekeeper's responsibility to keep the resident's rooms clean but they did not keep them clean like they should. -The housekeepers only deep cleaned the resident's rooms when state was in the building. -The residents did not have a clean-living environment in the facility.-He/She has witnessed resident's sinks overflowing and not draining. During an interview on 2/9/26 at 1:00 P.M., Licensed Practical Nurse (LPN) A said:-He/She was not aware of any sinks missing in the 200 hall bath houses. -He/She has not witnessed a continuous flow of water in the 200-hall bathtub.-He/She was not aware of any toilets in the 200 hall bath houses overflowing.-Housekeeping could be better about keeping the resident's rooms and bathroom cleaned. During an interview on 2/9/26 at 1:30 P.M. Administrator Assistant said:-He/She was not aware of any bath houses that do not have sinks or have continuous running baths or toilets. -Some of the residents will turn water on in the shower houses and leave the water running but other than that.-Housekeeping staff was responsible for keeping the resident's rooms cleaned.-Staff should be better about keeping the resident's rooms clean.-Maintenance was responsible for maintaining the heater units in the resident's rooms.-He/She was not aware of any resident's sinks being plugged up. During an interview on 2/13/26 at 2:40 P.M., Administrator said:-There was one shower on the women's unit that didn't work, and they were waiting on a part coming in the mail to fix it.- All the residents on the women's unit had an alternative shower to use.-He/She was not aware of any bathroom not having a sink.-He/She was not aware of any continuous running water in any of the bathtubs in the bath houses. -He/She was not aware of any toilets that have problems with overflowing. During an interview on 2/13/25 at 2:55 P.M., Housekeeping A said:-All resident's rooms were cleaned daily.-When resident rooms are cleaned, housekeepers also clean the resident's bathrooms.-When they cleaned the resident's rooms, that included sweeping and mopping the floors.-The floor techs were the ones responsible for stripping and waxing the floors. -When they did a deep cleaning, that was when the windows and base boards were cleaned. 4. Observation on 2/26/26 at 9:00 A.M. during a Life Safety Code (LSC) walk-through inspection with the DOM showed:-The top control panel of an HVAC (heating, ventilation, and air conditioning) unit in the Main Dining Room showed a rectangular panel opening at the north end of the unit was approximately (app.) 7 inches ( ) by 10 inches and had no cover on it exposing the metal edges around the opening's sides that were bent up causing sharp edge. Complaint Number: 2736619