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	03/12/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one sampled resident (Resident #1) out of 14 sampled residents was free from abuse. On 03/06/26, the Director of Nursing (DON) placed his/her hand around the resident's neck area, and held the resident against a wall, resulting in a scratch on the resident's neck area. The resident expressed fear, flashbacks, nightmares of the DON coming back to strangle him/her, stating he/she did not feel safe living at the facility. The observed incident occurred at 7:40 P.M., and the DON continued to work his/her shift until 9:45 P.M. The employee was not removed from the facility or removed from contact with residents per facility policy. The facility census was 131 residents. The Administrator was notified on 03/10/26 at 3:24 P.M. of an Immediate Jeopardy (IJ) which began on 03/06/26. The IJ was removed on 03/12/26 as confirmed by surveyor onsite verification.Review of the facility Abuse and Neglect Policy, dated 11/28/16 and revised on 06/12/24, showed:-Purpose:-Physical Abuse is purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal of inhumane manner. Handling a resident with any more force than is reasonable for a resident's proper control, treatment or management. Can include, but not limited to hitting, slapping, punching, biting, kicking, and corporal punishment.-Mental Abuse includes the use of verbal or nonverbal conduct with causes or has potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or depression.-Involuntary Seclusion refers to the separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will.--Employees of this facility who have been accused of mistreatment will be immediately removed from contact with any residents and must leave the facility pending the results of the investigation and review by the Administrator.--If the alleged abuse is by the Administrator or the DON, at the direction of the RCMC Executive [NAME] President/Chief Operating Officer or the RCMC [NAME] President for Operations, the Administrator or DON may remain at the facility, but are only permitted to be in non-resident areas or his/her office and should have no resident contact pending the outcome of the investigation.1. Review of Resident #1's Preadmission Screening and Resident Review (PASRR, A preadmission screening used to help ensure individuals with serious mental disorder and/or developmental disabilities are not inappropriately placed in nursing homes for long term care and receive the services they need in their residential setting), dated 07/23/25, showed the following diagnoses:-- Schizoaffective Disorder.--Bipolar I Disorder. --Disruptive Mood Dysregulation Disorder- (DMDD)- (a childhood mental health condition characterized by severe, chronic irritability and frequent, intense temper outbursts that are disproportional to the situation).--Oppositional Defiant Disorder- (ODD)- (a behavioral disorder characterized by a persistent pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months).--Borderline Personality Disorder (BPD)- (a mental health condition characterized by intense emotional instability, impulsivity, and chaotic relationships, often stemming from childhood trauma or genetic factors).--Unspecified Neurocognitive Disorder R/T self-harm related brain injury- (a diagnosis used when a clinician observes significant cognitive decline-such as memory loss, (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	mirror and was holding a piece of it.-The resident threatened to stab staff if they came closer and then proceeded to stab and cut his/her arm with the mirror.-After some time, the resident threw the mirror piece down and the DON removed the mirror from the area. -At that point he/she stepped away because the situation appeared to be controlled with the other three staff members present.-The resident then became aggressive toward the DON.-The DON attempted to restrain the resident against the wall.-The AA and LPN A then placed the resident in a hold.-After observing that the situation was being managed by staff and medical, he/she left the area and returned to his/her assigned work duties.Review of CNA C's written statement, dated 03/07/26, showed:-He/she responded to the unit for a Code Green.-The resident was outside on the smoking deck with cuts on his/her arm.-He/She and three other staff followed the resident to his/her room.-The resident broke his/her plastic mirror and was holding a piece of it.-The resident threatened to stab a staff with it if they came closer.-The resident then stabbed his/her arm and cut it, then threw it down, and the DON got rid of it.-He/she stepped away because the situation seemed under control.-The resident became aggressive towards the DON.-The DON attempted to restrain the resident next to the wall.-The AA and LPN A helped the DON put the resident in a hold then CNA C went back on his/her unit.Review of RN A's written statement, dated 03/06/26, showed:-Responded to a Code [NAME] on the unit at approximately 7:30 P.M.-Upon entering the unit, the resident could be heard yelling loudly and threatening.-Entered the smoking patio where the resident was sitting with his/her head in his/her hands and being very defiant, threatening staff to stay away.-The resident then ran to his/her room and was followed by LPN A, the DON, and him/herself.-The resident ran to the corner of the room and grabbed a sharp, pointed object that appeared to be fashioned from the broken mirror.-The resident raised it above his/her head yelling I dare you, don't come closer.-The DON and LPN A made many attempts at verbal de-escalation and CPI techniques were initiated; however, the resident was not responsive and did not comply with staff direction.-The resident turned the object toward him/herself and attempted to slice the dorsal (top) surface of his/her left forearm with the instrument.-The DON attempted to physically subdue the resident after CPI interventions were not able to be employed due to the resident thrashing with the sharp instrument.-CPI interventions were again attempted, but were unsuccessful due to continued noncompliance.-The resident was then physically subdued by the DON to prevent harm to him/herself of others.-The situation was brought under control after LPN A assisted the DON with CPI techniques. Review of the AA undated text message from RN A received at 11:52 P.M., showed:-He/she responded to a Code [NAME] on a unit.-When entering the unit, the resident could be heard yelling loudly and threatening staff, stating for staff not to come any closer.-Upon entry to the room, the DON was present and attempting verbal de-escalation.-The resident was observed standing in the corner of the room holding what appeared to be a self-made pointed sharp object approximately one foot in length, raised above his/her head in a threating manner.-The resident was yelling statements including, I dare you, don't come closer.-The DON and LPN A made many attempts at verbal de-escalation and CPI techniques were initiated; however, the resident was not receptive and did not comply with staff direction.-The resident then turned the object toward him/herself and attempted to slice the dorsal (top) surface of his/her forearms with the instrument.-The DON attempted to physically subdue the resident after CPI interventions were not able to be employed due to the resident thrashing with the sharp instrument.-The resident subsequently ran to the hall still holding the object and continued yelling threats toward staff.-CPI interventions were again attempted, but were unsuccessful due to continued noncompliance.-The resident was then physically subdued by the DON in order to prevent harm to him/herself and others. Review of RN A's undated and untimed interview with Administrator B showed: -At 7:30 P.M. on 03/06/26 a Code [NAME] was called. -LPN A and he/she made their way to the unit. -Upon arrival the resident was on the smoke deck yelling get away from him/her. -LPN A and he/she observed the resident leave for his/her room and observed the DON enter the resident's room. -The resident picked up a piece of plastic that was shaped into a pointed object. -The resident was standing in corner. -The (continued on next page)

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	265822	A. Building B. Wing	03/12/2026

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident had the object overhead saying, don't come near me. -The DON was on other side of bed and 5 feet away from the resident. -The DON picked up two pieces of plastic tiles and stated, come on I have mine too. -LPN

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an employee to resident altercation with injuries and possible abuse immediately, but no later than two hours, after the altercation happened to the state survey agency. This deficient practice affected one sampled resident (Resident #1) out of 14 sampled residents. The facility census was 131 residents. Review of the facility Abuse and Neglect Policy, dated 11/28/16 and revised on 06/12/24, showed:-It is the policy of the facility to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within the prescribed time frame.-The facility will report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required and take all necessary corrective actions depending on the results of the investigation.-Definition of 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. This also includes the deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental, and psychosocial wellbeing. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse facilitated or enabled using technology. -Any owner, operator, employee, manager, agent, or contractor of the facility can report an allegation of abuse/neglect/exploitation to the agency hotline without fear of retaliation.-When suspicion of abuse/neglect/exploitation or reports of abuse/neglect/exploitation occur, the following procedure will be initiated:1. The Licensed Nurse will:a. Respond to the needs of the resident and protect him/her from further incident.b. The facility shall immediately call 911 when there is a medical emergency. See also Code Status/Emergency. Procedure/ Medical Emergencies Policy. All other notifications, such as under the Elder Justice Act, should be made using a non?emergency number. See Elder Justice Act -Reporting Reasonable Suspicion of a Crime.d. Notify the Administrator or designee.e. Notify the attending physician, resident's family/legal representative, and Medical Director.g. Document actions taken in the medical record.2. The Administrator or designee will:c. Refer to the State Operations Manual (SOM) for reporting and utilize the Abuse NeglectReporting Decision Tree to assess the particular incident. Best practice is toinclude the SOM and Decision Tree with the investigation. Should the incident be areportable event, notify the appropriate agencies immediately: as soon as possible,but no later than 24 hours after discovery of the incident. In the case of seriousbodily injury, no later than 2 hours after discovery or forming the suspicion. Shouldthe event not be reportable, continue and complete the investigation with allsupporting information and place file with all investigations.d. The Administrative Investigation will consist of any pertinent information describingthe situation being investigated, the names of all staff and residents involved, theroot cause of the incident, the recommendations from the investigation including thefacts that prove or disprove the alleged situation occurred, the plan of correction oraction by the Administrative staff, all statements attached from residents and staffinvolved and any training or education that the Administration feels needs to beprovided to staff or residents to ensure education has been provided to preventfuture similar situations.g. Follow up with appropriate agencies, during business hours, to confirm the reportwas received.1. Review of Resident #1's undated admission Record showed the resident had the following diagnoses:-Schizoaffective Disorder, Bipolar type (a chronic mental health condition combining schizophrenia symptoms (hallucinations, delusions) with severe mood episodes (mania and sometimes depression));-Post Traumatic Stress Disorder (PTSD - a mental health condition triggered (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by experiencing or witnessing terrifying events involving actual or threatened death, serious injury, or sexual violence).-Anxiety; and-Autistic Disorder (a lifelong neurodevelopmental condition affecting communication, social interaction, and behavior, typically appearing in early childhood).Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff and used for care planning), dated 02/27/26, showed the resident assessed as cognitively intact.Observation of facility camera footage, dated 03/06/26 at 7:40 P.M., showed:-Registered Nurse (RN) A stood with his/her hand behind his/her back to the side of Resident #1's doorway. The DON stood with his/her back to the hallway in the resident's doorway. -Certified Nurse Aide (CNA) D stood on the opposite side of the doorway from RN A. -CNA D left the doorway and walked down the hall toward the nursing station. -The resident had his/her left arm up in front of his/her forehead and the right arm stretched out moving backwards from his/her doorway. -The DON extended both arms toward the resident with Licensed Practical Nurse (LPN) A behind the DON and RN A remaining next to the resident's doorway.-The DON walked toward the resident and the resident moved backwards to the wall opposite of his/her doorway. -The resident's left hand made contact with the DON's right elbow. The DON's right arm was outstretched, placing his/her hand or forearm against the resident's clavicle (collarbone) neck area. -LPN A stood on the resident's right side. The DON faced the resident, who was up against the wall. RN A stood on the opposite wall facing toward the DON, LPN A, and the resident. -The DON raised and extended both arms toward the resident's neck, clavicle, shoulder area. The resident raised both arms with elbows bent in front of him/her in an attempt block the DON. The DON lifted his/her left foot off the ground and positioned between the resident's legs to block the resident against the wall.-LPN A stood next to the DON and the resident. LPN A attempted a Crisis Prevention Intervention (CPI - behavioral health techniques for de-escalation) hold on the resident. RN A moved toward the DON and the resident to separate the DON from the resident.-The DON and the resident pushed back and forth against each other with outstretched arms. -LPN A leaned between the DON and the resident to attempt a CPI hold. RN A moved behind the DON and spoke to him/her.-The Assistant Administrator (AA) came from the nursing station and stepped between the DON and the resident. -The DON moved to the resident's left side and pushed the resident's back against the wall, holding the resident against the wall. The AA stood in front of the resident, LPN A stood on the right side of the resident, and RN A stood at the cart. -The camera showed the resident with LPN A in front, the AA on the right, and the DON on the left side of the resident. LPN A and the AA attempted to separate the DON from the resident. -The DON stepped toward the middle of the hall. LPN A showed on the left side and the AA on the right side of the resident. RN A remained at the cart. The DON raised a hand, stepped forward, pointed toward the resident, and spoke. -The DON walked toward the exit doors and left the unit. -RN A took the cart back towards the nursing station. -AA and LPN A stayed with the resident and began walking toward the nursing station. Review of the resident's Incident note, dated 03/06/26 at 7:30 P.M., showed:-Code [NAME] (behavioral health incident) called on the unit.-The resident had a self-inflicted injury to him/her left forearm.-DON present and staff responded to code and followed the resident from the smoke patio to his/her room.-Once in his/her room, the resident increased in self-injurious behavior.-CPI verbal techniques utilized unsuccessfully.-The AA tapped the DON out, because the resident was yelling and targeting the DON with his/her threating behavior.Review of the facility Initial Reporting Form, dated 03/08/26, showed:-Allegation Type reported was physical abuse.-LPN A notified the facility that on 03/06/26 staff had to utilize CPI techniques to ensure the resident safety from him/herself. -CPI techniques failed.-No physical harm. The resident did not disclose to staff any fear or harm after the incident occurred. The resident was without any visible injuries noted. -Witnesses were LPN A and RN A.-Law enforcement was notified of the incident. During an interview on 03/09/26 at 12:12 P.M., the AA said:-He/she and the DON were discussing what needed to be done about the incident on 03/06/26 and the incident needed to be reported to the administrator. -He/she called the administrator on 03/06/26 at 10:54 P.M. and left a message about (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident self-harming. (The event occurred around 7:40 PM)-The administrator called back at 11:12 P.M. and again at 11:59 P.M. to get more details about the resident self-harming. -The administrator's responsible for the reporting to the proper agencies.-He/she didn't report employee to resident abuse, because he/she only saw the DON use ineffective CPI techniques. -He/she felt the DON was too tall to use proper CPI techniques with the resident. During an interview on 03/09/26 at 2:06 P.M., LPN A said:-On 03/06/26, the AA said he/she would handle the reporting of the incident to the Administrator. -He/she sent a written statement to AA's cell phone regarding the self-harm, but was afraid to report the DON's abuse, because the AA and the DON were his/her superiors and he/she afraid of retaliation. -He/she went to the facility on [DATE] to talk with the Administrator and then gave a written statement of all events that happened on 03/06/26.-He/she told the Administrator to watch the video of the incident.-The administrator's responsible to report the abuse to state. During an interview on 03/10/26 at 9:39 A.M., RN A said:-He/She did not report the incident on 03/06/26 because the AA said he/she would take care of calling the Administrator to report the incident.-He/She thought the incident was not appropriate. During interviews on 03/09/26 through 03/12/26, the Administrator said:-The AA never reported the DON not following CPI training and putting his/her hands on the resident's neck during a Code Green. -It was reported the resident tried to self-harm on the night of 03/06/26. -The incident happened around 7:30 P.M.-The AA left a message on his/her cell phone and he/she called the AA back about the incident and the AA said nothing about the DON.-He/she found out what really happened on the night of 03/06/26 from LPN A when he/she came to the facility on [DATE] to write his/her statement of the events that took place during the incident.-He/she gave the Initial Reporting Form to Receptionist A to fax to the state and federal agencies on 03/08/26. -Receptionist A told him/her on 03/09/26 the fax failed. -The incident should have been reported per facility policy. During an interview on 03/09/26 at 12:38 P.M., the Receptionist said:-He/she was given the Incident Report to fax on the morning of 03/09/26 by the Administrator.-He/she faxed the report and got busy with other duties.-He/she did not check and see if the faxed report went through until the Administrator asked for the transmission report on 03/09/26 to show when the report was faxed.-He/she went to get the report, and the transmission said failed. -He/she didn't refax the report because the Administrator asked for the report back.2798107

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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 interview and record review the facility failed to provide appropriate, necessary behavioral health services for one sampled resident (Resident #1) out of 14 sampled residents. On 03/26/26, facility staff failed to implement the resident's care plan for behavioral interventions and implement Crisis Prevention Intervention (CPI- behavioral techniques for de-escalation) techniques with the resident, when the resident became agitated on the smoke deck. The facility census was 130. Review of the facility's Behavioral Health Services Policy, revised 10/31/24, showed:-The purpose of the policy was to ensure all residents received necessary behavioral health services to assist them in reaching and maintain their highest level of mental and psychosocial functioning.-The facility staff were to ensure the residents were receiving necessary behavioral health care which were person-centered and reflect the resident's goals for care while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.-Behavioral health care and services were to be provided in an environment that was conducive to mental and psychosocial well-being. -The facility staff were to monitor the resident closely for expressions or indications of distress.-If the resident showed signs of distress, the staff were to evaluate if those changes in behavior were unavoidable.-The facility staff were to develop person-centered care for any concerns identified with the resident.-The staff were to maximize the resident's dignity, autonomy, privacy, socialization, independence, and safety.-The facility staff were to have interventions that were person-centered, evidence-based, culturally competent, trauma-informed, and in accordance with professional standards of practice.Review of the facility CPI Training, dated 2023, showed the goal of CPI training is to equip employees with the necessary skills to prevent and safely manage crisis situations, ensuring a safe and supportive environment for everyone. Review of the facility's undated handbook for CPI showed: -Safety interventions range from verbal and environmental non-restrictive interventions to non-restrictive disengagements and restrictive interventions. The goal is to choose the safety intervention that is a last resort, reasonable, and proportionate. -Disengagements and restrictive interventions are not risk-free and are highly traumatic for everyone involved. It can affect a person physically and mentally. These effects can be long lasting or even life-threatening. -Many individuals in your care might have already been through traumatic experiences. A disengagement or restrictive intervention can trigger previous traumatic experiences. -Holding. A restrictive safety intervention necessary to restrict a person's range of movement to prevent the infliction of harm to self or others. -Standing Hold: Medium Level Restriction - Staff begin in the low-level restriction. Apply the Outside Principle by placing the palm of your furthest hand at the resident elbow. Apply the Inside Principle, bringing your nearest arm underneath and resting your arm over the person's forearm. Cup your hand to avoid gripping and squeezing. Stand close, adjusting your furthest leg so you remain balanced and stable. Use your body to maintain contact at the shoulder, hip, and thigh. Encourage the person to keep their arms in front of their body.Review of the employee training records showed:-Licensed Practical Nurse (LPN) A and Registered Nurse (RN) A trained in CPI on 01/22/26. -Director of Nursing (DON) trained in CPI on 01/29/26. -Assistant Administrator (AA) was trained in CPI on 02/02/26. 1.Review of Resident #1's Preadmission Screening and Resident Review (PASRR-A preadmission screening used to help ensure individuals with serious mental disorder and/or developmental disabilities are not inappropriately placed in nursing homes for long term care and receive the services they need in their residential setting.), dated 07/23/25, showed the following diagnoses:--Schizoaffective disorder bi-polar type: (a chronic mental health condition combining schizophrenia symptoms (hallucinations, delusions, disorganized speech) with manic episodes and sometimes major depression).--Bipolar I disorder: (a chronic, severe mental health condition characterized by at least one, often hospitalized , manic episode lasting at least 7 days or requiring (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	immediate care, usually alternating with intense depressive episodes). --Disruptive Mood Dysregulation Disorder (DMDD): (a childhood mental health condition characterized by severe, chronic irritability and frequent, intense temper outbursts that are disproportional to the situation).--Oppositional Defiant Disorder (ODD): (a behavioral disorder characterized by a persistent pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months).--Borderline Personality Disorder (BPD): (a mental health condition characterized by intense emotional instability, impulsivity, and chaotic relationships, often stemming from childhood trauma or genetic factors).--Unspecified Neurocognitive Disorder R/T self-harm related brain injury: (a diagnosis used when a clinician observes significant cognitive decline-such as memory loss, language, or executive dysfunction-but cannot determine the specific, underlying cause).--Autism Spectrum Disorder (ASD): (is a lifelong developmental condition typically appearing in early childhood, characterized by challenges with social interaction, communication, and restricted or repetitive behaviors).--Traumatic Brain Injury (TBI): (is a disruption in normal brain function caused by an external force, such as a blow, jolt, or piercing object to the head). -The resident's symptoms included high risk behaviors, isolation, poor self-care, and mood liability including other symptoms.-He/she had endorsed audible hallucinations (sensory perceptions of hearing sounds such as voices, music, or noises, without any corresponding external stimulus) that tell him/her to wake up when he/she was sleeping.-He/she denied wanting to harm others.-He/she had a history of a violent temper and frequently banged his/her head and needed a safe secure setting. -The resident had a history of multiple psychiatric admissions and had attempted suicide multiple times along with banging his/her head enough to require staples and causing a closed head injury/traumatic brain injury.Review of Resident #1's admission Records showed the resident admitted to the facility on [DATE] and re-admitted on [DATE] with the following diagnoses:-Schizoaffective Disorder, Bipolar type with severe mood episodes (mania and sometimes depression)).-Post Traumatic Stress Disorder (PTSD - a mental health condition triggered by experiencing or witnessing terrifying events involving actual or threatened death, serious injury, or sexual violence).-Anxiety.-Autistic Disorder.Review of the resident's Care Plan, dated 10/08/25, showed: -The resident will have decreased signs and symptoms of the diagnoses of Autism, Traumatic brain Injury (TBI), Suicidal Ideations (SI), and PTSD.-Ensure the environment is safe.-Offer behavior modification programs and diversional activities.-Seek professional help from counselor or psychologist.-Weekly meeting with the Administrator as desired.-He/she will be able to identify triggers, learn and utilize positive coping strategies, demonstrate control of emotions and relaxation techniques, and be free from injury.-Coping skills include music, writing books on computer, talking with others, reading, and diamond art.-Preferred interventions include headphones and music and others respecting boundaries.-Avoid confrontation and be mindful of his/her personal space.-Do not argue or get defensive with him/her.-Closely monitor the resident for signs of agitation and work with him/her to reduce impulse feelings of anger.-Encourage the resident to express his/her emotions in a safe environment, allowing him/her the freedom to acknowledge his/her feelings and release any repressed emotions that could be causing him/her distress.-Decrease stimulation around the resident during signs of anxiety.-Do not to get into a power struggle with the resident. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by staff and used for care planning), dated 02/27/26, showed the resident assessed as follows: -cognitively intact.-inattention and disorganized thinking fluctuate.-moderate issues with his/her mood.-little interest or pleasure doing things 2 - 6 days per 2 weeks.-feeling down, depressed, or hopeless 7 - 11 days per 2 weeks.-Feeling bad about self- 7 - 11 days per 2 weeks.-trouble concentrating 2 - 6 days per 2 weeks.-Thoughts that you would be better off dead or hurting self in some way never or 1 day per 2 weeks.Observation of facility camera footage, dated 03/06/26 at 7:40 P.M., showed:-Registered Nurse (RN) A stood with his/her hand behind his/her back to the side of Resident #1's doorway. The DON stood with his/her back to the hallway in the resident's doorway. -Certified Nurse Aide (CNA) D stood on the opposite side of the (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	doorway from RN A. -CNA D left the doorway and walked down the hall toward the nursing station. -The resident had his/her left arm up in front of his/her forehead and the right arm stretched out moving backwards from his/her doorway. -The DON extended both arms toward the resident with Licensed Practical Nurse (LPN) A behind the DON and RN A remaining next to the resident's doorway.-The DON walked toward the resident and the resident moved backwards to the wall opposite of his/her doorway. -The resident's left hand made contact with the DON's right elbow. The DON's right arm was outstretched, placing his/her hand or forearm against the resident's clavicle (collarbone) neck area. -LPN A stood on the resident's right side. The DON faced the resident, who was up against the wall. RN A stood on the opposite wall facing toward the DON, LPN A, and the resident. -The DON raised and extended both arms toward the resident's neck, clavicle, shoulder area. The resident raised both arms with elbows bent in front of him/her in an attempt block the DON. The DON lifted his/her left foot off the ground and positioned between the resident's legs to block the resident against the wall.-LPN A stood next to the DON and the resident. LPN A attempted a Crisis Prevention Intervention (CPI - behavioral health techniques for de-escalation) hold on the resident. RN A moved toward the DON and the resident to separate the DON from the resident.-The DON and the resident pushed back and forth against each other with outstretched arms. -LPN A leaned between the DON and the resident to attempt a CPI hold. RN A moved behind the DON and spoke to him/her.-The Assistant Administrator (AA) came from the nursing station and stepped between the DON and the resident. -The DON moved to the resident's left side and pushed the resident's back against the wall, holding the resident against the wall. The AA stood in front of the resident, LPN A stood on the right side of the resident, and RN A stood at the cart. -The camera showed the resident with LPN A in front, the AA on the right, and the DON on the left side of the resident. LPN A and the AA attempted to separate the DON from the resident. -The DON stepped toward the middle of the hall. LPN A showed on the left side and the AA on the right side of the resident. RN A remained at the cart. The DON raised a hand, stepped forward, pointed toward the resident, and spoke. -The DON walked toward the exit doors and left the unit. -RN A took the cart back towards the nursing station. -AA and LPN A stayed with the resident and began walking toward the nursing station. Review of the resident's Incident note, dated 03/06/26 at 7:30 P.M., showed:-A Code [NAME] (behavioral health incident) called on the unit.-The resident had self-inflicted injury to his/her left forearm.-The DON and LPN A responded to the Code [NAME] and followed the resident from the smoke patio to his/her room.- The resident had an increase in self-injurious behavior, once in his/her room. -CPI verbal techniques were utilized unsuccessfully with the resident.-The resident became physically aggressive with staff.-A CPI approved hold attempted with the resident while in hallway.-The AA tapped (signal that the person is no longer needed in the process) the DON out, due to resident yelling and targeting the DON with threating behavior.-Resident placed in an approved CPI hold and escorted to the smoke patio.Review of the facility Initial Reporting Form, dated 03/08/26, showed:-Allegation type reported was physical abuse.-LPN A notified the facility that on 03/06/26 staff had to utilize CPI techniques to ensure the resident safety from him/herself. -CPI techniques failed.-No physical harm. The resident did not disclose to staff any fear or harm after the incident occurred. The resident was without any visible injuries noted. -Witnesses were LPN A and RN A.-Law enforcement was notified of the incident. Review of the police report, dated 03/08/26 at 6:30 P.M., showed:-Local law enforcement dispatched to the facility on [DATE] at 6:30 P.M. for a report of non-aggravated assault which occurred on 03/06/26 at 7:30 P.M. -Victim: Resident #1 -Suspect: DON, who was charged and arrested. -Witness: RN A. -Resident reported being choked by the DON. -RN A reported on 03/06/26 at 7:30 P.M., he/she responded with another staff to the resident's room. When he/she arrived, the DON was in the resident's room with the resident. The resident held a broken piece of plastic and threatened to harm him/herself. The DON picked up another piece of jagged material and made antagonistic statements to the resident. The resident walked out of the room with his/her hands at his/her side. The DON followed the resident into the hallway. RN A observed the DON push the (continued on next page)

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	265822	A. Building B. Wing	03/12/2026

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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