STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265822	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2026
NAME OF PROVIDER OR SUPPLIER Bridgewood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 protect seven sampled residents (Resident #1, #2, #5, #6, #8, #12, and #16) out of 18 sampled residents from physical abuse between residents. On 3/23/26 at 7:30 P.M. Resident #2 approached Resident #1 and a verbal argument between the residents escalated into a physical argument with both Resident #1 and Resident #2 punching one another in the face and torso areas. Resident #1 then pulled a broken pair of scissors from his/her pants pocket and stabbed Resident #2 in the left forearm. Resident #2 was sent to the hospital and diagnosed with a concussion and received two sutures to the left forearm. On 3/25/26 at about 8:00 P.M., Resident #3 struck Resident #6 in the right eye which caused Resident #6 to fall and hit his/her head on the wall. Resident #3 then hit and pushed Resident #6's head against the floor and Resident #6 sustained a visible hematoma (a collection of clotted or partially clotted blood that pools outside of blood vessels, often causing swelling, pain, and skin discoloration) with redness and right eye irritation. On 3/26/26 at 2:50 P.M., Resident #8 was struck by Resident #7. On 3/30/26 at 5:45 P.M., Resident #18 grabbed Resident #5 and took Resident #5 to the ground which caused a hematoma to the resident's head. On 3/31/26 at approximately 4:30 P.M., Resident #13 was observed striking Resident #12 on the right side of the face following a verbal altercation. There was no observable injury. On 4/4/26 at 5:00 P.M., Resident #14 struck and scratched Resident #16 on the left side of Resident #16's face and head. Resident #16 had a busted/ swollen lip and complained of mouth pain. The facility census was 129 residents. The Administrator was notified on 4/7/26 at 12:55 P.M. of the Immediate Jeopardy (IJ) which began on 3/23/26. The IJ was removed on 4/7/26, as confirmed by surveyor onsite verification.Review of the facility's 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. It 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.1.Review of Resident #1's Preadmission Screening and Resident Review (PASRR, DA-124C, a required form to be submitted for any client who requests admission to a Medicaid certified bed regardless of the client's payment source; this includes dually certified beds both Medicare and Medicaid), dated 2/18/16, showed: -Diagnosis of Schizophrenia (a chronic, severe mental disorder characterized by disruptions in thought processes, perceptions, and behaviors, often causing a disconnection from reality).-He/She endorsed audible hallucinations (sensory perceptions of hearing sounds such as voices, music, or noises, without any corresponding external stimulus) and was frequently seen talking to himself/herself.-Had a history of difficulty getting along with others and had frequent altercations, evictions and fear of strangers.-Had failed at less restrictive environments due to aggressive behaviors. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by staff and used for care planning), dated (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265822	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2026

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2/27/26, showed:-Was cognitively intact.-Had no behaviors or did not refuse cares.-Had moderate issues with his/her mood. Review of Resident #2's PASRR, dated 2/3/24, showed:-Diagnoses of: 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 immediate care, usually alternating with intense depressive episodes), major depressive disorder (MDD-a serious, common mental health condition characterized by persistent sadness, hopelessness, and loss of interest in activities (anhedonia) lasting at least two weeks), psychosis (a set of symptoms indicating a loss of contact with reality, characterized by hallucinations (seeing/hearing things not there) and delusions (false, fixed beliefs), schizophrenia, and epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures caused by sudden, abnormal electrical activity in the brain).-He/She showed signs of psychosis in the past where an internal force made him/her do things, yell things and lose control of his/her body.-He/She became combative towards his/her caregivers requiring a medication to calm him/her down.-The resident's early onset epilepsy could have caused several cognitive impairments including memory loss, slow processing, and poor safety awareness. Review of the resident's quarterly MDS, dated [DATE], showed:-Was cognitively intact.-Had moderate issues with mood.-Had no negative behaviors. Review of the Facility Registered Nurse Investigation (RNI), dated 3/23/26 at 8:00 P.M., showed:-The nature of the incident was physical aggression not involving the head.-Resident #1 had been taken to the lobby to use the phone.-While in the lobby, he/she was mistakenly given a package with a pair of jeans that belonged to Resident #2.-When Resident #1 realized the jeans weren't his/hers, he/she decided to sell them to another resident.-Resident #2 learned his/her jeans were missing and confronted Resident #1.-Staff observed the verbal escalation during shift change, however, the residents weren't separated before the incident became physical.-During the altercation, Resident #1 struck Resident #2 in the arm with broken scissors.-The incident was substantiated by the facility investigation as the resident's property was mishandled and staff identified the argument, but did not intervene soon enough to separate the residents and prevent the injury requiring a hospital visit and staples. Review of the Police Report, dated 4/2/26, showed:-On 3/23/26 at 9:50 P.M., police officers were dispatched to the facility regarding a cutting.-Upon arrival, officers made contact with Certified Nursing Assistant (CNA) A who stated at 7:25 P.M., he/she observed Resident #1 and Resident #2 engaged in a physical altercation., Both residents threw punches at one another.-That was when Resident #1 produced a pair of broken scissors and began to stab Resident #2.-The residents were broken up by several staff members and CNA A pried the broken scissors out of Resident #1's hand.-Resident #2 stated that on 3/22/26 Resident #1 approached Resident #2 admitting he/she had taken Resident #2's package containing jeans.-Resident #2 assumed Resident #1 had taken them by mistake, but when Resident #2 asked Resident #1 for the jeans, Resident #1 stated he/she had sold them to another resident.-When Resident #2 asked who had the jeans and the receipt from the sale of the jeans so that he/she could clear up the confusion, Resident #1 became agitated, and struck Resident #2 on the face multiple times while holding a pair of broken scissors.-In the altercation, the residents fell to the floor and Resident #1 stabbed Resident #2 in the arm which caused a deep wound.-The facility staff were able to separate the two residents and the officers noticed Resident #2 was bleeding from his/her left forearm.-Resident #2 was transported to the hospital where he/she received two staples to close the wound and a neck brace.-Resident #2's guardian was contacted and wished to press assault charges. Resident #1 was taken to jail. Review of Resident #2's Nursing Progress Notes dated 3/23/26 at 8:18 P.M., showed:-The trigger for the incident with Resident #1 was loss/theft of personal belongings leading to emotional distress and confrontation. Review of Resident #2's hospital record, dated 3/23/26, showed:-He/she had a stab wound to the under portion of his/her left forearm.-The stab wound was repaired by the trauma physician and the resident was cleared for discharge back to the (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility. Review of a written statement from CNA A, dated 3/23/26, showed:-He/She witnessed Resident #1 and Resident #2 fighting and carrying on.-He/She witnessed Resident #1 doing a striking motion at Resident #2 and then both residents fell to the floor.-He/She then saw Resident #1 with a pair of scissors which he/she immediately took from Resident #1's hand.-He/She continued to tell them to stop fighting and when finally able to break up the fight, he/she saw Resident #2 bleeding from the forearm.-Certified Medication Technician (CMT) A called the police and the situation de-escalated. During an interview on 4/6/26 at 10:15 P.M., CNA A said:-At around 7:30 P.M. on 3.23/26, he/she was coming around the corner of the unit and heard a verbal altercation going on.-He/She ran to the residents to find Resident #1 swinging at Resident #2 hitting him/her in the face before producing a broken pair of scissors which he/she also began swinging at Resident #2.-He/She worked to break up the fight, grabbing the broken scissors while CMT A called the police.-Once the residents were broken apart and the residents both falling to the floor, he/she noticed Resident #2 bleeding from the left forearm.-He/She later found out the whole fight was over a pair of jeans that went to the wrong resident. During an interview on 4/8/26 at 3:55 P.M., CMT A said:-When he/she saw the scissors in Resident #1's hand, he/she called a Code [NAME] (a staff emergent response to resident behavior).-Resident #1 ended up stabbing Resident #2 in the arm before the staff were able to get them de-escalated. Review of a written statement completed by Licensed Practical Nurse (LPN) A, dated 3/23/26, showed:-He/She witnessed Resident #1 stab Resident #2 in the left forearm over a pair of jeans.-Both residents were fighting and staff intervened.-Resident #2 was sent to the hospital and Resident #1 went to jail. During an interview on 4/9/26 at 8:00 P.M., LPN A said:-He/She was standing near the medication cart counting narcotics with the day shift nurse.-He/She heard CMT A say, stop, stop, stop, leave him/her alone!-CMT A called for Code [NAME] when the residents didn't stop.-The next thing he/she knew the residents were fighting and Resident #1 pulled out broken scissors and waved it at Resident #2.-While staff were trying to assist in breaking up the two residents, Resident #1 cut Resident #2 in the left forearm. During an interview on 4/2/26 10:00 A.M., Resident #1 said:-Resident #2 came at him/her accusing him/her of stealing the pants but he/she got the pants from the front desk, and they were sent to him/her.-He/She never cut the resident on purpose but when the staff went to break up the incident, they all fell, and Resident #2 fell on the scissors which was what caused the cut. During an interview on 4/3/26 at 1:30 P.M., Resident #2 said he/she just asked for his/her pants back and Resident #1 stabbed him/her. Observation of Resident #2 on 4/2/26 at 10:30 A.M., showed two staples had just been removed and the wound was approximately 2.5 centimeters (cm) by 2.5 cm by 0.1 cm with a reddened area surrounding the wound. During an interview on 4/10/26 at 3:30 P.M., the Director of Nursing (DON) said the incident was abuse as a resident was injured at the hands of another resident. During an interview on 4/17/26 at 11:30 A.M., facility Administrator B said he/she understood why this was abuse as Resident #1 showed motive for stabbing Resident #2 due to Resident #2 believing his/her pants had been stolen by Resident #2 and Resident #1 caused harm to Resident #2. 2. Review of Resident #3's Facility admission Record showed he/she was admitted on [DATE] with a diagnosis of schizophrenia. Review of the resident's quarterly MDS, dated [DATE], showed:-Was cognitively intact.-Had moderate issues with mood.-Had physical behaviors directed towards others such as hitting, kicking, punching, throwing objects one to three days per week throughout the look-back period. Review of the resident's Nursing Progress Note, dated 3/25/26 at 7:50 P.M., showed:-The resident was engaged in a resident-to-resident altercation where Resident #6 was observed striking Resident #3 three times causing Resident #6 to fall and hit his/her head against the wall.-Resident #3 then proceeded to bang Resident #6's head on the floor before the residents were separated.-Resident #3 was assessed and showed no apparent injuries. Review of Resident #6's Facility admission Record showed he/she was admitted on [DATE] with the following diagnoses: schizoaffective disorder and antisocial personality disorder (a chronic mental health condition characterized by a long-term pattern of manipulating, exploiting, or violating the rights of others. Review of the resident's quarterly MDS, (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	dated [DATE], showed:-Was cognitively intact.-Had disorganized thinking, rambling speech and illogical talk.-Moderate issues with mood.-No negative behaviors throughout the look-back period. Review of resident's Nursing Progress Notes dated 3/25/26 at 7:50 P.M., showed:-Resident #3 and Resident #6 had an altercation where Resident #6 allegedly struck Resident #3 three times.-Resident #3 then punched Resident #6 in the eye causing Resident #6 to fall and hit his/her head on the wall.-Resident #3 then banged Resident #6's head on the floor before they were separated.-Staff observed a hematoma forming above Resident #6's right eye with surrounding redness and a reddened right eye. Review of the facility RNI, dated 3/25/26 at 9:00 P.M., showed:-The type of incident was physical aggression involving the head.-On 3/25/26 at around 8:00 P.M., the staff reported a resident-to-resident altercation involving Resident #3 and Resident #6.-Upon arrival both residents were engaged in physical aggression where Resident #6 was observed to have been struck in the right eye which caused him/her to fall and hit his/her head on the wall.-Resident #3 then made contact with Resident #6's head against the floor.-A visible hematoma with redness and right eye irritation was noted to Resident #6.-Emergency Medical Services (EMS) was activated, however, Resident #6 refused treatment multiple times as well as refusing nursing assessments.-The facility investigation was substantiated as abuse, Resident #6 received a head injury with a visible hematoma.-The cause of the resident-to-resident abuse appeared to have been exposure to an aggressive resident and that resident's refusal of care post head injury. Observation on 4/3/26 at 12:00 P.M., of Resident #6's head showed a raised and darkened area was visible on the right side of his/her forehead just above the right eyebrow. During an interview on 4/23/26 at 12:30 P.M., LPN C said:-He/She was the charge nurse on the evening the altercation occurred.-Neither resident had been problematic during the day shift per report given to him/her by the day shift nurse.-Resident #3 could escalate very quickly and lash out at whomever happened to be around at the time and many times, he/she showed no signs of escalation or any change in behavior prior to lashing out.-He/she heard an argument and ran to where it was coming from.-As soon as he/she got to the residents, Resident #6 was already on the floor with Resident #3 standing over Resident #6.-Resident #6 had a bump forming on his/her forehead, but Resident #6 refused any treatment. During an interview on 4/3/26 at 1:35 P.M, Resident #3 said:-Nothing happened.-He/She didn't know what the issue was.-He/She didn't hit or shove anyone down. During an interview on 4/9/26 at 4:44 P.M., CMT B said he/she noted Resident #6 had a reddened area on his/her forehead that appeared to be a hematoma. During an interview on 4/10/26 at 3:30 P.M., the DON said the resident to resident incident likely was abuse as there was an injury to Resident #6. During an interview on 4/10/26 at 4:00 P.M., Administrator A said:-He/she did not believe the incident constituted abuse as he/she did not think the area on Resident #6's head was caused by the altercation between the residents.-Resident #6 always had a raised discolored spot on his/her forehead even before the incident.-The incident happened very quickly and was stopped by LPN C as soon as she heard the altercation. 3. Review of Resident #7's face sheet showed he/she admitted on [DATE] with the following diagnoses: schizophrenia, traumatic brain injury (TBI), borderline personality disorder, depression. adjustment disorder, post-traumatic stress disorder (PTSD), and bipolar disorder. Review of the resident's Quarterly MDS, dated [DATE], showed he/she was cognitively intact. Review of Resident #8's face sheet showed he/she admitted on [DATE] with the following diagnoses:-Schizophrenia.-TBI. Review of the resident's Quarterly MDS, dated [DATE], showed he/she was cognitively intact. Review of the resident's Behavior Note, dated 03/26/2026 at 2:43 P.M., showed he/she was involved in a resident-to-resident altercation with Resident #7 during a banking/activity interaction. Resident#8 was observed raising his/her voice during a verbal disagreement regarding money. Resident #7 escalated and struck Resident #8. Review of the facility RNI, dated 3/28/26, showed:-On 3/26/26 at 2:50 P.M. an incident of physical aggression.-Resident #7 was engaged in a verbal discussion regarding money related to a prior exchange.-Resident #8 became verbally escalated, raised his/her voice, and was struck by Resident #7. During an interview on 3/27/26 at 8:16 A.M., Administrator A (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	said:-Resident #7 sold Resident #8 some shoes for $5 three months ago and Resident #7 wanted his/her $5. -Resident #8 yelled he/she didn't owe Resident #7 $5.-Resident #7 hit Resident #8 on the back of Resident #8's right ear. There was an abrasion. -Resident #8 did not hit back and Resident #7 walked away. During an interview on 4/8/26 at12:38 P.M., Resident #7 said:-Resident #8 owed him/her money for shoes.-Resident #8 said he/she was not going to pay and screamed at him/her twice. Once in the smoking room and then in the dining room.-If Resident #8 had not screamed at him/her, nothing would have happened.-Resident #8 said, I ain't going to pay you shit.-Resident #8 swung at him/her first.-He/She hit Resident #8 in the mouth.-He/She was protecting him/herself.-He/She was not going to let anyone swing on him/her.-The Assistant Administrator was there.-Staff broke it up. During an interview on 4/8/26 at 12:46 P.M., Resident #8 said:- Resident #7 hit him/her.-He/she did not owe Resident #7 anything and told Resident #7 he/she did not. During an interview on 4/8/26 at 4:32 P.M., the DON said:-The altercation happened during banking/activity.-Resident #8 asked Resident #7 for money after he/she was denied any money from banking/activity and Resident #7 had received money from the banking activity.-The Assistant Administrator often did banking/activity.-He/she defined the altercation as abuse and preventable. 4. Review of Resident #5's Facility admission Record showed the resident was admitted on [DATE] with a diagnosis of paranoid schizophrenia. Review of the resident's quarterly MDS, dated [DATE], showed:-Was not cognitively intact.-Had disorganized thoughts, is frequently incoherent, and showed rambling speech.-Had daily physical and verbal behaviors including screaming, swearing, kicking, hitting, and breaking items throughout the look-back period. Review of Resident #18's PASRR dated 11/7/24 showed:-Diagnoses of schizophrenia and schizoaffective disorder.-A long history of both verbal and physical aggression along with a history of both alcohol and polysubstance abuse. Review of the resident's quarterly MDS, dated [DATE], showed:-Was cognitively intact.-Had moderate issues with mood.-Had no negative behaviors throughout the look-back period. Review of the facility RNI, dated 3/30/26, showed:-The type of incident was physical aggression involving the head.-The staff were not to argue or get defensive with the residents.-At approximately 5:45 P.M., Resident #5 became agitated outside where residents were hanging out.-Resident #5 then continued to escalate and as he/she was being led back inside the facility by staff, Resident #5 dismantled a portion of the air conditioner unit skirt, removing it and swinging it towards staff.-At that point Resident #18 intervened by grabbing Resident #5 and taking him/her to the ground causing an injury to the resident's head from hitting the floor. During an interview on 4/8/26 at 3:55 P.M., LPN B said:-Resident #5 had the front portion of the air conditioner unit skirt in his/her hands and waved it around like he/she was going to hit people with it.-Staff were trying to get him/her to drop the item, but Resident #5 was refusing.-At that point, Resident #18 grabbed Resident #5 and slammed Resident #5 to the floor.-Staff then got the residents separated and took Resident #5 away for treatment as he/she hit his/her head when he/she went to the floor.-Staff called the police and EMS and Resident #5 was taken to the hospital for treatment of a possible head injury. Review of Resident #5's Hospital emergency room discharge paperwork, dated 3/30/26 at 6:45 P.M., showed:-The resident was seen for a potential head injury.-Instructions for monitoring for a head injury/concussion were sent to the facility with the resident and included in the resident's medical record. During an interview on 4/8/26 at 4:40 P.M., Resident #18 said: -He/She believed that all things have a soul and that even inanimate objects like tables and air conditioner skirts have souls.-So, when he/she saw Resident #5 get mad and pull the skirt off the air conditioner and throw it on the ground, it made him/her angry.-He/She said to Resident #5, how would you feel if someone pulled on you like that and slammed you down? So I grabbed him/her and slammed him/her to the floor and that was it, I just walked away after that.-He/She thought Resident #5 should know how the air conditioner skirt felt. During an interview on 4/6/26 at 4:30 P.M., Resident #5 said:-He/she didn't do anything,-He/she tried to stay out of trouble. During an interview on 4/10/26 at 3:30 P.M., the DON said the incident was preventable abuse when Resident #5 was not removed from the environment. During an interview on 4/17/26 at 11:30 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A.M., facility Administrator B said:-Had the staff removed Resident #5, the other residents would not have escalated and gotten involved causing Resident #5 to get injured requiring a hospital visit.-He/she felt it was likely abuse that could have been prevented with a quicker staff response. 5. Review of Resident #13's face sheet showed he/she admitted on [DATE] with the following diagnosis: bipolar disorder, ADHD, PTSD, autistic disorder, and anxiety. Review of the resident's Quarterly MDS, dated [DATE], showed he/she was cognitively intact. Review of Resident #12's face sheet showed he/she admitted on [DATE] with the following diagnosis: schizophrenia, delusional disorder, depression, intellectual disability, bipolar disorder, and anxiety. Review of the resident's Quarterly MDS, dated [DATE], showed he/she was cognitively intact. Review of the facility RNI, dated 4/7/26, showed:-On 03/31/26 at approximately 4:30 P.M., Resident #13 was observed striking Resident #12 on the right side of the face following a verbal altercation.-The investigation determined there was a resident-to-resident physical altercation without injury. During an interview on 4/8/26 at 12:09 P.M., Resident #13 said:-Resident #12 threw ice on a staff member. He/She had a flashback of someone doing this to his/her mom, so he/she hit Resident #12.-He/She hit Resident #12 in the jaw and then Resident #12 hit him/her. Resident #12 then walked away.-He/She was not hurt; they were cool now.-He/She told Resident #12 to put him/herself in my shoes and the resident said he/she would have done the same thing.-It happened in the front TV room.-Lots of staff responded. During an interview on 4/8/26 at 12:21 P.M., Resident #12 said:-Resident #13 hit me in the back of the head. During an interview on 4/8/26 at 4:45 P.M., CMT B said: -He/She was passing medication when Resident #12 was throwing chairs. A Code [NAME] was called for help.-Resident #12 was mad about money then he/she threw a drink on him/her.-Resident #13 came out of nowhere and hit Resident #12. During an interview on 4/8/26 at 4:32 P.M., the DON said:-This was a money situation. Resident #12 had no money on the books.-Resident #12 wanted a soda and then threw his/her drink on CMT B.-Resident #13 hit Resident #12 and then walked away and by definition this was a behavior resulting in abuse when a resident hit another resident.-There was nothing predictable, Resident #13 came out of nowhere. 6. Review of Resident #14's face sheet showed he/she admitted [DATE] with the following diagnoses: schizoaffective disorder and anxiety. Review of Resident #16's face sheet showed he/she admitted [DATE] with the following diagnoses: schizophrenia, anxiety, autistic disorder, PTSD, depression, personality disorder, obsessive compulsive disorder, and intellectual disorder. Review of the resident's comprehensive MDS, dated [DATE], showed he/she was cognitive intact. Review the resident's behavior note, dated 4/5/26 at 10:45 A.M., showed:-He/She was assessed following resident-to-resident altercation. The resident reported he/she was sitting in the dining area when Resident #14 approached and struck him/her in the face and head.-Physical assessment completed. Resident #16 was noted to have a swollen/lacerated lip to left side with small amount of bleeding and superficial scratches noted to scalp.-He/She rated pain 4/10 to mouth area.-No active bleeding at time of reassessment. Review of the facility RNI, dated 4/5/26 at 4:55 P.M., showed:-On 4/4/26 at 5:00 P.M. a resident-to-resident physical altercation involving the head.-Resident #14 entered the dining room and became physically aggressive toward Resident #16.-Resident #14 struck and scratched Resident #16 on the left side of Resident #16's face and head. Resident #16 had a laceration/ swollen lip and received Tylenol (over the counter pain medication) for mouth pain. Review of Resident #16's Psychosocial Post-Incident Impact Note, dated 4/05/2026 at 12:22 P.M., showed:-He/She was involved in an incident as the victim.-He/She did not feel safe with Resident #14.-He/She wanted to press charges against Resident #14. Review of Resident #16's Health Status Note, dated 4/5/26 at 12:32 P.M., showed:-Nursing assessment found his/her dental was intact with a little bruise on the lip.-He/She rated his/her pain at 5/10 and Ibuprofen 600mg was ordered and administered. During an interview on 4/8/26 at 11:20 A.M., Resident #16 said:-Resident #14 told him/her to come to his/her room. Resident #14 said he/she wanted to hurt another resident and wanted Resident #16 to hurt these other residents too.-Resident #14 acted strangely. Resident #14 pointed at the ceiling, said others were listening, and then told Resident #16 to leave.-Later in the (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hangout, Resident #14 ran up on him/her out of nowhere. Resident #14 pushed him/her and then grabbed his/her hair, even pulled some hair out. Resident #14's nails were in his/her scalp.-The resident said he/she was going to beat the living shit out of my ass.-He/she was scared and did not like being around Resident #14.-He/she does not like how Resident #14 will yell, curse, hit and or touch him/her. During an interview on 4/8/26 at 3:34 P.M., the DON said:-Resident #14 accused Resident #16 of masturbating and being after a boyfriend.-Resident #16 scratched on his/her scalp, left lip bruised.-Resident #16 was confused why Resident #14 attacked him/her.-Resident #16 told the nurse he/she was scared of Resident #14.-Resident #16 was given Tylenol when he/she said his/her mouth hurt. 7. During an interview on 4/17/26 at 11:30 A.M., facility Administrator B said he/she understood that sometimes altercations happen quickly, however, once a staff member hears voices raised, they should be going towards that and determining if the residents are escalating and if so, call a Code [NAME] immediately. NOTE: At the time of the abbreviated survey, the violation was determined to be at the immediate jeopardy level J. Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). 2962055, 2973798, 2970712, 2965860, 29868717, 2964638

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to follow facility policy by not gathering witness statements when conducting an investigation of abuse for four sampled residents (Resident #3, #5, #6, and #18) out of 23 sampled residents. The facility census was 129 residents. Review of the facility policy for Abuse and Neglect, revised 6/12/24, showed the Administrator/Designee was to complete an administrative investigation to include personal statements from staff and residents involved in any situation that had any type of accusation of abuse including resident abuse. 1.Review of Resident #3's Facility admission Record showed he/she had a diagnosis of schizophrenia (a chronic, severe mental disorder characterized by disruptions in thought processes, perceptions, and behaviors, often causing a disconnection from reality). Review of the resident's Nursing Progress Note, dated 3/25/26 at 7:50 P.M., showed:-The resident was engaged in a resident-to-resident altercation where Resident #6 was observed striking Resident #3 three times causing Resident #6 to fall and hit his/her head against the wall.-Resident #3 then proceeded to bang Resident #6's head on the floor before the residents were separated. -Resident #3 was assessed and showed no apparent injuries. Review of Resident #6's Facility admission Record showed he/she had a diagnosis of schizoaffective disorder (a chronic mental health condition combining schizophrenia symptoms (hallucinations, delusions) with mood disorder symptoms (mania or depression). Review of the resident's Nursing Progress Note, dated 3/25/26 at 7:50 P.M., showed:-Resident #3 and Resident #6 had an altercation where Resident #6 allegedly struck Resident #3 three times.-Resident #3 then punched Resident #6 in the eye causing Resident #6 to fall and hit his/her head on the wall.-Resident #3 then banged Resident #6's head on the floor before they were separated.-Staff observed a hematoma forming above Resident #6's right eye with surrounding redness and a reddened right eye. Review of the Facility Registered Nurse Investigation (RNI), dated 3/25/26 at 9:00 P.M., showed:-The type of incident was physical aggression involving the head.-On 3/25/26 at around 8:00 P.M., staff reported a resident-to-resident altercation involving Resident #3 and Resident #6.-Upon arrival both residents were engaged in physical aggression where Resident #6 was observed to have been struck in his/her right eye which caused him/her to fall and hit his/her head on the wall.-Resident #3 then made contact with Resident #6's head against the floor.-A Code [NAME] (a staff emergent response to resident behavior) was called and staff intervened immediately, separating the residents and placing them in safe areas.-Administrator A's signature was on the investigation noting it was completed. -Review showed there were no witness statements included for the investigation. During an interview on 4/9/26 at 4:44 P.M., Certified Medication Technician (CMT) B said he/she did not write a statement regarding the situation and was not asked about what happened. During an interview on 4/23/26 at 12:30 P.M., Licensed Practical Nurse (LPN) C said he/she was usually interviewed and asked to write what happened regarding an abuse allegation directly after the incident, but not this time. He/she did not write a statement regarding Resident #3 and Resident #6. 2. Review of Resident #5's Facility admission Record showed the resident had a diagnosis of paranoid schizophrenia. Review of Resident #18's Preadmission Screening and Resident Review (PASARR, DA-124C, a required form to be submitted for any client who requests admission to a Medicaid certified bed regardless of the client's payment source; this includes dually certified beds both Medicare and Medicaid), dated 11/7/24 showed the resident was admitted with a diagnosis of schizophrenia and schizoaffective disorder. Review of the Facility RNI, dated 3/30/26, showed:-The type of incident was physical aggression involving the head.-The staff were to not argue or get defensive with the residents.-At approximately 5:45 P.M., Resident #5 became agitated outside where residents were hanging out.-Resident #5 continued to escalate and as he/she was being led back inside the facility by staff, Resident #5 dismantled a portion of the air conditioner unit skirt, removing it and swinging it towards staff.-At that point Resident #18 intervened by grabbing Resident #5 and taking him/her to the ground causing an injury to the resident's head from hitting the floor.-Review (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed there were no witness statements included for the investigation. During an interview on 4/8/26 at 3:55 P.M., LPN B said:-He/she had been the primary staff member involved in the altercation and was not asked to write a statement. -He/she usually wrote a statement for the altercations he/she was involved in as a witness. During an interview on 4/10/26 at 3:30 P.M., the Director of Nursing (DON) said he/she did not know LPN B had not written a statement until it was asked for and not found. 3. During an interview on 4/10/26 at 3:30 P.M., the DON said:-A complete investigation should include a written statement from each staff witness as well as any resident who was capable of explaining what occurred. -If the involved residents were unable to write what happened in a written statement, a staff member could write the statement for the residents as the resident relayed what had happened.-The investigations were usually collected by Administrator A and he/she had been directed by Administrator A to just handle the RNI and the nursing portion of the investigation and Administrator A would handle everything else.-He/she was used to being very methodical with the investigations, collecting all the information, including the written statements, and ensuring all pieces of the investigation were present and organized before he/she presented them to the Administrator. During an interview on 4/10/26 at 4:00 P.M., Administrator A said:-He/she understood a full investigation should include written witness statements of both staff and residents.-He/she thought the facility had collected witness statements from all parties involved, but was unable to provide them for the incidents on 3/25/26 and 3/30/26.-He/she provided the RNI as the complete investigation. During an interview on 4/17/26 at 11:30 A.M., Administrator B said:-He/she expected the charge nurse to begin the RNI and then the investigation should go to the DON for input.-He/she expected that all staff and residents involved in the incident would make a written statement and turn it into the DON.-Once the DON had collected the information and done his/her portion of the investigation, he/she would expect the investigation packet to be given back for him/her to finish and ensure that all portions of the investigation, including the written statements were all present and organized. 2968717, 2964638

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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 staff failed to implement facility practices and procedures to support behavioral health services when resident's had verbal altercations that lead to physical altercations for two sampled residents (Resident #1 and #2) out of 18 sampled residents. On 3/23/26 Certified Medication Technician (CMT) A witnessed a verbal argument between Resident #1 and Resident #2 and failed to initiate a Code [NAME] (a behavioral emergency or a request for immediate assistance to de-escalate a combative, aggressive, or out-of-control resident, often involving a specially trained response team) in a timely manner. Resident #1 and Resident #2 escalated into a physical argument where both Resident #1 and Resident #2 punched one another and Resident #1 stabbed Resident #2 in the left forearm with a pair of scissors. Resident #2 was sent to the hospital and diagnosed with a concussion and received two sutures to the left forearm. The facility census was 129 residents.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 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 staff were to ensure the residents were receiving necessary behavioral health care which was 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.-Any concerns with behaviors were to be discussed with the Multi-disciplinary Team to assist in determining the underlying causes of mood and behavior changes, including differential diagnosis.-The staff were to document the changes, including the frequency of occurrence and potential triggers in the resident's record,-The team was to ensure that appropriate follow-up assessments were completed if needed. Review of the facility's Crisis Prevention Intervention (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. Review of the facility policy for Screens/Searches Upon Entering the Facility, revised 4/3/24, showed:-The purpose of the policy was to keep all residents and staff safe at all times while in the facility.-All items considered as contraband must be secured.-All sharp objects including glass, razors or any other sharp objects were to be secured by facility staff and not kept with the resident. 1. Review of Resident #1's Preadmission Screening and Resident Review (PASRR, DA-124C, a required form to be submitted for any client who requests admission to a Medicaid certified bed regardless of the client's payment source; this includes dually (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	certified beds both Medicare and Medicaid), dated 2/18/16, showed:-Diagnosis of Schizophrenia (a chronic, severe mental disorder characterized by disruptions in thought processes, perceptions, and behaviors, often causing a disconnection from reality).-He/She endorsed audible hallucinations (sensory perceptions of hearing sounds such as voices, music, or noises, without any corresponding external stimulus) and was frequently seen talking to himself/herself.-Had a history of difficulty getting along with others and had frequent altercations, evictions and fear of strangers.-Had failed at less restrictive environments due to aggressive behaviors. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by staff and used for care planning), dated 2/27/26, showed:-Was cognitively intact.-Had no behaviors and did not refuse cares.-Had moderate issues with his/her mood. Review of the resident's Nursing Care Plan, dated 3/21/24, showed:-The resident was triggered when people stole things from him/her, people getting in his/her personal space, and people yelling at him/her.-Drawing/painting, going outside, smoking a cigarette and attending group therapy helped to de-escalate him/her. Review of the resident's Individualized Service Care Plan (ICSP), updated 4/1/25, showed:-His/Her triggers were having things stolen from him/her and being asked to push other residents in wheelchairs.-He/She calmed down when able to paint/draw, offered a shower, and when offered a cigarette. Review of Resident #2's PASRR, dated 2/3/24, showed:-Diagnoses of 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 immediate care, usually alternating with intense depressive episodes), Major Depressive Disorder (MDD-a serious, common mental health condition characterized by persistent sadness, hopelessness, and loss of interest in activities (anhedonia) lasting at least two weeks), Psychosis (a set of symptoms indicating a loss of contact with reality, characterized by hallucinations (seeing/hearing things not there) and delusions (false, fixed beliefs), Schizophrenia, and Epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures caused by sudden, abnormal electrical activity in the brain).-Signs of psychosis in the past where an internal force made him/her do things, yell things and lose control of his/her body.-He/she became combative towards his/her caregivers which required medication to calm him/her down.-The resident's early onset epilepsy could have caused several cognitive impairments including memory loss, slow processing, and poor safety awareness. Review of the resident's quarterly MDS, dated [DATE], showed:-Was cognitively intact.-Had moderate issues with mood.-Had no negative behaviors. Review of the resident's original Nursing Care Plan, dated 4/1/25, showed:-Somone stealing from him/her, someone getting in his/her personal space, people yelling and not being able to go outside the building was a trigger for the resident.-The staff were to allow him/her to draw and paint, offer psychotherapy, and offer a cigarette to help calm him/her down if needed. Review of the resident's ICSP, dated 4/1/25, showed:-The resident's triggers were being bullied and people stealing from him/her.-The facility staff were to assist the resident with staying on task.-The staff was to attempt to re-direct any unacceptable behavior.-If possible, the staff were to explain to the resident why the behavior was not acceptable and intervene to protect the safety and rights of the resident and other involved residents.-The staff were to incorporate the resident's coping skills which were having coffee or soda, watching TV or playing chess on his/her phone.-The staff should ensure the resident was not giving away money or belongings to other residents. During an interview on 4/7/26 at 6:00 P.M., Activity Aide A said:-On 3/23/26 around 4:00 P.M. he/she happened to be in the lobby waiting on his/her ride home.-Resident #1 came up to use the phone in the lobby and while the resident was on the phone, he/she noticed a package with the resident's name on it.-He/She asked Resident #1 if the package belonged to him/her, to which he/she said it did.-He/She handed Resident #1 the package and the resident left the lobby after the phone call ended.-He/She had never been educated on how to receive and distribute packages.-Since the package had Resident #1's name on it, he/she (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	gave it to the resident after the resident confirmed it was for him/her.-He/She was relatively new to the facility and didn't realize Resident #1's first name was the same as Resident #2's last name, or he/she wouldn't have given the resident the package. Review of the Facility Registered Nurse Investigation (RNI), dated 3/23/26 at 8:00 P.M., showed:-The nature of the incident was physical aggression not involving the head.-Resident #1 had been taken to the lobby to use the phone.-While in the lobby, he/she was mistakenly given a package with a pair of jeans that actually belonged to Resident #2.-When Resident #1 realized the jeans weren't his/hers, he/she decided to sell them to another resident.-Resident #2 learned his/her jeans were missing and confronted Resident #1.-Staff observed the verbal escalation during shift change, however, the residents weren't separated before the incident became physical.-During the altercation, Resident #1 struck Resident #2 in the arm with broken scissors.-Staff intervened and separated the residents using appropriate CPI techniques.-The incident was substantiated by the facility investigation as the resident's property was mishandled, and staff identified the argument but did not intervene soon enough to separate the residents and prevent the injury requiring a hospital visit and staples. Review of Resident #2's Nursing Progress Notes, dated 3/23/26 at 8:18 P.M., showed the trigger for the incident with Resident #1 was loss/theft of personal belongings leading to emotional distress and confrontation. Review of the Police Report, dated 4/2/26, showed:-On 3/23/26 at 9:50 P.M., police officers were dispatched to the facility regarding a cutting.-Upon arrival, officers made contact with Certified Nursing Assistant (CNA) A who stated at 7:25 P.M., he/she observed Resident #1 and Resident #2 engaged in a physical altercation, both residents threw punches at one another.-That was when Resident #1 produced a pair of broken scissors and began to stab Resident #2.-The residents were broken up by several staff members and CNA A pried the broken scissors out of Resident #1's hand.-Resident #2 stated that on 3/22/26 Resident #1 approached Resident #2 admitting he/she had taken Resident #2's package containing jeans.-Resident #2 assumed Resident #1 had taken them by mistake, but when Resident #2 asked Resident #1 for the jeans, Resident #1 stated he/she had sold them to another resident.-When Resident #2 asked who had the jeans and the receipt from the sale of the jeans so that he/she could clear up the confusion, Resident #1 became agitated, and struck Resident #2 on the face multiple times while holding a pair of broken scissors.-In the altercation, the residents fell to the floor and Resident #1 stabbed Resident #2 in the arm which caused a deep wound.-The facility staff were able to separate the two residents and the officers noticed Resident #2 was bleeding from his/her left forearm.-Resident #2 was transported to the hospital where he/she received two staples to close the wound and a neck brace.-Resident #2's guardian was contacted and wished to press assault charges so Resident #1 was taken to jail. Review of Resident #2's hospital record, dated 3/23/26, showed:-He/she had a stab wound to the under portion of his/her left forearm.-The stab wound was repaired by the trauma physician and the resident was cleared for discharge back to the facility. Review of Resident #2's medical record showed staff did not document they notified the Psychiatric nurse practitioner after the incident on 3/23/26. Review of a written statement from CNA A, dated 3/23/26, showed:-He/She was around the corner of the unit and heard yelling between two residents.-He/She witnessed Resident #1 and Resident #2 fighting and carrying on.-He/She witnessed Resident #1 doing a striking motion at Resident #2 and then both residents fell to the floor.-He/She then saw Resident #1 with a pair of scissors which he/she immediately took from Resident #1's hand.-He/She continued to tell them to stop fighting and when finally able to break up the fight, he/she saw Resident #2 bleeding from the forearm.-CMT A called the police, and the situation de-escalated. During an interview on 4/6/26 at 10:15 P.M., CNA A said:-At around 7:30 P.M. on 3/23/26, he/she came around the corner of the unit and heard a verbal altercation going on.-He/She ran to the residents to find Resident #1 swinging at Resident #2 hitting him/her in the face before producing a broken pair of scissors which he/she also began swinging at Resident #2.-He/She worked to break up the fight, grabbing the broken scissors while CMT A called the police.-Once the residents were broken apart, and the residents both falling to the floor, he/she then (continued on next page)

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F 0740 Level of Harm - Actual harm Residents Affected - Few	noticed Resident #2 bleeding from the left forearm.-He/She probably should have called a Code [NAME] as soon as he/she heard the yelling, but instead just tried to get it all broken up. -They are told to call a Code [NAME] as soon as the situation begins to escalate.-Neither resident had any altercations in the past that he/she was aware of.-Resident #1 did his/her drawing or painting as his/her coping skills and Resident #2 usually just stayed in his/her room or to himself/herself. -He/She was surprised the two residents had the fight at all.-He/She had not reviewed either residents' ICSP, but knew he/she could find them on the computer or on the application on his/her phone.-He/she was not sure what the residents' triggers or interventions were as he/she had never had to de-escalate either resident in the past.-The residents weren't supposed to sell, borrow or steal other residents' belongings, but they do it all the time and it's hard to stop. During an interview on 4/8/26 at 3:55 P.M., CMT A said:-He/She responded to the verbal altercation between the residents.-Resident #2 was saying Resident #1 stole his/her pants.-He/She did not call a Code [NAME] until he/she saw the scissors in Resident #1's hand.-Resident #1 ended up stabbing Resident #2 in the arm before the staff were able to get them de-escalated.-The staff were supposed to call Code [NAME] as soon as they saw arguing, but this all happened really fast.-Most of the residents don't like it when other residents mess with their belongings and especially since Resident #1 tried to sell the pants, he/she could see how that really escalated Resident #2.-The residents weren't supposed to borrow or take other residents' belongings, but it happened all the time and on some of the other units, it was the cause of a lot of fights between residents. Review of a written statement completed by Licensed Practical Nurse (LPN) A, dated 3/23/26, showed:-He/She witnessed Resident #1 stab Resident #2 in the left forearm over a pair of jeans.-Both residents were fighting and staff intervened.-He/She retrieved a pair of blue jeans from another resident and returned them to Resident #2.-Resident #2 was sent to the hospital and Resident #1 went to jail. During an interview on 4/9/26 at 8:00 P.M., LPN A said:-He/She stood near the medication cart counting narcotics with the day shift nurse.-He/She heard CMT A say, stop, stop, stop leave him/her alone!-CMT A called for Code [NAME] when the residents didn't stop. -The Code [NAME] should have been called as soon as CMT A heard arguing and not wait until the residents were fighting, and they all had been taught to do this. -The next thing he/she knew the residents were fighting and Resident #1 pulled out broken scissors and waved it at Resident #2.-While staff tried to assist in breaking up the two residents, Resident #1 cut Resident #2 in the left forearm.-They called the police and ambulance for the residents.-He/She wasn't sure when Code [NAME] got called, but it all happened really fast.-He/She had no idea Resident #1 had kept scissors after they were used.-Staff should have gotten the scissors back from the resident as soon as the resident was done with them.-The staff should call a Code [NAME] as soon as they see residents start to escalate and not wait until someone gets hurt. -A lot of resident-to-resident altercations take place over the residents borrowing, stealing, selling items. The residents are educated not to do it, but they still do. -A lot of residents were triggered by having their belongings messed with by other residents or taken by other residents.-He/She was not aware of the situation with the jeans and the wrong resident got the jeans and was trying to sell them.-The staff who work at the front desk should know the protocol for checking in packages to make sure they get to the correct resident and that nothing dangerous is brought into the facility. During an interview on 4/2/26 10:00 A.M., Resident #1 said:-He/She didn't steal any pants.-He/She just does his/her art and that is it.-He/She kept the scissors locked up in a drawer in his/her room. He/She used the scissors, which were kiddie scissors to cut his/her paper that he/she drew on.-Resident #2 came at him/her accusing him/her of stealing his/her pants, but he/she got the pants from the front desk, and they were sent to him/her.-He/She never cut the resident on purpose, but when the staff went to break up the incident, they all fell, and Resident #2 fell on the scissors which was what caused the cut.-He/She tried to give the resident his/her pants back when he/she found out they were not his/hers, but Resident #2 said no and told him/her to get out.-He/She never sold the pants to anyone. Observation of Resident #2 on 4/2/26 at 10:30 A.M., (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265822	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/14/2026
NAME OF PROVIDER OR SUPPLIER Bridgewood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 11515 Troost Kansas City, MO 64131	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Actual harm Residents Affected - Few	showed he/she had staples removed from the left forearm and the wound was approximately 2.5 centimeters (cm) by 0.1 cm with a reddened area surrounding the wound. During an interview on 4/3/26 at 1:30 P.M., Resident #2 said:-He/She didn't know what happened to his/her pants that were sent to him/her by his/her guardian.-The next thing he/she knew, Resident #1 offered to sell the pants to him/her for eight dollars.-Resident #2 told him/her the pants did not belong to him/her, but Resident #1 refused to give them back.-He/She never told Resident #1 to get out of his/her room.-He/She just asked for his/her pants back and Resident #1 stabbed him/her.-It made him/her mad when people mess with his/her belongings and when he/she found out that Resident #1 had his/her pants and tried to sell them, that really made him/her feel angry. During an interview on 4/10/26 at 3:30 P.M., the Director of Nursing (DON) said:-Resident #2 could get agitated but not usually directed at another resident.-He/She believed this would not have happened at all if the appropriate steps were taken to ensure the correct resident got the correct item.-The residents were educated about not buying, selling or trading items, but many still do it.-He/she believed that a Code [NAME] was not called quickly enough in this situation, to stop the residents from getting physical. -He/she would have expected the staff who first heard the arguing to immediately call a Code [NAME] while the altercation was still just verbal.-The staff should always take the scissors back from Resident #1 as soon as he/she finished using them.-The resident should never have kept scissors in his/her room.-He/She believed the staff do not always intervene and separate residents in a timely manner by waiting until it was physical when it started verbal. -He/She expected the staff involved to call the Code [NAME] as soon as they heard/saw the verbal argument and all the staff had been educated on this practice.-All residents were educated about not borrowing, stealing, selling items, but they continued to do it from time to time, and it did cause issues when it happened.-All staff were educated in how to find and utilize the ICSP where all resident triggers and interventions were documented, and if they were not familiar with a resident, the staff should always look at those triggers and interventions prior to caring for the resident on that shift. During an interview on 4/14/26 at 10:45 A.M., the Psychiatric Nurse Practitioner (PNP) said:-He/she was not notified of the resident-to-resident altercation between Resident #1 and Resident #2. He/she or one of his/her colleagues should always be notified so they can make recommendations for the residents and staff involved. He/she expected to have been notified of every incident, every behavior and every time a resident required an as needed (PRN) medication to calm them down. He/she could not provide appropriate care and input if he/she didn't know what was going on with residents' behaviors.-He/She was a part of the Multidisciplinary Team who assisted in making proper recommendations for the residents, especially when the resident was struggling with their behaviors.-These particular residents were not ones he/she heard a lot about as they were not residents who usually had a lot of behaviors.-Now that he/she was aware, he/she would look into what occurred and provide feedback and education for the staff and residents involved.-He/she expected the Code [NAME] be called as soon as a staff member heard a verbal altercation and he/she was aware the staff had been educated on that practice, as this was a part of the education provided. During an interview on 4/17/26 at 11:30 A.M., facility Administrator B said:-He/She expected the proper protocol would have been followed when it came to issuing the resident a package to ensure the correct resident got the correct package. -He/she expected that any staff member who might have the responsibility of handing out a resident package be fully educated in the process.-He/she expected that all staff would know where to locate the residents' ICSP and use it to identify resident triggers and interventions.-When it came to the incident, he/she would have expected staff to call a Code [NAME] as soon as the arguing between the residents was heard/observed. They had educated all staff prior to this incident to all a Code [NAME] as soon as residents began to escalate. -He/She would have expected the staff to remove the resident with the weapon in order to keep the other resident safe. -He/she would have expected staff to have not allowed the resident to have scissors to use whenever desired and that the staff to keep track of when the scissors were returned to the staff instead of allowing the resident to keep them. 2962055