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	04/22/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent physical abuse of four residents (Resident #1, #4, #5, and #6) out of six sampled residents. On 4/14/26 Resident #5 kicked Resident #6 on the leg. Resident #6 struck Resident #5 with a closed fist on the right side of the head. Resident #5 sustained swelling to his/her head and Resident #6 sustained injury to his/her right knuckles. On 4/16/26, Resident #6 kicked Resident #4. On 4/17/26 Resident #2 struck Resident #1 resulting in a laceration to Resident #1's left eye. The facility census was 127 residents.Review of the facility Abuse and Neglect Policy, dated 6/12/24, showed:-Abuse is the willful infliction of injury, intimidation or punishment resulting in physical harm, pain or mental anguish.-Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish.-Physical abuse was purposefully beating, striking, wounding, or injuring any resident or any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner.-Physical abuse also included, but is not limited to, hitting, slapping, punching, biting, and kicking. 1. Review of Resident #5's admission Record face sheet showed the following diagnoses:-Bipolar disorder, (mood disorder that can cause intense mood swings).-Intermittent explosive disorder, (a mental health condition characterized by recurrent, uncontrollable and disproportionate outbursts of rage, verbal aggression or violence).-Attention deficit hyperactivity disorder, (ADHD, a common neurodevelopmental disorder typically diagnosed in childhood, often lasting into adulthood).-Unspecified intellectual disabilities.-Major depressive disorder, (a serious, common mood disorder characterized by persistent sadness, loss of interest and low energy for at least two weeks).-Mental disorder.-Anxiety disorder, (a common mental health condition characterized by excessive worry that interferes with daily life). Revies of Resident #5's Pre-admission Screening and Resident Review (PASRR) dated 8/8/16 showed:-A history of mental illness, depression, angry outbursts, ADHD and suicidal ideation (thoughts or preoccupation with ending one's own life).-He/She was very childlike and had the mind of a 7-year-old.-A history of anxiety, attention deficit, mania, (abnormally high energy, euphoric or irritable mood and reduced sleep), poor decision-making skills, and poor judgement. Review of Resident #5's Minimum Data Set (MDS- a federally mandated assessment completed by facility staff) dated 4/8/26 showed the resident assessed as cognitively intact. Review of Resident #6's admission Record Face Sheet showed the following diagnoses:-Bipolar disorder.-ADHD.-Bipolar II disorder, (a mental health disorder characterized by alternating patterns of depressive episodes and abnormally elevated and extreme mood changes).-Chronic Post-Traumatic Stress Disorder, (a persistent mental health disorder lasting over three months following prolonged, repeated trauma).-Generalized anxiety disorder.-Autistic disorder, (a neurodevelopmental condition affecting communication, behavior and social interaction). Review of Resident #6's PASRR dated 2/23 showed:-Behavioral difficulty and/or mental illness symptoms requiring 24-hour monitoring/management.-A history of panic, anxiety, depression, irritability, agitation, struggles with paranoia and anxiety amongst crowds, anger control issues, ongoing boundary issues, inappropriate sexual behavior, and counseling for anger outbursts.-Impaired (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 - Actual harm Residents Affected - Few	judgement and insight and required staff supervision and verbal cues to maintain appropriate boundaries with both males and females. Review of Resident #6's MDS dated [DATE] showed the resident assessed as cognitively intact. Review of the facility investigation dated 4/14/26 showed:-The incident occurred at approximately 6:20 P.M.-The incident involved physical aggression involving the head.-Resident #5 was observed in the main front hall engaged in a verbal altercation with a peer, Resident #6, regarding another resident.-His/Her assigned 1:1 aide, Certified Nurse Aide (CNA) A, attempted to redirect him/her and instructed him/her to walk away.-While attempting to disengage, Resident #5 kicked Resident #6 on the leg.-Resident #6 responded by striking Resident #5 on the right side of the head, resulting in visible swelling.-Resident #6 sustained injury to his/her right hand/knuckles during the strike.-Review of records, staff interviews and resident statements confirmed a resident-to-resident altercation precipitated by verbal conflict and impulsive behavior.-Conclusion/outcome of the investigation substantiated a resident-to-resident altercation involving Resident #5 as the initiating aggressor and Resident #6 as the retaliatory responder.-The altercation was not accidental. Review of Resident #5's facility Progress Note dated 4/14/26 at 6:20 P.M. showed:-He/She was observed in the main front hall engaged in a verbal altercation with peer, Resident #6, regarding another resident.-Resident #5 presented with increased agitation, argumentative tone and difficulty following redirection.-His/Her assigned 1:1 aide, CNA A, attempted to redirect him/her and instructed him/her to walk away.-Resident #5 appeared to comply, however prior to fully disengaging, he/she kicked Resident #6 on the leg, initiating physical contact.-Resident #6 responded by striking Resident #5 on the right side of the head.-Assessment revealed several lumps to the right side of Resident #5's head; ice applied, and neurological checks initiated. Review of Resident #6's Progress Note dated 4/14/26 at 6:48 P.M. showed:-Resident #5 kicked Resident #6 in the leg while being redirected by staff.-Resident #6 responded by striking Resident #5 on the right side of the head.-Assessment revealed injury to Resident #6's right hand/knuckles; ice applied. During an interview on 4/21/26 at 10:33 A.M., Resident #5 said:-He/She was not dealing with Resident #6 anymore. -The abrasions and swelling he/she had were gone. -He/She did not go to the hospital. -It made him/her mad when Resident #6 hit him/her, but now they were friends. During an interview on 4/21/26 at 10:50 A.M., Resident #6 said:-He/She got into a fight with Resident #5. -Resident #5 said he was going to kick Resident #6 in the face and later he/she did kick him/her. -He/She did not know why. -After Resident #5 kicked him/her, he/she snapped and punched Resident #5. -He/She did not know how many times he/she punched Resident #5. -Staff pulled the two of them apart.-He/She was not trying to harm Resident #5, but was just proving his/her point to quit starting things with people. -He/She hit Resident #5 on purpose. -Resident #5 was the one who started the fights. -It made him/her mad when Resident #5 started the fights. Review of CNA A's written statement dated 4/14/26 showed:-He/She was standing next to Resident #5 by the doors and the resident exchanged words with Resident #6.-He/She suggested to Resident #5 he/she walk down the hall to calm down, so things did not escalate.-Resident #5 then kicked Resident #6 prior to trying to walk Resident #5 away and Resident #6 charged Resident #5 and the fight broke out.-He/She tried to break it up before things got bad.-He/She yelled Code Green (staff emergency behavioral response) to get other staff to help and staff came and helped. During an interview on 4/21/26 at 1:49 P.M., CNA A said:-He/She was on a 1:1 observation with Resident #5 for four days. -He/She was there when Resident #5 kicked Resident #6. -The two residents did not get along very well. -Resident #5 did not want to be on 1:1 so he/she was frustrated. They were exchanging words about another resident and waiting for time in the hangout area. -He/She encouraged Resident #5 to go back to his/her room. -Resident #5 kept exchanging words, but started walking away. -Resident #5 said I am going to kick you in the face to Resident #6.-He/She encouraged Resident #5 to continue to show good behavior, so he/she could get off 1:1. -Resident #6 said Do it, so Resident #5 kicked at him/her in the shin.-He/ She tried to get between them and break it up and Resident #6 got Resident #5 on the floor, and they started hitting each other. Review of CNA B's written statement dated 4/14/26 showed:-CNA A called Code [NAME] (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	for Resident #5 and Resident #6.-He/She quickly responded and got Resident #6 off Resident #5.-Resident #5 and Resident #6 were fighting. During an interview on 4/22/26 at 3:31 P.M., CNA B said:-He/She was in the hallway turned away with another resident to his/her right, down the hall.-He/She heard Resident #5 and Resident #6 yelling.-He/She called Code [NAME] immediately when he/she saw what was going on and started running to the area.-CNA A grabbed Resident #5.-He/She grabbed Resident #6, gently pulling him/her and using a calm voice and said, Come here, Resident #6. During an interview on 4/21/26 at 11:50 A.M., the Psychiatric Nurse Practitioner (NP) said:-He/She was aware of the Resident #5 and Resident #6 altercation.-Resident #6 had obsessive thoughts. -He/She saw him/her yesterday and would not take him/her off 1:1 observation. -Resident #6 said he/she did not have anything to lose. -Resident #6 said everything, like his/her TV, had been taken away. -He/She thought Resident #6 had low intellectual function and could not reason that if he/she did one thing, there would be a consequence. -Resident #5 had been on 1:1 observation. During an interview on 4/22/26 at 3:30 P.M., the DON said:-Resident #5 and Resident #6 got into it because Resident #5 had a crush on Resident #6.-Resident #6 was talking about another resident and Resident #5 heard it and got jealous.-Resident #5 and Resident #6 got physical and the 1:1 staff got between them.-The staff person told Resident #5 to walk away and Resident #5 did walk away, then turned and kicked Resident 6.-Then Resident #5 and Resident #6 started hitting. 2. Review of Resident #4's admission Record face sheet showed he/she was admitted to the facility on [DATE]. Review of Resident #4's MDS dated [DATE], showed the resident assessed as cognitively impaired. Review of Resident #4's Care Plan dated 4/16/24 showed:-He/She stayed to him/herself.-He/She was at risk for psychosocial decline related to a peer kicking him/her on the leg without instigation. Review of Resident #6's progress note dated 4/16/26 at 4:13 P.M. showed:-A Code [NAME] was called to the back hall.-He/She kicked Resident #4.-He/She was upset he/she did not have access to the hangout area.-He/She spoke with the DON and Administrator.-He/She was placed on 1:1 observation. Review of Resident #4's Progress Notes dated 4/17/26 at 11:48 A.M. showed:-Resident #6 demonstrated increasing agitation and inappropriate focus on a peer, Resident #4, in the days leading up to the incident.-The incident occurred when the resident became physically aggressive toward staff during redirection and subsequently redirected aggression toward Resident #4, kicking him/her in the shin.-Resident #4 sustained no injury. Review of the facility investigation dated 4/16/26 showed:-The incident occurred on 4/16/26 at approximately 2:30 P.M.-There was a physical altercation not involving the head.-Residents #4 and Resident #6 were involved.-On 4/16/26, staff reported an incident involving Resident #6, who had a known history of behavioral escalation, fixation, and difficulty with redirection.-On the day of the incident, Resident #6 left his/her assigned unit against direction after being instructed to remain due to ongoing behavioral concerns.-Resident #6 directed aggression toward Resident #4 who was walking by and kicked Resident #4 in the shin.-The incident was substantiated as a resident-to-resident altercation initiation by Resident #6.-Findings supported Resident #6 exhibited escalating behaviors over several days culminating in physical aggression toward Resident #4, who sustained no injury.-The altercation was not preventable. During an interview on 4/21/26 at 10:50 A.M., Resident #6 said:-He/She was upset the day he/she kicked Resident #4. -He/She found out another resident's mom did not want him/her around him/her.-It was spur of the moment. He/She was just upset. -He/She was not friends with Resident #4.-Resident #4 irritated him/her. During an interview on 4/21/26 at 11:08 A.M., Resident #4 said:-He/She remembered Resident #6 kick him/her. -He/She did not get injured when Resident #6 kicked him/her. -He/She guessed it made him/her upset. -He/She didn't do anything back to Resident #6. 3. Review of Resident #1's admission Record face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:-Intracranial injury without loss of consciousness, (brain injury).-Personal history of traumatic brain injury.-Convulsions, (sudden, involuntary shaking or stiffening of the body caused by rapid, uncontrolled muscle contractions).-Paranoid schizophrenia, (a chronic mental health disorder defined by intense, irrational and persistent auditory hallucinations). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's MDS dated [DATE], showed the resident assessed as cognitively intact. Review of Resident #2's admission Record face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses:-Mild cognitive impairment.-Paranoid schizophrenia.-Anxiety disorder. Review of Resident #2's quarterly MDS, dated [DATE], showed he/she was assessed as cognitively intact. Observation and interview on 4/21/26 at 10:22 A.M., showed Resident #1 had two scratches of approximately 1/2 inch in length above his/her left eyebrow; and he/she said:-Resident #2 bumped into him/her. -He/She did not go to the hospital. -He/She did not take any pain medicine. -The staff cleaned his/her eye up and put a Band Aid on it. -He/She denied falling or hitting his/her head. -He/She didn't think anything of it when Resident #2 hit him/her. During an interview on 4/21/26 at 9:50 A.M., Resident #2 said:-Resident #1 was threatening him/her. -Resident #1 bumped into him/her and he/she hit him/her.-He/She was trying to hurt Resident #1.-He/She hit Resident #1 on purpose. Review of the written statement by CNA C dated 4/17/26 showed:-He/she saw Resident #2 squaring up with Resident #1.-He/She and CNA D ran over to stop them, but Resident #2 hit Resident #1 in the eye, and when they yelled at Resident #2 to stop, he/she hit Resident #1 again.-Resident #1 hit his/her head on the wall and fell to the floor. During an interview on 4/22/26 at 3:13 P.M., CNA C said:-When the incident first started, he/she was in the men's back hall.-He/She turned around after hearing yelling and saw both residents raise fists, squaring up.-Resident #2 hit Resident #1 above the eye. Review of the written statement of CNA D dated 4/17/26 showed:-Resident #1 and Resident #2 were in the hall and Resident #2 bumped into Resident #1.-Resident #1 asked Resident #2 what was his/her problem.-That was when they both started squaring up.-Resident #2 hit Resident #1 two times in the face. During an interview on 4/22/26 at 3:15 P.M., CNA D said:-The residents were in the front hall, and he/she was in the back hall.-Resident #2 bumped into Resident #1, then asked, What's your problem?-Resident #1 raised his/her fist first. Review of the written statement by CNA E dated 4/17/26 showed:-He/She saw Resident #1 and Resident #2 were coming towards the back.-Resident #2 was walking and Resident #1 said, You bumped me.-Resident #2 kept walking and Resident #1 squared up and said, Come on Resident #2, and Resident #2 hit Resident #1. During an interview on 4/22/26 at 3:20 P.M., CNA E said:-He/She saw Resident #1 and Resident #2 were going toward each other.-Resident #2 said, Man, what do you want?-He/She yelled, Don't hit him/her, please!-There was one hit and it was over. During an interview on 4/21/26 at 11:50 A.M., the Psychiatric NP said:He/She did a telehealth with Resident #2 and the resident hung up on him/her. -He/She came out and saw Resident #2; Resident #2 did not really want to talk much and that was normal for him/her. During an interview on 4/22/26 at 3:30 P.M., the DON said:-Resident #2 bumped into Resident #1. -There was no injury except an abrasion on Resident #1's left eye. -Resident #2 had not had any behaviors recently. 4. During an interview on 4/21/26 at 11:50 A.M., the Psychiatric NP said:-Even with 2-3 staff members on the hallway, you did not know what was going through the residents' heads and the staff could not always predict impulsive behavior. -He/She was not going to medicate for behaviors. -For aggression and violence, he/she was not going to bump up any medication, especially for a one-time thing. -If something happens frequently then she might look at it, or if it is repeated aggression. -It was abuse when someone kicks you for no reason. During an interview on 4/22/26 at 3:40 P.M., the Administrator said the residents were impulsive with overstimulation, and their actions were not predictable. 2987469, 2986292, 2983800