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	05/06/2026

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 for one sampled resident (Resident #1) out of 14 sampled residents. On 4/24/26, Resident #2 struck Resident #1 on the head and face. Resident #1 sustained facial injuries, including two black eyes, scratches under the eyes, injury/marking in the middle of the nose area, abrasion on the right forehead and red marks on both cheeks. Resident #1 was sent to the hospital. The facility census was 121. 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 12/12/24, showed the following diagnoses:--Bipolar Disorder (Mood disorder that can cause intense mood swings).--Anxiety Disorder (a common mental health condition characterized by excessive worry that interferes with daily life).--Mood Disorder.--Adjustment Disorder.--Impulse Control.--Intermittent Explosive Disorder (a mental health condition characterized by recurrent, uncontrollable and disproportionate outbursts of rage, verbal aggression or violence).--Autism (a neurodevelopmental condition affecting communication, behavior and social interaction).-A history of being homeless.-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 judgement and insight and required staff supervision and verbal cues to maintain appropriate boundaries with both males and females. Review of Resident #1's admission Record showed the resident admitted to the facility on [DATE] and re-admitted on [DATE] with the following diagnoses:-Bipolar Disorder.-Chronic Obstructive Pulmonary Disease (lung disease).-Cardiac (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	Murmur.-Attention-Deficit Hyperactivity Disorder (ADHD- a common neurodevelopmental disorder typically diagnosed in childhood, often lasting into adulthood).-High Blood Pressure.-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 Disorder.-Autistic Disorder. Review of Resident #1's Minimum Data Set (MDS - a federally mandated assessment tool completed by staff and used for care planning), dated 4/1/26 showed:-Was cognitively intact.-Had inattention and disorganized thinking that fluctuates.-Had no behaviors and did not refuse cares. Review of Resident #2's undated admission Record showed the resident admitted to the facility on [DATE] and re-admitted on [DATE] with the following diagnoses:-Schizoaffective Disorder, Bipolar Type (a chronic mental health condition combining schizophrenia symptoms (hallucinations, delusions, disorganized speech) with manic episodes and sometimes major depression).-Anxiety Disorder.-Intermittent Explosive Disorder.-Adult Antisocial Behavior (a chronic pattern of disregarding the rights, safety, and feelings of others). Review of Resident #2's PASRR, dated 8/18/25, showed:-Schizophrenia-Schizoaffective Disorder, Bipolar Type.-He/She had a history of verbally/physically aggressive behaviors.-He/She had demonstrated poor medication compliance and had refused long-acting injectable antipsychotics. Review of Resident #2's quarterly MDS, dated [DATE], showed the resident assessed as:-cognitively intact.-displays inattention and disorganized thinking that fluctuated.- physical, verbal, and other behaviors that occurred one to three days per week.- no rejections of cares Review of the Facility Registered Nurse Investigation (RNI), dated 4/24/26 at 10:54 A.M., showed:-The incident was Resident-to-Resident physical altercation with injury.-Resident #1 and Resident #13 were sitting at a table talking when Resident #2 sat at the table.-Resident #2 began making comments toward Resident #1.-Resident #1 told Resident #2 to leave him/her alone and stay away.-The verbal exchange escalated, Resident #2 became aggressive and began striking Resident #1.-Resident #1 sustained visible facial injuries, including two black eyes, scratches under the eyes, injury/marking in the middle of the nose area, abrasion on the right forehead and red marks on both cheeks.-Resident #1 was sent to the hospital for evaluation and treatment.-Police involvement placed on-hold pending guardian coordination (per consent/legal requirements).-Telehealth visit with Psychiatric Nurse Practitioner (PNP) gave order to send Resident #1 to the hospital for eval and treatment.-Resident #1's guardian will contact the police and file assault charges against Resident #2.-The incident was substantiated by the facility investigation for resident-to-resident physical aggression involving Resident #1 and Resident #2, resulting in injury and hospital transfer. Review of Resident #1's Behavior Note dated 4/24/26 at 11:39 A.M., showed:-One-to-one monitoring for resident safety ended on 4/24/26.-Resident went to the hang out and started talking to Resident #13.-Confronted Resident #2 by saying that Resident #13 wanted to break up with Resident #2 and to leave Resident #13 alone.-Then struck Resident #2 with a closed fist to the right cheek.-Resident #2 retaliated by hitting Resident #1 several times in the face causing lumps, surface lacerations and bruising.-Residents were separated by staff.-Resident #1 put back on one-to-one monitoring.-Skin assessment on Resident #1 had abrasion to right cheek, middle forehead, left eye bruising, and lump above left eye. Review of Resident #2's Behavior Note dated 4/24/26 at 12:18 P.M., showed:-Resident #2 confronted Resident #1 for sitting next to Resident #13.-Resident #2 was yelling and cussing Resident #1 out.-Resident #1 told Resident #2 to get out of Resident #13's face and told Resident #2 that he/she and Resident #13 were broken up.-Resident #2 then threatened to kill Resident #1 and Resident #1 struck Resident #2 with a closed fist to the right cheek.-Resident #2 then struck Resident #1 in the face several times.-Resident #2 had a Telehealth visit with Psychiatric Nurse Practitioner (PNP).-Skin assessment on Resident #2 showed bruising to the right cheek. Review of a written statement from Resident #1, dated 4/24/26, showed:-He/She was sitting down talking to Resident #13 in the dining room.-Resident #2 approached him/her and wanted him/her to move.-He/She told Resident #2 that Resident #13 did not want Resident #2 and that Resident #13 wanted another resident.-He/She asked Resident #13 who do you love more, Resident #2 or the other (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	resident, and Resident #2 hit him/her.-Staff came to pull Resident #2 off him/her. During observation and interview on 5/5/26 at 1:04 P.M., Resident #1 said:-Resident #2 got mad because he/she was talking to Resident #13.-Resident #2 hit him/her, knocking him/her out of the chair onto the floor.-Staff came and got Resident #2 off him/her.-He/She had scratches on the bridge of his/her nose from his/her glasses being hit and an abrasion on the right side of his/her forehead.-He/She will stay on one-to-one monitoring until he/she knows what Resident #2 is going to do.-He/She feels safe living at the facility with Resident #2 out of the facility.-He/She went home with his/her guardian from the hospital for the night for safety.-He/She did not sleep that night. Review of Resident #13's annual MDS dated [DATE], showed he/she was cognitively intact. During an interview on 5/6/26 at 2:26 P.M., Resident #13 said:-He/She was sitting at a table talking with Resident #1.-Resident #2 came to the table and started yelling at Resident #1 and attacked Resident #1.-He/She feels safe living at the facility with Resident #2 out of the facility. Review of a written statement from Resident #2, dated 4/24/26, showed:-Resident #2 and Resident #13 were sitting outside in the smoke area talking.-Resident #1 sat down in front of Resident #2 and Resident #13 and said, [Resident #13] is not with you anymore because [Resident #13] is with another resident.-After a slew of curse words at each other, Resident #2 said Resident #1 hit him/her in the face.-Resident #2 said it stung, and he/she became furious and began to constantly hit Resident #1 with rage.-Resident #2 said, I will always defend myself against bullies. During an interview on 5/6/26 at 5:00 P.M., Resident #2 said:-Resident #2 came barging into the interview with the Administrator and the Director of Nursing yelling saying they are lying and taking his/her belongings while in the hospital.-Staff tried to redirect Resident #2 but he/she was not redirectable.-Resident #2 kept yelling Resident #1 hit him/her first in the face.-The facility staff are lying saying he/she hit Resident #1 first.-He/She protected him/herself and hit Resident #1 back.Review of a written statement from Certified Medication Technician (CMT) A, dated 4/24/26, showed:-He/She was walking through the dining room when he/she seen Resident #2 yelling at Resident #1 to stop talking to him.-Resident #2 stood up and started hitting Resident #1.-He/She rushed over to break them up. During an interview on 5/5/26 at 2:03 P.M., CMT A said:-He/She was getting ready to pass noon medications when he/she walked into the dining room from the hallway.-He/She heard Resident #1 and Resident #2 yelling at each other.-He/She was on his/her way over to Resident #1 and Resident #2 when Resident #2 stood up and started hitting Resident #1 in the face.-He/She and other staff separated the resident and took them out of the dining room. Review of a written statement from CMT B, dated 4/24/26, showed:-He/She was in hangout (resident sit and visit with each other) and Resident #2 swung on Resident #1 because Resident #1 was pressing him/herself on Resident #13.-Resident #2 stood over Resident #1 yelling then took off.-He/She ran to the CODE to remove the residents. During an interview on 5/5/26 at 2:18 P.M., CMT B said: -He/She was in the dining room during hangout time watching the residents.-He/She looked over to where the yelling was coming from and seen Resident #2 hit Resident #1.-He/She went over to separate Resident #2 and Resident #1.-Other staff removed the resident and he/she kept watching the other residents. Review of a written statement from Certified Nurse Aide (CNA) A, dated 4/24/26, showed:-Resident #1 and Resident #2 were sitting at the table.-He/She saw Resident #2 punching Resident #1 to the floor.-That was when two staff members jumped into break it up. During an interview on 5/5/26 at 2:46 P.M., CNA A said:-He/She was in the dining room watching the residents.-He/She saw Resident #2 punch Resident #1while on the floor.-It was very noisy during hangout and did not hear any yelling before Resident #2 punch Resident #1.-A Code [NAME] was called for staff members to respond to the dining room.-He/She was not on the code team and continued to watch the other residents for safety. During an interview on 5/5/26 at 11:33 A.M., the psychiatric Nurse Practitioner (PNP) said:-He/She had a telehealth visit with Resident #1 and Resident #2.-He/She gave an order to send Resident #1 to the hospital for evaluation and treatment due to head injuries.-He/She was aware that Resident #2 had been refusing medications for several weeks and was having increased outburst yelling at staff and other residents (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	but nothing physical.-Resident #2 had just came back from an in-patient stay for psychiatric treatment on 4/2/26 due to refusing medications.-Resident #2 says he/she does not need the medications and does not like how the medications make him/her feel.-An order was given for Resident #2 to be placed on a 96 hour hold for psychiatric treatment. During an interview on 5/6/26 at 4:16 P.M., the Administrator and the Director of Nursing (DON) said:- Resident #1 and Resident #2 were separated and away from each other.-Resident #1 was assessed for injuries and it was noted a scratch to the bridge of the nose, abrasion to the right forehead and both eyes had started to turn black and blue.-Telehealth call with PNP, order was given to send Resident #1 to the hospital due to head injuries.-Resident #2 refused telehealth call with PNP and went to his/her room without further incident.-Resident #1 placed on one-to-one monitoring for safety when returned back to the facility. 2294182