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	05/19/2026

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, interviews and record review, the facility failed to ensure that two sampled residents (Resident #1 and Resident #4) out of five sampled residents were free from abuse. On 5/8/26, Resident #2 struck Resident #1 on the face- resulting in a laceration to Resident #1's right eye requiring five sutures. On 5/17/26, Resident #5 kicked Resident #4 in the head resulting in a bump on Resident #4's forehead and a laceration on the scalp requiring two staples. The facility census was 121 residents.Review of the facility 's Abuse and Neglect Policy, dated 6/12/24, showed:-Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations.-Physical Abuse was purposeful beating, striking, wounding, or injuring any resident of any manner whatsoever mistreating or maltreating a resident in a brutal or inhumane manner.-Physical abuse included handling a resident with any more force than is reasonable for a resident's proper control, treatment or management.-Physical abuse also included, but was not limited to, hitting, slapping, punching, biting, and kicking. Review of the facility's Smoking Safety Regulations dated 6/29/23 showed:-The facility will provide direct supervision for smoking by patients classified as not responsible. 1. Review of Resident #2's admission Record face sheet showed the resident admitted to the facility on [DATE] with the following diagnoses:- Schizoaffective disorder, bipolar type, (a chronic mental health condition combining symptoms such as hallucinations, delusions, and disorganized thinking-with major mood disorder symptoms like mania or depression).-Major depressive disorder.-Generalized anxiety, (a mental health conditions characterized by persistent, excessive, and uncontrollable fear or worry that interferes with daily life). Review of Resident #2's Level II Pre-admission Screening and Resident Review (PASRR) dated 7/8/22, showed a history of needing direction and redirection, inability to focus, wandering in hallways, inability to participate in activities requiring an average amount of concentration and focus, history of disorganized and bizarre behavior, and lacking insight into his/her illness. Review of Resident #2's quarterly Minimum data set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 3/9/26, showed the resident assessed as cognitively intact. Review of Resident #1's admission Record face sheet showed the following diagnoses:-Persistent traumatic brain injury, (a progressive, degenerative brain disease linked to repeated head impacts).-Major depressive disorder, (a serious mental health condition characterized by persistent, intense sadness or loss of interest impacting daily life).-Mild cognitive impairment, (intermediate stage between normal aging and dementia).-Mental disorder, not specified-Bipolar disorder, (chronic mental health condition characterized by intense, fluctuating mood shifts including extreme highs and lows).-Concussion with loss of consciousness, (a mild traumatic brain injury caused by a bump, flow or jolt to the head or body). Review of Resident #1's PASRR dated 10/21/20, showed the resident had a history of seizure, memory deficits, aggressive behavior, wandering, requiring frequent redirection and verbal cues, impulsivity, pacing restlessness, medication non-compliance and repeating statements. Review of Resident #1's quarterly MDS dated [DATE], showed the resident assessed as moderately cognitively (continued on next page)

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	impaired. Review of the facility's Registered Nurse Investigation (RNI) dated 5/8/26 showed:-On 5/8/26 at approximately 9:00 A.M., a resident-to-resident altercation occurred on the men's smoke deck involving Resident #1 and Resident #2.-Resident #1 and Resident #2 were on the front hall smoke deck when Resident #1 asked Resident #2 for a cigarette.-Resident #2 refused.-Resident #1 became verbally aggressive, repeatedly using racial slurs and threatening statements toward Resident #2 while approaching closely into his/her personal space.-Resident #2 asked Resident #1 multiple times to back away.-Resident #2 believed Resident #1 was going to physically assault him/her due to his/her aggressive behavior and threats.-Resident #2 then struck Resident #1 one time in the right eye area with a closed fist.-Staff immediately intervened and separated both residents.-Resident #1 sustained a laceration approximately 3-4 cm to the right eye area and was assessed immediately.-Resident #1 later received six sutures.-This was a result of abuse. Review of Resident #1's hospital After Visit Summary dated 5/8/26 showed:-He/She was seen for a facial laceration.-His/her laceration was repaired with 5 sutures. Review of Resident #1's Physical Assessment involving the head dated 5/8/26 showed:-He/She was out on the smoke deck on the front hall.-He/She told Resident #2 to give him/her his/her cigarette and Resident #2's response was to refuse.-Resident #2 was sitting on a bench and Resident #1 approached him/her and called him/her a nigger and got close to his/her face.-Resident #2 told Resident #1 to back up and Resident #1 repeated the racial slur and said, I'll beat your ass.-Resident #2 then hit Resident #1 with a closed fist to the right eye causing a 3-4 cm laceration.-The nurse cleansed and dressed the laceration and Resident #1 was sent to the hospital for further evaluation.-Resident #1 stated, I did not know he/she was mad cause I called him a [racial slang]. I did not know that was why he/she hit me. Oh, man.-Resident #1 was oriented to person but disoriented to time and place. He/She was confused and combative. Review of Resident #1's written statement dated 5/8/26 showed:-He/She did not understand that calling a racial name was wrong.-He/She pushed Resident #2 because Resident #2 had an attitude when he/she asked for a cigarette.-It was not smoke time.-He/She could not get cigarettes, so he/she asked Resident #2 for one of his/hers. Observation and interview on 5/15/26 at 11:00 A.M. showed Resident #1 had approximately 1-inch laceration above his/her right eye. He/She said: -Resident #2 found a cigarette.-Resident #2 and Resident #3 were passing the cigarette back and forth.-He/She did not hit Resident #2.-He/She got close to Resident #2's face.-He/She pushed Resident #2 after Resident #2 hit him/her.-Resident #2 hit him/her because he/she had the cigarette.-Resident #2 hit him/her for no reason over the cigarette.-He/She did not call Resident #2 any names.-It was not a smoke break.-There were two staff out on the smoke deck.-He/She was sent to the hospital.-He/She boxes, so he/she was not afraid of Resident #2.-He/She was upset when Resident #2 hit him/her.-The two of them had not had a fight before. Review of Resident #2's written statement dated 5/8/23 showed:-He/She was smoking a cigarette with Resident #3.-Resident #1 said, Sit over here, [racial slang]. Get your ass up [racial slang].-He/She was offended and terrified of Resident #1 because Resident #1 continued to call him/her out his/her name and talk crazy to him/her.-Resident #1 was in front of Resident #2's face, so Resident #2 hit Resident #1 because he/she was sitting down and Resident #1 was standing over him/her.-He/She stated he/she could have just walked away, but did not want Resident #1 to catch him/her on the low. During an interview on 5/15/26 at 11:25 A.M., Resident #2 said:-He/She was smoking a cigarette on the smoke deck.-It was smoke time.-Resident #3 was also out there.-Resident #1 came out there and called him/her a [racial slang], a slut and a ho, and got in his/her face.-Resident #1 pushed him/her first.-Then he/she hit Resident #1.-He/She did not know how many times he/she hit Resident #1.-He/She did not remember if he/she used a fist.-He/She was not trying to hurt Resident #1, he/she just hit him/her back.-He/She was defending him/herself. Review of the Resident #3's quarterly MDS dated [DATE] showed he/she assessed as cognitively intact. During an interview on 5/15/26 at 11:40 A.M., Resident #3 said:-The other two residents fought about cigarettes.-It was smoke time.-CNA B walked up and saw the two residents fighting and broke it up. Review of the written statement by CNA B (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	dated 5/8/26 showed:-He/She walked by two residents who were arguing.-He/She proceeded to separate the two residents. During an interview on 5/19/26 at 1:25 P.M., CNA B said:-He/She was walking through the hall past the smoke deck.-The smoke deck door was open and it looked like Resident #1 and Resident #2 were arguing.-When he/she went out, Resident #1 was bleeding. 2. Review of Resident #5's admission Record face sheet showed the resident admitted with the following diagnoses:-Asperger's Syndrome (a neurodevelopmental condition characterized by difficulties with social interaction, nonverbal communication, and restricted, repetitive patterns of behavior).-Paranoid Schizophrenia (a chronic mental health disorder characterized by intense, irrational delusions and auditory hallucinations).-Major Depressive Disorder.-Anxiety Disorder.-Mild Intellectual Disability (a neurodevelopmental condition characterized by mild limitations in learning, social, and practical life skills).-Impulse Disorder (a mental health condition characterized by an inability to resist urges or impulses that may harm oneself or others).-Obsessive Compulsive Personality Disorder (a chronic mental health condition characterized by a pervasive, rigid preoccupation with orderliness, extreme perfectionism, and mental/interpersonal control).-Schizoaffective Disorder.-Dissociative Identity Disorder (a complex mental health condition where a person's identity fragments into two or more distinct, alternating personality states). Review of Resident #5's Quarterly MDS dated [DATE], showed the resident assessed as severely cognitively impaired and had behaviors. Review of the resident's undated Care Plan showed:-Per Preadmission Screening and Resident Review (PASRR) Behaviors include physically threatening strikes others provoked.-Has a history of physical aggression toward staff and peers.-Staff should be aware of body stance and facial expressions when approaching the resident.-Staff should closely watch the resident for signs of anxiety and act before he/she loses control.-Staff should not get too close and remember the resident's personal space. Review of Resident #4's admission Record Face Sheet showed the resident admitted to the facility with the following diagnoses:-Disorganized schizophrenia-Bipolar disorder-Anxiety disorder-Unspecified psychosis Review of Resident #5's RNI dated 5/17/26 at 8:04 P.M. showed:-The incident involved physical aggression involving the head.-The incident occurred on 5/17/26 at approximately 8:00 P.M.-The aggressor was Resident #5 and the victim was Resident #4.-On 5/17/26 staff noted that Resident #5 abruptly stood up from his/her chair and approached peer Resident #4 in an aggressive manner without provocation.-Staff observed Resident #5 strike Resident #4 in the head with significant force, causing visible bleeding to the head area.-Nursing staff immediately responded and separated both residents, and stabilized the Resident #4 to prevent additional blood loss.-Vital signs were obtained and Resident #4 remained alert and responsive during assessment.-The resident was transferred to the hospital for further evaluation and treatment.-The incident was substantiated as resident-to-resident physical aggression.-This was a result of abuse. Review of Resident #4's hospital Patient Visit Information dated 5/17/26 showed:-He/She was seen for a head injury and scalp laceration.-The wound on the back of his/her scalp required 2 staples to close. Review of Resident #5's Progress Note dated 5/17/26 at 7:22 P.M. showed he/she attacked Resident #4 unprovoked and kicked Resident #4 with his/her leg, which led to Resident #4 peer bleeding through the head. Observation and interview on 5/18/26 at 11:45 A.M. showed Resident #4 had an approximate 1-inch in diameter bump above his/her left eye, with a small, reddened area in the center and an approximately 1-inch laceration on the back of his/her scalp with 2 staples. He/she said: -He/She didn't know what happened.-He/She was unable to answer any other questions. During an interview on 5/18/26 at 11:55 A.M., Resident #5 said:-He/she did not know about kicking Resident #4.-He/She was in a different body than the one that kicked.-He/She knew what his/her other bodies were doing.-Resident #4 tried to beat him/her up, but he/she stopped him/her.-He/She kicked Resident #4 in the head.-He/She had to switch his/her bodies.-He/She ended the interview at that point. During an interview on 5/18/2.6 at 1:30 P.M, CMT/CNA C said:-He/She was present when Resident #5 kicked Resident #4.-He/She was assigned 1:1 (one staff person to one resident) observation with Resident #5 that day and was sitting next to Resident #5.-Resident #5 was smoking (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	a cigarette and sitting.-Resident #5 stood up and kicked Resident #4 out of nowhere.-Resident #5 then tried to sit back down like nothing had happened. During an interview on 5/19/26 at 10:50 A.M., the Nurse Practitioner said:-Resident #5 was very delusional.-He/She was not sure even being on 2:1 (two staff person to one resident) supervision could have prevented the incident between Resident #4 and Resident #5.-Resident #4 was delusional. That alone could have triggered Resident #5.-A resident who talked out loud to him/herself could be a trigger for Resident #5 if he/she believed he/she was being talked about.-He/She felt the incident between Resident #4 and Resident #5 was behavior related.-Hitting and kicking other residents was abuse. During an interview on 5/19/26 at 11:45 A.M., the Director of Nursing (DON) said:-Resident #5 had not had any structure.-Resident #5 was impulsive and his/her first instinct was to hit and attack.-Resident #4's talking might have triggered Resident #5.-The staff person doing the 1:1 supervision with Resident #5 would not necessarily have known if Resident #4 had been triggering him/her.-He/She thought Resident #5 might have hit the back of his/her head on the railing outside.-The lump on the forehead came from the kick.-It was abuse when residents kick and hit one another. During an interview on 5/19/26 at 1:15 P.M., CMT/CNA D said:-He/She was at the smoke break when Resident #5 kicked Resident #4.-Resident #4 was not doing anything but smoking his/her cigarette.-Resident #4 was sitting on the ground with his/her legs crossed, and Resident #5 was sitting on the [NAME].-Resident #5 was not agitated at the time.-This was abuse, but he/she wishes there were another worse word than abuse to describe it. Incident 3009028, Incident 3016149, 3016151