STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265822	A. BUILDING _____ B. WING _____	06/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.

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F 0742 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to comprehensively assess, develop an individualized care plan and provide necessary treatment and services for one sampled resident (Resident #1) who was admitted to the facility with a history of exit seeking behaviors and eloped from the facility on 1/7/20 and 6/10/20. The resident was located two blocks from the facility after he/she eloped on 6/10/20. Three residents were sampled from the resident's unit, in which 22 residents resided. The facility census was 162 residents. Record review of the facility's policy titled, Monitoring of Residents, dated 4/6/17 showed: -A system is in place for residents who require increased monitoring for behavioral/psychiatric and medical issues. -Residents who require more intensive monitoring is defined as; hourly checks by a Licensed Nurse or one:one monitoring by the designated employee assigned by the Licensed Nurse, a face to face check is defined by the employee visually seeing the face of the resident. -Residents may require more intensive monitoring based on their medical and behavioral/psychiatric needs. -Residents who are showing poor impulse control including verbal/physical aggression, elopement ideation's, suicidal/homicidal ideation's, decompensation mentally or medically may also be placed on one to one or two to one (within eyesight of staff at all times) monitoring at the discretion of the administrative staff. -A one to one or two to one will be determined at the severity of the behavior and at the discretion of the Administrator, Director of Nursing (DON), Management Team and the Physician. -Residents who require intensive monitoring of one to one will have a dedicated staff member at all times within eye sight. -Residents may require based on behavior/medical issues a more intensive monitoring which would require the licensed nurse to visually check the resident more often than every two hours. -All residents on each unit will be monitored by visual checks at least every two hours by the licensed nurse or may be provided more intensive monitoring by the licensed nurse every hour. -Special units will not be left unattended at any time. -Certified Nursing Assistants (CNA's) will continue to monitor residents at the discretion of administration; this provides direction only to the CNA's and the Licensed Nurse will be the only designated employee to guarantee face checks are completed unless the resident requires one to one monitoring by the designated employee assigned by the Licensed Nurse. -CNA's can be provided direction to monitor the resident in a timely manner at the discretion of administration for a medical or behavior decompensation. -The facility recognizes that the Licensed Nurse is the only truly dedicated employee to provide face checks every two hours or if required more intensively every one hour; the facility will not depend on the CNA's to guarantee intensive timely monitoring checks, however, the administration will continue to assign time checks with the understanding that CNA's time may vary based upon the care needs of the resident and assigned duties in the facility. -Licensed Nurses will be required to sign intensive monitoring checks of at least every two hours and leave a voice mail report. -The intensive monitoring checks could be more frequent than two hours based on medical and psychiatric decompensation of the resident. Record review of the facility's policy titled Elopement Policy and Procedures, dated 4/6/17 showed: -The first person aware of an elopement will call a Code White to the area of the believed elopement, if known. -If the resident is believed to possibly still be inside the facility, the first person to be aware of the missing resident is to page for all units to search room to room for the resident. -All rooms, closets, bathrooms, and work areas are to be searched. -If the resident has in fact left the facility, notify the resident's family or guardian. -The person to notify the family or guardian will be designated by the Administrator. -The Charge Nurse on duty will initiate the facility grounds search. -The Charge Nurse on duty will call the police to report the elopement when the resident is not found in the building or grounds. -The Charge Nurse on duty will provide the police department with the following information pertaining to the resident: --Name, sex, age, time discovered missing. --Where the resident was last seen and when. --Physical description (picture if available). ---Height. ---Race. ---Color of hair. ---Color of eyes. --Physical impairments. --Mental impairments. --Language spoken. --Color and type of clothing worn. --If the resident is harmful to self or others. --Home address if any known friends or relatives. -The Administrator will initiate the emergency call list and coordinates the search. -As each person on the call list is notified they will call the next person and then go to the facility to assist with the search. -After the resident has been located and returned to the facility: --Notify the family or guardian. --Notify all persons involved in the search. --Perform a full body assessment. --Obtain vital signs. --Document all findings. --Notify the Physician. --Complete Investigation Elopement Form. --Initiate Intensive Monitoring protocol upon return for attempted/actual elopement. -Notification of state agencies will be at the discretion of the Administrator/designee. 1. Record review of Resident #1's facility face sheet dated 12/5/19 showed: -He/she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].). --Anxiety disorder (a psychiatric disorder causing feelings of persistent anxiety). --Restlessness and agitation (an acute, severe and pathological complication of many chronic psychiatric disorders including [MEDICAL CONDITIONS] includes excess motor activity coupled with a feeling of inner anxiety). Record review of the resident's most recent Pre-admission Screening for Mental Illness/Mental [MEDICAL CONDITION] or Related Condition (PASARR) dated, 7/31/19 showed: -He/she had a [DIAGNOSES REDACTED]. -Oriented to person, place and time. -Problematic behaviors: --Cursing/swearing. --Disturbs other residents. --Physically threatening. --Tries to escape. --Suspicious of others. --Had functional limitations in interpersonal functioning, concentration, persistence, pace, or adaptation to change with the last six months. -Had required intensive treatment or has received supportive services for an episode of significant disruption within the last two years. -Had serious mental illness as defined by PASARR. -Did not need specialized psychiatric services which can only be provided in an inpatient psychiatric setting. -Did need psychiatric rehabilitative services of a lesser intensity which can be provided by the nursing facility. Record review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool the facility uses for care planning), dated 3/11/20 showed: -Brief Interview of Mental Status (BIMS) score of 15, which indicates the resident has no cognitive deficits. -Behaviors exhibited during this period showed: --Delusions (a belief or altered reality that is persistently held despite evidence or agreement to the contrary, generally in reference to a mental disorder). --Hallucinations (a perception of having seen, heard, touched, tasted, or smelled something that wasn't actually there). --Wandering not exhibited. -Resident was independent (required no assistance from staff or staff oversight) for Activities of Daily Living (ADLs-routine activities people do every day without assistance, such as: eating, bathing, getting dressed, toileting, transferring and continence). Record review of the resident's care plan dated 12/13/19 and updated on 1/7/20 and 6/9/20 showed: -Resident was a high elopement risk and has eloped from two or more prior facilities. -had a history of [REDACTED]. -Monitor behavior of exit seeking, report to DON, Administrator and Resident Care Coordinator any behaviors of curiosity of vent systems, ceiling tiles, etc. -Resident is impulsive and may just attempt to run at any time or location. -Place

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

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.

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F 0742 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) resident's photo in elopement book and all resident statistics. -Report immediately to DON, Administrator, Guardian and police if resident is unable to be located. -Resident eloped from courtyard of facility on 1/7/20 by climbing railing onto the roof, Physician, Guardian and Police notified, resident was recovered 0.7 miles from facility within hours after elopement. -Update of care plan on 1/7/20 showed: --Resident will be one to one for any outside appointments. --Resident will be one to one for all outside resident activities. --Resident will have elopement assessment completed quarterly and as needed. --When staff has the resident outside on facility grounds, the staff member will have a walkie talkie and/or cell phone to notify the facility front desk/designee if the resident tries to elope from facility and elopement protocol will be intimated. --When out of the facility the resident will have one on one escort and staff will notify facility via phone or walkie talkie to activate elopement protocol. -Update of care plan on 6/9/20 showed: --The resident forcibly opened fire door and eloped to wooded area, returned to facility via staff and assessed, no injury, no reason for elopement, one on one for protective oversight. --Local police department notified, state and guardian notified, all staff notified and search began after code white (elopement) called. Record review of the resident's Elopement Risk assessment dated [DATE] showed a cumulative score of 26, which indicated the resident was a high elopement risk. 2. Record review of Resident #4's annual MDS dated [DATE] showed a BIMS score of 12 out of 15 which indicated the resident was cognitively intact. 3. Record review of the facility's investigation dated 6/9/20 showed: -At 5:30 P.M., on 6/9/20 Certified Medication Technician (CMT) A was cleaning up water in a room on the men's back hall. -He/she heard two loud bangs and the door alarm sound from the exit door at the south end of the back hall. -CMT A immediately came out of the room that he/she was working in and observed the exit door to be open and the alarm was going off. -CMT A immediately notified the Administrator that the back door had been kicked open. -The Administrator immediately notified the Worlds of Focus Coordinator to go to the back hall and assist the staff to search every room to check for any residents that did not come to dinner. -The DON was in the dining room and immediately initiated a head count of all residents with the assist of staff. -The Administrator and Assistant Administrator immediately went outside to search around the building. -During the search surrounding the building, the DON notified the Administrator via phone that Resident #1 was unable to be located within the facility. -The Code team was then assembled and the search for Resident #1 was initiated per facility protocol outside of the facility by the entire Code Team. -The Code team searched for the resident outside of the facility starting around 5:40 P.M. -At 5:40 P.M., the DON notified the local police department and guardian of the resident that the resident had left the building without prior authorization. -At 5:45-5:50 P.M., Local police arrived at the facility and collected information to identify the resident and gave assistance with the search for Resident #1. -At 6:00 P.M., Maintenance staff returned to the facility and the fire door was reinforced by Maintenance staff. -The DON notified Division of Health and Senior Services (DHSS) at 9:00 P.M. -The resident was taken into facility custody at approximately 9:15 P.M., by the Administrator and was returned to the facility. -The DON notified DHSS of the resident return to the facility at 9:30 P.M. -Upon arrival of resident's return to the facility he/she was assessed by the charge nurse on duty and placed on one to one intensive monitoring until is/her transfer to the hospital for evaluation. -Resident #1 was interviewed by the Administrator and stated, My Bible keeps telling me to leave, I kept kicking the door. The door opened and I took off, I jumped over the fence and headed into the woods. -The facility concluded that It is reasonable to believe that his incident was not caused by abuse or neglect and was not preventable and is not a previous ongoing problem that the facility could have foreseen due to prior history and there is no reasonable predictability for this due to protective oversight is provided 24 hours a day. -The fire door alarm sounded. -A staff member notified the Administrator immediately of the elopement. -An immediate search was initiated which included the local police. -The resident was located near the facility and returned unharmed with no injuries. -Care Plan changes: --Assessment by nurse. --hospitalization evaluation and treatment. --Special Focus List. --Reinforce the exit doors to 12,000 pounds Maglock system (Hybrid design of magnetic electromechanical lock includes two springloaded, hardened steel jaws that deliver up to 4,000 pounds of holding power. In a forced-entry assault, the jaws of the lock clamp down on the armature plate and hold firm). --Continue to seek discharge placement. --Continue behavior monitoring one on one. -There was one staff (CMT A) and two residents including Resident #1 at the time of the incident. During an interview on 6/10/20 at 10:00 A.M., the resident said: -He/she just broke through the door. -He/she just slammed it open. -He/she climbed over the fence when he/she got out. -He/she doesn't know why he/she wanted to leave or where he/she was going. -He/she said Resident #4 helped him/her, and then corrected him/herself and said no, that Resident #4 was sitting on the couch and the rest of the residents on the unit were eating in the dining room. -A few times he/she had tried to get out that door and it didn't work but this time it worked. During an interview on 6/10/20 at 10:45 A.M., Resident #4 said: -He/she was sitting on the couch when he/she heard the bangs. -Did not help Resident #1 kick the door. During an interview on 6/10/20 at 11:00 A.M., CMT A said: -It was about 5:30 P.M., on 6/9/20. -All of the residents were in the dining room except for Resident #1 and Resident #4. -He/she stayed on the unit, as two of the residents did not want to go to the dining room. -He/she was in a resident's room wiping up spilled water, and that he/she was to stay on the unit with the other two residents. -That is when he/she heard two loud bangs and the door alarm. -He/she rushed out of the room to find that Resident #1 was not in sight and Resident #4 was sitting on the couch. -He/she called the receptionist to call a Code White (elopement). -He/she was told that the resident was found walking down a trail by the administrator. -He/she said the resident told him/her that he/she was leaving the facility because he/she wanted a beer. -He/she said that he/she did not know if Resident #1 had tried to open the door before. -They do hourly visual checks on Resident #1. During an interview on 6/10/20 at 11:30 A.M., Staff B (World of Focus Coordinator) said: -World of Focus is a free program the facility uses to focus on residents one on one. -If the resident chooses to participate, the program will enable the resident to be engaged in his/her care. -The program is incentive based, as when they finish the program, we recommend that they go to a less restrictive environment. -Resident #1 participates in the program and engages with him/her weekly at minimum. -We are assigned residents, and document on their behavior daily. -There was no suggestion in his/her meetings with the resident, that the resident was going to elope from the facility. -The resident was on hourly visual checks. During an interview on 6/10/20 at 11:50 A.M., the Maintenance Director said: -The regular egress (the action of going out of, or leaving a place) has 4,000 pounds per lock. -This means that it would theoretically require 4,000 pounds of pressure to open the lock. -The facility was adding another lock now, to the bottom of the door, and with the existing lock at the top of the door, that is 8,000 pounds of pressure required to open the door. -The facility has ordered an additional lock to place in the middle of the door, which will bring the amount of pressure required to open the door to 12,000 pounds. -He/she thinks what happened was when the resident kicked the door, it sort of torqued (a twisting motion) at the bottom of the door, and the door opened. -The door was new in September of 2019. -The facility was also adding additional Maglocks to the remaining doors on the unit, so that each door will have multiple maglocks. -Maintenance Director was not aware that Resident #1 had tried to open the door previous to this incident. Observation on 6/10/20 at 11:55 A.M., showed the Maintenance Director kicked the bottom of the door twice and the door torqued open approximately four inches, before adding the additional mag lock. During an interview on 6/10/20 at 12:10 P.M., the MDS Coordinator said: -After the last incident of elopement with Resident #1, they put elopement care plans in place for all of the residents who were an elopement risk. -Was not aware that the resident had tried to open the door previously. -The staff monitor the resident's on that unit with visual checks hourly. During an interview on 6/10/20 at 12:15 P.M., the DON said: -When Resident #1 eloped in January, they increased monitoring. -The resident did not have any further issues, no exit seeking behaviors, so he/she allowed the team to lower the the frequency of monitoring. -The only staff on the unit at the time of the elopement was CMT A. -CMT A was expected to monitor the two residents that did not go to the dining room. -The only residents on the unit at the time were Resident #1 and Resident #4. -The rest of the staff were in the dining room with the remaining residents. -A nurse and two CNA's were in the dining room. -The CMT was going back and forth on the unit checking rooms for any other residents and found a spill. -They do behavior monitoring by exception. -If a resident exhibits a behavior, we document the behavior in American Health Technology (AHT) electronic charting system. -Then, we place the resident's chart on the hot rack (designated rack for frequent charting). -If a resident is not having behaviors, a nurse would not chart in a nurses note or place the chart on the hot rack. -We perform visual checks on all residents every two hours. -The physician or the nurse practitioner sees the residents weekly and psychiatrist sees the residents quarterly. -Every 30 days, he/she knows that the resident is seen either by medical or psychiatric staff. -Resident #1 had no behaviors documented. -They will keep the resident on one to one monitoring until we are given the okay to send the resident to an out of town psychiatric facility. -When the resident comes back from that facility, they will see what the psychiatric recommendations are, but may have to keep the resident on one to one observation. -Was not aware that Resident #1 had tried to open the door previously. During an interview on 6/10/20 at 1:00 P.M., The Administrator said: -The maglock was 4,000 pounds. -The second maglock would require 8,000 pounds

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F 0742 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) of pressure to open. -The third maglock to be installed will require 12,000 pounds of pressure to open. -It is just amazing that the resident was able to open the door with the 4,000 pound maglock. -They are still working on transferring the resident to the out of town psychiatric hospital. -The resident will remain on one to one observation until he/she transfers out of the building. -They had sent the resident to the hospital for evaluation and treatment right after the elopement, but the hospital sent him/her right back and said that there was no reason to keep him/her. -When the resident returns from the hospital, we will keep him/her on one to one until we can find alternative placement for him/her, to a facility that maybe can meet his/her needs. -Was not aware that Resident #1 had tried to open the door previously. During an interview on 6/19/20 at 8:35 A.M., the resident's Guardian said: -He/she doesn't know what the facility can do to keep the resident safe, he/she has escaped from everywhere he/she has ever been. -He/she was part of the homeless community for years, and feels like he/she has picked up a lot of tricks to manage confinement. -Resident is very smart, facility reports to me that he/she tries to sneak silverware out of the dining room to use to try and get out, so the staff have to monitor that at each meal. -He/she just doesn't know what else to do. During an interview on 6/16/20 at 2:00 P.M., the resident's physician said: -This resident is very, very smart. -He/she doesn't know what the answer is to keep him/her safe. -The resident is like El Chopo he/she keeps escaping. -The only thing that a facility can do with a resident like this, is maybe keep the resident on one to one observation. -He/she doesn't know how facilities can do this, and sees this more and more frequently. -Was not aware that Resident #1 had tried to open the door previously. MO 233