

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 11/15/2024
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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35013</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were securely stored for two medication carts when on 11/2/24 and 11/3/24 staff left two medication carts unlocked and unattended and four residents (Residents #1, #2, and #3, and #4) were able to obtain medications from the carts. Residents #1, #2 and #3 accessed the unlocked cart obtaining Metformin (a drug for diabetes), Seroquel (a drug for psychiatric disorders), and Buspirone (a drug used to treat anxiety). Resident #4 accessed the narcotic box and took sixteen 5 milligram (mg) tablets of Oxycodone (narcotic). Resident #4 said he/she ingested 11 tablets. The facility census was 154 residents.</p> <p>The Administrator was notified on 11/13/24 at 4:45 P.M., of the Past Non-Compliance Immediate Jeopardy (IJ) which began on 11/3/24. Upon discovery, all staff were in-serviced on medication storage. The IJ was corrected 11/5/24.</p> <p>Review of the facility Medication Storage Policy, revised 5/18/24, showed:</p> <p>-The purpose of the policy was to ensure all medications housed on facility premises were stored using proper security.</p> <p>-All drugs were to be stored in locked medications carts with only authorized personnel having access to the keys to the medication carts.</p> <p>-During medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage cart.</p> <p>-All narcotics and controlled medications were to be stored under double lock and key.</p> <p>1. Review of Resident #1's Preadmission Screening and Resident Review (PASRR, a required assessment tool used to ensure individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care), dated 12/10/20, showed:</p> <p>-He/She had the following diagnoses:</p> <p>--Bi-Polar Disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs).</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>--Psychotic Disorder (a group of symptoms that describe a severe mental disorder where a person loses touch with reality).</p> <p>-- Schizoaffective Disorder (a mental condition that causes loss of contact with reality and mood problems).</p> <p>--Unspecified Mood Disorder (a variety of conditions characterized by a disturbance in mood as the main feature).</p> <p>--Psychotic Disorder (a mental disorder in which there is a severe loss of contact with reality).</p> <p>--Traumatic Brain Injury related to a frontal lobe ablation (a surgical procedure to the front and side of the brain, done to treat seizure disorders) in attempt to control a chronic seizure disorder (TBI-damage to the brain usually due to an external force),</p> <p>-He/she had a history of substance abuse in the past, including methamphetamine (a powerful and highly addictive stimulant drug that effects the brain) and marijuana (a mind-altering drug produced by the Cannabis sativa plant).</p> <p>-He/she made poor decisions with issues staying on task.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff and used for care planning), dated 8/14/24, showed he/she:</p> <p>-Was cognitively intact.</p> <p>-Had delusions (misconceptions or beliefs that are firmly held, contrary to reality).</p> <p>Review of the resident's nursing care plan, dated 11/3/24, showed:</p> <p>-He/she had a history of illicit drug use.</p> <p>-The resident was to obtain his/her medications only from the staff in the designated area only.</p> <p>2. Review of Resident #2's PASRR dated 3/13/20, showed:</p> <p>- Diagnoses including Schizoaffective Disorder and methamphetamine use.</p> <p>-History of unpredictable behaviors.</p> <p>-He/she made poor decisions.</p> <p>Review of the resident's nursing care plan, dated 10/6/24, showed:</p> <p>-He/she required medication monitoring, set-up and administration.</p> <p>-He/she had a history of behaviors requiring protective oversight.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #2's written statement, dated 11/3/24, showed:</p> <ul style="list-style-type: none"> -On the evening of 11/2/24, Resident #3 and Resident #1 saw the medication cart was unlocked, so they decided to steal from it. -All he/she knew was that when he/she came out of the quiet room, Resident #1 and Resident #3 were stuffing medication cards into their shirts and pants. -Later on that night, the facility staff searched his/her room and asked if he/she knew where any of the pills were. -He/she told the staff that he/she had an empty prescription card and he/she showed it to the staff stating someone else put it there and that was all he/she knew. <p>During an interview on 11/13/24 at 12:06 P.M., Resident #2 said:</p> <ul style="list-style-type: none"> -Resident #1 and Resident #3 did it. -They kept saying to do it, so he/she did it and took a medication card. -He/she did not ingest any medicine. <p>Review of Resident #3's written statement, dated 11/3/24, showed:</p> <ul style="list-style-type: none"> -He/she took some medications out of the medication cart and there were seven in the card. -He/she got the medication card because he/she heard another resident hollering about it. -The medication cart was already open when he/she took the medication card. -He/she did not get to take any more, because Resident #1 got all but one card, so one card was all he/she got. <p>During an interview on 11/13/24 at 12:14 P.M., Resident #3 said:</p> <ul style="list-style-type: none"> -He/she took some medicine from the medication cart, but he/she didn't ingest any medicine because the staff got the medication card from him/her. -He/she found the cart unlocked. <p>Review of LPN A's undated written statement showed:</p> <ul style="list-style-type: none"> -He/she noticed there were some crushed medications which needed to be administered so he/she walked away from the medication cart to administer those with the oncoming nurse attending to the cart. -Ambulance staff also arrived to take another resident to the hospital so he/she also had to provide the paperwork for the hospital transfer. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-He/she then counted narcotics with LPN B and gave LPN B the keys.</p> <p>-There were residents standing and sitting around the medication cart and they were told to leave during the cart count.</p> <p>-He/she finished the medication cart count, assisted another resident to the bathroom and went to clock out for home.</p> <p>-He/she found no issues with the medication cart count at shift change and he/she knew he/she locked the cart.</p> <p>During an interview on 11/21/24 at 4:45 P.M., LPN A said:</p> <p>-He/she had nothing to do with the medication cart having been unlocked.</p> <p>-He/she counted the medications with the oncoming nurse who then had the keys.</p> <p>-He/she knew he/she locked the cart when he/she left to administer the crushed medications.</p> <p>-He/she had no idea how the residents got into the medication cart to take any medication cards.</p> <p>Review of LPN B's written statement, dated 11/2/24, showed:</p> <p>-He/she was not working the unit where the medication cards were taken.</p> <p>-He/she just offered to help count narcotics as the oncoming nurse on that unit was running late and he/she wanted to help.</p> <p>-He/she counted with LPN A and kept the keys to the narcotic box until the night shift nurse could get there to re-count.</p> <p>-All that he/she knew was that once the oncoming nurse arrived on the unit, he/she counted with LPN A and went to the unit where he/she was assigned.</p> <p>During an interview on 11/21/24 at 6:00 P.M., LPN B said:</p> <p>-He/she was just helping out the day shift and counting the medication cart as the night shift nurse was running late.</p> <p>-He/she simply counted and kept the narcotic keys until the night shift nurse arrived and he/she counted again with that person.</p> <p>-By the time he/she counted with the night shift, everything had been figured out regarding the missing medication cards.</p> <p>During an interview on 11/13/24 at 4:30 P.M., Nurse Practitioner (NP) A said:</p> <p>-He/she was notified of the incident a little while after it happened.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>--Mood Disorder (a variety of conditions characterized by a disturbance in mood as the main feature).</p> <p>--Schizophrenia.</p> <p>-He/she had a substance related disorder.</p> <p>-His/her medications were to have been ordered, stored, and administered by the facility staff.</p> <p>-He/she was appropriate for long term care placement.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed he/she:</p> <p>-Was cognitively intact.</p> <p>-Showed verbal aggression toward others one to three days per week.</p> <p>-Showed other behavioral symptoms not directed at others such as wandering, rummaging, screaming, scratching or hitting self, one to three days per week.</p> <p>Review of the resident's nursing care plan, dated 9/2/24, showed:</p> <p>-He/she had a history of substance and alcohol abuse.</p> <p>-He/she was to attend therapeutic education groups.</p> <p>-He/she had a history of bringing contraband into the facility.</p> <p>-The resident was caught smoking marijuana in his/her room [ROOM NUMBER]/3/24.</p> <p>-The staff was to provide education for the resident in regard to the rules of not having any contraband in the facility.</p> <p>-On 11/3/24, the resident was noted to have taken a card of Oxycodone from an unlocked and unattended medication cart, according to him/her, taking 11 Oxycodone tablets.</p> <p>-The resident was sent to the hospital and upon return was immediately placed on one-to-one staff observation.</p> <p>-The staff increased their assessments of the resident and he/she showed no negative signs or symptoms from ingesting the medication.</p> <p>-The resident was to obtain his/her medications only from the staff in the designated area only.</p> <p>-The medication cart was to never be unattended and/or unlocked.</p> <p>Review of the Facility RNI, dated 11/4/24 at 11:23 A.M., showed:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-He/she attempted to state that he/she gave the remaining pills to other residents and staff who all denied having any knowledge of the incident.</p> <p>Review of Resident #4's written statement, dated 11/3/24, showed the drawer was unlocked so he/she took the card of Oxycodone.</p> <p>During an interview on 11/13/24 at 11:31 A.M., Resident #4 said:</p> <p>-He/she was coming down the hall from getting a soda, saw the medication cart unlocked with the keys in the narc box, he/she opened it, took the first card and stuffed it down his/her pants.</p> <p>-He/she took the medication card and took 11 of the pills, four of them at 3:00 P.M., four of them at 5:00 P.M. , and three of them at 6:00 P.M.</p> <p>-He/she gave the other five to resident's and staff.</p> <p>-The CMT should have been told to keep his/her keys and lock the medication cart.</p> <p>Review of CMT B's written statement, dated 11/3/24, showed:</p> <p>-He/she had his/her cart locked the whole day and the keys were in his/her possession.</p> <p>-He/she did recall throwing the keys away when he/she organized the cart so could have thrown the keys away.</p> <p>During an interview on 11/3/24 at 2:37 P.M., CMT B said he/she left the keys in the narcotic box with the cart unlocked when he/she went to fill the water pitcher for the medication cart.</p> <p>Review of Resident #5's quarterly MDS dated [DATE] showed he/she was cognitively intact.</p> <p>Review of Resident #5's written statement, dated 11/3/24, showed:</p> <p>-He/she saw Resident #4 walk around the medication cart when CMT B walked away.</p> <p>-Resident #4 then bent down, opened the medication cart drawer and pulled something out.</p> <p>-Resident #4 then backed up toward the vending machines before walking forward like he/she was coming out of the vending room.</p> <p>During an interview on 11/13/24 at 11:15 A.M., Resident #5 said:</p> <p>-He/she saw Resident #4 take something from the medication cart right before the 4:30 P.M., smoke break.</p> <p>-At shift change he/she told CMT B and LPN D what happened.</p> <p>Review of Resident #4's hospital Patient Visit Information sheet, dated 11/3/24, showed:</p> <p>(continued on next page)</p>		

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 11/15/2024
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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-He/she was treated after taking Oxycodone throughout the day.</p> <p>-He/she was stable to return to the facility.</p> <p>-He/she voiced no thoughts of harming himself/herself or others and stated he/she did not take the medication in attempt to end his/her life.</p> <p>-It was recommended the resident avoid drug and alcohol use in the future.</p> <p>-He/she was to follow up with his/her physician in two to three days.</p> <p>During an interview on 11/13/24 at 11:18 A.M., Unit Manager A said:</p> <p>-He/she was leaving for the day when he/she saw that CMT B showed a card of Oxycodone 5 mg were missing from a medication cart.</p> <p>-CMT B told LPN C who was the charge nurse.</p> <p>-LPN C then searched the medication cart and overflow cart before search both carts himself/herself without locating the card of Oxycodone.</p> <p>-He/she notified the DON of the incident and staff began looking in resident's rooms for the medication card.</p> <p>-As he/she was finishing his/her call to the DON, Resident #5 came and told CMT B that he/she had seen Resident #4 getting into the medication cart.</p> <p>-He/she went to Resident #4's room and found the medication card of Oxycodone rolled up in his/her basketball shorts.</p> <p>During an interview on 11/13/24 at 3:04 P.M., LPN D said:</p> <p>-The medication card of oxycodone was discovered between 3:00 P.M., and 4:00 P.M., during the narcotic count with CMT B.</p> <p>During an interview on 11/13/24 at 4:30 P.M., NP A said:</p> <p>-He/she was informed about Resident #4 having stolen Oxycodone from an unlocked medication cart because the keys had been left inside the narcotic box.</p> <p>-Resident #4 had a strong history of illicit drug use and had recently been caught smoking marijuana in the facility.</p> <p>-He/she does not believe the resident actually ingested any of the oxycodone as he/she did not test positive for opiates.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-If any other resident, especially a resident who did not have a history of drug use had ingested 11 Oxycodone tablets in the time frame the resident allegedly ingested the medication, would likely go to sleep and not wake up.</p> <p>-It was very dangerous to leave keys in the narcotic box and the medication cart unlocked as the residents residing in the facility were very vulnerable to stealing medications and harming themselves.</p> <p>-He/she would have expected CMT B to have locked the cart and taken the keys with him/her, never leaving the medication cart unlocked and unattended.</p> <p>-The frustrating part was that CMT B had been educated to lock his/her cart and always keep the keys with him/her, just a couple of hours prior to the incident.</p> <p>During an interview on 11/14/24 at 2:30 P.M., the DON said:</p> <p>-After the first medication misappropriation, all staff who provided medication to residents were educated on keeping the medication carts locked when not passing medications and to always have the medication cart keys with them.</p> <p>-The last of the staff, including CMT B had just been educated on medication cart management about two hours before the second incident happened with the Oxycodone.</p> <p>-He/she expected all CMTs and licensed staff to never leave a medication cart unattended and unlocked.</p> <p>-If the medication cart was unlocked, he/she expected the person responsible for that medication cart to be directly in front of the cart.</p> <p>-He/she expected the person in charge of the medication cart to always keep the keys to the cart with them at all time.</p> <p>During an interview on 11/14/24 at 2:45 P.M., the Administrator said:</p> <p>-There were no videos of this incident. Resident #5 was the only witness.</p> <p>-He/she expected all facility staff who provided medications to residents keep the medication cart always locked when not attended. CMT B should not have left the keys in or on the cart unattended and walked away for any reason.</p> <p>-He/she expected the staff in charge of the medication cart to keep the keys with them at all times, never leaving them in the narcotics drawer.</p> <p>#MO00244597</p> <p>#MO00244569</p>