

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/31/2026
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)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to follow the facility policy and ensure timely and correct documentation of medication administration and pre-signed medication was administered prior to the medication being administered for two sampled residents (Resident #1 and Resident #5) of eight sampled residents. The facility census was 114 residents. Review of the facility's policy titled Medication Administration Policy, dated 06/26/24, showed:-It was the policy of this facility to ensure the safe and effective administration of all medications by utilizing best practice guidelines.-Staff were to ensure that the six rights of medication administration were followed:--Right resident.--Right medication.--Right dosage.--Right route.--Right time.--Right documentation.-Staff were expected to sign the medication administration record (MAR) after administering the medications.-Staff were expected to report and document any adverse side effects or refusals. 1.Review of Resident #1's admission Record showed he/she admitted to the facility with a diagnosis of Diabetes Mellitus (DM- a metabolic disease). Review of the resident's Physician Order Sheet (POS), dated July 2026, showed:-An order for Atorvastatin Calcium (used to treat high cholesterol) Oral Tablet 80 milligrams (mg), take one tablet by mouth in the morning for hyperlipidemia (high cholesterol).-An order for Ezetimibe (used to treat high cholesterol) Oral Tablet 10 mg, give one tablet by mouth in the morning related to high cholesterol.-An order for Farxiga (used to improve blood sugar levels) Oral Tablet 10 mg, give 10 mg by mouth one time a day for DM.-An order for Gabapentin (used to treat nerve pain) Oral Capsule 100 mg, give one tablet by mouth at bedtime for polyneuropathy (a medical condition where many peripheral nerves malfunction at the same time).-An order for Invega (used to treat severe mental and mood disorders) Oral Tablet Extended Release 24-hour three mg, give one tablet by mouth in the morning related to schizoaffective disorder (a mental health condition that includes features of both schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves) and a mood disorder).-An order for Lisinopril (used to treat high blood pressure and heart failure) Oral Tablet 20 mg, give 20 mg by mouth one time a day for DM.-An order for Mirtazapine (used to treat depression) Oral Tablet 30 mg, give one tablet by mouth at bedtime related to major depressive disorder (MDD- a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).-An order for Omeprazole (used to treat heartburn) Oral Capsule Delayed Release 40 mg, give one capsule by mouth in the morning related to gastro-esophageal reflux disease (GERD- when stomach contents leak backwards into the esophagus) without esophagitis (inflammation or irritation of the lining of the esophagus).-An order for Sertraline hydrochloride (HCl) (used to treat depression) Oral Tablet 100 mg, give one tablet by mouth at bedtime related to MDD.-An order for Clonazepam (used to treat seizure or panic disorders) Oral Tablet one mg, give one tablet by mouth two times a day related to anxiety disorder.-An order for Topiramate Oral Tablet 200 mg, give one tablet by mouth two times a day related to schizoaffective disorder.-An order for Fiber Oral Tablet 625 mg, give one tablet by mouth (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	three times a day for constipation.-An order for Tramadol HCl (used to manage moderate to moderately severe pain) Oral Tablet 50 mg, give one tablet by mouth three times a day related to low back pain. An interview with Resident #1 was attempted on 07/30/26 at 12:00 P.M., but the resident refused to speak with surveyor on-site. Review of the residents July 2026 electronic Medication Administration Record (eMAR) on 07/30/26 at 1:25 P.M. showed: -The resident missed four out of 29 opportunities of administration related to his/her Atorvastatin Calcium Tablet.-The resident missed two out of 30 opportunities of administration related to his/her Ezetimibe Oral Tablet.-The resident missed two out of 30 opportunities of administration related to his/her Farxiga Oral Tablet.-The resident missed four out of 29 opportunities of administration related to his/her Gabapentin Oral Capsule.-The resident missed two out of 30 opportunities of administration related to his/her Invega Oral Tablet.-The resident missed two out of 30 opportunities of administration related to his/her Lisinopril Oral Tablet.-The resident missed four out of 29 opportunities of administration related to his/her Mirtazapine Oral Tablet.-The resident missed two out of 30 opportunities of administration related to his/her Omeprazole Oral Capsule.-The resident missed four out of 29 opportunities of administration related to his/her Sertraline Oral Tablet.-The resident missed five out of 59 opportunities of administration related to his/her Clonazepam Oral Tablet.-The resident missed five out of 59 opportunities of administration related to his/her Topiramate Oral Tablet.- The resident missed nine out of 88 opportunities of administration related to his/her Fiber Oral Tablet.-The resident missed nine out of 88 opportunities of administration related to his/her Tramadol Oral Tablet. Review of the resident's paper July 2026 Medication Administration Record (MAR), printed on 07/30/26 at 3:15 P.M., showed:-Certified Medication Technician (CMT) D had signed off as administering all of the missed opportunities of the resident's Atorvastatin Calcium Tablet. -CMT D had signed off as administering all of the missed opportunities of the resident's Ezetimibe Oral Tablet.-CMT D had signed off as administering all of the missed opportunities of the resident's Farxiga Oral Tablet.-CMT D had signed off as administering all of the missed opportunities of the resident's Gabapentin Oral Capsule.-CMT D pre-signed the resident's Gabapentin Oral Capsule as administered even though the medication was not due until 7:00 P.M. on 07/30/26.- CMT D had signed off as administering all of the missed opportunities of the resident's Invega Oral Tablet.- CMT D had signed off as administering all of the missed opportunities of the resident's Lisinopril Oral Tablet.- CMT D had signed off as administering two of the missed opportunities of the resident's Mirtazapine Oral Tablet.- CMT D had signed off as administering all of the missed opportunities of the resident's Omeprazole Oral Capsule.- CMT D had signed off as administering all of the missed opportunities of the resident's Sertraline HCl Oral Tablet.- CMT D had signed off as administering all of the missed opportunities of the resident's Clonazepam Oral Tablet.- CMT D had signed off as administering all of the missed opportunities of the resident's Topiramate Oral Tablet.- CMT D had signed off as administering all of the missed opportunities of the resident's Fiber Oral Tablet.- CMT D had signed off as administering all of the missed opportunities of the resident's Tramadol HCl Oral Tablet. During an interview on 07/31/26 at 9:05 A.M., CMT D said:-He/She documented Resident #1's medication administration for the missing days on 07/30/26.-He/She thought that he/she had completed all of the documentation within the appropriate timeframe until 07/30/26.-He/She had been using a hotspot to document medication administration in real time due to internet issues at the facility, but the hot spot had intermittent issues.-The staff were also given remote access so staff could use their personal phones to document.-He/She had been directed on 07/30/26 to sign off on Resident #1's paper MAR by the Director of Nursing (DON).-He/She had signed off Resident #1's Gabapentin Oral Capsule accidentally when he/she had been asked to sign Resident #1's paper MAR.-Staff should (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his/her Gabapentin Capsule.-The resident missed 11 out of 87 opportunities of administration related to his/her Valium Oral Tablet. Review of the resident's paper July 2026 MAR, printed on 07/30/26 at 3:15 P.M., showed: -Only one page of the paper MAR was received.-CMT B had signed off as administering all of the missed opportunities of the resident's Timolol Maleate Solution 0.5% eye drops. -CMT B pre-signed the resident's Timolol Maleate Solution 0.5% eye drops as administered even though the medication was not due until 7:00 P.M. on 07/30/26. -CMT B had signed off as administering all of the missed opportunities of the resident's Gabapentin Capsule.-CMT B had pre-signed the resident's Gabapentin Capsule as administered even though the medication was not due until 7:00 P.M. on 07/30/26. -CMT B had signed off as administering all of the missed opportunities of the resident's Valium Oral Tablet.-CMT B had pre-signed the resident's Valium Oral Capsule as administered even though the medication was not due until 7:00 P.M. on 07/30/26. During an interview on 07/31/26 at 9:48 A.M. CMT B said:-The internet had stopped working and was using a hot spot to document medication administration.-His/Her hot spot stopped working but he/she did not have access to a paper MAR at that time.-He/She had not used a paper MAR before.-He/She had been asked by the DON on 07/30/26 to sign off on Resident #5's MAR.-He/She signed off on Resident #5's Timolol Maleate Solution 0.5%, Gabapentin Oral Capsule, and Valium Oral Tablet accidentally when he/she had been asked to sign Resident #5's paper MAR.-Staff should never document that a medication was administered before administering the medication.-Resident #5 did receive all of his/her medication.-He/She should not have back documented Resident #5's medication administration on Resident #5's paper MAR.-He/She should have requested a paper MAR from nursing management when he/she was having issues with his/her hot spot.-Staff were expected to document medication administration as close to the actual administration time as possible.-He/She did not follow facility policy or the five rights of medication administration when he/she documented on Resident #5's paper MAR on 07/30/26. 3. During an interview on 07/30/26 at 1:41 P.M., CMT C said:-If a resident refused medication, the staff were expected to report the refusal to the nurse and the DON.-The staff were also expected to document a progress note related to the refusal.-If a resident refused a medication or if there was another reason why a resident missed a medication then staff were to mark no on the MAR.-When staff mark no on the MAR a different screen will pop-up and the staff could indicate why and make a progress note. -He/She looked at the eMAR and said there was no reason for all of the missing documentation related to Resident #1's and Resident #5's eMARs. -The DON would normally follow up with staff after each shift to ensure appropriate documentation was completed. During an interview on 07/30/26 at 1:55 P.M., Registered Nurse (RN) A said:-If a resident refused medication, the staff were expected to report the refusal to nursing management.-When documenting medications staff could indicate that medication was refused by clicking a number and then the system would auto-populate a place for staff to document a progress note.-He/She was unsure why Resident #1 and Resident #5 had missed documentation to their eMARs.-The staff were always expected to document medication administration and there would be no reason for not having appropriate documentation. During an interview on 07/30/26 at 2:17 P.M., the Administrator and DON said:-The facility had an internet outage that had lasted approximately ten days.-The missing documentation on Resident #1's and Resident #5's eMARs were during the internet outage period.-Some staff were using personal hotspots to document medication administration.-Some of the staff did not have personal hotspots and utilized paper documentation during the internet outage.-They would be able to provide the paper documentation for Resident #1 and Resident #5 that was completed during the internet outage. During an interview on 07/30/26 at 3:10 P.M., CMT C said:-He/She had forgotten about the internet outage, because he/she had used a (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hot spot during that time and his/her work was unaffected.-There was not any instruction given on how to document medication administration during the internet outage.-There had been issues with the internet prior to the most recent internet outage and had been instructed at that time to use his/her hotspot.-Paper MARs were to be made available to all pertinent staff so documentation of administration could continue without issue. During an interview on 07/31/26 at 8:50 A.M., the DON said:-When the internet was down some of the staff's hot spots were also not working and had to go back to document the medication administration at the end of the shift.-Some of the staff forgot to finish the medication administration documentation.-He/She was unaware the staff had not completed the documentation until 07/30/26 when it was requested. -He/She had no other documentation to provide related to Resident #5's medication administration during the internet outage.-The paper MARs were signed off on 07/30/26 which was why the documentation did not align within the timeframe of the internet outage. During an interview on 7/31/26 at 9:20 A.M. Pharmacy Manager A said:-He/She was a licensed pharmacist.-He/She would have expected the staff to follow the five rights of medication administration. During an interview on 07/31/26 at 10:09 A.M. the DON said:-He/She had directed CMT B and CMT D to document on Resident #1's and Resident #5's paper MAR on 07/30/26.-He/She should not have directed CMT B and CMT D to back sign Resident #1's and Resident #5's medication administration.-Staff should not document medication administration before the medication is actually administered.-He/She thought CMT D had pre-signed Resident #1's Gabapentin Oral Capsule accidentally when he/she had directed CMT D to sign off on Resident #1's paper MAR.-He/She thought CMT B had pre-signed Resident #5's Timolol Maleate Solution 0.5%, Gabapentin Oral Capsule, and Valium Oral Tablet accidentally when he/she had directed CMT B to sign off on Resident #5's paper MAR.-Staff were expected to follow facility policy and the five rights of medication administration.-CMT B and CMT D were not following policy or the five rights of medication administration when they signed off on Resident #1's and Resident #5's paper MARs on 07/30/26.-There were no paper MARs available for staff to use during the internet outage.-Resident #1 and Resident #5 should have had completed documentation on their eMARs and paper MARs at the time of administration. 3111187 and 3111027		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on interview and record review, the facility failed to follow the facility's Crisis Prevention Institute (CPI) policy for one sampled resident (Resident #3) with a history of aggression towards staff out of eight sampled residents. On 07/20/26 around 8:30 A.M., Resident #3 became mad and impatient with Certified Medication Technician (CMT) related to a change in medication administration, resulting in the resident's medication administration being delayed. The resident demanded the CMT hurry up. CMT A told the resident he/she could wait or come back later, because the CMT was finishing a different resident's medication administration. The resident again demanded the CMT speed up and the CMT ignored the resident. The resident then walked up to the entrance door of the medication room, started to curse the CMT, and told CMT A that he/she was done. CMT A did not call a code green to alert onsite staff of escalating resident behavior. Rather, CMT A replied to the resident he/she would mark the resident refused his/her medications. The statement further upset the resident, resulting in the resident yelling and charging at the medication room door. CMT A used a non-approved technique, grabbed the resident by his/her collar, and moved the resident to the ground which resulted in an abrasion to the resident's right cheek and right eyebrow. The resident additionally complained of pain to his/her right ankle and big right toe. The facility census was 114 residents. The Administrator was notified on 07/29/26 at 11:25 A.M. of the past non-compliance deficiency which began on 07/20/26. The facility immediately completed re-education of CPI training with CMT A, and all other staff present on Resident #3's unit. All staff were educated on resident rights, medication pass, code green response, CPI, abuse prevention, and team communication. The deficiency was corrected on 07/23/26. Review of the facility's CPI Training, dated 2023, showed the goal of CPI training is to equip employees with the necessary skills to prevent and safely manage crisis situations, ensuring a safe and supportive environment for everyone. Review of the facility's undated handbook for CPI showed:-Safety interventions range from verbal and environmental non-restrictive interventions to non-restrictive disengagements and restrictive interventions. The goal is to choose the safety intervention that is a last resort, reasonable, and proportionate.-Disengagements and restrictive interventions are not risk-free and are highly traumatic for everyone involved. It can affect a person physically and mentally. These effects can be long-lasting or even life-threatening.-Many individuals in your care might have already been through traumatic experiences. A disengagement or restrictive intervention can trigger previous traumatic experiences.-Holding. A restrictive safety intervention necessary to restrict a person's range of movement to prevent the infliction of harm to self or others. Review of the facility's Behavioral Health Services Policy, revised 10/31/24, showed:-The purpose of the policy was to ensure all residents received necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning.-The facility staff were to ensure the residents were receiving necessary behavioral health care which were person-centered and reflect the resident's goals for care while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.-Behavioral health care and services were to be provided in an environment that was conducive to mental and psychosocial well-being.-The facility staff were to monitor the resident closely for expressions or indications of distress.-If the resident showed signs of distress, the staff were to evaluate if those changes in behavior were unavoidable.-The staff were to maximize the resident's dignity, autonomy, privacy, socialization, independence, and safety.-The facility staff were to have interventions that were person-centered, evidence-based, culturally (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	competent, trauma-informed, and in accordance with professional standards of practice. 1. Review of Resident #3's admission Record showed he/she admitted to the facility with the following diagnoses:-Schizoaffective disorder (a mental health condition that includes features of both schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves) and a mood disorder).-Major depressive disorder (MDD- a disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).-Bipolar disorder (a mood disorder that can cause intense mood swings). Review of the resident's significant change Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff), dated 05/19/26, showed:-The resident was cognitively intact.-The resident had physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing) one to three days within the seven-day look back period. Review of the resident's care plan, dated 07/20/26, showed:-The resident had negative behaviors which included charging people, seeking revenge, hitting, and tackling.-The resident used walking away, watching television, drinking coffee and soda, and playing chess on his/her phone as coping skills.-The resident's triggers included bullying and stealing from the resident.-The resident was at moderate risk for long-term care violence with the following interventions in place:--Alert back-up staff, security, or police and request assistance when needed.--Use effective therapeutic communication.--Be prepared to apply behavior management and self-protection teachings according to organizational policy.--The resident had a behavior trigger of loss of control.-On 07/20/26 the resident was verbally and physically aggressive with a staff member during medication administration resulting in a fall with minor injury. Review Resident #3's progress note, dated 07/20/26, showed:-On 07/20/26 at approximately 8:30 A.M., the resident was involved in a physical altercation with a CMT during medication pass.-Resident #3 reported frustration with the medication pass process because it differed from his/her previous experiences.-The CMT reported Resident #3 became verbally aggressive, entered the medication room, and attempted to strike staff.-The investigation identified the primary root cause was behavioral escalation resulting from a change in Resident #3's expected medication pass routine combined with delayed implementation of crisis intervention procedures. Review of the resident's Admin/RN Investigation, dated 07/20/26, showed:-The incident occurred on 07/20/26 at approximately 8:30 A.M.-The type of incident was verbal aggression, resident initiated.-Resident #3, CMT A, Licensed Practical Nurse (LPN) A, Certified Nursing Assistant (CNA) A, CNA B, and CNA C were all involved in the incident.-Investigative Narrative Note:--On 07/20/26 at 8:30 A.M. the Director of Nursing (DON) initiated an investigation after a resident alleged abuse during the morning medication pass.--The resident reported becoming frustrated because the medication pass process differed from his/her usual routine.--The resident stated that CMT A used excessive force.--CMT A reported the resident became verbally aggressive, entered the medication room, attempted to force his/her way inside, and tried to strike staff.--The investigation found the medication pass method was acceptable, but slower due to CMT A being reassigned unexpectedly.--The resident had a documented history of aggression.--The resident sustained minor abrasions to the right eyebrow and right cheek and reported right ankle and great toe pain.-Conclusion of investigation:--The investigation determined the incident occurred during an escalating interaction between the resident and staff while medications were being administered.--The evidence supports the resident became verbally aggressive and that a physical altercation occurred while staff attempted to maintain safety and medication security.--Although the responding staff used CPI intervention, the investigation determined that Code [NAME] (a behavioral emergency and/or incident needing physical support and presence when an individual poses a threat to himself/herself or others) procedures were not initiated as early as and approved CPI techniques (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were not consistently followed.--There was insufficient evidence to conclude that staff intentionally caused harm; however, the response did not fully meet facility expectations for de-escalation, teamwork, and crisis intervention. During an interview on 07/28/26 at 1:08 P.M., the resident said:-He/She had been waiting a long time to get his/her medication.-CMT A was not completing the medication pass like the other CMTs.-He/She expressed frustration to CMT A and then left the situation.-He/She had been called back by CMT A.-He/She could not remember very well what happened after that or what he/she said to CMT A.-He/She was not trying to get into the medication room.-He/She had been tackled by CMT A and put into a headlock.-He/She had minor injuries from the incident that were now fully healed.-He/She had a cut on his/her cheek and eyebrow.-He/She also had some ankle pain and big right toe pain.-He/She did not feel like he/she had done anything to provoke the situation. Review of an Employee Witness Statement, dated 07/20/26 completed by CMT A, showed:-He/She had been reassigned to pass medications.-The resident started getting mad and impatient with him/her related his/her medications.-The resident was demanding that he/she hurry up because it normally didn't take other CMTs as long.-He/She told the resident that he/she could wait or come back later, because he/she was finishing a different resident's medication administration.-He/She was putting away medications when the resident started demanding again that he/she speed up.-He/She ignored the resident at that time.-The resident then walked up to the entrance door of the medication room and started to curse him/her.-The resident told him/her that he/she was done.-He/She then told the resident that he/she would mark that he/she refused his/her medications.-That statement set him/her off and came back yelling.-He/She tried to calm the resident down while also closing the door to keep distance from the resident.-The resident then charged at the door.-He/She was behind the door to continue to keep away from the resident.-The resident then charged the door again with more force and pushed himself/herself into the medication room.-The resident then started to attack him/her and the resident fell as Code [NAME] was called. During an interview on 07/28/26 at 2:38 P.M., CMT A said:-He/She had been asked to pass medications because a staff member called in.-He/She had never passed medications to the resident before.-The resident was getting frustrated because the other residents on the unit had been calling him/her names.-He/She had been putting away another resident's medication when the resident said f--k this. I am walking away.-He/She had already started to get the resident's medication out, so he/she told the resident that it would count it as a refusal.-The resident then turned back around.-The resident had passed the threshold of the medication room doorway and was wiggling his/her finger in his/her face.-He/She tried to shut the door, but the resident used his/her forearms to slam into the door.-He/She braced for impact, and told the resident that he/she needed to chill and that he/she needed to go away.-The resident then ran into the door again.-He/She thought at that point in time that a Code [NAME] had been called.-When the resident got into the medication room, he/she grabbed onto the resident's shirt collar and assisted the resident to the ground.-It appeared the resident was falling, so that was why he/she guided the resident to the ground.-He/She was not trying to harm the resident.-Holding a resident by the collar was not an appropriate CPI hold.-He/She tried verbal de-escalation first.-He/She also thought that by closing the door to keep distance from the resident was going to be more effective. During an interview on 07/28/26 at 3:04 P.M., Resident #3 said he/she had mixed feelings about CMT A but ultimately felt safe around CMT A and at the facility. Review of a Witness Statement, dated 07/20/26, completed by CMT E showed:-On 07/20/26 he/she was sitting in the medication room when the resident came to the medication area requesting his/her medications.-The resident asked several times for his/her medication.-CMT A instructed the resident to wait.-The resident was upset by this response and continued to demand his/her medications.-CMT (continued on next page)		

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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.			
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Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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