Missouri Department of Health and Senior Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29304	A. BUILDING: _____ B. WING _____	C 04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WORNALL PLACE	501 WEST 107TH STREET KANSAS CITY, MO 64114

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A4776	19 CSR 30-86.047(35) Protective Oversight Protective oversight shall be provided twenty-four (24) hours a day. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident ' s guardian of the resident ' s departure, of the resident ' s estimated length of absence from the facility, and of the resident ' s whereabouts while on voluntary leave. I/II This regulation is not met as evidenced by: Class II Based on interview and record review, the facility failed to provide protective oversight for one sampled resident (Resident #1) out of nine sampled residents by not ensuring call lights were answered in a timely manner and to complete an individualized fall care plan for the resident after he/she had been assessed with a heightened risk for falls. The facility census was 38 residents. The facility policy titled Resident Call System and Door Alarm Response was requested but not provided by the facility. 1. Review of Resident #1's undated face sheet showed he/she was admitted with diagnoses that included: -Hypertension (high blood pressure). -Cardiac Pacemaker (a small, implantable medical device that helps regulate the heart's rhythm by delivering electrical impulses). Review of the resident's Post Fall Evaluation dated 2/22/26 showed the resident: -Had an unwitnessed fall on 2/22/26 at 5:39 A.M. in his/her bedroom, near the bed and his/her dresser. -Vital signs were taken by facility staff and all	A4776		

5.1.26

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were within normal range.
-Was "ok" but had pain in his/her right elbow and knee. It was noted that the resident had a skin tear on his/her right elbow.
-Stated the pain was at a level 4 (indicating moderate pain that is distracting but generally manageable, allowing you to continue daily activities).
-Was observed to be barefoot and was not using his/her walker.
-Had physical signs of a possible head injury, noted by the presence of blood on the back of the resident's head. The resident was transported to the hospital for evaluation.
-Physician and emergency contact were notified of the resident's fall.

Review of the resident's Emergency Department (ED) Provider Note dated 2/22/26 showed:
-The resident was seen in the ED with the chief complaint of a fall.
-The resident stated he/she lost his/her balance while attempting to get out of bed that morning.
-Emergency Medical Services (EMS) reported that the resident was on the floor for one to two hours after falling before staff noticed.
-The resident had an X-Ray (a quick, painless imaging test that uses a small amount of electromagnetic radiation to produce images of the body's internal structures, primarily bones and dense tissues) of his/her right elbow and a CT scan (a noninvasive, painless diagnostic test that uses X-rays and computer software to create detailed, 3D cross-sectional images (slices) of internal body structures) of his/her head.
-The X-Ray showed no fracture (a broken or cracked bone, where the tissue has separated) or dislocation (the displacement of bones at a joint from their normal position, usually causing pain, swelling, and temporary immobilization,

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commonly resulting from falls or sports), and the CT scan showed no intracranial hemorrhage (brain bleed).
-A wound noted on the back of the resident's head was thoroughly cleaned; it was determined to be a small superficial laceration (a torn, ragged, or irregular wound caused by skin tearing due to blunt trauma, shearing forces, or sharp objects, often leaving deeper tissues exposed) on the posterior (back) scalp.

Review of the facility's Alarm Report dated 2/22/26 showed:
-The resident pressed his/her call light at 3:34 A.M.
-His/Her call light sounded for 1 hour, 32 minutes, and 29 seconds before staff responded.

Review of the resident's Personal Service Plan, under the section titled Escort & Mobility, dated 3/9/26 showed:
-The resident had a heightened risk for falls.
-He/She had experienced a fall in the last 12 months.
-He/She used a walker as a mobility aid.
-The Universal Fall Precautions were listed; it was noted that this applied to all facility residents.
-The lack of individualization to address the resident's needs in relation to falls.

During an interview on 3/9/26 at 12:07 P.M., the resident said he/she:
-Pushed his/her call light and no one answered.
-Doesn't know how long it took, but it took the staff a very long time to come to help him/her.
-Always pressed his/her call light when he/she needed assistance.

During an interview on 3/9/26 at 12:52 P.M., Certified Nurse Assistant (CNA) C said:

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A4776	Continued From page 3 -He/She was aware that sometimes it took staff a long time to respond to call lights. -Staff tried to respond within 15 minutes. During an interview on 3/9/26 at 1:00 P.M., CNA E said: -It usually took staff five to seven minutes to respond to a call light. -Staff are expected to respond within 15 minutes. During an interview on 3/9/26 at 1:05 P.M., CNA D said: -Staff have 15 minutes to respond to call lights. -If they are not caring for a resident at the time of a call light going off, staff are expected to respond to call lights within three to five minutes. During an interview on 3/9/26 at 1:11 P.M., CNA B said: -There are times when staff don't respond to call lights for about an hour. -He/she has found that there have been times when he/she has discovered a resident may press their call light by accident and staff doesn't respond. During an interview on 3/9/26 at 1:18P.M., the facility Administrator said: -The resident had a fall and pressed his/her call light. -When staff went into resident room, he/she had blood coming from his/her head. -He/She reviewed the call light response log and discovered that staff did not respond to call light for over an hour. -Staff had been in serviced that they have 15 min to respond to a call light. -The call light system, rings to pager which all staff are to carry. -If for some reason a staff member doesn't have	A4776		

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A4776	Continued From page 4 a pager, the Certified Medication Technicians (CMTs) carry a walkie and will announce that a call light needs to be responded to. -All staff carry walkies. -He/She is able to pull the call light response log and can watch in real time that a residents call light was pressed and when staff responds to silence the call light. During an interview on 3/9/26 at 1:18 P.M., Health Wellness Coordinator said: -It has been reported that residents have long wait periods after they press call lights. -The facility Administrator advised staff that call lights had to be answered within 15 minutes. During an interview on 3/9/26 at 1:52 P.M., Family Member A said: -Since October 2025 the resident has had two falls. -He/She was notified by facility staff that the resident had an injury fall and was being sent to the hospital for evaluation. -The resident told him/her that he/she (the resident) pressed his/her call light button multiple times, and it took staff a very long time to come to assist him/her. -The resident reported pressing the call light button at least 40 times. -The facility Administrator told him/her that the resident was left for 1 hour, 30 minutes and 29 seconds after call light was pressed. -The resident told him/her pressed his/her call light 40 times during that time. MO00260976	A4776		
A4797	19 CSR 30-86.047(46) Safe & Effective Medication System	A4797		

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A4797	Continued From page 5 The administrator shall develop and implement a safe and effective system of medication control and use, which assures that all residents ' medications are administered by personnel at least eighteen (18) years of age, in accordance with physicians ' instructions using acceptable nursing techniques. The facility shall employ a licensed nurse eight (8) hours per week for every thirty (30) residents to monitor each resident ' s condition and medication. Administration of medication shall mean delivering to a resident his or her prescription medication either in the original pharmacy container, or for internal medication, removing an individual dose from the pharmacy container and placing it in a small cup container or liquid medium for the resident to remove from the container and self-administer. External prescription medication may be applied by facility personnel if the resident is unable to do so and the resident ' s physician so authorizes. All individuals who administer medication shall be trained in medication administration and, if not a physician or a licensed nurse, shall be a certified medication technician or level I medication aide. I/II This regulation is not met as evidenced by: Class II Based on interview, and record review, the facility failed to ensure that there was a system in place for licensed nursing staff to monitor medications for one resident (Resident #6) who self-administered their own medications; to ensure that all medications the resident was self-administering were listed on the Physician's Order Sheet (POS), and to document a complete and through investigation when it was reported	A4797		

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that the resident's narcotic medications were missing out of nine sampled residents. The facility census was 38 residents.

Review of the facility Medication Administration policy dated March 2024, showed:
-Residents who desire to self-administer medication should be permitted to do so if the admitting physicians/healthcare provider verifies it is appropriate, the nurse has confirmed the resident's abilities in this regard, and any applicable state requirements are met.
-Locking the resident's apartment door is considered the first level for securing medications.
-Residents who self-administrator should store controlled medications in a locked drawer or cabinet, so they are not accessible to others.
-Controlled medications are considered double locked in a drawer/cabinet and when the apartment door is locked.
-The absence of guidance to staff regarding the monitoring of medications self-administered by residents.

1. Review of Resident #6's Face sheet showed he/she admitted with the following diagnoses:
-Bipolar disorder (chronic mental health condition characterized by extreme mood swings, ranging from high-energy manic or hypomanic episodes to severe depression).
-Insomnia (common sleep disorder characterized by difficulty falling asleep, staying asleep, or waking too early).
-Chronic Kidney Disease (slow, progressive loss of kidney function over months or years).
-Hyperkalemia (serious condition characterized by elevated potassium levels in the blood often caused by kidney disease, medications, or excessive intake).

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-Irritable Bowel Syndrome (a common, chronic functional disorder of the gastrointestinal tract, causing symptoms like abdominal pain, bloating, gas, and diarrhea or constipation).

Review of the resident's Self-Administration Assessment dated 9/5/25, showed resident was capable of administering his/her own medications.

Review of the resident's Care Plan date 3/3/26 showed:
-He/She managed his/her medications including self-administering, ordering, coordinating and safe storage.
-Facility staff conducted an assessment of resident's ability to self-manage medications.
-He/She took seven or more medications including narcotic and antipsychotic medications.
-Conduct periodic review of medications.
-There was no clarification as to who was responsible for conducting the review or what was to be reviewed.

Review of the facility investigation dated 3/19/26 through 3/23/26 showed:
-The resident said:
--That when he/she moved into the facility in September 2025 he/she had five Oxycodone (a strong, prescription-only semi-synthetic opioid analgesic (narcotic pain reliever) used to treat moderate to severe pain) pills in a pill bottle.
--He/She kept the Oxycodone in his/her bathroom cabinet; all his/her other medications were kept in a drawer in his/her living room.
--Since September 2025 he/she only had to take the Oxycodone two times and he/she texted Family Member B both times.
--He/She last took the medication sometime in January 2026 and at that time he/she had three

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A4797	Continued From page 8	A4797		

pills remaining in the bottle.
--On 3/7/26 Family Member B brought in the required medication lock box and went to get the Oxycodone and discovered the bottle was empty.
--The resident stated he/she also didn't routinely lock his/her door when he/she left his/her room.
-Family Member B said:
--The prescription was brought with the resident when he/she moved into the facility.
--The prescription was well over a year old but the resident kept the medication just in case he/she needed pain medication, and the former Health and Wellness Director was aware.
--He/She confirmed that the resident had five pills at move in and had only taken two of the pills when he/she discovered that the medication was missing.
-The former Health and Wellness Director had advised him/her that the resident needed a lock box for his/her medication and when he/she brought it to the facility he/she went to place the medication in the locked box is when he/she discovered the Oxycodone was missing.
-The remainder of the investigation only consisted of staff interviews and had no conclusion that outlined a root cause or steps the facility would take to ensure other residents were affected.

Review of the resident's Physician Order Sheet (POS), dated April 2026, showed the resident did not have a physicians order for Oxycodone-Acetaminophen.

During an interview on 4/8/26 at 9:15 A.M., the Administrator said:
-The residents narcotic medications were not locked up properly.
-There have been no in-services done only on narcotics medication storage for residents that self-administer their own medication.

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A4797	Continued From page 9 -The resident reported narcotics were missing out of his/her pill bottle. -Has no form of monitoring residents medications daily. During an interview on 4/8/26 at 9:30 A.M., the resident said: -His/her pills inside a pill bottle were missing. -He/she told his/her family that pills were missing and reported it to the facility. -At the time the pills went missing they were not locked. During an interview on 4/8/26 at 9:42 A.M., Family Member B said: -He/She wasn't aware the resident had to have narcotic medications double locked inside room. -The resident didn't have medicine locked up. -All the resident's medications were being stored in an unlocked cabinet in the resident's room. -He/She keeps the resident's excess medication and leaves the resident only seven days' worth of medicine. -One pill bottle of Oxycodone with five pills was left in the bathroom cabinet. -The prescription was from some time in 2025, he/she found the bottle was empty around 3/18/26. During an interview on 4/8/26 at 10:16 A.M., Level One Medication Aide (L1MA) said he/she had no way of knowing if residents that self-administer their own medication have missing medications or if they are taking their medications. During an interview on 4/8/26 at 10:36 A.M., the Corporate Nurse said: -He/she does monthly checks to make sure residents are still able to self-administrator their	A4797		

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A4797	Continued From page 10 own medications. -There is no way of tracking residents medications daily. MO00261311	A4797		

PLAN OF CORRECTION

Provider Name:	Brookdale Wornall Place ALF II
Street Address, City, Zip:	501 W. 107th Street, Kansas City, MO, 64114
Date of Survey:	4.8.2026
Provider number:	29304

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A4776	19 CSR 30-86.047 (35) Protective Oversight Staff re-inserviced on answering call lights timely, prioritizing resident safety needs, and following escalation procedures when response times approach 15 minutes. Management will continue to monitor the response time and address non-compliance as necessary. ED and Assisted Living Director will be responsible for compliance.	6.1.2026
A4797	10 CSR 30-86.047 (46) Safe & Effective Medication System Nursing staff re-inserviced on requirement to complete monthly self-administration of medication assessments, verification that facility has orders for all resident medications and that resident is taking medications appropriately per physician's orders. Staff re-inserviced on regulation requiring residents who self-administer medications to store medications in a locked drawer, cabinet or lock box. Staff re-in serviced on reporting changes in condition or cognition that may indicate resident needs for additional support with medication management. ED and Assisted Living Director will be responsible for compliance.	6.1.2026

5.1.26