

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Brookfield Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 Telegraph Road Downey, CA 90240	
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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 19) was free of significant medication errors, when:1. Resident 19's orders for Percocet (medication used to treat moderate or severe pain) and methocarbamol (a muscle relaxer used to relieve muscle, bone, and joint pain) were not clarified.2. Resident 19 was administered methocarbamol and Percocet together. These deficient practices had the potential to result in Resident 19 experiencing sedation (when given too much a medication that makes an individual sleepier or less conscious than intended) and respiratory arrest (when an individual stops breathing). Findings: During a review of Resident 19's admission Record (Face Sheet), the admission Record indicated Resident 19 was admitted to the facility on [DATE]. Resident 19's diagnoses included displaced fracture of the greater trochanter of the left femur (a break in the prominent, bony knob on the outer part of the left thigh bone and the broken pieces are moved out of their normal alignment), displaced fracture of the distal phalanx of the left index finger (a break in the tiny bone of the second finger on the left hand), scoliosis (an abnormal, sideways curvature of the spine that can appear as a C or S shape) and chronic pain syndrome (persistent pain lasting more than three to six months). During a review of Resident 19's Minimum Data Set (MDS- a resident assessment tool), dated 10/23/2025, the MDS indicated Resident 19's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 19 required maximal assistance (helper does more than half the effort) with toileting, bathing, lower body dressing, and personal hygiene. The MDS indicated Resident 19 was receiving a scheduled pain medication regimen. The MDS indicated Resident 19's pain occasionally affected her sleep, therapy activities, and day-to-day activities. During a review of Resident 19's History and Physical (H&P), dated 10/26/2025, the H&P indicated Resident 19 had the capacity to understand and make decisions. During a review of Resident 19's Physician Orders, dated 2/3/2025, the Physician Orders indicated the following: 1. Methocarbamol (a muscle relaxer used to relieve muscle, bone, and joint pain) 750 milligrams (mg, a unit of measurement), by mouth three times a day for scoliosis and chronic pain, do not give with Percocet (medication used to treat moderate or severe pain) or temazepam (medication to treat insomnia, which is the trouble sleeping). 2. Percocet 10-325 mg, by mouth every five hours as needed for moderate to severe pain. During an interview on 12/4/2025 at 8:35 a.m., with Pharmacist 1, Pharmacist 1 stated methocarbamol and Percocet had similar side effects such as sedation, drowsiness, and dizziness. Pharmacist 1 stated the side effects could potentially increase when methocarbamol and Percocet were administered together. Pharmacist 1 stated Resident 19's methocarbamol and Percocet should not be administered within an hour of each other due to Resident 19's physician order to not administer methocarbamol with Percocet. During an interview on 12/4/2025 at 12:51 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 19's methocarbamol was scheduled to administer three times a day and Percocet was administered in an as needed basis. LVN 1 stated according to Resident 19's methocarbamol order, the licensed nurses were not supposed to administer methocarbamol with Percocet or temazepam. LVN 1 stated she interpreted that order to give the medications at least an hour apart. LVN 1 stated Resident 19's methocarbamol order should have been more specific because do not give could be (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interpreted not to give both at the same time, within an hour, or a time frame less than an hour. LVN 1 stated Resident 19's methocarbamol should have specified not to give within an hour with Percocet. LVN 1 stated Resident 19's Percocet order does not specify whether to give with methocarbamol. LVN 1 stated Resident 19's Percocet order was an issue because the Percocet could be given as needed and the licensed nurse may not know the special instruction to avoid giving with methocarbamol. LVN 1 stated because methocarbamol and Percocet had sedative effects and if given together put Resident 19 at risk for oversedation (when given too much a medication that makes an individual sleeper or less conscious than intended) and respiratory arrest (when an individual stops breathing). During an interview on 12/4/2025 at 1:33 p.m., with Registered Nurse (RN) 1, RN 1 stated do not give with could be interpreted different ways. RN 1 stated Resident 19's methocarbamol and Percocet should not be given an hour or two hours within each other. RN 1 stated Resident 19's methocarbamol and Percocet orders should have been clarified to specify the administration time frame parameters (specific, measurable instructions that guide the safe and effective use of a medication). RN 1 stated with vague and nonspecific medication orders, Resident 19 was at risk of being administered methocarbamol and Percocet too close together which could lead to oversedation, respiratory distress, and increased risk for falls. During a concurrent interview and record review on 12/4/2025 at 1:39 p.m., with RN 1, Resident 19's Medication Administration Audit Report, dated 10/1/2025 through 10/31/2025 and 11/1/2025 through 11/30/2025, and Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 10/1/2025 through 10/31/2025 and 11/1/2025 through 11/30/2025, were reviewed. RN 1 stated Resident 19's Medication Administration Audit Report and MARs indicated methocarbamol and Percocet were administered 15 times either within an hour of each other or at the same time. RN 1 stated due to the sedative side effects of both methocarbamol and Percocet, Resident 19 was at risk of oversedation and respiratory distress. The Medication Administration Audit Reports and the MARs indicated methocarbamol and Percocet were given within an hour on the following dates and times:- 10/20/2025, methocarbamol administered at 12:49 p.m. and Percocet administered at 12:54 p.m.- 10/22/2025, methocarbamol administered at 10:26 a.m. and Percocet administered at 11:18 a.m.- 10/24/2025, methocarbamol administered at 1:42 p.m. and Percocet administered at 1:15 p.m.- 10/30/2025, methocarbamol administered at 9 a.m. and Percocet administered at 9 a.m.- 10/30/2025, methocarbamol administered at 6:58 p.m. and Percocet administered at 6:58 p.m.- 10/31/2025, methocarbamol administered at 10:27 a.m. and Percocet administered at 11:15 a.m.- 11/4/2025, methocarbamol administered at 6:19 p.m. and Percocet administered at 6 p.m.- 11/5/2025, methocarbamol administered at 9:45 a.m. and Percocet administered at 9:48 a.m.- 11/6/2025, methocarbamol administered at 5:40 p.m. and Percocet administered at 5:40 p.m.- 11/8/2025, methocarbamol administered at 9:21 a.m. and Percocet administered at 9:21 a.m.- 11/14/2025, methocarbamol administered at 5:22 p.m. and Percocet administered at 6:06 p.m.- 11/15/2025, methocarbamol administered at 6:08 p.m. and Percocet administered at 7:01 p.m.- 11/16/2025, methocarbamol administered at 2:57 p.m. and Percocet administered at 2:55 p.m.- 11/18/2025, methocarbamol administered at 1:39 p.m. and Percocet administered at 1:04 p.m.- 11/27/2025, methocarbamol administered at 2:02 p.m. and Percocet administered at 1:55 p.m. During an interview on 12/4/2025 at 2:33 p.m. with the Director of Nursing (DON), the DON stated medication orders should be specific and the licensed nurses were responsible for clarifying any vague orders with the physician. The DON stated Resident 19's methocarbamol order could have different interpretations since the order did not have specific administration time frame parameters. The DON stated Resident 19's order resulted in the licensed nurses administering methocarbamol and Percocet too close together which could lead to Resident 19 experiencing oversedation, respiratory distress, and altered consciousness. During a review of the facility's Policy and Procedure (P&P) titled, Medication Administration- General Guidelines, revised 11/2021, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	practices. The P&P indicated, Medications are administered in accordance with written orders of the attending physician.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a comprehensive care plan with interventions for two of eight sampled residents (Resident 19 and 48) to address:1. Resident 19's use of methocarbamol (a muscle relaxer used to relieve muscle, bone, and joint pain).2. Resident 48's lack of dentures (a removable dental appliance that replaces missing teeth and surrounding tissues).This deficient practice had the potential to negatively affect Resident 19 and 48's mental, physical, and psychosocial well-being and had the potential to delay the delivery of necessary care and services.Findings:1. During a review of Resident 19's admission Record (Face Sheet), the admission Record indicated Resident 19 was admitted to the facility on [DATE] with diagnoses included displaced fracture of greater trochanter of the left femur (a break in the prominent, bony knob on the outer part of the left thigh bone and the broken pieces are moved out of their normal alignment), displaced fracture of distal phalanx of the left index finger (a break in the tiny bone of the second finger on the left hand), scoliosis (an abnormal, sideways curvature of the spine that can appear as a C or S shape) and chronic pain syndrome (persistent pain lasting more than three to six months). During a review of Resident 19's History and Physical (H&P), dated 10/26/2025, the H&P indicated Resident 19 had the capacity to understand and make decisions. During a review of Resident 19's Minimum Data Set (MDS- a resident assessment tool), dated 10/23/2025, the MDS indicated Resident 19's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 19 required maximal assistance (helper does more than half the effort) with toileting, bathing, lower body dressing, and personal hygiene. The MDS indicated Resident 19 received scheduled pain medication regimen. The MDS indicated Resident 19's pain occasionally affected her sleep, therapy activities, and day-to-day activities.During an interview on 12/4/2025 at 10:10 a.m., with the Minimum Data Set Coordinator (MDSC), the MDSC stated care plans were developed to address why the residents were in the facility, their medications, and any conditions that require specific care. The MDSC stated care plans were a communication tool to ensure all staff were aware of the residents' needs. The MDSC stated care plans should be developed to address medications the residents received to ensure the necessary monitoring for side effects were implemented.During a concurrent interview and record review on 12/4/2025 at 10:14 a.m., with the MDSC, Resident 19's Orders, dated 12/4/2025, and Care Plans, dated 10/19/2025 through 12/4/2025, were reviewed. The Orders indicated to give methocarbamol (a muscle relaxer used to relieve muscle, bone, and joint pain) 750 milligrams (mg, a unit of measurement), by mouth three times a day for scoliosis and chronic pain, do not give with Percocet (medication used to treat moderate or severe pain) or temazepam (medication to treat insomnia, which is the trouble sleeping). The Care Plans indicated were no Care Plans to address Resident 19's use of methocarbamol. The MDSC stated Resident 19 had an order to administer methocarbamol with specific instructions not to administer with Percocet or temazepam. The MDSC stated a Care Plan should have been developed with interventions to ensure those medications were not administered together and to include monitoring for sedation. The MDSC stated Care Plans were an additional tool to provide an overview of Resident 19's plan of care. The MDSC stated without a Care Plan addressing Resident 19's use of methocarbamol, Resident 19 was at risk of not receiving the necessary care.During an interview on 12/4/2025 at 2:23 p.m., with the Director of Nursing (DON), the DON stated Care Plans summarized everything regarding the resident's plan of care. The DON stated care plans developed for medications included interventions such as administering medications as ordered and monitoring as needed. The DON stated Resident 19 would have benefited from having a care plan for her methocarbamol's use to (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ensure the licensed nurses were aware to not to administer methocarbamol with Percocet and temazepam. The DON stated although there were orders in place, having a Care Plan would be a plus and without the necessary Care Plan, Resident 19's conditions and medications would not be accurately reflected. 2. During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing) and dementia (a progressive state of decline in mental abilities). During a review of Resident 48's H&P, dated 8/26/2025, the H&P indicated Resident 48 was awake, oriented to self, followed simple commands. The H&P indicated Resident 48 had limited capacity to make decisions due to cognitive impairment. During a review of Resident 48's MDS, dated [DATE], the MDS indicated Resident 48's cognition was moderately impaired. The MDS indicated Resident 48 required moderate assistance (helper does less than half the effort) for eating, oral hygiene, upper body dressing, and personal hygiene. The MDS indicated Resident 48 was dependent on staff for toileting hygiene, shower/bathing, lower body dressing and putting on/taking off footwear. During a review of Resident 48's electronic medical record, Resident 48's care plan for missing dentures was unable to be located. During an interview on 12/2/2025 at 11:02 a.m. with Resident 48, Resident 48 stated she lost her upper and lower dentures. Resident 48 stated she had informed the Social Services Director (SSD) she lost her dentures, and the SSD was assisting her in getting new ones. During an interview on 12/5/2025 at 9:48 a.m. with SSD, SSD stated Resident 48 had informed her she lost her dentures. SSD stated she did not develop a care plan for Resident 48 not having dentures. SSD stated Resident 48 did require a care plan for not having dentures. SSD stated Resident 48's care plan interventions should be to make sure Resident 48 had no problem chewing, ask if she had pain when chewing, make sure her food intake was good and to check if Resident 48 lost weight. SSD stated if Resident 48 did not have a plan of care for missing dentures, Resident 48 would be at risk of not receiving proper care. During an interview on 12/5/2025 at 1:56 p.m. with the DON, the DON stated a care plan was a map for resident's care and an overview of resident's health. The DON stated things got care planned to inform staff the plan of care for residents. The DON stated if something did not get care planned a resident may not receive the correct care. The DON stated Resident 48 required a care plan for missing dentures. The DON stated new interventions and goals should have been developed for missing dentures. The DON stated an intervention could be a dental consultation and diet modification. During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 12/2023, the P&P indicated, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement fall prevention interventions for one of three sampled residents (Resident 1) when staff failed to: 1. Complete all sections of Resident 1's Fall Risk Evaluation, and develop a short-term fall care plan, following his fall on 11/13/2025. 2. Conduct a Fall Risk Evaluation after Resident 1's fall on 11/21/2025. 3. Revise Resident 1's fall risk care plan following his falls on 11/13/2025 and 11/21/2025. These deficient practices placed Resident 1 at risk for repeat falls and potential injury. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was originally admitted to the facility on [DATE], and re-admitted on [DATE] with diagnoses including reduced mobility, abnormal posture, limited ability or inability to move one side of the body following a stroke (loss of blood flow to a part of the brain) affecting his left side. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 11/21/2025, the MDS indicated Resident 1's cognition (process of thinking) was moderately impaired. The MDS indicated Resident 1 was dependent on staff for all mobility while in and out of bed. During a review of Resident 1's Change of Condition Assessment (COC), dated 11/13/2025, the assessment indicated staff found Resident 1 on his back, next to his bedside table. During a review of Resident 1's Fall Risk Evaluation, dated 11/13/2025, the evaluation indicated two sections of the assessment that contributed to calculating Resident 1's risk for falls were not completed. The final evaluation indicated Resident 1 was not at risk for further falls. During a review of Resident 1's COC, dated 11/21/2025, the COC indicated staff found Resident 1 with his lower back and legs on the floor, and Resident 1 stated he slid off the bed. During a review of Resident 1's care plan titled At risk for falls, created 8/20/2025, the care plan indicated Resident 1 was at risk for falls. The care plan did not indicate it was revised following Resident 1's falls on 11/13/2025 or 11/21/2025. During an interview on 12/4/2025 at 2:41 p.m. with Registered Nurse (RN) 1, RN 1 stated after a fall, a Fall Risk Evaluation had to be completed immediately to identify further fall risk. RN 1 stated all sections of the evaluation had to be completed to ensure all potential risk factors were identified. RN 1 stated staff had to develop a short-term care plan to ensure all staff were aware of the required interventions to prevent further falls. During a concurrent interview and record review on 12/4/2025 at 2:46 p.m. with RN 1, Resident 1's care plan titled At risk for falls, created 8/20/2025, was reviewed. RN 1 stated Resident 1 did not have a short-term care plan developed after his fall on 11/13/2025. RN 1 stated that a short-term care plan should have been developed. During a concurrent interview and record review on 12/4/2025 at 2:48 p.m. with RN 1, Resident 1's Fall Risk Evaluation, dated 11/13/2025, was reviewed. RN 1 stated staff did not complete all sections of Resident 1's Fall Risk Evaluation and his fall risk would have been higher if it was completed. RN 1 stated all sections should be completed to get an accurate score and to identify the necessary interventions. RN 1 stated staff did not indicate Resident 1 was chairbound, did not walk, and was prescribed four different categories of high-risk medications. During an interview on 12/4/2025 at 2:55 p.m. with RN 1, RN 1 stated after Resident 1's fall on 11/21/2025, staff did not conduct a Fall Risk Evaluation. During a review of the facility's policy and procedure (P&P) titled Fall Management System, revised 12/2023, the P&P indicated that residents with high risk factors for falls were to have an individualized care plan developed. The P&P indicated that when a resident sustained a fall, a fall risk evaluation was to be completed and the care plan was to be updated.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure oxygen therapy (a medical treatment that provides extra oxygen to breathe, typically prescribed for individuals with conditions causing low blood oxygen levels) was administered as ordered by the physician for two of 18 sampled residents (Residents 72 and 19). This deficient practice placed Resident 72 and Resident 19 at risk of sustaining complications of receiving too much supplemental oxygen. Findings: 1. During a review of Resident 72's admission Record, the admission Record indicated Resident 72 was initially admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 72's diagnoses included congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), upper respiratory infection, and asthma (a long-term condition that affects the airways in the lungs). During a review of Resident 72's Minimum Data Set (MDS, a resident assessment tool) dated 11/25/2025, the MDS indicated Resident 72's cognition (process of thinking) was moderately impaired. During a review of Resident 72's physician order, dated 11/21/2025, the physician order indicated Resident 72 was to receive oxygen therapy at two (2) liters per minute (L/min, a unit for measuring oxygen delivery rate). The physician order indicated staff could increase the delivery rate to three (3) L/min as needed. During observations on 12/2/2025 at 10:36 a.m., and 12/2/2025 at 2:50 p.m., at Resident 72's bedside, Resident 72 was receiving oxygen therapy at a rate of 3.5 L/min. During a concurrent interview and record review on 12/4/2025 at 2:38 p.m. with Registered Nurse (RN) 1, Resident 72's physician order, dated 11/21/2025 was reviewed. RN 1 stated Resident 72's orders indicated Resident 72 should not receive oxygen above 3 L/min. RN 1 stated Resident 72's oxygen should be administered as ordered. During a review of the facility's document titled Job Description - Registered Nurse, dated 12/2021, the document indicated the Registered Nurse was to administer services as appropriate and in accordance with applicable standards. 2. During a review of Resident 19's admission Record, the admission Record indicated the facility admitted Resident 19 on 10/19/2025. Resident 19's admitting diagnoses included chronic respiratory failure with hypoxia (long-term condition where the lungs consistently fail to get enough oxygen into the blood), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and hypertension (HTN-high blood pressure). During a review of Resident 19's Minimum Data Set (MDS - a resident assessment tool) dated 10/23/2025, the MDS indicated Resident 19 had moderate cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). During a review of Resident 19's physician order, dated 10/19/2025, the order indicated Resident 19 was to receive oxygen therapy at three (3) liters per minute (L/min, a unit for measuring oxygen delivery rate). The order did not indicate that oxygen delivery was titratable. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/3/2025 at 8:48 a.m., at Resident 19's bedside, Resident 19 was observed receiving oxygen therapy at a rate of 2.5 L/min. During an observation on 12/3/2025 at 3:16 p.m., at Resident 19's bedside, Resident 19 was observed receiving oxygen therapy at a rate of 2.5 L/min. During an interview on 12/3/2025 at 3:35 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 19's orders indicated Resident 19 should receive continuous oxygen at 3 L/min.^ LVN 2 stated Resident 19's oxygen should be administered as ordered. During an interview on 12/3/2025 at 3:45 p.m. with Registered Nurse (RN) 2, RN 2 stated Resident 19's orders indicated Resident 19 should receive continuous oxygen at 3 L/min.^ RN 2 stated Resident 19's oxygen should be administered as ordered. During a review of the facility's Licensed Vocational Nurse/Licensed Practical Nurse job description, dated 11/2021, the P&P indicated Licensed Vocational nurses were to provide services as appropriate and within standards of practice. During a review of the facility's Registered Nurse job description, dated 11/2021, the P&P indicated registered nurses were to provide services as appropriate and within standards of practice.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a meal that was attractively appealing and palatable for one of two sampled residents (Resident 71). This deficient practice had the potential for Resident 71's individual dietary and nutritional needs not being met, causing Resident 71 to not want to eat. Findings: During a review of Resident 71's admission Record, the admission Record indicated Resident 71 was newly admitted to the facility on [DATE]. Resident 71's diagnoses included diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing) and congestive heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 71's History and Physical (H&P), dated 12/4/2025, the H&P indicated Resident 71 was awake, alert, and was able to answer questions appropriately. During a review of Resident 71's Order Summary Report, dated 12/2/2025, the Order Summary Report indicated an order for a consistent carbohydrate (essential macronutrients-sugars, starches, and fiber, they are the body's main fuel source) diet ([CCHO] a diabetes management plan focused on eating same amount of carbohydrates each meal daily), soft and bite sized. During a concurrent observation and interview on 12/3/2025 at 1:03 p.m. with Resident 71, observed Resident 71 eating lunch. The meal tray contained a green-colored pureed food item. Resident 71 stated she did not know what the green glob was. Resident 71 stated the food looked like baby food and did not want to taste it. Resident 71 then scooped some of the food onto a spoon and tasted it. Resident 1 stated it was not good and she was not going to eat it. Resident 71 stated her food was supposed to be cut into small pieces. During an interview on 12/5/2025 at 1:11 p.m. with the Dietary Supervisory (DS), the DS stated a soft and bite size diet was for residents that could tolerate chewing soft food but required dental work. The DS stated a resident prescribed a soft and bite size diet should have not received food that was pureed. The DS stated pureed food was meant for residents that could not chew. The DS stated it was important to serve food according to the resident's diet order and to offer a nutritional and palatable meal that residents will eat. During an interview on 12/5/2025 at 2:04 p.m. with the Director of Nursing (DON), the DON stated all residents must receive meals according to their prescribed diet. The DON stated it was important to provide palatable food to residents to promote food intake. During a review of the facility's policy and procedure (P&P) titled Level 6: Soft and Bite Sized, dated 2025, the P&P indicated a soft and bite sized diet was designed for residents who experience biting limitations but can chew food items for swallowing.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Brookfield Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 Telegraph Road Downey, CA 90240	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain infection control measures for one of five sampled residents (Resident 61) when: 1. Resident 61 was placed on contact precautions (using extra barriers, like gowns and gloves, to stop germs from spreading by touching a sick person or things in their room) with no visual signage to ensure hands were washed with soap and water. 2. Licensed Vocational Nurse (LVN) 2 performed hand hygiene with alcohol-based hand rub (ABHR- a liquid that is rubbed on the hands to quickly kill germs and stop their spread, without needing soap and water) instead of soap and water upon exiting Resident 61's room. These deficient practices had the potential to result in the spread of clostridium difficile (C. diff- a highly contagious bacteria that causes severe diarrhea) to the residents and staff. Findings: During a review of Resident 61's admission Record (Face Sheet), the admission Record indicated Resident 61 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 61's diagnoses included type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), myocardial infarction (heart attack), and end stage renal disease (irreversible kidney failure). During a review of Resident 61's Minimum Data Set (MDS- a resident assessment tool), dated 10/10/2025, the MDS indicated Resident 61's cognition (process of thinking) was intact. The MDS indicated Resident 61 was dependent on staff's assistance with bathing, upper/lower body dressing, and putting on/taking off footwear. During a review of Resident 61's Situation, Background, Assessment, Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents), dated 12/1/2025, the SBAR indicated on 12/1/2025, Resident 61 had three loose stools. The SBAR indicated Resident 61's physician ordered for a stool sample to rule out clostridium difficile (C. diff- a highly contagious bacteria that causes severe diarrhea) and to place Resident 61 on contact isolation precautions (using extra barriers, like gowns and gloves, to stop germs from spreading by touching a sick person or things in their room). During a review of Resident 61's Order Summary Report, order dated 12/1/2025, the Order Summary Report indicated to place Resident 61 on contact precautions due to loose stool and pending C. diff results. During a review of Resident 61's Infection Surveillance, dated 12/2/2025, the Infection Surveillance indicated Resident 61 had three diarrhea episodes within a 24-hour period. The Infection Surveillance indicated the staff and Resident 61 were educated to increase hand hygiene with soap and water. The Infection Surveillance indicated Resident 61 was on contact and spore precautions (infection control measures for bacteria spread by touching a person or their environment that form hardy spores, requiring dedicated soap and water handwashing) due to loose stool. During a review of Resident 61's Test Results, dated 12/3/2025, the Test Results indicated Resident 61 was positive for C. diff. During a concurrent observation and interview on 12/3/2025 at 8:42 a.m., with Licensed Vocational Nurse (LVN) 2, outside of Resident 61's room, the sign outside of Resident 61's room indicated Resident 61 was on contact precautions and to clean hands when exiting the room. LVN 2 stated Resident 61 was on contact precaution because she had loose stools. LVN 2 stated Resident 61's C. diff results were pending. During an observation on 12/3/2025 at 8:43 a.m., with LVN 2, in Resident 61's room, observed LVN 2 put on a disposable gown and gloves prior to entering the room. LVN 2 asked for consent to check Resident 61's blood pressure (the force of the blood pushing against the artery walls as the heart pumps it through the body) before preparing Resident 61's medications. After LVN 2 checked Resident 61's blood pressure, she removed her gown and gloves and returned to the medication cart where she used the alcohol-based hand rub (ABHR- a liquid that is rubbed on the hands to quickly kill germs and stop their spread, without needing soap and water) to clean her hands. LVN 2 unlocked the medication cart, opened the medication drawer, and prepared to prepare Resident 61's medications. During a concurrent observation and interview on 12/3/2025 at 8:50 a.m., with LVN 2, in Resident 61's room, upon observing the State Surveyor washing her hands with soap and water (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Brookfield Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 Telegraph Road Downey, CA 90240	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	upon exiting Resident 61's room, LVN 2 walked into the restroom and washed her hands with soap and water. LVN 2 stated although Resident 61's C. diff results were pending; she should have done all the precautions as if Resident 61 had a definitive result. LVN 2 stated after checking Resident 61's blood pressure and removing her gown and gloves, she was supposed to wash her hands with soap and water. LVN 2 stated C. diff spores were removed from the hands only by using soap and water and the ABHR was not strong enough. LVN 2 stated by using the wrong hand hygiene method, there was an increased risk of spreading C. diff to other residents and staff. During a concurrent observation and interview on 12/3/2025 at 8:54 a.m., with LVN 2, outside of Resident 61's room, the sign outside of Resident 61's room indicated Resident 61 was on contact precautions and to clean hands when exiting the room. The sign did not specify how to wash hands upon exiting. LVN 2 stated Resident 61 was on contact precaution but with additional spore prevention interventions such as washing hands with soap and water. LVN 2 stated the sign did not specify the hand washing method. During an observation on 12/3/2025 at 9:16 a.m., outside of Resident 61's room, observed the Director of Nursing (DON) passing through the hallway. The DON reminded LVN 2 to wash her hands with soap and water when exiting the room. During an interview on 12/3/2025 at 1:03 p.m., with Infection Preventionist Nurse (IPN) 2, IPN 2 stated Resident 61 was on transmission-based precautions (TBP- extra infection control steps used for residents with known or suspected infections that spread easily) due to the suspected C. diff infection. IPN 2 stated until Resident 61's results are finalized; the staff had to follow the guidelines to prevent the spread of C. diff in the facility. IPN 2 stated C. diff produced spores, which were easily spread, and hand washing with soap and water was a necessary way to ensure the spores were not left on the individual's hands. IPN 2 stated the ABHR was not strong enough to efficiently clean the hands. IPN 2 stated Resident 61 was placed on contact precautions, however, there was no specification to wash hands with soap and water. IPN 2 stated the staff were informed of Resident 61's status however, without the proper signage, the staff members could forget and not realize they needed to wash their hands with soap and water. IPN 2 stated by performing the incorrect hand washing method after attending to Resident 61, if spores were present on the hands, C. diff could easily be spread to other residents and staff members in the facility. During an interview on 12/4/2025 at 2:39 p.m., with the DON, the DON stated once Resident 61 experienced loose stool on 12/1/2025, Resident 61 was placed on contact precautions. The DON stated Resident 61 should have been placed on contact and spore precautions to specify the only appropriate hand washing method was with soap and water. The DON stated when LVN 2 did not wash their hands with soap and water after attending to Resident 61 and prior to returning to the medication cart, the risk of spreading C. diff in the facility increased. During a review of the facility's Policy and Procedure (P&P) titled, Infection Prevention and Control Program Standard and Transmission-Based Precautions, revised 4/2025, the P&P indicated, It is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions. During a review of the Centers for Disease Control and Prevention's (CDC- the national public health agency of the United States) webpage topic, link https://www.cdc.gov/c-diff/prevention/index.html, titled, Preventing C. diff, dated 12/18/2024, the webpage indicated, Washing your hands with soap and water is the best way to prevent the spread of C. diff from person to person.		