STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265644	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookfield Health Care Center	215 East Pratt Brookfield, MO 64628

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide sufficient staffing to ensure one dependent resident (Resident #24) was able to smoke outside, ensure residents received restorative services or to ensure call lights were answered timely to accommodate resident needs for five residents (Resident #5, #13, #16, #22, and #24) in a review of 16 sampled residents. The facility census was 25. Review of the facility's policy, Call Lights Accessibility and Timely Response, revised 04/30/24, showed all staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desired, the appropriate personnel should be notified. During an interview on 06/12/25 at 7:30 P.M., the Assistant Director of Nursing (ADON) said the facility had no restorative program at this time. 1. Review of the undated Facility Assessment showed the following: -Average daily census is 23; -Disease/Conditions and physical/cognitive disabilities for which the facility provides care for include neurological systems, including hemiparesis (muscle weakness on one side of the body), hemiplegia (partial paralysis on one side of the body), paraplegia (paralysis that affects all or part of the trunk, legs, and pelvic organs), quadriplegia (paralysis that affects the ability to move the uppers and lower body), cardiovascular accident/stroke (a medical condition where blood flow to the brain is interrupted that can include sudden numbness or weakness and difficulty walking), neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet) and muscle weakness; -The facility assessment will be used to inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care; -Resident acuity affecting nursing aides: assistance provided with dressing - 14, assistance provided with bathing - 23, assistance provided with transfers - 19, assistance provided with eating - one, assistance provided with toileting - 13, assistance provided with mobility - 16, assistance provided with splints/braces - one and assistance provided with behavioral symptoms - three; (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Facility resources (staffing): One Director of Nursing (DON), one Assistant Director of Nursing (ADON), four Licensed Practical Nurses (LPN), six Registered Nurses (RN), four medication aides or technicians, 12 Certified Nursing Assistants (CNA), zero Restorative Nursing Assistant, one infection preventionist and one regional minimum data set (MDS) nurse; -Overall staffing needs: Nurse Aides (CNAs, NAs, medication technicians) - three; -Staffing needs as per resident unit: CNAs - three; -Staffing needs as per shift (adjust as needed) Days: CNAs - three; -Specialized rehabilitation services - zero rehabilitation techs; -Staffing was based on acuity. 2. Review of the facility's Report of Nursing Staff Directly Responsible for Resident Care, dated 05/09/25 through 06/08/25, showed the following dates with two CNA's scheduled on the day shift when the facility assessment identified three CNA's were needed for the shift: -05/16/25; -05/18/25; -05/19/25; -05/26/25; -05/29/25; -05/31/25; -06/02/25; -06/04/25; -06/05/25; -06/06/25; -06/07/25; -06/08/25. 3. Review of the resident council meeting minutes showed the following: -On 04/02/25, residents said call lights were not working and the residents wanted the call lights answered timely; the staff responsible were the Maintenance Supervisor and the Director of Nursing; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 05/08/25, residents wanted call lights answered timely and the staff responsible was the Assistant Director of Nursing (ADON); -On 06/04/25, residents wanted call lights answered timely and the staff responsible were the ADON and the Administrator. 4. Review of Resident #5's face sheet showed his/her diagnoses included chronic osteomyelitis (a long-term bone infection and chronic pain syndrome (persistent pain that last weeks to years). Review of the resident's care plan, revised on 05/02/25, showed the following: -Acute pain/chronic pain; -Administer pain medications per order. Review of the resident's quarterly minimum data set (MDS), a federally mandated assessment instrument completed by facility staff, dated 05/20/25, showed the following: -Cognitively intact; -Scheduled pain medication and as needed pain medication given. Review of the resident's call light logs, dated 06/06/25 through 06/09/25, showed the following: -On 06/06/25 at 12:27 A.M., the call light went unanswered for 20 minutes; -On 06/06/25 at 2:15 A.M., the call light went unanswered for 19 minutes; -On 06/06/25 at 4:06 P.M., the call light went unanswered for 19 minutes; -On 06/06/25 at 5:23 P.M., the call light went unanswered for 42 minutes. Review of the resident's June 2025 medication administration record (MAR) showed an as needed oxycodone hydrochloride (a narcotic pain medication) 10 milligrams (mg) administered on 06/06/25 at 5:57 P.M. Review of the resident's call light logs, dated 06/06/25 through 06/09/25, showed the following: -On 06/07/25 at 5:51 P.M., the call light went unanswered for 21 minutes; -On 06/07/25 at 7:09 P.M., the call light went unanswered for 19 minutes; -On 06/08/25 at 3:41 P.M., the call light went unanswered for 27 minutes. Review of the resident's June 2025 MAR showed an as needed oxycodone hydrochloride 10 mg administered on 06/08/25 at 4:55 P.M. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's call light logs, dated 06/06/25 through 06/09/25, showed on 06/09/25, at 11:05 A.M., the call light went unanswered for 19 minutes. During an interview on 06/09/25 at 2:38 P.M., the resident said sometimes it took almost 40 minutes for staff to answer the call light. When he/she turned on the call light it was usually to request a pain pill. Review of the resident's call light log for 06/09/25 showed at 8:58 P.M., the call light went unanswered for 26 minutes. During an interview on 06/10/25 at 6:41 A.M., the resident said he/she had the call light on for about 30 minutes yesterday evening (6/9/25) before staff responded so he/she could get a pain pill. 5. Review of Resident #13's Care Plan, dated 02/05/25, showed the following: -Diagnoses include quadriplegia (paralysis of all extremities), contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints), neuropathy (weakness, numbness and pain from nerve damage, usually in the hands and feet) and chronic pain related to trauma; -Impaired physical mobility; -Resident will be free of complications of immobility; -Assist resident in performing movements / tasks; -Evaluate skin for areas of blanching or redness; -Observe ROM in all joints; -Passive ROM shiftly; -Dependent on staff for all ADL's; -Resident eats in his/her room, and is fed by staff; -Resident is an aspiration risk. Review of the resident's annual MDS, dated [DATE], showed the following: -Cognitively intact; -Limited ROM all extremities; -Dependent on staff for all activities of daily living (ADL'S); -PRN (as needed) pain medications, no non-med interventions for pain; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Takes opioid (pain relieving medication) daily; -No therapy, no range of motion or other ADL's provided by restorative nursing. Review of the resident's call light log, dated 06/06/25 through 06/09/25, showed the following: -On 06/06/25 at 3:15 A.M., the call light went unanswered for 37 minutes; -On 06/06/25 at 10:32 P.M., the call light went unanswered for 28 minutes; -On 06/07/25 at 9:56 A.M., the call light went unanswered for 37 minutes. During an interview on 06/11/25 at 4:15 P.M., the resident said the following: -Sometimes he/she had problems with staff answering call lights timely; -He/She has had to wait an hour for staff when he/she had pain and discomfort; -When he/she lays on any type of wrinkle it burned and having to wait for a long time was miserable; -Waiting an hour have your call light answered made him/her feel staff did not care about him/her; -There was not enough staff to do ROM with him/her; -The aides will assist him/her to stretch when he/she asks, but it was not the same as a good ROM program where he/she would receive active ROM to all joints for several repetitions; -He/She felt guilty asking the aides with a full assignment to do more than a few stretches because it took time and they were very busy; -Since his/her contractures have gotten worse, he/she has knots in his/her muscles and it was miserable; his/her muscles will get so tight he/she could feel pulsations in the muscle. 6. Review of Resident #22's care plan, last updated 02/04/25, showed the following: -Chronic pain, polymyalgia rheumatica (PMR)(is a condition causing pain and stiffness, primarily in the shoulders, neck, and hips), tremors, and frequent falls; -Resident has impaired visual function; -Resident uses oxygen; -Trouble swallowing; -Eight falls in the last year (not all in the facility); (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Ensure the resident's call light is in reach at all times, ensure prompt response to all request for assistance; -Chronic pain administer medications as ordered; -Resident requires limited physical assistance from staff for: dressing and walking in his/her room; -Resident requires extensive physical assistance from staff for: toilet use, transfers, and personal hygiene. Review of the resident's significant change MDS, dated [DATE], showed the following: -Cognition moderately impaired; -Requires supervision/touching assistance from staff members for eating, upper body dressing, to walk 10 feet, and wheel 50 feet with two turns; -Requires partial/moderate assistance from staff for oral hygiene, personal hygiene, and walk 50 feet with two turns; -Requires substantial/maximal assistance from staff for lower body dressing, putting on/taking off footwear, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer, walk 150 feet, and wheel 150 feet; -Dependent on staff for toileting hygiene and to shower/bathe. Review of the resident's call light log, dated 06/06/25 through 06/09/25, showed the following: -On 06/06/25 at 7:39 A.M., the call light went unanswered for 18 minutes; -On 06/06/25 at 11:33 A.M., the call light went unanswered for 18 minutes; -On 06/06/25 at 6:00 P.M., the call light went unanswered for 26 minutes; -On 06/06/25 at 9:37 P.M., the call light went unanswered for 17 minutes; -On 06/07/25 at 4:36 A.M., the call light went unanswered for 27 minutes; -On 06/07/25 at 10:08 A.M., the call light went unanswered for 29 minutes; -On 06/07/25 at 6:15 P.M., the call light went unanswered for 42 minutes; -On 06/07/25 at 7:43 P.M., the call light went unanswered for 19 minutes; -On 06/08/25 at 5:41 A.M., the call light went unanswered for 56 minutes; -On 06/08/25 at 10:44 A.M., the call light went unanswered for 17 minutes; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 06/08/25 at 3:51 P.M., the call light went unanswered for 31 minutes; -On 06/09/25 at 1:14 A.M., the call light went unanswered for 28 minutes; -On 06/09/25 at 2:46 A.M., the call light went unanswered for 18 minutes; -On 06/09/25 at 6:37 A.M., the call light went unanswered for 24 minutes; -On 06/09/25 at 7:36 P.M., the call light went unanswered for 52 minutes; -On 06/09/25 at 11:16 P.M., the call light went unanswered for 41 minutes. During an interview on 06/11/25 at 12:36 P.M., the resident said sometimes he/she has to wait a long time to get his/her call light answered. The resident's spouse (present at time of interview) said the resident has to wait a long time to get his/her call light answered at meal times and shift change. The resident and his/her spouse said they do not feel like the facility has enough staff during busy times like meals and shift changes to answer call lights. 7. Review of Resident #24's face sheet showed the following: -He/She was his/her own person; -Diagnoses of pulmonary fibrosis (chronic lung disease) and acute respiratory failure with hypoxia (absence of enough oxygen in the tissue to sustain bodily functions). Review of the resident's smoking and safety assessment, dated 04/08/25, showed the following: -The resident uses tobacco products; -The resident follows the facility's policy on location and time of smoking; -The resident was able to demonstrate safe smoking techniques without the help of staff. Review of the resident's care plan, revised 04/10/25, showed the following: -He/She used tobacco; -The resident requires supervision while smoking. Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff, dated 05/12/25, showed the following: -Cognitively intact; -Dependent for chair and bed-to-chair transfers. Review of the resident's call light log, dated 06/06/25 through 06/08/25, showed the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 06/06/25 at 10:41 A.M., the call light went unanswered for 22 minutes; -On 06/06/25 at 5:44 P.M., the call light went unanswered for 24 minutes; -On 06/06/25 at 9:37 P.M., the call light went unanswered for 19 minutes; -On 06/07/25 at 12:58 P.M., the call light went unanswered for 28 minutes; -On 06/08/25 at 7:34 A.M. the call light went unanswered for 37 minutes. Review of the resident's progress notes, dated 6/8/25 at 8:54 A.M., showed the resident was upset and crying due to not being able to go out to smoke. Staff educated the resident there were only two aides and one nurse working, and they were all busy assisting with breakfast, so there was nobody available to get the resident up with the mechanical lift and take him/her outside to smoke. The resident was still upset at 9:00 A. M. Review of the resident's call light log, dated 06/09/25 at 10:30 A.M., showed the call light went unanswered for 21 minutes. During an interview on 06/09/25 at 3:05 P.M., the resident said the following: -He/She was a smoker; -He/She required a mechanical lift and two staff to get out of bed; -When he/she went out to smoke, a staff member had to stay with her; -Call light response time varied, there were many occasions he/she had to wait 30 to 45 minutes; -Call light response time was slower on the day shift than during the evening or night shifts. Observation on 06/10/25 at 7:49 A.M. showed the following: -Resident shouting from room stating why am I being ignored; -Certified Medication Technician (CMT) N entered the room and asked the resident what was wrong; -The resident said he/she was supposed to go out for the 7:00 A.M. smoke break, but was still waiting 45 minutes later; -CMT N exited the room and walked down the hall looking for other staff; -At 7:53 A.M. the Assistant Director of Nursing (ADON) and Social Services Director (SSD) entered the resident's room and the ADON said staff would not be able to take him/her out right now due to the time; -The resident yelled he/she was tired of always missing smoke breaks because of staff. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/12/25 at 3:02 P.M. the SSD said the following: -The resident had been educated on the facilities smoking schedule and to utilize his/her call light prior to the scheduled time if he/she wanted to go out to smoke; -The resident had been educated that if his/her light was not answered in 15 minutes, then staff were busy providing cares, which the resident had also been educated as taking priority over smoke breaks; -The resident was educated that he/she was not being denied going to smoke, but would have to wait for cares that were higher priority; -The 7:00 A.M. smoke time was the hardest to accommodate as staff are busy getting other residents up to breakfast and feeding and monitoring them. 8. Review of Resident #16's face sheet showed his/her diagnoses include lumbar region radiculopathy (pinching of the nerves at the root which can cause pain or weakness). Review of the resident's care plan, revised on 05/16/25, showed the following: -The resident has current functional performance; -Needs limited assistance of one person for bed mobility and dressing; -Needs extensive assistance of one person with personal hygiene and toilet use; -Anticipate the resident's needs for pain relief and respond immediately to any complaints of pain. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Partial/moderate assistance from staff for oral hygiene, upper body dressing and personal hygiene; -Substantial/maximum assistance from staff for bathing, roll left and right, sit to lying, lying to sitting on the side of the bed, sit to stand transfer, chair/bed-to-chair transfer, toilet transfer and tub/shower transfers; -Dependent on staff for toileting hygiene, lower body dressing and putting on/taking off footwear; -Frequently incontinent of bowel and bladder. Review of the resident's call light logs, dated 06/06/25 through 06/09/25, showed the following: -On 06/06/25 at 1:14 A.M., the call light went unanswered for 18 minutes; -On 06/07/25 at 10:06 A.M., the call light went unanswered for 27 minutes; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 06/08/25 at 5:30 A.M., the call light went unanswered for 20 minutes; -On 06/08/25 at 9:27 P.M., the call light went unanswered for 20 minutes; -On 06/09/25 at 5:25 A.M., the call light went unanswered for 41 minutes. 9. During an interview on 06/11/25 at 4:45 P.M., CNA M said the following: -The resident has contractures, especially in his/her right arm; -The facility did not have a restorative aide or anyone designated to do a full ROM program; -IT was difficult to answer call lights at meal times and shift change times; -The facility did not have enough staff to stay with the residents eating in their room who were aspiration risk, assist in the dining room and answer lights. It was not possible to be in two places at once. During an interview on 06/12/25 at 1:03 P.M., CNA D said the following: -It was difficult to answer call lights with only two CNA's on the floor; -When there are only two CNA's on the floor, it was hard to take the residents to smoke and answer the call lights timely; -Call lights should be answered within five minutes if there was no an emergency. During an interview on 06/12/25 at 1:09 P.M., CNA E said call lights should be answered within five minutes. During an interview on 06/12/25 at 1:16 P.M., CNA F said call lights should be answered in less than five minutes. During an interview on 06/11/25 at 10:05 A.M., and 06/12/25 at 7:21 P.M., Registered Nurse (RN) C said the following: -They did not know how to run the call light report so no one was monitoring the call light report; -Days and evening shift could be tricky on answering call lights during mealtimes and staff breaks; -Sometimes smoke breaks were late because there was no staff to take the resident out at the assigned time due to mealtimes and less staff on evening shift; -Call lights should ideally be answered within 5 minutes. During an interview on 06/12/25 at 7:30 P.M., the Assistant Director of Nurses (ADON) said the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A resident should be allowed to go out to smoke during assigned times regardless of the staffing situation; -Call lights should be answered as quickly as possible with 15 minutes pushing the limit and no more than 20 minutes; -The restorative program has been hard to implement due to staffing issues with no DON in the building to oversee the restorative program. During an interview on 06/12/25 at 7:30 P.M., the Director of Nurses (DON) said the following: -Call lights should be answered as quickly as possible, ideally within 5 minutes with 15 minutes pushing the limit; -If a resident needed to go to smoke break and the assigned staff was busy, she would expect other staff be utilized to complete the smoke break. During an interview on 06/12/25 at 7:55 P.M., the administrator said the following: -Call lights should be answered in a timely manner; -Resident smoke breaks should occur as scheduled; if the assigned staff cannot complete the smoking task, other staff should be utilized; -He had not had a DON until 06/09/25, so had not been able to effectively look at all the processes to see if additional staffing was needed; -He did not know if the facility needed higher number of staff during meal times and shift changes or reorganization to make sufficient use of staff. MO254369

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to provided a Registered Nurse (RN) eight consecutive hours a day, seven days a week. Additionally the facility failed to have a full time Director of Nursing (DON) from 05/10/25 through 06/09/25. The facility census was 25. Review of the facility's policy, Sufficient Staff Policy, revised 05/18/24, showed the following: -It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident; -Except when waived, the facility must use the services of an RN for at least eight consecutive hours a day, seven days a week; -The DON may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Review of the undated Facility Assessment showed the following: -The facility had a DON; -Staffing patterns: RN eight hours per resident day; -Overall staffing needs: RN's to provide direct care one total needed, RN's available to provide direct care (includes DON and RN's with administrative duties) two total needed. 1. Review of the RN individual employee timecards from 05/05/25 through 06/09/25 showed the following: -On 05/05/25 there were no hours of RN coverage in 24 hours reviewed; -On 05/06/25 there were 5.75 hours of RN coverage in 24 hours reviewed; -On 05/09/25 there were 5.5 hours of RN coverage in 24 hours reviewed; -On 05/12/25 there were 5.5 hours of RN coverage in 24 hours reviewed; -On 05/16/25 there were no hours of RN coverage in 24 hours reviewed; -On 05/19/25 there were 5.25 hours of RN coverage in 24 hours reviewed; -On 05/23/25 there were 7.5 hours of RN coverage in 24 hours reviewed; -On 05/27/25 there were 5.75 hours of RN coverage in 24 hours reviewed; -On 05/28/25 there were 6 hours of RN coverage in 24 hours reviewed; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265644	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookfield Health Care Center	215 East Pratt Brookfield, MO 64628

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-On 05/30/25 there were 4 hours of RN coverage in 24 hours reviewed; -On 06/01/25 there were no hours of RN coverage in 24 hours reviewed; -On 06/02/25 there were 5/75 hours of RN coverage in 24 hours reviewed. During an interview on 06/12/25 at 7:21 P.M., RN C said the following: -There had been multiple days the facility did not have an RN for eight hours of the day; -When he/she worked, he/she had been serving as the RN in the building; -He/She did not always work eight hours when serving as the RN in the building; -There had been multiple days since he/she stepped down as the DON that the building had been without a full-time DON; -The facility had been without a full-time DON for almost a month. During an interview on 06/09/25 at 9:45 A.M. and 06/12/25 at 7:30 P.M., the Assistant Director of Nursing (ADON) said the following: -The facility did not have a full-time DON at this time; -The facility was without a DON from the period of 05/10/25 through 06/09/25; -During that time, the corporate DON was in the facility some, but not full-time, and not for the entire time the facility was without a DON; -There should be an RN in the building eight hours each day; -There should be a full-time DON. During an interview on 06/12/25 at 7:50 P.M., the administrator said the following: -He was aware of the requirement for an RN in the building eight hours of every day; -Recently the facility had not had an RN in the building eight hours of every day; -There should be a full-time DON in the facility. MO254153 MO254369