

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265644	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/15/2025
NAME OF PROVIDER OR SUPPLIER Brookfield Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one resident (Resident #1), in a review of nine sampled residents, received care and treatment in accordance with professional standards of practice when the resident presented with stroke like symptoms including facial drooping on the left side, slurred speech, delayed responses, and left sided weakness on 8/25/25. The Director of Nursing (DON) advised the resident's family that given the resident's age, treatment would potentially be limited. The facility failed to send the resident to the hospital for evaluation. The resident sustained a stroke and the resident's functional abilities declined as a result. Prior to the episode the resident was able to walk with a cane or walker for 125 feet, transfer from a wheelchair to the bed with minimal assistance and could use three pound weights on both his/her ankles during therapy. After the episode the resident was unable to sit for 30 seconds on the edge of the bed without support, stand for 10 seconds without support, was dependent on staff for sit to stand positioning and bed to chair transfers. The resident had severe mobility impairment and required assistance of two staff with a cane to take steps. The facility census was 23. Review of the facility's Notifying Clinicians Policy, dated 6/26/24, showed the following: -The purpose of the policy was to ensure the clinicians are properly notified of a resident's change in condition and overall health and/or mental status; -The clinician shall be notified of changes in conditions, emergent situations, routine diagnostics, and concerns of the resident's overall health status that included changes in behaviors, agitation, and anything regarding a change in the resident's baseline or condition; -The nurse will initiate verbal communication with the clinician when a condition or incident arises with a resident which would warrant an immediate implementation of a change in plan of care to include physician advisement or initiation of physician orders to avoid a delay in treatment that may cause worsening in condition. Review of WebMD (a health information website that provides up to date medical content) showed the following: -Signs of a stroke included one side of the face may sag, one arm may droop when both are raised, speech may sound strange or slurred; -If a person exhibits signs of a stroke, someone needs to call 911 immediately. Don't call your physician or family first; -You should get to the hospital as quickly as possible; -90% of people who have strokes have a blood clot that blocks the blood flow to the brain; -Once at the hospital, within 10 minutes a physician will complete an exam, within 15 minutes the physician will get blood tests, within 25 minutes a Computed Tomography (CT, a diagnostic imaging procedure that uses a combination of x-rays and computer technology to produce detailed images of the inside of the body, including the bones, muscles, fat, organs, and blood vessels) scan will be done to tell what kind of stroke occurred, and once the physician has the CT results treatment will begin; -If an ischemic stroke (when a blood clot blocks an artery in the brain, cutting off blood flow) was identified a blood clot busting drug would be administered, but it should happen within three hours of the stroke; -If a hemorrhagic stroke (occurs when a blood vessel in the brain ruptures and bleeds into the surrounding brain tissue) was identified, surgery may be needed to stop the bleeding. Review of Resident #1's undated face sheet showed the following: -The resident admitted to the facility on [DATE]; -The resident had diagnoses that included unspecified dementia (a chronic condition that causes a decline in mental functioning, such as thinking, remembering, and reasoning, to the point that it interferes with daily life), high blood pressure, and cognitive communication deficit (trouble participating in conversations and difficulty understanding what was said). Review of the resident's Care Plan, dated 6/30/25, showed the following: -The resident was at risk for falls. Determine the resident's ability to transfer and initiate fall risk precautions; -The resident will be able to communicate basic needs daily. Ask simple questions and clear statements, communicate with the resident/family/caregivers regarding the resident's capabilities and needs, limit changes to the resident's general routine, and use a calm, gentle approach; -There was no documentation that showed the resident had symptoms of muscle weakness or slurred speech. The plan did not show the amount of staff assistance needed for the resident. Review of the resident's Significant Change Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 7/16/25, showed the following: -The resident's cognition was severely impaired; -The resident usually understood others and made self-understood; -The resident required supervision for rolling in bed, change from sitting to lying positioning, transfers, ambulation, eating, and dressing; -The resident used a cane or walker to assist him/her with ambulation; -The resident had no impairments of upper or lower extremities. Review of the resident's Occupational Therapy treatment note, dated 8/21/25 at 9:00 A.M. showed the</p>		