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	03/18/2026

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician, timely, for one resident (Resident #3), in a review of four sampled residents, when the resident's continuous positive airway pressure (CPAP, a machine that keeps the airway open during sleep for persons with sleep apnea) mask broke on 1/24/26. The resident went 12 days in the facility without using the CPAP at night, due to not having a functioning mask available. The facility also failed to notify the physician when the resident experienced a change in condition on 01/31/26, which included low oxygen saturation, lethargy and anxiety. Staff sent the resident to the hospital on [DATE]. The resident was hypercapnic (condition characterized by abnormally high levels of carbon dioxide in the blood), was hospitalized for two days, and required treatment with a bilevel positive airway pressure (BiPap) machine (noninvasive ventilator used to assist breathing by delivering pressurized air through a mask) to reduce the amount of carbon dioxide in the resident's blood. The census was 34.Review of the facility's Noninvasive Ventilation-CPAP policy, dated 5/14/24, showed the following:-Noninvasive ventilation referred to the administration of ventilator support without using an invasive device;-CPAP was a respiratory therapy intervention used to provide a patent airway during periods of sleep apnea. It uses air pressure generated by the machine, delivered through a tube into a mask that fits over the nose or mouth;-Replace equipment immediately when it is broken or malfunctions;-Replace equipment routinely in accordance with manufacturer recommendations. Review of the Resident #3's care plan, dated 10/28/25, showed the following:-The resident's diagnoses included chronic obstructive pulmonary disease (COPD, lung disease), chronic respiratory failure, and sleep apnea;-Elevate head of bed to prevent shortness of breath while lying flat;-The resident had oxygen therapy;-Monitor for signs and symptoms of respiratory distress and report to physician as needed: respirations, pulse oximetry (checks percent of oxygen in the blood), restlessness, diaphoresis (sweating), headaches, lethargy (state of severe exhaustion, sluggishness, or lack of energy and motivation), confusion, cough, accessory muscle usage, and skin color;-Humidified oxygen via nasal cannula at six liters to keep oxygen saturations above 90%. Review of the resident's physician orders, dated January 2026, showed an order to apply the CPAP on the resident at bedtime with oxygen connected with settings of 14/8 and pressure support (PS, extra boost of pressure the machine provided when a person breathes in, compared to when a person breathed out) 6.0 related to COPD, and obstructive sleep apnea (serious sleep disorder where throat muscles relax too much during sleep, causing the airway to collapse and block breathing) (original order dated 10/20/25). Review of the resident's treatment administration record (TAR), dated 1/24/26, showed the staff did not apply the resident's CPAP. Review of the resident's nurse note, dated 1/25/26 at 2:14 A.M., showed the CPAP mask was missing. Review of the resident's TAR, dated 1/25/26, showed the staff did not apply the resident's CPAP. Review of the resident's nurse note, dated 1/26/26 at 10:38 A.M., showed the CPAP mask was no longer in use, awaiting a new mask. Review of the resident's TAR, dated 1/26/26, showed the staff did not apply the resident's CPAP. Review of the resident's nurse note, dated 1/27/26 at 1:33 A.M., showed waiting for arrival of replacement pieces. Review of the resident's TAR, dated 1/27/26, showed the staff did not apply the resident's CPAP. Review of the resident's nurse note, dated (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 0684 Level of Harm - Actual harm Residents Affected - Few	1/28/26 at 12:17 A.M., showed awaiting parts and pieces to repair machine. Review of the resident's TAR, dated 1/28/26, showed the staff did not apply the resident's CPAP. Review of the resident's TAR, dated 1/29/26, showed the staff did not apply the resident's CPAP. Review of the resident's nurse note, dated 1/30/26 at 2:01 P.M., showed the resident was not using CPAP, awaiting mask. Review of the resident's TAR, dated 1/30/26, showed the staff did not apply the resident's CPAP. Review of the resident's nurse note, dated 1/31/26 at 12:23 A.M., showed the following:-Oxygen saturation of 91% (normal range 95% - 100%) on oxygen via nasal cannula;-The resident was lethargic;-He/She was anxious, which was a recent change in mood;-The resident asked the staff if something was wrong with him/her. Review of the resident's nurse note, dated 1/31/26 at 2:25 A.M., showed the resident was anxious/worried asking if anything was wrong with him/her because he/she never slept the day away like he/she did. Review of the resident's nurse note, dated 1/31/26 at 3:24 A.M., showed the following:-The resident was anxious this night and asked if something was wrong with him/her;-The resident said he/she doesn't sleep like he/she did;-He/She needed a silicone mask which was to be on order;-Oxygen saturation lower than normal.(There was no documentation the nurse contacted the physician regarding the resident's change in condition.) Review of the resident's TAR, dated 1/31/26, showed the staff did not apply the resident's CPAP. Review of the resident's TAR, dated 2/1/26, showed the staff did not apply the resident's CPAP. Review of the resident's TAR, dated 2/2/26, showed the staff did not apply the resident's CPAP. Review of the facility's email to the equipment supplier, dated 2/3/26 at 12:08 P.M., showed the following:-The facility had a resident who immediately needed a new CPAP mask and straps on his/her CPAP machine;-The Director of Nursing (DON) requested advice on how to order a new one. Review of the equipment supplier's email, dated 2/3/26 at 12:22 P.M., showed the supplier did not provide CPAP supplies. The facility then contacted their Corporate Office to find out who the correct supplier was for CPAP masks. Review of the resident's TAR, dated 2/3/26, showed the staff did not apply the resident's CPAP. Review of the resident's nurse note, dated 2/4/26 at 7:13 A.M., showed the following:-The staff found the resident not verbally responding or behaving as normal;-His/Her lips were slightly purple and his/her fingers were purple;-Oxygen saturation was 75% on 5 liters of oxygen;-The staff attempted several times to reposition the resident and assisted with oxygen intake, but his/her oxygen saturation stayed at 75% or just below;-The nurse contacted the physician, who gave an order to send the resident to the hospital for evaluation and treatment. Review of the resident's nurse note, dated 2/4/26 at 1:50 P.M., showed the resident was transferred to another hospital related to being on BiPap machine and having elevated carbon dioxide levels and also had a urinary tract infection. Review of the resident's hospital history and physical, dated 2/4/26, showed the following:-The resident had chronic respiratory failure and normally wore supplemental oxygen at 5 liters per nasal cannula at all times and CPAP with oxygen nightly;-Per facility report, the resident's CPAP was broken for three weeks;-The staff sent the resident to the hospital on 2/4/26 with altered mental status due to hypercapnia, likely associated with known CPAP malfunction;-The resident went without CPAP therapy at night for two to three weeks. Review of the resident's hospitalist progress note, dated 2/4/26, showed the resident needed to have home CPAP replaced prior to discharge. Review of the resident's nurse note, dated 2/6/26 at 2:00 P.M., showed the resident was readmitted to the facility. Review of the resident's physician orders, dated 2/6/26, showed to apply the CPAP on the resident at bedtime with oxygen connected with settings of 14/8 and PS 6.0 related to COPD and obstructive sleep apnea. Review of the resident's TAR, dated 2/6/26, showed the staff did not apply the resident's CPAP. Review of the resident's quarterly Minimum Data Set (MDS), federally mandated assessment instrument completed by facility staff, dated 2/25/26, showed the following:-The resident was cognitively intact;-No refusal of care;-He/She experienced shortness of breath or trouble breathing when lying flat;-He/She used oxygen therapy and noninvasive mechanical ventilator as a resident of the facility within the last fourteen days of the assessment. During an interview on 3/18/26 at 9:55 A.M., Resident #3 said the following:-He/She had an adverse reaction from the old (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	CPAP, resulting in being hospitalized ;-The staff provided him/her with a new mask that worked better. During an interview on 3/18/26 at 10:26 A.M., the Assistant Director of Nursing (ADON)/Licensed Practical Nurse (LPN) said the following:-The staff was unable to apply the resident's CPAP because the mask was broken;-The resident went without the CPAP for a few days;-The staff documented when they did and did not apply the CPAP;-He/She knew the resident's carbon dioxide levels were increased so the staff sent him/her to the hospital. During an interview on 3/18/26 at 3:38 P.M., LPN A said the following:-The resident's CPAP mask broke, but the staff tried to keep it together with tape; however, a piece of the mask was broken and lost, the staff couldn't utilize the mask;-He/She worked with the resident on 1/31/26 when the resident showed a change in status and reported his/her concerns with the DON, but didn't call the physician;-He/She didn't remember calling the physician about the broken mask or when the resident had a change in condition;-He/She didn't call the physician because the resident didn't have any changes in lung sounds and was maintaining his/her oxygen saturation with the oxygen;-The resident slept more than usual but was still alert and oriented. During an interview on 3/19/26 at 8:34 A.M., LPN B said the following:-He/She knew the resident's CPAP mask was broken, but he/she didn't report it to the physician;-He/She didn't find any changes in the resident during the daily respiratory assessment, so he/she didn't call the physician regarding any changes;-He/She worked the day the resident returned from the hospital;-He/She called the physician to notify him/her the resident returned to the facility;-The physician said the resident needed a CPAP mask as soon as possible;-LPN B was not aware a mask had arrived and was available for the resident and LPN B did not look for the mask. During interviews on 3/18/26 at 10:30 A.M. and 1:10 P.M., the DON said the following:-She expected staff to contact her and the resident's physician when a CPAP mask was broken;-She didn't remember when the staff told her the resident's CPAP mask was broken. During an interview on 3/18/26 at 1:50 P.M., the Administrator said the following:-She expected the nurses to contact the physician when an ordered piece of care equipment was not functioning;-The nurses should contact the physician when a resident had a change from baseline;-The first email sent to order a new CPAP mask was sent to the wrong supplier;-When the facility contacted the correct supplier, it only took a couple of days to receive the CPAP mask. During an interview on 3/18/26 at 2:09 P.M., the resident's Primary Care Physician said the following:-The staff notified him/her of the resident's broken CPAP mask and change in condition;-He/She ordered the facility to get a new CPAP mask as soon as possible.-He/She didn't have a specific date on when the facility notified him/her about the resident's broken mask and change in condition. #2746113