STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675539	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Bradford at Brookside	301 West Park Drive Livingston, TX 77351

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on observation, interview and record review the facility failed to ensure residents had the right to be treated with respect and dignity for 1 of 6 residents reviewed for resident rights. (Resident #1) The facility failed to ensure CNA C did not put her fingers in Resident #1's face. This failure could cause the resident to be distressed and could cause residents to feel disrespected. Findings included: Record review of Resident #1 face sheet dated 05/19/25 indicated a [AGE] year-old female initially admitted to the facility on [DATE]. Resident #1 had diagnoses including alzheimer's disease (a progressive disease that destroys memory and other important mental functions), cerebral infarction (occurs when blood flow to the brain is blocked, causing brain tissue to die), anxiety disorder, dysphagia following cerebral infarction (difficulty swallowing), dysphagia oral phase (difficulty with the initial stages of swallowing) and schizophrenia (a disorder that affects a person's ability to think feel, and behave clearly). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1 was rarely understood and usually understood others. No BIMS assessment was performed on Resident #1. Resident #1 required moderate assistance for oral hygiene and eating. Resident #1was dependent with toileting hygiene, personal hygiene, and shower/bathe self. Resident #1 was always incontinent to bowel and bladder. Record review of Resident #1's care plan dated 04/17/25 indicated: Resident #1 had impaired cognitive function/dementia or impaired thought process. Interventions: administer medications as ordered. Monitor/document for side effects and effectiveness. Ask yes/no questions in order to determine the resident's needs. Communicate with the resident, family and caregiver regarding resident's capabilities and needs. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/19/25 at 9:47 A.M., Family Member #1 said she had a video of aides putting their fingers in her family member mouth. She said the aides that was putting their fingers in her family member's mouth was CNA C and CNA E. She said after watching the video she did not know what the reasoning was for the aides putting their fingers in her family member's face. She said when she watched the video 3 days later after the incident happened it was disturbing to see them doing this to her family member. She said later she had a conversation with CNA C. Family Member #1 said she liked to laugh and joke with her family member. Family Member #1 said she told CNA C she thought they were laughing at her family member. She said she did not speak to CNA C until a month ago about the incident, because management removed her and CNA E from her family member's hall. She said one day she spoke to CNA C and CNA C told her she had thought about what she did to her family member a couple months ago and that was not right, so she apologized for her behavior. During an observation and interview on 5/19/25 at 12:47 P.M., Resident #1 was lying in bed watching T.V. Resident #1 said she was comfortable. During an observation on 5/20/25 at 8:25 A.M., the surveyor received a video from Family Member #1 via text message. Surveyor observed CNA E and CNA C preparing to perform incontinent care for Resident #1 as she laid in bed. As Resident #1 was laid in bed CNA C kept putting her fingers in Resident #1's face continuously. After several attempts of putting her fingers in Resident #1's face, Resident #1 tried to bite CNA C fingers. The footage clearly showed Resident #1 was agitated and CNA C stopped putting her fingers in her face afterwards. During an interview on 5/20/25 at 8:46 A.M., the Interim DON said he did not believe Resident #1's behaviors were due to how staff were treating her. He said he had observed the CNA's take care of her on a daily basis. The Surveyor showed the Interim DON video footage from Resident #1's camera. After watching the video of CNA C providing care to Resident #1, he said, it was not appropriate for CNA C to place her hands in the resident's face. During an interview on 5/20/25 at 9:07 A.M., the Regional Director of Clinical Services asked to see the video footage from Resident #1's camera. She said it was not appropriate for CNA C to put her hands in a Resident #1's face. During an interview on 5/20/25 at 9:45 A.M., CNA C said she was playing with Resident #1 when she put her fingers in Resident #1's face. She said everyday was different with her Resident #1. She said she did not play with her anymore since she found out she had dementia (a group of thinking and social symptoms that interferes with daily functioning). CNA C said she did not feel like it was appropriate behavior for her to put her fingers close to Resident #1's mouth. She said once the family member got involved, she apologized to her for her actions with her Resident #1. She said she was a new CNA when she did that. During an interview on 5/21/25 at 9:38 A.M., LVN A said she felt like staff putting their fingers in a resident's face was inappropriate. She said she would not do that to a resident. She said a staff member putting their fingers in a resident's face could affect their dignity. She said she would not want anyone to put their hands in her face. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/25 at 10:01 A.M., the Interim DON said the video could have been interpreted in a different way that might lead someone to think that CNA C was trying to distract Resident #1 from not fighting. He said he had not spoken to CNA C. He said he saw CNA C's fingers in Resident #1's face, but he could not hear anything from the video. He said CNA C putting her fingers in Resident #1 face could affect her dignity and her trying to bite the CNA's finger was a way to express she did not like her putting her fingers in her face. He said the facility was going to do in servicing on resident rights with all staff. During an interview on 5/21/25 at 10:30 A.M., the Regional Director of Clinical Services said she did not speak to CNA C to know the intention of the video, but what she saw she thought was CNA C was being playful with the resident, until the resident tried to bite the staff. She said that was clearly an indication that the resident did not like the staff members fingers in her face. She said that behavior could affect the residents' dignity. She said the facility would do trainings over dignity to ensure that type of behavior was not happening in the facility. She said she would not feel comfortable with staff putting their fingers in her face. Record review of the facility's policy on Resident Rights revised December 2016 indicated: Employees shall treat all residents with kindness, respect, and dignity. 1.Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: .a. a dignified existence; .b.be treated with respect, kindness, and dignity.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 1 of residents (Resident #1) reviewed for resident abuse. The facility failed to ensure Resident #1 was free from abuse when CNA C put her fingers in Resident #1's face. This failure could cause the residents at risk of disrespect, mental anguish, and/or emotional distress. Findings included: Record review of Resident #1 face sheet dated 05/19/25 indicated a [AGE] year-old female initially admitted to the facility on [DATE]. Resident #1 had diagnoses including alzheimer's disease (a progressive disease that destroys memory and other important mental functions), cerebral infarction (occurs when blood flow to the brain is blocked, causing brain tissue to die), anxiety disorder, dysphagia following cerebral infarction (difficulty swallowing), dysphagia oral phase (difficulty with the initial stages of swallowing) and schizophrenia (a disorder that affects a person's ability to think feel, and behave clearly). Record review of Resident #1's quarterly MDS assessment dated [DATE] indicated Resident #1 was rarely understood and usually understood others. No BIMS assessment was performed on Resident #1. Resident #1 required moderate assistance for oral hygiene and eating. Resident #1was dependent with toileting hygiene, personal hygiene, and shower/bathe self. Resident #1 was always incontinent to bowel and bladder. Record review of Resident #1's care plan dated 04/17/25 indicated: Resident #1 had impaired cognitive function/dementia or impaired thought process. Interventions: administer medications as ordered. Monitor/document for side effects and effectiveness. Ask yes/no questions in order to determine the resident's needs. Communicate with the resident, family and caregiver regarding resident's capabilities and needs. During an interview on 5/19/25 at 9:47 A.M., Family Member #1 said she had a video of aides putting their fingers in her family member mouth. She said the aides that was putting their fingers in her family member's mouth was CNA C and CNA E. She said after watching the video she did not know what the reasoning was for the aides putting their fingers in her family member's face. She said when she watched the video 3 days later after the incident happened it was disturbing to see them doing this to her family member. She said later she had a conversation with CNA C. Family Member #1 said she liked to laugh and joke with her family member. Family Member #1 said she told CNA C she thought they were laughing at her family member. She said she did not speak to CNA C until a month ago about the incident, because management removed her and CNA E from her family member's hall. She said one day she spoke to CNA C and CNA C told her she had thought about what she did to her family member a couple months ago and that was not right, so she apologized for her behavior. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 5/19/25 at 12:47 P.M., Resident #1 was lying in bed watching T.V. Resident #1 said she was comfortable. During an observation on 5/20/25 at 8:25 A.M., the surveyor received a video from Family Member #1 via text message. Surveyor observed CNA E and CNA C preparing to perform incontinent care for Resident #1 as she laid in bed. As Resident #1 was laid in bed CNA C kept putting her fingers in Resident #1's face continuously. After several attempts of putting her fingers in Resident #1's face, Resident #1 tried to bite CNA C fingers. The footage clearly showed Resident #1 was agitated and CNA C stopped putting her fingers in her face afterwards. During an interview on 5/20/25 at 8:46 A.M., the Interim DON said he did not believe Resident #1's behaviors were due to how staff were treating her. He said he had observed the CNA's take care of her on a daily basis. The Surveyor showed the Interim DON video footage from Resident #1's camera. After watching the video of CNA C providing care to Resident #1, he said, it was not appropriate for CNA C to place her hands in the resident's face. During an interview on 5/20/25 at 9:07 A.M., the Regional Director of Clinical Services asked to see the video footage from Resident #1's camera. She said it was not appropriate for CNA C to put her hands in a Resident #1's face. During an interview on 5/20/25 at 9:45 A.M., CNA C said she was playing with Resident #1 when she put her fingers in Resident #1's face. She said everyday was different with her Resident #1. She said she did not play with her anymore since she found out she had dementia (a group of thinking and social symptoms that interferes with daily functioning). CNA C said she did not feel like it was appropriate behavior for her to put her fingers close to Resident #1's mouth. She said once the family member got involved, she apologized to her for her actions with her Resident #1. She said she was a new CNA when she did that. During an interview on 5/21/25 at 9:38 A.M., LVN A said she felt like staff putting their fingers in a resident's face was inappropriate. She said she would not do that to a resident. She said a staff member putting their fingers in a resident's face could affect their dignity. She said she would not want anyone to put their hands in her face. During an interview on 5/21/25 at 10:01 A.M., the Interim DON said the video could have been interpreted in a different way that might lead someone to think that CNA C was trying to distract Resident #1 from not fighting. He said he had not spoken to CNA C. He said he saw CNA C's fingers in Resident #1's face, but he could not hear anything from the video. He said CNA C putting her fingers in Resident #1 face could affect her dignity and her trying to bite the CNA's finger was a way to express she did not like her putting her fingers in her face. He said the facility was going to do in servicing on resident rights with all staff. During an interview on 5/21/25 at 10:30 A.M., the Regional Director of Clinical Services said she did not speak to CNA C to know the intention of the video, but what she saw she thought was CNA C was being playful with the resident, until the resident tried to bite the staff. She said that was clearly an indication that the resident did not like the staff members fingers in her face. She said that behavior could affect the residents' dignity. She said the facility would do trainings over dignity to ensure that type of behavior was not happening in the facility. She said she would not feel comfortable with staff putting their fingers in her face. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy on Abuse, Neglect, Exploitation and Misappropriation Prevention Program revised April 2021 indicated: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms . 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including but not necessarily limited to . a. facility staff . Record review of the facility's policy on Resident Rights revised December 2016 indicated: Employees shall treat all residents with kindness, respect, and dignity. 1.Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: .a. a dignified existence; .b.be treated with respect, kindness, and dignity.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48958 Based on observation, interview and record review the facility failed to ensure residents with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 of 3 residents (Resident #2) reviewed for pressure injury. The facility failed to ensure the Treatment Nurse measured and adequately documented Resident #2's wound in the EMR when it was initially found on 05/15/2025. These failures could place residents at risk for deterioration of wounds. Findings included: Record review of Resident #2's face sheet dated 05/19/25 indicated a [AGE] year-old female initially admitted to the facility on [DATE]. Resident #2 had diagnoses including major depressive disorder (a serious mental illness characterized by persistently low mood, loss of interest or pleasure in activities, and other symptoms like changes in sleep, appetite and energy), down syndrome (a genetic chromosome 21 disorder causing developmental and intellectual delays) and urinary tract infections (an illness in any part of the urinary tract, the system of organs that makes urine). Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated Resident #2 was rarely understood and usually understood others. No BIMS assessment was conducted for Resident #2 due to severe cognitive impairment. Resident #2 required moderate assistance for oral hygiene, toileting hygiene, shower/bathe self, personal hygiene, roll left and right and sit to lying. Resident #2 was always incontinent of bowel and bladder. Record review of Resident #2's care plan dated 04/24/25 indicated pressure ulcer prevention: assess for appropriate footwear. Encourage out of bed. Therapy disciplines to screen, evaluate, and treat as indicated. Record review of a facility's wound report dated 05/14/25 indicated Resident #2 was not listed on the report. Record review of Resident #2's order summary report dated 05/15/25 indicated wound treatment: collagen every shift, cleanse wound to right gluteal fold with normal saline or skin cleanser. Pat dry. Apply collagen to wound bed. Cover with dry dressing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's progress note dated 05/21/25 by the Treatment Nurse indicated: Skin Issue: #001: Skin issue has been evaluated. Location: Rear right thigh. Additional location information: right gluteal fold. Issue type: Abrasion. Wound acquired in-house. Exact date: 05/15/2025 Signs and symptoms of infection: None. Painful: No. Staged by: In-house nursing. Length (cm): 2.6 Width (cm): 0.4 Depth (cm): 0.1 Undermining: No. Tunneling: No. Epithelial: 100%. Exudate amount: Light. Exudate type: Serous: clear watery fluid, which is separated from solid elements. Odor after cleansing: None. Periwound: Attached. Surrounding tissue: Fragile. Surrounding tissue: Blanching. Dressing appearance: Intact. Dressing saturation: Minimal less than 25%. Cleansing solution: Generic wound cleanser. Other primary dressing: Collagen sheet Secondary dressing: Dry. Additional care: Incontinence management. Additional care: Moisture barrier. During an interview on 5/19/25 at 10:53 A.M., Resident #2's family member said Resident #2 was not getting wound care until CNA F contacted someone. She said Resident #2 received the sore to the back of her legs from the facility a couple of weeks ago. She said all she wanted was for Resident #2 to be taken care of. During an interview on 5/20/25 at 1:42 P.M., Resident #2 said she did not hurt her leg and it does not hurt. During an interview and observation on 5/20/25 at 1:52 P.M., CNA B said Resident #2 had an open area on the back of her right leg and she thought it was from her pulling up her brief. She said she knew the sore had been on the Resident #2 for at least 2 weeks. She knew or didn't know how long the area had been opened. CNA B showed the surveyor the shallow opening, pink/red, moist area to the back of Resident #2's right thigh below her buttocks which appeared to be a stage 2 pressure injury with no signs and symptoms of infections. The area was opened to air with no dressing during time of observation. During an interview on 5/20/25 at 2:20 P.M., CNA D said the open area had been on Resident #2 for about 2 or 2 1/2 weeks. She said it was a reoccurring thing that comes and goes. She said she reported it to LVN G and the Treatment Nurse. She said she does not remember the exact date she reported the wound. During an interview on 5/20/25 at 2:52 P.M., the Treatment Nurse said she had not put the wound assessment for Resident #2 in the EMR yet, because staff told her about the wound last week. She said she put the orders in for Resident #2's wound treatment on 5/15/25 and she went on vacation for the next 4 days. She said she just returned back to work today. She said she put a wound treatment in the system for Resident #2's wound 5/15/25 and had a nurse to cover her tasks while she was off and on the weekends. She said the nurse covering her treatments for her when she was off just did not do the wound assessment form for Resident #2 for her when she was off. She said she had been the treatment nurse at the facility for 2 years. She said she was notified of the new skin issue with Resident #2 on 5/15/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/20/25 at 3:03 P.M., the Treatment Nurse said she did not complete the wound assessment for the new skin issue for Resident #2. She said she looked at Resident #2's wound, but she never filled out the wound form for that area. She said the treatments pop up on the wound tab in the EMR to let the nurse know the treatment needs to be done. She said the aides had notified her that Resident #2 had a spot on the back of her leg right leg where she pulled up the brief. She said the CNA notified her of the skin issue on 5/15/25. She said she did not remember who the CNA was that notified her of the new skin issue. She said she had the measurements in her bag that she took on 5/15/25, but she had not filled out the wound form in the EMR. During an interview on 5/20/25 at 3:36 P.M., the Regional Director of Clinical Services said whenever a new wound was found in the facility, it should be measured and documented. She said the Treatment Nurse told her she found the new wound on Resident #2 and started a new treatment, but she just didn't document the measurements. She said the nurses should be doing measurements and documenting the wounds they find in the EMR. She said there was an initial skin assessment that should be done in EMR for new skin issues and she could not find it at this time. During an interview on 5/21/25 at 9:25 A.M., the Interim DON provided the surveyor with a skin assessment for Resident #2 dated 5/13/25. Surveyor informed him that the Treatment Nurse said that she assessed the wound on 5/15/25, but did not document the measurements in EMR, he said he agreed. During an interview on 5/21/25 at 9:38 A.M., LVN A said the nurse was responsible for documenting a new wound. She said if it happened while the Treatment Nurse was there, she would go ahead and assess the wound and take care of the resident and notify the Treatment Nurse about the skin issue. She said an initial assessment should be performed to understand the severity of the skin issue. She said if there was no documentation on a wound no one would know it was there and it would not be monitored. During an interview on 5/20/25 at 9:50 A.M., the Treatment Nurse said if she was not at the facility the charge nurse was responsible for documenting new skin issues. She said she was busy the day of 5/15/25 and she did not have a good excuse as to why she did not document Resident #2's wound and measurements. She said not being able to tell if the wound had worsened could cause infection. During an interview on 5/21/25 at 10:01 A.M., the Interim DON said the charge nurse or the treatment nurse was responsible for documenting a new wound. He said sometimes things happens and it just slipped her mind, but the treatment was there. He said sometimes staff just get distracted. He said an initial wound assessment should be documented so the wound could be monitored. He said without wound documentation how would we know how the wound was progressing? He said he ran the wound care report every week to follow up to make sure the documentation was completed. During an interview on 5/21/25 at 10:30 A.M., the Regional Director of Clinical Services said the responsibility of documenting new wounds fell on the charge nurse or the wound care nurse. She said the Treatment Nurse told her she got in a hurry and forgot to put Resident #2's wound measurements in the system. She said the initial wound assessment was important to monitor for improvement or decline. She said the DON monitored the documentation of the wounds. She said she did go over everything in the EMR with the Treatment Nurse and in-serviced her on documentation of wounds . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy on Patient Care Management System 1 Skin dated July 2022 indicated 4. Any newly identified wounds will be addressed by the Treatment Nurse or charge nurse to include assessment and documentation of the skin site and initiate appropriate clinical interventions. Notify patient's representative and medical provider of any new or change in existing wound(s) and document in EMR . 5. A wound assessment will be completed by the treatment nurse or charge nurse and a narrative of each site will be documented weekly for any pressure injury and non-pressure skin condition, including but not limited to arterial ulcers, diabetic neuropathy ulcers, venous insufficiency ulcers, bruises, skin tears, and surgical wounds. Wound measurements will be in centimeters . 7. A pressure injury plan of care or a non-pressure injury plan of care will be completed by the treatment nurse or charge nurse upon identification of pressure ulcers and updated with any changes to interventions and upon resolution . 9. The certified nurse aide will notify the treatment nurse or charge nurse of any newly identified skin issues .