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	04/23/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident's drug regimen was free from significant medication error, in excessive dose (including duplicate drug therapy) for 1of 6 residents (Residents #2) reviewed for unnecessary medications. The facility failed to ensure Resident #2's routine pain medication, Hydrocodone-Acetaminophen Tablet (prescribe for acute pain, opioid agonist and a Schedule II controlled substance) 10-325 mg one tablet by mouth four times a day was not duplicated on 04/06/2026 at 9:00 p.m. by LVN C. The failure could place residents at risk for being administered unnecessary pain medication and could have adverse reactions including over sedation and decline in health condition.Record review of Resident #2's face sheet, dated 04/22/2026 indicated a [AGE] year-old male originally admitted on [DATE] and readmitted on [DATE] with diagnoses of ulcerative colitis (chronic inflammatory bowel disease (IBD) that causes inflammation in the colon lining), Crohn's disease (type of inflammatory bowel disease (IBD) that causes swelling and irritation of the tissues, called inflammation, in the digestive tract), tracheostomy (surgically created opening in the front of the neck into the trachea (windpipe) to provide an airway for breathing), chronic pain, and acute respiratory infection (infection of the upper or lower respiratory tract causing common cold to pneumonia). Record review of Resident #2's significant change in status MDS assessment, dated 03/07/2026, indicated a BIMS score of 15 indicating Resident #2 was cognitively intact. Pain management assessment indicated Resident #2 received scheduled pain medications. He was independent with self-care and mobility tasks. Record review of Resident #2's care plan, dated 12/02/2025, indicated pain management. Interventions included, Assess for change in bowel habits, appetite, and ability to rest/sleep. Assess for presence of pain at frequent routine intervals and before/after specific activities. When assessing for pain, speak slowly and clearly, and loud enough for residents to hear. If using hearing aid, make certain that it is in place and functional. Assess for ability to read the pain scale. Record review of Resident #2's care plan, dated 04/07/2026, indicated Resident #2 had a history of being involved in alleged misappropriation (intentional, unauthorized, and improper use property) related to pain medications. Interventions included, 1. Pain assessment completed. 2. Lipid panel ordered. 3. Police notified. 4. Reported to HHSC. 5. Drug screens initiated. 6. Ad Hoc QAPI. 7. In-services initiated on pharmacy services, misappropriation, drug and alcohol policy, steps to counting narcotics. Record review of Resident #2's physician orders, dated 04/22/2026, indicated the following: Hydrocodone-Acetaminophen Tablet 10-325 mg give one tablet by mouth four times a day for pain related to chronic pain and Atorvastatin Calcium (helps lower cholesterol) Oral Tablet 80 mg give one tablet by mouth at bedtime. During an observation and interview on 04/22/2026 at 1:10 p.m., Resident #2 was ambulating independently within the facility. Resident #2 said he recalled the incident with a duplication of pain medication error. He said he knew his medications, but his Hydrocodone-Acetaminophen (acute/chronic pain med) and Atorvastatin Calcium (used to treat high cholesterol and to reduce the risk of heart attack, stroke, angina, and to decrease the chance that heart surgery will be needed in people who have heart disease or who are at risk of developing heart disease) looked similar in color, shape and size, so when he took the meds, he did not realize he had taken two Hydrocodone instead of one Hydrocodone and one Atorvastatin pill on the evening of (continued on next page)

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 - Few	04/06/2026. He said he had no negative effects from the medication duplication error. He said the facility ordered labs, but he refused the labs he really did not like needles and did not feel the labs were necessary. During an interview on 04/22/2026 at 4:30 p.m., LVN C said she initially was hired as a medication aide to administer medications. She said on 04/06/2026 she was working as a medication aide and at 9:00 p.m. she was preparing Resident #2's routine bedtime medications and realized she accidently popped two Hydrocodone pain pills when logging the medication out of the narcotic control count. She said she identified the mistake and removed a white oblong rounded pill (thinking it was the duplicated Hydrocodone pill) from the medication cup and then administered the prepared medications to Resident #2. She said it was later identified she had removed Resident #2's Atorvastatin Calcium, which looked similar, from the prepared bedtime medications instead of the duplicated Hydrocodone. She said she accidentally prepared and administered Resident #2 two Hydrocodone on 04/06/2026 during his bedtime medication administration. She said she received training and staff shadowing during her first three days of medication administration orientation She said she received training and in-services during orientation (prior to incident) and after the incident from the facility especially regarding medication administration, unnecessary medications, and medication errors. She said a negative effect if a resident received a duplication of pain medication could cause over sedation, increase drowsiness, and respiratory status change. She said she was suspended related to the medication error or misappropriation incident and later resigned. During an interview on 04/22/2026 at 4:50 p.m., MA D said she provided LVN C training during her orientation process. She said she explained to her during the orientation to follow the 5 R's rule (Right Patient, Right Drug, Right Dose, Right Route, and Right Time) when administering medication. She said during the orientation process with LVN C she trained her to slow down when reconciling medications, to stay alert, and free from distraction while preparing medications. She said she told LVN C if medication errors occurred, and/or if medications needed to be wasted, she should have the charge nurse or supervisor verify the wasted medication and both sign the narcotic control count book for verification and routine medications required verification if wasting as well. She said that if any issues with wasting medications or possible duplications of medication occurred, the charge nurse should be notified prior to administering the medications to verify the correct medications were administered to the resident. During an interview on 04/23/2026 at 2:50 p.m., the DON said she expected facility staff to administer medications as prescribed by the physician, and if a medication error or unnecessary medications occurred, the charge nurse was to complete an assessment, notify the DON, MD, and resident or RP. She said the management team would initiate investigation, in-services, competency checks on medication administration, and narcotic counts and emergency QAPI with medical director involvement. She said she as the DON would notify the administrator for authority notification, if applicable. She said the facility initially reported the incident as a missing Hydrocodone-Acetaminophen but during investigation discovered LVN C had administered a duplicate dose on 04/06/2026 during the bedtime medication regimen. She said a negative outcome for Resident #2 receiving duplicate dose of Hydrocodone-Acetaminophen10-325 mg, it could cause increase drowsiness, change in respiratory status, and interactions with other medications. She said after the medication error was identified, and MD notified, new orders for labs ordered but Resident #2 refused the labs to be obtained. She said Resident #2 was closely monitored after the incident identified with no negative outcomes identified. During an interview on 04/23/2026 at 3:10 p.m., the RDCS said she expected facility staff to administer medications as ordered by the physician. She said all unnecessary medications should be reported to the charge nurse and DON immediately. She said involved residents should be monitored for adverse effects and appropriate training provided to staff regarding incidents. She said the incident should be QAPI (a data-driven framework to maintain and enhance care quality in healthcare facilities) and performance improvement initiated. She said the risk of unnecessary or duplicate pain medications could be dizziness, drowsiness, and lightheadedness. During an interview on 04/23/2026 at 3:20 p.m., the Administrator said his expectations were that all (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff adhere to administering medications as prescribed. He said receiving unnecessary or duplicate medications could cause adverse effects. Record review of a facility policy titled, Unnecessary Drugs, dated 12/30/2025, indicated the following, Policy: It is the facility's policy that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical and psychosocial well-being free from unnecessary drugs Policy Explanation and Compliance Guidelines: 1. The indications for initiating, maintaining, or discontinuing medication(s) are determined by evaluating the resident's physical, behavioral, mental, and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks, and the preferences and goals for treatment. The resident's medical record should include documentation of this evaluation and the rationale for chosen treatment options. 2. The facility will ensure that the initiation or change in a medication is not: a. Due to a medical condition or problem (e.g., pain, fluid or electrolyte imbalance, infection, obstipation, medication side effect or polypharmacy) that can be expected to improve or resolve as the underlying condition is treated or the offending medication(s) are discontinued; b. Due to environmental stressors alone, that can be addressed to improve the symptoms; and c. Due to psychological stressors alone, that can be expected to improve or resolve as the situation is addressed. 3. The attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen in collaboration with residents and/or representatives, other professionals, and the interdisciplinary team. Each resident's drug regimen will be reviewed on an ongoing basis, taking into consideration the following elements: a. Dose (including duplicate therapy); b. Duration of use; c. Indications and clinical need for medication; d. Adequate monitoring for efficacy and adverse consequences; e. Preventing, identifying and responding to adverse consequences; f. Any combination of the reasons stated above. 4. Documentation will be provided in the resident's medical record to show adequate indications for the medication's use and the diagnosed condition for which it was prescribed.

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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 establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Residents #1) observed for infection control. The facility failed to implement EBP for Resident #1 during a wound care and dressing change on 04/23/2026. This failure could place residents at risk of communicable diseases.Record review of admission Record, dated 04/23/2026, indicated Resident #1 was a [AGE] year old female, admitted on [DATE], with diagnoses including Alzheimer's Disease (progressive disease that destroys memory and other important mental functions), cerebral infarction (lack of adequate blood supply to brain cells deprives them of oxygen and vital nutrients which can cause parts of the brain to die off), major depression (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), dysphagia (difficulty swallowing), schizophrenia (is a serious mental health condition that affects how people think, feel and behave), and pressure ulcer (bedsore are wound that occur from prolonged pressure on skin) of buttocks. Record review of Resident #1's quarterly MDS assessment, dated 03/25/2026, indicated she was severely impaired cognitively. She rarely/never made herself understood and sometimes understood others. She was dependent on facility staff and/or maximum assistance for self-care and mobility tasks. Record review of Resident #1's care plan, dated 10/07/2025, indicated Resident #1 had a pressure ulcer with interventions for infection control precautions. Record review of physician's orders for Resident #1, dated 04/22/2026, indicated EBP related to chronic wound every shift following facility policy to use for patients with any of the following (when contact precautions do not otherwise apply): wounds or indwelling medical devices, regardless of MDRO colonization(state where a microorganism, such as a bacterium or fungus, has successfully established a presence and is multiplying on or within a host body) statusinfection or colonization with an MDRO. During an observation on 04/23/2026 at 8:40 a.m., outside of Resident #1's room was an EBP signage. There was a 3-drawer PPE cart located at the entrance to Resident #1's room. Resident #1 was lying in bed; she did not respond appropriately to interview questions. During an observation on 04/23/2026 at 8:45 a.m., NP A (consulting wound care NP) and LVN B provided care to Resident #1's right buttock stage 3 (serious skin injury characterized by full-thickness skin loss, exposing the fatty tissue beneath) pressure injury. NP A and LVN B, during direct contact with Resident #1, did not wear a gown during the wound assessment, procedure, and dressing change. During an interview on 04/23/2026 at 9:15 a.m., LVN B said she failed to follow the EBP because she forgot to wear a gown during Resident #1's wound assessment and care, and dressing change. She said she was trained on EBP and should have applied a gown prior to entering the room to perform care. She said that not wearing a gown during the wound assessment and care could spread infection or cross contamination. During an interview on 04/23/2026 at 9:20 a.m., NP A said she was the interim consulting wound care NP to assess and oversee Resident #1's wound care. She said she failed to follow the EBP because she forgot to wear a gown during Resident #1's wound assessment and procedure. She said she should have followed facility policy on EBP and should have applied a gown prior to entering the room to perform care. She said that not wearing a gown during the wound assessment and care could spread infection or cross contamination. During an interview on 04/23/2026 at 1:40 p.m., the ICP said she expected the facility staff and consultants, including the wound care NP, to follow the EBP policy when providing direct care to residents identified as requiring EBP which included residents with chronic wounds, indwelling devices, and MDROs. She said Resident #1 was on EBP because she had a Stage 3 pressure ulcer requiring precautions and staff and vendors should be wearing PPE when providing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound assessment and care. The ICP said she provided facility staff training on infection control measures and EBP annually and as needed. The ICP said not following the EBP as ordered could lead to spread of infection, transfer of bacteria, putting both staff and residents at risk. During an interview on 04/23/2026 at 2:45 p.m., the DON said she expected facility staff and consultants, including the wound care NP, to apply PPE when providing direct resident care for residents with EBP ordered. She said Resident #1 was on EBP because she had a pressure ulcer requiring precautions and staff should be wearing the proper PPE while providing direct care to her wound. She said EBP should be followed by staff and vendors with direct care provided to residents with MDROs, wounds, and indwelling devices. The DON said the risk of failing to perform EBP could lead to spread of MDROs, infections to other residents or even staff. During an interview on 04/23/2026 at 3:00 p.m., the RDCS said she expected that facility staff and consultants to follow the EBP policy, orders, and signage when providing direct care to residents requiring EBP which includes wounds (chronic wounds such as pressure ulcers, diabetic and stasis ulcers), indwelling medical devices (tracheostomy, feeding tubes, urinary catheters, central lines, etc.) and infection or colonization with a targeted MDRO when contact precautions do not otherwise apply. She said the risk of failing to perform EBP could lead to spread of MDROs, and other infections to the other residents or even staff. During an interview on 04/23/2026 at 3:15 p.m., the Administrator said his expectations were that all staff adhere to the EBP policy, orders and signage when providing high- contact care for residents requiring EBP (residents with MDROs, chronic and pressure wounds, and indwelling devices). He said not following EBP as required could cause spread of infection or cross contamination. Record review of facility policy titled, Enhanced Barrier Precautions, dated 12/30/2025, indicated the following: .Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.2. Initiation of enhanced barrier precautions: . b. An order for enhanced barrier precautions will be obtained for residents with any of the following i. Wounds (e.g., chronic wounds such as pressure ulcers diabetic foot ulcers unhealed surgical wounds and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO . 3. Implementation of enhanced barrier precautions: a. Make gowns and gloves available immediately here or outside of the residence room. Note: face protection may also be needed if performing activities with risk of splash or spray (i.e., wound irrigation, tracheostomy care). b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the residence room. 4. High contact resident care activities include:.h. Wound care: any skin opening requiring a dressing.