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	08/27/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 18 Residents (Resident #7) who were reviewed for dignity. The facility failed to ensure LVN J spoke to Resident #7 in a way that promoted his dignity and self-worth. The failure could place residents at risk of decline in their sense of dignity level of satisfaction with life and feeling of self-worth. The findings included: Record review of Resident #7's face sheet dated 08/26/25 indicated he was admitted on [DATE] and readmitted [DATE]. He was [AGE] years old with diagnoses of dementia, and cancer of the esophagus. Record review of Resident #7's Annual MDS assessment dated [DATE] indicated he had a BIMS of 14 which indicated that his cognition was intact. He was not getting his antianxiety medication. Record review of the investigation worksheet for Resident #7's dated 07/30/25 indicated the allegation was made on 7/30/25 at 2:30 p.m. and was reported to state on 07/30/25 at 4:30 p.m. Record review of Resident #7's Provider Investigation Report dated 07/30/25 indicated Resident #7 said LVN J was arguing with him about his medication, then she called him stupid. The DON at that time (ex-employee) assessed the resident with no injuries. Resident #7 said he had no more concerns. The nurse was sent home pending the investigation. The facility called the physician and family member. The physician reordered the resident's lorazepam 0.5 mg. The facility interviewed the other residents on the hall with safe interviews, and no other residents had issue with this nurse. The findings indicated inconclusive for the allegation of abuse. The nurse was terminated for being unprofessional and her conduct was not the facility's policy. Record review of the witness statement dated 07/31/25 indicated CNA H said LVN J asked her to come to Resident #7's room with her. The statement indicated LVN J told the resident his medication had been discontinued. The resident told LVN J he felt like he was having withdrawals and when could he get his medication. LVN J said that was a stupid thing to say telling the resident he could not have withdrawals from that medication. CNA H said Resident #7 became upset and LVN J just walked out. The witness indicated she apologized to Resident #7 for the nurse actions and immediately reported the incident to the interim DON and the new Administrator. During a phone interview on 08/27/25 at 11:15 a.m., LVN J said Resident #7 was yelling and cursing at her. She said, You know he was drug seeking. She denied calling the resident stupid. LVN J said the medication had been discontinued. She said she did not call the resident's physician about the resident saying he thought he was having withdrawals. During a phone interview on 08/27/25 at 12:30 p.m., CNA H said she remembered the incident between LVN J and Resident #7. She said she answered Resident #7's call light, and he wanted medication, so she reported that to LVN J. She said LVN J asked her to come to the room to be a witness. She said Resident #7 was not rude to LVN J and he was trying to explain to the nurse that he thought he was having withdrawals from the medication being discontinued. She said LVN J told Resident #7 that was a stupid thing to say. CNA H said the resident was not rude and did not curse at LVN J; however, she was unprofessional and rude to the resident. CNA H said it was verbal abuse, and she had been trained to report, so she went to Administrator and reported. During a phone interview 08/27/25 at 1:00 p.m., the Resident #7's family said he was in the hospital for his GI and esophagus. His family said the resident said the nurse was rude on 07/30/25. She said she had talked to her with an attitude before, but she did not report it. She said she was proud of the CNA that reported the incident. She said the facility should be homelike and no one should be rude and unprofessional. She said that was not severe verbal abuse; however, it was verbal abuse. Record review of Resident #7's physician orders date August 2025 indicated lorazepam 0.5 mg was restarted on 07/30/25. Record review of the alleged perpetrator's LVN J employee file indicated a hire date of 03/04/25, all the pre-hire checks were done, and her nurse license was current. The file contained her completed orientation for abuse on hire. During an interview on 08/27/25 at 10:10 a.m., the Administrator said LVN J was terminated on 07/31/25 due to her behavior of being rude to a resident which went against their policies. During an interview on 08/27/25 at 10:45 a.m., the DON said her expectation was for all the residents to be free of verbal and physical abuse. She said she was not the DON on 07/30/25; however, she would not stand for the residents to be verbally abused and said she had zero tolerance for the resident to be spoke to like that. Record review of the Abuse Protocol dated June 2013 indicated 1. Our facility will not condone Patient abuse, neglect, mistreatment or misappropriation of patient property (collectively Patient Abuse by

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician was consulted regarding a need to alter treatment for 1 of 18 residents reviewed for notification of changes. (Resident #4) The facility did not consult with Resident #4's physician about the pattern of low blood pressure over multiple days and of the blood pressure medication being held for 5 of 50 opportunities in August 2025. This failure could place residents at risk for complications due to delayed or failed physician intervention. Record review of the face sheet for Resident #4, an [AGE] year-old female, indicated admission to facility on 05/16/2025 with diagnosis including hypertension (high blood pressure). Record review of Resident #4's admission MDS dated [DATE] included diagnoses of coronary artery disease and high blood pressure. Resident #4's BIMS score was 09, indicating moderately impaired cognition. Record review of Resident #4's care plan dated 05/17/2025 indicated altered cardiovascular status related to hypertension. Interventions included monitor for serious side effects related to the medication such as a higher or lower blood pressure than usual, rapid heartbeat, and falling. Record review of Resident #4's physician orders dated 05/19/2025 included metoprolol tartrate 100 mg tablet - Give one tablet twice daily related to hypertension (high blood pressure). Parameters set by the physician were to hold for SBP (top number) less than 110 and/or DBP (bottom number) less than 50 and/or HR less than 50. (SBP refers to the pressure in the arteries when the heart beats and pumps blood throughout the body - diastolic blood pressure refers to the pressure your blood is pushing against your artery walls while the heart muscle rests between beats). Record review of Resident #4's August 2025 MAR included prescribed metoprolol tartrate 100 mg - one tablet by mouth twice daily related to hypertension - hold for SBP less than 110 and/or DBP less than 50 and/or HR less than 50. On the following dates, Resident #4's metoprolol tartrate 100 mg was held and coded as being held due to being outside the prescribed parameters: 08/10/2025 - AM BP 109/55;08/11/2025 - PM BP not documented;08/12/2025 - AM BP not documented;08/13/2025 - AM BP 104/52; and08/21/2025 - AM BP 118/58.Record review of the Nurse Notes dated 08/01/2025 through 08/27/2025 for Resident #4 gave no indication or documentation of physician notification of Resident #4's metoprolol tartrate 100 mg being held on 5 occasions from 08/10/2025 through 08/21/2025. During an interview 08/26/2025 at 3:00 p.m., the DON reviewed Resident #4's August 2025 MAR with the surveyor. The DON acknowledged the metoprolol tartrate 100 mg was documented as held due to the prescribed parameters. She said best practice would be for the nursing staff to notify the physician when medications with parameters were held 3 times, or even immediately. The DON said the potential adverse effects for residents could be dizziness or weakness. The DON said the best practice would be for nursing staff to document in the resident's electronic record when notifying physician of medications being held. During an interview on 08/27/2025 at 9:15 a.m., the RDCS said her expectation was for the physician to be notified each time a resident's medications were held. She said notification must have been overlooked. She said possible negative effects to a resident could be their BP going lower, possibly leading to falls, injuries, or dizziness. During an interview on 08/27/2025 at 2:12 p.m., MA G said they verbally informed the nurses when any medication was held or refused. When BP medications were withheld, they rechecked the BP prior to informing the nurse. MA G said the nurses then would assess the residents. During an interview on 08/27/2025 at 2:30 p.m., LVN B said the MAs were to report to them when medications were held or refused by residents. She said she was unaware Resident #4's metoprolol had been held when outside prescribed parameters. LVN B said when reported to the nurses, they would assess the resident and notify physician when warranted. Record review of policy dated January 2024 titled Physician Notification indicated the following: . It is the responsibility of the nursing staff to observe change, make an assessment, and notify the physician as indicated based on the assessment. The nurse will notify the physician of any change in condition.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain personal privacy during delivery of personal care and services to 1 of 18 residents (Resident #47) reviewed for privacy. The facility failed to provide Resident #47 with a privacy curtain that would close completely. This failure could place residents at risk of loss of dignity due to lack of privacy. Findings included: Record review of the face sheet dated 08/27/25 indicated Resident #47 was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnosis included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, and fear that are strong enough to interfere with daily living). Record review of the care plan dated 04/03/25 indicated Resident #47 required assistance with ADLs and to turn and reposition every 2 hours related to her terminal illness. Record review of the quarterly MDS dated [DATE] indicated Resident #47 had a BIMS score of 9 indicating she had moderate cognitive impairment, was dependent for personal hygiene and toileting, and was always incontinent of bladder and bowel. During an observation and interview on 08/25/25 at 10:10 a.m., Resident #47 was in bed in her room with Hospice CNA E at her bedside. Hospice CNA E said Resident #47 had no privacy. She said she had told the nurses and CNAs at the facility that her privacy curtain would not close, and nothing had been done to fix the curtain. She then pulled the privacy curtain and when extended completely it left an approximate 3-foot open gap. The curtain was too short to close completely. Resident #47 said she would be more comfortable during her bed baths if her privacy curtain shut all the way. She said she got embarrassed when people came in the room when she was receiving a bed bath or personal care because the curtain didn't close, and she was afraid someone would see her. She said it had been too short for a long time, but she was not sure if she ever told anyone. She said facility staff had seen that it was too short, so she thought they knew. During an interview on 08/26/25 at 2:25 p.m., CNA F said she usually provided care for Resident #47. She said she knew that the privacy curtain was not long enough to close all the way. She said when she provided personal care to Resident #47 that she just tried to position the curtain for the least exposure of the resident. CNA F said she had never reported to anyone that Resident #47's privacy curtain did not close. During an observation and interview on 08/26/25 at 3:30 p.m., the DON viewed Resident #47's privacy curtain and said it was too short to close. She said no one had ever reported the issue to her or the facility and she would have the curtain replaced immediately. She said she expected all residents to have privacy during personal care and for staff to report any issues that prevented providing residents with privacy. During an interview on 08/26/25 at 3:34 p.m., the Administrator said he would make sure that Resident #47's privacy curtain was replaced. He said protecting every resident's privacy was important to the resident and the facility. During an interview on 08/26/25 at 4:25 p.m., Resident #47 said the facility had hung a new privacy curtain and it closed all the way around. She said she was happy to have her new curtain. During an interview on 08/27/25 at 1:27 p.m., the DON said no staff or outside vendor had ever reported that Resident #47's privacy curtain was too short to close. She said all staff should pull the privacy curtain closed and shut the door to the room when providing personal care to a resident. She said she expected all staff to protect the privacy and safety of all residents. She said all staff had been trained on resident rights and privacy. She said staff or the outside vender should have reported that Resident #47's privacy curtain would not close. Record review of a facility policy titled Confidentiality of Information and Personal privacy, last revised October 2017, indicated . Our facility will protect and safeguard resident confidentiality and personal privacy. 2. The facility will strive to protect the resident's privacy regarding his or her: d. personal care.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure resident assessments accurately reflected the resident's status for 1 of 18 resident (Resident #2) reviewed for accuracy of assessments. The facility failed to accurately complete the MDS assessment to indicate Resident #2's tobacco use. This failure could place residents at risk of not receiving the appropriate care and services to maintain their highest level of well-being. Findings include: Record review of Resident #2's face sheet, dated 08/25/25, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted [DATE]. Resident #2 had diagnoses which included chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe). Record review of a Smoking safety screen, dated 07/25/25, indicated Resident #2 was safe to smoke without supervision but would be supervised per facility policy. Record review of Resident #2's care plan, initiated 07/24/25, indicated Resident #2 was a smoker at risk of injury with interventions that included staff would store and distribute the resident's smoking materials and monitor. Record review of Resident #2's admission MDS assessment, dated 07/31/25, indicated Resident #2 was not marked for current tobacco use during the assessment period. The assessment indicated Resident #2 had a BIMS score of 13 of 15, which indicated intact cognition with a diagnosis of chronic obstructive pulmonary disease. During an interview on 08/25/25 at 8:00 a.m., Resident #2 said she smoked cigarettes, multiple times a day. She said staff kept her smoking supplies and monitored her while she smoked. During an interview and observation on 08/26/25 at 3:10 p.m., Resident #2 was sitting in her wheelchair smoking a cigarette during smoking break that was observed lit by staff, and she was monitored during the smoking episode. Resident #2 said she smoked daily since admission and the staff kept her smoking supplies, lit her cigarette and monitored during her smoking time. During an interview on 08/26/25 at 3:25 p.m., LVN B said she was providing care for Resident #2 today (08/26/25) and Resident #2 smoked daily. She said the staff kept her smoking supplies and monitored her during smoking times. LVN B said MDS Nurse A was responsible for all MDSs in the facility and smoking should be documented on the MDS assessment. During an interview on 08/26/25 at 3:25 p.m., MDS nurse A said she was responsible for all MDSs in the facility. She said MDS Nurse D came twice a week and helped with some MDSs. She said the backup was the Regional Case Manager that did some random checks on random MDSs. MDS Nurse A said she was educated on completion of MDS and received frequent update trainings. MDS Nurse A said Resident #2 smoked daily and should have been marked as tobacco use on the MDS. She said she overlooked it. MDS Nurse A said the resident risk of a resident that used tobacco not marked on the MDS was the MDS did not provide an accurate picture of the resident, no resident risk. She said the facility follows the RAI (Resident Assessment Instrument, a process for evaluating residents in nursing home) for a facility policy. During an interview on 08/26/25 at 3:30 p.m., the DON said MDS A was responsible for all MDSs in the facility and the Regional Case Manager was the backup which did random checks on MDS. She said the MDS nurses were educated on completion of MDSs. The DON said Resident #2's MDS was overlooked and not marked for tobacco use. She said there was no resident risk of tobacco use not marked on an MDS for a resident that used tobacco. She said the MDS was just not accurate. The DON said her expectation was all MDS completed accurately. During an interview on 08/26/25 at 3:40 p.m., the Administrator said MDS Nurse A was responsible for all MDSs in the facility and educated on completion of MDSs. He and the Regional Case Manager was the backup that completed random checks on MDS. The Administrator said Resident #2's MDS was overlooked and not marked for tobacco use. He said there was no resident risk of tobacco use not marked on an MDS for a resident that used tobacco He said the MDS was not accurate. The Administrator said his expectation was all MDS completed accurately. Attempted interview on 08/26/25 at 4:00 p.m., with Regional Case Manager with no return call. Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2024, indicated . J1300: Current Tobacco Use . Steps for Assessment 1. Ask the resident if they used tobacco in any form during the 7-day look-back period. 2. If the resident states that they used tobacco in some form during the 7-day look-back period, code 1. Yes. Coding Instructions, Code, no: if there are no indications that the resident used any form of tobacco. Code 1, yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents who needed respiratory care were provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for 1 of 2 (Resident #67) residents reviewed for respiratory care with tracheostomy. The facility failed to ensure Resident #67's oxygen was administered at the correct setting of 4-6 liters per minute on 08/25/25 as ordered by the physician. This failure could place residents who receive oxygen at an increased risk for receiving oxygen at the wrong rate which could lead to hypercapnia (too much carbon dioxide in the blood), pulmonary oxygen toxicity (damage to the lung lining tissues and air sacs), hypoxemia (low levels of oxygen in the blood, decreasing the oxygen supply to vital organs), and shortness of breath.Record review of Resident #67's face sheet indicated she was readmitted [DATE] was [AGE] years old with diagnoses which included acute respiratory failure with hypoxia, chronic obstructive pulmonary disease and heart failure. Record Review of Resident #67's admission Minimum Data Set assessment dated [DATE] indicated she received continuous oxygen therapy and received tracheostomy care. Resident #67's was rarely/never understood. Record review of Resident #67's comprehensive care plan dated 08/12/25 indicated Resident #67 had oxygen therapy related to acute respiratory failure with hypoxia. The interventions included provide oxygen as ordered. Record review of Resident #67 's physician's orders dated August 2025 indicated her orders included oxygen at 4-6 LPM per oxygen concentrator via trach with start date of 08/12/25. Trach - Air Compressor every day and night shift with Setting = 60 PSI start date of 08/06/25. During an observation on 08/25/25 at 8:30 a.m., revealed Resident #67 was in her bed and was receiving O2 at 8 LPM via oxygen concentrator per her tracheostomy. The air compressor was set on 40 PSI. During an interview and observation on 08/25/25 at 2:38 p.m., LVN B and LVN C checked Resident #67's orders in the computer, after surveyor intervention. LVN B and LVN C said the O2-concentrator setting should have been between 4-6 LPM per the concentrator not 8 LPM. LVN B changed the setting on the air compressor to 60 PSI. LVN C turned the concentrator to 6LPM. LVN B and LVN C said they had been trained on administering oxygen. They said they knew to follow the physician's orders to ensure the residents received the right amount of oxygen to prevent complications like low oxygen saturation. LVN C checked Resident #67's O2 saturation and said Resident #67 was at 94%. LVN B said they were both responsible however she said LVN C was in training. During an interview on 08/26/25 at 2:10 p.m., the DON said she wanted the nurses to follow the physician's orders. She said the resident could not receive enough oxygen, if the concentrator settings were not followed as per doctor's orders. Record review of the policy on Oxygen Administration dated October 2010 indicated Purpose The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation 1. Verify that there is a physician's order for this procedure.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services to ensure the accurate administration of medications for 1 of 18 residents reviewed for medication administration. (Resident #3)The facility failed to follow the physician's orders related to blood pressure medication and did not administer a PRN medication for Resident #3. This failure could place the residents at risk of not receiving necessary medications and a decline in health. Record review of the face sheet for Resident #3, indicated a [AGE] year-old male, with a readmission date of 07/27/2025 with diagnoses including hypertension (high blood pressure) and anxiety disorder. Record review of Resident #3's Quarterly MDS dated [DATE] indicated a BIMS of 14 indicating cognition intact. Diagnoses included high blood pressure and anxiety disorder. Record review of Resident #3's comprehensive care plan dated 03/03/2025 indicated diagnosis of hypertension. Interventions included to administer medication as ordered; monitor for serious side effects related to the medication such as a higher or lower blood pressure than usual. Record review of the physician's orders dated August 2025 indicated Resident #3 was prescribed clonidine HCl 0.2 mg. Instructions included to give 1 tablet by mouth every 8 hours PRN for BP if the SBP (top number) was over 160. (SBP refers to the pressure in the arteries when the heart beats and pumps blood throughout the body - diastolic blood pressure refers to the pressure your blood is pushing against your artery walls while the heart muscle rests between beats).Record review of Resident #3's MAR dated August 2025 indicated on the following dates and times, Resident #3's BP was elevated above the prescribed parameters and clonidine had not been administered as prescribed:*08/05/2025 at 09:00 a.m., BP was 184/78; *08/07/2025, at 09:00 a.m., BP was 166/98;*08/07/2025, at 09:00 p.m., BP was 167/90;*08/08/2025, at 09:00 p.m., BP was 168/88;*08/09/2025, at 09:00 a.m., BP was 161/82;*08/15/2025, at 09:00 a.m., BP was 164/78;*08/19/2025, at 09:00 a.m., the BP was 166/89;*08/23/2025, at 09:00 a.m., the BP was 182/79; and *08/24/2025, at 09:00 a.m., the BP was 165/89. During an interview on 08/26/2025 at 3:00 p.m., the DON said her expectations were for the LVNs to administer all medications as prescribed by the physician. The DON said Resident #3 should have received the clonidine at the time when the BP was over the parameters set by the physician. The DON said possible adverse effects of not receiving medications as prescribed included risk of a stroke or BP could go higher. During an interview on 08/27/2025 at 02:12 p.m., MA G said the MAs do not give PRN medications. She said the nurses gave all the PRN medications. MA G said she was unaware of the clonidine order because it would be on the nurse MAR and not the MA MAR.During an interview on 08/27/2025 at 2:30 p.m., LVN B said she had been unaware of Resident #3's SBP being elevated above 160. She said the MAs normally reported abnormal BPs to the nurses and the nurses would assess and/or medicate as needed. She added she would start asking the MAs about any BPs out of range. Review of the facility policy dated December 2012 titled Administering Medications indicated. Medications shall be administered in a safe and timely manner, and as prescribed. 3. Medications must be administered in accordance with the orders, including any required time frame.

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	08/27/2025

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 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 interviews and record review, the facility failed to ensure residents were free of any significant medication errors for 1 of 18 residents reviewed for medication administration. (Resident #3).The facility failed to ensure clonidine 0.2 mg (used to lower blood pressure) was administered to Resident #3 as ordered from 08/01/2025 - 08/27/2025. (there were 9 opportunities) This failure could place residents at risk for not receiving medications as ordered by their physician. Record review of the face sheet for Resident #3, indicated a [AGE] year-old male, with a readmission date of 07/27/2025 with diagnoses including hypertension (high blood pressure) and anxiety disorder. Record review of Resident #3's Quarterly MDS dated [DATE] indicated a BIMS of 14 indicating cognition intact. Diagnoses included high blood pressure and anxiety disorder. Record review of Resident #3's comprehensive care plan dated 03/03/2025 indicated diagnosis of hypertension. Interventions included to administer medication as ordered; monitor for serious side effects related to the medication such as a higher or lower blood pressure than usual. Record review of the physician's orders dated August 2025 indicated Resident #3 was prescribed clonidine HCl 0.2 mg. Instructions included to give 1 tablet by mouth every 8 hours PRN for BP if the SBP (top number) was over 160. (SBP refers to the pressure in the arteries when the heart beats and pumps blood throughout the body - diastolic blood pressure refers to the pressure your blood is pushing against your artery walls while the heart muscle rests between beats).Record review of Resident #3's MAR dated August 2025 indicated on the following dates and times, Resident #3's BP was elevated above the prescribed parameters and clonidine had not been administered as prescribed:*08/05/2025 at 09:00 a.m., BP was 184/78; *08/07/2025, at 09:00 a.m., BP was 166/98;*08/07/2025, at 09:00 p.m., BP was 167/90;*08/08/2025, at 09:00 p.m., BP was 168/88;*08/09/2025, at 09:00 a.m., BP was 161/82;*08/15/2025, at 09:00 a.m., BP was 164/78;*08/19/2025, at 09:00 a.m., the BP was 166/89;*08/23/2025, at 09:00 a.m., the BP was 182/79; and *08/24/2025, at 09:00 a.m., the BP was 165/89. During an interview on 08/26/2025 at 1:00 p.m., Resident #3 said he had prescriptions for blood pressure medications. He said he had experienced no ill effects such as dizziness, headaches, or light-headedness. He said he does not know when blood pressure was elevated. During an interview on 08/26/2025 at 3:00 p.m., the DON said her expectations were for the LVNs to administer all medications as prescribed by the physician. The DON said Resident #3 should have received the clonidine at the time when the BP was over the parameters set by the physician. The DON said possible adverse effects of not receiving medications as prescribed included risk of a stroke or BP could go higher.During an interview on 08/27/2025 at 02:12 p.m., MA G said the MAs do not give PRN medications. She said the nurses gave all the PRN medications. MA G said she was unaware of the clonidine order because it would be on the nurse MAR and not the MA MAR. During an interview on 08/27/2025 at 2:30 p.m., LVN B said she had been unaware of Resident #3's SBP being elevated above 160. She said the MAs normally reported abnormal BPs to the nurses and the nurses would assess and/or medicate as needed. She added she would start asking the MAs about any BPs out of range. LVN B said Resident #3 had not exhibited any adverse effects of not receiving the clonidine, nor voiced any concerns that she was aware of. Review of the facility policy dated December 2012 titled Administering Medications indicated. Medications shall be administered in a safe and timely manner, and as prescribed. 3. Medications must be administered in accordance with the orders, including any required time frame.

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	08/27/2025

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

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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 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interview and record review, the facility failed to ensure the social worker had the required qualifications for 1 of 1 facility reviewed for social worker qualifications. The Social Worker hired on 12/09/2024, as a full-time social worker was not licensed by the Texas State Board of Social Worker Examiners. This failure could place all residents at risk for unmet social services and psychosocial needs. Record review of an employee file on 08/27/2025 indicated the SW was not a licensed social worker and held a bachelor's degree in social work. The facility hired her as a social worker on 12/09/2024. Review of the facility's January 2017 job description for the Social Worker position indicated Qualifications: Minimum of a bachelor's degree in social work or in human services fields. Licensed per state requirements or eligible for licensure. Record review of the ASWB licensure examinations website dated 08/28/2025, indicated the following process: To become a licensed social worker in Texas, you must earn a CSWE-accredited degree in social work, complete a Texas specific jurisprudence exam, pass the relevant Association of Social work boards (ASWB) exam, undergo a fingerprint background check, and fulfill supervised practice hours for clinical licenses, all while applying through the Texas Board of Social Worker Examiners (part of the Texas Behavioral Health Executive Council) to maintain your license. During an interview on 08/27/2025 at 12:00 p. m., the Administrator said the SW had been employed at the facility since December 2024. The Administrator said the SW had a bachelor's degree in social work and had been preparing to take the licensure exam. He said currently, the SW was not licensed. The administrator said the facility employed a licensed social worker on a PRN basis, and so she was not assigned to oversee the current social worker. During an interview on 08/27/2025 at 1:00 p.m., the SW said she had passed the ASWB examination and had taken the required fingerprint background check. The SW said she had not taken the SW Jurisprudence Exam. The SW said some of her duties included participating in care plan meetings with residents and family, promotes resident rights, provides individual and group help for residents and/or family at times of adjustment, crisis or particular needs. Record review of a Certificate of Completion - Texas State Board of SW Examiners Jurisprudence Exam awarded to [SW] in recognition of having successfully completed online examination dated 08/27/2025 (after surveyor intervention).