STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265835	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookhaven Nursing & Rehab	3405 West MT Vernon Springfield, MO 65802

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	Based on interview and record review, the facility failed to protect each resident's right to be treated with dignity and respect when one staff (Certified Medication Tech (CMT) F) spoke to one resident (Resident #1) disrespectfully in a raised voice and threatening manner. The facility census was 70.Review of the facility policy titled, Your Rights, As a Resident in a Long-Term Care Facility, undated, showed the following:-Residents will always be provided with the highest level of care and service, and if for any reason a resident feels that such needs are not being met by their facility staff, they are entitled to a variety of avenues in which to resolve their concerns;-Residents shall be treated with consideration, respect, and full recognition of dignity and individuality.1. Review of Resident #1's face sheet (admission data) showed the following:-admission date of 06/28/23;-Diagnoses included unspecified dementia (loss of memory) and schizophrenia (impairment in a person's daily functioning).Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 07/05/25, showed the following information:-Memory problems with moderately impaired cognitive skills;-No behaviors noted. Review of the resident's care plan, revised on 07/01/25, showed the following:-Has history of suicidal ideation;-There are times when the resident may act and say things that are not real or true. Staff to provide frequent monitoring and support;-Received antipsychotic medications related to schizoaffective disorder;-Risk for pain related to my medical complexities;-Receiving anti-anxiety medications.Review of the resident's progress notes dated 08/30/25, at 1:50 P.M., showed the Director of Nursing (DON) documented the resident and Certified Medication Tech (CMT) F noted to have had a verbal disagreement in hallway during medication pass. The resident became agitated, smacked the medication cart with his/her hand, and called the staff member a bitch. Staff members intervened separating the resident and the CMT. Situation was deescalated and resident was redirected to his/her room without further incidence.Review of the resident's written statement, undated, showed the resident said he/she rolled his/her wheelchair to the medication cart and asked for his/her medications from CMT F. He/she was told he/she would have to wait. The resident said he/she did not want to wait until noon to get his/her meds. At this time the resident smacked the cart with his/her hand and called the staff member a bitch because he/she was upset, due to the fact the CMT F's response was if the resident kept asking , the resident would be the last person to receive his/her meds.During interviews on 09/03/25, at 10:19 A.M. and 10:35 A.M., the resident said the following:-He/she had some issues with getting his/her medications late;-CMT F didn't want anyone near his/her cart, but wanted to go room-to-room to pass the resident's medications;-On 08/30/25, around 10:00 A.M., he/she needed his/her pain meds as he/she had pain. On a scale of 1 to 10, 10 being the highest, she rated his/her pain that morning at 8. He/she asked CMT F for his/her pain meds. CMT F told him/her the meds would get passed out when they get passed out. The resident said he/she did hit the medication cart, as he/she was upset by what CMT F had said. After the resident hit CMT F's med cart, the CMT said if you hit my cart again that will be the last time you hit it;-He/she didn't know if CMT F was threatening him/her, as they had been arguing. He/she didn't want to be around CMT F because he/she was not friendly.Review of Certified Nurse Aide (CNA) H's written statement, undated, showed CNA H noted he/she was coming out of another resident's room, into the hallway. He/she overheard CMT F say if you bump into my cart one more time it will be the last time you ever bump into the cart.During an interview on 09/04/25, at 8:55 A.M., CNA H said if he/she was working on 08/30/25 during the day. He/she could hear CMT F as he/she was talking with a raised voice. CMT F said to the resident, if he/she hit the cart one more time, that would be the last thing the resident hit. He/she said that it wasn't something to say to a resident and it was disrespectful and threatening.Review of the Housekeeper Supervisor's (HS) written statement, undated, showed he/she was in the hallway and overheard a verbal altercation between the resident and CMT F. He/she said the resident approached the medication cart asking for his/her morning medication. CMT F responded with you will have to wait, I will get to you and to stop speaking to CMT F that way. He/she states the resident was not rude when asking for his/her medication and replied, I'm just asking for my morning meds.Review of CMT F's written statement, undated, showed CMT F noted he/she was in the hallway passing meds to another resident. The resident rolled up to his/her cart asking for his/her morning medication and CMT F told the resident he/she would have to wait since there were three more residents ahead of him/her. At that time the resident hit the med cart and called CMT F a bitch. CMT F said the resident said he/she was going to kick his/her ass and CMT F's response back to the resident was if you hit me, it will be the last time you hit

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to provide care per policy and standards of practice and failed have a system in place for timely administration of medications to residents when staff administered one resident's (Resident #2) medication late. The facility census was 70.Review of the facility's policy titled, Medication, Administration Guidelines, undated, showed the following:-It was the purpose of this facility that residents receive their medications on a timely basis and in accordance with established policies.1. Review of Resident #2's face sheet (brief resident profile) showed the following information:-admission date of 08/21/25;-Diagnoses included bipolar disorder (mental health condition with extreme mood swings between periods of mania), anxiety disorder, heart failure, hypertension (high blood pressure), and heart failure.Review of the resident's September 2025 Physician Order Sheet (POS) showed the following: -An order, dated 08/21/25, for alprazolam (used to treat anxiety) 1 milligrams (mg), three times daily as needed for anxiety;-An order, dated 08/21/25, for carvedilol (used to treat circulation issues in the heart) 25 mg, two times daily, for heart issues;-An order dated 08/21/25, for clonidine HCl (high blood pressure) 0.1 mg, two times daily, for high blood pressure;-An order, dated 08/21/25, for lamotrigine (used to treat epilepsy and bipolar disorder) 150 mg, one tablet by mouth two times per day, for bipolar disorder;-An order, dated 08/21/25, for loperamide (used to control diarrhea) 2mg capsule every six hours as need for diarrhea;- An order, dated 08/21/25, for magnesium oxide 400 mg tablet, one tablet by mouth two times a day for chronic diastolic heart failure; -An order, dated 08/21/25, for oxycodone (used to treat pain) 10 mg tablet, one tablet every six hours as needed for pain;- An order, dated 08/21/25, for pantoprazole (used to treat heart burn) 40mg tablet, one table two times per day, for gastro-esophageal reflux disease, one scoop by mouth one time a day related to constipation;-An order, dated 08/21/25, for promethazine (used to treat nausea) 25 mg tablet , one tablet every eight hours as needed for nausea;-An order, dated 08/21/25, for Ventolin HFA inhaler (used to treat asthma) 90 micrograms, (breathing problems) two puffs every four hours as needed for asthma;- An order, dated 08/22/25, for aspirin 81 mg by mouth one time per day for long term use of aspirin;- An order, dated 08/22/25, for lisinopril 40 mg (used treat high blood pressure) tablet, one tablet by mouth one time a day for high blood pressure;-An order, dated 08/22/25, for lurasidone 80 mg (used to treat bipolar disorder) two tablets by mouth one time daily for bipolar disorder;-An order, dated 08/22/25, for sertraline 100 mg (used to treat bipolar disorder) two tablets one time daily for bipolar disorder;-An order, dated 08/27/25, for trazadone 100 mg (used to treat sleep problems), give with 150 mg to equal 250 mg at bedtime for insomnia (sleep disorder);- An order dated 08/27/25, for trazadone 150 mg, give with 100 mg to equal 250 mg at bedtime for insomnia.Review of the resident's September 2025 Medication Administration Record (MAR) showed the following medications were scheduled for administration at 8:00 A. M. -Aspirin 81 mg;-Carvedilol 25 mg;-Clonidine 0.1 mg;-Lamotrigine 150 mg;-Lisinopril 40 mg;-Lurasidone 80 mg;-Magnesium 400 mg;-Pantoprazole 40 mg-Meclizine HCl 12.5 mg;-Sertraline 200 mg.Observation on 09/03/25, at 10:09 A.M., showed Certified Medication Technician (CMT) A prepared medications for administration to the resident including the following medications:-Aspirin 81 mg;-Carvedilol 25 mg;-Clonidine 0.1 mg;-Lamotrigine 150 mg;-Lisinopril 40 mg;-Lurasidone 80 mg;-Magnesium 400 mg;-Pantoprazole 40 mg-Meclizine HCl 12.5 mg;-Sertraline 200 mg.-CMT A administered all medications as at 10:15 A.M., two hours and 15 minutes after the scheduled administration time. During an interview on 09/03/25, at 9:45 A.M., the resident said he/she doesn't always get his/her meds at the scheduled time. He/she got his/her 8:00 P.M. , meds around 9:00 P.M. or 9:30 P.M. yesterday.During an interview on 09/03/25, at 1:24 P.M., Certified Medication Technician (CMT) A said the following:-The MARs tell staff which medications and times the medications are to be administered;-Staff clicks each medication in the electronic record and that indicated staff administered the medication;-Medications can be administered one hour before or after the time they're due, if it's given after that time frame it's late;-There is one CMT for halls 100, 200, and 300, which is around 50 residents. He/she has the heaviest medication load in the morning and some medications are always late. During interviews on 09/03/25, at 1:32 P.M., Registered Nurse (RN) B said the following:-The MARS shows staff what medications to administer and the time to administer:-The facility has one CMT for halls 100 through 300, and one CMT on 400 and 500 halls;-Medications may be administered one hour before and one hour after the prescribed time. If staff administer an 8:00 A.M., after 9:00 A.M., it would be given late;-Staff should be administering medications as ordered by the physician.During interviews on 09/03/25 at 1:50 P.M., RN C said the following:-The facility has one CMT to administer medications on 100 through 300

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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. (continued on next page)

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F 0755 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 record review and interview, the facility failed to provide pharmacy services to meet the needs of each resident when the facility failed to properly transcribe ordered medications, failed to clarify medication orders timely, and failed to administer medications as ordered for one resident (Resident #4) went he/she discharged from the hospital. The facility census was 70.Review of the facility's policy titled, Physician's Orders, undated, showed the following:-Physician's orders must be signed by the physician and dated when such order was signed;-Current lists of orders must be maintained in the clinical record of each resident to avoid confusion and errors;-Physician's orders must be reviewed and renewed;-Medication orders specify the type, route, dosage, frequency, and strength of the medication orders.Review of the facility's policy titled, Medication, Administration Guidelines, undated, showed the following:-It is the purpose of this facility that residents receive their medications on a timely basis and in accordance with established policies;-If there is doubt concerning the administering of medications, the physician's order must be verified before the medication is administered.1. Review of Resident # 4's face sheet (brief resident profiled) showed the following information:-admission date of 07/05/25 with latest return of 08/08/25;-Diagnosis included schizoaffective disorder, bipolar type (mental health condition that combines symptoms such as hallucinations, delusions with bipolar symptoms such as high or low episodes), anxiety disorder (excessive worry), insomnia (sleep disorder causing difficulty with falling or staying asleep), unspecified psychosis (experiences symptoms such as delusions), depression (persistent feelings of sadness), post-traumatic stress disorder (PTSD (condition that develops after experiencing or witnessing a traumatic event), and pain disorder exclusively related to psychological factors.Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool completed by staff), dated 07/10/25, showed the following:-Cognitively intact;-Independent with all daily living skills;-No behaviors noted.Review of the resident's care plan, last revised on 07/08/25, showed the following:-Resident has history of/at risk for suicidal ideation. Resident had documented events, associated with suicidal and hospitalizations. Staff to assess for suicidal thoughts. Staff to place resident 1:1 observations. Staff to observe for signs/symptoms of depression;-Resident has PTSD, has developed fear, terror, dread, or helplessness following exposure to a traumatic event. Maintain safety and integrity during post traumatic episode, using appropriate therapeutic interventions;-At times resident may act or say things that are not real or true;-Resident at risk for mood changes, adjustment issues, side effects of medications due to chronic schizoaffective disorder, bipolar type. Staff will administer anti-depressants as directed. Assess/document/review with physician any side effects. Staff will administer anti-psychotic as directed and assess for any side effects. Assess/document/report to physician any changes in mood/behaviors;-Resident is unable to make decisions on his/her own due to schizoaffective disorder, bipolar type. Therefore, resident has a guardian who makes decisions for him/her. Review of the resident's August 2025 progress notes showed the following:-On 08/02/25, at 7:02 P.M., Licensed Practical Nurse (LPN) G documented the resident presented to the nurses' station and said he/she wasn't feeling well. Certified nurse aide (CNA) obtained vitals which were stable. The resident went to the dining area and told another resident that he/she was dizzy and didn't feel well. This nurse directed a CNA to get a wheelchair and take the resident to his/her room to lie down. The resident cursed at the nurse and proceeded to his/her room. After several minutes this nurse went to the resident's room and talked with the resident. The resident said his/her significant other just broke up with him/her and he/she wanted to self-harm. The nurse contacted the guardian and received permission to send resident to the hospital for evaluation and treatment. Resident exited building approximately 6:00 P.M.;-On 08/04/25, at 1:07 P.M., the resident returned to the facility with new orders entered. Physician communication sent for provider to advise on changes per hospital discharge and red alerts triggered for clozapine (antipsychotic medication primarily used to treat severe, treatment-resistant schizophrenia) and changes made to oxybutynin (used to treat symptoms of an overactive bladder) per hospital discharge with physician communication to advise.Review of the physician communication form, dated 08/04/25, showed form sent to the medical director, stating new order for fluphenazine (antipsychotic medicine that is used to treat psychotic disorders such as schizophrenia) 5 milligram (mg) two tablets three times daily, triggers a red alert with clozapine, and Seroquel (used to treat the symptoms of schizophrenia, bipolar disorder and major depressive disorder) 300 mg at bedtime for insomnia triggers red alert for clozapine. Please advise on adding new orders. Review of