STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455412	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookhaven Nursing and Rehabilitation Center	1855 Cheyenne Carrollton, TX 75010

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 0600 Level of Harm - 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. (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 0600 Level of Harm - 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 residents had the right to be free from neglect for 1 (Resident #1) of 9 residents reviewed for neglect. 1. The facility failed to ensure Resident #1 was not neglected when she fell from her bed and remained on the floor beside her bed for approximately 4 hours on 07/30/25. 2. The facility failed to ensure RN A and CNA B did Routine Resident Checks every 2 hours on Resident #1 during their shift on 07/30/25. The non-compliance was identified as past non-compliance. The facility corrected the non-compliance before surveyor's entrance. These failures could place residents at risk for humiliation, fear, shame, agitation, decreased quality of life and possibly death. Findings included:Record review of Resident #1's admission Record revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Resident #1's diagnoses included: hypokalemia (condition where the potassium levels in the blood are lower than normal), cerebral infarction (occurs when blood flow to the brain is interrupted, leading to brain tissue damage), depression, hypertension (high blood pressure), gastro-esophageal reflux disease (GERD) without esophagitis (a condition where stomach acid flows back into the esophagus without causing inflammation or damage to the esophageal lining), constipation, osteoarthritis in the right knee (joint disease that causes pain, stiffness, and swelling in the joints), and age-related osteoporosis without current pathological fracture (a condition that weakens bones, making them more prone to fractures), and dementia. Record review of Resident #1's Quarterly MDS assessment dated [DATE], reflected she had severe cognitive impairment with a BIMS score of 2. Resident #1 used a wheelchair and walking cane for assistance with mobility and was independent and did not require any assistance with rolling left and right, sit to lying, lying to sitting on the side of the bed, sit to stand, chair/bed-to-chair transfer, or toilet transfer. Resident #1 needed assistance with setup or clean-up with tub/shower transfer, walking 10 feet, walking 50 feet with two turns, and walking 150 feet. Resident #1 did not have any falls prior to being admitted to the facility. Record review of Resident #1's Care Plan reflected the following entries:An entry dated 06/29/2025 and revised on 08/26/2025 reflected: Focus: [Resident #1] was at risk for falls related to impaired balance/gait, weakness and use of psychotropic medications.Goal: [Resident #1 will have decreased risk for serious injury or hospitalization as a result of falling through the next assessment review period. Date Initiated: 08/29/2025, Revision on: 08/17/2025, Target Date: 07/30/2025 .Interventions: Discuss/review fall(s) at morning meetings, IDT/QA meetings, and as indicated. Date Initiated: 06/29/2025 Encourage locking of brakes on Wheelchair.Date Initiated: 06/29/2025 Encourage resident to voice needs as well as to seek/await staff assist with transfers.Date Initiated: 06/29/2025 Encourage use of self-help devices as indicated.Date Initiated: 06/29/2025 Ensure glasses are clean, in good repair and worn appropriately.Date Initiated: 06/29/2025 Ensure resident wears appropriate, well-fitting footwear to minimize the risk ofSlipping.Date Initiated: 06/29/2025 Fall risk quarterly and prn per facility policy.Date Initiated: 06/29/2025 Keep call light within reach.Date Initiated: 06/29/2025 Keep environment clear of unnecessary objects. Keep bed locked and in lowest position unless otherwise ordered/indicated. Date Initiated: 06/29/2025 Nursing staff will monitor for side effects/adverse reactions to medications.Date Initiated: 06/29/2025 Refer to therapies and/or restorative, as indicated.Date Initiated: 06/29/2025 Safety training, retraining and education as needed.Date Initiated: 06/29/2025 An entry dated 08/26/2025 reflected: Focus: [Resident #1] was at risk for skin breakdown due to decreased mobility.Goal: [Resident #1] will have no skin breakdown in the next 90 days. Date Initiated: 08/26/2025 and Target Date: 07/30/2025. There were no Interventions in place. Record review of Resident #1's Skin Assessment for 07/30/25 at 5:00 AM due to an un-witnessed fall revealed, that Resident #1 had a small scrape on her upper right arm and denied pain. Record review of Resident #1's Neurological Check on 07/30/25 at 6:14 AM, revealed that she was complaining of vomiting and diarrhea. [Resident #1] denied any pain or discomfort or emotional distress. Record review of Resident #1's X-rays on 07/31/25 revealed that impressions were taken of the skull, hips, and chest and the findings revealed that there was no evidence of any fractures present in all areas. Record review of the facility's Admissions List for 02/01/25 to 08/26/25 revealed that Resident #1 was admitted to the facility from an acute care hospital on [DATE]. Record review of the facility's Incident Logs for 02/26/25 to 08/26/25 revealed on 07/30/25 at 5:00 PM, Resident #1 had an unwitnessed fall. Record review of the facility's In-service Training Log reflected that the staff's previous training on Resident Rights was conducted by Administrator on 07/23/25. The In-Service Training Logs reflected the staff were trained on the facility's