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	10/03/2025

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	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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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for three (Residents #1, #3, and #4) of five residents reviewed for abuse.The facility Administrator and DON failed to protect Resident #1, Resident #3, and Resident #4 from abuse by Resident #2.On 09/09/25, Resident #2 pushed the wheelchair of Resident #4. Resident #4 hit Resident #2. Resident #2 hit Resident #4 back.On 09/29/25 Resident #2 cursed at Resident #1 and Resident #3. He also pulled out a knife from his shoe and threatened them with it.On 10/02/25 Resident #2 threated to kill Resident #1 and chased after her on 10/02/25. Resident #1 suffered psychosocial harm. An IJ was identified on 10/02/25. The IJ template was provided to the facility on [DATE] at 4:50 PM. While the IJ was removed on 10/03/25, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm because all staff had not been trained on the Plan of Removal. This failure could place residents at risk of continued abuse and harm.Findings included: 1.Record review of Resident #1 's admission MDS, dated [DATE], reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMs score was 15. Her cognitive skills for daily decision making were intact. Her diagnoses included anxiety, depression, post-traumatic stress disorder, schizophrenia, and arthritis. The resident used an electric wheelchair. Record review of Resident #1's Care Plan, dated 09/15/25, reflected:Trauma Informed Care: Resident had a previous/recent traumatic event.Facility interventions included:Identify triggers (any stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening) which may re-traumatize resident: (specify triggers such as physical touch, tone of voice, object, sound, smell, sight, violent movie/news, etc.) Review of Resident #1's Nurse notes reflected:10/01/25 2:54 PM Psychiatrist FNP saw the resident who was referred to her for medical management. Received order to continue Xanax (anti-anxiety medication) 0.5 milligrams orally every eight hours for 30 days for anxiety. The resident was informed. Written by ADON M An interview on 10/02/25 at 12:45 PM with Resident #1 revealed she was outside in the smoking area during smoke break. Resident #1 was upset and said she felt Resident #2 was causing her psychosocial harm. She said Resident #2 was mentally abusing her. Resident #1 said Resident #2 threatened to kill her many times. She said she usually did not go out to the smoke area, but the ADON N was with Resident #2 where he was smoking away from the other residents. An interview on 10/02/25 at 12:55 PM with Resident #1 revealed she was upset. She said she wanted to know how to get a restraining order against Resident #2. 2.Record review of Resident #2's admission MDS, dated [DATE], reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His BIMS score was 00. He sometimes understood sometimes and sometimes he understood others. The resident had delusions, physical behavioral symptoms directed toward others, and verbal behavioral symptoms directed toward others. His diagnoses included non-Alzheimer's dementia and schizophrenia. The resident used a manual wheelchair. Record review of Resident #2's Care Plan, dated 10/01/25, reflected:*Resident had episodes of verbal and physical behavioral symptoms as evidenced by poor impulse control with a diagnosis of schizophrenia. Facility interventions included: Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document.*Resident had a communication problem related to unclear speech and difficulty understanding and making self-understood.Facility interventions included: Be conscious of resident position when in groups, activities, and the dining room to promote proper communication with others. Record review of Resident #2's Notes written by RN A reflected:09/29/25 11:34 AM .Patient remain stable during this shift but continue to be non-compliant with care and verbally abusive to another resident this morning, the attention of this Nurse was called reporting patient was noted outside at the courtyard auguring with another resident and in the middle of the argument patient pull out a kitchen knife from his shoe, this Nurse immediately went outside at the courtyard and calmly assessed patient and ask patient if he have any knife on him, patient stated yes he has a knife and has taken it back to his room, this Nurse went straight to patient room and got the knife out of patient drawer in his room, this Nurse asked patient if he has any plans of hurting himself or others, patient replied NO this Nurse educate patient on safety precautions that must be observed at all time to keep him and other residents safe and that include not having any sharp object with him at any time and not getting close to any resident during an argument and to report any concerns he may have to the Nurse, supervisor or Administrator, patient verbalized understanding , patient refused his morning meds and bp check this morning, MD/DON notified, all safety and universal Precautions were