

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/04/2025
NAME OF PROVIDER OR SUPPLIER  Brookhaven Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0628  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.  (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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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to complete a discharge summary that included a recapitulation of the resident's stay that included diagnoses, course of treatment, pertinent labs, a final summary of the resident's status and reconciliation of all pre-discharge medications with the resident's post-discharge medications for 1 of 5 residents (Resident #1) reviewed for closed records. The facility failed to ensure Resident #1 was discharged from the facility with a discharge summary that included an accurate and current description of the clinical status of the resident. The facility failed to provide the required notice to the Office of the long-term Care Ombudsman regarding the discharge of Resident#1. This failure could place residents at risk for not receiving appropriate and timely care due to confusion among various facilities, agencies, practitioners, and caregivers involved with the resident's care. Findings Included: Record review of Resident #1's MDS dated [DATE], reflected the [AGE] year-old male resident was admitted to the facility on [DATE]. Diagnoses included: Schizophrenia (a chronic mental health condition characterized by a combination of cognitive symptoms that significantly impair a person's daily functioning), anemia (a condition in which there is an abnormally low number of red blood cells (RBCs) or hemoglobin in the blood), hypertension (a condition in which the force of blood against the artery walls is consistently too high). Further review of the Resident #1's MDS, dated [DATE], revealed there was no documented BIMS score. Resident #1's MDS section E0200. Behavioral Symptom - Presence and Frequency reflected Resident#1 had Physical behavioral symptoms directed toward others (this behavior occurred once), Verbal behavioral symptoms directed toward others (this behavior occurred 4-6 times but less than daily). Record review of Resident #1's DISCHARGE - Recapitulation of Stay reflected one dated 10/02/2025 discharge to [hospital name 2]. There was no documented Discharge - Recapitulation of Stay for 10/03/2025 when Resident one went to the hospital. Record review of Resident #1's Physician orders dated 10/03/2025 revealed the following: Send to hospital for further evaluation and treatment. Interview with Ombudsman on 11/04/2025 at 10:09 AM revealed on 10/3/2025 the facility contacted her to get a list of suitable facilities for Resident#1's alternative placement. She stated SW B told her Resident#1 was going for treatment but did not specify the facility. She stated in immediate discharges the facility must provide clinical discharge summary of the residents to the receiving facility, and the notice of discharge to the Ombudsman manager which was not done. Attempted interview with FM 2 on 11/04/2025 at 1:43 PM was unsuccessful. A voicemail was left with a call back number. Attempted interview with FM1 on 11/04/2025 at 1:45 PM was unsuccessful. The surveyor left a voicemail with a call back number. Interview with LVN A on 11/04/2025 at 4:30PM revealed she was the nurse when Resident#1 was transferred to. She stated that she was not aware if he signed a discharge notice. Interview with SW B on 11/04/2025 at 4.45pm revealed that she did not send clinical documents or complete discharge summary because the former Administrator and the DON oversaw the transfer. Interview with SW C on 11/04/2025 at 2:10PM revealed she was the geriatric social worker at behavioral hospital. She stated the hospital was an acute stay behavioral hospital that stabilized behavior then discharged patients and it was not for long-term placement. She stated that Resident#1 was transferred to the hospital to evaluate and establish a medication regimen that would regulate his behavior and there was no clinical discharge summary provided. Interview with the DON on 11/04/2025 at 3:55pm revealed that she had been employed for a month. When asked if there was a clinical discharge summary or documentation dated 10/03/2025 the DON stated she could not find any documentation. She stated that the last week of October 2025 there was an email that SW C had gotten everything that she needed to find Resident#1 a new facility. She stated it was necessary to provide clinical discharge summary to the receiving hospital for continuum of care. Interview with LVN A on 11/04/2025 at 4:30PM revealed she was the nurse when Resident#1 was transferred to. She stated that she was not aware if he signed a discharge notice. She stated that she did not complete a discharge summary or the E-interact (a set of dashboard checklists, and automatic triggers designed to work together to assist care teams to reduce acute care transfers) because it was a busy day. She stated that failure to provide discharge summary to the admitting facility could result in the residents not receiving the care they deserve. Interview with MD on 11/04/2025 at 4.40pm revealed he called the ER and gave report to the ER Doctor and spoke with case management staff and notified them the resident would not be returning to the facility. He stated whenever a Resident transferred to the ER from the nursing home, the facility called and gave report to the receiving hospital. He stated that he did not make a discharge</p>		