

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675352	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/08/2025
NAME OF PROVIDER OR SUPPLIER  Brentwood Place Three		STREET ADDRESS, CITY, STATE, ZIP CODE  3505 S Buckner Blvd Bldg 4 Dallas, TX 75227	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50222</p> <p>Based on interview and record review, the facility failed to ensure the right to be free from abuse for one (Resident #36) of seven residents reviewed for abuse.</p> <p>The facility failed to ensure Resident #36 was free from abuse. On 3/07/2024 Hospitality Aide B called Resident #36 trash and used profanity when speaking to Resident #36.</p> <p>The noncompliance was identified as past noncompliance (PNC). The noncompliance began on 3/07/2024 and ended on 3/12/2024. The facility had corrected the noncompliance before the investigation began.</p> <p>This failure could place residents at risk for abuse and psychological harm.</p> <p>Findings included:</p> <p>Record review of Resident #36's Quarterly MDS dated [DATE] revealed Resident #36 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of anxiety, depression, and schizophrenia (a mental disorder). The MDS also revealed a BIMS score of 15 (suggested no cognitive impairment) and Section E of the MDS revealed no behavioral symptoms were present.</p> <p>Record review of Resident #36's undated care plan revealed Resident #36 was at risk for altered moods and depression.</p> <p>Record review of the PIR dated 3/07/2024 revealed on 3/07/2024 that Resident #36 reported Hospitality Aide B called him trash and used profanity.</p> <p>In an interview on 1/07/2025 at 8:32 a.m., Resident #36 reported a hospitality aide called him trash three times and used profanity. Resident #36 stated that the staff member was terminated and no one else had ever spoken to him like that again. Resident #36 stated the incident did not hurt him but made him mad. Resident #36 stated it was just words, and once she was gone that it was over with.</p> <p>(continued on next page)</p>

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 1/07/2025 at 10:04 a.m., Hospitality Aide B stated Resident #36 came out of nowhere telling her that she was always talking about other people. Hospitality Aide B stated Resident #36 cursed at her and called her names. Hospitality Aide B stated she then asked Resident #36 if she was all of the things he called her, then did that mean that he was white trash. Hospitality Aide B stated she was fed up with Resident #36 and started calling him names like trash. Hospitality Aide B reported she then left the area and reported Resident #36 to the nurse. Hospitality Aide B stated her actions may be abuse, but Resident #36 was abusing her.</p> <p>Record review of witness statements dated 3/7/2024 revealed two residents witnessed the incident and confirmed the Hospitality Aide called Resident #36 trash.</p> <p>In an interview on 1/07/2025 at 10:40 a.m., the ADM reported the two residents that witnessed the incident were not available for interview because one had passed away and the other transferred to another facility.</p> <p>In an interview on 1/07/2025 at 9:46 a.m., the DON reported Hospitality Aide B was immediately suspended when Resident #36 reported the incident. The DON reported Hospitality Aide B acted like the incident was not a big deal because Resident #36 had a BIMS of 15. The DON reported Hospitality Aide B was terminated, safe surveys were completed to ensure no one else was affected by the incident, a trauma assessment was completed on Resident #36 that revealed no harm, and all staff were in-serviced regarding verbal abuse and customer service. The DON stated the risk to the residents depended on their life experiences but could have placed them at risk for trauma. The DON stated prior to this incident that all employees received training over abuse and neglect during orientation and in-services as needed afterwards. The DON stated all staff were responsible for monitoring everyone and reporting any signs or incidents of abuse or neglect to the administrator.</p> <p>In an interview on 1/07/2025 at 10:40 a.m., the ADM reported Hospitality Aide B was immediately suspended after the incident was reported. The ADM reported when he spoke with Hospitality Aide B that she admitted to calling the resident trash. The ADM stated Resident #36 told him he was fine and there was no harm to him. The ADM stated cursing at a resident or calling them names was bad customer service. The ADM stated customer service training included resident rights and abuse and neglect.</p> <p>Record review of facility policy titled Abuse Prevention and Prohibition Program, with a revision date of 10/24/2022, revealed Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse.</p> <p>The facility took the following actions to correct the noncompliance prior to the investigation:</p> <p>In an interview on 1/07/2025 at 9:46 a.m., the DON reported Hospitality Aide B was terminated, safe surveys were completed to ensure no one else was affected by the incident, and all staff were in-serviced regarding verbal abuse and customer service.</p> <p>Record review of Hospitality Aide B's employee file revealed Hospitality Aide B was placed on suspension 3/07/2024 and employment was terminated on 3/12/2024 for violation of policy and procedure.</p> <p>Record review of safe surveys dated 3/12/2024 revealed all residents responded they were not abused, were treated with respect, and felt comfortable telling the staff about their concerns.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of in-service titled Abuse and Neglect, with a date of 3/7/2024, revealed 44 staff signatures and the summary listed on the in-service stated, We are not to engage in any type of verbal altercation with any residents, it is a form of verbal abuse. The residents have the right to say what they like. We are to remain professional and walk away, report behaviors to their charge nurse.</p> <p>In an interview on 1/08/2025 at 4:34 p.m., the DON reported they included training specifically for verbal abuse and started checking the staff's knowledge during their in-services by asking the staff questions about abuse and customer service. The DON stated she and the administrator completed daily knowledge checks and education with every shift for 30 days. The DON reported after 30 days they did weekly checks and education for four weeks. The DON stated after that they started doing monthly in-services that included knowledge checks and education that would continue every month from now on. The DON stated she was responsible for ensuring all staff were educated. The DON stated she or the ADM would initial when the checks were completed on a form.</p> <p>In an interview on 1/08/2025 at 4:40 p.m., the ADM confirmed that after this incident knowledge checks and education were performed on every shift for 30 days. The ADM stated they did weekly education and knowledge checks after that, and then monthly education and knowledge checks were completed. The ADM stated he reviewed the education and knowledge check sheets with the DON every month to ensure they were completed.</p> <p>Record review of March calendar with title Resident's Rights, Abuse and Neglect, Customer Service revealed initials daily by the DON and ADM from March 8, 2024, until March 31, 2024.</p> <p>Record review of April calendar with title Resident's Rights, Abuse and Neglect, Customer Service revealed initials daily by the ADM from April 1, 2024, until April 7, 2024. Initials by the DON or ADM were present weekly or more often from April 8, 2024, until April 30, 2024.</p> <p>Record review of May calendar with title Resident's Rights, Abuse and Neglect, Customer Service revealed initials on dates May 3, 15, and 26th by the DON or ADM.</p> <p>Record review of in-service binder revealed in-services titled Abuse and Neglect, were completed monthly from June 2024 until December 2024.</p> <p>In an interview on 1/07/2025 at 7:53 a.m., Housekeeper C reported cursing at a resident would be verbal abuse. Housekeeper C stated he receives training for abuse and neglect about twice a month and was trained before he started working. Housekeeper C stated the DON provides the trainings and asks the staff questions about abuse to make sure they understand.</p> <p>In an interview on 1/07/2025 at 7:55 a.m., Housekeeper D stated she receives training on abuse and neglect at least monthly, and it includes verbal abuse. Housekeeper D described verbal abuse as yelling or cursing at residents.</p> <p>In an interview on 1/07/2025 at 10:24 a.m., Activities Coordinator E stated cursing at a resident would be verbal abuse. Activities Coordinator E stated that getting loud with a resident could be verbal abuse, and if staff was not able to handle a situation, then they should go get someone else. Activities Coordinator E reported she receives training on customer service and abuse monthly. Activities Coordinator E reported customer service training teaches staff how to treat residents with respect.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 1/07/2025 at 12:44 p.m., RN F stated they do abuse and neglect training monthly that includes verbal abuse. RN F also stated that there is training on customer service. RN F reported customer service is speaking to the resident in a calm tone and not using bad language.</p> <p>In an interview on 1/07/2025 at 1:14 p.m., RN G reported she receives monthly training for abuse and neglect that also included customer service. RN G stated cursing is verbal abuse and that she would immediately intervene if she witnessed any abuse.</p> <p>In an interview on 1/08/2025 at 9:15 a.m., LVN H reported she had monthly training on abuse and neglect. LVN H stated training included customer service and verbal abuse. LVN H described verbal abuse as calling the residents names or speaking to the resident in an offensive way.</p> <p>In an interview on 1/08/2025 at 10:32 a.m., RN I stated she received abuse and neglect training when she first started. RN I reported that abuse and neglect trainings were done monthly and included verbal abuse. RN I stated verbal abuse means you could not talk to residents any way you want to. RN I stated you have to be respectful to the residents.</p> <p>In an interview on 1/08/2025 at 10:37 a.m., MA J reported he had abuse and neglect training monthly that included verbal abuse. MA J stated verbal abuse was spoken words that were inappropriate and offensive to the person that was spoken to.</p> <p>In an interview on 1/08/2025 at 10:40 a.m., CNA K stated she received training for abuse and neglect monthly and it included verbal abuse. CNA K described verbal abuse as someone cursing at a resident or yelling at a resident.</p> <p>In an interview on 1/08/2025 at 10:51 a.m., CNA L reported abuse and neglect training was done monthly with the DON and ADM. CNA L described verbal abuse as swearing at residents or belittling the residents or anything said in a negative form.</p> <p>In an interview on 1/08/2025 at 10:56 a.m., Hospitality Aide M stated she received abuse and neglect training prior to working the floor and received it monthly now. Hospitality Aide M reported verbal abuse was included and that verbal abuse was when you talked to the resident in a mean way that you were not supposed to be doing.</p> <p>In an interview on 1/08/2025 at 11:00 a.m., Hospitality Aide N stated she started working two days ago and received training on abuse and neglect before she worked the floor. Hospitality Aide N stated the training included verbal abuse and stated verbal abuse could be mistreating the resident with your tone or using curse words.</p>		