STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675352	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Place Three	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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (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 0761 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 observation, interview and record review the facility failed to, in accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access for four (Resident #1) of ten residents reviewed for medication storage. The facility failed to ensure there was no nasal spray inside Resident #1's room on 10/21/2025. This failure could place residents at risk of misuse of medications that could lead to overdosing or underdosing.Findings included: Record review of Resident #1's Face Sheet, dated 10/21/2025, reflected a [AGE] year-old male admitted to the facility on [DATE]. The resident was diagnosed with failure to thrive (significant decline in physical and emotional well-being), depression (persistent feeling of sadness or loss of interest), anxiety (intense or excessive fear or worry), and malignant ascites (accumulation of fluid in the belly due to cancer). Record review of Resident #1's Comprehensive MDS Assessment, dated 10/17/2025, reflected the resident was cognitively intact with a BIMS score of 15. The Comprehensive MDS Assessment indicated the resident had cancer, depression, and anxiety. Record review of Resident #1's Comprehensive Care Plan, dated 10/09/2025, reflected the resident had a terminal prognosis related to hepatic malignancy and one of the goals was the resident would be free from depression and anxiety. One of the interventions was to assess the residents coping strategies. The Comprehensive Care Plan did not indicate that the resident can administer his medications. Record review of Resident #1' Physician Order on 10/21/2025 reflected the resident did not have an order for nasal spray. Record review of Resident #1's Assessment Notes on 10/21/2025 reflected no assessment for self-administration of medications, no clear instructions for self-administrations, and no assessment the resident was competent to manage their own medications. During an observation and interview on 10/21/2025 at 8:35 AM, revealed Resident #1 was in his bed, awake. it was observed that a nasal spray was on top of his side table in plain view. When asked about the nasal spray, the resident said he got the medication when he was admitted to a hospital and the medication had been on his side table. During an observation and interview on 10/21/2025 at 8:58 AM, LVN B stated there should be no medications inside the rooms of the residents unless they had an assessment that they could self-administer their medications. She said it might result in overmedication. She said the residents might be taking them every hour and nobody would know. She said if the resident was not taking the medication, confused residents might enter the room and might get hold of the medication. She went inside Resident #1's room and saw the nasal spray on the resident's side table. She took the nasal spray and said she would put it inside the medication room. She said she did not notice the medications when she did her rounds. She said the medications should be inside the cart if the resident needed it so the staff could administer it. She said she did not know who left the medications inside the rooms of the residents. She said she would also contact the resident's family member to know if they brought the medication and educate them about letting them know if they were bringing any medication. In an interview on 10/08/2025 at 11:35 AM, ADON A stated there should not be any medications inside the residents' rooms because the resident might be confused and use the medications as often as they want without anybody monitoring it. She said other confused residents might enter the room and use the medication as well. She said the other residents might be allergic to it or use it in a different route. She said the resident might be suffering from any psychological disorder. She said she would also check if Resident #1 needed the nasal spray so they could request an order for the nasal spray so the staff could administer it. She said the expectation was for the staff to always scan the rooms for any medications inside. She said they already started an in-service about medication storage as soon as they were notified that medications were observed inside Resident #1's room. In an interview on 10/21/2025 at 12:06 PM, the DON stated the nasal spray should not be inside Resident #1's room. She said according to Resident #1, the nasal spray was from the hospital when he was admitted . The DON said, even though the resident was not using it, it should not be inside the room. She said she would check with the resident if he needed the nasal spray so she could get an order for it. She said the risk could be the resident using it without any assessment and might be using it more than as ordered, and nobody would know. She said she already started an in-service about medication storage. In an interview on 10/21/2025 at 1:21 PM, the Administrator stated the expectation was for the staff to scan the rooms of the residents when they do their rounds because medications inside the rooms of the residents could be harmful for the residents. He said the DON already started an in-service and he would monitor the staff adherence to the policy. Record review of