

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675680	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Place One		STREET ADDRESS, CITY, STATE, ZIP CODE 3505 S Buckner Blvd Bldg 2 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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>42214</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that residents had a comfortable and homelike environment for one (100 - hall) of six halls reviewed for physical environment.</p> <p>The facility failed to ensure the temperatures on the facility's 100 - hall was maintained at a range of 71 to 81 Fahrenheit when the heating unit would not produce hot air.</p> <p>This failure placed residents at risk of living in an uncomfortable environment leading to a decreased quality of life.</p> <p>Findings included:</p> <p>Observation of the facility's 100-hall on 12/06/24 at 10:49 a.m. revealed a hall thermostat reading of 68 degrees Fahrenheit.</p> <p>In a confidential resident interview on 12/06/24 at 10:51 a.m., a resident stated the last few nights in the facility had been cold. The resident stated they were offered second blankets and had not been told there was an issue with the facility's heating system. The resident stated they were not disturbed by the temperature in their room but was observed to lay in bed and place 2 blankets over their entire body, including their head .</p> <p>Observation with the Maintenance Supervisor on 12/06/24 at 11:05 a.m. revealed the temperature of the 100-hall, taken with a laser thermometer, was 69.6 degrees Fahrenheit.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 12/06/24 at 11:09 a.m., the Maintenance Supervisor stated he had been the facility's maintenance supervisor for a little over a year. The Maintenance Supervisor stated the facility was kept at a steady 70 degrees Fahrenheit in the winter and 72 degrees Fahrenheit in the summer. The Maintenance Supervisor stated temperatures would be adjusted throughout the day, depending on outside temperatures and at the request of residents. The Maintenance Supervisor stated he checked the facility's temperature daily and would adjust as needed. The Maintenance Supervisor stated he believed a temperature of 70 degrees Fahrenheit was compliant with state and federal rules and he was not aware that the minimum temperature was 71 degrees Fahrenheit. The Maintenance Supervisor stated keeping the facility at temperatures outside of 71 to 81 degrees Fahrenheit could lead to residents being uncomfortable in the facility. The Maintenance Supervisor stated he would adjust the temperature on the 100- hall and monitor to ensure the temperature was within the correct range.</p> <p>On 12/06/24 at approximately 11:15 a.m., the Campus Maintenance Manager approached the state surveyor and the Maintenance Supervisor and stated he had bumped up the temperature on the 100-hall to 72 degrees Fahrenheit and the hall would soon be in compliance.</p> <p>In an interview on 12/06/24 at 12:20 p.m., the ADMIN stated when the temperature of the 100-hall was increased the air conditioner came on and made the hall colder. The ADMIN stated he had the Maintenance Supervisor and the Campus Manager look into the issue, and an issue with the 100-halls heating system was found. The ADMIN stated a pressure switch on the roof was out, which caused the air conditioner to come on when the heat was turned on. The ADMIN stated the switch was replaced and the 100-hall was properly heated, and the temperature was now 71 degrees Fahrenheit.</p> <p>In a follow-up interview on 12/06/24 at 2:11 p.m., the ADMIN stated that had been the facility's administrator for four days. The ADMIN stated it was the expectation for the facility to be in compliance regarding facility temperatures, at all times. The ADMIN stated residents were offered blankets or to move to a more comfortable part of the building when temperature complaints were received. The ADMIN states the Maintenance Supervisor was expected to monitor the facility's temperature to ensure temperatures were at an appropriate level. The ADMIN reiterated that there was a pressure switch that failed, which was why the 100-hall's temperature was low, the repair was made, and the hall was properly heated. The ADMIN stated temperatures that were not within the appropriate range could lead to resident discomfort, especially with low outside temperatures. The ADMIN stated he would in-service facility staff on proper facility temperatures, maintenance request procedures, and would conduct random facility temperature checks to ensure the facility in compliance in the future .</p> <p>Record review of the facility's maintenance logs, dated 09/01/24 to 12/06/24, revealed no documented evidence regarding facility heating unit concerns.</p> <p>Record review of the facility's grievance logs, dated 09/01/24 to 12/06/24, revealed no grievances filed regarding the facility's temperature or residents' rooms being too cold.</p> <p>A related policy was requested from the ADMIN on 12/06/24 at 11:50 a.m., the ADMIN stated the facility did not have a related policy, as it followed the Texas Administrative Code directly.</p>		