

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 07/23/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for one of six (Residents #3) reviewed for Reasonable Accommodation of Needs. The facility failed to provide a working communication system, that was easily at reach, that would allow Resident #3 the ability to safely call for staff for assistance. This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they needed support for daily living. Findings include: Review of Resident #3's Quarterly MDS assessment dated [DATE] reflected Resident #3 was a [AGE] year-old male initially admitted to the facility on [DATE] and readmitted on [DATE] his diagnoses included hypertension (elevated blood pressure), Alzheimer's disease (is a brain disorder that causes memory loss, thinking problems, behavior changes, and brain cell death), muscle weakness, need for assistance with personal care, and dementia (diseases that affect memory, thinking, and the ability to perform daily activities). Resident#3 had a BIMS Score of 00, which indicated sever cognitive impairment. The MDS also reflected Resident #3 was dependent on staff for ADLs, including bed to wheelchair transfers. Record review of Resident #3's Care Plan dated 06/09/25, reflected the following: Focus: [Resident#1] is risk for falls related to confusion, gait/balance problems, incontinence, poor communication/comprehension, unaware of safety needs. Goal: [Resident#3] will be free of falls through the review date. Interventions: Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. An observation on 07/22/25 at 2:10 PM revealed Resident #3 was asleep in his bed. Resident #3's call light cord was entangled around the head of the bed frame, with call button on the floor and out of reach of the Resident. In an interview and observation on 07/22/25 at 2:16 PM CNA B entered Resident#3 room, looked for the call light, and pulled the cord that was entangled by the head of bed frame, and clipped the call light button to Resident#3 blanket. CNA B stated the call light should be within the Resident reach and not in the floor. She further stated if there was an emergency, he would not be able to call for help. In an interview on 07/22/25 at 2:45 PM the DON stated her expectation were, the call light to always be within resident reach. She stated it was the responsibility of all the staff to make sure the call light was accessible to the resident before leaving the room. The DON stated the risk to the resident would be the inability to call for help, and it could lead to a fall. In an interview on 07/22/25 at 3:56 PM The Administrator stated everyone in the facility should answers the call light. He stated the call light button is supposed to always be within the resident reach. He stated If there was a delay in the response, the resident could try to get up and had a fall. A record review of the facility's policy with revised date October 24, 2022, titled Communication-Call System revealed I. The Facility will provide a call system to enables residents to alert the nursing staff from their beds and toilet/bathing facilities. Procedure II. Call cords will be placed within the resident's reach in the resident's room.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 675680	If continuation sheet Page 1 of 3

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to provide the necessary services for residents who were unable to carry out activities of daily living to maintain good grooming and personal hygiene for 2 residents (Resident #1 and #Resident #2) of 6 residents reviewed for ADLs. The facility failed to ensure: 1. Resident #1 had her fingernails cleaned and trimmed on 07/22/25.2. Resident #2 had her fingernails cleaned and trimmed on 07/22/25. These failures could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, and a de Findings included: 1. Record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected Resident #1 was a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] her diagnoses included hypertension (elevated blood pressure), diabetes mellitus (elevated blood sugar), muscle weakness, need for assistance with personal care, and dementia (diseases that affect memory, thinking, and the ability to perform daily activities). Resident #1's had a BIMS score of 6, which indicated severe cognitive impairment. The MDS assessment indicated Resident #1 required maximum assistance with personal hygiene. Record review of Resident #1's Care Plan dated 05/15/25, reflected the following: Focus: [Resident#1] has an ADL selfcare performance deficit related to Dementia and muscle weakness. Goal: [Resident#1] will maintain current level of function . Personal hygiene. Interventions: Personal hygiene.the Resident requires substantial/maximal assistance (X1) staff participation with personal hygiene . In an observation and interview on 07/22/25 at 10:22 AM revealed Resident #1 was laying in her bed. Resident#1 nails on both hands were approximately 0.4cm in length extending from the tip of her fingers, and jagged. The nails were discolored tan with black matter underneath. Resident #1 stated she would like her fingernails trimmed and cleaned. In an interview on 07/22/25 at 10:25 AM CNA A looked at Resident#1 fingernails and stated she would clean and trim them today after Resident#1 shower. CNA A stated that both CNAs and Nurses were responsible for nailcare. She said that if Resident has diabetes, then nurses trim their fingernails. She stated that if nails were long and dirty, residents may be at risk of infection. 2. Record review of Resident #2's Quarterly MDS assessment dated [DATE] reflected Resident #2 was [AGE] year-old female with initial admission date to facility on 11/16/2017. Resident #2 had diagnoses of Hypertension (elevated blood pressure), and dementia (diseases that affect memory, thinking, and the ability to perform daily activities). Resident #2 had BIMS score of 7 which indicated severe cognitive impairment. Resident #1 needed maximum assistance for personal hygiene. Record review of Resident #2's Comprehensive Care Plan revised on 07/16/25 reflected, Focus: [Resident #2] has an ADL Self Care, Performance Deficit related to Confusion, fatigue, Impaired balance, limited mobility. Goal: [Resident #2] will maintain current level of function in Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene through the review date. Intervention: PERSONAL HYGIENE/ORAL CARE: the resident requires extensive assistance (times one) staff participation with personal hygiene . In an observation and attempted interview on 07/22/25 at 11:02 AM revealed Resident #2 was up in her wheelchair in the dining room. The Resident's nails on both hands were approximately 0.4cm in length extending from the tip of her fingers. The nails were discolored tan and had brown colored residue underneath. Resident #2 was not able to participate in interview and just kept looking at her fingernails. In an interview and observation on 07/22/25 at 11:06 AM RN C stated that both nurses and CNAs were responsible for doing nail care for the residents. She stated that fingernails should be trimmed and cleaned on shower days and as needed. She stated that Resident #2 had dirty, untrimmed nails and they will provide nail care to the Resident after lunch. She stated that dirty nails could lead to risk in infections. In an interview on 07/22/25 at 2:45 PM, the DON stated nail care should be completed as needed and every time aides wash the residents' hands. The DON stated nails should be observed daily. The DON stated nurses were responsible for trimming the nails of residents who were diabetic, and CNAs could trim other residents' nails. The DON stated she expected CNAs to offer to cut and clean nails if they were long and dirty. The DON stated the ADON, and the DON would do the routine rounds to monitor. The DON stated residents having long and dirty could be an infection control issue. Record review of the facility policy titled, Grooming Care of the Fingernails and Toenails undated reflected, Nail care is given to clean and keep the nails trimmed . Fingernail are trimmed by Certified Nursing Assistants except for residents with the following condition A. Diabetes or circulatory impairment of the hands, B. Ingrown, infected, or painful nails .</p>		