STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675680	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Place One	3505 S Buckner Blvd Bldg 2 Dallas, TX 75227

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion for one of four (Resident #4) reviewed for range of motion. The facility failed to apply Resident #4's splints to his left and right hand and braces to right and left foot as ordered by the physician. This failure could place residents at risk for decline in range of motion, decreased mobility, and worsening of contractures. Findings included:Record review of Resident #4's 5-day MDS assessment, dated 02/18/26, reflected a [AGE] year-old male with an admission date of 05/29/20. Resident #4 had BIMS score of 15 which indicated he was cognitively intact. He required substantial to maximum assistance for personal hygiene and had not refused care. He had functional limitation in range of motion upper extremities on both sides but no limitation on lower extremities. Diagnoses included diabetes, cerebral vascular accident (stroke) and hemiplegia (paralysis on one side of the body). He had received occupational therapy (therapy that focus on regaining dexterity and strength in fine motor skills), physical therapy (therapy that aims to improve, maintain and restore physical movement) and restorative nursing services in the 7 days prior to the MDS assessment. Record review of Resident #4's Physician order summary report dated 04/08/26 reflected, Late entry for 2/27 OT Splint orders: Patient to wear resting hand (splint that holds the wrist, thumb, and fingers in neutral position to prevent contractures) to left and a C-Grip (prevent thumb from contracting) to right hand daily, or a tolerated.PT/OT Splint order: Patient to wear bilateral AFO (Ankle-foot brace used to hold the foot in the correct position to help prevent foot drop) daily, or as tolerated with a start date of 03/05/26. Record review of Resident #4's care plan with an initiation date 02/16/26 reflected, Focus.Patient have left hand and a C-roll to right hand and lower extremity bilateral AFO's.Interventions initiated on 03/09/26.Provide Passive Range of motion to lower extremities as tolerated, patient to wear bilateral AFO daily, or as tolerated.Provide Passive Range of Motion to upper extremities daily or as tolerated, apply left resting hand splint daily or tolerated 3-4- hours. Apply right C-grip 3-4 hours. Or as tolerated. Record review of Resident #4's CNA task list dated 03/26/26 through 04/08/26 reflected, Patient to maintain joint Range of motion. Check skin before and after. Report to nursing for any condition. Provide Passive Range of motion to upper extremity or as tolerated. Apply L/R resting hand splint daily or tolerated 3-4- hours. Apply L/R C-grip 3-4 hours. Or as tolerated.Patient to wear bilateral AFO daily or as tolerated. Every day from 03/26/26 through 04/08/26 with the exception of 04/04/26 and 04/05/26 had 15 minutes documented. 04/04/26 and 04/05/26 no time was listed and not applicable was checked. During an observation and interview on 04/07/2026 at 10:30 a.m. Resident #4 was observed lying in bed. Resident was observed to have contractures to his left hand and was unable to open his left hand completely. He had some mobility in his right hand and was able to move his index finger, second finger and thumb but his 3rd and 4th finger were contracted toward the palm of his hand. There was no splint in use. Splints were observed sitting on his chest of drawers and Ankle-Foot orthotics were observed sitting on his wheelchair. Resident #4 stated he used splints on his hands and feet when the staff puts them on (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him. He stated the staff does not put them on every day. He stated he gets up on Tuesdays and Thursdays and stated he was not sure what time he would be getting up today. During an observation on 04/07/2026 at 01:45 p.m. revealed Resident #4 was lying in bed watching television. No splints were observed on his hands or feet. During an observation and interview on 04/08/2026 at 10:05 a.m. Resident #4 was observed lying in bed. No splints were in use on both hands or his feet. Resident #4 stated no one had put his splints on today. He stated the staff did not get him up yesterday but stated he did not ask them to get him up and stated he did not want to get up today. During an interview on 04/08/2026 at 11:00 AM with the DOR, she stated Resident #4 was not currently on therapy services. She stated he did have orders for splints to bilateral hands and Ankle foot orthotics for both feet to help prevent further contractures. She stated the facility recently lost their restorative aide so she and the MDS nurse had trained the CNAs and Nursing staff on which residents needed splint placement. She stated therapy was also assisting some with splint placement but stated they did not have any way to document when they did the placement of the splints since he was not on therapy services. She stated Resident #4 was pretty good with wearing his splints. She stated she did not assist with his splint placement yesterday and was not sure if anyone from therapy had assisted. During an interview on 04/08/2026 at 11:10 a.m. with CNA B, she stated therapy had trained them on which residents needed splint placement. She stated Resident #4 had hand splints. She stated she had put on the hand's splints before breakfast and then took them off when breakfast came around 7:00 a.m. She stated had not put his ankle splints on. She stated she had not put his hand's splints back on because he only needed them for 15 minutes. She stated it was on their task list for them to put the splints on and take them off but stated she had not been documenting when she put them on and when she took them off. During an observation and interview on 04/08/26 at 11:13 a.m. CNA B entered Resident #4's room and asked the resident if she could put on his hand splints and he stated yes. Resident #4 stated the splints had not been put on him this morning. CNA B placed the splints on both hands but did not offer to put on his ankle foot orthotics. During an interview on 04/08/2026 at 11:40 a.m. the MDS nurse stated they had a restorative aide who had recently left. She stated they had not had a restorative aide for about 3-4 weeks, so they had to move the restorative needs onto the CNAs. She stated the therapy department trained all of the CNAs and Nurse's on which residents had splints, or range of motion needs and placed the tasks on the CNAs task list in the electronic record. She stated the CNAs and the nursing staff were responsible for ensuring the splints were put on the residents and taken off per the required amount of time. She stated the nurses were responsible for checking the skin after the removal of the splints. She stated they had placed all of the splint placement on the day shift. During an interview on 04/08/2026 at 11:55 a.m. with LVN A, she stated she was the 6-2 p.m. charge nurse. She stated they had received training from therapy about which residents required splints. She stated Resident #4 required hand splints and stated she thought he only had to wear them for 15 minutes. She stated the CNAs were responsible for putting on the splints and the nurses were responsible for checking the skin. She stated she thought CNA B had put Resident #4's hand splints on before breakfast which was served around 7:00 a.m. but took them off so he could eat breakfast. She stated she did not know anything about Resident #4's ankle foot orthotics and stated she was not sure what an ankle foot orthotic was. She stated the only splints she was aware of was the hand splints. She stated the purpose of the splints was to prevent worsening contractures. During a follow up interview on 04/08/2026 at 2:01 p.m. with the MDS nurse she stated they eliminated the 15-minute time section from the CNAs task list. She stated that was an old Restorative timing for the amount of time spent for the placement of the splints, not the duration of the use of the splints. She stated they had started in-serving the staff on putting in the time they put on a splint and a time they take it off. During an interview on 04/09/2026 at 10:00 a.m. with the COTA she stated she had worked with Resident #4 when he was on therapy services and upon discharge they had written orders for him to have his ankle foot orthotics on both feet and splints to both hands. She stated they do not write restorative plans any longer since they do not (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have a restorative program. She stated they had assisted some with putting on the Residents splints since the facility had been without a restorative aide but stated they had not been documenting anywhere on when they put the splints on, take them off, or if they refused. She stated she simply tells the nurse if the resident refused. She stated Resident #4 was pretty good about wearing his splints. She stated ultimately it was the CNAs who were responsible for putting on and taking off the splints once they had received training. During an interview with the DON on 04/09/2026 at 10:30 a.m., she stated when they lost the restorative aide they met with therapy to set up training for the staff on the residents who needed splint placement. She stated originally it was going to be the nurses who were responsible, but then they decided to place it on the CNAs task list to put the splints on and have the nurses perform the skin checks after the splints were removed. She stated they did a poor job communicating the expectations with staff which resulted in staff not understanding the need to document when a splint was placed, when it was taken off, and if the resident refused it. She stated going forward it was going to be placed on the Nursing Administration record so they could assess the skin before they placed the splints and assess when they removed the splints. She stated this way they had a way to see if a resident was allowing them to place the splints and to ensure the splints were still fitting properly or if they needed to be referred back to therapy. She stated the purpose of splints were to help maintain or improve a resident's range of motion. She stated failing to provide range of motion and ordered splints could result in worsening a resident's contracture. Record review of the facility's policy titled, Splinting, revised June 2020, reflected, Purpose- To prevent contractures or decreased tone and to protect joint alignment.RNA staff may apply splints under the supervision on of the Nursing Department.A physician's order will be obtained for the use of a splint.A Care Plan [NAME] be completed initially by OT with specific splinting schedule, application and/or positioning instructions and precautions for RNA and Nursing Staff.The RNA responsible for splint application will document and initial on the Schedule for Splint Application eah time splint is applied and removed.

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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. Based on observation, interview, and record review it was determined the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 4 medication carts observed for medications labeling and storage. The Hall 400/500 medication cart contained an over-the-counter medication bottle of Aspirin CR 81 mg oral tablet with faded and nonvisible expiration date on 04/07/26. This failure could place residents at risk for not receiving the therapeutic benefit of the medication or adverse reaction to expired medication. During observation/interview on 04/07/26 at 10:42 AM of the medication cart for Hall 400/500 with MA C, revealed top-drawer holding over the counter residents' medications. There was a bottle of Aspirin 81 mg CR tablets with faded and nonvisible expiration date. MA C stated he used the same bottle and gave Residents in Hall 400/500 their morning dose of Aspirin 81 mg CR. MA C stated it was his responsibility to check the medication cart daily at the start of the shift to make sure all the medications on the cart were up to date, and if there were expired medication to remove it from the residents' stock. MA C stated giving residents' medication with unknown expiration date, and that may be expired could have a negative effect, because of the outcome the medication potency was reduced, and it was ineffective. Review of 40 residents MARs in the 400/500 halls revealed there were 10 residents receiving Aspirin 81 mg CR daily in the morning. All the 10 residents were administered their morning Aspirin 81 mg on the AM of 04/07/26 by MA C. During an interview on 04/09/26 at 11:50 AM with the DON she stated the charge nurses/MAs were supposed to check the medication carts for any expired medications and the pharmacists checked the medication carts monthly. The DON stated the aspirin bottle with nonvisible expiration date should be removed from the residents' medication stock and replaced with appropriate one. The DON stated this was supposed to be completed to prevent side effects like the medication being ineffective if they were expired, also chemical composition of the medications could change if the medication was expired. Record review of the facility policy titled Medication Storage in the Facility with revised date of January 2026 reflected, . This policy applies to all licensed nurse, medication aides (where permitted), pharmacy staff, providers, and facility leadership.General Medication Storage Requirements. immediately removed any unlabeled, expired, or discontinued medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 5 residents (Resident #8) reviewed for infection control. The facility failed to have Resident#8 ,with dialysis permanent catheter (a medical device used to access the bloodstream for dialysis) and undated dressing, was on enhanced barrier precaution. This failure could place residents at risk for infection and cross contamination. A record review of Resident #8's Quarterly MDS assessment, dated 03/04/26, reflected Resident #8 was a [AGE] year-old male admitted to the facility on [DATE], and readmitted on [DATE]. His diagnoses included hypertension (elevated blood pressure), Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD), dependent on dialysis treatment, and Non-Alzheimer's Dementia (neurodegenerative disorders that cause cognitive decline, behavioral changes, or memory loss, but are caused by different brain pathologies than Alzheimer's). Resident #8 had a BIMS score of 05 which indicated severe cognitive impairment. Section O - Special Treatments, Procedures, and Programs, part J1 was coded: dialysis. Record review of Resident#8 care plan dated 03/04/26 revealed no indication of permanent central venous catheter for dialysis treatment. Record review of Resident#8 doctor orders dated 04/09/26 revealed no order for EBP or dialysis catheter. In an observation and interview on 04/09/26 at 10:41 AM revealed MA C entered Resident #8's room to check Resident#8's blood pressure. There was no signage of EBP in front of Resident#8 room, or in the room, and no supplies for PPE in the room to indicate to staff member or visitor that Resident#8 supposed to be on EBP, and wear a gown and visit for any high contact with the Resident. MA C sanitized his hands put on gloves but not a gown. MA C checked Resident blood pressure. MA C pulled resident sleeves to check for arteriovenous dialysis access in the resident both upper extremities, and unbuttoned Resident#8's T-shirt to look at the permanent catheter for dialysis access in the left upper chest. Resident#8 had scar tissues in both upper extremities related to old dialysis access. MA C removed his gloves, sanitized his hands and exited the room. Interview revealed MA C did not know that Resident#8 was supposed to be on EBP. In interview with the dialysis clinic charge nurse over the phone on 04/09/26 at 10:55 revealed: Residents with permanent central venous catheter for dialysis treatment, the recommendation for the facility staff members from the dialysis clinic were not to do anything with the permanent central venous catheter for dialysis treatment, and the dialysis clinic nurses were responsible for changing the site dressing with each dialysis treatment. In an interview on 04/09/26 at 11:00 AM, the ADON stated she was the infection preventionist for the facility. The ADON stated any resident with medical devices was supposed to be in EBP including Resident#8 with permanent central venous catheter for dialysis treatment. The ADON stated Resident#8 had been in the facility for many years and used to have an arteriovenous access for dialysis treatment (a nonmedical device). The ADON stated that it was the responsibility of the charge nurse that assessed Resident#8 after he got the permanent central venous catheter to update the Resident record to reflect the need for EBP. The ADON stated not having Resident#8 on EBP could put the Resident at risk of developing infection. In an interview on 04/09/26 at 3:47 PM with the DON, she stated Resident#8 should had been in EBP related to his permanent central venous catheter for dialysis treatment. The DON stated the charge nurses for Resident#8 either forgot or failed to notice that he was changed from arteriovenous access for dialysis treatment to a permanent central venous catheter for dialysis treatment, so they did not update his status and, did not put him on EBP. She further stated it may be due to poor assessment or lack of recognition. The DON stated she got the physician order and put Resident#8 on EBP. The DON stated the risk to Resident#8 not being in EBP was cross contamination, and development of infection. Record review of the facility's policy, Hand Hygiene/Hand Washing, revised April 1, 2025, reflected, Enhanced Barrier Precaution (EBP) refers to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contract resident care activities that are associated with a high risk of MDRO colonization when contact precaution do not otherwise apply and/ or transmission such as presence of indwelling devices (e.g., urinary catheter.vascular catheter .