

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/29/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Place Two		STREET ADDRESS, CITY, STATE, ZIP CODE 3505 S Buckner Blvd Bldg 3 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on interview, and record review, the facility failed to protect a resident's right to be free from neglect for 1 (Resident #1) of two residents reviewed for neglect. The facility failed to protect Resident #1 from neglect when they failed to conduct adequate therapeutic drug monitoring of Resident #1's lab levels who was receiving lithium. This led to Resident #1 being admitted to acute care hospital on 06/30/23 and was diagnosed with acute toxic encephalopathy secondary to lithium toxicity. Lab records revealed Resident #1's lithium level was 5.3 mmol/L (critical level) when he arrived at the hospital. The noncompliance was identified as PNC. The IJ began on 06/01/23 and ended on 10/02/23. The facility had corrected the noncompliance before the survey began on 02/27/24. This failure placed residents at risk for neglect and for serious adverse outcomes including drug toxicity, need for hospitalization , and/or death. Findings included: Record Review of Resident #1's Comprehensive MDS, dated [DATE], reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included anxiety disorder, depression, schizophrenia [a serious mental disorder in which people interpret reality abnormally], elevated blood pressure, and type 2 diabetes mellitus. His BIMS score was 08 which indicated Resident #1's cognition was moderately impaired. Functional status reflected Resident #1 was extensive assist and required assistance of 1 staff for toileting and personal hygiene. Record review of Resident #1's Care Plan reflected the following: Focus: Resident #1 requires psychotropic medications (lithium) for diagnosis of schizoaffective disorder bipolar type. Goal: Resident #1 will be/remain free of drug related complications. Interventions: administer medications as ordered, monitor/document for side effects and effectiveness. Record review of Resident #1's Order Summary for June 2023 revealed the following: Lithium carbonate oral tablet 300 mg. Give 1 tablet by mouth two times a day. The order was prescribed on 06/01/23 by MD. Further review revealed: - No order to monitor lithium level routinely. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Psych Services company may treat and evaluate for psych medication management. The order was prescribed on 06/07/23. - UA/C/S STAT for drowsiness. The order was prescribed on 06/26/23. - Lithium level in AM. The order was prescribed on 06/29/23. Record review of the MAR for Resident #1 revealed the resident received Lithium carbonate oral tablet 300 mg. 55 times out of 55 opportunities between the dates of 06/01/23 through 06/30/23. Record review of Resident #1 Laboratory Report dated 06/30/23 revealed: Lithium, Serum critical! 4.5 mmol/l. Reference range: 0.6-1.2. Record review of Resident #1's nurses note dated 06/30/23 electronically signed at 04:00 PM revealed LVN A called NP and notified her about Resident #1 critical level of lithium. NP gave an order to send Resident #1 to the hospital for further evaluation. Record review of Resident #1's nurses note dated 06/30/23 electronically signed at 08:01 PM by the DON revealed Resident #1 was lethargic; LVN A called 911 and sent Resident #1 to the hospital for further evaluation and treatment. Record review of hospital History of Present Illness Report for Resident #1, dated 06/30/23, revealed, This is a [AGE] year-old male with past medical history of schizoaffective disorder, diabetes mellitus who presented to the hospital via EMS from the nursing home with lithium toxicity . Level lithium done at SNF showed levels of 4.5 on 6/29/23 . In the ED today patient's lithium level was 5.3. Record review of the Hospital History and Physical Reports for Resident #1, dated 06/30/23, revealed the following: Assessment and plan: - Acute on chronic kidney disease (when kidneys suddenly become unable to filter waste products from your blood) in presence of lithium toxicity. Plan on dialyzing patient. - Lithium toxicity. Lithium level 5.3 on admission; recheck levels after dialysis and 6 hours later. - Acute toxic encephalopathy (a reversible brain dysfunction syndrome caused by factors such as systemic toxemia) secondary to lithium toxicity. Record review of the Hospital Chemistry report for Resident #1, dated 06/30/23, revealed the following lab results: BUN (what forms when protein breaks down) 68 mg/dL (6 - 24 mg/dL); Creatinine (this test is done to see how well the kidneys work) 6.20 mg/dL (0.7 - 1.3 mg/dL); and eGFR (a test that measures the level of kidney function) Non-African American 9.6 (60 or above is normal). Lithium level 5.3 mmol/l (0.2 - 1.6). Record review of Pharmacy Recommendations Report dated 06/07/23 revealed: Resident #1. The following anti-psychotic medication requires documentation of psych diagnosis to support long-term therapy. Lithium currently linked to mood. The report did not reveal any recommendation about monitoring lithium level. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/28/23 at 1:27 PM, the NP stated the expectation for a resident on lithium was typically to have the initial level with the admission labs and would continue to monitor the lithium level. The NP stated she did not remember Resident #1. The NP stated monitoring lithium level would help to adjust the dose and prevent lithium toxicity. On 02/27/24 at 10:12 AM, attempted to call the RP, unsuccessful. Interview on 02/28/23 at 04:09 PM, Pharmacy Consultant stated she conducted a medication review for Resident #1 on 06/06/23. She stated she did include the lithium, but she did not remember why she did not include the monitoring level. She stated resident on lithium required routine monitoring to avoid toxicity. Interview on 02/28/23 at 12:51 PM, the MD stated her expectation of residents who received lithium was they often checked lithium level if a resident had issues. The MD stated if a resident was on psychotropic medication, she would refer the resident to the psych doctor. The MD stated she did not remember what happened with Resident #1. She stated if Resident #1 was on lithium she would refer him to psych services. The MD also stated if the psych services had made an order to monitor lithium level, she would have agreed to it. Record review of Resident #1 psychiatric services note dated 06/20/23 revealed the following: Referring: MD. Service provided: New referral. The notes did not reveal lithium monitoring. On 02/28/24 at 12:08 PM, Attempted to call Psych Services staff, unsuccessful. Interview on 02/28/23 at 05:29 PM, the DON stated not providing appropriate lithium monitoring would be considered neglect. He stated the expectation for a resident receiving lithium was labs were to be drawn and to monitor lithium level. The DON stated monitoring labs for psych medication were usually ordered by the MD or by the psych doctor. The DON stated he was unsure why monitoring labs were not ordered by the MD for Resident #1. The DON stated the potential risk to the resident in not having labs done to monitor lithium level, the lithium dose could be too high and have adverse effects such as toxicity. Interview on 02/29/23 at 12:20 PM, the RNC stated the normal practice for a resident receiving lithium was the serum level be checked routinely depending on the physician order. He stated the expectation the nurse to notify the physician if a resident on lithium did not have an order for monitoring lithium level. He stated not doing so would be neglect. The Adm was notified on 02/29/24 at 03:05 PM that a PNC IJ situation had been identified due to the above failures. It was determined these failures placed Resident #1 in an IJ situation on 06/01/23. The facility implemented the following interventions: Review of a neglect/abuse in-service dated 09/25/23 was provided by the Adm to all staff Record review of order listing report reflect Resident #2 on lithium. Interviews and record review reflected serum level for lithium was done routinely and reflected no concerns. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the inservice dated 10/02/23 revealed the RNC in-serviced ADONs and nurses on timely report labs, notify physician on time, review admission orders. Notify physician if monitoring order for psych medication was missing. Further review of the inservice dated 10/02/23 revealed charge nurse would review all new admission orders and verify with the physician on all new lithium and required lab orders, ADONs would be responsible for reviewing the admission orders in the interval of 24 hours for lithium have the appropriate monitoring orders. The DON would review the admission orders in 72 hours, and the RNC would do a weekly review. Record review of the inservice dated 10/02/23 revealed the RNC in-serviced the DON, ADON B, ADON C and LVN A on Lab/Radiology/Physician orders: transcribing physician orders and clarification of physician order relater to medication monitoring. An impromptu Quality Assurance and Performance Improvement was completed on 10/09/23with the MD, Administrator, DON, ADONs, and Social Worker. Record review revealed on 02/28/23, the facility reviewed of all residents in the facility and identified no other resident on lithium or any other psychotropic medication requiring therapeutic monitoring. Interview on 02/28/23 were conducted from 2:23 PM to 5:29 PM with the following staff who represented all shifts: ADON B, ADON C, LVN D, LVN E, LVN A, LVN F, LVN G, and MA I. Individual interviews revealed they had received in-service training on abuse and neglect. All staff were able to verbalize understanding of in-service training regarding abuse and neglect. Interviews on 02/29/23 were completed from 11:48 AM to 12:12 PM with the DON, ADON B, and ADON C which revealed they were in-serviced on abuse and neglect. Review of the facility's policy titled Abuse Prevention and Prohibition Program, revised August 2020 reflected, .Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property On 02/29/24 at 3:05 PM the Administrator was informed an Immediate Jeopardy was determined to have existed from 06/01/23 to 10/02/23. The IJ was determined to have been removed on 10/02/23 due to the facility's implemented actions that corrected the non-compliance prior to the beginning of the investigation on 02/27/24.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on interview and record review the facility failed to ensure all alleged violations involving abuse and neglect were reported immediately, but not later than 2 hours after the allegations were made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, for one (Resident #1) of five residents reviewed for abuse and neglect. The facility failed to report allegation of neglect involving Resident #1 to the appropriate State Agency immediately on 04/21/23. This failure could place residents at risk of abuse and neglect. Findings Include: Record Review of Resident #1's Comprehensive MDS, dated [DATE], reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included anxiety disorder, depression, schizophrenia [a serious mental disorder in which people interpret reality abnormally], elevated blood pressure, and type 2 diabetes mellitus. His BIMS score was 08 which indicated Resident #1's cognition was moderately impaired. Functional status reflected Resident #1 was extensive assist and required assistance of 1 staff for toileting and personal hygiene. Record review of Resident #1's Care Plan reflected the following: Focus: Resident #1 requires psychotropic medications (lithium) for diagnosis of schizoaffective disorder bipolar type. Goal: Resident #1 will be/remain free of drug related complications. Interventions: administer medications as ordered, monitor/document for side effects and effectiveness. Record review of Resident #1's Order Summary for June 2023 revealed: Lithium carbonate oral tablet 300 mg. Give 1 tablet by mouth two times a day. The order was prescribed on 06/01/23 by MD. Record review of Resident #1's Order Summary for June 2023 revealed no order to monitor lithium level routinely. Record review of the MAR for Resident #1 revealed the resident received Lithium carbonate oral tablet 300 mg. 55 times out of 55 opportunities between the dates of 06/01/23 through 06/30/23. Record review of Resident #1's Order Summary for June 2023 revealed: UA/C/S STAT for drowsiness. The order was prescribed on 06/26/23. Record review of Resident #1's Order Summary for June 2023 revealed: Lithium level in AM. The order was prescribed on 06/29/23. Record review of Resident #1 Laboratory Report dated 06/30/23 revealed: Lithium, Serum critical! 4.5 mmol/l. Reference range: 0.6-1.2. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's nurses note dated 06/30/23 electronically signed at 04:00 PM revealed LVN A called NP and notified her about Resident #1 critical level of lithium. NP gave an order to send Resident #1 to the hospital for further evaluation. Record review of Resident #1's nurses note dated 06/30/23 electronically signed at 08:01 PM by the DON revealed Resident #1 was lethargic; LVN A called 911 and sent Resident #1 to the hospital for further evaluation and treatment. Record review of hospital History of Present Illness Report for Resident #1, dated 06/30/23, revealed, This is a [AGE] year-old male with past medical history of schizoaffective disorder, diabetes mellitus who presented to the hospital via EMS from the nursing home with lithium toxicity . Level lithium done at SNF showed levels of 4.5 on 6/29/23 . In the ED today patient's lithium level was 5.3. Record review of the Hospital History and Physical Reports for Resident #1, dated 06/30/23, revealed the following: Assessment and plan: - Acute on chronic kidney disease (when kidneys suddenly become unable to filter waste products from your blood) in presence of lithium toxicity. Plan on dialyzing patient. - Lithium toxicity. Lithium level 5.3 on admission; recheck levels after dialysis and 6 hours later. - Acute toxic encephalopathy (a reversible brain dysfunction syndrome caused by factors such as systemic toxemia) secondary to lithium toxicity. Record review of the Hospital Chemistry report for Resident #1, dated 06/30/23, revealed the following lab results: BUN (what forms when protein breaks down) 68 mg/dL (6 - 24 mg/dL); Creatinine (this test is done to see how well the kidneys work) 6.20 mg/dL (0.7 - 1.3 mg/dL); and eGFR (a test that measures the level of kidney function) Non-African American 9.6 (60 or above is normal). Lithium level 5.3 mmol/l (0.2 - 1.6). Record review of Pharmacy Recommendations Report dated 06/07/23 revealed: Resident #1. The following anti-psychotic medication requires documentation of psych diagnosis to support long-term therapy. Lithium currently linked to mood. The report did not reveal any recommendation about monitoring lithium level. Interview on 02/28/23 at 05:29 PM, the DON stated not providing appropriate lithium monitoring would be considered neglect. He stated he did not report the incident to the Adm because he focused on the nursing side of the incident to check all other resident on psych medication and make sure they have lab monitoring orders in the charts. He stated his understanding was any allegation of abuse or neglect was a reportable incident in a timely manner. The DON stated a negative outcome was the neglect could continue and escalate. In an interview on 2/29/24 at 11:28 AM, Adm stated he was not aware of Resident #1's incident of neglect. He stated he would report it right way. The Adm stated a negative outcome for not reporting allegations of abuse and neglect was if there was intent it could be putting the resident at risk. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Abuse Prevention and Prohibition Program, revised August 2020 reflected, .IX. Reporting/Response - A. Facility Staff are Mandatory Reporters. i. Facility owners, operators, employees, managers, agents, and contractors are obligated by the Elder Justice Act and any state specific regulations to report known or suspected instances of abuse of elder or dependent adults . ii. Facility Staff will report known or suspected instances of abuse to the Administrator, and his/her designee . C. Reporting Requirements. I. If the reportable event results in serious bodily injury, a telephone report shall be made to the local law enforcement agency immediately and no later than two (2) hours of the observation, knowledge or suspicion of the physical/sexual abuse .		

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 Based on interview and record review, the facility failed to ensure each resident's drug regimen did not have an excessive dose, for an excessive duration, with inadequate monitoring for 1 of 2 residents (Resident #1) reviewed for unnecessary medications. The facility failed to conduct adequate therapeutic drug monitoring of Resident #1's lab levels who was receiving lithium. This led to Resident #1 being admitted to acute care hospital on 06/30/23 and was diagnosed with acute toxic encephalopathy secondary to lithium toxicity. Lab records revealed Resident #1's lithium level was 5.3 mmol/L (critical level) when he arrived at the hospital. The noncompliance was identified as PNC. The IJ began on 06/01/23 and ended on 10/02/23. The facility had corrected the noncompliance before the survey began on 02/27/24. This failure could place residents taking psychotropic medications at risk for serious adverse outcomes including drug toxicity, need for hospitalization , and/or death. Findings included: Record Review of Resident #1's Comprehensive MDS, dated [DATE], reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included anxiety disorder, depression, schizophrenia [a serious mental disorder in which people interpret reality abnormally], elevated blood pressure, and type 2 diabetes mellitus. His BIMS score was 08 which indicated Resident #1's cognition was moderately impaired. Functional status reflected Resident #1 was extensive assist and required assistance of 1 staff for toileting and personal hygiene. Record review of Resident #1's Care Plan reflected the following: Focus: Resident #1 requires psychotropic medications (lithium) for diagnosis of schizoaffective disorder bipolar type. Goal: Resident #1 will be/remain free of drug related complications. Interventions: administer medications as ordered, monitor/document for side effects and effectiveness. Record review of Resident #1's Order Summary for June 2023 revealed the following: Lithium carbonate oral tablet 300 mg. Give 1 tablet by mouth two times a day. The order was prescribed on 06/01/23 by MD. Further review revealed: - No order to monitor lithium level routinely. - Psych Services company may treat and evaluate for psych medication management. The order was prescribed on 06/07/23. - UA/C/S STAT for drowsiness. The order was prescribed on 06/26/23. - Lithium level in AM. The order was prescribed on 06/29/23. Record review of the MAR for Resident #1 revealed the resident received Lithium carbonate oral tablet 300 mg. 55 times out of 55 opportunities between the dates of 06/01/23 through 06/30/23. (continued on next page)		

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1 Laboratory Report dated 06/30/23 revealed: Lithium, Serum critical! 4.5 mmol/l. Reference range: 0.6-1.2. Record review of Resident #1's nurses note dated 06/30/23 electronically signed at 04:00 PM revealed LVN A called NP and notified her about Resident #1 critical level of lithium. NP gave an order to send Resident #1 to the hospital for further evaluation. Record review of Resident #1's nurses note dated 06/30/23 electronically signed at 08:01 PM by the DON revealed Resident #1 was lethargic; LVN A called 911 and sent Resident #1 to the hospital for further evaluation and treatment. Record review of hospital History of Present Illness Report for Resident #1, dated 06/30/23, revealed, This is a [AGE] year-old male with past medical history of schizoaffective disorder, diabetes mellitus who presented to the hospital via EMS from the nursing home with lithium toxicity . Level lithium done at SNF showed levels of 4.5 on 6/29/23 . In the ED today patient's lithium level was 5.3. Record review of the Hospital History and Physical Reports for Resident #1, dated 06/30/23, revealed the following: Assessment and plan: - Acute on chronic kidney disease (when kidneys suddenly become unable to filter waste products from your blood) in presence of lithium toxicity. Plan on dialyzing patient. - Lithium toxicity. Lithium level 5.3 on admission; recheck levels after dialysis and 6 hours later. - Acute toxic encephalopathy (a reversible brain dysfunction syndrome caused by factors such as systemic toxemia) secondary to lithium toxicity. Record review of the Hospital Chemistry report for Resident #1, dated 06/30/23, revealed the following lab results: BUN (what forms when protein breaks down) 68 mg/dL (6 - 24 mg/dL); Creatinine (this test is done to see how well the kidneys work) 6.20 mg/dL (0.7 - 1.3 mg/dL); and eGFR (a test that measures the level of kidney function) Non-African American 9.6 (60 or above is normal). Lithium level 5.3 mmol/l (0.2 - 1.6). Record review of Pharmacy Recommendations Report dated 06/07/23 revealed: Resident #1. The following anti-psychotic medication requires documentation of psych diagnosis to support long-term therapy. Lithium currently linked to mood. The report did not reveal any recommendation about monitoring lithium level. Interview on 02/28/23 at 1:27 PM, the NP stated the expectation for a resident on lithium was typically to have the initial level with the admission labs and would continue to monitor the lithium level. NP stated she did not remember Resident #1. NP stated monitoring lithium level would help to adjust the dose and prevent lithium toxicity. On 02/27/24 at 10:12 AM, attempted to call the RP, unsuccessful. (continued on next page)		

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 02/28/23 at 04:09 PM, Pharmacy Consultant stated she conducted a medication review for Resident #1 on 06/06/23. She stated she did include the lithium, but she did not remember why she did not include the monitoring level. She stated resident on lithium required routine monitoring to avoid toxicity. Interview on 02/28/23 at 1:27 PM, the NP stated the expectation for a resident on lithium was typically to have the initial level with the admission labs and would continue to monitor the lithium level. The NP stated she did not remember Resident #1. The NP stated monitoring lithium level would help to adjust the dose and prevent lithium toxicity. Interview on 02/28/23 at 12:51 PM, the MD stated her expectation of residents who received lithium was they often checked lithium level if a resident had issues. The MD stated if a resident was on psychotropic medication, she would refer the resident to the psych doctor. The MD stated she did not remember what happened with Resident #1. She stated if Resident #1 was on lithium she would refer him to psych services. The MD also stated if the psych services had made an order to monitor lithium level, she would have agreed to it. Record review of Resident #1 psychiatric services note dated 06/20/23 revealed the following: Referring: MD. Service provided: New referral. The notes did not reveal lithium monitoring. On 02/28/24 at 12:08 PM, Attempted to call Psych Services staff, unsuccessful. Interview on 02/28/23 at 05:29 PM, the DON stated the expectation for a resident receiving lithium was labs were to be drawn and to monitor lithium level. The DON stated monitoring labs for psych medication were usually ordered by the MD or by the psych doctor. The DON stated he was unsure why monitoring labs were not ordered by the MD for Resident #1. The DON stated the potential risk to the resident in not having labs done to monitor lithium level the lithium dose could be too high and have adverse effects such as toxicity. Interview on 02/29/23 at 12:20 PM, the RNC stated the normal practice for a resident receiving lithium was the serum level be checked routinely depending on the physician order. He stated the expectation the nurse to notify the physician if a resident on lithium did not have an order for monitoring lithium level. The Adm was notified on 02/29/24 at 03:05 PM that a PNC IJ situation had been identified due to the above failures. It was determined these failures placed Resident #1 in an IJ situation on 06/01/23. The facility implemented the following interventions: Record review of the in-service dated 10/02/23 revealed the RNC in-serviced the DON on tracking on Lithium monitoring. Record review of order listing report reflect Resident #2 on lithium. Interviews and record review reflected serum level for lithium was done routinely and reflected no concerns. Record review of the in-service dated 10/02/23 revealed the RNC in-serviced ADON and nurses timely report labs, notify physician on time, review admission orders. Notify physician if monitoring order for psych medication was missing. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/29/2024
NAME OF PROVIDER OR SUPPLIER Brentwood Place Two		STREET ADDRESS, CITY, STATE, ZIP CODE 3505 S Buckner Blvd Bldg 3 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 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the inservice dated 10/02/24 revealed charge nurse would review all new admission orders and verify with the physician on all new lithium and required lab orders, ADONs would be responsible for reviewing the admission orders in the interval of 24 hours for lithium have the appropriate monitoring orders. The DON would review the admission orders in 72 hours, and the RNC would do a weekly review. Record review of the inservice dated 10/02/23 revealed the RNC in-serviced the DON, ADON B, ADON C and LVN A on Lab/Radiology/Physician orders: transcribing physician orders and clarification of physician order relater to medication monitoring. An impromptu Quality Assurance and Performance Improvement was completed on 10/09/23 with the MD, Administrator, DON, ADONs, and Social Worker. On 02/28/23, review of all residents in the facility and identified no other resident on lithium or any other psychotropic medication requiring therapeutic monitoring. Interviews on 02/28/23 were conducted from 2:23 PM to 5:29 PM with the following staff who represented all shifts: ADON B, ADON C, LVN D, LVN E, LVN A, LVN F, LVN G, and MA I. Individual interviews revealed they were in-serviced on lithium toxicity and lab monitoring. The charge nurse would review all new admission orders and verify with the physician on all new lithium and required lab orders. Interviews on 02/29/23 were completed from 11:48 AM to 12:12 PM with the DON, ADON B, and ADON C which revealed they were in-serviced on tracking lithium monitoring and being responsible to check the new admission orders in timely manner. They were also educated on follow up labs to all high-risk medications. Review of the facility's policy titled Guidelines for Psychotherapeutic Medications, not dated reflected, .V. Anticonvulsant / Antimania Therapy. A. When anticonvulsants are utilized for treatment of behavior, monitoring of behaviors and side effects shall be completed. Informed consent shall be obtained and documented for each new order or dose increase. Serum drug levels shall be performed per physician order and the physician shall be notified of results according to facility policy On 02/28/24 at 6:20 PM the Administrator was informed an Immediate Jeopardy was determined to have existed from 06/01/23 to 10/02/23. The IJ was determined to have been removed on 10/02/23 due to the facility's implemented actions that corrected the non-compliance prior to the beginning of the investigation on 02/27/24.		

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49415 Based on observation, interview, and record review, the facility failed to provide food that was palatable for 3 (Resident #3, #4, #5) of 9 residents reviewed for food palatability. The facility failed to serve food that was palatable and nutritive. This failure could affect residents by placing them at risk of weight loss, altered nutritional status and diminished quality of life. Findings Included: Record Review of Resident #4 was a [AGE] year-old admitted to the facility 2 1/2 years ago. Interview on 2/27/24 at 12:23 p.m. Resident #4, said the quality of the food is horrible and tasted bad. Record Review of Resident #5 was a [AGE] year-old admitted to the facility on [DATE]. Interview on 2/28/24 at 11:13 a.m. with Resident #5, laughed when asked how the food was at the facility. Resident said it was a joke and is not good at all. Interview on 2/28/24 at 4:40 p.m. with Resident #4, he had chicken noodle soup for lunch. He showed me a picture of breakfast that morning. The picture showed oatmeal in a Styrofoam 3 compartment container which had scrambled eggs in a small section and oatmeal in the larger section. The oatmeal was in solid form and had a circle shaped scoop of oatmeal on top. Resident said it felt like there was a brick in it. Resident said he did not eat it because it was so thick. Observation on 2/28/24 at 12:45 p.m. of last tray off the last hall delivery cart. Meal Calendar showed: Cheese Stuffed Shells w/Marinara and Parmesan, Broccoli Florets, Garlic Bread Stick, Snickerdoodle Cookies and beverage of choice or water. A brownie was on tray instead of the cookies. The temperature of the food was room temperature and did not have any warmth to any of the food. The broccoli was mushy and overcooked. Interview on 2/28/24 at 1:16 p.m. with Dietary Manager, said the broccoli should not be overcooked. She said they just sear the broccoli before it goes on the steam table as it will continue to cook on the steam table. Record Review of Resident #3 was [AGE] years old and was admitted on [DATE]. Interview on 2/28/24 at 1:37 p.m. with Resident #3, said the broccoli on the lunch tray was funky. He had a couple pieces of broccoli that were there and drank the rest like a V8. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reviewed record on 2/28/24 Recipe for Broccoli Florets which stated: Bring water to a boil in a heavy pot or steam jacketed kettle. May also place vegetables in a steam table pan and steam until tender. Do not overcook. Also, recipe stated: Prepare vegetables close to serving time. Cook in small batches. Vegetables will continue to cook on steam table. Reviewed policy on 2/28/24 for Vegetable Cookery which stated: Nutrition services department employees ensure that food is prepared in a manner that preserves quality, maximized nutrient retention, and obtains the maximum yield of the product.		