STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675702	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Place Two	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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44786 Based on interview and record review, the facility failed ensure residents were free of any significant medication errors for one (Residents #1) of five residents reviewed for medications. 1. The facility failed to ensure LVN A held the Losartan Potassium 100 MG oral tablet when Resident #1's diastolic pressure and pulse was less than 60 on 10/05/24. 2. The facility failed to ensure RN B held the Losartan Potassium 100 MG oral tablet and Hydralazine HCl 50 MG oral tablet when Resident #1' diastolic pressure and pulse was less than 60 on 10/12/24. 3. The facility failed to ensure LVN C held the Hydralazine HCl 50 MG oral tablet when Resident #1's diastolic pressure and pulse was less than 60 on 10/05/24 and 10/06/24. 4. The facility failed to ensure RN D held the Hydralazine HCl 50 MG oral tablet when Resident #1's diastolic pressure and/or pulse was less than 60 on 10/04/24 and 10/08/24. These failures could place residents at risk of not receiving their medications as ordered or possible illness. Findings included: Record review of Resident #1's face sheet, dated 10/18/24, reflected a [AGE] year-old male, who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had a diagnosis of Nontraumatic Intracerebral Hemorrhage in Brain Stem (stroke when a blood clot forms in the brain), Hyperlipidemia (high levels of fat in the blood), Type 2 Diabetes (body does not produce enough insulin or use insulin properly), Hypertensive Heart Disease without Heart Failure (chronic high blood pressure causes complications to the heart), Chronic Kidney Disease, and End Stage Renal Disease (terminal condition where kidneys can no longer filter waste from the blood). Record review of the active physician's order dated 10/03/24, reflected the following: Losartan Potassium Oral Tablet 100 MG Give 1 tablet via G-tube in the morning for Hypertension. Hold for SBP <110, DBP <60 and/or HR/Pulse <60 and notify MD/NP/PA. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hydralazine HCl Oral Tablet 50 MG Give one tablet via G-tube every 8 hours for Hypertension. Hold for SBP <110, DBP <60 and/or HR/pulse <60 and notify MD/NP/PA. Record review of Resident #1's Medication Administration Record dated October 2024 reflected the following: 10/04/24 15:00 (3:00 PM) dose RN D documented a blood pressure reading of 135/58 and a pulse of 58. RN D documented the Hydralazine as given. 10/05/24 LVN A documented a blood pressure reading of 130/58 and a pulse of 55. LVN A documented the Losartan as given. 23:00 (11:00 PM) dose LVN C documented a blood pressure reading of 128/50 and a pulse of 72. LVN C documented the Hydralazine as given. 10/06/24 23:00 (11:00 PM) dose LVN C documented a blood pressure reading of 130/50 and a pulse of 54. LVN C documented the Hydralazine as given. 10/08/24 15:00 (3:00 PM) RN D documented a blood pressure reading of 118/86 and a pulse of 52. RN D documented the Hydralazine as given. 10/12/24 RN B documented a blood pressure reading of 147/56 and a pulse of 57. RN B documented the Losartan as given. Record review of the progress notes on Resident #1's electronic record reflected not documented adverse effects. On 10/18/24 at 10:35 AM, Surveyor called Resident #1's Primary Care Physician; there was no answer, and no voicemail could be left. In an interview on 10/18/24 at 12:20 PM, Resident #1 stated he was just about to take a nap, said he was okay and did not have any concerns. On 10/18/24 at 2:36 PM, Surveyor called Resident #1's Primary Care Physician; there was no answer, and no voicemail could be left. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/18/24 at 3:15 PM, RN B stated he did not remember giving Losartan or Hydralazine to Resident #1 incorrectly. He stated he just started working on his own at the facility could not remember all residents or their medications. RN B stated the risk of not giving those medications as ordered was the blood pressure could drop. In an interview with the DON and the Administrator on 10/18/24 at 3:17 PM, the DON stated the facility trained the nurses to follow the physician's orders. The DON stated all nurses should be following the physician's orders. The DON stated he would complete a re-education with staff, because the physician orders should be followed. The DON stated there had been no adverse effects with Resident #1. The DON stated he tried to reconcile the medication administration records weekly but did not know why or how he missed the issue with the medications not given as ordered. The DON stated the risk of not giving the medications as ordered was a decrease in blood pressure. The Administrator stated he agreed with the DON, not giving the medication as ordered could leave to a decrease in blood pressure. On 10/18/24 at 3:25 PM, Surveyor called RN D and did not receive an answer or returned call. On 10/18/24 at 3:40 PM, Surveyor called LVN C and did not receive an answer or a return call. In an interview on 10/18/24 at 3:46 PM, LVN A stated she did not recall giving the Losartan to Resident #1 incorrectly. She stated she always checked Resident #1's blood pressure manually and knew to follow the doctor's order. LVN A stated the risk of not following the doctor's order was the resident's blood pressure could drop. She stated she would not give medication outside of the parameters. Record review of the facility's undated policy titled, Medication Administration, reflected the following: Purpose To provide practice standards for safe administration of medications for residents in the Facility. VI. Tests and taking of vital signs, upon which administration of medications or treatments are conditioned, may be performed as required by state law, and the results recorded. VII. When administration of the drug is dependent upon vital signs or testing, the vital signs/testing will be completed prior to administration of the medication and recorded in the medical record . Procedure IV. Nursing Staff will keep in mind the seven rights of medication when administering medication: A. The right medication B. The right amount (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. The right resident D. The right time E. The right route F. Right indication G. Right outcome . V. Additional considerations include: C. The Rule of 3 - The Licensed Nurse administering medications will perform 3 checks comparing the physician's order, pharmacy label, and Medication Administration Record (MAR). . VII. The resident's MAR will be reviewed for allergies and/or special considerations for administration including: A. Manufacturer's specifications (not recommendations) regarding the preparation and administration of the drug or biological. B. Accepted professional standards and principles. C. Vital sign parameters and lab results as appropriate. VIII. Compare the Licensed Practitioner's prescription/order with the MAR (first check).