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	06/04/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 1 (Resident #1) of 6 residents reviewed for ADLs. The facility failed to ensure Staff provided consistent showers/baths for Resident #1. These failures could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life. Findings included: Record review of Resident #1's quarterly MDS assessment, dated 05/19/25, reflected a [AGE] year-old-male admitted to the facility on [DATE]. Resident #1's diagnoses included dementia, muscle weakness, and need for assistance with personal care. His BIMs score of 06/15 indicating sever cognition impairment. His functional status reflected extensive assistance with bathing. Record review of Resident #1's comprehensive plan of care dated 05/27/25 reflected, Focus: Resident#1 has potential for an ADL self-care performance deficit related to Amputation, and Dementia. Goals: resident#1 will demonstrate the appropriate use of adaptive device to increase ability in (., toilet use and personal hygiene) through the review date. Intervention . BATHING: The resident requires substantial/max assist with bathing. Record review of residents showers schedule revealed Resident #1 was on the evening shower schedule Tuesdays-Thursdays-Saturdays. Record review of Resident#1's undated shower sheet revealed since April 15, 2025, Resident #1 received showers on day of 4/15/25, and 4/22/2025 , bed bath on day of 4/29/25 for the two weeks of April. Resident#1 received shower on 05/01/2025 and refused shower on 05/06/2025 for the May, 2025, and on the day of 06/03/2025 he refused. An observation and interview on 06/04/25 at 04:35 PM, revealed Resident #1 was lying in bed wearing only a T-shirt and the incontinent brief, partially covered with a small blanket. Resident#1 had an odor about him, with unshaved facial hair. Resident#1 stated he had not received showers in a week and wanted to be showered. When asked about his unshaved facial hair, he replied it was okay with him if he was unshaved or having long beard. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the DON on 06/04/25 at 3:41 PM revealed the CNAs were supposed to inform the charge nurse anytime a resident refused a shower. He stated showers were to be done on the shower days, and if the resident refused, they were to notify the charge nurse and they were to document it in the shower sheets. The DON stated charge nurses signed the shower sheets and were expected to ensure residents were showered. The DON said that Resident#1 had dementia and was forgetful, and he was getting his showers all time. He stated lack of personnel hygiene could lead to skin problems and overall dignity. Interview on 06/04/25 at 4:48 PM, LVN C stated residents were showered on their assigned shower days unless they refused. LVN C stated residents were asked three times after refusals and were offered bed baths instead. LVN C stated Resident#1 should get his shower in the evening shift every other day or three times a week. She stated herself as a charge nurse was responsible to make sure the CNAs gave residents their showers according to their schedule. She stated the risks to the residents were skin break down, rash, infection development, dignity, and will not feel good about themselves. At the surveyor exit time 7:00 PM on 06/04/2025 the DON was unable to furnish the document to prove Resident#1 was getting his shower as scheduled. A record review of the facility's policy Resident Rights - Quality of Life , revised August 2020, reflected . Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, and individuality. XII. Demeaning practices and standards of care that compromise dignity are prohibited. Facility staff will promote dignity and assist residents as needed .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident with urinary incontinence, based on the resident's comprehensive assessment, received the appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for one (Resident #1) of 6 residents reviewed for incontinent care. The facility failed to ensure Resident #1 was assisted with incontinence care and toileting in a timely manner on 06/04/2025. This failure could place residents at risk of skin breakdown, infection and a diminished quality of life by not receiving care and services to meet their toileting needs. Findings included: Record review of Resident #1's quarterly MDS assessment, dated 05/19/25, reflected a [AGE] year-old-male admitted to the facility on [DATE]. Resident #1's diagnoses included dementia, muscle weakness, and need for assistance with personal care. His BIMs score of 06/15 indicating sever cognition impairment. His functional status reflected extensive assistance for personal hygiene. He was frequently incontinent of bowel and bladder. Record review of Resident #1's comprehensive plan of care dated 05/27/25 reflected, Focus: Resident#1 has potential for an ADL self-care performance deficit related to Amputation, and Dementia. Goals: Resident#1 will demonstrate the appropriate use of adaptive device to increase ability in (., toilet use and personal hygiene) through the review date. Intervention: Toilet use: the resident requires setup with clean up assistance to use toilet. He is incontinent of bowel and bladder. PERSONAL HYGIENE/ORAL CARE: the resident requires substantial/max assistance with personal hygiene and oral care. Observation and interview on 06/04/25 at 10:10 AM, Resident #1 was lying in bed wearing only a T-shirt and the incontinent brief, partially covered with a small blanket. There was a strong smell of urine in Resident #1's room, the exposed incontinent brief was swollen large with liquid. Resident #1 was unable to answer questions during the interview. CNA A came into Resident #1's room to answer his call light. When asked if Resident #1 had been checked and changed. CNA A stated she had not changed the resident since the start of her shift at 6:15 AM this morning. CNA A shift started at 6:00 AM. CNA A did not provide any explanation for the delay in providing incontinent care to Resident #1. During the process of providing incontinent care to Resident #1 by CNA A this surveyor observed the resident's skin, and there was redness noted on his Scrotum. The charge nurse LVN B was notified by CNA A and got order to apply Antiseptic skin protection external ointment 50% to the reddened area. Interview on 06/04/25 at 11:50 AM, LVN B stated the charge nurses and CNAs supposed to do rounding at least every 2 hours to check residents and change them if they were wet. LVN B stated the risk of incontinent care not being provided on time would be skin break down, and infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/04/25 at 3:41 PM the DON stated the charge nurses and CNAs supposed to do rounds room to room at least every 2 hours to check residents and change them if they were wet. The DON stated the risk of incontinent care not being provided on time would be skin break down, infection, and resident dignity. A record review of the facility's policy Resident Rights - Quality of Life, revised August 2020, reflected . Each resident shall be cared for in a manner that promotes and enhances the quality of life, dignity, respect, and individuality. XII. Demeaning practices and standards of care that compromise dignity are prohibited. Facility staff will promote dignity and assist residents as needed by . B. Promptly responding to the resident's request for toileting assistance .

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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 control program designed to prevent the development and transmission of infection for one (Resident #1) of six resident observed for infection control. Facility failed to ensure CNA A performed hand hygiene and changed gloves while providing incontinence care to Resident # 1. Facility failed to ensure CNA A and LVN B performed hand hygiene before touching clean gloves. This failure could place the residents at risk for infection. Findings included: Record review of Resident #1's quarterly MDS assessment, dated 05/19/25, reflected a [AGE] year-old-male admitted to the facility on [DATE]. Resident #1's diagnoses included dementia, muscle weakness, and need for assistance with personal care. His BIMs score of 06/15 indicating severe cognition impairment. His functional status reflected extensive assistance for personal hygiene. He was frequently incontinent of bowel and bladder. Record review of Resident #1's comprehensive plan of care dated 05/27/25 reflected, Focus: Resident#1 has potential for an ADL self-care performance deficit related to Amputation, and Dementia. Goals: resident#1 will demonstrate the appropriate use of adaptive device to increase ability in (., toilet use and personal hygiene) through the review date. Intervention: Toilet use: the resident requires setup with clean up assistance to use toilet. He is incontinent of bowel and bladder. PERSONAL HYGIENE/ORAL CARE: the resident requires substantial/max assistance with personal hygiene and oral care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/04/25 at 10:13 AM revealed CNA A entered Resident #1's room with clean brief, and handful of gloves. She put the supplies on the bedside table. She donned the clean gloves. CNA A unfastened Resident #1's brief. The brief looked soaked with dark yellow liquid inside with strong odor. CNA A folded it and pushed it between Resident #1's legs. CNA A cleaned Resident #1's front area, and his scrotum looked red. CNA A helped Resident #1 turned to his right side. CNA A folded the dirty brief and disposed of it in the trash bag. CNA A, without changing gloves, got a clean brief and applied it on Resident #1. When asked to further check Resident #1's scrotum, she acknowledged the redness. CNA A called LVN B to Resident #1's room. CNA A changed gloves using the pile of gloves she had on the table with hand hygiene and cleaned Resident #1 front area one more time. CNA A removed gloves, pulled the blanket over the resident while waiting for LVN B. LVN B came in holding gloves in her hands, washed hands, and donned the gloves. LVN B checked Resident #1's scrotum, and stated it had some redness, and no skin breakdown, she asked Resident #1 if he had pain, and he denied having pain. LVN B instructed CNA A to put a barrier cream on Resident #1's scrotum. CNA A went outside the room and got cream Peri Guard with more gloves on her hands, and she put them on the table. CNA A washed hands and donned the glove she put over the table. LVN B removed gloves, washed hands, and before exiting the room, LVN B changed her mind and asked CNA A to not put the Peri-Guard cream on the Resident #1 redness until she called the MD and notified him and get order for treatment. CNA A finished putting the brief on Resident #1. CNA A put socks, pants, and shoes on Resident #1. CNA A removed gloves. LVN B came in holding glove in her hands, she put the glove on table washed hands and donned the gloves. CNA A washed hands donned gloves. CNA A unfastened Resident #1 brief and LVN B put the Peri guard cream on Resident #1's scrotum. Both staff helped Resident #1 transfer from bed to wheelchair. Both staff removed gloves, washed hands, and left the room. In an interview on 06/04/25 at 10:42 AM, CNA A stated she was to wash hands before and after care. CNA A also stated she was supposed to change gloves and complete hand hygiene after removing the dirty brief. CNA A stated she was not supposed to get and carry the gloves on her hand before performing hand hygiene. CNA A further stated she used to get the gloves needed for residents' care in a clean plastic bag. CNA A stated she was supposed to change gloves before going from dirty to clean task, and complete hand hygiene before getting the clean gloves to prevent the spread of infection. In an interview on 06/04/25 at 10:47 AM, LVN B when asked for getting, and holding the clean gloves in her hands before performing any form of hands hygiene, she replied, she should not get the gloves before hand hygiene. LVN B stated not following the proper donning of PPE; like contaminating the glove before putting them on; could cause cross contamination, and development of infection for the residents. In an interview on 06/04/25 at 03:41 PM, the DON stated during incontinent care the staff were to complete hand hygiene before and after care. The DON also stated in between care CNA A was to complete hand hygiene and change gloves because her hands, and the gloves were considered dirty after cleaning the resident and removing the dirty brief. The DON further stated the staff were not supposed to carry gloves in their hands going to residents' room before performing hand hygiene. The DON stated the staff were to complete proper donning and doffing of PPE during residents' care to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy titled Hand Hygiene, revised June 2020, reflected Policy: The facility considers hand hygiene the primary means to prevent the spread of infections. Procedures: . Facility staff and volunteers must perform hand hygiene procedures in the following circumstances including but not limited to . viii. After removing personal protective equipment . VII. The use of gloves does not replace hand hygiene procedure .