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	07/02/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring and administering of all medications to meet the needs of each resident for one (Resident #1) of five residents reviewed for pharmacy services.The facility failed to enter a physicians' order for Nitroglycerin 0.4mg sublingual tablet that was administered to Resident #1 on 06/19/2026. This failure could place residents at risk of not receiving medications as ordered by the physician and a delay in treatment and worsening of their condition.Findings included Review of Face Sheet dated 07/02/2026 reflected Resident #1 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 was diagnosed with Type 2 Diabetes Mellitus (chronic metabolic disease where the body either resists insulin or doesn't produce enough of it, leading to high blood sugar), Peripheral Vascular Disease (slow, progressive circulation disorder characterized by narrowed, blocked, or weakened blood vessels outside the heart and brain), Chronic Kidney Disease (kidneys are damaged and gradually lose their ability to filter waste and excess fluid from your blood), and history Pulmonary Embolism (life-threatening medical emergency where a blood clot (usually from a deep vein in the legs) travels to the lungs and blocks an artery, stopping blood flow). Review of a Progress Note for Resident #1dated 06/19/2026 revealed Resident complained of chest pain and was assessed and given one dose of nitroglycerin [nitro] 0.4mg. Resident however decided to call 911 while he was being treated. 911 came and took him to ER [sic] [Emergency Room]. NP [Nurse Practitioner], DON and resident's next of kin notified. Review of the Order Summary Report for Resident #1 dated 07/02/2026 reflected there was no order for Nitroglycerin 0.4mg sublingual tablet. Review of the MAR for Resident #1 dated June 2026 reflected there was no order for Nitroglycerin 0.4mg sublingual tablet. In an interview with the DON on 07/02/2026 at 9:13 AM it was revealed Resident #1 recently went out to hospital. The DON stated he was on the phone with the nurse when the paramedics showed up to the facility for Resident #1. The DON stated one dose of nitro had been administered to Resident #1 for chest pain. In an interview with Resident #1 on 07/02/2026 at 9:45 AM it was revealed he had lived in the facility for a month. Resident #1 stated he recently went to the hospital due to having trouble breathing. Resident #1 stated he called 911 himself. Resident #1 stated his nurse called his physician and gave him some medication, but he felt he needed to go to the hospital. Resident #1 did not specify what the medication was that the nurse administered. In an interview with the DON on 07/02/2026 at 10:15 AM it was revealed the facility had an emergency medication kit (e-kit) which LVN A pulled the nitro from to administer to Resident #1. The DON stated a physician's order should have been put into the EHR [Electronic Health Record] as a new order and then the medication would have been signed out by LVN A on the MAR. The DON stated the order was to give the nitro three times, five minutes apart. After the 3rd dose the nurse would call 911 if the chest pain had not resolved. The DON stated he would look to see if he was able to locate the physician's order for the nitro. In an interview with the DON on 07/02/2026 at 10:48 AM it was revealed he was unable to locate a telephone physician's order documented in the EHR. The DON stated he only located the Progress Note where it was indicated Resident #1 received the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication. The DON stated he had begun education with the nurses to ensure physician's orders were transcribed into the EHR when a new order was received. In an interview with LVN A on 07/02/2026 at 11:02 AM it was revealed LVN A explained Resident #1 was sent to the emergency room for evaluation and treatment of chest pain. LVN A stated Resident #1 complained of chest pain, so he contacted the physician and spoke with the NP. NP gave a telephone order for nitro. LVN A stated he had another nurse pull the nitro from the e-kit. LVN A stated he administered one dose of nitro to Resident #1 and Resident #1 called 911 himself. LVN A stated it was normal procedure to enter the telephone order into the EHR but due to the medical emergency and 911 showing up he forgot to go back and enter the information. LVN A stated failing to enter a telephone order could result in a resident potentially missing a prescribed medication. LVN A stated the DON had already contacted him and conducted an education on the procedures of entering a telephone order prior to Investigator calling him. An attempt was made to contact LVN B on 07/02/2026 at 12:17 PM but no message could be left due to the mailbox being full. A text message was sent to LVN B on 07/02/2026 at 12:18 PM requesting a return call. No return call was received prior to the end of the investigation. An attempt was made to contact LVN B on 07/02/2026 at 2:12 PM but no message could be left due to the mailbox being full.NOTE: LVN B was scheduled to work on 07/02/2026. At 2:45 PM LVN B had not arrived at work for her 2:00 PM to 10:00 PM shift. In an interview with the DON on 07/02/2026 at 2:31 PM it was revealed it was the practice of the facility to receive a telephone order from the physician and immediately transcribe the information into the EHR. The DON stated when he spoke with LVN A it was an emergent situation and LVN A hurried to get the telephone order for nitro and forgot to go back and transcribe the telephone order. The DON stated he audited the EHR the following Monday but Resident #1 was discharged from the EHR preventing him from being able to correct the EHR. The DON was asked what the risk of failing to transcribe a telephone order. The DON would not directly answer the question. The DON answer by stating if the nurse did not have an order if the medication was needed in the future the physician would be contacted again and the physician would give the order again. Review of Telephone Orders for Medication dated 01/2025 reflected Purpose: To reduce errors associated with misinterpreted verbal or telephone communication of physician orders. Policy:I. Verbal communication of prescription or medication orders and test results is limited to urgent situations in which immediate written or electronic communication is not feasible. II. Abbreviations should be avoided when an order is given or received. Procedure:I. Receiving A Telephone Order (TO)A. The authorized prescriber identifies self, specifies the resident's name and communicates the order. B. The receiver documents the order immediately on the prescriber form including:i. Date and time order is received;ii. Patient name;iii. Drug name (brand or generic);iv. Strength or concentration;v. Dose;vi. Frequency;vii. Route;viii. Quantity and/or duration;ix. Name of prescriber;x. Signature of order recipients.II. The authorized prescriber must countersign the order within a reasonable timeframe after communicating the order.