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	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Place Two	3505 S Buckner Blvd Bldg 3 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure the resident had a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely for 3 of 10 residents restrooms (Resident Restroom [ROOM NUMBER], Resident Restroom [ROOM NUMBER], and Resident Restroom [ROOM NUMBER]) reviewed for hot water, 1 of 10 (Resident Restroom [ROOM NUMBER]) for restroom leaks and 1 of 8 residents (Resident #58) reviewed for bed linens. The facility failed to ensure residents had hot water in Resident Restroom [ROOM NUMBER], Resident Restroom [ROOM NUMBER], and Resident Restroom [ROOM NUMBER] on 3/3/26 and 3/4/26.The facility failed to ensure Resident Restroom [ROOM NUMBER] was free from leaks on 3/3/26 and 3/4/26. The facility failed to ensure Resident #58 was provided with clean and sanitary pillowcase on 3/3/2026. These failures could place residents at risk of exposure to infectious diseases, unsanitary environment and a decline in quality of life. 1 and 2. Record review of Work Orders for the facility reflected concerns with hot water heater on 9/19/25 and 9/23/25. During an observation and interview with residents in Resident Restroom [ROOM NUMBER] on 3/3/26 at 10:30 a.m. revealed the water was not hot in the restroom faucet when the hot water was on for 7 minutes. There were two residents in the room and both revealed they had no hot water and noted the plumbing from the faucet was leaking. During an observation and interview with the resident in Resident Restroom [ROOM NUMBER] on 3/3/26 at 10:34a.m. revealed no hot water form the restroom hot water faucet after 7 minutes of running. The resident residing in the room revealed he had luke warm water but never hot water. During an observation in Resident Restroom [ROOM NUMBER] on 3/3/26 at 10:37 a.m. revealed the water was not hot in the restroom faucets after the hot water was on for 7 minutes. The resident was not present at the time of the observation. Interview with the resident from Resident Restroom [ROOM NUMBER] on 3/4/26 at 10:22 a.m. revealed he had not noticed his hot water in the restroom was not hot. During a confidential group interview with six residents during an undisclosed date and time revealed one resident had no hot water in their restroom faucet and had not had hot water for a long time. The resident revealed he had spoken to the Administrator and nurses about his concern, and it had not been resolved. The resident revealed he had not had hot water since his admission several months ago. During an interview and observation with the Maintenance Director on 03/04/2026 at 2:38 p.m. revealed the following:-Resident Restroom [ROOM NUMBER]'s faucet had a hot water temperature of 78 degrees and the plumbing under the sink was leaking water into a trashcan.-Resident Restroom [ROOM NUMBER] was 75 degrees-Resident Restroom [ROOM NUMBER] was 91 degrees The Maintenance Director revealed the hot water in resident restrooms should have been between 98 degrees and 110 degrees. The Maintenance Director revealed he checked all restroom hot water temperatures first thing every Monday morning and had not had any complaints about hot water. The Maintenance Director revealed there were two halls that used the same water heater and if there were too many showers the restrooms in resident rooms run out of hot water. The Maintenance Director was unable to explain the reason the other resident restrooms had hot water in the same hall, but Resident (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Restroom [ROOM NUMBER], Resident Restroom [ROOM NUMBER] and Resident Restroom [ROOM NUMBER] did not. The Maintenance Director revealed whenever he received a complaint about hot water, he checked the water heater temperature outside and if it was correct he would inform staff not to use the showers until the water was warm again. The risk to the residents of not having had the correct hot water temperature in their restroom faucets was they could have been exposed to bacteria that could have caused sickness. The Maintenance Director revealed he was unaware of the leak in Resident Restroom [ROOM NUMBER] and would fix it immediately because it could have been an accident hazard. During an interview on 03/05/2026 at 1:21 p.m., the Administrator revealed the Maintenance Director checked faucet temperatures in resident restrooms weekly. The Administrator revealed they repaired issues immediately when they were made aware of issues. The Administrator revealed the facility had gotten a new water heater (2025). The Administrator was unable to explain the reason some restrooms had hot water and others did not. The Administrator revealed he would get with the Regional Maintenance Director on the issue to help determine the cause and correct it. The Administrator revealed the residents having not had the appropriate hot water temperature in the restrooms could affect them because the residents could not perform good hand hygiene in their rooms. Record review of facility's policy Water Temperature revised 8/2020 .the facility ensures water is maintained at temperatures suitable to meet residents' needs. 2.Record review of Resident #58's Quarterly MDS, dated [DATE], reflected Resident #58 was a [AGE] year-old male admitted on [DATE] with pertinent diagnoses of hypertension (high blood pressure), traumatic brain injury (disruption in brain flow), malnutrition, and asthma. He had BIMS of 15 indicating he was cognitively intact. During an observation and interview on 03/03/2026 at 11:04 a.m., Resident #58's pillow on his bed did not have a pillowcase. The pillow was stained with multiple brown spots all over it. Resident #58 revealed he would like a pillowcase and was about a month since he had a pillowcase. He revealed he had informed a staff member about wanting a pillowcase but did not recall which staff member or how long it was since he informed the staff member. He revealed he would not like a new pillow although it was stained. During an observation on 03/04/2026 at 1:44 p.m. , Resident # 58 had no pillowcase for his pillow on his bed. During an interview and observation on 03/04/2026 at 3:54 p.m., the Staffing Coordinator revealed she was filling in as a CNA for Resident #58's hall. The Staffing Coordinator revealed Resident # 58's pillow had no pillowcase on it. The Staffing Coordinator revealed CNAs were usually responsible for making beds and it included putting clean bed sheets and pillowcases on resident's bed. The Staffing Coordinator revealed the risk of the resident not having a pillowcase could result in declining resident's quality of life. During an interview on 03/04/2026 4:20 p.m., CNA A revealed CNAs were responsible for ensuring residents had clean bedsheets and pillowcases. CNA A she revealed was not regularly assigned to Resident #58 and could not state the reason he had not had a pillowcase for almost a month. CNA A revealed she provided Resident #58 with a clean pillowcase just before this interview. During an interview on 03/05/2026 at 12:17 p.m., the DON revealed CNAs were responsible for making beds and providing them with clean linen that included bedsheets, blankets and pillowcases. The DON revealed it was his expectation that Charge Nurses oversaw the CNAs to ensure a home-like environment was maintained in resident's rooms. The DON revealed the risk of not providing pillowcases included possible skin issues and decline in residents' quality of life. During an interview on 03/05/2026 at 2:59 PM, LVN B revealed he worked as a charge nurse on Resident #58's hall. LVN B revealed Resident #58 had not informed him about the missing pillowcase. LVN B revealed CNAs were responsible for providing clean linens to residents, and charge nurses were required to supervise the CNAs. LVN B revealed not having clean linens could result in denying the residents' right to a clean, home-like environment. Review of facility's policy Laundry Services revised on 8/2020 reflected .The Facility employs adequate staff to ensure that linen is kept clean, in good repair, and in sufficient quantities to meet the needs of our patients.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration for 3 of 6 residents (Resident #29, Resident #15 and Resident #89) reviewed for hydration. The facility failed to ensure Residents#29 received a drink during lunch service on 3/3/26.The facility failed to ensure Resident #15 received a drink during lunch services on 3/3/26 and 3/4/26.The facility failed to provide Resident #89 drinking water on 3/3/26. These could place residents at risk of discomfort, dehydration, and/or a diminished quality of life. 1. Record review of Resident #29's face sheet, dated 3/5/26, revealed a [AGE] year-old male with an admission of 1/6/25. Resident #29 had the following active diagnoses: need for assistance with personal care, Thiamine Deficiency (condition that causes neurological and cardiovascular disease stemming from malnutrition or chronic alcohol use), hypo-osmolality and hyponatremia (electrolyte disorder linked to fluid retention or excessive loss of fluid) and esophagitis (inflammation or swelling of the esophagus). Record review of Resident #29's Comprehensive MDS Assessment, dated 12/18/25, revealed a BIMs score of 0 which indicated a severe cognitive impairment. The MDS indicated Resident #29 required partial/moderate assistance for eating. Record review of Resident #29's care plan, dated 1/12/2026, reflected, . Resident #29 has potential for dehydration or potential fluid deficit r/t hypo-osmolality and hyponatremia. Resident #29 will be free of symptoms of dehydration and maintain moist mucous (the slippery, wet, inner linings of body cavities and organs such as the nose and mouth).Interventions: Monitor and document intake and output as per facility policy. Date Initiated: 03/08/2025. Monitor/document/report to MD PRN s/sx of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin (a sign where skin, when pinched and released it remains in a raised position instead of snapping back quickly), cracked lips, furrowed tongue(deep grooves on the top surface and sides of the tongue), new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes. Date Initiated: 03/08/2025. During an observation of Resident #29 during lunch service on 3/3/26 at 12:01 p.m., revealed he was served his food and had no drink. At 12:15 p.m. Resident #29 finished his plate of food and still had no drink. The Activities Director was observed asking residents what they wanted to drink and she was passing out drinks. The Activity Director had not approached Resident #29 during meal service. An unidentified staff was observed picking up Resident #29's meal tray at 12:29 p.m. and he continued without a drink. During an attempted interview with Resident #29 on 3/3/26 at 1:05 p.m. revealed resident was unable to answer any questions coherently. 2. Record review of Resident #15's face sheet, dated 3/5/26, revealed a [AGE] year-old male with an admission date of 11/18/25. Resident #15 had the following active diagnoses: Type 2 Diabetes (chronic disorder characterized by high blood sugar resulting from the body's inability to use insulin properly), Lymphedema (swelling typically in the arms and legs caused by a buildup in lymph fluid), acute kidney failure (a sudden rapid loss of kidney function usually occurring within hours or days that causes dangerous waste buildup, fluid imbalance and electrolyte disruption in the blood), unspecified opened wound, right foot and need for assistance with personal care. Record review of Resident #15's quarterly MDS assessment, dated 2/25/26, revealed a BIMs score of 14 (scale of 0-15) which indicated severe cognitive impairment. The MDS revealed Resident #15 required supervision or touch assistance for eating and partial assistance for transfers. During an observation of Resident #15 during lunch service on 3/4/26 at 12:05 p.m., Resident #15 was served his lunch tray without a drink. Several staff were observed serving drinks, however Resident #15 was not offered a drink. At 12:32 p.m., Resident #15 finished his meal and he continued not having a drink. During an observation of Resident #15 during lunch service on 3/4/26 at 12:28 p.m. revealed resident was (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	served his meal tray without a drink. At 12:46 p.m. resident #15 finished his meal and continued not having a drink. 3. Record review of MDS assessment, dated 01/03/2026, reflected Resident #89 was a [AGE] year-old female, readmitted on [DATE], diagnoses included necrotizing fasciitis (Life-threatening flesh-eating bacterial infection that destroys skin, fat, and muscle tissue), Type 2 diabetes (Elevated blood sugar level). Resident #89 had a BIMS score of 15 indicating intact cognitive function, needed supervision/touching assistance with chair/bed-to-chair transfers and occasionally incontinent of urine and bowel. Record review of care plan, dated 05/03/2026, reflected Resident #89 had . impaired visual function . initiated date on 04/14/2025 reflected Resident #89 was high risk for falls related to left below- knee amputation, gait/balance problems. Interventions/tasks. Resident #89 needs a safe environment with: . personal items within reach . During an interview and observation on 03/03/2026 at 10:22 a.m. with Resident #89 reflected resident was lying in her bed, she revealed she had not gotten drinking water that day and the facility staff had not provided her water and ice on a regular basis. Resident #89 revealed at times she drank water off her bathroom sink faucet. It was observed the Resident #89 had an empty water pitcher on her table. Interview and observation on 03/03/2026 at 02:36 p.m. with Resident #89 in her room revealed the staff had not brought her drinking water and the water pitcher was observed empty on her table. Interview on 03/03/2026 at 02:40 p.m. with CNA J revealed he worked on the 400 hall in the afternoon shift. CNA J revealed one of his responsibilities was to provide drinking water and ice to the residents several times during his shift and had not done it that day because he came in late for work. CNA J revealed he had not provided drinking water and ice to Resident #89 yet, he revealed not having had enough water to drink could have led to dehydration among residents. He revealed he had received training and in-service within a month on the topics of importance of hydration and resident rights. During a confidential group interview of 6 residents on an undisclosed date and time revealed the residents had not gotten water and ice at night. They revealed the facility had just gotten a new ice machine and went for 2 to 3 days without ice. They revealed the staff would go to the store for ice but had not got enough. Interview with LVN I on 03/04/2026 at 2:05 p.m. revealed she assisted with passing out meal trays and drinks during breakfast and lunch. LVN I revealed it was the nurses' responsibility to confirm each resident received the appropriate types of liquid for each meal. LVN I revealed the regular drinks were served by staff such as CNAs and Nurses while the thickened liquids were brought out on the trays from the kitchen. LVN I revealed all residents should have always had a drink during each meal whether it was water, juice or coffee. LVN I revealed the risk to the residents of not having received a drink during their meals was dehydration. LVN I revealed the ice machine at the facility was broken for a couple of days in the last month, but the facility always had ice. LVN I revealed when the facility had no ice they would have gone to building 3 or 1 for ice. LVN I revealed the expectation was for residents to have ice water throughout the day. Interview with Dietician K on 03/04/2026 at 2:33 p.m. revealed the standard protocol for serving drinks to residents was the staff served drinks listed on the tray tickets. Dietician K revealed the facility had a dining excellence program in which they should have been serving beverages to the residents ahead of the meal tray. Dietician K revealed every resident should have a drink at every meal and staff should have been offering at least two drinks for each meal. Dietitian K revealed if a resident refused a drink the staff should document it. Dietitian K revealed it was a team effort to ensure all residents received drinks during every meal service. Interview with the Activity Director on 03/05/2026 at 10:10 a.m. revealed she helped with passing out drinks occasionally in the dining room. The Activity Director revealed she would ask residents what they wanted to drink and would check their tickets to confirm they could drink what they were asking for. The Activity Director revealed the expectation was all residents should have gotten drinks at every meal service and should have been provided with more drinks if the residents requested. The Activity Director revealed she could not recall any residents declining drinks for meal service on 3/3/26 or 3/4/26. The Activity Director was unable to state the reason Resident #29 and Resident #15 had not gotten drinks on 3/3/26 or 3/4/26. The Activity Director revealed she believed the risk to (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the residents of not having gotten any drinks during the meal service was they could have been thirsty or the residents could have had an unfulfilled desire. The Activity Director revealed it was a joint effort to make sure all residents received drinks during meal service. The Activity Director revealed the facility always had ice for the residents' drinks. The Activity Director was unable to state how they ensured they had ice when the icemaker was broken. The Activity Director revealed residents had gotten ice water on the days the machine was broken. Interview with the Dietary Manager on 03/05/2026 at 10:26 a.m. revealed residents who needed thickened liquid beverages got them on their food tray from the kitchen; however, the other beverages were offered to the residents from the beverage cart. The Dietary Manager revealed beverages were passed out by staff to residents during their meal service. The Dietary Manager revealed it was the responsibility of the nursing staff and CNAs to ensure all residents had drinks with every meal. The Dietary Manager revealed she liked beverages given out before trays were delivered but staff could pass drinks out anytime during meal service. The Dietary Manager revealed the risk of not having drinks during meal service or throughout the day could have resulted in residents having hydration concern. The Dietary Manager revealed the facility's ice machine was not working for two days and during those two days they were obtaining ice from other buildings. An interview with CNA L on 03/05/2026 at 10:34 a.m. revealed during meal service sometimes kitchen staff provided resident drinks, but when the kitchen was short the CNAs or nurses provided the drinks to the residents. CNA L revealed all residents should have had a drink with their meals. CNA L revealed residents should not have gotten their drinks after their meal, they should have had it before or during their meal. CNA L revealed CNAs and nurses should have been monitoring residents to ensure they had drinks. CNA L was unable to answer what the risks were for residents that had not received drinks during meal service because she insisted all residents get drinks during meal service. An interview with the DON on 03/05/2026 at 1:12 p.m. revealed all residents should have had drinks during their meals. The DON revealed dietary staff were responsible for determining the type of drink. The DON revealed the nursing department should have been observing whether residents received drinks throughout the day and during meal service. The DON revealed best practice was drinks were served before the meals were served. The DON revealed the risk to the residents of not having received drinks during the meal would have been a decrease in satisfaction for the residents and increased frustration. The DON revealed it was the responsibility of the CNAs to provide water and ice to residents several times during their shift. The DON revealed all the staff received in service training on resident rights and hydration. The DON revealed lack of drinking water throughout the day could have led to resident dehydration. An interview with the Administrator on 03/05/2026 at 1:20 p.m. revealed all residents should have been given drinks with their meals. The Administrator revealed the expectation was residents stay hydrated throughout the day. The Administrator revealed the risk to the residents of not having gotten drinks at mealtime or throughout the day was dehydration. Record review of the facility's policy entitled, Nutrition/Hydration Management, dated 1/2026, reflected .Nutrition and hydration management is an interdisciplinary process designed to improve residents' quality of life. The program emphasizes regular assessment and monitoring of nutritional and hydration status through clinical indicators such as body weight, biochemical measures, and hydration levels, with prompt responses to unplanned weight changes or hydration concerns. Individualized care plans are developed for each resident based on comprehensive assessments, ensuring tailored interventions to meet specific needs. The management program is consistently implemented and evaluated for effectiveness, with adjustments made as necessary. Nursing staff receive ongoing training in current nutrition and hydration practices to maintain high-quality care standards.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed for food safety for the facility's only kitchen.The facility failed to ensure the holding temperature was below 40 degrees F (Fahrenheit) for pureed potato salad served for lunch on 3/4/26.This failure could place residents at risk for food-borne illness, and food contamination.Findings included:During an observation and interview on 3/4/2026 11:46 a.m., of the lunch service revealed pureed potato salad was at 90 degrees F. (Pureed foods are smooth, lump-free food, made by blending or grinding cooked foods for those with chewing or swallowing difficulties).The Dietary Manager proceeded to scoop out the pureed potato salad to individual portions and prepared about 12-16 small cups, covered them and placed them in the freezer to cool them down further. The Dietary Manager stated the pureed potato salad should be at 41 degrees F and needed to cool down further before serving.During an observation on 3/4/2026 at 12:07 p.m., [NAME] F had started serving lunch for the residents. The Dietary Manger removed the individual potato salad and was getting ready to serve to the residents. The Dietary Manager proceeded to record temperature for the individual portioned pureed potato salad. The temperature of one individual portion cup was 86 degrees F and the temperature of another individual portion cup was 84 degrees F. The Dietary Manager proceeded to hand over the pureed potato salad cup to [NAME] F to serve until this surveyor intervened regarding incorrect holding and serving temperature of cold foods.During an interview on 03/04/2026 4:29 p.m., with the Dietitian stated cold food items, such as pureed potato salad should be held at 41 degrees F or lower. The Dietitian stated if the salad was at a higher temperature after cooking, it needed to be cooled down to 41 degrees F and served over ice during service. She stated serving food at incorrect temperatures posed a risk to residents including the potential for foodˆborne illness and concerns related to palatability.During an interview on 03/05/2026 at 9:19 a.m., with the Dietary Manager, she stated the pureed potato salad should be held and served at 41 F or below. She reported that both the cooks and she were responsible for ensuring food items were held and served at the appropriate temperatures. She explained that [NAME] F had prepared the pureed potato salad on the morning of 03/04/2026 and did not have adequate time to cool it down. The Dietary Manager stated because the lunch meal service was approaching, she decided to portion the pureed potato salad into individual cups to help it cool down faster. She stated she replaced the pureed potato salad with a different food item for residents requiring a pureed diet because the potato salad had not cooled down to 41 F and was not at the correct temperature for service. She stated she knew cold foods must be held and served at 41 F or below, and failure to follow correct holding and serving temperature requirements could result in foodˆborne illness and decreased palatability.In an interview on 03/05/2026 at 9:31 a.m., [NAME] F stated she was the morning cook on 03/04/2026 and prepared the pureed potato salad that morning for lunch service. She stated all cold foods must be held and served at 41 F, and the pureed potato salad had not cooled to the correct temperature for service. She stated that if cold pureed potato salad was not held at the appropriate temperature, it should not be served to residents due to the risk of foodˆborne illness.Record review of the facility's policy titled, Food Temperatures, dated 12/2020 reflected, .Policy: Foods prepared and served in the facility will be served at proper temperatures to ensure food safety . If temperatures do not meet applicable serving temperatures, reheat the product or chill the product to the proper temperature for hot foods of 165 for 15 seconds and chill cold foods to be [less than] 41 .If temperatures are not at acceptable levels and cannot be corrected in time for meal service, and appropriate menu substitution should be implemented.Record review of Food and Drug Administration Food Code, dated 2022, reflected, . (2), the FOOD shall have an initial temperature of 5 C (41 F) or less when removed from cold holding temperature control, or 57 C (135 F) or greater when removed from hot holding temperature control.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received proper treatment and care to maintain mobility and good foot health for 1 of 5 residents (Resident #66) reviewed for foot care. The facility failed to provide adequate foot care for Resident #66. This failure could place residents at risk for infection, impaired mobility, and poor foot health as well as a decline in their quality of life.Record review of Resident #66's face sheet, dated 3/5/26, reflected a [AGE] year-old male, admitted [DATE]. Resident #66 had the following active diagnoses: need for assistance with personal care, chronic pain, unsteadiness on feet, mood disorder, Generalized Anxiety Disorder (a chronic mental health condition defined by excessive, uncontrollable, and persistent worry about daily events) and Major Depressive Disorder (a mental health condition characterized by persistent intense feelings of sadness, hopelessness and loss of interest in activities).Record review of Resident #66's Order Summary Report, dated 3/5/26, reflected an active order dated 3/4/26 Resident request for Podiatrist consult for toenails.Record review of Visit Summary from Podiatrist on 12/5/25 reflected Resident #66 was not seen.Record review of Resident #66's MDS Comprehensive assessment, dated 12/4/25, revealed resident's cognition was intact with a BIMS score of 15.Resident #66 needed partial assistance with putting footwear on and taking it off.Record review of Resident #66's Care Plan Progress Note, dated 1/15/26, reflected, .A quarterly care plan meeting was conducted with the resident, who is their own responsible party, and the interdisciplinary team.The resident was referred to ancillary services for podiatry, dental, and optometry.Record review of Visit Summary from Podiatrist on 2/12/26 reflected Resident #66 was not seen.During an observation and interview of Resident #66 in his room on 03/03/2026 at 10:21 a.m. revealed resident's toenails were long, thin, jagged with yellow discoloration. Resident #66 revealed his toenails hurt and the podiatrist needed to cut them. Resident #66 revealed when the podiatrist came last month, he was told he was not on the list for services. Resident #66 revealed he told his nurses several times he needed to see the Podiatrist because he wanted his toenails cut. He revealed the last time his toenails were cut was at another facility and had not gotten them cut at this facility since his re-admission. During an interview with LVN I on 03/04/2026 at 2:05 p.m., LVN I revealed she cut Resident #66's fingernails on Sunday (3/1/26) but had not cut his toenails. LVN I revealed she asked him if he wanted his toenails cut and he did not respond. LVN I revealed she was unsure if Resident #66 had gotten his toenails cut since his admission to the facility. LVN I revealed she had not noticed Resident #66's toenails were long, but she would ensure he was referred to Podiatry. LVN I denied Resident #66 had ever asked her to see the Podiatrist and noted Resident #66 typically asked for everything. LVN I revealed the risk to the resident of not having had his nails cut timely would have been infection, ingrown nails or pain.An interview with the Social Worker Interim on 03/05/2026 10:20 a.m. revealed Resident #66 was on the podiatry list since July of 2025 and she was unsure why he was not seen. The Social Worker Interim revealed the resident was on the list for Podiatry and was scheduled for 3/27/26. The Social Worker Interim revealed Podiatry came to the facility monthly and was not sure of the reason he was not seen. The Social Worker Interim revealed the possible reason he was not seen was the Podiatrist saw residents every 60 days and they probably attempted to see him while he was out of the facility between July of 2025 and November of 2025 and assumed he continued not at the facility when they came, and his name was on the list in error. The Social Worker Interim revealed she was unable to say the risk to the resident for not being seen by Podiatry because it was a nursing thing.An interview with the DON on 03/05/2026 at 12:58 p.m. revealed the nurses' assessed residents every Sunday and identified whether a resident needed Podiatry services. The DON revealed once the resident was identified they provided the resident's information to the social worker and the social worker would add them to the Podiatry list. The DON revealed he was unaware whether Resident #66 needed podiatry services and revealed Resident #66 had never asked him for (continued on next page)

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	675702	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Place Two	3505 S Buckner Blvd Bldg 3 Dallas, TX 75227

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Podiatry services. The DON revealed Resident #66 was provided nail care on Sunday and had not requested podiatry. The DON was unable to provide documentation that showed Resident #66 was provided with toenail care or that the resident had declined toenail care. The DON revealed he could not say what the risk was to the resident for not having had nail care because it was dependent on the condition of the resident's nails during his assessment. The DON revealed if the nails were thick, long and discolored then the resident would have been at risk of infection or pain.Record review of the facility's policy entitled, Referrals to Outside Services, dated 8/2020 reflected .The Director of Social Services coordinates the referral of residents to outside agencies/programs to fulfill resident needs for services not offered by the Facility. To facilitate this process, the Facility maintains service provider contracts with a variety of providers. Services may coordinate include, but are not limited to dental, audiology, vision, psychiatric, and podiatry services.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide treatment and services to prevent complications of enteral feeding for one of two (Residents #92) residents reviewed for feeding tubes. The facility failed to ensure LVN G administered medications through Resident #92's G-Tube by gravity, and instead she pushed the water flushes and medication with the plunger and syringe on 03/03/26. This failure could place residents at risk of abdominal discomfort, nausea and tube rupture.Findings included: Record review of Resident #92's Quarterly MDS assessment, dated 12/25/25, reflected a [AGE] year-old female admitted to the facility on [DATE]. Staff assessed Resident #92 to be severely cognitively impaired. She received 51% or more of total calories through tube feeding. Diagnoses included traumatic brain injury (a disruption in brain function caused by a violent blow) and dysphasia (difficulty swallowing). Record review of Resident #92's Care Plan, dated 09/17/25, reflected, [Resident #92] requires tube feeding.related to dysphagia .Interventions Every shift 30 ml pre/post medication and 5-10 ml water between each medication . Record review of Resident #92's Physicians Order Summary Report, dated 03/04/26, reflected, .every shift flush enteral tube with 30 ml water pre/post medication administration and 5-10 ml water between each medication . with a start date of 03/15/24. During an observation on 03/03/26 at 11:09 a.m. revealed LVN G at the medication cart pouring two tablets of Tylenol 325 mg from the bottle and placing the tablets into a plastic sleeve and crushing them. LVN G poured the crushed pills into a plastic medication cup and added 10 cc of water to the cup. LVN G then filled a plastic cup with water, put on gloves and gown and entered Resident #92's room. LVN G placed the G-tube (a tube inserted through the abdomen that delivers nutrition directly to the stomach) pump on hold, assessed the resident's lung and bowel sounds and elevated the head of bed to approximately 80 degrees. LVN G then retrieved a Luer lock syringe (medical device with screw on tip), attached the syringe to the G-tube and checked for residual (remaining left over portion). LVN G then removed the syringe, drew up 30 cc of water and connected it to the G-Tube and pushed the water into the tube with the plunger rather than allowing it to flow by gravity. She then disconnected the Luer lock syringe, drew up the dissolved Tylenol and re-attached the syringe to the g-tube and again pushed the medication in with the plunger, instead of allowing it to flow by gravity. LVN G then removed the syringe, drew up 30 cc of water, reattached the syringe to the G-tube and plunged it through the G-Tube. In an interview with LVN G on 03/03/26 at 11:20 a.m., she stated Resident #92 had a small G-tube which required them to use the Luer lock syringe. She stated she did not think she could give the medication or water by gravity because of the type of syringe they had to use. She stated she had not tried to give the medication by gravity. She stated she was not sure of the risk of pushing medications versus giving them by gravity. During an interview on 03/03/25 at 12:55 p.m., the DON stated the facility policy was to flush G-tubes with 30cc of water before and after medications, and medications were to be given by gravity. He stated pushing the medications could cause discomfort to Resident #92. He stated they would in-service the staff to ensure all were aware of the facility's protocol. Record review of the facility's policy, Medication-Administration, revised January 2025, reflected, To ensure medications administered via enteral tubes (G-tube.) are delivered safely, effectively, and in accordance with prescriber orders, manufacturer guidelines, .and current nursing standards of practice.Pour the dissolved or diluted medication into the syringe and allow the medication to flow by gravity. Do not force flush.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who needed respiratory care were provided with such care, consistent with professional standards of practice and the comprehensive person-centered care plan, for one of two (Resident #71) reviewed for quality of care. The facility failed to ensure the supplemental oxygen was provided at the physician ordered rate for Resident #71. This failure could place residents who received oxygen therapy at risk of oxygen toxicity. Findings included: Record review of Resident #71's quarterly MDS assessment, dated 01/05/26, reflected a [AGE] year-old female, admitted to the facility on [DATE] and readmitted [DATE]. She had a BIMS score of 4 which indicated she was severely cognitively impaired. Diagnoses included respiratory failure, pneumonia (serious lung infection), dementia, and dysphagia (difficulty swallowing). She was dependent on ADLs and required maximum assistance with transfers. The MDS assessment did not indicate she received oxygen therapy in the previous 14 days. Record review of Resident #71's care plan, dated 12/15/25, reflected, [Resident #71] has impaired gas exchange related to pneumonia, acute hypoxemic respiratory failure (condition where the lungs cannot adequately transfer oxygen to the blood) .Interventions.Administer oxygen as prescribed or per standing order. Record of Resident #71's Physician order summary report, dated 03/05/26, reflected, oxygen at 2 Liters per minute via nasal cannula every shift., with a start date of 02/02/26. Record review of Resident #71's MAR, dated March 2026, reflected, .O2 @ 2 liters per minute via nasal cannula every shift with a start date of 02/02/26. The MAR was signed off by staff on the day shift, evening shift and night shift from 03/01/26 through the day shift on 03/04/26 which indicated O2 was administered at 2 liters per minute. During an observation on 03/03/26 at 10:45 a.m., revealed Resident #71 had a nasal cannula in place, and the oxygen flow rate was set to deliver 3.5 liters per minute via an oxygen concentrator. During an interview with Resident #71 on 03/03/26 at 10:46 a.m. was attempted, but resident was non-responsive. An observation 03/04/26 at 1:12 p.m. of Resident #71 revealed her lying in her bed with nasal cannula in place. The oxygen concentrator was set to deliver 3.5 liters per minute of oxygen. In an observation and interview with LVN H on 03/04/26 at 1:55 p.m. he revealed he was the 6:00 a.m. - 2:00 p.m. Charge nurse for today. LVN H entered Resident #71's room observed the concentrator and stated it was set on 3.5 liters per minute. LVN H stated he was not sure what the orders were for the oxygen setting and went to his computer to check the orders and verified the orders were for 2 liters per minute. LVN H retrieved the pulse oximeter (device used to test concentration of oxygen in the blood) and checked the resident oxygen blood levels which had a reading of 93. He stated he was not sure why the concentrator was set on 3.5 liters or who placed it on 3.5 liters per minute. He stated the nurses were responsible for assessing any resident who was on continuous oxygen. He stated he had not assessed her respiratory status today (03/04/26), stating, he had just not gotten around to it today. He stated the nurses had to have orders for the amount of oxygen to be delivered and they were not allowed to give more than was ordered. He stated he would call the MD to determine what rate of oxygen the resident needed. He stated the risk of too much oxygen was toxicity. LVN H re-entered Resident #71's room and turned the oxygen concentrator to 2 liters per minute. An interview with the DON on 03/05/26 at 12:55 p.m. revealed any resident with oxygen had to have an order with the number of liters per minute to be delivered. He stated providing inaccurate amounts of oxygen could make the residents' breathing worse and could result in toxicity. He stated the nurses were supposed to check the oxygen levels each shift and as needed. He stated the doctor usually provided them with a range to be able to adjust the oxygen levels if the resident's oxygen saturation levels dropped below a certain level. He stated he would in-service the staff on the expectation of monitoring while a resident was receiving oxygen. Record review of the facility's policy titled, Oxygen Administration, dated June 2020, reflected, Purpose- To prevent or reverse hypoxemia (low oxygen level) and provide oxygen to the tissue.A physician's order (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is required to initiate oxygen therapy, except in an emergency situation. The order shall include Oxygen flow rate.Method of administration.usage of therapy (continuous or prn) .Titration (increasing or decreasing) instructions (if indicated) .Indication for use.Oxygen saturation s will be measured and documented at a minimum of daily for resident receiving oxygen therapy.

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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, the facility failed to ensure that drugs and biologicals used in the facility were secured and stored in accordance with current accepted professional principles for 1 of 3 medication carts (Nurse cart for Hall 200) observed for medication storage. The facility failed to ensure LVN G kept Resident #92's medications secured during medication administration on 03/03/26. This failure could place residents at risk of gaining access to unlocked medications that were not prescribed to them. Findings included: During an observation on 03/03/26 at 11:09 a.m. revealed LVN G was at the medication cart in front of Resident #92's room. LVN G poured two tablets of Tylenol 325 mg from the bottle and placed the tablets into a plastic sleeve and crushed them. LVN G poured the crushed pills into a plastic medication cup and added 10 cc of water to the cup. LVN G then filled a plastic cup with water. LVN G then put on gloves and a gown and entered Resident #92's room, leaving the medication on top of the medication cart out of the sight of LVN G. There were two residents observed in the hallway close proximity of the medication cart. LVN G placed the G-tube pump on hold, assessed the resident's lung and bowel sounds and elevated the head of bed to approximately 80 degrees. LVN G's back was to the medication cart and out of her clear site. After assessing Resident #92, LVN G returned to the medication cart and retrieved the medication and cup of water and re-entered the resident's room and administered the medication During an interview with LVN G on 03/03/26 at 11:20 a.m., she stated she though it was kay to leave the medication on top of the medication cart as long as it was within her sight. She then acknowledged her back was to the medication cart while she was assessing the resident and positioning her for the medication administration. She stated the risk of leaving the medication on top of the cart in the hallway was another resident could pick it up and take it. In an interview on 03/03/25 at 12:55 p.m. the DON stated all the staff were trained on medication storage and the expectation of keeping medication carts locked and secured and were never to leave medication on top of the cart unsecured. He stated leaving it on the cart, out of the sight of the staff, could result in another resident picking up the medication and taking something not prescribed for them. He stated they would in-service the staff on proper medication storage and handling. Record review of the facility's policy titled, Medication Storage, revised January 2026, reflected, To establish standard that safeguard residents by preventing unauthorized access to medications.Store medications in clean, dry, well-lit, temperature-controlled areas.Security and access.Access is restricted to authorized, licensed staff.Direct observation Standard: A cart may remain unlocked only when it is continuously withing the authorized staff members direct, unobstructed line of sight, without requiring significant head turning or repositioning.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the therapeutic diets as prescribed by the attending physician for 1 (Resident #13) of 3 residents observed for therapeutic diets.The facility failed to provide Resident #13 with his regular diet minced and moist (MM5) texture as designated on his physician order on 3/4/2026.This failures could place residents at risk for poor intake, weight loss, unmet nutritional needs, and choking.Findings included:Record review of Resident #13's annual MDS Assessment, dated 01/03/2026, reflected Resident #13 was a [AGE] year-old male readmitted to the facility on [DATE]. His diagnoses included stroke (disruption in blood flow to the brain), hypertension (high blood pressure), malnutrition, and dysphagia (difficulty swallowing, indicating a disruption in moving food or liquid from the mouth to the stomach). He had BIMS of 0 indicating Resident #13 had severe cognitive impairment.Record review of Resident #13's Care plan, revised on 1/20/2026, reflected, Focus: [Resident #13] has a diet order other than Regular and is at risk for unplanned weight loss or gain. Regular diet, Minced & Moist (MM5) texture, thin consistency. Goal: [Resident #13] will maintain ideal weight and receive proper nutrition daily for x 90 days. Intervention.[Speech therapy] evaluation and Treatment per Physicians orders as condition warrants. (IDDSI [The International Dysphagia Diet Standarizations Initiative] Minced & Moist (MM5) diet is soft, cohesive, bite-sized, or minced food (4mm for adults) requiring minimal chewing and no biting.)Record review of Resident #13's physician order, dated 12/29/2025, reflected, Regular Diet Minced and Moist (MM5) texture, thin consistency. Record review of Resident #13's lunch meal ticket, dated 3/4/2026, reflected, Diet: Regular, texture: Minced and Moist MM5). Resident's choice meal: Pureed black beans, Minced potato salad (no onion/ no celery/ relish), pureed fruit cobbler, **alternate choices** minced marinated chicken with thick gravy (MM5). During an observation on 03/04/2026 at 12:26 p.m., revealed Resident #13 was served whole baked beans, two half slices of bread, one piece of chicken breast covered with gravy, pureed potato salad and frozen nutrition treat for lunch. Resident #13 pulled chicken apart with fork and used left hand only to put a small piece of chicken in his mouth. Resident #13 did not appear to struggle with swallowing or coughing. ADON C was present in the dining room for lunch service. During an interview on 03/04/26 at 12:27 p.m., Resident #13 was attempted to be interviewed regarding his diet, however Resident #13 did not answer any questions. During an observation and interview on 03/04/26 at 12:28 p.m., ADON C stated Resident #13's meal did not match his meal ticket and stated it was the wrong texture. ADON C was observed calling the Dietary Manager to check Resident #13's lunch meal. Resident #13 did not take any more bites of his meal. During an observation and interview on 3/04/26 at 12:30 p.m., the Dietary Manager stated Resident#13 was on minced and moist diet and should have been served pureed beans, pureed breads and minced chicken. She took Resident #13's meal to the kitchen and provided him with a new lunch meal that included minced chicken, pureed beans, pureed bread and pureed potato salad. Resident #13 continued to eat his minced and moist texture diet without any difficulty. During an interview on 03/04/2026 at 1:59 p.m., ADON C stated nurses were responsible for checking diet trays before they were passed on to residents. She stated nurses were required to verify the meal texture, portion sizes, and any additional items or adaptive devices. She stated the diet provided to Resident #13 was not of the appropriate texture and the resident was at risk of choking and poor food intake. During an interview on 03/04/2026 2:12 p.m., LVN D stated it was not his turn to check the meal trays but was filling in for a different nurse. He stated nurses were responsible for checking meal trays to ensure the food texture matched the dining ticket and the tray. He stated that if the texture was incorrect, the tray should be taken back to the kitchen and shown to staff so it could be corrected. He stated there was a risk the resident could choke. During an interview on 03/04/2026 2:28 p.m., Speech Therapist E stated she had seen Resident #13 in January 2026 and determined (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #13's safest diet texture was minced and moist for all foods. She stated any resident who was on minced and moist texture needed to be served minced meats, pureed beans and pureed bread. She stated failure to provide acceptable diet texture could possibly lead to choking and poor swallowing. During an interview on 03/04/2026 at 3:46 p.m., the DON stated nurses assigned to dining room service were responsible for ensuring residents received the correct diet. He stated he conducted a lung assessment for the Resident #13 and notified the physician regarding the incorrect diet texture. He stated that staff were in-serviced on different diet textures per IDDSI standards in January 2026. He stated that the risk of not providing the therapeutic diet as ordered by the physician could lead to choking, poor food intake, and unmet nutritional needs. During an interview on 03/05/2026 at 9:26 a.m., the Dietary Manager stated the diet aide calls-out the diet order, and the cook prepared the plate in the kitchen. She stated once the tray was prepared, it should be placed on the cart to be put into service and checked by nursing for accuracy. She stated that a nurse was always present during each meal service. She stated that all cooks and dietary aides were trained on diet textures and procedures. She stated the risk, in addition to resident dissatisfaction, was risk of choking, included the possibility of not following the physician's orders for therapeutic diet. Record review of facility policy entitled, Therapeutic Diets , dated 1/1/2025, reflected, Purpose: To ensure that the Facility provides therapeutic diets to residents that meet nutritional guidelines and physician orders. Policy. Therapeutic diets are diets that deviate from the regular diet and require a physician's order. Per the physician's order, therapeutic diets are planned, prepared, and served.