

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676045	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Brentwood Terrace Healthcare and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2885 Stillhouse Road Paris, TX 75460	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to treat each resident with respect and dignity and provide care in a manner that promotes maintenance or enhancement of his or her quality of life for 1 of 4 residents (Resident #1) reviewed for resident rights. The facility failed to ensure CNA A treated Resident #1 respectfully when he required assistance with his TV, and she failed to address him prior to exiting his room on 11/11/2025. This failure could place residents at risk of decreased self-worth, loss of dignity, and a diminished quality of life. Findings included: Record review of Resident #1's face sheet dated 11/12/2025 indicated he was a [AGE] year-old male initially admitted to the facility 12/31/2021 and re-admitted on [DATE], with diagnoses which included chronic obstructive pulmonary disease (chronic inflammatory lung condition that affects the respiratory system), heart failure (chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen), and anxiety disorder. Record review of Resident #1's Quarterly MDS assessment dated [DATE] indicated he was able to make himself understood and was understood by others. The MDS assessment indicated Resident #1's hearing was adequate. The MDS assessment indicated Resident #1 had a BIMS score of 13, which indicated his cognition was intact. The MDS assessment indicated Resident #1 required supervision or touching assistance with eating and substantial/maximal assistance with toileting hygiene. Record review of Resident #1's care plan reviewed 10/31/2025 indicated he was dependent on staff for meeting emotional, intellectual, physical, and social needs, and enjoyed relaxing and watching television. Resident #1's care plan indicated he had a TV and TV remote in his room to provide daily choice of programs. Resident #1's care plan indicated he had impaired visual function, and a communication problem to anticipate and meet his needs. Resident #1's care plan indicated he had a hearing deficit to not cut off or interject when the resident was speaking maintain eye contact while speaking to resident, and to speak in a clear voice and face him when speaking to the resident. During an interview and observation on 11/11/25 at 9:12 AM, Resident #1 said the staff were rude to him. Resident #1 said he had difficulty hearing, but he overheard the staff talking bad about him. Resident #1 said the staff said he was crazy and made the comments don't listen to him because he is crazy. Resident #1 said he had reported it to the nurses and everyone knew. Resident #1 was unable to provide names of the staff. Resident #1 said he was not able to work the remote to his TV because he could not see. Resident #1 requested for his TV volume to be increased, and CNA A came to assist. CNA A walked into the room and told the surveyors in a decreased voice he usually does not want his TV on its because y'all are in here. Surveyor asked CNA A to please assist Resident #1 with his TV because he could not hear it. Surveyor informed Resident #1 CNA A to assist him and stepped out of the room. Surveyor walked out of the room into the hallway. Resident #1's door was open, CNA A was observed with her back to Resident #1, facing the TV, pointing the remote at the TV. When she said, I have to get batteries, and walked out of the room. As she walked out of the room Resident #1 was heard saying What?. CNA A continued to exit the room. During an interview on 11/11/2025 at 1:59 PM, CNA A said Resident #1 had visual impairment and was hard of hearing. CNA A said there was no problem with her making the comment that Resident #1 only wanted the TV on because the surveyors were in his room because he could not hear her. CNA A said there were no dignity issues associated with the way she treated Resident #1 or with her walking away from him without explaining why she was leaving the room when he questioned her. CNA A said she did not talk bad about any of the residents, and she had never said Resident #1 was crazy.,During an interview on 11/12/2025 at 12:38 PM, the DON said she expected the staff to explain to the residents what they were doing. The DON said she had not received any complaints about CNA A. The DON said she did not want any of the staff to speak negatively about the residents. The DON said CNA A walking away from Resident #1 could make him feel confused about the situation. During an interview on 11/12/2025 at 1:05 PM, the Administrator said he expected the staff to explain to the residents what they were doing and prior to leaving the room ensure the residents' needs were met. The Administrator said everyone was responsible for treating the residents with dignity and respect. The Administrator said speaking about the residents in front of them, even if they were not able to hear, and walking away from them without explaining could make them feel bad. Record review of the facility's undated policy titled, Resident Rights, indicated, A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 dispensing and administering of all drugs and biologicals to meet the needs of each resident and determined that drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled for 1 of 4 residents (Resident #2) reviewed for pharmacy services. The facility failed to ensure Resident #2's Qulipta (medication used to treat migraines) was administered as ordered on 10/31/2025, 11/01/2025, and 11/02/2025. This failure could place the residents at risk of not having medications available for use and medications errors. Findings included: Record review of Resident #2's face sheet dated 11/12/2025 indicated he was a [AGE] year-old male initially admitted to the facility on [DATE] with diagnoses which included quadriplegia (paralysis of all four limbs, and the trunk of the body) and migraine. Record review of Resident #2's Quarterly MDS assessment dated [DATE], indicated he was usually understood and usually understood others. Record review of Resident #2's MDS assessment indicated he had a BIMS score of 15, which indicated his cognition was intact. The MDS assessment indicated Resident #2 received scheduled and PRN pain medication. Record review of Resident #2's care plan reviewed 10/21/2025 indicated he had a potential for uncontrolled pain related to migraines, immobility, and contractures (a shortening of muscles, tendons, skin, and nearby soft tissues that causes the joints to shorten and become very stiff, preventing normal movement). Record review of Resident #2's Order Summary Report dated 11/12/2025 indicated Qulipta 60 mg give 1 tablet via g-tube one time a day for migraines with a start date of 08/22/2024. Record review of Resident #2's October 2025 MAR indicated Qulipta 60 mg give 1 tablet via g-tube one time a day was not administered on 10/31/2025. Record review of Resident #2's November 2025 MAR indicated Qulipta 60 mg give 1 tablet via g-tube one time a day was not administered on 11/01/2025 and 11/02/2025. During an interview on 11/11/2025 at 9:44 AM, Resident #2 said he did not receive his headache medication twice. Resident #2 said the nurses told him they were out of his medication. Resident #2 said it was about 2 weeks ago. During an interview on 11/11/2025 at 4:19 PM, LVN B said at the beginning of November 2025 she had not administered Resident #2's Qulipta. She said she was told by LVN C that the medication had been ordered from the pharmacy but had not been delivered and she was not able to administer it. LVN B said she did not know when it was ordered. LVN B said she did not call the pharmacy because she was still training when this happened. LVN B said she had not notified the doctor that Resident #2's Qulipta had not been administered. LVN B said she was training with LVN C, and LVN C notified the doctor. LVN B said it was important for the residents to receive their medications as ordered by the physician for their health and for their mental and physical well-being. During an interview on 11/11/2025 at 9:21 PM, LVN C said Resident #2's Qulipta ran out at the beginning of November 2025, and he did not receive it. LVN C said she was unsure how many doses he missed, but they were waiting on the pharmacy to deliver the medication. LVN C said when a resident did not have a medication, they should contact the pharmacy and notify the doctor. LVN C said she did not contact the pharmacy to see why his Qulipta was not delivered because she was not the only nurse who had not administered the medication. LVN C said she did not notify the doctor about Resident #2's missed doses of Qulipta. LVN C said not administering Resident #2's Qulipta could result in him having headaches. During an interview on 11/12/2025 at 9:14 AM, the Pharmacist said a refill was ordered for Resident #2's Qulipta on 10/31/2025 and was delivered to the facility on [DATE]. The Pharmacist said the facility had not reached out to get the medication delivered sooner. The Pharmacist said if the facility had contacted them and requested a quicker delivery it could have been done. During an interview on 11/12/2025 at 12:24 PM, the DON said the nurses were supposed to call the pharmacy prior to the residents' medications running out. The DON said if a medication was not administered the physician should be contacted. The DON said she was not aware Resident #2's Qulipta was not administered. The DON said the nurses should have contacted her to notify her of the doses of the missed medication, but they did not. The DON said not administering medications as ordered by the physician could result in a negative outcome. During an interview on 11/12/2025 at 12:50 PM, the Administrator said if a medication was not in the building, he expected the nurses to contact the pharmacy and get the medication delivered immediately. The Administrator said it was the nurse's responsibility to ensure medications were administered as ordered, and his expectations were if they did not, they should notify the ADON and DON. The Administrator said he was not medical; therefore, he was not</p>		