STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676045	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Terrace Healthcare and Rehabilitation	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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the necessary care and services in the area of hygiene, grooming, and incontinent care for 1 of 16 residents (Resident #1) reviewed for activities of daily living. The facility failed to ensure Resident #1 was provided with incontinent care every two hours as recommended for Resident #1, which resulted in bed linens being saturated with urine. This failure could result in pressure injuries, infection, psychosocial harm, and a decreased quality of life. Findings included: Record review of Resident #1's face sheet dated 03/04/2026 revealed a [AGE] year-old female admitted [DATE] and readmitted [DATE] with diagnoses which included cerebral infarction (occurs when an artery blockage cuts off blood flow and oxygen to the brain), chronic obstructive pulmonary disease (a lung disease that makes breathing difficult), dysphagia (difficulty swallowing), diabetes mellitus type 2 (a chronic metabolic disorder where the body fails to produce enough insulin resulting in high blood glucose), bipolar disorder (a mental health condition alternating between intense highs and lows), heart failure (a condition where the heart muscle cannot pump blood efficiently), hyperlipidemia (high cholesterol), chronic kidney disease stage 3(moderate kidney damage) and seizures (uncontrolled bursts of electrical activity in the brain that cause temporary changes in consciousness, behavior, or muscle movement). Record review of Resident #1's quarterly MDS dated [DATE] revealed no hearing, vision or communication deficits and a BIMS score of 15 indicating intact cognition. Further review of the MDS revealed Resident #1 had upper and lower extremity range of motion impairment, required the use of a wheelchair for mobility, was independent in eating, required maximum assistance in upper body dressing, bathing and was dependent in peri-care / toilet hygiene, bed mobility, transfers and lower body dressing. Record review of Resident #1's care plan revealed a focus area indicating resident received diuretic therapy (involves using medications to increase urine output), was incontinent of bowel, had a potential for impairment to skin integrity related to yeast infection of the groin, had an ADL self-care deficit for bed mobility and toilet use, and had bladder incontinence and was at risk for skin breakdown. Record review of Resident #1's physicians orders dated 03/04/2026 revealed an order for Nystatin External Powder 100000 unit / gram (topical) dated 10/22/2025 apply to affected area topically every 12 hours as needed for yeast or redness, cleanse with normal saline or soap and water, pat dry and apply powder and an order for Nystatin External Cream 100000 units / gram (topical) dated 03/01/2026 apply to vaginal/perineal area topically every shift for yeast for 7 days with a stop date of 03/08/2026. Record review of resident's skin assessment dated [DATE] & 02/25/2025 revealed resident had no open areas but continued with treatment to yeast infection to abdominal folds. Record review of nurse aid tasks for 02/25/2026 revealed incontinent care was checked off for each shift but did not indicate the number of times per shift that peri-care was provided to Resident #1. During an interview and observation of Resident #1 on 03/04/2026 at 8:39 a.m., resident stated she was soiled with urine and was waiting to be changed. Resident #1 allowed surveyor to visualize brief and bed pad, slight urine odor noted, brief did not appear to be saturated at this time and was the appropriate size. Resident #1 stated she believes that staff are coming in her room and turning off the light, however, could not identify a staff (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	member who had done this this morning or on 02/25/2026. This surveyor noted that Resident #1's call light was not on during this interview. Resident #1 stated that on 02/25/2026, she was left in her brief for over five hours which resulted in her bed linens to be saturated with urine. Resident #1 stated she did not have any skin breakdown. During a phone interview with the Ombudsman on 03/04/2026 at 10:39 a.m., the Ombudsman stated that she visited Resident #1 on 02/25/26 at approximately 11:30 a.m. and found resident crying and soaking wet. The Ombudsman stated she allowed Resident #1 to use her personal phone to contact the Texas Health & Human Services hotline. The Ombudsman stated that she notified the ADON and observed aides enter resident's room to provide peri-care while she was speaking with the ADON. During an interview on 03/04/2026 at 3:40 p.m., CNA A stated Resident #1 utilized XXL briefs and that the briefs are kept in her room. CNA A stated that she was not aware of a time when Resident #1 was soaked or soiled due to not being changed. CNA A stated that Resident #1 will call for assistance as needed and sometimes she will say, I did not want to bother you, but she had never found resident soaked in her bed. During an interview on 03/04/2026 at 4:06 p.m., Hospitality Aide B stated she had worked at the facility over 1 1/2 months and that she had worked multiple times on 100 Hall with Resident #1. Hospitality Aide B stated that Resident #1 will put on the call light when she needs to be changed and that she uses the largest brief. Hospitality Aide B stated that she did not recall a time when Resident #1 was soiled or excessively wet that would indicate she had not been changed. During an interview on 03/04/2026 at 4;14 p.m., Hospitality Aide C stated that she has worked at the facility for approximately 2 months and stated she was aware that Resident #1 utilizes the largest brief size and her briefs were kept in her closet. Hospitality Aide C stated that she had never observed Resident #1 soaked when she called for incontinent care. During an interview on 03/04/2026 at 4:30 p.m., LVN D stated she did not recall a specific date or event when Resident #1 was found soaked with urine due to not being changed. Stated at times Resident #1 would refuse toileting care in the nighttime due to preference to sleep, but during the day she usually would put on the call light as needed. During an interview on 03/04/2026 at 4:55 p.m., ADON LVN E stated that Resident #1 had facility provided briefs that were XXL and kept in her room, and she wound never run out of briefs. LVN E stated that Resident #1 would utilize the call light as needed and during her shift, she had not been left unattended. The ADON LVN E stated that she recalled the Ombudsman identified concern regarding Resident #1 and while they were speaking in the hallway, the nurse aides entered her room to provide care. During an interview on 03/04/2026 a 5:40 p.m., CNA D revealed that she worked on 100 hall on 02/25/2026 where Resident #1 resided and was familiar with her incontinent care needs. The CNA D revealed she was rushed throughout her shift but stated she had no concerns about getting her tasks completed. CNA D stated that Resident #1 will put on the call light when she needed assistance and although she could not recall what times or how often she checked on Resident #1, she does feel she provided the necessary care on her shift. During an interview on 03/04/2026 at 5:50 p.m., the DON stated that she was not notified Resident #1 had been left in her bed without toileting assistance. The DON stated that Resident #1 utilized her call light without difficulty and was not always accepting of staff interactions. The DON stated she expected nursing staff to round at a minimum every two hours to ensure residents incontinent care needs are being met appropriately. The DON stated she would monitor effectiveness of this by reviewing skin care concerns and trends for infection. The DON stated she was ultimately responsible to ensure residents are clean and incontinent care needs are met. During an interview on 03/04/2026 at 5:50 p.m., the Administrator stated that he expected the nursing staff to provide incontinent care as needed for all residents. The Administrator stated that failure to provide incontinent care could result in increased skin breakdown and increased infections. The Administrator stated that the DON is responsible for all nursing care and he was ultimately responsible to ensure the care if provided appropriately. Review of facility incontinent care policy or activities of daily living policy did not occur prior to survey exit. According to State Operations Manual 483.24(b) Activities of daily living. the facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: (b)(3) elimination-toileting.