

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/21/2026
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with dementia received appropriate treatment and services to maintain their highest practicable well-being for 1 of 7 residents reviewed for dementia care. (Resident #1)The facility failed to ensure CNA A, NA B, and RN C provided appropriate dementia care and services while providing incontinent care for Resident #1 on 7/21/26.This failure could place residents with dementia at risk for increased behaviors and decreased quality of life.Findings included:Record review of Resident #1's face sheet dated 7/21/26 indicated she was [AGE] years old and admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #1 had diagnoses including dementia (decline in cognitive abilities such as memory, reasoning, language, and behaviors that interfere with ADLs), anxiety disorder (mental health condition characterized by excessive, persistent, and uncontrollable fear or worry), schizoaffective disorder, bipolar type (mental health condition with a combination of schizophrenia [complex chronic brain disorder that impairs a person's ability to think, feel, and perceive reality] symptoms, like hallucinations [sensory experiences where a person sees, hears, smells, tastes, or feels things that do not exist outside their mind] and delusions [false belief that persists despite overwhelming contradictory evidence], with severe mood swings from extreme sadness to excitement), major depressive disorder (persistent sadness), and hypertension (high blood pressure).Record review of Resident #1s quarterly MDS assessment dated [DATE] indicated she was sometimes understood and sometimes understood others. The MDS indicated she had a BIMS of 3, which indicated she had severe cognitive impairment. The MDS indicated Resident #1 had fluctuating inattention and disorganized thinking. The MDS indicated Resident #1 had physical, verbal, and other behavioral symptoms occurring 1-3 days during the look back period. The MDS indicated Resident #1 rejected care 1-3 days during the look back period. The MDS indicated Resident #1 required substantial/maximal assistance for toileting hygiene and partial/moderate assistance with dressing her lower body and toilet transfers. The MDS indicated Resident #1 was independent rolling side to side. The MDS indicated Resident #1 was frequently incontinent of bladder and occasionally incontinent of bowel.Record review of Resident #1's undated care plan indicated the following:Resident #1 had impaired cognitive function/dementia or impaired thought processes with interventions including engaging the resident in simple, structured activities that avoid overly demanding tasks and keep resident's routine consistent and try to provide consistent care givers as much as possible to decrease confusion.Resident #1 had demonstrated physical behaviors towards others with interventions including to notify the charge nurse of any physically abusive behaviors, clinical staff and hospice nurse to review medications and changes to medications to decrease her agitation level because she had some recent gradual dose reductions that were not beneficial for 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
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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	kill me, Daddy, get off of me, get off of me, Daddy. RN C said, Ms. {Resident's name} stop yelling, you're fine. Resident #1 said as she was almost crying as she continued to holler Daddy, then said bitch, bitch, bitch as she continued to grab and kick at the staff. Resident #1 then started hollering Momma, Momma, O God as CNA A pushed draw sheets under Resident #1 and then applied a cream to her bottom. Resident #1 said Get out of here you son of a bitch as she was trying to grab NA B. RN C said, Don't hit at people, don't hit at people Ms. {Resident #1's name}, Ms. {Resident #1's name} stop. CNA A then rolled Resident #1 onto her back and had to grab Resident #1's hands multiple times to deflect them as Resident #1 was trying to grab her arm as she was trying to get her brief pulled up between her legs as Resident #1 kicked at them. RN C said, Let her put your under ware on, let her put your under ware on, you're okay, listen to me, quit kicking, quit kicking, quit kicking and Resident #1 said get off of me!. The video ended at 10:34 AM. Record review of video footage of a second video dated 7/21/26 beginning at 10:34 AM was a continuation of the previous video. CNA A finished fastening Resident #1's brief and said to NA B, we're going to take this shirt off as Resident #1 continued to holler Momma, Momma. RN C was at the end of the bed and said Stop, kicking me as CNA A and NA B took off Resident #1's shirt and put a gown on her. Resident #1 yelled Momma, Momma, that why I don't like it and you're gonna die. RN C said yes, eventually, but not today. Resident #1 tried to grab CNA A's face with her right hand and CNA A grabbed her hand and told her to stop. Resident #1 said you stop, God damn it, I just want to get out of here and CNA A said, no ma'am. CNA A then pulled her gown down over her legs and Resident #1 tried to hit/grab CNA A again and she grabbed her hand and put it back down and covered her up. RN C then told Resident #1 they were all done and asked Resident #1 if she wanted some water and she said no. RN C told Resident #1 that they were just trying to clean her up to keep her clean and dry. Resident #1 told RN C you are a lying bitch and RN C said, you can call me whatever you want to, I'm just taking care of you and told her, Goodnight baby. RN C said, thank you for letting us take care of you and Resident #1 said thank you. The video ended at 10:38 AM. During an interview on 7/21/26 at 10:55 AM, Resident #1's family member said Resident #1 had occasional issues with aggressiveness. Resident #1's family member said the facility had done a pretty good job taking care of Resident #1 in the memory care unit. Resident #1's family member said however, she had just watched a video on the camera and there were two staff members, a young black male aide and another, older female black aide providing incontinent care. Resident #1's family member said the older black aide was very rough and held her mom's arms to her chest when she was resistant to care and then used a sheet to wipe between Resident #1's butte cheeks and Resident #1 was raw from having a yeast infection. Resident #1's family member said the nurse, RN C, came in during the care and was trying to comfort Resident #1 during the care. Resident #1's family member said the young male black aide was being very sweet and gentle with Resident #1 during the care. Resident #1's family member said however, when the older black aide came into the room initially, she believed Resident #1 was asleep and the aide just started cranking the bed up, to raise the bed, and it shook the whole bed. Resident #1's family member said she felt that the older aide startled Resident #1 because the aide did not say anything to Resident #1 before she started to crank on the bed. Resident #1's family member said Resident #1 was very upset during the care and felt the whole situation could have been handled better and communicated better to Resident #1. During an interview on 7/21/26 at 2:30 PM, RN C said she had worked at the facility for nine years and normally worked in the memory care unit on the 6 AM to 6 PM shift. RN C said she did not see the first part of the care provided to Resident #1 the morning of 7/21/26, but she was called into the room (located next to the nurse's station) to assist CNA A and NA B while they were trying to perform incontinent care. RN C said Resident #1 was kicking and (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have told the staff to stop care and had them come back later. RN C said she made a mistake and should have told the staff to stop care and tried again after Resident #1 had calmed down. During an interview on 7/21/26 at 5:20 PM, the ADON said if a resident with dementia or any resident was resisting or refusing care, staff should stop care if resisting, try re-approaching later or try another staff member, and if still resisting, then the nurse should reach out to the physician. The ADON said often times when a resident with dementia was resistant to care it was because of pain. The ADON said she had reviewed the video footage that morning of CNA A providing incontinent care to Resident #1, and it was disgusting. The ADON said the whole situation should have been stopped long before when the resident was yelling, hitting, and kicking at the staff. The ADON said CNA A had been sent home as soon as they were informed of the incident on 7/21/26, pending the results of the investigation. The ADON said that was not how they provided care for dementia residents at their facility. The ADON said Resident #1 was probably made to feel scared and helpless when staff did not explain what they were going to do, before they did it, and continued to provide care while she was resisting care. During an interview on 7/21/26 at 5:26 PM, the ADM stated the incident with Resident #1 the morning of 7/21/26, probably caused the resident to be terrified when the staff came in and did not talk to her and just started cranking the end of the bed and then did not stop care when she resisted and was kicking and hitting at the staff. The ADM said Resident #1 probably did not know what was happening. The ADM said he would expect the staff to follow the facility's policies and procedures related to the care of residents with dementia. He said CNA A, CNA B and RN C had been in-serviced on caring for residents with dementia prior to the 7/21/26 incident and they were currently re-educating all staff. Record review of CNA A's electronic course training log indicated she had completed the courses titled Dementia for Nursing facilities on 4/09/26, Person-centered Behavioral Management, Behavioral Management Techniques, Helping a Person with Dementia and What is Dementia: Etiology and Treatment that were marked with a status of completed but there were no dates of completion. Record review of CNA B's electronic course training log indicated he had completed the courses titled Dementia: Types and Causes, Behavioral Health: Dementia, Behavioral Management Techniques, and What is Dementia: Etiology and Treatment on 6/29/26. Record review of RN C's electronic course training log indicated she had completed the courses titled Dementia Care in Nursing Facilities on 3/07/26, Behavior Management Techniques on 9/06/25, Helping a Person with Dementia on 9/06/25 and What is Dementia: Etiology and Treatment on 9/05/25. Record review of the facility's undated policy titled Dementia Policy, indicated . Some individuals with dementia may have coexisting symptoms or psychiatric conditions such as depression or bipolar affective disorder, paranoia, delusions or hallucinations. Progressive dementia may exacerbate these and other symptoms . behavioral or psychological symptoms are often related to the brain disease in dementia; however, behavior and other symptoms may also be caused or exacerbated by environmental triggers . behavior often represents a person's attempt to communicate an unmet need, discomfort or thoughts that they can no longer articulate . Caring for a Resident with Dementia . fundamental principles of care for a person with dementia include an interdisciplinary team approach that focuses holistically on the needs of the resident as well as the needs of the other residents . it is important for the facility to have systems and procedures in place to assure that assessments were timely and accurate; interventions were described, consistently implemented, monitored, and revised as appropriate in accordance with current standards of practice . Individualized Approaches and Treatment . this step implements the care plan interventions to address the needs of a resident with dementia . it addresses the causes and consequences of the resident's behavior and staff communication and interactions with residents and families to try to prevent potentially distressing behaviors or (continued on next page)		

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