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	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Terrace Healthcare and Rehabilitation	2885 Stillhouse Road Paris, TX 75460

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on interviews and record review, the facility failed to ensure residents and/or the residents' representatives the right to participate in the development and implementation of his or her person-centered plan of care for 1 of 20 residents (Resident #68) reviewed for resident rights. The facility failed to ensure Resident #68's representative was invited to participate in the development and review of Resident #68's care plan. This failure could place residents at risk of not having needs met by depriving them the opportunity to participate in the decision making regarding their care. Findings included: Record review of Resident #68's face sheet dated 06/04/25, indicated an [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses of dementia (memory loss), muscle weakness, and anxiety. Record review of Resident #68's quarterly MDS assessment dated [DATE], indicated she was usually understood and usually understood others. Resident #68 had short/long term memory problems and her cognition was severely impaired. Record review of Resident #68's comprehensive care plan dated 04/02/24, indicated Resident #68 had impaired cognitive function, impaired thought processes and communication related to dementia. The care plan interventions included to communicate with the resident/family regarding resident's capabilities and needs. Record review of Resident #68's EMR on 06/04/25, did not reveal a care plan conference had been completed or uploaded. During an interview on 06/02/25 at 10:50 AM, Resident #68's representative said she had not been invited to a care plan meeting since Resident #68 admitted to the facility February of last year (2024). She said she would like to be invited to the care plan meetings so she would be aware of what was going on with Resident #68's care. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/04/25 at 09:26 AM, the SW reviewed Resident #68's EMR and said she did not see where a care plan meeting had been completed. The SW said a care plan meeting was to be completed quarterly and as needed. The SW said a care plan meeting was conducted to update the resident's family and to see if they had any issues or concerns. The SW said the MDS Coordinator and herself were responsible for ensuring the care plan meetings were being completed. She said she was unsure of how Resident #68's care plan meetings were missed. She said from what she could tell, Resident #68 had not had a care plan meeting since she admitted to the facility. During an interview on 06/04/25 at 11:42 AM, the RNC said the care plan meetings should be held at least quarterly. She said the care plan meetings were held to ensure the families were being updated with the current plan of care. The RNC said the SW was responsible for ensuring the care plan meetings were being conducted as required. During an interview on 06/04/25 at 11:46 AM, the Administrator said he expected the care plan meetings to be to be held at least quarterly. He said the care plan meetings were held with the resident and family to ensure the plan of care was best suited for the resident. The Administrator said the SW was responsible for ensuring the care plan meetings were being conducted. During an interview on 06/04/25 at 12:08 PM, MDS Coordinator B said the SW was responsible for setting up the care plan meeting. Record review of the facility's undated policy Comprehensive Care Planning, indicated .The facility will provide the resident and resident representative, if applicable, with advance notice of care planning conferences to enable resident/resident representative participation. Resident and resident representative participation in care planning can be accomplished in many forms such as holding care planning conferences at a time the resident representative is available to participate, holding conference calls or video conferencing .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on interviews, observations, and record review the facility failed to ensure residents were free from abuse for 1 of 20 residents (Resident #47) reviewed for resident abuse. The facility did not ensure Resident #47 was free from abuse when Resident #4 hit Resident #47 in the head. The noncompliance was identified as PNC. The past noncompliance began on 04/21/25 and ended on 04/24/25. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: Resident #47 Record review of Resident #47's face sheet, dated 06/04/25, reflected Resident #47 was an [AGE] year-old male, readmitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy (brain chemical imbalance in the blood), dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life), and Alzheimer's (progressive disease that destroys memory and other important mental functions). Record review of the quarterly MDS assessment, dated 03/05/24, reflected Resident #47 made himself understood and understood others. The MDS assessment did not address Resident #47's BIMS score. The staff assessment reflected Resident #47 had short- and long-term memory problem. The MDS reflected Resident #47 had no behaviors or refusal of care during the look-back period. Record review of Resident #47's comprehensive care plan revised 01/10/23 reflected Resident #47 had behavior problem including cursing, talking to self, physical aggression toward staff during care, and history of grabbing and/or verbal threats to others. The care plan interventions included anticipate/meet the resident's needs and monitor behavior episodes and attempts to determine underlying cause. Resident #4 Record review of Resident #4's face sheet, reflected Resident #4 was an [AGE] year-old female, readmitted to the facility on [DATE] with diagnoses which included bipolar disorder (mental health condition characterized by significant mood swings), schizophrenia (a condition that can make you feel detached from reality and can affect our mood), delusions (unshakable belief in something that is not true) disorder, and anxiety disorder. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #4's annual MDS, dated [DATE], reflected Resident #4 made herself understood and usually understood others. Resident #4's BIMS score was 14, which indicated his cognition was intact. The MDS reflected Resident #4 had no behaviors or refusal of care during the look-back period. Record review of Resident #4's comprehensive care plan initiated on 04/21/25 reflected Resident #4 had potential to demonstrate physical behaviors and poor impulse control. The care plan interventions included analyze of key times, places, circumstances, triggers, what de-escalates behavior and document. The interventions also included if the resident had physical behaviors toward another resident, immediately intervene to protect the residents involved and call for assistance. Record review of the facility's PIR dated 04/24/25 with an incident category of abuse was signed by the Administrator on 04/24/25. The PIR reflected CNA N reported that Resident #4 hit Resident #47 in the head while in the dining room. The PIR included a witnessed statement by CNA N that reflected she witnessed Resident #4 hitting Resident #47 in the head while taking a tray to the kitchen. The witnessed statement reflected CNA N immediately reported the incident to the charge nurse. The PIR included a witnessed statement by MDS Coordinator B as he was walking from Hall 1 to nursing station when Resident #4 yelled out Hey get off my foot, MDS Coordinator B stated he noted Resident #4 sitting in her wheelchair in day room and noted her pushing Resident #47's wheelchair away from her stating he ran over her foot. The witnessed statement written by Social Services reflected Resident #4 stated he (pointing at Resident #47) run over her foot, so she hit him. The PIR included a skin assessment for Residents #4 and #47 completed 04/21/25 reflected no new skin issues, psychiatric assessment for Resident #4 completed 04/21/25, social service notes for Residents #4 and #47 completed 04/21/25 reflected no s/s of distress and no new orders, trauma informed PRN assessment for Resident #47 completed 4/21/25 reflected negative for any new findings, Q15 minute monitoring log for Resident #4 with (start date 04/21/25, end date 04/22/25) reflected no new behaviors noted, resident safe surveys with no areas of concerns dated for 04/21/25, staff/resident and resident to resident monitoring completed 05/23/25 reflected no new behaviors noted. The PIR reflected staff was in-serviced promptly on abuse and neglect including resident to resident completed 04/21/25 reflected who the abuse coordinator was, how to contact the abuse coordinator and when to notify the abuse coordinator. During an observation and attempted interview on 06/02/25 at 12:01 p.m., Resident #47 was sitting in his wheelchair next to the bed. Resident #47 was non-interview able. During an observation and interview on 06/02/25 at 2:38 p.m., Resident #4 was lying in bed. Resident #4 stated, I haven't hit nobody when asked if she remembered the incident between her and Resident #47. Resident #4 stated, I don't remember him running over my foot. During an interview on 06/02/25 at 2:45 p.m., CNA N stated Resident #4 and Resident #47 was sitting in the day room when Resident #47 run over Resident #4 foot with his wheelchair. CNA N stated she was taking a tray into the dining room from lunch when she heard Resident #4 and Resident #47 arguing and by the time she laid the tray down to intervene that was when Resident #4 hit Resident #47 on his head which was loud enough that everyone heard it. CNA N stated she did not see the part when Resident #47 run over Resident #4 foot. CNA N stated she intervened immediately by separating the residents and notifying LVN O. An attempted telephone interview on 06/04/25 at 1:48 p.m. with LVN O, was unsuccessful. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 06/02/25 beginning at 10:00 a.m., - with 10 residents (#4, #47, #68, #54, #132, #17, #129, #130, #76, #131) regarding abuse and neglect with a focus presented on resident-to-resident physical abuse reflected they all denied abuse. During staff interviews beginning on 06/02/25 at 10:00 a.m. and ending 06/04/25 at 3:13 p.m.,- with LVN (A, D, E, O), RN (C, K), CNA (L, M, N, P, R, T), MA G, MDS Coordinator (B, F), Laundry Aide S, Human Resources, Dietary Manager, ADON revealed they were in serviced 04/21/25 on abuse/neglect including resident to resident and were able to define abuse, when to report, and whom to report it to. During an interview on 06/04/25 at 2:27 p.m., the Regional Compliance Nurse stated she was aware of the abuse allegation between Residents #4 and #47 and was told by the DON that the residents were separated immediately, skin assessments were completed to make sure there were no harm, safe surveys were completed to make sure everyone was ok, and trauma assessments were completed to ensure that no one had a negative psychosocial outcome from it. During an interview on 06/04/25 at 2:39 p.m., the Administrator stated he was the abuse coordinator for the facility. The Administrator stated he was aware of the incident between Residents #4 and #47. The Administrator stated the victims did not have any changes in behavior since the incident. The Administrator stated abuse was monitored daily during rounds by visiting with residents and directly observing the residents and facility. The Administrator stated once he was learned of any allegations he reported accordingly, investigate, and ensure all residents were protected. Record review of the facility's policy titled Abuse/Neglect revised 03/29/18 reflected . the resident has the right to be free from abuse . Residents should not be subjected to abuse by anyone, including, but not limited to . other residents .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43047 Based on interview and record review, the facility failed to ensure assessments accurately reflected the resident status for 1 of 20 residents (Resident #4) reviewed for MDS assessment accuracy. The facility did not ensure Resident #4's MDS assessment was accurately coded for PASRR (a preliminary assessment completed for all individuals before admission to a Medicaid-certified nursing facility to determine whether they might have a mental illness or intellectual disability). This failure could place residents at risk for not receiving care and services to meet their needs. Findings included: Record review of Resident #4's face sheet, reflected Resident #4 was an [AGE] year-old female, readmitted to the facility on [DATE] with diagnoses which included bipolar disorder (mental health condition characterized by significant mood swings), schizophrenia (a condition that can make you feel detached from reality and can affect our mood), delusions (unshakable belief in something that is not true) disorder, and anxiety disorder. Record review of Resident #4's annual MDS assessment, dated 05/02/25, reflected in Section A1500 (PASRR) asked Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? This section was marked 0 which meant No. Section A.1510 Level II Preadmission Screening and Resident Review (PASRR) Conditions did not have A. Serious mental illness, B. Intellectual Disability, or C. Other related conditions checked. Resident #4 made herself understood and usually understood others. Resident #4's BIMS score was 14, which indicated his cognition was intact. Record review of Resident #4's comprehensive care plan revised on 10/03/24 reflected Resident #4 had a diagnosis of ID and was PASRR positive. The care plan interventions included Resident #4 was receiving habilitation coordination and independent living skills trainings. During an interview on 06/04/25 at 1:14 p.m., MDS Coordinator B stated MDS Coordinator F was responsible for Resident #4's MDS annual MDS. MDS Coordinator B stated if the resident was PASRR positive yes should have been marked that the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition and mental illness/ID should have been checked. MDS Coordinator B stated MDS Coordinator F was out today due to personal reasons. MDS Coordinator B stated it was important to ensure the MDS was accurate so services will be evaluated and given. During an interview on 06/04/25 at 1:37 p.m., the Regional Reimbursement Specialist stated he expected yes to be marked that the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition and mental illness/ID should have been checked. The Regional Reimbursement Specialist stated he expected the Administrator to be responsible for monitoring and overseeing MDS accuracy. The Regional Reimbursement Specialist stated it was important for MDS accuracy to reflect the resident's status. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/04/25 at 1:55 p.m., the Regional Compliance Nurse stated there was not a policy and procedure regarding MDS assessment accuracy. The Regional Compliance Nurse stated the facility followed the RAI manual. During an interview on 06/04/25 at 2:39 p.m., the Administrator stated he expected the MDS to be marked correctly because Resident #4 was PASRR positive. The Administrator stated he monitored accuracy by random as needed audits/spot checks. The Administrator was unable to recall his last audit. The Administrator stated it was important to ensure MDS accuracy to ensure the residents received the necessary services.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47612 Based on interview and record review the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this was not possible or resident preferences indicate otherwise for 1 of 2 residents reviewed for nutritional status (Resident #54). The facility failed to ensure Resident #54's enteral feeding (a form of nutrition that was delivered into the digestive system as a liquid form via the feeding tube) was administered as ordered by the physician on 05/30/2025. This failure could place residents at risk for malnourishment, illness, skin breakdown, and decreased quality of life. Findings included: Record review of Resident #54's face sheet dated 06/03/2025, indicated a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included dysphagia (difficulty swallowing), gastrostomy hemorrhage (bleeding associated with a gastrostomy, which was a surgical procedure creating an opening in the abdomen to insert a feeding tube into the stomach), muscle wasting and atrophy (loss of muscle mass). Record review of the Comprehensive MDS assessment dated [DATE], indicated Resident #54's speech was unclear, but he was able to make himself understood, and understood others. The MDS assessment indicated Resident #54's had a BIMS score of 10 which indicated his cognition was moderately impaired. The MDS assessment did not indicate Resident #54 had a weight loss or weight gain of 5% or more in the last month or 10% or more in the last 6 months. The MDS assessment indicated Resident #54 had a feeding tube. Record review of Resident #54's comprehensive care plan revised dated 04/15/2025, indicated he had required the use of a feeding tube and was at risk for aspirations (accidentally inhaling food, liquid, or other material into the lungs instead of the digestive system), weight loss, and dehydration. The care plan interventions included to administer tube feeding as ordered. Record review of Resident #54's order summary report dated 05/06/25, indicated he had the following orders, Enteral feed order: Nutren 2.0 250cc via peg tube with 60 cc peg flush before and after feeding with a start date 02/14/2024. During an interview on 06/02/2025 at 3:16 p.m., Resident #54 stated he did not receive his 4:00 p.m. feeding on 05/30/2025. Resident #54 stated he felt like the nurse did not give it to him because he had spoken with the state surveyor earlier that day. During an interview on 06/04/2025 at 12:00 p.m., RN K stated it was her responsibility to administer Resident #54 feedings on time. RN K stated Resident # 54's feeding was important to provide the nutrients he needed. RN K stated the risk to Resident #54 would be weight loss and skin breakdown. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/04/2025 at 1:15 p.m., the Corporate Nurse stated she expected the enteral feedings to be administered as ordered. The Corporate Nurse stated the nurse was responsible for ensuring this was done. The Corporate Nurse stated failure to provide the enteral feedings as ordered could cause Resident #54 to have weight loss. The Corporate Nurse stated she would monitor by watching a portion of enteral feeding, medication pass, and checking weights. During an interview on 06/04/2025 at 1:30 p.m., the Administrator stated his expectations were for nursing staff to follow physician orders The Administrator stated the nurse was responsible for ensuring the feedings were being administered as ordered. The Administrator stated failure to provide the enteral feedings as ordered could cause Resident #54 to have weight loss. Record review of the facility's undated policy titled Resident Weight , The nursing service department was responsible for all feeding equipment and the administration of tube feedings

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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** 43047 Based on observation, interview, and record review the facility failed to ensure that residents who need respiratory care were provided such care consistent with professional standards of practice for 1 of 12 residents (Resident #132) reviewed for oxygen therapy. The facility failed to ensure Resident #132 had a physician's order in her chart for oxygen. This failure could place residents who receive respiratory care at risk for developing respiratory complications and a decreased quality of care. Findings Included: Record review of Resident #132's face sheet, dated 06/04/25, reflected Resident #132 was a [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis which included COPD (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of the MDS assessment, accessed on 06/04/25, reflected Resident #132's admission MDS had not been completed yet. Record review of Resident #132's comprehensive care plan initiated on 05/24/25 reflected Resident #132 received oxygen therapy. The care plan interventions give medications as ordered by physician, monitor for s/sx of respiratory distress and report to MD PRN. The care plan did not address how many liters Resident #132 should be at. Record review of Resident #132's physician order summary report, dated 06/03/25, reflected there was not an order for oxygen in the summary. During an observation and interview on 06/02/25 at 11:08 a.m., Resident #132 was lying in bed wearing oxygen via nasal cannula. Resident #132's five-liter oxygen concentrator was set on 2 lpm. Resident #132 stated she wore oxygen all the time due to COPD. During an observation on 06/03/25 at 4:22 p.m., Resident #132 was wearing oxygen via nasal cannula while sitting on a bedside commode. Resident #132's five-liter oxygen concentrator was set on 2 lpm. During an interview beginning on 06/04/25 at 12:37 p.m., LVN A stated she was Resident #132's 6am-6pm charge nurse. LVN A stated Resident #132 had been wearing oxygen since admission. After reviewing Resident #132's electronic medical records, LVN A stated Resident #132 did not have an order for oxygen. LVN A stated she was unaware Resident #132 did not have an order for oxygen until the state surveyor intervention. LVN A stated all nurses were responsible for checking the orders in PCC to ensure there was an order for oxygen. LVN A stated it was important to ensure oxygen orders were placed in Resident #132's electronic medical records because if the resident did not need oxygen, she could come dependent on the oxygen or if the oxygen was taken away because there was no order, Resident #132 could become hypoxic (an absence of enough oxygen in the tissues to sustain bodily functions). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An attempted telephone interview on 06/04/25 at 1:28 p.m. with RN C, the nurse that admitted Resident #132, was unsuccessful. During an interview on 06/04/25 at 2:27 p.m., the Regional Compliance Nurse stated she expected Resident #132 to have an order for oxygen upon admission. The Regional Compliance Nurse stated the charge nurse that admitted Resident #132 should have entered the order upon admission. The Regional Compliance Nurse stated the nursing administration, which included the DON/ADONs, were responsible for monitoring and overseeing by checking orders upon admission to ensure accuracy. The Regional Compliance Nurse stated it was important to ensure oxygen orders were place in PCC to communicate with all nurses that resident needs oxygen. During an interview on 06/04/25 at 2:39 p.m., the Administrator stated if the resident was receiving oxygen she should have had an order. The Administrator stated the admission was responsible for ensuring an order was placed in PCC. The Administrator stated the DON and ADONs were responsible for monitoring and overseeing by reviewing the admission order after a new admission. The Administrator stated it was important to ensure an oxygen order was place in PCC for resident safety. Record review of an undated facility policy titled, Oxygen Administration, indicated, the amount of oxygen by percent of concentration or L/min, and the method of administration, is ordered by the physician .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 2 of 3 residents (Resident #17 and Resident #54) reviewed for medication administration accuracy. 1. The facility failed to ensure Resident #17 received his blood sugar checks or insulin for 21 out of 31 days during May 2025. 2.The facility failed to ensure Resident #54 received his Metoprolol (used to treat heart condition, lowers blood pressure, reducing the risk of strokes and heart attacks) on 05/30/2025 at 4:00 p.m. These failures could place residents at risk of not receiving the therapeutic effect of the medication. The findings included: 1.Record review of Resident #17's face sheet dated 06/04/25, indicated a [AGE] year-old male who admitted [DATE] and readmitted to the facility on [DATE] with diagnoses which included diabetes mellitus type 2 (also known as diabetes, a chronic disease that occurs when the body has high blood sugar levels), schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors), and high blood pressure. Record review of Resident #17's quarterly MDS assessment dated [DATE] indicated Resident #17 was usually able to make himself understood and understood others. The MDS assessment indicated Resident #17 had a BIMS score of 12, indicating his cognition was moderately impaired. The MDS assessment indicated Resident #17 had received insulin 7 days out of the 7-day look-back period. The MDS assessment indicated Resident #17 had received a hypoglycemic medication within the last 7 days of the look-back period. Record review of Resident #17's comprehensive care plan, revised on 05/23/25, indicated Resident #17 had Diabetes Mellitus. The care plan interventions were for staff to give medication as ordered by the doctor. Record review of Resident #17's order summary report dated 03/15/25 indicated Resident #17 had an order for the following: Humalog Kwik Pen Subcutaneous Solution Pen-injector 100 units per milliliter (Insulin Lispro), Inject as per the sliding scale: if 0 - 150 = 0; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 450 = 12 units. Call the physician if above 400, subcutaneously, before meals and at bedtime, related to type 2 diabetes mellitus. Record review of Resident #17's order summary report dated 06/03/25, after surveyor intervention, indicated Resident #17 had an order for the following: (continued on next page)

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	676045	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Terrace Healthcare and Rehabilitation	2885 Stillhouse Road Paris, TX 75460

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Humalog Kwik Pen Subcutaneous Solution Pen-injector 100 units per milliliter (Insulin Lispro), Inject as per the sliding scale: if 0 - 150 = 0; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401 - 450 = 12 units. Call the physician if above 400, subcutaneously, two times a day (7:00 am and 4:00 pm), related to type 2 diabetes mellitus. Record review of the MAR dated 05/01/25 through 05/31/25 revealed Resident #17's blood sugar was not checked at 11:00 am on the following days: 05/01/25, 05/02/25, 05/04/25, 05/05/25, 05/06/25, 05/07/25, 05/08/25, 05/09/25, 05/11/25, 05/12/25, 05/13/25, 05/15/25, 05/16/25, 05/19/25, 05/20/25, 05/21/25, 05/23/25, 05/25/25, 05/27/25, 05/28/25, 05/29/25. Record review of the MAR revealed the nurses had placed a number 3 under their initial, which indicated Resident #17 was away from the facility. During a phone interview on 06/02/25 at 2:21 p.m., the case manager said she worked at the adult habilitation center, where they specialize in mental health or developmental disability diagnosis. She said Resident #17 came to their facility Monday through Friday from 9 am until 2 pm. She said they were unable to give any medication to any resident while at their facility. She said the facility the resident (s) resided in was responsible for administering their residents' medication if required. During an interview on 06/03/25 at 9:20 a.m., LVN D said she was the nurse for Resident #17. She said on the days she worked, and Resident #17 was not in the facility because he was at the adult habilitation center, she would put a 3 on his medication administration records for his 11:00 am blood sugar check/insulin. She said the 3, indicating he was not in the facility for his 11:00 am blood sugar check or insulin if required. She said she did not notify the physician because she thought the physician was aware he missed the 11:00 am blood sugar check or insulin. During a phone interview on 06/03/25 at 10:22 a.m., the Medical Director said he was unaware Resident #17 was not receiving his blood sugar checks or medication while at the adult habilitation center. He said the facility notified him today (06/03/25), and he made some medication changes. He said Resident #17 was non-compliant with following his diabetes management, but missing his medication could cause his blood sugar levels to be higher and require more insulin. During an interview on 06/03/25 at 4:09 p.m., Resident #17 said he went to the adult habilitation center Monday through Friday. He said that while he was at the center, he did not receive his 11:00 am blood sugar check or insulin. He said he did receive his blood sugar checks and insulin on the weekend while he was at the facility. During an interview on 06/04/24 at 12:53 p.m., LVN A said she was one of Resident #17's primary nurses. She said Resident #17 was at the adult habilitation center Monday through Friday. She said she would put a 3, which meant not given, on his medication administration record because he was not in the facility. She said she was unaware that the adult habilitation center did not check to monitor his blood sugars or give him medication as ordered. She said without his medication, it could cause him to go into diabetic ketoacidosis (a serious complication of diabetes). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/04/25 at 2:00 p.m., the Regional Nurse Consultant said she expected medication to be given as ordered. She said she was aware the adult habilitation center did not give medication, but did not realize Resident #17 was not receiving his 11:00 am blood sugar checks or insulin medication. She said the facility was responsible for giving the medication as ordered. She said Resident #17 could have had a negative outcome with his blood sugars being either too high or too low. During an interview on 06/04/25 at 2:27 p.m., the Administrator said he expected staff to follow the physician's orders. He said the nurses should have ensured Resident #17 received his blood sugars or insulin as ordered. He said the DON was responsible for ensuring medication was being given. The Administrator said failure to check blood sugars could impact their blood sugar levels by being too low or too high. 47612 2.Record review of Resident #54's face sheet dated 06/03/2025, indicated a [AGE] year-old male who initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included dysphagia (difficulty swallowing), gastrostomy hemorrhage (bleeding associated with a gastrostomy, which was a surgical procedure creating an opening in the abdomen to insert a feeding tube into the stomach), muscle wasting and atrophy (loss of muscle mass). Record review of the Comprehensive MDS assessment dated [DATE], indicated Resident #54's speech was unclear, but he was able to make himself understood, and understood others. The MDS assessment indicated Resident #54's had a BIMS score of 10 which indicated his cognition was moderately impaired. The MDS assessment indicated Resident #54 had a feeding tube. Record review of Resident #54's comprehensive care plan revised dated 04/15/2025, indicated he had hypertension with interventions to give anti-hypertensive medication as ordered. Record review of Resident #54's order summary report dated 05/06/25, indicated he had the following orders, Metoprolol 25 mg give 1 tablet via gastrostomy tube twice a day 8:00 a.m. and 4:00 p.m. with start date 02/14/2024. During an interview on 06/02/2025 at 3:16 p.m., Resident #54 stated he did not receive his 4:00 p.m. medication on 05/30/2025. Resident #54 stated he felt like the nurse did not give him because he had spoken with the state surveyor earlier that day. During an interview on 06/04/2025 at 12:00 p.m., RN K stated it was her responsibility to administer Resident #54's medications on time. RN K stated Resident # 54's medications were important to ensure he received the treatment he needed. RN K stated the risk to Resident #54 could leave his condition untreated. During an interview on 06/04/2025 at 1:15 p.m., the Corporate Nurse stated she expected the medications to be administered as ordered by the physician. The Corporate Nurse stated the nurse was responsible for ensuring this was done. The Corporate Nurse stated the failure to provide the medications as ordered could result in a change of condition. The Corporate Nurse stated she would monitor by watching a medication pass. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/04/2025 at 1:30 p.m., the Administrator stated his expectations were for nursing staff to follow physician orders The Administrator stated the nurse was responsible for ensuring the medications were being administered as ordered. The Administrator stated it was important for compliance and resident safety. The Administrator stated he was not clinical, so he was unsure of the risk. The Administrator stated he would monitor by direct observation and in-service. Record review of the facility's policy titled, Medication Orders, from Pharmacare USA V3-2025, indicated, Policy: Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. Record review of the facility's policy titled, Medication Administration and General Guidelines, from Pharmacare USA V3-2025, indicated, Policy: Medications are administered as prescribed, by State Regulations, using good nursing principles and practices and only by persons legally authorized to do so. #17. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g., resident not in facility at scheduled dose time, initial dose of antibiotic), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN documentation. The physician must be notified when a dose of medication has not been given. If an electronic medical record is being utilized than the caregiver administering the medication will enter the correct documentation that will then be electronically date/time stamped with their initials.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46928 Based on observations, interviews, and record review, the facility failed to ensure that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 2 of 20 residents (Resident #129 and Resident #130) and 1 of 7 medication carts (400 hall Nurse Medication Cart) reviewed for drugs and biologicals. 1. The facility failed to ensure RN C secured the 400 hall Nurse Medication Cart, when she went in Resident #47's room to obtain his blood sugar on 06/02/25. 2. The facility did not ensure Resident #129's inhaler (a device that delivers medication directly into the lungs by inhaling it) was not left on her dresser. 3. The facility did not ensure Resident #130's nystatin cream (antifungal medication) was not left on her bedside table. These failures could place residents at risk of not receiving drugs and biologicals as needed, medication errors, medication misuse, and drug diversion. Findings included: 1. During an observation and interview on 06/02/25 at 11:41 AM, RN C entered Resident #47's room to obtain his blood sugar. RN C left the nurse's medication cart unlocked. RN C proceeded to obtain Resident #47's blood sugar. RN C said she forgot to lock the cart because was nervous. RN C said the nurse cart should always be locked when leaving it unattended. RN C said she was responsible for ensuring the cart was locked. RN C said failure to lock the cart was a safety concern and a resident could have walked by and gotten into the cart. During an interview on 06/04/25 at 11:42 AM, the RNC said she expected medication carts to be to be locked when leaving unattended. She said failure to properly lock the medication cart could leave other residents at risk for getting into the cart. The RNC said the nurse or medication aide was responsible for ensuring medication carts were kept locked when leaving unattended. During an interview on 06/04/25 at 11:46 PM, the Administrator said he expected medications carts to be to be locked when leaving unattended. He said by not properly locking the medications carts, residents could access the cart. The Administrator said the nurse or medication aide were responsible for ensuring medication carts were kept locked with leaving unattended. 43047 2. Record review of Resident #129's face sheet, dated 06/04/25, reflected Resident #129 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included COPD (chronic inflammatory lung disease that causes obstructed airflow from the lungs), and asthma (chronic condition that affects the airways in the lungs). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the MDS assessment, accessed on 06/04/25, reflected Resident #129's admission MDS had not been completed yet. Record review of Resident #129's comprehensive care plan initiated on 05/23/25 reflected Resident #129 had emphysema (long term lung condition that causes shortness of breath) and COPD. The care plan interventions included give aerosol (spray) or bronchodilators (inhaler) as ordered and monitor/document side effects and effectiveness. Record review of the order summary report dated 06/02/25 reflected an active physician order for Albuterol Sulfate HFA Inhalation Aerosol Solution (medication used to treat or prevent bronchospasm (muscles that line bronchi (airway in your lungs) tighten or narrowing of the airway in the lungs) 90 mcg/act: 2 puff inhales orally one time a day for COPD with a start date 05/24/25. During an interview and observation on 06/02/25 at 11:12 a.m., Resident #129 was lying in bed. An inhaler that was labeled Albuterol Sulfate HFA Inhalation Aerosol was on her dresser. Resident #129 stated she did 2-3 puffs as needed and it really depended on how bad she felt. Resident #129 stated she brought it from home. During an interview and observation on 06/02/25 at 11:48 a.m., with MA G revealed Resident #129's inhaler was located on the nurse's medication cart. MA G stated the medication was administered by a nurse one time a day, every day. During an observation on 06/03/25 at 8:02 a.m., Resident #129 was eating her breakfast. An inhaler that was labeled Albuterol Sulfate HFA Inhalation Aerosol was on her dresser. During an observation and interview on 06/04/25 at 12:33 p.m., Resident #129 was sitting on her bed. An inhaler that was labeled Albuterol Sulfate HFA Inhalation Aerosol was on her dresser. Resident #129 stated she told someone that it was her inhaler, and she did not use the one that was in the nurse's medication cart, when asked if she had let the facility know that she had one her dresser. Resident #129 was unable to give the staff name that she told. 3. Record review of Resident #130's face sheet, dated 06/04/25, reflected Resident #130 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnoses which included gastroenteritis (stomach virus) and colitis (inflammation of the colon). Record review of the MDS assessment, accessed on 06/04/25, reflected Resident #130's admission MDS had not been completed yet. Record review of Resident #130's comprehensive care plan did not address nystatin cream. Record review of Resident #130's order summary report dated 06/02/25 reflected there was not an order for nystatin cream in the summary. During an observation and interview on 06/02/25 at 11:01 a.m., Resident #130 was lying in bed. A tube that was labeled nystatin cream was on her bedside table. Resident #130 stated she used it because her private area itched. Resident #130 stated her husband brought the medication to her. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 06/03/25 at 8:15 a.m., Resident #130 was lying in bed. Resident #130 stated her husband took the medication home on 06/02/25. During an interview beginning on 06/04/25 at 12:37 p.m., LVN A stated Residents #129 and #130 had not been evaluated for self-administration of medications. LVN A stated if a resident was able to self-administer, he/she must be assessed for competence. LVN A stated she saw Resident #130's nystatin cream over the weekend and told her she was not allowed to keep the cream in her room. LVN A stated Resident #130 told her that her husband would take the medication home. LVN A stated she was unaware Resident #129 had an inhaler on her dresser. LVN A stated medications should be stored on the medication cart. LVN A stated it was important to ensure medications were not left at bedside for resident safety. During an interview on 06/04/25 at 2:27 p.m., the Regional Compliance Nurse stated her expectations were that medications were locked in the medication cart and administered by the nurse or MA. The Regional Compliance Nurse stated to self-administrate, an assessment for self-administration must be completed and an order obtained from the MD. The Regional Compliance Nurse stated the nursing administration, which included the DON and ADONs, were responsible for monitoring and overseeing medications at bedside by daily facility rounds. The Regional Compliance Nurse stated it was important to ensure medications were not left at bedside for resident safety. During an interview on 06/04/25 at 2:39 p.m., the Administrator stated medications should not be left at bedside. The Administrator stated medications should be locked and secured and administered by the nurse or MA. The Administrator stated the charge nurse should be ensuring medications were not left at bedside. The Administrator stated the DON and ADONs were responsible for monitoring and overseeing medication storage by daily rounds. The Administrator stated it was important to ensure medications were not left at bedside for resident safety. Record review of the facility's policy undated policy titled Storage of Medication indicated . Medications and biologicals are stored safely, securely, and properly following manufacturers recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications .2 . Medications rooms, carts and medication supplies are locked and attended by persons with authorized access . Record review of an undated facility policy titled Self-Administration of Medications by Residents Policy, indicated . 2. If the resident desires to self-administer medications as assessment is conduced by the IDT of the resident's cognitive, physician, and visual ability to carry out the responsibility . 6. All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage, and then give unauthorized medications to the charge nurse for return to the family or responsible party .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45879 Based on observations, interviews, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 4 residents (Resident #76, Resident #54, and Resident #131) reviewed for infection control. 1.The facility failed to ensure CNA L performed hand hygiene while providing incontinent care for Resident #76 on 06/02/25. 2. The facility failed to ensure LVN D applied a gown when she administered an IV medication to Resident #131 on 06/03/25. 3. The facility failed to ensure LVN E applied a gown when she administered medications via a gastrostomy tube (feeding tube) to Resident #54 on 06/03/25. 4.The facility failed to ensure CNA L and CNA M applied a gown when they administered care to Resident #54 on 05/30/2025. These failures could place any resident at the facility at risk for cross-contamination and the spread of infection. Finding included: 1.Record review of Resident #76's face sheet, dated 06/04/25, revealed an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses to include dementia (progressive loss of intellectual functioning), muscle weakness, and Congestive heart failure, or heart failure, is a long-term condition in which your heart can't pump blood well enough to meet your body's needs. Record review of Resident #76's quarterly MDS assessment, dated 04/11/25, indicated Resident #76 understood and was understood by others. Resident #76's BIMS score was 08, which indicated her cognition was moderately impaired. The MDS indicated Resident #76 required assistance with toileting, bed mobility, dressing, personal hygiene, transfers, and eating. The MDS indicated she was frequently incontinent of bladder. Record review of Resident #76's comprehensive care plan revised on 11/07/24, indicated Resident #76 was incontinent of bladder. The care plan interventions were for staff to provide incontinent care at least every 2 hours and apply a moisture barrier after each episode. During an observation on 06/02/25 at 11:40 a.m., CNA L provided incontinent care for Resident #76. She wiped her front area and then her backside without changing her gloves or performing hand hygiene. She then grabbed a clean brief, applied it, pulled down her gown, and assisted Resident #76 to her wheelchair with the same dirty gloves still on. CNA L then removed her gloves, gathered her equipment, washed her hands, and left the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/02/25 12:03 p.m., CNA L said she did not realize she did not perform hand hygiene or change her gloves after wiping Resident #76's front, then wiping her back and touching the clean brief and her gown with dirty gloves. S. The Regional Nurse Consultant said they went over incontinence care and hand washing upon hire, annually, and as needed. She said nurse management oversaw infection control and cross-contamination. She said staff should change gloves and practice hand hygiene to prevent infection and cross-contamination. During an interview on 06/04/25 at 12:17 p.m., the Administrator said he expected all staff to use proper hand hygiene techniques between dirty and clean areas with all care. The Administrator said the DON was responsible for ensuring staff were trained on incontinent care and infection control. He said improper hand hygiene could place residents at risk for cross-contamination.he said she knew, that without hand hygiene or removing dirty gloves, she could cause cross-contamination. During an interview on 06/04/25 at 11:44 a.m., LVN A said she was Resident #76's nurse. She said she expected the CNAs to perform incontinent care the correct way. She said she expected them to change their gloves between clean and dirty to prevent cross-contamination. During an interview on 06/04/25 at 2:00 p.m., the Regional Nurse Consultant said she expected the CNAs to perform incontinent care correctly. She said she expected staff to change their gloves between dirty to clean and use hand hygiene between glove changes Record review of CNA L's proficiency on incontinent care and handwashing was dated 05/26/25. 46928 2. Record review of Resident #131's face sheet dated 06/03/25, indicated a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses which included sepsis (a serious condition in which the body responds improperly to an infection, causing organ damage and sometimes death) and cellulitis (bacterial infection involving the inner layers of the skin) of the right lower limb. Record review of Resident #131's admission MDS assessment dated [DATE], indicated he had a BIMS score of 10, which indicated his cognition was moderately impaired. Resident #131 had received IV antibiotics within the last 14 days of the look back period. Record review of Resident #131's comprehensive care plan dated 05/21/25, indicated Resident #131 was on enhanced barrier precautions with the interventions for gloves and gown should be donned if any of the following activities were to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, bathing, or high-contact activity. Record review of Resident #131's order summary report dated 06/03/25, indicated he had the following orders: o Flush IV line with 10 mls of normal saline before and after medication with an order start date of 05/21/25. o Flush IV with 10 ml normal saline q shift with an order start date of 05/21/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Vancomycin 1 GM give 1 GM intravenously two times a day for wound with a start date of 05/29/25. During an observation and interview on 06/03/25 at 8:09 AM, LVN C entered Resident #131's room to administer vancomycin 1 GM IV via his PICC (a thin flexible tube that is inserted into a vein in the upper arm for IV antibiotics or IV medications) line. LVN C performed hand hygiene, applied gloves, flushed Resident #131's PICC line with 10 ml of normal saline and set the IV at 200 mls/hour to administer the vancomycin medication. LVN C did not apply a gown before she administered Resident #131's medication. LVN C removed her gloves and performed hand hygiene. Resident #131 had a 3-drawer plastic bin, with PPE, inside his room to the left side of the door and EBP signage on his door. LVN C said she missed applying the gown because she was very nervous. LVN C said she should have applied the gown to protect Resident #131 from bacteria. LVN C said she was responsible for ensuring proper PPE was worn. During an interview on 06/04/25 at 11:42 AM, the RNC said she expected proper PPE to be worn when caring for a device or if the staff was providing close personal care to residents on EBP. The RNC said PPE should have been worn when providing IV and peg-tube medications. The RNC said failure to apply proper PPE placed the residents at risk for infection. The RNC said the person caring for the device was responsible for ensuring EBP precautions were followed. During an interview on 06/04/25 at 11:46 AM, the Administrator said he expected EBP precautions to be followed as per the facility's policy and when it was required. The Administrator said PPE should be worn when providing IV medications or when providing medications through a peg-tube to protect the resident from any infections. The Administrator said the staff taking care of the resident was responsible for ensuring proper PPE was worn. During an interview on 06/04/25 at 3:13 PM, the ADON H, said she was the Infection Preventionist. ADON H said she expected the staff to follow the EBP protocol. She said if a nurse was providing medications through an IV or peg tube, PPE should be worn. She said failure to apply proper PPE placed the residents at risk for exposure to bacteria. ADON H said the nurse was responsible for ensuring proper PPE was worn. 47612 Resident #54 Record review of Resident #54's face sheet dated 06/04/25, indicated a [AGE] year-old male who initially admitted to the facility on [DATE] with diagnoses of quadriplegia (paralysis that affects all limbs and body from the neck down) and dysphagia (difficulty swallowing). Record review of Resident #54's annual MDS assessment dated [DATE], indicated he was able to make himself understood and understood others. Resident #54 had a BIMS score of 10 which indicated his cognition was moderately impaired. Resident #54 was dependent on staff with all ADLs. The MDS assessment indicated Resident #54 had a feeding tube. (continued on next page)

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 06/04/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #54's comprehensive care plan dated 04/03/24, indicated Resident #54 was on enhanced barrier precautions with the interventions for gloves and gown to be donned if any of the following activities were to occur: linen change, resident hygiene, transfer, dressing, toileting/incontinent care, bed mobility, wound care, enteral feeding care, catheter care, bathing, or high-contact activity. 3. Record review of Resident #54's order summary report date 06/03/25, indicated Resident #54 had the following orders: o Enteral Feed Order flush tube with 60 ML water before and after medication and feedings with an order start date of 02/13/24. o Hydroxyzine 50 mg give one tablet via peg tube (tube inserted in the stomach for nutrition or medications) three times a day for itching with an order start date of 03/03/25. o Clonazepam 0.5 mg give one tablet via peg tube three times a day related to anxiety with an order start date of 09/26/24. o Lyrica 100 mg give one capsule via peg tube four times a day for pain with a start date of 03/25/25. o Zofran 4 mg give one tablet via g-tube 3 times a day for nausea/vomiting with a start date of 11/18/24. o Tylenol 325 mg give 2 tablets via g-tube every 6 hours as needed for pain with a start date of 02/13/24. During an observation and interview on 06/03/25 at 11:00 AM, LVN E prepared Resident #54's medications. LVN E obtained the following medications: 1 capsule of Lyrica 100mg, 1 tablet of clonazepam 0.5mg, 1 tablet of ondansetron 4 mg, 1 tablet of hydroxyzine 50 mg, and 2 tablets of Tylenol 325 mg. LVN E entered Resident #54's room to administer his routine medications via his peg tube. LVN E performed hand hygiene, applied gloves, administered all medications via his peg tube, removed her gloves and washed her hands. LVN E failed to apply a gown. Resident #54 had a 3-drawer plastic bin, with PPE, inside his room to the left side of the door and an EBP signage on his door. LVN E said Resident #54 was on EBP precautions which indicated gown and gloves were required when providing direct patient care. LVN E said she forgot to apply her PPE because the state surveyor made her nervous. LVN E said failure to apply proper PPE placed the resident at risk for bacteria. LVN E said she was responsible for ensuring EBP precautions were followed. 4. During a video observation dated 05/30/2025, on 06/03/2025 at 11:00 a.m., CNA L and CNA M were observed coming into Resident#54's room to provide care, applied their gloves, bathed resident's face, chest, and abdomen without applying a gown. During an interview attempt on 06/03/2025 at 11:42 a.m., surveyor attempted to contact CNA M by phone and left voicemail to return call. (continued on next page)

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	06/04/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/03/2025 at 2:44 p.m. CNA L stated she had worked for the facility for 3 days prior to giving Resident #54 care on 05/30/2025. CNA L stated she had been trained on when to apply PPE. CNA L stated it was important to wear PPE because you did not want to contaminate Resident #54's catheter and a feeding tube. CNA L stated the risk to Resident #54 was infection. During an interview on 06/04/2025 at 1:15 p.m., the Corporate Nurse stated she expected proper PPE to be worn when providing close personal care to residents on EBP. The Corporate Nurse stated it was the nursing staff's responsibility to wear PPE when providing personal care. The Corporate Nurse stated it was important to wear PPE for infection control. The Corporate Nurse stated she would monitor by in-service and entering Resident rooms to make sure staff was properly donning PPE. During an interview on 06/04/2025 at 1:30 p.m., the Administrator stated his expectations were for the staff to don and doff PPE correctly. The Administrator stated it was important to wear PPE to ensure no cross contamination. The Administrator stated it was the individual staff members responsibility to wear PPE correctly. The Administrator stated he was not clinical, so he was unsure of the risk. The Administrator stated he would monitor by direct observation and in-service. Record review of the facility's policy titled, Fundamentals of Infection Control Precautions, section AD 03-08, indicated, A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions. 1. Hand Hygiene: Hand hygiene continues to be the primary means of preventing the transmission of infection. Record review of the facility's undated policy Enhanced Barrier Precautions, indicated .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing .Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomy .