STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676270	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Place Four	3505 S Buckner Blvd Bldg 5 Dallas, TX 75227

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner that promotes maintenance or enhancement of his or her quality of life for 1 of 6 residents (Resident # 63) reviewed for resident rights. The facility failed to ensure Resident # 63 was assisted with eating in a dignified manner on 06/08/25, CNA H stood while feeding the resident. This failure could place residents at risk for decreased quality of life, quality of care, and self-esteem. Findings included: Review of Resident #63's quarterly MDS assessment, dated 05/07/25, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMS score was 15/15 indicating cognitively intact. Her active diagnoses included acute and chronic respiratory failure, presence of artificial larynx, hypertension. In Section GG-Functional Abilities-A. Eating: Dependent. Review of Resident #63's care plan dated 03/27/25 reflected, [Resident63] has Self Care Performance Deficit r/t Respiratory failure, trach .muscle weakness. Goal. [Resident#63] needs will be met per staff through the next review date. Interventions . EATING: The Resident requires total assistance to eat. During an observation on 06/08/25 at 1:21 PM, Resident #63 was in bed with the head of the bed elevated, and CNA H was standing while assisting Resident #63 with her meal. Resident #63 was unable to interview on how she felt about staff standing during her meal. During an interview on 06/08/25 at 1:30 PM, CNA H stated she supposed to sit next to Resident #63 while assisting with her meal today. She said she should have gotten a chair and sat while assisting because standing could make a resident uncomfortable. During an interview on 06/11/25 at 11:31 AM, the DON said that all staff was responsible for ensuring resident's dignity was maintained and all staff was trained on resident rights. He said when a resident required assistance with meals, the staff should be seated to prevent the resident from being uncomfortable. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy titled Resident Rights with revised date August 2020 indicated, . The 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 .

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a discharge MDS was electronically completed and transmitted to the CMS System within 14 days after completion for one (Resident #32) of one resident reviewed for discharge assessments. The facility failed to complete and transmit Resident #32's discharge MDS assessment within 14 days of completion. This failure could place the residents at risk of having incomplete records. Findings include: Review of Resident #32's face sheet, dated 06/09/25, reflected Resident #32 was a [AGE] year-old female with initial admission date to the facility of 09/10/2024 and discharged from the facility on 01/17/2025. Review of Resident #32's MDS assessments on 06/09/25 revealed Resident #32 did not have a discharge MDS assessment completed. This MDS record was identified as greater than 120 days late on the resident assessment facility task. An interview on 06/09/25 09:56 AM with the MDS Nurse revealed all residents who were discharged from the facility and not anticipated to come back should have a discharge MDS completed. She stated that she was responsible for completing all MDS assessments. She stated the timeframe for completing and transmitting discharge assessments was within 14 days of discharge or death. She reviewed Resident #32's MDS assessments and stated she had started the assessment but failed to complete and transmit it to CMS within the stipulated time frame of 14 days. She stated that failure to do so would lead to CMS not being aware if the resident was still residing in the facility and may show up as a current resident in the facility. An interview on 06/11/25 at 09:47 AM with the DON revealed his expectation was for all MDS assessments to be completed in a timely manner. He stated that MDS Nurse was responsible for completing all assessments, and he provided oversight as needed. He stated that the failure to do so would lead to possible interference with resident care after discharge and not reflect accurately on census with CMS. An interview on 06/11/25 01:16 PM with the Administrator revealed that the Facility MDS Nurse was responsible for completing all MDS assessments in a timely manner, and it was his expectation that all the MDS assessments were completed and transmitted to CMS within the stipulated time frame. He stated that failure to do so will lead to CMS not being aware if the resident was still residing in the facility. The Administrator stated the facility did not have a policy on MDS assessments referred to CMS RAI manual. (RAI- Resident Assessment Instrument is a comprehensive nurse assessment and care planning process used by the long-term care facilities as a requirement for reimbursement under Medicare and Medicaid). (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CMS Long term care facility resident assessment Instrument 3.0 user's manual dated October 2024 reflected, . 09. Discharge Assessment-Return Not Anticipated . Must be completed within 14 days after the discharge date .Must be submitted within 14 days after the MDS completion date.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan for each resident that included measurable objective and timeframes to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 (Resident #58) of 6 residents reviewed for comprehensive care plans. The facility failed to implement the care plan for Resident #58 by not applying the splint daily to his right arm and hand contraction. This failure could place residents at risk for not having individualized care and services to meet their needs. Findings included: Review of Resident #58's Face Sheet dated 06/10/25 reflected he was admitted to the facility on [DATE] with a diagnosis of hemiplegia affecting right dominant side. Review of Resident #58's care plan dated 04/22/25, revealed [Resident #58] has an Alteration in musculoskeletal status r/t Right hand CONTRACTURES. Goal. [Resident #58] will remain free of complications related to fracture, such as contracture formation, embolism and immobility through review date. Intervention. ASSIST APPLYING Right RESTING HAND SPLINT DAILY. Further review of the care plan revealed no document of Resident#58 refusing the application of splint to his right arm. Observation on 06/08/25 at 11:17 AM revealed the Resident #58 lying in bed wearing daytime attire, no splint was on his right arm and hand. Resident#58 was unable to respond to interview. Observation and interview on 06/09/25 at 09:17 AM revealed the Resident #58 was up in wheelchair in the TV room, and there was no splint on his right arm. CNA J looked at the Resident#58 not having the splint on his right arm, and stated, the therapy staff put the splint on the resident. Interview with the Physical Therapy Manager revealed there should be an order for a splint. The Physical Therapy Manager stated she would check the physician orders for a splint for Resident #58. The Physical Therapy Manager ignored the question for who was responsible for the resident's contracted arm care. The Physical Therapy Manager checked her laptop and stated restorative care worked with him and he refused the splint . She further stated Resident #58's refusal was care planned . Interview on 06/10/25 at 12:27 PM the MDS Coordinator stated care plan updates depended on what was happening. She stated she reviewed the care plan every 92 days. She stated if the care plan was not updated, the residents would not get the care they were supposed to get. She stated care plans instructed direct resident care staff to know the residents' needs. She further stated the care plan was the blueprint to take care of the residents. In interview on 06/11/25 at 11:31 AM, the DON stated the nurses, the ADONs, and DON were responsible for updating the care plan. He stated the implications for the residents if the care plan was not updated was it could affect the plan of care for the Resident; meeting Resident #58's needs and his contraction could get worst. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's current, undated Care Plans, Comprehensive Person-Centered policy reflected: .include measurable objective and timeframe; Describe the services that are to be finished to attain or maintain the resident's highest practicable physical, mental, and psychosocial wee-being .include the residents stated goals upon admission and desired outcome; changes may be made to the Comprehensive Care Plan on an ongoing basis for the duration of the residents stay.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 4 (Resident #16, Resident #62, Resident #194 and Resident#29) of 18 residents reviewed for ADLs. The facility failed to ensure: 1- Resident #16 had her thumb nail cleaned and trimmed on 06/09/25. 2- Resident #62 had his fingernails cleaned and trimmed on 06/08/25. 3- Resident #194 had his fingernails cleaned and trimmed on 06/08/25. 4- Resident #29 had his fingernails cleaned and trimmed on 6/8/25. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections, and a decreased quality of life. Findings included: 1-Record review of Resident #16's Annual MDS assessment dated [DATE] reflected Resident #16 was a [AGE] year-old female admitted to the facility with initial admission date of 08/01/2022. Her relevant diagnoses included Cerebrovascular accident (disruption to blood flow to brain), hemiplegia (paralysis of one side of the body), Diabetes mellitus (high blood glucose), hyperlipidemia (high blood lipid levels) ,End Stage renal disease (kidney functioning at severely reduced capacity requiring medical intervention), Hypertension (high blood pressure). Resident #16's BIMS score was 07, which indicated Resident #16's cognition was severely impaired. The MDS assessment indicated Resident #16 required substantial assistance with personal hygiene. Record review of Resident #16's Comprehensive Care Plan revised on 08/16/2022, reflected Focus: [Resident #16] has an ADL Self Care Performance Deficit related to Hemiplegia. Goal: Will maintain current level off unction in (Specify Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene; ADL Score) through the review date. Intervention: Personal Hygiene: Substantial(extensive) assist x 1-2 staff. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 6/9/25 at 10:47 AM of Resident #16's left thumb nail revealed it was almost 1.5-2 inches long, thickened, jagged, bended outward, separated from the nail bed and discolored. Resident #12 stated that she would like the nail to be trimmed, and the nail did not hurt, but was long and looked dirty. Resident #12 added that she did not remember when she was last asked about trimming her thumb nail. Resident #16's right hand was contractures. In an interview on 06/09/25 03:59 PM with CNA C, she stated she worked in the facility for about a year and was familiar with Resident #16's care. She stated CNAs and Nurses were responsible for nail care. She said Resident #16 refused nail care at times. She stated that Resident #12's thumb nail looked discolored, long, and thickened, and ideally should have been cut. She also added that not trimming or cleaning fingernails could lead to infections. In an interview and observation on 06/09/25 04:02 PM with ADON D, she asked Resident #16 if she would like her left thumb nail to be cut. Resident #16 responded she would like it to be trimmed since it looked bad and was too long. ADON D added she would ask the physician and put in podiatry consult since the thumb nail was too thick to be trimmed by the facility staff. She added Nurses or CNAs perform nail care, and her expectation was nail care to be performed during shower times or as needed. She added She expected nursing staff to offer nail care to all residents. She added risk of long, dirty fingernails was loss of quality of life and potential infections. An interview on 06/09/25 04:10 PM with LVN E revealed she was a new nurse in the facility and started working about three weeks ago. She added she was not very familiar with Resident #16's care. She stated CNAs and Nurses were responsible for nail care. She added Resident #16 had history of refusals. However, nail care should be offered to all residents. She stated the risk of not cutting and cleaning nails was lapses in infection control and loss of quality of life. 2- Record review of Resident #62's Comprehensive MDS assessment dated [DATE] reflected Resident #62 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included hemiplegia and hemiparesis following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), cognitive communication deficit, and contracture of muscle, multiple sites. He had a BIMS score of 06/15, indicating sever cognitive impairment. The MDS assessment indicated Resident #62 required maximal assistance of 2 persons with personal hygiene. Record review of Resident #62's Care Plan dated 04/08/25, reflected the following: Focus: [Resident #62] has an ADL self-care performance deficit related to cerebral infarction. Goal: [Resident #62] will maintain current level of function in ADLs through the next review date. Interventions: . Personal hygiene: the resident requires total assistance with personal hygiene care . An observation on 06/08/25 at 11:12 AM revealed Resident #62 was laying in his bed. The nails on both hands were approximately 0.4 cm in length extending from the tip of his fingers. The nails were discolored tan, and had dark brown colored residue underside. Resident #62 stated he would like his fingernails cleaned and trimmed. In an interview on 06/09/25 at 08:46 AM, CNA/SC F stated CNAs were allowed to cut the residents' nails if they were not diabetic. CNA/SC F stated she did not see Resident #62's nails that morning. She stated she would do it right then. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3-Record review of Resident #194 's Comprehensive MDS assessment dated [DATE] reflected Resident #194 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included type 2 diabetes mellitus, schizophrenia, hypertension, and need for assistance with personal care. He had a BIMS score of 06 out of 15, indicating severe cognitive impairment. The MDS assessment indicated Resident #194 required substantial/maximal assistance with personal hygiene. Record review of Resident #194's Care Plan dated 05/31/25, reflected the following: Focus: [Resident #194] has an ADL self-care performance deficit related to activity intolerance, fatigue, limited mobility. Goal: [Resident #194] will maintain current level of function in ADLs through the next review date. Interventions: . Personal hygiene: the resident requires supervision to limited (Partial/moderate) x 1 staff participation with personal hygiene care . An observation on 06/08/25 at 09:38 AM revealed Resident #194 was laying in his bed. The nails on both hands were approximately 0.9 cm in length extending from the tip of his fingers. The nails were discolored tan and had dark brown colored residue underneath. Resident #194 stated he would like his fingernails cleaned and trimmed. In an interview on 06/09/25 at 09:05 AM, CNA G looked at Resident #194's fingernails and stated they needed to be trimmed and cleaned. CNA G stated CNAs were allowed to cut the residents' nails if they were not diabetic. CNA G stated since Resident #194 was diabetic, she was going to clean his fingernails and notify the charge nurse to trim his fingernails. 4-Record review of Resident #29's Quarterly MDS assessment dated [DATE] reflected Resident #29 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses included contracture of muscle of left hand, cognitive communication deficit, and cerebral infarction (a condition that occurs when blood flow to the brain is blocked. The blockage can lead to brain tissue death). Resident #29's BIMS score was not determined because Resident #29 was unable to complete the interview. The MDS assessment indicated Resident #29's cognitive skills for daily decision making were severely impaired. The MDS assessment indicated Resident #29 required maximal assistance with personal hygiene. Record review of Resident #29's Care Plan revised 02/20/25, reflected the following: Focus: [Resident#29] has an ADL self-care performance deficit related to cerebral infarction . Goal: [Resident #29] will maintain current level of function in ADLs through the next review date . Interventions: . Personal hygiene . Resident requires total assistance with personal hygiene care . An observation on 06/08/25 at 11:55 AM revealed Resident #29 was laying in his bed. The nails on both hands were approximately 0.5 cm in length extending from the tip of his fingers. The left hand was contracted, and the nails were pressing on the palm of the left hand. Observation reflected no skin breakdown. Resident #29 was unable to answer questions. In an interview on 06/09/25 at 9:13 AM, CNA J stated CNAs were allowed to cut the residents' nails if they were not diabetic. CNA J stated she did not see Resident #29's nails when she did her rounds. She stated she would do it right then. She stated the risk would be infection and injury. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/10/25 at 8:56 AM, the DON stated nail care should be completed as needed and every time aides washed the residents' hands. The DON stated nails should be observed daily. The DON stated nurses were responsible for trimming the nails of residents who were diabetic, and CNAs could trim other residents' nails. The DON stated he expected CNAs to offer to cut and clean nails if they were long and dirty. The DON stated the ADONs would do the routine rounds to monitor. The DON stated residents having long and dirty nails could be an infection control issue. Record review of the facility's policy titled, Grooming Care of the Fingernails and Toenails undated reflected, Purpose: Nail care is given to clean and keep the nails trimmed .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for two (Resident #12 and Resident #64) of three residents reviewed for incontinence care. The facility failed to ensure: 1. Resident #64's foley catheter was secured prior to transferring Resident #64 from the toilet to his wheelchair on 06/09/25. 2. The facility failed to ensure CNA G provided appropriate perineal care for Resident #12 when she failed to separate the labia when cleaning the resident on 06/09/25. These failures placed residents at risk for the development and/or worsening of urinary tract infections and dislodgement of the foley catheter. Findings included: 1. Record review of Resident #64's quarterly MDS assessment, dated 04/29/25, reflected he was a [AGE] year-old male admitted to the facility on [DATE]. His BIMs score was 5 indicating his cognitive was severely impaired. His diagnoses included pyelonephritis (kidney infection), neuromuscular dysfunction (condition where the nerves connection the bladder to the brain and spinal cord are damaged, leading to problems with bladder control and emptying), and need for assistance with personal care. The resident required maximal assist for toileting and personal hygiene. The resident had an indwelling catheter. Record review of Resident #64's care plans, dated 04/22/25 reflected: The resident had an indwelling foley catheter. Facility interventions included monitor/document for pain/discomfort due to catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 06/09/25 at 1:30 PM revealed Resident #64 was sitting on the toilet. The catheter tubing was not strapped to the resident's leg to prevent it from pulling out. CNA F was in the room, and wearing gloves and a gown. CNA M was standing by the toilet door and wearing gloves and gown. CNA F entered the toilet to assist resident with cleaning and transfer to the wheelchair. CNA F unhooked the catheter bag from the wheelchair side and handed it to CNA M. Resident #64 complained of pain to the penial area. CNA F removed her gloves and gown, and left the room to notify the nurse. CNA F came back to the room with RN N; both put on gowns and gloves. RN N assisted the resident while sitting on the toilet . RN N instructed CNA F and CNA M to transfer the resident to his bed. CNA F proceeded to clean the resident's buttocks. With the assistance of CNA M, CNA F transferred the resident from the toilet to his wheelchair and from his wheelchair to his bed. In an interview with CNA F on 06/09/25 at 02:15 PM, CNA F stated the resident should have had his catheter secured. She stated she informed the nurse. CNA F stated they had not had any recent training on foley catheter care, but knew they were supposed to always keep the foley catheter tubing secured to the resident leg to prevent pulling and injury. In an interview with RN N on 06/09/25 at 02:25 PM, she stated the catheter should have secured before they transferred the resident, but they just got nervous with someone watching them. She stated failing to secure the catheter could cause trauma to the bladder if the catheter got pulled. In an interview with the DON 06/10/25 at 08:56 AM, he stated any resident with a foley catheter should have it secured, to ensure the resident's catheter did not get pulled out causing trauma or injury. The DON stated he would do skills check on catheter care for all CNAs. 2. Record review of Resident #12's quarterly MDS assessment, dated 05/05/25, reflected a [AGE] year-old female originally admitted to the facility on [DATE], and readmitted on 10/14 24. She had a BIMS score of 12 out of 15 indicating moderate cognitive impairment. She required substantial/maximal assistance for toileting care. Her active diagnoses included hypertension, diabetes mellitus, septicemia (a serious condition where bacteria enters the blood stead and spreads throughout the body, and schizophrenia. Record review of Resident #12's care plan, dated on 05/05/25, reflected, Focus. [Resident#12] has an ADL Self Care Performance Deficit r/t Confusion, Impaired balance, Musculoskeletal impairment. Goal. [Resident#12] will maintain current level of function in through the next review date. Interventions/Tasks. toileting: incontinent of bowel and bladder, x2 person assist An observation on 06/09/25 at 2:05 PM revealed CNA G and CNA K entered Resident #12's room. Both staff washed their hands and put on gloves. CNA G unfasted the resident's brief. CNA G pushed the brief down between Resident#12's legs. CNA G wiped down each side of her groin area, revealing the resident had a bowel movement that had pushed up between her legs. CNA G wiped to remove the bowel movement from the resident's inner thighs, then wiped across the pubic mound but did not spread her labia and wipe down the middle. Both staff rolled the resident onto her side, revealing a large soft bowel movement. CNA G continued to clean from front to back until all bowel movement was removed. CNA G then removed her gloves, performed hand hygiene, and re-gloved before placing a clean brief under the resident. Both CNAs turned Resident#12 side to side and to her back, finished putting the brief on her, and fastened it. Both CNAs pulled the cover on the Resident#12. Both CNAs gathered the trash, removed their gloves, performed hand hygiene, and left the room. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/09/25 at 2:21 PM. CNA G stated, she cleaned the Resident#12's labia will pushing the brief down between the Resident's leg. When asked if that how it supposed to be done, she replied she was supposed to open the resident's labia and clean it with wipes, and not the diaper. She stated she would go back and re-perform Resident #12's incontinent care to make sure Resident#12 private area did not have any more feces. She stated the risk to the resident was a UTI, or infection if feces was still left in her vagina. She stated she received training during orientation. In an interview with the DON on 06/11/25 at 11:31 AM, he stated the CNAs were supposed to follow the proper procedure for incontinence care which included spreading the labia and wiping down the middle using wipes, not the brief, to ensure the residents were clean and to help reduce infection risk. Review of the facility policy , Catheter Care, revised June 2020, reflected: . Anchor the catheter with a leg strap to prevent excessive tension on the catheter, which can lead to urethral tears or dislodging the catheter .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care, was provided such care, consistent with professional standards of practice for 1 (Resident #63) of 6 residents reviewed for tracheostomy care. LVN I failed to maintain sterile technique during tracheostomy (a surgical opening in the neck providing a direct airway through the trachea) care, and change gloves with hands hygiene going from dirty to clean task. These failures could place residents at risk for respiratory infections. Findings included: Review of Resident #63's quarterly MDS assessment, dated 05/07/25, reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her BIMS score was 15/15 indicating cognitively intact. Her active diagnoses included acute and chronic respiratory failure, presence of artificial larynx, hypertension. In Section O-Special Treatments, Procedures, and Programs it revealed she required oxygen therapy, and tracheostomy (trach) care. Review of Resident #63's care plan dated 03/27/25 reflected, [Resident63] has Tracheostomy related to impaired breathing mechanics .Interventions .Ensure that trach ties are secured at all times . Monitor/document respiratory rate, depth and quality. Check and document every shift/as ordered . Review of Resident #63's Physician's orders with start/active dated 03/16/25, reflected, Change and date trach ties, mask, .weekly Fridays and as needed. In an observation on 06/10/29 at 11:22 AM, revealed LVN I inside of Resident #63's room. She donned a gown, gloves, and mask. LVN I had an unopened trach kit, T-drain sponge, tracheostomy tube holder, Q tips cotton swap, a bottle of normal saline, and a sterile glove on draped bedside table. LVN I assessed Resident #63's oxygen saturation, and lungs. LVN I removed her gloves, sanitized hands, opened the trach kit, the sterile gloves package, there was one glove only. LVN I got another sterile glove from a basket on the residents breathing supplies table. LVN I opened the sterile gloves package, and without performing any form of hands hygiene, she put on the sterile gloves. LVN I opened the bottle of normal saline with the sterile gloves and poured it into the reservoir in the trach kit. LVN I removed the old T-drain sponge dressing from the Resident #63 trach site and disposed of it. LVN I cleaned the site with normal saline using the Q tip cotton swap. LVN I placed the clean T-drain sponge dressing under the trach collar wearing the same gloves. LVN I removed her gloves and gown, washed her hands. LVN I gathered the trash disposed of them in the trash can and left the room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/10/25 at 11:44 AM, LVN I stated the trach care was supposed to be a sterile procedure and she stated she did not do a sterile procedure. She stated she thought there was supposed to be 2 sterile gloves in the package, and it threw her when there was only one. She stated the reason it was supposed to be a sterile procedure was to reduce the risk of introducing infection into the lungs. She stated she should had performed hand hygiene after opening the sterile gloves package and pour the normal saline before putting on the sterile gloves. She stated she was supposed to change gloves with hand hygiene after removing the old T-sponge dressing, and before applying the clean one. In an interview with the DON on 06/11/25 at 11:31 AM, he stated the trach care was supposed to be a sterile procedure. The DON stated the reason it was supposed to be a sterile procedure was to reduce the risk of infection and pneumonia. The DON stated LVN I should perform hand hygiene before putting on the sterile gloves. The DON stated LVN I should change gloves with hand hygiene before handling the clean sponge. Record review of the facility's policy, Tracheostomy Care' dated June 2020, reflected, .In addition to routine care, stoma dressing, and trach ties will be changed when wet or soiled .Gather supplies .Wash hands .don gloves .Inspect skin and stoma site for sing or symptoms of infection, skin irritation, or open areas. If there is a tracheostomy dressing, remove the old dressing from around the tracheostomy tube and discard .Clean around the tracheostomy site .with a cotton swab or gauze pad moistened in normal saline .Repeat the cleaning process until wet and dried mucus is removed. Use a clean cotton swab or gauze pad each time . Pat the area dry with a gauze pad .Apply a precut (non-[NAME] dressing) around the insertion site .Suction resident as needed .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 (100/200 hall) of 3 nurse medication carts reviewed for pharmacy services. The facility failed to ensure LVN O, LVN P, and LVN R responsible for the 100/200 hall nurse cart , counted controlled drugs every shift change. This failure could place residents at risk of not having the medication available due to possible drug diversion. Findings Included: Record review and observation on 06/08/25 at 09:53 AM, of the 100/200 hall nurse cart , with LVN K revealed missing signatures for Off duty and On duty nurses for 06/06/2025 (6:00 AM to 2:00 PM shift), 06/06/25 (2:00 PM to 10:00 PM shift), and 06/07/2025 (10:00 PM to 6:00 AM shift) of the narcotic count sheet. Interview on 06/10/2025 at 12:04 PM, LVN O stated she should have signed the narcotic sheet after counting the narcotics, on 6/6/25 at the beginning and at the end of the shift 6 AM to 2 PM. She stated she got busy with a resident asking for ice and did not go back to sign the count sheet. She stated she knows that she supposed to signed immediately after the count was done. She stated the risk would be potential for drug diversion. Interview on 06/10/25 at 2:35 PM, LVN R stated he should have signed the narcotic sheet after counting the narcotics on 6/6/25 at the beginning and at the end of the shift 2 PM to 10 PM. LVN R stated, I counted the narcotics, but I got busy with a new admission. LVN R stated this failure could potentially cause a drug diversion. He stated he was trained and learned that he supposed to sign the narcotic count sheet immediately after counting with the other nurse. Interview on 06/10/25 at 4:28 PM, LVN P stated she should have signed the narcotic sheet after counting the narcotics on 6/7/25 at the beginning and at the end of the shift 10 PM to 6 AM. LVN P stated, she counted with the other nurse but forgot to go back and sign the count sheet. She stated she knows that she should sign the count sheet immediately after the count but sometime time you get interrupted LVN P stated this failure could potentially cause a drug diversion. Interview on 06/10/25 at 8:56 AM, the DON stated he expected nurses to sign the narcotic count sheet at the beginning and at the end of their shift after they completed count with the incoming and off-going nurse. The DON stated if the staff was not signing the narcotic count sheets, he was unable to prove they were counting. The DON stated it was important to ensure a drug diversion did not occur. The DON stated the ADONs would daily check the cart on the weekdays and the weekend supervisor during the weekends for monitoring. Review of the facility's policy Receiving Controlled Substances dated September 2018, did not address the concerns.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that the medication error rate was not 5% or greater. The facility had a medication error rate of 8 %, based on 2 errors of 25 opportunities, which involved one of five residents (Residents #74) and one of four staff (MA L) reviewed for medication errors, in that: The facility failed to ensure: MA L instructed Resident #74 to chew Aspirin low dose chewable and to place the sublingual (a pharmacological route where medication were placed under the tongue to dissolve and be absorbed directly into the bloodstream) buprenorphine under her tongue when administering medications. These failures could place residents at risk for not receiving therapeutic effects of their medications. The findings include: A record review of Resident #74's Quarterly MDS assessment, dated 05/07/25, reflected a [AGE] year-old female with an admission date of 11/15/24. She had a BIMS score of 10, which indicated her cognition was moderately impaired. Diagnoses included chronic embolism (long-term presence of blood clots), chronic kidney disease, and muscle weakness. A record review of Resident #74's medication administration records dated 05/09/25 reflected Resident #74 was to receive the following medications: Aspirin Low Dose Oral Tablet Chewable 81 MG (Aspirin) Give 1 tablet by mouth one time a day for pain -Order Date05/06/2025 Buprenorphine HCl-Naloxone HCl Sublingual Film 8-2 MG (Buprenorphine HCl-Naloxone HCl Dihydrate) Give 1 tablet sublingually one time a day for narcotic dependence. -Order Date05/06/2025 During a medication pass observation on 06/09/25 at 07:47 a.m., MA L administered the following medications to Resident #74: - Vitamin C 500 mg x 1 tablet - Aspirin 81 mg x 1 tablet- chewable (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Eliquis 5 mg x 1 tablet - Methocarbamol 500 mg x 2 tablets - Multi-vitamin x 1 tablet - Zinc 50 mg x 1 tablet - Vitamin B1 x 1 tablet - Bupren-Naloxone 8mg - 2mg sl (sublingual) x 1 tablet - Pregabalin 75 mg cap x 1 tablet. In an interview with MA L on 06/09/25 11:06 AM, verified what medications was administered to Resident # 74 on 06/09/25 and stated she missed read that the Aspirin was chewable, and the Buprenorphine was sublingu al. She stated the medication must be given as ordered by the physician. In an interview with the DON on 06/10/25 at 08:56 AM, he stated he expected the staff to follow the 5 rights of medication administration which are right drug, right dose, right route, right patient, and right time. He stated failing to follow these rights put residents at risk of not receiving all their medications or could lead to drug interactions if the correct medication or dosage was not given. He stated the MAs should always go to the Charge nurse, the ADON or himself if there were any question about a medication and they should clarify with the physician any order for the chewable medication to change it to regular medication if resident can swallow medications. Record review of the facility policy titled Medications-Administration, not dated, reflected, .Nursing staff will keep in mind the seven rights of medication when administering medication: A. the right medication, B. the right amount, C. the right resident, D. the right time, E. the right route, F. right indication, G. right outcome . The Rule of 3 - the licensed nurse administering medication will perform 3 checks comparing the physician's order, pharmacy label, and medication administration record .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 (100/200 hall nurses cart) of 3 medication nurse cart reviewed for pharmacy services in that: The facility failed to ensure: 1. LVN K responsible for the 100/200 hall nurses cart , removed medications in unsecure containers from the Nurses Cart. 2. The 100/200 hall nurses cart did not have 1 insulin pen for Resident #19 with no open date. Observation of the pen reflected it was used. These failures could affect residents resulting in diminished effectiveness, and not receiving the therapeutic benefits of the medications, and place residents at risk of not having the medication available due to possible drug diversion. The findings included: Record review and observation on 06/08/25 at 09:53 AM, of Nurses Cart Hall 100/200, with LVN K revealed: - The blister pack for Resident #3's tramadol 50 mg tablet (controlled medication used for pain) had 1 blister seal broken and the pill still inside the broken blister. - The pen of insulin lantus 100 unit/ml for Resident #19 with no open date. Observation of the pen reflected it was used. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/08/25 at 1:19 PM, LVN K stated the count was done at shift change and the count was correct. She stated she did not check the blister packs during the count. She stated she was unaware when the blister pack seal was broken, and she was not aware of who might have damaged the blister. She stated the risk would be a potential for drug diversion. She stated the nurses and med aides were responsible to check the medication blister packs for broken seals during the count of narcotics during the change of the shift. She stated when a broken seal was observed, she would waist the pill with another nurse. LVN K stated she gave insulin to Resident #19 in the morning at 7:00 AM and she did not check the pen for the open date. LVN K stated the purpose of putting an open date was for expiration purposes because the insulin was only good for 28 days. She stated after 28 days the insulin would be ineffective. Interview on 06/10/25 at 8:56 AM, the DON stated he expected if a blister pack medication seal was broken the pill should be discarded. The DON stated it would not be acceptable to keep a pill in a blister pack that was opened. The DON stated the risk would be potential for drug diversion and infection control issue. He stated nurses was responsible for checking the medication blister packs for broken seals during the count on the change of shifts. The DON stated the ADONs were supposed to check the carts daily. The DON stated the insulin flex pens and vial, once opened, needed to be dated because each insulin pen and vial had a specific day's shelf life and if not thrown out by that time the insulin could lose its effectiveness. The DON stated the pharmacy consultant checked the carts monthly and he stated ADONs were supposed to do random checks of the medication carts for monitoring. Record review of the facility's policy titled Storage of Medications, dated September 2018, revealed in part . Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal, and reordered from the pharmacy . Certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmics, nitroglycerin tablets, and blood sugar testing solutions and strips require an expiration date shorter than the manufacturer's expiration date once opened to ensure medication purity and potency . The nurse shall place a date opened sticker on the medication and record the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days from opening .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen reviewed for food and nutrition services. 1. The facility failed to ensure food items were properly stored in the facility kitchen on 06/08/25. 2. The facility failed to ensure [NAME] A performed adequate hand hygiene while preparing lunch meal on 06/09/25. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination. Findings included: Observation on 6/8/25 at 9:30 AM revealed a scoop in the bulk oatmeal bin in the dry storage area. Observation on 6/8/25 at 9:33 AM in the facility refrigerator revealed a zip top bag had about 6-7 cut strawberries, 1 lemon, and about 10-12 grapes in it without a date and label. Observation on 6/9/25 at 11:34 AM in the kitchen prep area revealed [NAME] A was making pureed food. [NAME] A did not wear any gloves. [NAME] A took out the pureed food from the blender in a serving container. She silenced a cell phone that was placed near the prep area. She then went to the sink area, rinsed the blender jar. She did not perform hand hygiene after returning back from the dish washing area to the food prep area. At the prep area, she added some of the cooked sweet potato casserole in the same blender jar and continued to make pureed casserole. After the pureed casserole was made, she got a dirty dish cloth from the side of the counter and proceeded to wipe off the counter with the dirty dish cloth. [NAME] A then proceeded to don gloves without washing her hands. After donning the gloves, she emptied the pureed casserole into a near-by serving container. She removed her gloves, did not wash hands, made a ball of the gloves, held it in the palm of her hands and proceeded to move some of the clean and sanitized plate covers to the serving area. In an interview on 06/09/25 01:19 PM, Dietary Aide B revealed all food items in the kitchen should be covered, labeled, and dated. She stated that all food items should have had use by date on them. She stated scoops should not be placed in bulk containers. She stated that everyone in the kitchen including dietary aides, cooks, and managers were responsible for appropriate food storage. She added that the risk to residents of not appropriately dating and labeling food items was residents could get sick. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/09/25 at 01:28 PM, [NAME] A revealed everyone in the kitchen, including cooks, dietary aides, and the Dietary Manager, was responsible for labeling and dating food items in the kitchen. She added that she was not aware who kept the fruit in the refrigerator. However, all items in the refrigerator should have been labeled and have use by date on them. She added that a dietary aide had used the oats for dessert and may have forgotten to put the scoop back in its place. She stated the scoop should not be placed in bulk containers for risk of food contamination. She added she was aware that hand hygiene was very important after moving from one task to other in the kitchen. She added she knew to wash hands with soap and water after moving from the prep area to the dishwasher area and back. She stated she was a little flustered in the kitchen since a surveyor was in the kitchen to observe meal service on 6/9/25. She stated risk of improper food storage or improper hand hygiene in the kitchen could lead to food spoilage and increased risk of residents being sick. An interview on 06/09/25 at 02:40 PM with the Regional Dietitian revealed that the facility's Dietary Manager was on leave and was not available for an interview. She added that she had been the Regional Dietitian for 6 months in the facility. She stated her expectation was that all food items should be covered, labeled, and dated. She also stated the scoop should not be stored in bulk container food. She stated she expected all kitchen staff to follow adequate hand hygiene which included washing hands with soap and water before and after changing kitchen tasks, and especially after moving from food prep to dishwashing area. She added the risk of improper food storage and inadequate hand hygiene could lead to cross contamination and the possible risk of food borne illness in residents. Review of the facility's policy titled Food Labelling and Dating revised 01/25/2025 reflected, .Food items will be labeled, dated, stored, thawed in accordance with good sanitary practice .VII. Any food items prepared for a meal that were not served may be retained to use later and are leftovers. Leftovers are placed in an airtight container or Ziplock bag and will be labeled with the leftover product name, date prepared, and discard date. Leftovers must be used by or discarded within 3 days of the preparation date. Review of the facility's policy titled Hand Hygiene revised 06/2020 reflected, Purpose: To ensure that all individuals use appropriate hand hygiene while at the Facility. Policy: The Facility considers hand hygiene the primary means to prevent the spread of infections Facility Staff and volunteers must perform hand hygiene procedures in the following circumstances including but not limited too . A. Wash hands with soap and water .vi. Before and after food preparation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676270	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brentwood Place Four	3505 S Buckner Blvd Bldg 5 Dallas, TX 75227

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Food and Drug Administration Food Code, dated 2022, reflected, . Food Storage.(B) . refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety 3-304.12 In-Use Utensils, Between-Use Storage. During pauses in Food preparation or dispensing, Food preparation and dispensing utensils shall be stored: (A) Except as specified under (B) of this section, in the food with their handles above the top of the food and the container; (B) In food that is not time/temperature control for safety food with their handles above the top of the food within containers or equipment that can be closed, such as bins of sugar, flour, or cinnamon .2-301.11 Clean Condition. The hands are particularly important in transmitting foodborne pathogens. Food employees with dirty hands and/or fingernails may contaminate the food being prepared. Therefore, any activity which may contaminate the hands must be followed by thorough handwashing in accordance with the procedures outlined in the Code . 2-301.12 Cleaning Procedure. Handwashing is a critical factor in reducing fecal-oral pathogens that can be transmitted from hands to food as well as other pathogens that can be transmitted from environmental sources.