STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675906	A. Building B. Wing	02/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benbrook Nursing & Rehabilitation Center	1000 McKinley St Benbrook, TX 76126

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48520 Based on observations, interviews, and records review, the facility failed to ensure a resident did not develop pressure ulcers/injuries (PU/PIs) unless clinically unavoidable and that the facility provided care and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new pressure ulcers/injuries from developing for 1 (Resident #1) of 7 residents reviewed for pressure ulcers/injuries. 1.The facility failed to perform complete and accurate skin assessments for Resident #1, following LVN A's skin assessment on 11/06/24 which revealed moisture associated skin damage to Resident #1's buttocks. These failures placed residents with pressure wounds at an unnecessary risk of complications such as pain, acquiring new wounds, worsening of existing wounds, and infection. Findings included: Review of Resident #1's face sheet on 02/08/24 revealed an [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included Hemiplegia and hemiparesis following cerebral infraction affecting left non dominant side (this is paralysis and weakness that affects one side of the body after a stroke), Chronic Obstructive Pulmonary Disease (this is a lung disease that blocks airflow and makes it difficult to breathe), neuromuscular dysfunction of the bladder (this is a condition where the nerves controlling the bladder function are damaged leading to problems with urine storage) , kidney stones, paroxysmal atrial fibrillation (an irregular heart rhythm), muscle weakness, and lack of coordination. Review of Resident #1's discharge MDS dated [DATE] revealed Resident #1 required substantial/maximal help assist-helper does more than half the effort: Helper lifts or holds trunk or limbs and provides more than half the effort to eat, to complete ADL's, to sit and stand, and to transfer. Further MDS revealed Resident #1 required partial assistance-helper does less than half the effort. Helper lifts, holds, or supports trunk and limbs, but provides less than half the effort for rolling left to right to roll from lying on back to left to right and return to lying on her back while in the bed. MDS also revealed Resident #1 required a manual wheelchair and was occasionally incontinent and had an indwelling catheter for urine. MDS did not reflect BIMS score for cognitive. Further review of Resident #1's Discharge MDS Assessment indicated Resident #1 did not have one or more unhealed pressure ulcers/injuries. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's care plan initiated on 09/26/24 revealed Resident #1 had limited physical mobility related to muscle weakness. The goal was for Resident #1 to remain free of complications related to immobility, including contractures, thrombus (blood clots), skin breakdown, fall related injury through the target date 01/09/25. The interventions were PT, OT referrals as ordered, PRN. Further care plan revealed Resident #1 had actual impaired skin integrity to the left hip related to discoloration initiated on 11/25/24. The goal was for Resident #1 to maintain or develop clean and intact skin by the review date. The interventions were to follow facility protocols for treatment of injury, to monitor/document location and treatment of skin injury, to report abnormalities, failure to heal, s/sx of infection, maceration (softening of skin) etc to MD. Review of Resident #1's November 2024 physician orders reflected apply skin prep to left hip discoloration and cover with foam dressing daily and as needed, order started on 11/25/24. The orders did not reflect pressure preventing measures such as air loss mattress or skin prep for the buttocks and sacral areas. Review of hospital records dated 09/18/24 to 09/20/24, noted Resident #1 had impaired functional mobility with altered mental status and a recent Urinary tract infection. Resident #1 was noted as having no wounds, incisions, or pressure ulcers. Review of Resident #1's weekly skin assessment dated [DATE] entered at 04:12 PM by LVN A reflected: Sacrum Redness (tail bone area). Left and Right hand bruising. Skin intact with a few areas to monitor. Review of Resident #1's weekly skin assessment dated [DATE] - 11/06/24 revealed no concerns with skin. Review of Resident #1's weekly skin assessment dated [DATE] entered at 09:39 AM by LVN A reflected: MASD (Moisture Associated Skin Damage) noted to resident buttocks; no open areas noted; new leg strap applied to resident right thigh; order received for triad paste application and was applied at the time of assessment. Review of Resident #1's weekly skin assessment dated [DATE] - 11/20/24 revealed no concerns with skin. Review of Resident #1's weekly skin assessment dated [DATE] entered at 11:08 AM by LVN A reflected: No new skin conditions at this time; discoloration continues to resident right hip and both hands. Skin assessment did not reflect the skin assessment of the buttocks nor the sacral areas. Review of Resident #1's nursing progress note dated 12/02/24 entered at 3:07 PM by LVN B reflected: Resident sent out to [Hospital name] for evaluation for failure to thrive per MD. Resident is observed fragile, weak, not eating for 3 days. Spo2 92% (oxygen), afebrile (no fever), pulse 98. Resident reports zero pain or discomfort. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's hospital record dated 12/02/24 revealed Resident #1 arrived at the hospital from the facility on 12/02/24 around 1:00 PM. The hospital ED provider diagnosed Resident #1 with a Decubitus ulcer of the back, stage 2, Pressure injury of deep tissue of left hip, left thigh, and sacral region (the tail bone). The hospital took pictures of the wounds on the left hip, left thigh, sacrum, and left shoulder . Review of hospital pictures dated 12/02/24 revealed pictures of wounds on the left shoulder with three purple and red (bruise color) spots on the shoulder blade, one unshaped dark purple area with some skin missing on the left hip, a dark purple area near Resident#1's groin area left side, a purple and scabbed area near the left inner thigh, and irregular shaped open area with purple and red of the tail bone area. In a phone interview with Resident #1's family on 02/07/25 at 2:25 PM, revealed Resident #1 had passed away on 12/06/24 after being placed on in hospital hospice. Resident #1's family stated Resident #1 lived with her prior to going to the facility for rehabilitation. She stated Resident 1 had a suprapubic catheter (this is a tube inserted directly into the bladder via the lower abdomen) before going to the facility due to some bladder complications. She stated Resident #1's catheter was changed to foley catheter (this is inserted in the bladder via the urethra) at the hospital. She stated Resident #1 had no wounds before going to the facility. She stated when she was notified that Resident #1 was sent to the hospital, she went to be with Resident #1. Resident #1's family stated she did not see Resident #1 while she was at the facility, and she was shocked and could not believe the condition of Resident #1 skinny and dehydrated. She stated when she saw Resident #1 skin at the hospital, I could not believe, they neglected her Resident #1's family stated she took some pictures of the wounds. In an interview and observation with CNA H and CNA I on 02/08/25 at 10:01 AM, they both stated they had not taken care of Resident #1. They stated shower sheets had pictures where they could mark off any skin conditions and the nurse would sign off the shower sheet. They both stated it was important to inspect residents' skin so that wounds did not get worse, and areas could be treated immediately. In an interview with CNA H on 02/08/25 at 12:07 PM, she stated she did not take care of Resident #1. She stated she had been employed at the facility for one month. She stated she was trained to report all skin change to the nurse. She stated that she documented on the shower sheets if there were any skin issues, and the nurse would sign off the shower sheet. She stated it was important to inspect residents' skin so that wounds did not get worse, and areas could be treated timely. Interview with LVN C on 02/08/25 at 1:00 PM, revealed LVN C stated she did wound care and skin assessments when she worked as the floor nurse. After seeing Resident #1's hospital wound pictures, she would have immediately let the physician know, got an air mattress, wound physician consultation, dietary consult, make sure wounds were covered, and repositing resident every two hours. She stated the process was for the admission nurse to complete a skin assessment on admission, then the wound care nurse would follow up and do another skin assessment, then if any skin concerns came up, a wound care nurse would obtain wound care consult. She stated all these interventions were put in place because a resident had a right to not have pressure ulcers if they could be avoided. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN F on 02/08/25 at 1:30 PM, revealed he had worked with Resident #1 on 11/19/24. He stated he did not do a skin assessment on Resident #1 because the task did not fall on his shift. He stated Resident #1 had been having issues with constipation and that was his focus and asked in report to follow up. He stated on the day that he worked with Resident #1, she did not have a bowel movement and he was not sure if the CNA gave the resident a shower or bed bath. He stated the expectation was that the CNAs would report to him any skin conditions or any changes they noticed to him as the nurse. He stated had he seen any wounds on Resident #1 he would have referred her to the wound care nurse. He stated it was both the nurses and the CNAs responsibility to report and to check the resident's skin when providing care. LVN F stated he did not complete a general skin assessment. He did not say why he did not complete it for a resident that had a wound. He sated he did not know that Resident #1 had any skin wounds or skin concerns. In an interview with the DON on 02/08/25 at 2:00 PM she stated she was very confident in LVN A's skin assessment. The DON stated LVN A, who was the facility wound care nurse, completed thorough skin assessments. The DON stated if LVN A had seen any decubitus ulcers on a resident, she would have freaked out and let her know and put in place measures to prevent further skin injuries. The DON stated CNA G checked Resident #1's skin on 12/01/24 and she did not report any concerns per documentation in [electronic medical Record]. The DON stated LVN A did a weekly skin assessment of head to toe on Resident #1 on 11/29/24 and there was no report of DTI except for the left hip bruising which they had in place, interventions for it. The DON stated she could not find the wound care list for October and November 2024 to show that Resident #1 had been seen by the facility wound care physician for the hip and hand bruising. She stated Resident #1 was scheduled to be seen by the wound care physician for the left hip however Resident #1 was not seen because she went out to an appointment for her catheter . The DON did not provide wound care list with Resident #1 on it. The DON stated the expectation was that skin assessment was done on admission, during showers and weekly by the wound care nurse. DON stated the nurses will notify the resident's attending physician or physician on call when there has been a new skin observation to obtain treatment and the CNA will verbally inform the Charge nurse, and Nurses will document skin issues in EMR, and CNA's will document new skin issues or injuries in EMR. In an interview with the Administrator on 02/08/25 at 4:15 PM, he stated the expectation was that skin assessments were completed weekly and as needed, nutrition consulted, wound consult, and treatments to be completed as ordered. He stated the wounds might have happened in the hospital because the hospital is more focused on breathing and not of the skin and it was likely that Resident #1 was not turned while she was in the emergency room . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN A on 02/08/25 at 6:00 PM, she stated she did not see any pressure injury to Resident #1's buttocks . She stated she only saw the left hip bruise and she put measures in place to clean, apply wound paste and to cover the area because Resident #1 was slender and needed padding to boney hip area. LVN A stated, if I put all these interventions for her hip, I would have put more for her sacrum had I seen any issues. LVN A stated a resident with impaired skin would have to be seen by the wound care doctor, they would have a special mattress (depending on movement), vitamins and supplements including protein would be ordered for the residents. She stated the resident would be repositioned every two hours to offload off the area with skin breakdown. She stated Resident #1 was on the list to be seen by the wound doctor on 11/26/24 however, when he came to the facility Resident #1 was not seen because she was out for her catheter, and she missed wound care appointment. She stated Resident #1 was on the list to be seen the following week (12/05/24). LVN A stated Resident #1's skin was intact when she did a skin assessment on 11/29/24. She stated the only area of concern was the left hip. LVN A stated the facility only did weekly skin assessments and if the CNA or nurse noticed something new, they would let her know. LVN A stated the reason Resident #1 had not been seen by the wound care doctor before was because all the skin concerns had resolved. She stated it was important to check residents' skin to make sure no new issues or the wounds did not get worse. She stated the resident had a right to be free from pressure ulcers if they can be avoided. LVN A did not provide wound care list with Resident #1 on the list for September 2024, October 2024, and November 2024, she stated all documents had been given to medical records. During a phone interview with CNA G on 02/10/24 at 10:58 AM, she stated she had worked with Resident #1 on 12/01/24 a double shift from 6 AM to 10 PM and she did not see any skin issues for Resident #1. CNA G stated she did not see the bruise on Resident #1 left hip. CNA G stated she repositioned Resident #1 every two hours and checked her for bowel movement however there was nowhere to document on [Electronic medical record]. CNA G stated she did not give Resident #1 a bed bath on that day because the facility did not do baths on Sundays. She stated she had been in-serviced in the past about skin and what to look out for and report to the nurse. She stated repositioning and checking the skin was important to prevent bed sores . Phone interview attempted with physician on 02/10/25 at 11:20 AM, voicemail left to return phone call. No call returned. In a phone interview with Resident #1's primary doctor on 02/17/25 at 2:35 PM, he stated any residents that had skin conditions and wounds were referred to wound care specialist that the facility used. He stated the facility also had a wound care nurse who followed all wound care related issues. He stated if a resident was seen by the wound Care team, and the resident was on a special diet with protein and vitamins and wound treatments and the resident's wound/s were not getting better that wound would be considered unavoidable. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview with the Wound Care doctor on 02/17/25 at 3:47 PM, revealed he had not seen Resident #1 since she admitted to the facility [09/23/24]. He stated he normally went to the facility on Thursdays to do wound care rounds and treatments however, being thanksgiving holiday week, he went to the facility on a Tuesday 11/26/24 and missed seeing Resident #1 because she was out of the facility. He stated Resident #1 was on his schedule to be seen that week. The wound care physician stated he worked with the facility wound care nurse [LVN A] during his wound care rounds. The wound care physician stated a DTI can happen in a matter of hours depending on what was going on with the patient health wise. He stated the first therapeutic treatment is to keep off the area that is starting to have concerns. He stated unaviodable wounds happened at times because the patient was not compliant [not following] with the treatment put in place to reduce and prevent wounds. He stated an example was a diabetic with an A1C of 12 and they did not want to change their diet and wanted to smoke, or a patient was put on an air mattress, but the family wanted a sheet on the mattress with having the sheet covering the mattress prevented the purpose of an air mattress to help prevent pressure ulcers by air circulation. He stated all you can do is document all the treatments in place . The wound care doctor stated without him seeing the wounds it was hard to determine the severity of Resident #1's wounds. Review of facility Wound Care skin and wound management policy and procedure provided by the facility, revised 10/2010 reflected Verify that there is a physician order Review the residents care plan to assess for any special needs for the resident . Review of the facility's Prevention of Pressure Injuries policy and procedure provided by the facility, revised 04/2020 reflected . read in part The purpose is to provide information regarding identification of pressure ulcer/injury risk factors and interventions .conduct a comprehensive skin assessment upon admission . according to resident risk factors, and prior to discharge .during assessment inspect: presence of erythema (redness), .inspect pressure points sacrum, heel, buttocks, coccyx, elbows, ischium, trochanter, etc, . moisturize dry skin daily, Reposition the resident as indicated on the care plan, Choose a frequency for repositioning based on the residents risk factor and current clinical practice guidelines, teach residents who could turn Independently the importance of repositioning for prevention measures associated with specific devices, consult current clinical practice guidelines Evaluate, Report and Document potential changes in skin Review the interventions and strategies for effectiveness on an ONGOING Basis .