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	03/12/2025

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43843 50445 Based on observation, interview, and record review, the facility failed to ensure a safe, clean, comfortable, and homelike environment was provided for 3 of 4 (Resident #1, #2, and #3) shared resident bathrooms and for 1 of 3 (Resident #10) residents rooms reviewed for environmental conditions. 1. The shared bathroom for Residents #1, #2, and #3 had dark brown dried substances on the toilet, the floor, and the wall. 2. Resident #10's room featured a blanket covering the air condition window unit and a towel placed on the base of the windowsill. Additionally, there were two openings in the wall behind the unoccupied bed B in the same room. These failures could affect residents and place them at risk of feeling uncomfortable as a result of living in an unclean and unsanitary environment and living in a room that showed signs of poor maintenance. Findings included: Review of Resident #1's MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted on [DATE]. She had a BIMS score of three indicating severe cognitive impairment. Review of Resident #2's Face Sheet reflected the resident was a [AGE] year-old female admitted on [DATE]. Review of facility electronic medical records noted no care plan or MDS were available for this newly admitted resident. Review of Resident #3's MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted on [DATE]. She had a BIMS score of 11 indicating moderate cognitive impairment. Record Review of Resident #10's Admission Record revealed, a [AGE] year-old male admitted to the facility on [DATE] with a primary diagnosis of Dysphagia, oropharyngeal (swallowing disorder that makes it difficult to move food from the mouth to the throat). (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #10's Care Plan, initiated date 06/06/2024, revealed, Focus: The resident has an ADL self-care performance deficit related to limited Mobility. Interventions: Upper body dressing: (partial/limited assist x1), Lower body dressing: (partial/limited assist x 1), and personal hygiene: (Set -up). Record Review of Resident #10's MDS Nursing Home Quarterly, dated 01/23/2025, revealed, Resident #10's BIMS score of 13 indicating the resident's cognition is intact. Residents #1, #2, and #3 were not interviewable due to cognitive impairment. In an observation and interview on 3/11/25 at 8:48 am, the shared restroom adjoining Resident #1's, #2's, and #3's rooms was observed. The restroom door frame was observed with multiple brown fingerprint smears. The floor throughout the bathroom had small brown droppings on the floor as well as small dirty pieces of white tissue and brown paper towel. Dirty footprints were observed across the tile. There was a dried brown stain trailing down the side of the commode. There was a dried brown substance pooled at the base of the commode. There was a ping-pong ball sized ball of brown substance stuck to the bathroom wall. The DON came by the room and confirmed these things appeared to be feces. She stated she would notify maintenance and have it cleaned immediately. In an interview on 03/11/25 at 04:14 pm, the DON stated that regarding the feces noted in Resident #1's, #2's, and #3's bathroom this morning, she would have expected that staff would have cleaned this immediately when it was noted, and that housekeeping would have then sanitized the area. She stated that all staff were responsible for this cleaning. She stated that housekeeping went through each room and each bathroom and did routine cleaning every day. She stated that a resident might feel, some concerns about their bathroom being in that condition. In an interview on 03/12/25 at 11:32 am, Housekeeper A stated, I apologize for yesterday. I did not know that the BM was on the wall. I should have known. He stated it had been an oversight that he had not seen that restroom on 3/10/25 when he made rounds. He stated that staff would typically call housekeeping to sanitize resident rooms after the staff had picked up the bulk. He stated that CNAs had access to cleaning supplies and can get them from him for this as well. He stated he had not been notified of the condition of the bathroom for Residents #1, #2, and #3. He stated the risk to a resident is, They could eat it and make them sick. It could cause intestinal issues. I guess it could cause infection. He stated that as a supervisor he would monitor the work of other housekeepers. He stated he went back, looked at other housekeeper's work, made corrections, and let them know. He also stated he provided training to other housekeepers. In an interview on 03/12/25 at 03:19 pm, the ADM stated he expected all staff to make rounds and immediately clean up any messes in the environment throughout the day and/or notify housekeeping. He stated all managers conducted morning rounds and checked all the residents and rooms in the mornings. He stated it sounded like he needed to make sure managers were checking all the bathrooms. Observation on 03/11/2025 at 12:00 pm and 03/12/2025 at 12:10 PM of Resident #10's room revealed, an air-condition wall unit in residents' room was covered with a personal blanket. The unit had been disconnected from the electrical outlet. Positioned above the wall unit was a window, with a rolled-up towel visible at the base of the windowsill. On the wall adjacent to the air conditioning unit the wall exhibited two openings, the first opening measured 1 foot in height by 4 inches in width, while the second opening measured 8 inches in width by 3 inches in height. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/11/2025 at 12:00 pm, Resident #10 stated he covered the air condition unit to keep the wind from blowing into the room and the towel on the windowsill to restrict outside air from blowing into the room causing the room temperature to become cold. He stated it has been covered for more than a few weeks. He stated he does not have a roommate but the opening in the wall has been there since his last roommate; he {former roommate} would push the bed into the wall. Interview on 03/12/2025 at 12:10 pm with the Maintenance Director revealed, the air condition unit has been nonoperational for about a week or two. He stated because the unit does not work it pulls outside air into the room. He stated the blankets are there to mitigate the air loss and maintain the current room temperature. He stated that the openings in the wall behind Bed B were dents. He stated that it was two to three weeks ago that he became aware of the maintenance concerns in Resident #10's room. He stated the previous maintenance guy was a quick fix guy and he would do things in a quick fix way. He stated that there was an order for repair in the facility maintenance system. He exited the room to obtain a measuring tape for accurate measure of the wall openings. When he returned to the room, he stated there was no longer an entry in the maintenance repair system for the openings in the wall or repair of the air-condition unit. He stated there was not a risk to the resident because the unit was covered; there is a risk to the resident for the opening in the wall as it could become a hiding place. Re-interview on 03/12/2025 at 12:15 pm with Resident #10 revealed he feels that the facility does not care because they knew the room was in this condition and failed to repair it in a timely manner. He stated that they half do things. Interview on 03/12/2025 at 3:13 PM with the Administrator revealed each manager is given 4-5 rooms to monitor daily as an ambassador for upkeep and cleanliness and report back. If there is an issue or concern with a resident's room, then it is reported on the maintenance online system for repair. He stated that they have to want to look in the rooms to see if there is a concern. The risk is that residents have rooms that are not homelike and that is one of their rights. Record Review of Work Orders for the facility dated January 1, 2025-March 11, 2025, revealed no order for Resident #10's room repairs. Review of facility policy revised December 2016 and titled, Resident Rights stated that, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45507 Based on interview and record review, the facility failed to ensure the right to be free from misappropriation of resident property for 1 of 1 (Resident #4) resident reviewed for misappropriation of property. The facility failed to ensure CNA B did not take Resident #4's debit card to buy the resident items and for CNA B's personal use. The noncompliance was identified as PNC. The noncompliance began on 11/20/2024 and ended on 12/04/2024. The facility had corrected the noncompliance before the survey began. This failure could place residents at risk exploitation and misappropriation of property. Findings included: Record review of Resident #4's Admission Record, dated 12/9/2024, revealed a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Chronic obstructive pulmonary disease (a lung disease that blocks airflow and makes it difficult to breathe), major depressive disorder, and anxiety. Record review of Resident #4's Quarterly MDS dated [DATE] revealed a BIMS score of 11, indicating moderate cognitive impairment. Record review of Resident #4's care plan, dated 09/09/2024, revealed Resident #4 was an elopement risk r/t history of attempts to leave the facility unattended and will reside on the secure unit for safety. Record review of the PIR, dated 12/10/2024, revealed At approximately 11:15 am on 12/4 Administrator was notified that [Resident #4's family member] called the police stating that she believed CNA [Name] had used [Resident #4's] debit card for unauthorized transactions. Further review of the PIR revealed .Police recovered missing card from CNA [Name]. Card returned to [Resident Name] by police. [CNA Name] suspended pending investigation . [Resident #4's family member] provided bank statements detailing alleged unauthorized transactions on 12/4. Facility provided [Resident #4's family member] a check in the amount of the unauthorized charges, $1009.82, and assisted with depositing the check in to [Resident #4's] bank account on 12/4. Employee file of [CNA B] reviewed and shows no related disciplinary actions or concerns on CNA Abuse/Exploitation registry. [CNA B's Name] terminated . Record review of undated handwritten statement revealed [Resident #4's Name] ask me to go to the store her [sic] a few times to do some shopping with [Resident #4] gave permission to use the card to get her things like cigarettes clothes shoes gas she gave me the pin number to the bank card. Written by [CNA B] Witnessed by [Administrator]. Review of screenshots Administrator received from Resident #4's family member of Resident #4's checking account revealed the following transaction details: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11/20/2024 for $35.07 [gas station Name] -11/21/2024 for $56.25 [gas station Name] -11/22/2024 for $56.72 [grocery store and supermarket Name] -11/29/2024 for $37.16 [gas station Name] -11/29/2024 for $65.42 [grocery store and supermarket Name] -12/02/2024 for $14.02 [grocery store and supermarket Name] -12/03/2024 for $85.18 [grocery store and supermarket Name] -11/21/2024 for $60.00 ATM withdrawal -11/29/2024 for $200.00 ATM withdrawal -11/30/2024 for $400.00 ATM withdrawal In an interview on 03/11/2025 at 2:30 PM, Resident #4 stated no one had taken her money or bank card from her. Attempted interview on 03/11/2025 at 3:04 PM with CNA B was unsuccessful as phone number was no longer in service. In an interview on 03/11/2025 at 4:25 PM, the Administrator stated Resident #4's family member notified him of suspicious activity on Resident #4's account. He stated the family member said there was only one debit card. He said CNA B admitted she took the debit card and bought things for the resident and herself. He stated when the police arrived at the facility, CNA B had Resident #4's debit card in her pocket before handing it over to the police. The Administrator stated he was not able to verify which of the requested items were purchased and delivered to Resident #4, and CNA B did not tell him which items were for herself. He said when the family member presented the bank statements, anything that looked inappropriate or suspicious from the date of when the fraudulent activity started, the facility replaced. He stated CNA duties did not include doing errands or shopping for Residents. In an interview on 03/12/2025 at 1:56 PM, CNA C stated she was in serviced after the incident. She stated she was to never take anything from a resident at all no matter what it was. She stated if a resident wanted to give her something, she would not accept it and let the Administrator know. CNA C stated it was a form of abuse and resident items could be misplaced or misused. In an interview on 03/12/2025 at 2:11 PM, CNA D stated she was in-serviced regularly on abuse. CNA D stated she was not supposed to accept money to go buy items requested by residents because anything could happen, it could be misconstrued, lost or she could be accused, and she did not want to be responsible. She stated the right person should take the responsibility, and said it was usually the Activity Director. CNA D stated taking and using a resident's debit card or money could be considered abuse. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/12/2025 at 3:00 PM, the DON stated her expectation was staff does not take anything from residents, not even to go to the vending machine. She said if residents requested items be purchased, staff should go to the department heads. She stated not following the policy could place residents at risk of getting money or belongings stolen. In an interview on 03/12/2025 at 3:14 PM, the Administrator stated his expectation was staff report misappropriation to him immediately. He stated all staff were in-serviced and it was already part of the new hire packet. He stated the risk to residents was financial burden. Record review of the facility policy titled Identifying Exploitation, Theft and Misappropriation of Resident Property revised April 2021 revealed: 1. Exploitation, theft and misappropriation of resident property are strictly prohibited. 2. It is understood by the leadership in this facility that preventing these occurrences requires staff education and training . 4. 'Misappropriation of resident property' means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. 5. Examples of misappropriation of resident property include: .b. theft of money from bank accounts; c. unauthorized or coerced purchases on the resident's credit card .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 45507 Based on observation and interview, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for 1 of 5 residents (Resident #5) reviewed for ADLs. The facility failed to ensure Resident #5's nails were trimmed, and beard shaved. These failures could place residents at risk of infection and a decreased quality of life. Findings included: Record review of Resident #5's Admission Record, dated 03/12/2025, revealed a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included osteoarthritis of knee, depression and anxiety. Record review of Resident #5's Quarterly MDS, dated [DATE], revealed a BIMS score of 13, indicating intact cognition. Further review revealed Resident #5 required substantial/maximal assistance with showering and personal hygiene. Record review of ADL sheet, dated 02/11/25 through 03/12/25 revealed Resident #5 had showers on 02/14/25, 02/28/25, 03/04/25, and 03/08/25, and refused on 02/11/25, 02/18/25, 03/03/25, and 03/11/25. In an observation and interview on 03/11/2025 at 11:41 AM, Resident #5 was lying in bed, had a beard and appeared to have food crumbs on his shirt. Resident #5's fingernails appeared un-trimmed and had a yellow-brownish substance underneath and around his nails and on his fingers. Resident #5 stated he would like to be shaved and has not had his nails cut. Resident #5 was not able to straighten all fingers completely. Resident #5 stated he gets a shower every once in a while, and his last shower was a few days ago. In an interview on 03/12/2025 at 1:46 PM, CNA C stated CNAs were responsible to give showers if there was not a shower aide. She said if a resident was not diabetic, CNAs were responsible to do nail care. She said Resident #5 would agree to showers, but most of the time refused. CNA C stated if Resident #5 refused care, and his family member was there, the family member could talk Resident #5 into taking a shower. When asked if she shaved Resident #5's beard, she said Resident #5 says not to touch his beard or his hair. She stated if nails were not trimmed, they could be long underneath and get dirty or scratch themselves. In an interview on 03/12/2025 at 3:00 PM, the DON stated CNAs were responsible for ADL care including showers and nail care. She stated if a resident refused, the CNA should attempt again and notify the charge nurse. She stated the risk for ADL care not being done was hygiene concerns and residents feeling not well kept. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/12/2025 at 3:14 PM, the Administrator stated direct care staff was responsible for ADL care and he expected that ADL care was offered and done to the best of their ability. He stated residents do have the right to refuse care and they were supposed to reengage and reattempt if they did refuse. Facility did not provide ADL policy. A second request for the facility ADL policy was sent to the Administrator and DON on 03/19/2025 at 7:00 AM and no policy was provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43843 45507 Based on observation, interview and record review the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 4 of 4 Residents (Resident #6, Resident #7, and Resident #9) reviewed for smoking, and 1 of 1 Resident (Resident #4) reviewed for environment. The facility failed to ensure Residents #6, Resident #7, and Resident #9 were provided supervision while smoking. The facility failed to ensure Residents #6, Resident #7, and Resident #9 were accurately assessed for smoking. The facility failed to ensure Resident #9 was assessed for smoking per facility policy. The facility failed to ensure Resident #4 did not have an electric kettle in her room on the secure unit. These failures could place residents at risk of harm, injury, or accidents. Findings included: Record review of Resident #6's Admission Record, dated [DATE], revealed a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Encephalopathy (this is a brain disease that alters brain function or structure) and unspecified visual loss. Record review of Resident #6's MDS, dated [DATE], revealed a BIMS score of 13 indicating the individual's cognition is intact. Record review of Resident #6's Care Plan, date initiated [DATE], reflected the resident is a smoker. Goal: the resident will not suffer injury from unsafe smoking practices. Interventions: The resident requires supervision while smoking. Record review of Resident #6's Smoking-safety screen, dated [DATE], revealed the resident is safe to smoke with supervision. Vision: Does resident have any visual deficit. 1. Yes. Safety: 6. Can resident light own cigarette? No. 7. Resident need for adaptive equipment. 7c. Supervision. 8. Does resident need facility to store lighter and cigarettes? 1. Yes F. IDTC Decision; 1 Notes on Safety from IDTC (i.e. resources required to support resident, other resident safety, potential injury, capabilities): IDT agrees the resident requires supervision while smoking d/t unspecified visual loss. 2. Team Decision: 2. Safe to smoke with supervision. 3. Rationale/conditions: IDT agrees the resident requires supervision while smoking d/t dx unspecified visual loss. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's admission MDS, dated [DATE], revealed an admitted to the facility on [DATE]. Further review revealed a BIMS score of 14, indicating intact cognition. Record review of Resident #7's care plan dated [DATE] revealed resident was a smoker. Record review of Resident #7's smoking assessment, dated [DATE], revealed resident did not have cognitive loss or dexterity problems but did have visual deficits, could not light own cigarette and needed supervision. Rationale/conditions: IDT agrees the resident requires supervision while smoking d/t Hordeolum externum (an infection of an oil gland at the edge of eyelid) unspecified eye. Record review of Resident #9's Admission Record revealed, a [AGE] year-old male, initially admitted on [DATE] and readmitted on [DATE] with diagnosis of Chronic obstructive pulmonary disease (a lung disease that blocks airflow and makes it difficult to breathe), with (Acute) Exacerbation. Record review of Resident #9's Quarterly MDS, dated [DATE], revealed a BIMS score of 13 indicating intact cognition. Record review of Resident #9's Care Plan, date initiated: [DATE], reflected the resident is a smoker. Goal: The resident will not suffer injury from unsafe smoking practices. Interventions: the resident requires supervision while smoking. Record review of Resident #9's Smoking- Safety Screen, dated [DATE], revealed, Category: Safe to smoke with supervision. E. Safety- Can resident light own cigarette? No. 7. Resident need for adaptive equipment 7c. Supervision. 8. Does resident need facility to store lighter and cigarettes? 1. Yes. F. IDTC Decision: 1. Notes on Safety From IDTC (i.e. resources required to support resident, other resident safety, potential injury, capabilities): Resident meets criteria for safe smoker. Smokers are supervised by staff during smoking breaks. 2. Team Decision: 2. Safe to smoke with supervision. 3. Rationale/conditions: Resident meets criteria for safe smoker. Smokers are supervised by staff during smoking breaks. No other smoking assessment had been completed for Resident #9. Record review of Resident #4's Admission Record, dated [DATE], revealed a [AGE] year-old female who admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of Chronic obstructive pulmonary disease , major depressive disorder, and anxiety. Record review of Resident #4's Quarterly MDS dated [DATE] revealed a BIMS score of 11, indicating moderate cognitive impairment. Record review of Resident #4's care plan, dated [DATE], did not reveal anything related to an electric kettle. In an observation and interview on [DATE] at 11:21 AM, Resident #4 was in her room sitting up in her w/c drinking coffee. A small blue kettle was observed plugged in near the sink. Resident #4 stated her family member sent it to her. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on [DATE] at 12:06 PM, Resident #6 walked out of her room holding a cigarette pack and a lighter. Resident #6 entered the code to go outside on the smoking area. Surveyors went outside and observed Resident #6 and Resident #7 smoking with no staff present. Resident #6 stated she knew the code to enter to go outside, staff were aware she smoked, and stated she was allowed to keep her smoking materials with her. Resident #6 stated she took about ,d+[DATE] smoke breaks a day and did not need an apron to smoke. Resident #7 was observed with a cigarette and lighter. Resident #7 stated she knew the codes and all residents knew the codes. Resident #7 stated she had been there about 4 months, and staff had never taken away her cigarettes or lighter. Resident #7 said the staff had nobody to bring them to smoke so she guessed that was why residents went out by themselves. In an interview on [DATE] at 1:02 PM, LVN E stated residents were not allowed to have their cigarettes or lighters in their possession and smoking materials were locked up behind the nurse's station. She stated residents had designated smoke times and must be supervised during smoking unless they sign out and go out the front and leave the facility. She said supervision meant that one of the workers on shift must light the cigarettes, pass them out and stay until everyone was done smoking. She stated the risk to residents having cigarettes and lighters was they could set something on fire or hurt someone else or themselves. In an interview on [DATE] at 1:04 PM, LVN G stated usually the aides supervised residents who smoked. He stated no residents were to have their lighters or cigarettes. He did not know who completed the smoking assessment and did not know what supervision meant since he did not complete the assessments. He stated if residents were not supervised while smoking, they could hurt themselves. In an interview on [DATE] at 1:09 PM, CNA F stated residents were not supposed to have cigarettes or lighters on their person and staff were to supervise residents while smoking. She stated supervision meant they pass out the cigarettes, light them and stay with residents until done. She said cigarettes and lighters were kept in a container behind the nurse's station. CNA F stated there were no residents that she knew of that were allowed to keep their cigarettes or lighters. She stated the risk to the residents of having a cigarette or lighter was because there have been some incidents of them falling asleep and burning themselves. In an interview on [DATE] at 1:15 PM, CNA H stated residents were not supposed to have their smoking materials and they were kept in the lock box behind the cart. She stated only staff can get into it or the person who smokes them. CNA H stated supervision meant making sure residents were smoking properly and they were safe. She said one staff member supervises and usually will light the cigarette or get the lighter back from the resident. She said residents were not allowed to go out in the smoking area with O2 because it could burn or blow up. She said the O2 tank should be inside at all times. She stated if residents were not supervised while smoking, they could burn themselves or anything could happen. Observation and interview on [DATE] at 1:11 PM, revealed Resident #9 smoking without any staff present. He stated he goes outside to smoke every couple of hours and keeps his cigarettes and lighter in his possession. (continued on next page)

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	03/12/2025

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 1:26 PM, the DON stated according to their policy, if a resident was a safe smoker, the resident can have a lighter and cigarette, and if an unsafe smoker, smoking materials were locked up. She stated safe and unsafe smokers were determined by the assessment. The DON said supervision meant staff would be out there with unsafe smokers. For safe smokers, supervision meant that staff just have eyes on them She stated if residents who were deemed unsafe smokers smoked without supervision, they could be at risk for burns. In an interview on [DATE] at 1:35 PM, the Administrator stated if residents were deemed safe smokers, they could have their paraphernalia. He said they encouraged residents to lock them up but also have a very able bodied population, and if they signed out and were able to purchase those items it would be hard to police. He said an assessment was completed to see if the resident would meet the criteria for safe smoking The Administrator stated his understanding of safe and unsafe smoking was whether under reasonable circumstances residents were safe to hold, light, smoke and extinguish a cigarette in a safe way. He stated residents on O2 were not supposed to go out on the smoking area with the O2 tank. He said the risk for residents who were deemed unsafe and went to smoke without direct supervision was they would have the potential for bodily harm and a burn. He stated if residents threw lit cigarettes on the ground, it could be a risk of fire. In an interview and record review on [DATE] at 1:35 PM, the Administrator stated Resident #7 was a safe smoker. Review of EHR revealed a smoking assessment had just been completed and was dated [DATE] and Resident #7 was a safe smoker. Review of the previous smoking assessment dated [DATE] indicated supervision was required. The Administrator stated he was not expecting the assessment for Resident #7 to say smoke with supervision. In an interview on [DATE] at 4:51 PM, the Social Worker stated she was responsible to do the smoking assessments when a resident first admits and then quarterly. She stated sometimes the nurse would assess but she mainly did them. She said she based the assessments on their BIMS, diagnoses and if they were a smoker and how often. She said especially when they first got there, she puts that they need supervision, since staff do not know them that well, and as a safety precaution. She said supervision meant having someone out there watching them smoke and having their smoking articles locked up at the nurse's station. She said if residents needed help with lighting cigarettes, then provide assistance with that. She stated there were residents who were safe smokers that were alert and oriented x3 (a person is alert and oriented to person, place and time), and had no impairments that may prevent them from smoking by themselves. She said she did see a risk if residents who were unsafe went to smoke by themselves. In an interview on [DATE] at 8:11 AM, the Administrator stated he had done a QAPI meeting about smoking, had done inservice and was still inservicing staff and would provide them to Surveyor when all done. In an interview on [DATE] at 3:00 PM, the DON supervision was based on diagnosis and case by case. She said some residents would be immediately unsafe and there was no way physically they could smoke safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 3:14 PM, the Administrator stated he re-educated staff this morning, and in serviced the SW directly on smoking assessment. He said he found that the assessments were inconsistent with the policy, redid all smoking assessments and corrected them and inserviced staff on the smoking policy, what a safe smoker was, and guidelines. He stated a safe smoker verified by smoking assessment meant they were allowed to smoke without staff, have cigarettes and a disposable lighter and not allowed to share paraphernalia with other residents. He said unsafe smokers, which continued to be the entire secure unit due to cognition, would take scheduled smoke breaks and not keep their materials. The Administrator said Resident #4 was not to have an electric kettle in her room and was not aware there was one in the room. He stated the risk to residents could be burns. Record review of facility policy, titled Smoking Policy - Residents Revised [DATE], revealed in part: This facility shall establish and maintain safe resident smoking practices . 8. A resident's ability to smoke safety will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. 9. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. 10. The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safety with the available levels of support and supervision. 11. Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking. 12. Residents who have smoking privileges are permitted to keep cigarettes, e-cigarettes, pipes, tobacco, and other smoking articles in their possession. Only disposable safety lighters are permitted. All other forms of lighters, including matches, are prohibited . No other policy on Accidents/Hazards was provided by the facility. 50445