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	05/30/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for one resident (Resident #2) of five reviewed for accidents. -The facility failed to ensure Resident #2 was provided with adequate supervision to prevent the misuse of a smoking product that contained THCA. This failure could place residents at risk for accidents that could lead to serious injury or harm. Findings include: Record review of Resident 2's face sheet, dated 5/29/25, reflected the resident was a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #2 had diagnoses which included: COPD (lung disease), bipolar disorder (mood disorder), hypertension (high blood pressure), generalized anxiety disorder (mood disorder), paroxysmal atrial fibrillation (heart condition) with presence of cardiac pacemaker (device that helps regulate an irregular heartbeat). Record review of Resident #2's Quarterly MDS assessment, dated 2/26/25, reflected he had a BIMS score of 13, which indicated he was cognitively intact. The MDS Assessment under Section GG-Functional Abilities, reflected Resident #2 required supervision with all ADLs. Record review of Resident #2's care plan, revised 5/14/25, reflected the resident had a behavior problem that included: throwing items, yelling, drug seeking behavior, not following smoking policy, paraphernalia r/t poor impulse control, with interventions that included: administering medications as ordered, discussing the resident's behavior and explain why behavior is inappropriate, and intervene as necessary to protect the rights and safety of others. Further review of this document reflected Resident #2 was a smoker with interventions that included: instructing the resident about smoking risks and hazards, instructing the resident about the facility's policy on smoking, notifying the charge nurse immediately of any violations of the policy, and that Resident #2 was able to smoke unsupervised. Record review of Resident #2's progress notes, dated 2/03/25 at 2:29 PM by the SW , reflected the following: (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Social Worker] and [MDS Nurse/LVN I] spoke to [Resident #2's] regarding his behaviors, to which he responded by smiling and nodding his head. [Resident #2] was then given a 30-day discharge notice and was informed his discharge date is 3/5/25. [Resident #2] was informed of the appeal process and stated he will be appealing the decision. No other concerns were voiced. Record review of Resident #2's progress notes, dated 3/05/25 at 8:35 PM by the ADON/IP, reflected the following: [Resident #2's] room noted to smell fragrant of marijuana. No signs of smoke in room at this time. [Resident #2] currently signed out of facility. [Administrator] notified. Care on going. Record review of Resident #2's progress notes, dated 3/08/25 at 9:47 PM by LVN H, reflected the following: [Resident #2] was seen wrapping up what seems to be like weed on a piece of paper, he later signed himself out to smoke came back into the facility smelling like weed, [Resident #2] stated he got the weed over the counter at the convenience store nearby. [Resident #2] is alert, able to communicate, took his nighttime medication and went to his room. Record review of Resident #2's progress notes, dated 4/05/25 at 9:50 PM by LVN H, reflected the following: Nurse aide reported that [Resident #2] was rolling up marijuana (weed) on a piece of paper in room, this nurse went to [Resident #2'S] room and [Resident #2] has put it awake [sic] Record review of Resident #2's progress notes, dated 4/06/25 at 8:04 AM by [MDS Nurse/LVN I], reflected the following: [MDS Nurse/LVN I] smelled marijuana smoke, went to smoking patio next to nurses station witnessed [Resident #2] sitting next to patio door smoking a joint. Informed [Resident #2] he cannot smoke that on premises. [Resident #2] stated It's legal if I can walk across the street and buy it, I can smoke it if I want to, go on. [Resident #2] visibly under the influence, eyes low and red. Notified weekend supervisor. Wknd supervisor and this nurse went to [Resident #2's] room where [Resident #2] was sitting on bed, showed weekend supervisor jar of grean [sic] leafy substance labeled THC-A and a orange pack of rolling papers, but refused to let supervisor confiscate it. [Resident #2] stated he bought it from the gas station across the street. Supervisor is following up with [Administrator]. Call light in reach. WCTM as able Record review of Resident #2's consolidated physician orders, dated 5/30/25, reflected in part the following: -Ambien oral tablet 5 mg-give 1 tablet by mouth at bedtime for DX: primary insomnia, Start date: 3/28/25 -Lurasidone HCL Oral tablet 80 mg-give 1 tablet by mouth one time a day related to bipolar disorder, current episode manic severe with psychotic features. Start date: 12/17/24 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Trazodone HCL oral tablet 100 mg-give 3 tablets by mouth at bedtime for insomnia. Start date 12/16/24 -Tylenol with Codeine #4 oral tablet 300-60 mg (Acetaminophen with codeine)-give 1 tablet by mouth every 6 hours as needed for pain. Start date 1/17/25 Record review of a letter provided by the Administrator from the State Agency regarding Resident #2's 30-day discharge, dated 5/09/25, reflected the following: Dear [Resident #2]: I have carefully considered the information presented regarding the appeal, and I am reversing the Agency's action. See the attached final order for complete information about my decision In an observation and interview on 5/29/25 at 9:26 AM, Resident #2 was sitting on the side of his bed trying to quickly remove something from his side table. Resident #2 asked the State Surveyors if we could speak to him outside of the room and we did so to provide any privacy he may have needed due to his roommate being present. Resident #2 expressed concerns for a rash that he had on his buttock and the infection control at the facility. Resident #2 returned to this room and the State Surveyors followed shortly after to inquire about the apparent marijuana-like smell that was in the room. Resident #2 was observed filling multiple smoking papers with a leafy substance he was removing from a can, and there was also a lighter on the table. Resident stated he bought the substance from the local smoke shop. The label on the can stated it was Premium indoor THCA flower. Resident #2 stated he used the THCA to help him with his anxiety. He stated the substance was legal and the facility allowed him to keep his smoking materials on him. Resident #2 stated he did not smoke in the room and that the facility provided designated smoking areas and smoke times. In an interview on 5/29/25 at 11:25 AM, CNA A stated she worked at the facility for 4 years. She stated she worked with Resident #2, and he was smoker who was assessed and considered a safe smoker, which meant he could keep his cigarettes and lighter on him. CNA A stated she had never seen Resident #2 with marijuana, but she would sometimes smell it on him when he passed by, and this was reported to the charge nurse and DON. She stated Resident #2 would always sign himself out of the facility to go into the community and that was when he would come back smelling like marijuana. In an interview on 5/29/25 at 11:39 AM, the MD stated he was aware that Resident #2 was using a product that contained THC and had educated the resident on the risks associated with it. The MD stated he had not observed or received reports of Resident #2 having any adverse reactions. The MD stated there were not a lot of risks; however, recent research showed possible symptoms of nausea and vomiting, and Resident #2 was at risk of enhanced sedation due to him already being on a sedative medication. The MD stated the symptoms were based on the amount that was used and there was no way to know how much Resident #2 was using. In an interview on 5/29/25 at 12:43 PM, the DON stated the facility assessed all residents who were smokers upon admission and change of condition to determine if they were able to safely smoke without assistance. The DON stated residents who were considered safe smokers were able to keep their smoking materials in their possession; however, they were still supposed to only smoke in designated areas and during smoke times. The DON stated some residents like Resident #2 had behaviors and would bring in non-tobacco products like CBD with traces of THC that they could get from the smoke shop. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/29/25 at 1:00 PM, the Administrator stated the facility issued Resident #2 a 30-day discharge notice twice for not following the facility's smoking policy, with the most recent one being in February 2025, but the decision was reversed after an appeal due to lack of evidence although there were over 100 pages worth of evidence submitted. He stated Resident #2 would not smoke in the designated smoking areas and would sign himself out of the facility and smoke in the parking lot or just outside of the premise whenever he wanted. The Administrator stated Resident #2 would go out into the community to do whatever he wanted, like smoking and drinking at the local bar, and he would also bring substance back into the facility. The Administrator stated staff were unable to violate Resident #2's rights and go through his belongings; however, if there was anything left out that Resident #2 was not supposed to have it was confiscated. The Administrator stated he confiscated marijuana twice from Resident #2. He stated when the rules were imposed on Resident #2, he would become upset and break the rules even more. He stated Resident #2's behaviors made it unsafe for himself and other residents. The Administrator stated since the State Agency denied the discharge, he did not know what else could be done. Record review of the facility's policy titled Smoking Policy, revised July 2017, reflected in part the following: Policy Statement This facility shall establish and maintain safe resident smoking practices. Policy Interpretation and Implementation: 1. Prior to, and upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. . 6. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include: a. current level of tobacco consumption; b. method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc.); c. desire to quit smoking, if a current smoker; and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). . 12. Residents who have smoking privileges are permitted to keep cigarettes, e 13. -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. 14. Residents are not permitted to give smoking articles to other residents. . 17. This facility maintains the right to confiscate smoking articles found in violation of our smoking policies. 18. Confiscated resident property will be itemized and ultimately returned to the resident, or his or her legal representative. When the property is returned will be determined during a meeting with the resident or representative regarding the circumstances that led to the confiscation. The facility's drug policy was requested from the Administrator on 5/29/25 at 7:00 PM and was not received by the time of exit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for one Resident (Resident #1) of seven residents reviewed for infection control. -The facility failed to follow the physician's order for contact isolation for Resident #2, who was diagnosed with ESBL, when there were no effective interventions in place to keep the resident isolated in her room and prevent the spread of the infection. This failure placed residents at risk for the spread of infections and decreased quality of life. Findings include: Record review of Resident 1's face sheet, dated 5/30/25, reflected the resident was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: mixed anxiety and depressed mood (mood disorder), heart disease with presence of cardiac defibrillator (device that monitors heart rhythms), hypertension (high blood pressure), opioid dependence, and seizure. Record review of Resident #1's admission MDS assessment, dated 4/09/25, reflected she had a BIMS score of 15, which indicated she was cognitively intact. The MDS Assessment under Section E-Behaviors, reflected Resident #1 exhibited behaviors of verbal aggression and wandering. Further review of the MDS Assessment under Section GG-Functional Abilities, reflected Resident #1 required supervision and partial to moderate assistance with all ADLs. Record review of Resident #1's care plan, dated 4/24/25, reflected the resident had mixed bladder incontinence with interventions that included: ensuring the resident had unobstructed path to bathroom and to monitor and document for s/sx of a UTI. The care plan reflected Resident #1 had the need for enhanced barrier precautions due to wound dressing. Interventions included: placing enhanced barrier precautions signage on the resident's door to notify staff and visitors of precautionary measures. Further review of the document reflected Resident #1 had behavior problems that included: non-compliance with care, preferring to conduct own wound care, barricading room door, non-compliance with signing in and out, tearing down enhanced barrier signage, entering resident rooms without permission, and non-compliance with smoking policy, with interventions that included: anticipating and meeting the resident's needs, assisting the resident to develop more appropriate methods of coping and interacting, providing education on polies and procedures to ensure safety, entering through another room when door is barricaded to check on resident's wellness, and intervening as necessary to protect the rights and safety of others. Record review of Resident #1's progress notes, dated 5/22/25 at 9:02 AM by LVN G, reflected the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[Resident #1] urine results ESBL. MD notified and N/O for ISO 7 days. [Resident #1] was asked to relocated [sic] for ISO [Resident #1] refused. [Resident #1] was given bed side commode and educated on the importance of ISO to stop the spread of infection and staying out of common areas. [Resident #1] refused to keep the bedside commode. [Resident #1] immediately removed the bedside commode once this nurse left the room. Continue to monitor. Record review of Resident #1's progress notes, dated 5/23/25 at 12:08 PM by LVN G, reflected the following: [Resident #1] is to remain on ISO for 7 days [Resident #1] observed ambulating throughout the facility and attending several smoking activities. [Resident #1] was educated on the importance of infectin [sic] control. [Resident #1] nodded in understanding has [Resident #1] continued to ambulate down the hallway. Continue to monitor. Record review of Resident #1's progress notes, dated 5/26/25 at 8:14 AM by LVN G, reflected the following: [Resident #1] refused to remain in room while on ISO and attended smoke breaks and roaming the halls visiting with other residents. [Resident #1] was educated on the importance of infection control. [Resident #1] stated to hell with infection control. as [Resident #1] continued to walk away from staff. Continuing to monitor. Record review of Resident #1's progress notes, dated 5/28/25 at 10:19 AM by LVN G, reflected the following: [Resident #1] was asked to use bedside commode to prevent the spread of infection. [Resident #1] refused to use bedside commode. Education provided. Continue to monitor. Record review of Resident #1's progress notes, dated 5/28/25 at 2:20 PM by LVN/Wound Care Nurse, reflected the following: [Resident #1] on contact isolation d/t ESBL [Resident #1] made aware; [Resident #1] offered to move rooms and [Resident #1] declined; [Resident #1] non- complaint with staying in room to prevent infection after education was provided; [Resident #1] stated she can go wherever she wants. MD made aware. Signage posted. Record review of Resident #1's consolidated physician orders, dated 5/20/25, reflected in part the following: -Isolation precautions: Contact; d/t ESBL-every shift for 7 days. Start date: 5/22/25; Discontinue date: 5/29/25 -Isolation precautions: Contact; d/t ESBL-every shift for 7 days. Start date: 5/29/25 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 5/29/25 at 9:00 AM, Resident #1 was observed in her room on contact isolation. Resident had signage on her door with a bin stocked with PPE. Resident #1 stated she admitted to the facility after being at a psychiatric hospital for depression from losing [family] Resident #1 stated she had just returned to the facility a couple of days ago from another hospital visit where she was being treated for MRSA in the wound on her leg. Resident #1 stated she was also told that she had ESBL in her urine and so she was on two different antibiotics for the ESBL and MRSA. Resident #1 stated the nurses were not properly caring for her infection and the facility was not being cleaned with Clorox to kill the bacteria. She stated the housekeeper told her they could not use Clorox because some residents were allergic to it. She stated she was able to use the toilet on her own but wore an adult brief in case she had an accident. She stated she washed her hands after using the bathroom. Resident #2 became fixated on stating that she had doctors in her family, so she knew how the facility was supposed to be caring for her, and how she had an attorney she was talking to. Resident #1 exhibited signs of paranoia by stating that everyone was against her and did not believe anything she said. Resident #1 had difficulty focusing on one thing at time and was not clear with thoughts. In an interview on 5/29/25 at 9:45 AM, the Housekeeping Supervisor stated she worked at the facility for a month. She stated the housekeepers were scheduled on 2 shifts (6:00 AM-2:30 PM and 2:00 PM-10:00 PM) on rotating days so there were housekeepers available during the weekdays and weekends. The Housekeeping Supervisor stated all resident rooms were cleaned and disinfected daily, and isolation rooms and common areas were disinfected multiple times a day and as needed. The Housekeeping Supervisor stated they used DC33 disinfectant and antibacterial solutions to clean. She stated housekeeping was responsible for gathering and cleaning residents' clothes and linens. She stated the clothes and linens were gathered and cleaned separately from all other laundry. She stated isolation laundry was identified by the different bag that it was placed in. In an observation on 5/29/25 at 10:25 AM, Resident #1 was observed outside of her room. While State Surveyors were in the facility's' kitchen, Resident #1 opened the door and stepped halfway into the kitchen stating she needed to speak with the State Surveyors again. There were staff present but the State Surveyor had to redirect Resident #1 back to her room. In an interview on 5/29/25 at 12:43 PM, the DON stated Resident #1 was the only resident on contact isolation for ESBL. She stated there were a few other residents on enhanced barrier precautions but there were no other known infections in the facility. The DON stated Resident #1 was going around telling everyone that she had MRSA; however, that had not been confirmed and the facility was waiting on results from the hospital. In an interview on 5/29/25 at 1:18 PM, the LVN/Wound Care Nurse stated she was treating a wound on Resident #1's left leg, but the resident was often non-compliant with wound care from the nurse and MD. She stated Resident #1 would try to do wound care herself. The LVN/Wound Care Nurse stated she was not aware of Resident #1 having MRSA in her wound; however, she was on contact isolation or having ESBL in her urine. The LVN/Wound Care Nurse stated Resident #1 went to hospital earlier this week and her discharge paperwork showed there were pending results for a wound culture. She stated Resident #1 was already on abx for ESBL and was started on another one at the hospital for prevention of infection of her wound. In an observation on 5/29/25 at 2:42 PM, Resident #1 was observed walking down the hallway near other residents with no staff present to redirect her. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 5/29/25 at 5:13 PM, CNA B stated she worked with Resident #1 and the resident was on contact isolation in her room due to having ESBL. CNA B stated staff had to wear a gown, gloves, and face shield when entering Resident #1's room, and wash hands frequently when caring for her. CNA B stated Resident #1 was independent with most care, including toileting. She stated Resident #1 was not monitored while toileting so she could not confirm if the resident washed her hands after toileting. CNA B stated Resident #1 refused to stay isolated in her room and had to be constantly redirected but she would not comply. CNA B stated Resident #1 went out to smoke with other residents and visited in their rooms and common areas. CNA B stated Resident #1's behavior was reported to the nurses. In an interview on 5/29/25 at 6:12 PM, the Administrator stated Resident #1 was able to use the toilet independently and only wore a brief in case she leaked from having a weak pelvic floor. The Administrator stated Resident #1 was cognitive enough to not urinate on the floor and the only way she could spread bacteria would be by putting her hand in her brief and touching surfaces or not using proper hand hygiene after toileting, which would place other residents at risk of infection. In an interview on 5/30/25 at 11:50 AM, the MD stated the risk of Resident #1 spreading ESBL to other residents were low due to her wearing an adult brief; however, if she did not remain isolated there was still a risk of her spreading the infection by leaking urine through her brief on common surfaces or touching surfaces with unclean hands. The MD stated he would normally place a catheter in residents with ESBL to further contain the urine; however, Resident #1 refused so placing her on contact isolation was the safest way to prevent the spread of ESBL in the facility. Record review of the facility's policy titled Isolation-Categories of Transmission-Based Precautions, revised October 2018, reflected in part the following: Policy Statement: Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Policy Interpretation and Implementation: 1. Standard precautions are used when caring for residents at all times regardless of their suspected or confirmed infection status. 2. Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected. These measures are determined by the specific pathogen and how it is spread from person to person. The three types of transmission-based precautions are contact, droplet and airborne. 3. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Centers for Disease Control and Prevention (CDC) maintains a list of diseases, modes of transmission and recommended precautions. . Contact Precautions: 1. Contact precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. 2. The decision on whether contact precautions are necessary will be evaluated on a case by case basis. 3. The individual on contact precautions will be placed in a private room if possible. If a private room is not available, the infection preventionist will assess various risks associated with other resident placement options (e.g., cohorting, placing with a low risk roommate).