

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675906	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2025
NAME OF PROVIDER OR SUPPLIER Benbrook Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on observation, interview and record review the facility failed to provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible for two of three shower rooms reviewed for environmental concerns.</p> <ol style="list-style-type: none"> 1. The facility failed to ensure the toilet in the 200 Hall shower room was operational and did not contain a dried brown substance (appeared to be feces) which was covered by a clear plastic trash bag. 2. The facility failed to ensure the 200 Hall shower room did not have a hole in the wall of which exposed the plumbing. 3. The facility failed to ensure the toilet in the 100 Hall shower room was operational which covered by a clear plastic trash bag. <p>These failures could place residents at risk of living in an unclean, uncomfortable and unhomelike environment.</p> <p>Findings include:</p> <p>In an observation on 6/03/25 at 10:05 AM, revealed a large (approximately 2-foot by 1.5-foot) hole in the wall behind the shower which had exposed plumbing pipes. The toilet in the shower room was covered by a clear trash bag. There was a brown substance that could be viewed through the trash bag . The shower room was locked and was not accessible to residents except when opened for them by staff. An unknown resident was observed exiting the shower room alone with wet hair at this time. Residents were not interviewed. The shower cleaning schedule was not ascertained.</p> <p>In an observation and interview on 6/03/25 at 10:10 AM, LVN A stated she was the regular nurse for the 200 Hall. She stated the hole in the wall with the exposed plumbing was access to the main shut off for the shower and it had been exposed, for a couple of weeks. LVN A removed the trash bag from the toilet and a dried brown material (appeared to be feces) was observed on the toilet seat and covered the inside of the toilet bowl. LVN A stated she hadn't been aware the toilet was not working. She noted the hole in the wall and the condition of the toilets could be considered unsightly or disturbing to residents. She reported a message should have been placed in the facility's electronic maintenance/communication application to notify maintenance. She stated she had not notified maintenance herself. She stated all staff were responsible for reporting maintenance concerns .</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation and interview on 6/03/25 at 10:15 AM, the 100 Hall shower room was noted with the toilet covered in a clear plastic trash bag. LVN B reported she was not sure how long the toilet had been broken but she had been aware it had been reported to maintenance. She reported all staff were responsible for reporting maintenance concerns.</p> <p>In an interview on 6/3/25 at 10:20 AM, the ADM was asked to contact the maintenance director or staff. He reported the maintenance director was out sick. He stated staff notified him this morning that there were plumbing concerns and feces was noted in the toilet of the Hall 200 shower room. He stated a plumber had since been called. He stated he had previously been unaware there was an issue, and did not know if the maintenance department was aware. The ADM stated he was not aware the toilet was not working in the shower room of hall 100. He stated the hole in the Hall 200 shower room had recently occurred when maintenance worked on the plumbing. The ADM stated maintenance needed to cover the hole with an access panel. He stated any staff who saw these maintenance issues were responsible for notifying maintenance and placing a request in the facility maintenance/communication application, and maintenance was responsible for the repairs. He noted these toilets were unsightly for residents and possibly an inconvenience, although he noted residents also had access to toilets in their rooms . Maintenance records were requested of the ADM but not received.</p> <p>In a telephone interview on 6/03/25 at 01:20 PM, the Director of Maintenance stated he had not been aware of the toilets not working in hall 200 and hall 100 shower rooms. He stated he had not put garbage bags over the toilet seats and did not know who had. He stated he had not received a work order but a work order should have been placed .</p> <p>Record review of the facility policy titled, Resident Rights, dated 2001 and revised December 2016, reflected 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</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>Based on observation, interview and record review the facility failed to ensure that licensed nurses had the specific competencies and skills sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care and nurse aides were able to demonstrate competency in skills and techniques necessary to care for resident's needs, as identified through resident assessments and described in the plan of care for two of two medication aides (MA E and MA C) and two of three nurses (LVN A and LVN D) reviewed for competent nursing staff .</p> <p>The facility failed to ensure staff knew how to identify an overfilled sharps container.</p> <p>This failure could place residents at risk of laceration or stick by sharps .</p> <p>The findings include:</p> <p>In an observation on 6/03/25 at 10:05 AM, revealed the sharps container hanging on the wall of the shower room in the 200 Hall was noted as overfilled beyond the manufacturer fill line and was still in use with the receptacle in the open position.</p> <p>In an interview on 6/03/25 at 10:10 AM, LVN A reported she had been the regular nurse for Hall 200. LVN A stated sharps containers were supposed to be emptied when the flap (receptacle) would no longer shut. She stated she was not sure who was responsible for emptying the sharps containers in the shower room. LVN A stated the training she had received was for the sharp's container on her medication cart and that it would be placed into a biohazard box if the sharp's container no longer shut. She stated she could ask the DON who had the key to the sharps container as she did not know for sure. She stated the overfilled sharps container was definitely a safety concern for residents.</p> <p>In an interview on 6/03/25 at 11:20 AM, MA C stated any staff using sharp's containers were responsible for emptying them and that, I will do it if it gets full. I don't let it get to where I can't flip it. If I can see stuff from the top, I change it out. I have a key to the sharp's container on this cart. MA C stated she believed she received training in the disposal of sharps but did not remember when it occurred. She stated if a sharp's box was overfilled, someone could get stuck.</p> <p>In an interview on 6/03/25 at 12:10 PM, LVN D stated sharp's containers were emptied when they appeared from the top to be full. She was not aware of the manufacturer's fill line marked on the container .</p> <p>In an interview on 6/03/25 at 02:34 PM, the ADM stated he expected sharp's containers to have been monitored and changed as needed. He stated sharp's containers should not be overfilled. The ADM stated it was the responsibility of anyone who used sharp's containers to change them when they were full. He stated the top of the sharp's containers was white and it could be seen when the lid was full. He stated the risk of a sharp box being overfilled would be someone could injure themselves. ADM did not asked and did not state what training staff had received regarding sharps or the importance of training or how residents could be affected by a lack of this training.</p> <p>In an interview on 6/03/25 at 03:40 PM with the ADM revealed he did not have any policies related to nursing competency and any policies related to sharps disposal.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 6/03/25 at 03:55 PM, the DON stated nurses were responsible for emptying full sharp's containers when the manufacturer fill line was reached. She stated the risk of an overfilled sharp box was the risk of getting stuck by a sharp. She reported staff in-service training began today (6/03/25) which included how to know when sharp's containers were full, when to empty them, how to empty them, and more. The DON reported the training included CNA's were to notify nurses should they notice full sharp's containers and for nurses and CNA's to be sure to monitor the sharp's containers in the shower room . The DON was not asked and did not state what training regarding sharps staff had previously received and did not provide in-service training records.</p>		