

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  08/09/2025
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)
F 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.  (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to, in response to allegations of abuse or neglect, ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, were reported immediately, not later than 24 hours if the events that cause the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedures for one (Resident #1) of five residents reviewed for reporting of abuse. The facility failed to report to the State Survey Agency the elopement of Resident #1 during July of 2025. This failure could place residents at risk for unresolved or future abuse or neglect. Findings included: Review of Resident #1's Face Sheet reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Review of Resident #1's Quarterly MDS dated [DATE] reflected diagnoses including Chronic Obstructive Pulmonary Disease (condition caused by damage to the lungs), coronary artery disease (disease caused by buildup of plaque in the arteries of the heart), anxiety disorder, and Depression. A BIMS score of 10 was reflected, indicating moderate cognitive impairment. Resident #1 scored 0 on wandering behaviors, which indicated the behavior was not exhibited. Review of Resident #1's Care Plan with start date 6/13/25 reflected Resident #1 had a focus of elopement risk r/t history of attempts to leave the facility unattended, and with impaired safety awareness with date initiated 9/09/24 and revised solely on 12/24/24. In an interview on 8/05/25 at 12:41 pm, CNA A stated that approximately two weeks prior (exact date unknown), Resident #1 had climbed out of a window on the female locked unit. She stated that she saw Resident #1's wheelchair sitting empty by an open window and had notified LVN B. She reported staff searched the unit and then the property, but that Resident #1 was not located, and staff began using their vehicles to search the community. She stated she found Resident #1 coming out of an auto parts store, the property adjacent to the facility, and escorted her back to the facility. She stated that the ADM arrived a short while later and threatened the jobs of staff if they were to say anything about the incident to anyone. In a telephone interview on 8/05/25 at 4:00 pm, LVN B stated about two weeks ago (exact date unknown), she was notified by CNA A that Resident #1 had gone out a window on the female locked unit. She stated that Resident #1 was not found at the facility but that she was returned to the facility by CNA A who reported that Resident #1 had been found at a nearby auto parts store. She stated she assessed Resident #1 upon her return to the facility and that she did not have any injuries. She stated that she called and notified the ADM and that he arrived approximately thirty minutes later and fixed the window that Resident #1 had kicked out. She stated she did not chart the elopement or her injury assessment because she was told by the ADM that he had to do an investigation, and he would take care of it. In an interview on 8/05/25 at 1:30 PM LVN C stated while working the evening shift approximately two weeks ago (exact date unknown) she was notified by CNA A that Resident #1 had gone out of a window on the female locked unit. She stated she immediately started looking for the resident after notifying LVN B. She stated she and other staff had been driving around the community looking for Resident #1. She reported she next saw Resident #1 walking up to the front of the building escorted by CNA A and was told that Resident #1 was found next door at an auto parts store. She stated that Resident #1 had not appeared to have any injuries. She reported that the ADM came to the facility about thirty minutes later but did not speak to her. She denied she was threatened or told not to say anything about the incident. She stated that when she worked the day shift the following day, she was told in report that Resident #1 had tried to elope, and she thought this was strange because Resident #1 had actually eloped. In an interview on 8/05/25 at 1:40 PM CNA D stated she was told by a CNA (name unknown) the day following the incident (date unknown) that Resident #1 had eloped and been found at an auto parts store on the prior evening shift and had been escorted back to the facility. She declined to state if her job had been threatened or she had been told not to say anything about the incident stating, I don't want to lose my job. They will retaliate against you and I don't want you writing anything that will cost me my job. In an interview and observation on 8/05/25 at 3:07 pm, Resident #1 stated she had left the facility through a window she had pushed through, maybe the start of last week (exact date unknown). She stated she went next door to an auto parts store and borrowed a lighter from a staff at the store because she wanted to smoke. She stated a female facility staff (name unknown) rolled up approximately twenty minutes later and escorted her back to the facility. She stated she left the facility because she missed her belongings and her apartment. She stated she did not think she spoke to the</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to, in response to allegations of abuse or neglect, have evidence that all alleged violations were thoroughly investigated, prevent further potential abuse and neglect while the investigation was in progress, report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and take appropriate corrective action if the alleged violation was verified one (Resident #1) of five residents reviewed for reporting of abuse. The facility failed to investigate and report to the State Survey Agency the results of the investigation of the elopement of Resident #1 during July of 2025. This failure could place residents at risk for unresolved or future abuse or neglect. Findings included: Review of Resident #1's Face Sheet reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Review of Resident #1's Quarterly MDS dated [DATE] reflected diagnoses including Chronic Obstructive Pulmonary Disease (condition caused by damage to the lungs), coronary artery disease (disease caused by buildup of plaque in the arteries of the heart), Anxiety Disorder, and Depression. A BIMS score of 10 was reflected, indicating moderate cognitive impairment. Resident #1 scored 0 on wandering behaviors, which indicated the behavior was not exhibited. Review of Resident #1's Care Plan with start date 6/13/25 reflected Resident #1 had a focus of elopement risk r/t history of attempts to leave the facility unattended, and with impaired safety awareness with date initiated 9/09/24 and revised solely on 12/24/24. In an interview on 8/05/25 at 12:41 pm, CNA A stated that approximately two weeks prior (exact date unknown), Resident #1 had climbed out of a window on the female locked unit. She stated that she saw Resident #1's wheelchair sitting empty by an open window and had notified LVN B. She reported staff searched the unit and then the property, but that Resident #1 was not located, and staff began using their vehicles to search the community. She stated she found Resident #1 coming out of an auto parts store, the property adjacent to the facility, and escorted her back to the facility. She stated that the ADM arrived a short while later and threatened the jobs of staff if they were to say anything about the incident to anyone. She reported she had received elopement training within the past six months. In a telephone interview on 8/05/25 at 4:00 pm, LVN B stated about two weeks ago (exact date unknown), she was notified by CNA A that Resident #1 had gone out a window on the female locked unit. She stated that Resident #1 was not found at the facility but that she was returned to the facility by CNA A who reported that Resident #1 had been found at a nearby auto parts store. She stated she assessed Resident #1 upon her return to the facility and that she did not have any injuries. She stated that she called and notified the ADM and that he arrived approximately thirty minutes later and fixed the window that Resident #1 had kicked out. She stated she did not chart the elopement or her injury assessment because she was told by the ADM that he had to do an investigation, and he would take care of it. She stated she was not aware of any prior elopement attempts by Resident #1. She reported she had received elopement training within the past six months. In an interview on 8/05/25 at 1:30 PM LVN C stated while working the evening shift approximately two weeks ago (exact date unknown) she was notified by CNA A that Resident #1 had gone out of a window on the female locked unit. She stated she immediately started looking for the resident after notifying LVN B. She stated she and other staff had been driving around the community looking for Resident #1. She reported she next saw Resident #1 walking up to the front of the building escorted by CNA A and was told that Resident #1 was found next door at an auto parts store. She stated that Resident #1 did not appear to have any injuries. She stated she was not aware of any prior elopement attempts by Resident #1. She reported that the ADM came to the facility about thirty minutes later but did not speak to her. She denied she was threatened or told not to say anything about the incident. She stated that when she worked the day shift the following day, she was told in report that Resident #1 had tried to elope, and she thought this was strange because Resident #1 had actually eloped. She stated that Resident #1 was placed on Q15 minute checks for elopement risks. She stated she had thought the windows were secured but that she noted someone working on the window the day following the incident. She reported she had received elopement training within the past six months. In an interview on 8/05/25 at 1:40 PM CNA D stated she was told by a CNA (name unknown) the day following the incident (date unknown) that Resident #1 had eloped and been found at an auto parts store on the prior evening shift and had been escorted back to the facility. She stated she was not aware of Resident #1 having eloped or attempting to elope prior to this incident. She declined to state if her job had been</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interviews and record reviews, the facility failed to ensure residents received adequate supervision to prevent accidents for one (Resident #1) of five residents reviewed for elopement. The facility failed to prevent Resident #1 from eloping from the facility on an unknown date in July 2025. The failure could place residents at risk for possible elopement, serious injuries, and harm. An Immediate Jeopardy (IJ) was identified on 08/08/25. The IJ template was provided to the facility on [DATE] at 3:32 pm. While the IJ was removed on 08/09/25, the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm, and a scope identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems. Findings include: Review of Resident #1's Face Sheet reflected she was a [AGE] year-old female admitted to the facility on [DATE]. Review of Resident #1's Quarterly MDS dated [DATE] reflected diagnoses including Chronic Obstructive Pulmonary Disease (condition caused by damage to the lungs), coronary artery disease (disease caused by buildup of plaque in the arteries of the heart), anxiety disorder, and Depression. A BIMS score of 10 was reflected, indicating moderate cognitive impairment. Resident #1 scored 0 on wandering behaviors, which indicated the behavior was not exhibited. Review of Resident #1's Care Plan with start date 6/13/25 reflected Resident #1 had a focus of elopement risk r/t history of attempts to leave the facility unattended, and with impaired safety awareness with date initiated 9/09/24 and revised solely on 12/24/24. In an interview on 8/05/25 at 12:41 pm, CNA A stated that approximately two weeks prior (exact date unknown), Resident #1 had climbed out of a window on the female locked unit. She stated that she saw Resident #1's wheelchair sitting empty by an open window and had notified LVN B. She reported staff searched the unit and then the property, but that Resident #1 was not located, and staff began using their vehicles to search the community. She stated she found Resident #1 coming out of [an auto parts store], the property adjacent to the facility, and escorted her back to the facility. She stated that the ADM arrived a short while later and threatened the jobs of staff if they were to say anything about the incident to anyone. In a telephone interview on 8/05/25 at 4:00 pm, LVN B stated about two weeks ago (exact date unknown), she was notified by CNA A that Resident #1 had gone out a window on the female locked unit. She stated that Resident #1 was not found at the facility but that she was returned to the facility by CNA A who reported that Resident #1 had been found at a nearby auto parts store. She stated she assessed Resident #1 upon her return to the facility and that she did not have any injuries. She stated that she called and notified the ADM and that he arrived approximately thirty minutes later and fixed the window that Resident #1 had kicked out. She stated she did not chart the elopement or her injury assessment because she was told by the ADM that he had to do an investigation, and he would take care of it. She stated she was not aware of any prior elopement attempts by Resident #1. Review of Resident #1's June 2025, July 2025, and August 2025 progress notes did not reflect any documentation to indicate an elopement or elopement attempt. A few progress notes reflected Resident #1 was on Q15 minute checks and had exhibited no exit seeking behaviors during a shift but did not indicate the reason for these checks and observations. The facility incident report log was reviewed for May 2025, June 2025, and July 2025 and no elopement incidents were reflected. The facility in-service training attendance roster titled, Elopement Drill and dated 6/13/25 was reviewed with 53 staff signatures noted present. In an interview on 8/05/25 at 1:30 PM LVN C stated while working the evening shift approximately two weeks ago (exact date unknown) she was notified by CNA A that Resident #1 had gone out of a window on the female locked unit. She stated she immediately started looking for the resident after notifying LVN B. She stated she and other staff had driven around the community looking for Resident #1. She reported she next saw Resident #1 walking up to the front of the building escorted by CNA A and was told that Resident #1 was found next door at an auto parts store. She stated that Resident #1 had not appeared to have any injuries. She stated she was not aware of any prior elopement attempts by Resident #1. She reported that the ADM came to the facility about thirty minutes later but did not speak to her. She denied she was threatened or told not to say anything about the incident. She stated that when she worked the day shift the following day, she was told in report that Resident #1 had tried to elope, and she thought this was strange because Resident #1 had actually eloped. She stated that Resident #1 was placed on Q15 minute checks for elopement risks. She stated she had thought the windows were secured but that she noted someone working on the window the day following the incident. In an interview on 8/05/25 at 1:40 PM CNA D stated she was told by a CNA (name</p>		