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	03/31/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure, based on the comprehensive assessment of a resident, a resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for three of five residents (Residents #1 #2, and #3) reviewed pressure ulcers. 1. The facility failed to consistently identify, measure and stage pressure ulcers on skin assessments for Residents #1, #2 and #3 from January 2026 through March 2026.2. The facility failed to update care plans to reflect current wounds for Resident #1 and Resident #2. 3. The facility failed to ensure wound care to skin and treatment orders for pressure ulcers were provided as directed for Resident #1 and Resident #3. These failures could place residents at risk of inconsistent tracking of wound status and progression, placing residents at risk for worsening pressure injuries, delayed healing and development of more advanced wounds. Findings included:1. Record review of Resident #1's face sheet, dated 03/28/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included hemiplegia and hemiparesis (paralysis and weakness on one side of the body), vascular dementia (cognitive impairment caused by reduced blood flow to the brain), muscle wasting and atrophy (loss of muscle mass and strength) and chronic kidney disease-stage 2 (mild kidney damage with decreased kidney function). Record review of Resident #1's admission MDS assessment, dated 02/05/26, reflected she had a BIMS score of 11, which indicated moderate cognitive impairment. Resident #1 had no physical or verbal behaviors directed towards others but had at least one episode of rejection of care during the previous assessment period. Resident #1 had range of motion impairment on one side of her lower extremity and used a wheelchair for mobility. Resident #1 was dependent and/or physically dependent on staff to complete bed mobility (rolling left to right, sitting up, laying down and bed/chair transfers). Resident #1 was always incontinent of urine and frequently incontinent of bowel. She weighed 85 pounds and was five foot five inches tall and was at risk of developing pressure ulcers. Resident #1 had one unhealed pressure wound that was a Stage 3 (a full-thickness skin injury that extends into the subcutaneous fat) that was present upon admission. Skin and wound treatments included a pressure reducing device for the bed and pressure wound/injury care. Record review of Resident #1's care plan, dated 01/27/26 and last revised 03/03/26, reflected [Resident #1] has pressure wound (lt heel); Interventions.Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (Date Initiated: 01/27/26). Resident #1's care plan did not reflect she had a sacral wound. Record review of Resident #1's Physician Order Summary, dated 03/31/26, reflected she was prescribed the following treatments:-Weekly Skin Assessment (start date 01/27/26)-Apply betadine-soaked gauze to pressure of Left heel; cover with ABD pad, wrap with kerlix and an ace wrap daily and as needed for soilage, as needed for to promote wound healing (start date 02/17/26)-Triad paste to be applied to sacral area every day shift to promote healing (start date 03/26/26) Record review of Resident #1's admission Braden Scale for Predicting Pressure Sore Risk, dated 01/28/26, reflected she had a score of 15, which indicated she was at risk. Record review of the following weekly skin assessments for Resident #1 reflected the sacral wound was repeatedly (continued on next page)

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

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	omitted from assessments after initial identification and heel wounds were inconsistently documented with absent measurements and staging on the following dates:01/27/26- Sacral wound identified; no measurements or stage documented.02/03/26-Sacral wound was not documented. New pressure areas to right and left heels identified. 02/10/26-Sacral wound not documented. Right heel pressure wound identified; no measurements or staging documented. 02/17/26-Sacral wound not documented. Right heel noted as redness only. Left heel documented as Stage 3 pressure wound; no measurements documented. 02/24/26-Sacral wound not documented. Left heel wound documented with no measurements of staging. Notes reflected excessive exudate and podiatry involvement. 03/03/26-Skin assessment left blank; no wound documented. 03/13/26- Left heel pressure wound identified; no measurements documented. Notes indicate Stage 3 pressure wound with treatment in progress. 03/17/26-Pressure wound of left heel -no measurements or stage reflected. 03/25/26-Sacral redness identified. Stage 3 pressure wound to left heel documented. Record review of Resident #1's March 2026 TAR reflected no wound treatment was documented as provided to her sacral area on 03/27/26, and to her left heel on 03/14/26, 03/17/26, 03/18/26 and 03/27/26. Record review of Resident #1's nursing progress notes on the dates of missing wound treatment on the TAR do not indicate any wound care was documented as provided. Record review of Resident #1's wound care physician visits reflected she was seen twice since admission, 02/03/26 and 02/10/26. On 02/03/26, the wound care physician noted Resident #1 had wounds on her left and right heels, with the left heel being a Stage 3 pressure injury with the wound description post op debridement at 2.8 x 3.1 x 0.3 cm with a wound area of 8.68 cm with the wound increasing in size. Resident #1's right heel was noted to be a deep tissue injury with a measurement of 1x2xUTD cm with a wound area of 2.00 cm and decreased in size. During the second wound care visit on 02/10/26, the wound care physician noted Resident #1's left heel had progressed to a stage 4 pressure injury and surgical debridement was completed with the post op wound bed measured at 2.9 cm x 3.4 cm x 0.3 cm (9.86 cm^2 surface area) and had increased in size, while the right heel DTI was measuring at 00 and the wound was noted to be epithelized. The facility did not provide any additional wound doctor visits notes for Resident #1 and no other visits were available in her clinical chart. An observation on 03/29/26 at 2:23 PM revealed Resident #1's wound care. Resident #1's left foot was observed wrapped in kerlix secured with Coban (a breathable cohesive bandage for securing dressings) and the dressing was dated 03/29/26. Resident #1 did not want the wound dressing to be redone. An interview with Resident #1 on 03/29/26 at 2:25 PM revealed her wound care was done in the morning every day. She said she was also seen by a podiatrist and reported no complaints. 2. Record review of Resident #2's face sheet, dated 03/28/26, reflected a [AGE] year-old female who admitted to the facility on [DATE]. Resident #2 had diagnoses which included hemiplegia and hemiparesis (paralysis and weakness on one side of the body), muscle wasting and atrophy (loss of muscle mass and strength), vascular dementia (cognitive impairment caused by reduced blood flow to the brain), type 2 diabetes (a condition affecting blood sugar control), mild protein-calorie malnutrition (inadequate intake of protein and calories affecting overall nutrition), peripheral vascular disease (reduced blood flow to the extremities, especially the legs and feet), joint contracture (permanent tightening of muscles or joints limited movement) and osteoporosis (weak and brittle bones at increased risk for fracture). Record review of Resident #2's quarterly MDS assessment, dated 02/24/26, reflected she most recently re-admitted to the facility after an acute hospital stay on 02/16/26. Resident #2's BIMS score was 07, which indicated severe cognitive impairment. Resident #2 had no signs or symptoms of delirium, no negative mood concerns, no physical or verbal behaviors directed towards others and no rejection of care issues. Resident #2 had range of motion issues on one side in her lower extremity and used a wheelchair for mobility. She was dependent on staff for bed and chair mobility, which included rolling from side to side. Resident #2 had an indwelling catheter and was always incontinent of bowel. Resident #2 weighed 144 pounds, was five foot seven inches tall and had significant weight loss during the last assessment period. She was at risk for developing pressure wounds but did not have (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	any identified pressure wounds and required no skin or wound treatments required. Record review of Resident #2's Care Plan, initiated 12/26/21 and last updated 04/07/25, reflected 1) The resident has potential for pressure ulcer development r/t limited mobility, incontinence, 2) [Resident #1] has potential/actual impairment to skin integrity of the (Lt posterior thigh) r/t MASD, 3) The resident has potential impairment to skin integrity r/t psoriasis (an autoimmune skin condition that causes itchiness and discomfort and causes thick, scaly areas of skin), dermatitis (a skin condition that causes dry and itchy patches of skin). Interventions included, Follow facility protocols for treatment of injury. Resident #2's care plan did not reflect any current pressure wounds. Record review of Resident #2's Physician Order Summary, dated 03/31/26, reflected the following orders: 1) Cleanse pressure to sacrum with NS/WC; pat dry and apply calcium alginate to the wound bed and cover with dry dressing every day shift and as needed to promote wound healing (Start date 03/06/26); and 2) Weekly skin assessment (start date 02/18/26). Record review of Resident #2's March 2026 TAR reflected wound treatment was provided to her sacrum per physician orders. Record review of the following weekly skin assessments for Resident #2 reflected on 02/18/26-Sacral wound identified with no measurements or staging documented; 02/25/26-Sacral wound-no staging documented-Notes reflected the wound measured 3.0cm x 2.1cm; 03/03/26- Sacral wound- no staging documented-Notes reflected the wound measured 6.8 cm x 5.0 cm x UTD; 03/13/26- Sacral wound identified; no measurements or staging documented. New areas of MASD to left and right lower buttock identified; 03/17/26- Sacral wound measured at 8.5 cm x 7.5cm x 0.4 cm and was Unstageable; 03/24/26-Sacral wound identified at a Stage 4, with measurements of 9.0 x 5.5x 0.5 cm. Notes reflected the wound had increased in size and the resident was seen by a wound physician. Record review of Resident #2's wound care physician notes reflected on 02/16/26, a wound to the sacrum was identified as MASD and measured 3.1 cm in length by 1.0 cm in width, with a depth unable to be determined. No signs of infection were noted and wound progress was documented as undetermined as it was the initial visit. Resident #2 was seen five more times and on 03/24/26, the wound care physician again evaluated the sacral wound again, which had become a Stage 4 pressure injury. Measurements reflected 9.0 cm x 5.5 cm with a post procedure depth of 0.6 cm and a total wound area of 49.50 cm. Documentation reflected the wound had evolved into a pressure injury requiring surgical debridement of devitalized tissue, which included subcutaneous tissue, muscle fascia and tendon. The physician noted evidence of tissue decline and the need for ongoing treatment. An observation on 03/29/26 at 1:44 PM of wound care for Resident #2 revealed the old wound dressing was dated 03/28/26, the wound was observed to be open with a deep, full-thickness tissue injury on the lower back/tailbone area where skin loss was complete, which exposed subcutaneous fat with a large amount of drainage. LVN B completed Resident #2's wound care appropriately and without concern. An interview with Resident #2 on 03/29/26 at 1:50 PM revealed staff took good care of her and treated her wound every day. Resident #2 said she was also seen by the wound doctor and reported no complaints. An observation of Resident #2's on 03/29/26 at 3:44 PM revealed her wound was on the sacrum, the resident was on an air loss mattress and wound care had been completed prior to the RN state surveyor viewing it. The dressing was dated 03/29/2026. With Resident #2's permission, LVN D pulled back the dressing with resident's permission and an open area was observed with redness around it, full-thickness tissue injury was on the lower back/tailbone area where skin loss was complete, exposing subcutaneous fat, moderate amount of dressing noted, no foul smell noted. An interview with LVN B on 03/31/26 at 3:45 PM revealed Resident #2 developed the pressure ulcer in-house after her overall health declined resulted in the resident being placed on hospice and started spending more time in bed. LVN B stated the facility did everything to prevent the development of the pressure ulcer to include having the resident on an air loss mattress and turning/repositioning the resident every two hours and as needed. 3. Record review of Resident #3's face sheet, dated 03/28/26, reflected a [AGE] year old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included unspecified dementia (decline in memory and thinking abilities without a specific identified (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cause), Alzheimer's disease (a progressive brain disorder that causes memory loss and cognitive decline) and muscle weakness (reduced strength affecting mobility and physical function). Record review of Resident #3's significant change MDS assessment, dated 02/27/26, reflected a BIMS score of 05, which indicated severe cognitive impairment. Resident #3 had no verbal or physical behaviors towards others and did not have any rejection of care issues. She had no range of motion issues and used a wheelchair for mobility and required partial/moderate assistance for bed mobility and transfers. Resident #3 was always incontinent of bowel and bladder and was at risk of developing pressure ulcers/injuries. The MDS reflected she had one unhealed pressure ulcer that was unstageable and was present upon admission. Additional skin conditions were MASD and treatments included a pressure reducing device for the bed and pressure ulcer/injury care. Record review of Resident #3's Care Plan related to wounds, initiated on 12/31/25 and last updated on 03/25/26, reflected: 1) The resident has potential for pressure ulcer development r/t immobility (Date Initiated: 12/31/2025)- Follow facility policies/protocols for the prevention/treatment of skin breakdown; 2) The resident has (unstageable) pressure ulcer (sacrum) r/t immobility (Date Initiated: 03/17/2026)-Administer treatments as ordered and monitor for effectiveness and follow facility policies; 3) The resident has infection of the wound to her sacrum (Date Initiated: 03/25/2026)-Administer antibiotic PO BID until 4/8/26 as per MD orders. Record review of Resident #3's Physician Order Summary, dated 03/31/26, reflected the following orders: 1) Weekly skin assessment (start date 12/23/25), 2) May be seen by facility wound physician as needed (start date 12/23/2025), and 3) Cleanse unstageable pressure to sacrum with NS/WC; pat dry; apply betadine; calcium alginate to be applied and dry dressing. every day and evening shift to promote wound healing (start date 03/30/26). Record review of Resident #3's March 2026 TAR reflected no treatment was documented as provided to her sacrum on 03/16/26, 03/21/26 and 03/22/26, and no medication was documented as applied to her left upper buttock redness to promote wound healing on 03/21/26, 03/22/26, 03/26/26 and 03/27/26. Record review of Resident #3's nursing progress notes on the dates of missing wound treatment on the TAR do not indicate that any wound care was provided. Record review of Resident #3's Braden Scale for Predicting Pressure Sore Risk at admission on [DATE] was 22, which indicated she was initially not at risk. A quarterly Braden Scale assessment on 03/19/26 indicated her score had decreased to 13, which indicated she was at moderate risk for pressure wound development. Record review of the following weekly skin assessments for Resident #3 reflected inconsistent identification and measurement of her sacral wound, with multiple skin assessments noted as refused or incomplete: In early January 2026, several weekly skin assessments were documented as refused or limited, with the nurses noting the resident did not allow a full skin assessment. During this time, documentation alternated between arm discoloration and no skin issues identified. On 02/05/26, multiple skin concerns were identified, which included bruising, redness and MASD. On 03/20/26, a sacral pressure wound measuring 6.5cm x 4.0 cm was identified and documented as unstageable. On 02/12/26, the sacral wound was not listed. Subsequent assessments on 02/24/26 reflected no identification of a wound concern. On 03/13/26, the skin assessment reflected a sacral wound again, with no measurements or staging. A new area of MASD was noted to Resident #3's left and lower right buttock. Record review of Resident #3's wound care physician notes reflected on 02/10/26, she was evaluated for a sacral wound identified as an unstageable pressure injury, measuring 4.0cm x6.5cm (26.0 cm). Documentation noted moderate serous drainage (thin, clear to pale yellow liquid-watery part of blood) and described the wound as demonstrating rapid, significant clinical decline at that time. No procedure was performed and treatment consisted of calcium alginate and dry dressing. Wound progress was documented as undetermined. Resident #3 continued to have six more weekly visits and on 03/24/26, the follow-up evaluation reflected the wound as a Stage 3 pressure injury, measuring 8.4cm x 4.1 cm (34.44cm). Drainage remained moderate and serious. Wound progress was specifically noted as increased in size. Treatment at that time included betadine, calcium alginate and dry dressing, with recommendation for antibiotic therapy. An interview with LVN (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A on 03/31/26 at 9:41 AM revealed the treatment nurse (WC LVN B) usually staged a resident's pressure injury, or the wound doctor. She stated when a resident developed a pressure injury, she was not sure who updated the care plan. She said, I give it to the treatment nurse and it goes from there down the line. LVN A stated the treatment nurse was responsible for all the residents' wound/skin treatments and related documentation. She stated if a charge nurse did wound care for a resident, it would only be PRN and there was a place to click off in the e-chart that it was completed, or the nurse could write a nursing note. LVN A stated the treatment nurse was responsible for weekly skin assessments for the residents but would sometimes delegate other charge nurses to complete them if she had too many to do. LVN A said she completed a weekly skin assessment before, but the wound care nurse did them for the whole facility. LVN A stated she had not measured any wounds on residents in the facility. She stated if a wound inconsistently appeared on the weekly skin assessments, it could be that the wound doctor came in and did an assessment and the wound had resolved and the resident's treatment orders were discontinued. She stated if that was the case, there would need to be a discontinued order to reflect it. An interview with the DON on 03/31/26 at 10:17 AM revealed a pressure injury could be staged by the facility nurses, but if they were not sure or uncomfortable, they could identify and document the general area and the treatment nurse could stage it with the doctor later. The DON stated treatment documentation included weekly measurements of resident wounds and weekly skin assessments completed by the treatment nurse, the purpose of which was to determine if a wound was getting larger or deteriorated. The DON stated she ensured wounds were measured consistently each week by checking the treatment nurses' skin assessments, reviewing wound doctor notes and asking about any skin concerns in the morning meetings. She stated a wound not documented correctly on a skin assessments were important because the wounds needed to be measured so the facility could know if they were getting better or worse. The DON stated if she noticed that it was occurring, she would reach out to the treatment nurse to inquire. The DON stated when a resident developed a pressure injury, the treatment nurse should update the care plan, stage the pressure injury and list the wound care interventions. She stated verification of resident wound treatment completion was done daily by nursing management by running an audit to review in the morning meeting of any missed treatments or medications. The DON stated if there were missing treatments on the TAR, she would have the treatment nurse follow up on it, since it is her area. The DON stated the treatment nurse (LVN B) chose to do all the residents' skin assessments (around 96) in the facility Mondays through Thursdays, so everyone should have one every seven days. The DON stated the treatment nurse (LVN B) scheduled completion of all residents' weekly skin assessments (approximately 96) from Monday through Thursday, with the expectation that each resident was assessed every seven days. She stated this scheduled was determined by the treatment nurse, and she had sufficient time during her eight-hour shifts and that additional support would be provided if needed. The DON further stated she reviewed resident charts to monitor wound care delivery but had not identified that wound measurements were not consistently documented or completed during weekly skin assessments. The DON stated that ensuring compliance with wound care planning and documentation was the responsibility of LVN B. An interview with the treatment nurse, LVN B on 03/31/26 at 10:40 AM revealed she could not stage a wound, only describe it, but the DON could stage a wound since she was an RN. LVN B stated she could also wait and go over it with the wound doctor when he came for his weekly visit. LVN B stated when a resident developed a pressure injury, she should be the person to update the care plan when she saw the wound. She stated she did not know the time frame to update the care plan, but she tried to do it as quickly as possible. LVN B stated wound treatment was documented on a resident's TAR and floor nurses were responsible for any treatment to wounds when she was not present at the facility. LVN B stated she was mainly responsible for the weekly skin assessments for all the residents in the facility and she had recently started getting the assessments to trigger on the e-chart each day from Monday through Thursday, and on Friday she wanted a break. She stated on Fridays, no skin assessment should (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	trigger unless it was a new admission. She stated this was a new system she was implementing to help her break up the number of weekly skin assessments she had to do during the week. LVN B stated residents' wound measurements were typically done when the wound doctor came for his weekly visit and she felt she had not missed measuring any residents' wounds. She stated when the wound doctor measured the wound, he documented it and she then transferred his measurements to the resident's weekly skin assessments. LVN B stated measurements were important, So we can monitor if it is getting better or worse, shrinking or growing. If we skip measuring, then now you lose track of monitoring.Then there is the possibility of something progressing or getting worse based on measurements. An interview with ADON C on 03/31/26 at 12:25 PM revealed when a new wound was identified, the charge nurses could not stage, so she expected them to notify the treatment nurse who would then complete a full skin assessment head to toe and notify the wound doctor or the primary physician. ADON C stated when a resident developed a pressure injury, the treatment nurse was responsible to update the care plan, She is all things wound care. ADON C stated she wanted to see the treatment interventions for a resident's wound on their care plan, such as a low-air loss mattress, cushions and physician ordered wound treatment. ADON C stated if a wound was worsening she expected the treatment nurse to notify the doctor because maybe something the facility was doing was not working and the resident needed more physician oversight. ADON C stated the treatment nurse was responsible for completing all residents' weekly skin assessments and she did not have oversight of her position, the DON did. ADON C said missing wound measurements on weekly skin assessments could result in the facility not being able to determine if a wound was getting better or worse and could leave gaps and holes for that specific wound care. Record review of the facility's policy titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol, (revised April 2018) reflected, Assessment and Recognition-. 1.In addition, staff or practitioner will describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue; 3. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions; 4. The physician will assist the staff to identify the type (for example, arterial or stasis ulcer) and characteristics (presence of necrotic tissue, status of wound bed, etc.) of an ulcer. Record review of the facility's policy titled, Wound Care, (revised October 2010) reflected, Documentation- The following information should be recorded in the resident's medical record: 1. The type of wound care given; 2. The date and time the wound care was given; 3.The name and title of the individual performing the wound care; 4. Any change in the resident's condition; 5.All assessment data obtained when inspecting the wound; 6. Any problems or complaints made by the resident related to the procedure; 7. If the resident refused the treatment and the reason(s) why; 8.The signature and title of the person recording the data.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 out of 2 medication carts (MC#1) reviewed for medication storage. The facility failed to ensure the male secure unit medication cart was free of undated and unlabeled insulin on [DATE]. This failure could place residents at risk of poor insulin blood sugar control from expired insulin.Findings include:During an observation and interview on [DATE] at 7:30 AM the state surveyor and LVN-PRN F observed: *Basaglar Kwik pen with no open date on the secure male unit medication cart.*Lantus Kwik pen with no open date on the secure male unit medication cart.*Lantus Kwik pen with no name and no open date on the secure male unit medication cart.During an interview on [DATE] at 7:35 AM, LVN-PRN F stated insulin should be dated as soon as the nurse opened it. LVN-PRN F stated insulin could not be effective after 28 days. LVN-PRN F stated insulin that did not have the resident name needed to have the resident name to make sure the correct resident got their medication. LVN-PRN F removed the undated and unnamed insulin from the medication cart and took it to the interim DON.During an interview on [DATE] at 7:40 AM, LVN A stated insulin should be dated as soon as it was opened and a resident identification sticker should be on the Kwik pen. LVN A stated insulin did not last a month and should be removed from the medication cart within 30 days. LVN A stated undated insulin could be expired and could cause residents to be hypoglycemic (blood sugar (glucose) level is lower than the standard range), hyperglycemic (lack of insulin) .or make residents sick. Each nurse was responsible for checking their cart and making sure the insulin was properly labeled. During an interview on [DATE] at 7:55 AM, LVN G stated insulin was dated as soon as it was opened to make sure the insulin was not expired and effective. During an interview on [DATE] at 10:30 AM, the interim DON stated nursing staff were responsible for checking their medication cart on every shift and making sure the insulins were labeled and dated. The interim DON stated insulin not labeled and dated were removed from the medication carts. The interim DON stated opened insulin was considered expired after 28 days.Record review of the facility's policy titled Administering Medications, revised 04/2019, reflected 12.When opening a multi-dose container, the date opened is recorded on the container.16. Insulin pens are clearly labeled with the resident's name or other identifying information. Prior to administering insulin with an insulin pen.

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	675906	A. Building B. Wing	03/31/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure in accordance with accepted professional standards and practices, the facility maintained medical records on each resident that were complete and accurately documented for one of five residents (Resident #1) reviewed for medical records. The facility failed to document physician-ordered weekly weights for Resident #1. The failure could place residents at risk for incomplete clinical records and an inability to accurately monitor nutritional status and changes in condition such as worsening pressure injuries, delayed healing and additional skin breakdown. Findings include:Record review of Resident #1's face sheet, dated 03/28/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included hemiplegia and hemiparesis (paralysis and weakness on one side of the body), vascular dementia (cognitive impairment caused by reduced blood flow to the brain), muscle wasting and atrophy (loss of muscle mass and strength) and chronic kidney disease-stage 2 (mild kidney damage with decreased kidney function). Record review of Resident #1's admission MDS assessment, dated 02/05/26, reflected she had a BIMS score of 11, which indicated moderate cognitive impairment. Resident #1 had no physical or verbal behaviors directed towards others but did have at least one episode of rejection of care during the previous assessment period. She weighed 85 pounds and was five foot five inches tall and was at right of developing pressure ulcers. Resident #1 had one unhealed pressure wound that was a Stage 3 (a full-thickness skin injury that extends into the subcutaneous fat))and was present upon admission. Skin and wound treatments included a pressure reducing device for the bed and pressure wound/injury care. Record review of Resident #1's care plan, dated 01/27/26 and last revised 03/03/26, reflected The resident has the potential for a nutritional problem r/t chronic kidney disease, cancer to the lung, history of pneumonitis (general inflammation of lung tissue (alveoli) not caused by infection)due to inhalation or vomit; Interventions: Monitor/record/report to MD PRN s/sx of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Record review of Resident #1's Physician Order Summary, dated 03/31/26, reflected Weigh weekly for 4 weeks every day shift every Thursday for weight monitoring for 4 Weeks (start 03/12/26). Record review of Resident #1's e-chart, which included her March 2026 MAR/TAR and vitals tab, reflected no weights were documented after the order was given on 03/12/26 through 03/31/26. An interview with LVN A on 03/31/26 at 9:41 AM revealed when weight loss was identified, she usually brought it up in the morning meeting and informed staff the resident's intake and output needed to be monitored, possibly reach out to the registered dietician and get supplements to get weight back on and maybe start putting them on weekly weights. LVN A stated the weights triggered on the wound care TAR and she believed the treatment nurse (LVN B) took care of it and sometimes distributed the task to the CNAs to help her record them on certain days. LVN A stated she looked to see if a resident's interventions were working nutrition wise by looking for weight changes and better appetite. She stated a resident's weight was supposed to be recorded on the MAR/TAR. LVN A stated she was not responsible for verifying if weights were taken or their accuracy. An interview with the DON on 03/31/26 at 10:17 AM revealed residents' weights should be recorded under the vitals tab on their e-chart, unless they refused, then the nurses had to complete a progress note. The DON stated newly admitted and re-admission residents should have a weekly weight for the first four weeks post admit, and then all residents should have one monthly thereafter. An interview with the treatment nurse, LVN B, on 03/31/26 at 10:40 AM revealed she was the weight loss monitoring nurse and she tried to keep up with monitoring resident weight losses and whether it was healthy or an unhealthy changes. She stated residents' weights were ideally done once a month and some had weekly weights which triggered on the e-chart. LVN B stated, I try to do them for the weekdays and if not, I have CNAs split (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them because I cannot do them all every single month. She stated she had no restorative aides to assist with taking weights. LVN B stated if a resident's weight was missing, she tried to obtain it right away. If she noticed weight appeared to be changing for a resident, then she tried to put them on weekly weights to monitor. An interview with the ADM on 03/31/26 at 12:10 PM revealed resident weights were taken, recorded and followed by the treatment nurse, LVN B. He stated she oversaw the facility's weight loss/gain system and he believed she had the CNAs doing the weights for the halls they worked on. The ADM stated when a resident was a new admission, his understanding was they got weekly weights for 3-4 weeks because, It gives a better weekly baseline versus a monthly which is a snapshot, you may not notice those changes. An interview with ADON C on 03/31/26 at 12:25 PM revealed LVN B was over the facility's weight system because she followed wounds and nutrition, which play together as a whole. She stated if weights were not being completed weekly as ordered, then it could cause the facility to miss any trends down or up in weight. LVN B stated when a resident admitted , the facility had to establish a baseline and consistently weigh the resident over a four week period. If no weights were recorded weekly after admission, ADON C stated she would expect to see a nursing note explaining why there was no weight recorded for that week. Record review of Resident #1's nursing progress notes from 03/12/26 through 03/31/26 reflected no recorded weights or refusals of weights to be taken. Record review of the facility's policy titled, Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol, (revised September 2017) reflected, 1. The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparisons over time;.4. The staff will report to the physician and dietitian any significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 1 of 5 Residents (Resident#1) reviewed for infection control. The facility failed to maintain a clean resident environment when dried fecal matter was observed smeared on Resident#1's bed frame. This failure could place residents at risk to exposed fecal matter which would increase the risk of health-associated infections.Record review of Resident 1#'s Quarterly MDS Assessment, dated 2/19/2026, reflected a [AGE] year-old female who was admitted on [DATE]. No BIMS score was recorded which indicated there was no interview. The resident had diagnoses which included pneumonia (an infection that inflames the air sacs in one or both lungs, causing them to fill with fluid or pus, resulting in cough, fever, chills, and breathing difficulties), muscle weakness, and Non-Alzheimer's Dementia (various incurable, progressive conditions that cause nerve cells [neurons] in the brain or spinal cord to malfunction and die, leading to cognitive decline). Record review of Resident #1's Comprehensive Care Plan, Date Initiated: 12/24/2025 Revision on: 01/22/2026 reflected The resident has an ADL self-care performance deficit r/t Dementia (a progressive decline in memory, language, problem-solving, and cognitive abilities severe enough to interfere with daily life). Interventions: Toileting Hygiene: Substantial/maximal assist). Record review of Resident #1's Comprehensive Care Plan Date Initiated: 03/25/2026 reflected: [Resident#1] has infection of the wound to her sacrum. [Resident#1] will be free from complications related to infection through the review date. Goal: [Resident#1] will be free from complications related to infection through the review date. Interventions included: Administer antibiotic (Bactrim DS 800-160 (is a double-strength, prescription combination antibiotic used to treat bacterial infections) (1) tab PO BID until 4/8/26) as per MD orders. Record review of Resident #1's active physician ordered reflected: Bactrim DS Oral Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim) (is a double-strength, prescription combination antibiotic used to treat bacterial infections) Give 1 tablet by mouth two times a day for wound infection for 14 Days Phone Active 03/24/2026. During an observation on 03/29/2026 at 3:00 PM revealed brownish dried substance on Resident#1 bed frames. The resident was not interview able. During an interview on 03/29/2026 at 3:05 PM with the Administrator he identified the smear as feces and stated all residents bed should be clean. He stated the risk to the resident was infection and stated he was going to have someone clean the feces immediately. He stated the nursing staff were responsible for cleaning bodily fluid then housekeeping would sanitize. He stated the staff had been in serviced on infection control to include keeping the residents' beds clean. During an interview on 03/29/2026 at 3:15 PM with LVN A, she stated the brown stuff was unsanitary and she was not sure if it was pudding or something else. She stated the CNAs were primarily responsible for cleaning any body fluids because they provided most of the incontinent care. She stated the nurses were also responsible for ensuring the residents were living in sanitary environments. She stated the risk to the residents was infection due to exposure to fecal matter. She stated she had been Inservice on infection control. During an interview on 03/29/2026 at 3:35 PM with CNA B reflected she had not observed the fecal smeared on the resident's bed before the state surveyor brought it to her attention. She stated it was the CNA's responsibility to ensure residents' beds were cleaned and free of bodily fluids and fecal matter. She stated the risk of the resident was infection. She stated she had been in serviced on infection control. During an interview on 03/29/2026 at 4:15 PM with the DON revealed her expectation was the nurses and CNAs were ensuring the residents were living in clean and sanitary environments. She stated it was the nursing staff's primary responsibility to clean any body fluids and feces on the resident's bed frame then housekeeping would sanitize and clean. She stated she was the interim DON but believed the staff (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had been in serviced on infection control. She stated the risk to the resident was health related infections. Record review of the facility policy titled: Standard Precautions reflected: 6. Environmental Control: Environmental surfaces, bedrails, bedside equipment, and other frequently touched surfaces areˆappropriately cleaned.