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	04/02/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to immediately notify, consistent with his or her authority, the resident representative(s) when there is a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for 1 out 3 residents reviewedLVN A failed to notify Resident #1's representative that he was found unresponsive and was transported to the local hospital. This failure placed residents at risk of not having representatives informed of changes in conditions, preventing representatives from being informed and making informed decisions about the residents' care. Findings included:Record review of Resident #1's face sheet dated [DATE] reflected, Resident #1 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 was diagnosed with Type 2 diabetes mellitus with diabetic chronic kidney disease (high blood sugar damages kidney filters (nephrons), causing protein leakage), long term (current)insulin, chronic kidney disease stage 3 unspecified (mild-to-moderate kidney damage with an eGFR between 30-59, meaning kidneys are not filtering waste efficiently) and unspecified Dementia (diagnosis used when cognitive decline, memory loss, and functional impairment are present). Record review of Resident #1 face sheet reflected Resident #1 had a POA representative. Record review of Resident #1's quarterly MDS, dated [DATE] reflected a BIMS of 11 which indicated Resident #1 had moderate cognitive impairment. Record review of Resident #1's incident report on [DATE] at 8:00 PM reflected, At approximately 2000 [8:00 PM] During routine rounds the nurse heard a thump from the hallways the door was closed. Upon entering the resident was behind the door of the room. The shoes were several feet away next to the bed, along with his wheelchair the call light was on the pillow. Resident did not call for help. Resident was able to stand up and get himself in the wheelchair denies pain no open areas, no lumps, no bruising tolerates Rom [Range of motion]. 149/78 [Blood pressure] 97.8[Temperature] 80 [heart rate] 18 [Respiratory rate] . Resident Description: Resident Unable to give Description.Record review of Resident #1's neurological flow sheet documented by LVN B reflected on [DATE], Resident #1's vitals were within range. Resident #1 was checked every 15 minutes at 8:00 pm, 4 times. Resident #1's vitals were checked every 30 minutes twice; then on [DATE] Resident #1 vitals were checked every hour.Record review of Resident #1's progress notes dated [DATE] to [DATE] reflected:On [DATE] a progress note written by LVN B at 8:45 PM reflected At approximately 2000 [8:00 PM] During routine rounds the nurse heard a thump from the hallways the door was closed. Upon entering the resident was behind the door of the room. The shoes were several feet away nest to the bed, along with his wheelchair . Resident was able to stand up and get himself in the wheelchair denies pain no open areas, no lumps, no bruising tolerates Rom. Resident drinks a regular soda, fried fish the family [NAME] earlier. BS 507 refused insulin provided coaching asymptomatic. NP. POA, Adon notified.Record review of Resident #1's order summary dated [DATE] reflected no new orders given.On [DATE] a progress note written by LVN B at 9:41 PM reflected, Resident up in his wheelchair denies pain or dizziness s/p fall incident. Drinks a cup a coffee with regular sugar provided education.On [DATE] a progress note written by LVN A at 3:04 AM reflected: (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed ambulating via w/c during first half of shift. around 0245 [2:45 AM] res observed in chair diaphoretic (excessive seating) and unresponsive. Could not get BP on res. O2 99 p 78 BS 550. sternum rubmedical technique used to assess a person's level of consciousness or responsiveness) ineffective, unable to take anything by mouth, EMS called. BS read as HI [Blood glucose level is extremely high] still unable to read BS res unarousable but breathing steady and unlabored. Res transported to ER.Record review of Resident #1's hospital records dated [DATE] reflected, Resident #1 was transferred from the SNF to the ER on [DATE] at 3:21 AM. The chief complaint reflected high blood sugar (Registered high on EMS equipment). Visit diagnoses reflected subdural hematoma (Collection of blood that forms between the brain and outer covering, often due to head trauma, hypertensive (very high blood pressure that happens without warning and cause organ damage), and chronic anticoagulation (long-term use of blood-thinning medications to reduce the body's ability to form clots). The hospital records revealed Resident #1 was transferred to another local hospital for hospice within the hospital on [DATE] at 2:48 PM and expired on [DATE] at 9:45 AM.During an interview on [DATE] at 5:30 AM, LVN A stated LVN B reported Resident #1 had an unwitnessed fall earlier in the evening. LVN A stated she continued with Resident #1 neurocheck. LVN A stated she let the ADON, Admin and NP know that Resident #1 was sent out to the hospital. LVN A stated with everything going on she forgot to call Resident #1's POA. During an interview on [DATE] at 5:50 AM LVN C stated a resident representative should be contacted when there was a change in condition, fall or sent out to the hospital so that family was aware of the resident status.During an interview on [DATE] at 7:06 AM, LVN D stated the resident representative needed to be contacted when residents were sent out to the hospital in case additional information was needed that the facility did not know.During an interview on [DATE] at 9:22 AM Resident #1's Family Member stated they received a call on [DATE] at night that Resident #1 had a fall and was doing ok. Resident #1's Family Member stated at 2 AM they received a call from the hospital, that Resident #1 was in the hospital. Resident #1's Family Member stated they were told by the facility that the resident was fine after the fall. Resident #1's family member stated they wanted to know what happened after the fall and how did he end up in the hospital. Attempted to call LVN B on [DATE] at 9:52 AM and could not leave a voicemail. Attempted to call the NP on [DATE] at 10:53 AM and left a voicemail. During an interview on [DATE] at 11:35 AM, the facility Doctor called back and stated he was not for sure if the facility called him about Resident #1's being sent to the hospital. During an interview on [DATE] at 2:00 PM, the interim DON stated staff should have called the resident representative to make sure the family was aware of what happened. The interim DON stated she collaborated with staff to make sure they understood what was expected of them.Record review of facility policy title Resident Rights, (revised 12/2016) reflected, o. be notified of his or her medical condition and of any changes in his or her condition.Record review of facility policy titled Change in a Resident's condition or status, revised 02/2021 reflected, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: b. there is a significant change in the resident's physical, mental, or psychosocial status;.