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	05/01/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all alleged violations involving abuse and neglect were investigated and reported to other officials (including the State Agency) and the administrator of the facility for 2 of 6 residents (Resident #1 and Resident #2) reviewed for reporting.The facility failed to follow its abuse policy by not reporting to the ADM of the alleged incident regarding Resident #1 pulling Resident #2 out their bed, so the ADM could not report the alleged incident to HHSC and the ADM could not investigate the alleged incident.This failure could place residents at risk for abuse and neglect.Findings included: Record review of Resident #2's face sheet, dated 05/01/2026, revealed an [AGE] year-old female, with a primary diagnosis of zoster (shingles, painful rash caused by reactivation of chicken pox virus). Other pertinent diagnoses included encephalopathy (group of condition that cause brain dysfunction), dementia, unspecified severity, with agitation (brain disease that alters brain function and causes a cognitive decline and agitated behaviors), Alzheimer's disease (brain condition that progressively destroys memory and other important mental functions), muscle weakness, lack of coordination, and abnormalities of gait and mobility. Record review of Resident #2's SNF Part A PPS Discharge MDS assessment (evaluation for when a resident's Medicare Part A coverage ends), dated 04/11/2026, revealed a BIMs (a standardized assessment to measure long and short-term memory) of 04, indicated severe cognitive impairment. Resident #2's functional abilities revealed she required full dependence or maximal assistance from staff; she could not walk 10 feet and used a wheelchair. Record review of Resident #2's progress notes, dated 04/29/2026, reflected, The nurse's aide informed us at the time of report that the resident was on the floor in front of her bed. Aide said it may have been her roommate that pulled her but could not be confirmed. Resident assessed w/ no injuries or pain. Vitals wnls. No bumps bruises or broken skin. Neuros started. DON, ADON, Family and Provider notified. Patient is sleeping in bed with eyes closed, respirations regular, even, and unlabored, no signs of distress noted. Bed is in lowest position with wheels locked. Call light and personal items within reach. Fluids and snacks offered. WCTM.Record review of Resident #1's face sheet, dated 05/01/2026, revealed a [AGE] year-old female, with a primary diagnosis of metabolic encephalopathy (brain disorder that occurs when a chemical imbalance of the blood affects the brain). Other pertinent diagnoses included severe dementia with agitation (brain disease that alters brain function and causes a cognitive decline and agitated behaviors), and delirium (rapidly developing severe confusion).Record review of Resident #1's MDS BIMS Staff Interview assessment, dated 04/07/2026, revealed Resident #1 had short-term and long-term memory problems and was severely impaired cognitively to make daily decisions. There was no score on the assessment document. Record review of Resident #1's progress notes, dated 04/01/2026 - 05/01/2026, did not reveal documentation about the alleged incident.Record review of Resident #2's Un-witnessed Fall incident report, dated 04/28/2026, reflected, . Nursing Description: The nurse's aide informed us at the time of report that the resident was on the floor in front of her bed. Aide said it may have been her roommate that pulled her but could not be confirmed. The resident was assessed, no injuries, bumps, bruises or broken skin. Resident (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	states no pain. Vitals were obtained. DON, ADON, Provider and family notified. WCTM.During an observation and attempted interview on 05/01/2026 at 9:54 a.m., Resident #1 wandered the hall and interacted with other residents without behaviors. Resident #1 was not interviewable; Resident #1 did not respond directly to the questions asked and appeared to be confused. During an interview on 05/01/2026 at 12:51 p.m. CNA A stated she saw Resident #1 pull Resident #2 out of her bed. She said the residents were roommates and it happened on 04/28/2026 at about 10:00 p.m. CNA A said she came in the next day and saw Resident #2's hospice nurse, who said they did not receive a call about the incident. CNA A said she asked Resident #1 about her actions and Resident #1 said she was just trying to help Resident #2. The CNA said she did not tell the ADM but told the 2:00 PM - 10:00 PM nurse and 10:00 PM - 6:00 AM nurse. CNA A said she felt weird (uncomfortable) about the situation because Resident #1 was still living in the room with Resident #2. CNA A said when the 10:00 PM - 6:00 AM CNA arrived at shift change, she told her about the alleged incident too. During an interview on 05/01/2026 at 1:45 p.m. with LVN B, she said she came into her shift on the morning of 4/29/2026 and received a report Resident #2 fell. LVN B said the nurse on shift said CNA A told him Resident #1 may have pulled Resident #2 out of bed. LVN B said the hospice nurse talked to CNA A that morning (04/29/2026), and CNA A informed hospice of what she saw. LVN B said she reported the alleged incident in the morning meeting on 04/29/2026 with the ADON and SW, she was not sure if the ADM was there that morning. LVN B said she would report the alleged incident because it was different from what was said (the unwitnessed fall). She said residents may need to change rooms because Resident #2 could not speak for herself. During an interview on 05/01/2026 at 2:57 p.m., the ADON said she was alarmed by Resident #2's progress notes regarding the incident and that it was a reported fall by the 10:00 p.m. - 6:00 a.m. nurse. The ADON said no one informed her of the alleged incident in the morning meetings or throughout the day. The ADON said the nurse that wrote the progress note told her it was an unwitnessed fall. The ADON said Resident #1 had not been aggressive and her actions had been pleasant and sweet. The ADON stated Resident #1 and Resident #2 were not roommates, and Resident #2 had not had a roommate in a while. The ADON said she read the progress note this morning and showed the ADM. She said she was told the progress note was mis-documentation and it was an unwitnessed fall. The ADON said she expected nursing staff to report any allegation of physical abuse to the ADM. She said the risk of not reporting was the behavior could be repeated if Resident #1 did not like Resident #2. During an attempted interview and observation on 05/01/2026 at 3:15 p.m., Resident #2 was asleep with no signs of distress or injuries observed. During another attempted interview and observation on 05/01/2026 at 4:10 p.m. of Resident #2, LVN C came to Resident #2's room with the state surveyor. Resident #2's cognitive impairment limited her ability to talk to the surveyor. LVN C assessed Resident #2's head to ensure of no injuries. Resident #2 was able to communicate with LVN C that she needed changed, the state surveyor left the room. During an interview on 05/01/2026 at 4:15 p.m., LVN C said there were no injuries on Resident #2. LVN C said if an incident occurred when she was not in the facility, she would check on that resident when she came in for her next shift. LVN C said she was not aware of the incident regarding Resident #1 and Resident #2. She said after a fall or an incident occurred, she would do head-to-toe assessments, ask residents to move their limbs to make sure there was no range of motion issues, and do visual assessments. LVN C said the facility would then call the doctor and the doctor would want to know of any injury and what warranted the incident. During an interview on 05/01/2026 at 4:32 p.m., the ADM said he was not aware of the alleged incident, and he had just read the progress note an hour or two before the interview. He said he had not heard a statement from CNA A. He said he had the ADON interview CNA A and she had said the same thing (witnessing Resident #1 pulling Resident #2 out of bed). The ADM said he did not know why CNA A did not call about the incident. The ADM said that was something he would normally report. The ADM said if there was reasonable belief, he would treat the alleged incident the same. He said Resident #2 could not get up and walk. He said Resident #1 was very agitated when she was first admitted but had adjusted a lot (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but needed redirection. The ADM said this was an allegation and it needed to be reported correctly. The ADM said his perspective of the note was that he would have questioned if it should have been reported. He said the entire staff were taught on who to report to and mandatory reporting, and part of it was notifying supervisors and himself. He said if staff believed they saw abuse or neglect or someone reported it, the facility had to report it. During an interview on 05/04/2026 at 8:50 a.m., Resident #2's hospice nurse said she was told about the alleged incident after it occurred by CNA A. The hospice nurse said she came to the facility for a routine visit, the day after the alleged incident, and CNA A asked if she knew about the fall and she said no. The hospice nurse said she asked the ADON to pull up the report so she could review the incident report and vital signs. The hospice nurse said she heard the ADON saying what CNA A was reporting was wrong. The hospice nurse said she saw the note where CNA A said she witnessed the roommate (Resident #1) pulling Resident #2 out of bed. The hospice nurse said, at that time, Resident #1 and Resident #2 were roommates. The hospice nurse said Resident #2 could not tell her about the alleged incident. She said she did not see any change or injury to Resident #2 and Resident #2 did not bear any weight. She said she initially had no idea about the alleged incident because no one reported it to her and the facility was always supposed to notify her. The hospice nurse said the ADON knew but did not know why the ADON did not contact her. The hospice nurse said staff were saying the incident was not confirmed by CNA A, but CNA A said she was helping Resident #1 to bed and turned around and saw Resident #2 on the floor. The hospice nurse said she asked CNA A to clarify, and CNA A then said she saw Resident #1 pull Resident #2 out of bed.Record review of the facility's Accident and Incidents - Investigating and Reporting policy, dated 07/2017, reflected: Policy Statement All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator.Policy Interpretation and Implementation1. The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident.5. The nurse supervisor/charge nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the director of nursing services within 24 hours of the incident or accident. 6. The director of nursing services shall ensure that the administrator receives a copy of the Report of Incident/Accident form for each occurrence. Record review of the facility's Abuse Investigation and Reporting policy, dated 07/2017, reflected: Policy StatementAll reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.Reporting 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility administrator, or his/her designee, to the following persons or agencies:a. The State licensing/certification agency responsible for surveying/licensing the facility.2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than:a. two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure that residents receive treatment and car in accordance with professional standards of practices for 1 of 6 residents (Resident #3) reviewed for quality of care. The facility failed to identify and provide treatment for the wound on Resident #3's hand, that was present for at least 3 days. This failure could place residents at risk for not receiving appropriate treatment and care, developing skin infections and decreased quality of life. Findings included:Record review of Resident #3's face sheet, dated 04/13/2026, revealed a [AGE] year-old female admitted with a primary diagnosis of metabolic encephalopathy (brain disorder that occurs when a chemical imbalance of the blood affects the brain). Other pertinent diagnoses included dementia (Brain disease that alters brain function and causes a cognitive decline), chronic lymphocytic leukemia of B-cell type not having achieved remission (slow-growing blood cancer, that shows signs of presence in blood despite treatment), epilepsy (seizure disorder), and type 2 diabetes mellitus with diabetic polyneuropathy (a disease that occurs when the body does not respond properly to insulin leading to high blood sugar levels and causes numbness, pain, and impairment to the legs and feet). Record review of Resident #3's quarterly MDS assessment (a set of standardized assessments done on admission, quarterly, and with a significant change of condition, on each resident), dated 04/02/2026, revealed she had a BIMs score of 13, indicating intact cognitive function with minimal to no impairments in memory or thinking abilities. Resident #3's functional abilities revealed she only needed setup or clean-up assistance and supervision. Record review of Resident #3's progress notes, dated 04/01/2026 - 05/01/2026, did not indicate compromised skin integrity or wounds.Record review of Resident #3's most recent weekly skin assessment, dated 04/27/2026, revealed no new skin issues. Record review of Resident #3's ADL tasks MONITOR - Skin Observation for 04/02/2026 - 05/01/2026, revealed None of the above observed or Not Applicable was selected for each day over the course of the 30 days. The other skin observations options included scratched, red area, discoloration, skin tear, open area, resident not available, and resident refused. During an observation and interview on 05/01/2026 at 9:35 a.m., Resident #3 showed the state surveyor an injury on her hand. Resident #3 said she injured her hand on the shower handle, where a metal wire was sticking out. She said the injury hurt and nothing had been done about it except she was given naproxen (medication to reduce pain and inflammation). Resident #3 said the injury occurred on Tuesday, 04/28/2026 on hall 200's shower. She said she was independent when she showered, so no one was in the shower when the injury occurred. Resident #3 said she told someone on Thursday, 04/30/2026, around 3:00 PM about the injury but she could not remember who. She said the wound was infected and she would hate to lose her hand. Resident #3 gave the state surveyor permission to take a picture of the wound on her hand. Observation of the wound revealed the wound was in the bottom right corner of the left hand. The wound was slightly larger than pea-sized, with dark purple discoloration in the center of the wound, a ring of blue and purple discoloration, and surrounded with a ring of redness. The bottom right quarter of the palm of the hand was pink and red. During an observation and interview on 05/01/2026 at 10:41 a.m., the ADON was observed checking both showers in the facility, on hall 100 and 200 hall, which revealed no metal wires sticking out of the handles. The ADON tested both handles and there were no hazardous materials that could cause an injury to a resident. The ADON said she was not aware of a wound on Resident #3's hand. The state surveyor showed the ADON the image of the wound and she said the nurse practitioner was at the facility and she would have him look at it. The ADON said the wound looked gnarly (unpleasant, gross). The ADON said CNAs were usually good about texting her and telling her about injuries. She said she expected CNAs to notify nurses immediately, and nurses to call the doctors, do skin assessments, and find out the cause. The ADON said because Resident #3's wound was open, the doctor needed to be notified and to provide treatment. She said LVN B was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	currently helping with wound care for residents on Monday, Wednesdays, and Fridays. During an interview on 05/01/2026 at 12:47 p.m., CNA A said last night, Thursday, 04/30/2026, Resident #3 told her that she had hurt herself in the shower. She said Resident #3 showed her the wound and said it happened from a wire in the shower. CNA A said she did not know of there being a wire in the shower. CNA A said she told LVN B and LVN B told her she already knew and Resident #3 just needed a bandage. CNA A said she did her part and it was her job to report to the nurse. During an interview on 05/01/2026 at 1:45 p.m., LVN B said she was just notified about Resident #3's wound and it occurred on Tuesday 04/28/2026. She said she asked Resident #3 about any pain and Resident #3 only told her about her migraine. LVN B said she asked Resident #3 why she did not tell anyone and Resident #3 said she told a CNA. LVN B said she did not think the wound was from a wire, but with the redness and purpleness on the wound, it was probably infected. She said it was infected from the wound being open and Resident #3 touched a lot of stuff. LVN B said Resident #3 was receiving triple antibiotic (ointment) and Bactrim (antibiotic oral medication). LVN B said she could not say how old the wound was but believed it could have happened Tuesday 04/28/2026. During an interview on 05/01/2026 at 2:57 p.m., the ADON said she made calls to staff and no one was aware of the injury to Resident #3's hand. The ADON said she called CNA A and CNA A told her she was not aware of anything happening to Resident #3's hand. The ADON said Resident #3 did not tell anyone about her hand and no one was aware. She said she did not know how old the injury was but believed Resident #3 picked at the wound because she was known to pick at wounds . The ADON said the wound was not new and definitely some days old. The ADON said Resident #3 was seen by the nurse practitioner and received antibiotics and treatment. The ADON said it was important to know about these types of injuries, so it did not happen to other residents. She said she did educate staff about notifying of new injuries to residents. During an interview on 05/01/2026 at 4:32 p.m., the ADM said he had maintenance check the showers for any wires sticking out. He said there was no indication that there were wires in the shower room. The ADM said Resident #3's wound did not look new, and he was surprised they only found out about it today. The ADM said weekly head-to-toe skin assessments were done. He said, in addition to the weekly skin assessments, direct care staff saw most stuff and knew observed skin issues were to be reported. The ADM said Resident #3 was independent and he would not be surprised if staff stood in the shower room with Resident #3 and not right next to her because she was reasonably independent. The ADM said the facility called the doctor, and ordered antibiotics because the wound looked red. He said he would probably have the showers looked at again because he was curious where the injury could have happened and it looked like a puncture. The ADM said all he could do was get it fixed and corrected.A policy regarding identifying and treatment of skin conditions was requested prior to exit; the policies provided were not applicable.