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	06/18/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview and record review, the facility failed to store drugs in a safe and secured manner to permit only authorized personnel to have access for 1 of 2 areas (Administrator's desk drawer and oxygen supply room on hall 100). The facility failed on 06/17/2026 to ensure that medications were secured behind a locked mechanism (either in the medication supply room or a medication cart) to ensure the safety of the residents when medications were found in an unsecured desk drawer in an unsecured office and in an unsecured oxygen room on hall 100 with the DON. This failure placed residents at risk of being able to access medications not prescribed to them, with the potential to have side effects or possible overdoses.Findings included: Observation on 06/17/26 at 1:40 PM revealed the DON was able to open the Administrator's door without key access as well as the Administrator's desk drawer without key access. The Administrator's desk did not have a locking mechanism on his desk. And the Administrator's office also had no working lock on his office door. Therefore, the door was unable to be locked. Observation revealed numerous packs of medications in the administrator's top right desk drawer including: 1 Simvastatin tab 20 mg, Prazosin Cap 1mg, Risperidone tab 2mg, Buspirone tab 7.5mg, Famotidine tab 20mg, Atorvastatin tab 10mg, Duloxetine DR cap 30mg, Baclofen tab 10mg, Carvedilol tab 25mg, Losartan tab 50mg, Olanzapine tab 10mg, and Hydralazine tab 25mg. Observation on 06/17/26 at 1:46 PM of the oxygen supply room behind the nurses' station on the 100-hall revealed the DON was able to open the door without key access. Observation also revealed there was a bottle of Atorvastatin tab 40 mg with 100 tablets inside the bottle as well as a bottle of Benzonatate cap 100mg with 26 capsules inside the bottle. The two bottles of medications were found behind an unlocked cabinet with no locking mechanism in the oxygen supply room. Interview on 06/17/26 at 1:50 PM with the DON revealed that the Administrator was out of town on vacation and unavailable for interview. Interview with the DON also revealed that it was the responsibility of all nurses to ensure that all medications were placed in a secure area. The DON stated that the facility policy was that all medications should be stored in the 200-hall medication room behind the locked door. The DON said that all narcotics are to be placed under a double locking system. The DON stated that all narcotics should be placed in her office behind her locked door and in a locked cabinet or in a locked drawer on a locked medication cart. The DON stated that discarded medications should be placed in the 200-hall medication room in a large trash can which has a lock on it. The DON stated that narcotics that are discarded as well as duplicate cards of narcotics are also placed in her locked office inside the locked cabinet in her office. The DON stated that management rounds daily in the medication rooms to look for items such as these to ensure that they are secure and not accessible to residents. The DON was unable to explain how or why medications were in the unsecured Administrator's desk drawer of the Administrator's unsecured office or in the unsecured oxygen supply room. The DON stated that if a resident had ingested any of these medications, the medication could have interacted with their own medications. The DON stated that their policy states to secure all medications. The DON revealed that if a staff member (not including a nurse) had found the medications, they should have reported it to a nurse or nurse (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	management on site immediately and brought it to them. The DON stated that she would in-service her nursing staff to ensure that they secure all medications. The DON stated that she would address the unsecured medications in the next QAPI meeting as well. Interview on 06/18/26 at 1:00 PM with LVN A revealed that she was unaware of the unsecured medications in the oxygen supply room behind the nurses' station on the 100-hall. LVN A also was unaware of any unsecured medications in the Administrator's desk drawer in his unsecured office. LVN A stated that the facility policy and procedure of receiving medications should prevent unsecured medications from being accessible to unlicensed staff because a nurse must sign for all medications. LVN A stated that if anyone finds medications unsecured, they should report it to nursing management immediately. The LVN A also stated that if residents found unsecured medications, they could take the medication inappropriately and possibly have an allergic reaction, change in blood pressure, or change in their heart rate. LVN A revealed that nurses and medication aides were responsible for securing all medications in the building. Interview on 06/18/26 at 5:09 PM with ADON revealed she was unaware of the unsecured medications in the oxygen supply room behind the nurses' station on the 100-hall. LVN A also was unaware of any unsecured medications in the Administrator's desk drawer in his unsecured office. The ADON said that the facility policy was that all incoming medications were signed by a nurse on duty. The ADON said that if medications are found unsecured, the DON should be notified immediately. The ADON also stated that it was the nurses' responsibility to ensure that medications are secured properly in the medication room and locked medication carts and medication bins. ADON stated that if residents consume medications that are not their medications, it could lead to abnormal vital signs. Review of facility's current Storage of Medications policy, revised November 2020, reflected the following: 1. Drugs and biologicals used in the facility are stored in locked compartments. Only persons authorized to prepare and administer medications have access to locked medications.3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.6. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use.