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	08/08/2024

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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35489 Based on interview, and record review the facility failed to recognize the resident had the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law and the facility must treat the decisions of a resident representative as the decisions of the resident for one (Resident #1) of three residents reviewed for resident rights. The facility failed to include Resident #1's RP when Resident #86 was asked to sign a disenrollment form in order to change her Medicare insurance. This failure could place residents at risk of not having their RP included to make informed decisions regarding their care resulting in delayed treatment or a decline in condition. Findings included: Review of Resident #86's Admission Record dated 08/08/24, reflected she was an [AGE] year-old woman, admitted on [DATE], with diagnoses of Alzheimer's dementia and other dementia. Resident #86 was listed as her only contact. Review of Resident #86's Admission MDS, dated [DATE], reflected she was able to make herself understood by others, and usually understood others. Resident #86 had a BIMS of zero, indicating severe cognitive impairment. Resident #86 exhibited fluctuating inattention and disorganized thinking, but had no intrusive behaviors during the seven-day lookback period. Resident #86's care plan, dated 06/27/24, reflected she was an elopement risk, and used antidepressant and psychotropic medications. Review of Resident #86's EMR reflected a document named Hospital Records , which contained the Resident #86's Admission Record (face sheet) from the discharging facility, dated 06/25/24. The face sheet reflected Resident #86 noted as her own Responsible Party, and the name and contact information for a family member (her RP), as her emergency contact #1. Review of the EMR for Resident #86, accessed on 08/08/24 at 3:00 PM, reflected her profile had her listed as her own sole contact and as Relationship: Self and No Contact Type Assigned. (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 0551

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

An interview on 08/06/24 at 4:06 PM with Resident #86's RP revealed the resident had been discharged immediately after being admitted to another facility, due to being an elopement risk. She described how her experience with the two facilities involved (the discharging facility and this facility) left her very angry and frustrated, and on 07/18/24 she went to the facility and took the resident out. She said the staff refused to release Resident #86's medications, and when she attempted to get the prescriptions refilled, she learned that the facility had changed the resident's insurance, and she was unable to do so. She said that she was able to re-fill the three most urgent and important medications out-of-pocket, but she could not afford to buy all of them herself, so the resident went without some of her medications as a result of the facility changing her insurance. Resident #86's RP said when she contacted the facility she was informed that they had gotten Resident #86 to sign the form herself, and anybody could tell by interacting with the resident that she was not mentally able to understand what she was signing. She said Resident #86 was at home with her and because she was able to get some of the medications herself, Resident #86 did not appear to have suffered without her medications, but she found it disturbing that the facility would allow someone with advanced dementia to sign a form to change their insurance, and because they did she was left to handle the repercussions of it.

An interview on 08/08/24 at 2:19 PM with the HR/BOM revealed she did change Resident #86's insurance, because the facility was not contracted with the Medicare advantage insurance the resident had, and they needed to switch her to regular Medicare so she could get therapy. She showed the surveyor the form Resident #86 signed, and said she had the resident sign the form with two other staff present , and they explained it. She said at the time, she did not have contact information for Resident #86's RP, and the resident was listed as her own RP. She said if the resident had a family member listed, they would have been notified and asked to sign the form. She was not aware it had caused any problems for the resident, and said the regular Medicare should have paid for the resident's medications.

An interview on 08/08/24 at 2:48 PM with the DON revealed the facility only received minimal information with Resident #86 when she was admitted . She said she did come with a medication list, which she provided to the surveyor. She said Resident #86's family member was very upset, and felt the facility was attempting to block her from getting the resident into a facility nearer her, but they really were doing their best to get the information they needed. The other facility would not accept her without the clinical information, which they did not have.

An interview on 08/08/24 at 3:02 PM with the SW revealed she remembered Resident #86, but had witnessed so many residents signing forms she could not remember if she witnessed Resident #86 doing so. She said she did the BIMS assessment herself, and she would not be comfortable with a resident who was not cognitively aware, and could not understand, signing forms, and Resident 86 was not able to make decisions about things like insurance. She said when they had a resident who was unable to make decisions for themselves, she would look further for contact information for their family, for example in their hospital records, and contact the family to make decisions. She said if they did not have family, they would attempt to find guardianship for the resident. She said allowing a resident who was unable to understand to change their insurance might jeopardize their insurance or medications.

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 08/08/24 at 3:21 with the Administrator revealed he did not remember the specific information, but he did remember that Resident #86's admission was a mess and the discharging facility barely sent any clinical information for her. He felt that the other facility had dumped her there. He said the other facility brought her to the facility, and even though they contacted them immediately for her clinical records, they were not forthcoming with the additional records. He said when the family member wanted her moved to another facility, having only two pages of clinical records caused problems because the other facility would not accept her without more records. He said they kept trying to get access to additional information about the resident, but it took some time. He said when they needed papers signed, and a resident could not understand, the staff should have contacted the RP or next-of-kin, and they did not have a representative who could sign, they attempted to get guardianship , but that was not a fast process, even when expedited. Review of an Against Medical Advice (AMA) form, dated 07/18/24, reflected Resident #86's RP signed the document, which said the resident was requesting to leave without the authority of, and against the advice of the attending physician. The form said the medical risks were explained, and the [NAME] understood the risks, and released the facility, personnel, and physician from responsibility. Handwritten on the form was Resident discharge to the hospital. No other concerns were voiced. The forms was signed by Resident #86's RP, the physician, and a witness (signature was illegible and identity of staff member unknown.) Review of the facility policy Discharging a Resident Without a Physician's Approval, revised October 2012, reflected: Policy statement: a physicians order should be obtained for all discharges, unless a resident or representative is discharging himself or herself against medical advice.; Policy interpretation and implementation: 1. Should a resident or his or her representative (sponsor), request an immediate discharge, the resident's attending physician will be promptly notified. 2. If the resident or representative (sponsor) insists upon being discharged without the approval of the attending physician, the resident and/or representative (sponsor) must sign a release of responsibility form. Should either party refuse to sign the release, such refusal must be documented in the residence medical record and witnessed by two staff members. (.) Review of an email from the DON, sent on 08/10/24, at 5:46 PM, reflected the facility did not have a policy which addressed a resident's cognitive fitness to sign their own documents, or notifying their RP of documents.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48177 Based on observation, interview and record review, the facility failed to ensure the residents received services in the facility with reasonable accommodation of each resident's needs for 1 of 25 residents reviewed for accommodation of needs. The facility failed to ensure Resident #35's call light was within reach of the resident. This failure could affect residents who needed assistance and could result in their needs not being met. Findings included: Record review of Resident #35's face sheet dated 8-8-2024, revealed a [AGE] year-old male admitted to the facility on [DATE] with a primary diagnosis of fracture of the left wrist and hand and secondary diagnosis of Parkinson's disease, dementia, altered mental status, and gait and mobility abnormalities. Record review of Resident #35's MDS assessment dated [DATE], disclosed a BIMS score of 5 indicating a severe cognitive impairment. The assessment further indicated Resident #35 was totally dependent (helper does all the effort) putting his shoes on and substantial/maximal assistance dependent (helper does more than half the effort) to move from a lying position in bed to a sitting position on the side of his bed. The assessment indicated Resident #35 was wheelchair bound and cannot walk. Record review of Resident #35's care plan dated 7-17-2024 indicated the resident had actual falls on 11-1-2023, 1-20-2024, 4-26-2024, and 5-24-2024. Resident #35's care plan stated he was at risk for falls and for staff to be sure the resident's call light was within reach and encourage Resident #35 to use the call light for assistance. In an observation and interview on 8-6-2024 at 2:30 PM, Resident #35 was observed lying on his bed. Resident #35 indicated he did not know where his call light was, and that staff had moved it. Upon observation, Resident #35's call light was tucked underneath his bed frame, on the floor, from the wall where Resident #35 could not reach it. In an observation and interview on 8-6-2024 at 2:35 PM, the Administrator entered Resident #35's room and was shown the call light being tucked under Resident #35's bed on the floor. The Administrator reached underneath the bed and put the call light within reach of Resident #35. Resident #35 was observed grabbing the call light and holding it in his hand. The Administrator stated the problem with the call light being underneath the Resident's bed was he could not reach it to call for help. The Administrator indicated Resident #35 yelled for help when he needs it. The Administrator expected staff to put the call light within reach of residents before they leave the room. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8-8-2024 at 11:00 AM, CNA E stated she has worked at the facility for 1.5 years and worked the hall Resident #35 resided on. CNA E stated she thought the reason Resident #35's call light was on the floor underneath his bed, out of reach, was because housekeeping came in his room, cleaned the bed, and forgot to put the call light back in place within reach of Resident #35. CNA E said the concern for Resident #35 not having his call light within reach was he was a fall risk and if he was having a hard time finding the call light, he could possibly fall. In an interview on 8-8-2024 at 11:25 AM, LVN C stated she has worked at the facility for 10 months and works the hallway where Resident #35 resides. LVN C stated that it was everyone's responsibility to ensure residents have their call lights within reach. LVN C stated the risk to Resident #35 not having his call light within reach was if he needed help he would not be able to easily contact staff. LVN C stated Resident #35 has yelled out for help. In an interview with the DON on 8-8-2024 at 12:00 PM revealed the concern for Resident #35 not having his call light within reach was that he was a fall risk and might need help. The DON stated that her expectation was for staff, before they exited resident's rooms, to ensure call lights are within reach. Record review of the facility's call light policy dated 9-2022 on 8-8-2024 at 4:00 PM stated: Call System, Resident Policy Heading Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Policy Interpretation and Implementation 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48122 Based on interviews and record review, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident, for 1 of 8 residents (Residents #17) reviewed for baseline care plans. The facility failed to ensure Resident #17's baseline care plan was completed. This failure could affect newly admitted residents and place them at risk of not receiving appropriate interventions to meet their current needs and communication among nursing home staff to ensure their immediate care needs were met. The findings included: Review of the clinical care plans of Resident #17 on August 8, 2024, at 8:25 AM revealed that there was not a baseline care plan started or completed between June 28, 2024 and August 8, 2024. Review of Resident #17's Admission Record, dated August 08, 2024, revealed a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included Unspecified Sequelae Of Unspecified Cerebrovascular Disease, Dysphagia, Oropharyngeal Phase, Unspecified Dementia, Unspecified Severity, With Agitation, Mild Neurocognitive Disorder Due To Known Physiological Condition With Behavioral Disturbance, Generalized Anxiety Disorder, Other Specified Disorders Of Brain, Muscle Weakness (Generalized), Unspecified Lack Of Coordination, as well as high blood pressure and high cholesterol. Record review on August 8, 2024 of Resident #17's Admission Assessments revealed a Nursing-Wandering Assessment completed on June 30, 2024, that showed the resident was at a moderate risk for wandering; reassessment on July 2, 2024 showed a change to high risk for wandering. A Nursing- Fall Risk Assessment completed on June 30, 2024, revealed resident was a high fall risk. MDS Brief Interview for Mental Status assessment revealed a score of 6 which indicated a severe impairment. Review of Resident #17's Admission MDS, dated [DATE], reflected a BIMS score of 6, indicating severe cognition impairment. The MDS further reflected Resident #17 had physical and verbal symptoms directed towards others, exhibited wandering behaviors 4-6 times a week but not daily, required staff's moderate assistance for oral hygiene, personal hygiene, toileting and showering, and supervision for eating. The MDS revealed Resident #17 was frequently incontinent of bladder and bowel. The MDS reflected Resident #17 was taking an antipsychotic, antidepressant, antibiotic, and antiplatelet medications. In an interview on August 8, 2024, at 12:14PM, the SW stated that baseline care plans were the responsibility to be completed by the MDS nurse. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on August 8, 2024, at 1:09PM LVN A stated that baseline care plans were the responsibility of the nursing team. LVN A stated the completion of the baseline care plan, was done in the first two day of admission to the facility. LVN A stated that if the baseline care plan were missed in the first two days it would be noticed at the weekly level of care meetings held on Tuesdays. LVN A stated that if a baseline care plan were not completed it could possibly impact the care a new resident received, such as staff members not knowing the resident not knowing the needs or interventions for that resident. In an interview of LVN B on August 8, 2024, at 1:28PM, the LVN stated that resident care plans were normally reviewed briefly on Mondays, the first day on duty after scheduled days off. LVN B also stated that a 24-hour report was reviewed for any changes in residents while off as well. LVN B shared that if a baseline care plan for a new resident were not completed it would be reported to the DON and would assist with completing if the missing area was nursing related. LVN B stated that if residents were not having care plans completed then residents would not be receiving the care they needed as staff would have no way to know what a resident required such as incontinent care, assistance with showering, would have been at risk from a fall if transfer status was not known, have elopement risk, and interventions for behaviors may have been unknown. In an interview on August 8, 2024, at 1:40 PM, CNA C stated the risk of not having a baseline care plan could result in staff missing a change of condition, the resident not being assisted with meals, missed changes in sleep patterns, falls, missed need for incontinent care, behavioral issues and interventions or redirection not as effective. In an interview on August 8, 2024, at 2:19 PM, CNA D stated if there were no baseline then the floor nurse would have been notified along with the ADON and DON. CNA D stated missing care plans could have a negative impact on a resident by staff not knowing dietary needs such as if a resident was a choking risk, what incontinent care needs were, who a contact person was for the resident, who specialty care providers were, what behavior issues the resident had in the past and how to best redirect the resident. In an interview with the DON on August 8, 2024, at 3;13PM, it was revealed that the goal was to have the baseline care plan complete within 24 hours of admission. The risk to residents who do not have care plans entered timely was inaccurate care being provided by staff. The DON stated that care plans were a process that began with the MDS nurse entering the baseline care plan. The DON stated she did not know what happened to Resident #17's baseline care plan. In an interview on August 8, 2024, at 3:48PM, the ADM stated that baseline care plans were to be entered within 72 hours of admission. The ADM stated that care plans were the responsibility of the nurse managers to make sure they were completed timely. The ADM shared that missing or incomplete care plans could impact a resident by causing a potential lapse in appropriate care if a resident was to have non-normal needs or requirements.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48122 Based on observations, interviews, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for a resident for 2 of 8 residents (Residents #17 and #25) reviewed for Comprehensive Care Plans. The facility failed to complete a comprehensive care plan for Residents #17 and #25. This failure could place residents at risk of not receiving necessary care and services. Findings included: 1.Review of Resident #17's Admission Record, dated August 08, 2024, revealed a [AGE] year-old male who admitted to the facility on [DATE]/24 with diagnoses that included Unspecified Sequelae Of Unspecified Cerebrovascular Disease, Dysphagia, Oropharyngeal Phase, Unspecified Dementia, Unspecified Severity, With Agitation, Mild Neurocognitive Disorder Due To Known Physiological Condition With Behavioral Disturbance, Generalized Anxiety Disorder, Other Specified Disorders Of Brain, Muscle Weakness (Generalized), Unspecified Lack Of Coordination, as well as high blood pressure and high cholesterol. Review of Resident #17's Admission MDS, dated [DATE], reflected a BIMS score of 6, indicating severe cognition impairment. The MDS further reflected Resident #17 had physical and verbal symptoms directed towards others, exhibited wandering behaviors 4-6 times a week but not daily, required staff's moderate assistance for oral hygiene, personal hygiene, toileting and showering, and supervision for eating. The MDS revealed Resident #17 was frequently incontinent of bladder and bowel. The MDS reflected Resident #17 was taking an antipsychotic, antidepressant, antibiotic, and antiplatelet medications. Review of Resident #17's care plan, dated July 19, 2024, revealed The resident has nutritional problem or potential nutritional problem (SPECIFY) r/t malnutrition. The care plan did not reflect any other care areas. 2.Record Review of Resident #25's Admission Record dated August 08, 2024, revealed a [AGE] year-old female who admitted to the facility on [DATE], with diagnoses that included Brief Psychotic Disorder, Generalized Anxiety Disorder, Dorsalgia, Unspecified (Pain in the Back), Complex Regional Pain Syndrome I, Unspecified, Complex Regional Pain Syndrome I, Unspecified, Muscle Wasting And Atrophy, Not Elsewhere Classified, Multiple Sites, and Unspecified Abnormalities Of Gait And Mobility. Resident was her own RP. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #25's Admission Care Plan, dated July 23, 2024, revealed that not all focus areas had goals or resident specific information. There were no goals or interventions or indication if Resident #25 did nor did not take a sedative/hypnotic therapy or if an antidepressant medication was used, goals for gradual dose reduction of those medications, or a long term plan for administration of the medications related to Resident #25 diagnoses of Generalized Anxiety Disorder and Brief Psychotic Disorder. In an interview on August 8, 2024, at 12:14PM, the SW stated that Comprehensive Care Plan categories were completed by the appropriate departments; the MDS LVN would monitor for completion by the departments, with the SW providing backup. The SW stated that the comprehensive care plans were usually completed on the same day as the IDT meeting. The EHR system would also notify when tasks such as comprehensive care plans were due on the responsible user's dashboard and then that user would alert the specific department that needed to complete their section if it was not their own area. The SW stated that the comprehensive care plan was to have been completed within 30 days of a resident admitting to the facility or within 7 days of the MDS being completed in the EHR. The SW also stated that if the MDS had been completed but there was no IDT meeting, or the resident did not want to participate, then the MDS LVN and SW would give the departments additional time to complete their sections of the comprehensive care plan to allow time for the RP to be contacted or the resident to change their mind and participate. In an interview of LVN A on August 8, 2024, at 1:09PM, LVN A stated that it was the responsibility of the nursing team to complete the baseline assessment which triggered the EHR to alert for the Comprehensive Care Plan to be completed. LVN A stated that it was the goal to have the Comprehensive Care Plan completed within seven days of a resident's admission to the facility. LVN A stated there were processes in place to keep a resident from not receiving a baseline or comprehensive care plan such as level of care meetings each Tuesday, morning meetings to discuss any admits, discharges, or changes on conditions, as well as the EHR alerts for any census changes. LVN A stated that if a care plan, either baseline or comprehensive, were not done it would be addressed in the next meeting. LVN A shared that for a resident to not have had a timely baseline or comprehensive care plan then the resident care could be impacted like a staff member who was new to the resident would not have known the plan of care or what interventions to use that were most effective. In an interview of LVN B on August 8, 2024, at 1:28PM, the LVN stated that resident care plans were normally reviewed briefly on Mondays, the first day on duty after scheduled days off. LVN B also stated that a 24-hour report was reviewed for any changes in residents while off as well. LVN B stated that if residents were not having care plans completed then residents would not be receiving the care they needed as staff would have no way to know what a resident required such as incontinent care, assistance with showering, would have been at risk from a fall if transfer status was not known, have elopement risk, and interventions for behaviors may have been unknown. In an interview on August 8, 2024, at 1:40 PM, CNA C stated that comprehensive care plans were checked when there was a new resident to know what level of care to expect to provide, what behaviors a resident may exhibit and the interventions that may have to be used. CNA C stated that if the comprehensive care plans are not in the EMR, staff were to ask the floor nurse for information on the resident and advise the floor nurse and DON of the information that was missing. CNA C stated that risk of not having a baseline or comprehensive care plan could result in staff missing a change of condition, the resident not being assisted with meals, missed changes in sleep patterns, falls, missed need for incontinent care, behavioral issues and interventions or redirection not as effective. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on August 8, 2024, at 2:19 PM, CNA D stated that care plans were not reviewed very often but previously has looked at care plans when charting for more information on a resident that has had a change of condition or behavioral issues. CNA D stated that if there were no baseline or comprehensive care plan then the floor nurse would have been notified along with the ADON and DON. CNA D shared that missing care plans could have a negative impact on a resident by staff not knowing dietary needs such as if a resident was a choking risk, what incontinent care needs were, who a contact person was for the resident, who specialty care providers were, what behavior issues the resident had in the past and how to best redirect the resident. In an interview with the DON on August 8, 2024, at 3;13PM, it was revealed that the goal was to have the baseline care plan complete within 24 hours of admission and the comprehensive care plan within 72 hours of admission when possible but no later than 30 days from admission. If a care plan is not entered, then that care plan was to be completed when discovered missing. The risk to residents who do not have care plans entered timely is inaccurate care being provided by staff. The DON stated that care plans were a process that began with the MDS nurse entering the baseline care plan and completing the MDS assessment, then the ADON and treatment nurses completing the comprehensive care plans and the DON would review daily for completion and sign off to close the comprehensive care plan when it was completed. When asked about the incomplete comprehensive care plans for residents #17 and #25, the DON stated she did not know what happened. In an interview on August 8, 2024, at 3:48PM, the ADM stated that baseline care plans were to be entered within 72 hours of admission and comprehensive care plans were to be completed within 14 days of the baseline care plan. The ADM stated that care plans were the responsibility of the nurse managers to make sure they were completed timely. The ADM had expectations of all staff who notice a care plan was missing or incomplete should notify their supervisor of what was missing or incomplete or to make the entries themselves if capable and qualified to do so. The ADM shared that missing or incomplete care plans could impact a resident by causing a potential lapse in appropriate care if a resident was to have non-normal needs or requirements.

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 08/08/2024
NAME OF PROVIDER OR SUPPLIER: Benbrook Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1000 McKinley St Benbrook, TX 76126	

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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 0727

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.

48177

Based on interview, observation, and record review, the facility failed to use the services of a registered nurse for 8 consecutive hours 7 days a week for 2 of 4 quarters of 2024 (Fiscal Year Quarter 2 January 1-March 31, and Quarter 3 April 1-June 30) PBJ reports reviewed for RN coverage.

The facility did not have RN coverage for 8 consecutive hours on weekends for: 01/06/2024, 01/07/2024, 01/13/2024, 01/14/2024, 01/20/2024, 01/21/2024, 01/27/2024, 01/28/2024, 02/03/2024, 02/04/2024, 02/10/2024, 02/11/2024, 02/17/2024, 02/18/2024, 02/24/2024, 02/25/2024, 03/02/2024, 03/03/2024, 03/09/2024, 03/10/2024, 03/16/2024, 03/17/2024, 04/06/2024, 04/07/2024, 04/08/2024, 04/13/2024, 04/14/2024, 04/20/2024, 04/21/2024, 04/27/2024, 04/28/2024, 05/04/2024, 05/05/2024, 05/11/2024, and 05/12/2024.

This failure could place residents at risk of lack of nursing oversight and higher level of care needed.

Findings included:

Record review of the CMS PBJ reports indicated Quarter 2 2024 (January 1-March 31) there were no consecutive 8 hours of RN coverage on weekends.

Record review of the facility's time stamped/punched hours for RN coverage revealed there was no RN coverage on weekends for the Month of April 2024 (04/06/2024, 04/07/2024, 04/08/2024, 04/13/2024, 04/14/2024, 04/20/2024, 04/21/2024) and none on the weekends of May 2024 (05/04/2024, 05/05/2024, 05/11/2024, and 05/12/2024).

In an interview on 8-8-2024 at 12:00 PM, the DON stated she has worked at the facility for 1.5 years, was an RN, and worked full-time at the facility. The DON said the facility could not provide consecutive RN coverage on the weekends from January - May 2024 because they lost their weekend RN and were not able to obtain another one during that timeframe. The DON stated if there was a need for an RN, she makes herself available to come into the facility to meet the need.

Record review of the facility's Staffing Policy called Nursing Services and Procedures Manual for Long-Term Care dated 10-2017, stated:

Staffing

Policy Statement

Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment.

Policy Interpretation and Implementation

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services .

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 48122 Based on observation, interview, and record review the facility failed to ensure the facility's only garbage storage dumpster, and surrounding enclosed area, was maintained in a sanitary condition to prevent the attraction, nesting, and accumulation of pests. The facility failed to ensure trash was not left outside of the dumpster on the ground. These failures could place residents at risk of contracting disease by attracting pests, disease carrying rodents, and having debris dangerous to residents. Findings included: During an observation on August 8, 2024 at 3:45 PM of the dumpster area, on the north side of the building, there was trash debris including but not limited to used latex gloves, glass shards, broken overbed rolling tray tables, oscillating floor fans, bariatric bedside commode, well used recliner chair, well used mattress, split open bag of landscape mulch, opened individual dose medication blister packets, and base of a wheelchair scale. In an interview on August 8, 2024, at 5:05PM with DM revealed that the dumpster area was the responsibility of the DM and kitchen staff. The DM stated that the DM and staff were to have picked up any trash or debris that was on the ground and place in the dumpster with the lid closed as there were to be no lose items on the ground and the dumpster was not to be overflowing. The DM stated that service company was to be called for an off schedule pick up when the dumpster got near full. The DM indicated that maintenance and the DM were ultimately responsible for the dumpster area. The DM stated the importance of being able to keep the dumpster area clean was to keep cats, rats, and animals in general out of the area. The DM stated the potential risk of the dumpster area not being kept clean could cause infection control issues. In an interview on August 8, 2024, at 5:16PM with the MTNC it was revealed that each employee who used the dumpster was responsible to ensure the lid closed securely and there was no trash or items on the ground around the dumpster. The MTNCE stated that when the dumpster was overflowing, staff were to notify MTNC or DM for a call to the service company for off schedule pick up. MTNC stated that the service company was scheduled to pick up once a day Monday-Saturday and prn when called. The MTNC revealed the maintenance department and housekeeping, who also fall under maintenance, are the ones responsible for the dumpster area. The MTNC stated that it was important for the dumpster lid to be kept closed as unauthorized people or animals could have accessed the area. The MTNC stated when the dumpster area was not maintained properly, the area posed potential risks to residents of bad odors, comfortability, attracted insects and pests. Staff had been informed that when they notice the dumpster was getting full, they needed to let him know so off schedule pick up could be arranged. (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on August 8, 2024, at 5:25PM, the ADM revealed the MTNC and housekeeping staff were responsible for the dumpster area daily to make sure all trash and items were securely in the dumpster and the lid closed. The ADM stated staff were to contact the MTNC and ADM if the dumpster reached a point of overflowing for the service company to make an off schedule pick up. The ADM stated the general upkeep to the dumpster area fell to the MTNC and ADM. The ADM stated it was important that the dumpster lid was kept closed to avoid smells and attracting pests. The ADM stated that when the dumpster area was not maintained correctly it posed a risk to residents of creating odors and infection control issues. Record review of the Food and Drug Administration Food Code 2022 dated 1-18-2023 stated: Chapter 5: Water, Plumbing and Waste Operation and maintenance: 5-501.110 Storing Refuse, Recyclables, and Returnables. REFUSE, recyclables, and returnables shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents. 5-501.111 Areas, Enclosures, and Receptacles, Good Repair. Storage areas, enclosures, and receptacles for REFUSE, recyclables, and returnables shall be maintained in good repair. 5-501.112 Outside Storage Prohibitions. (A) Except as specified in (B) of this section, REFUSE receptacles not meeting the requirements specified under 5-501.13(A) such as receptacles that are not rodent-resistant, unprotected plastic bags and paper bags, or baled units that contain materials with FOOD residue may not be stored outside. (B) Cardboard or other packaging material that does not contain FOOD residues and that is awaiting regularly scheduled delivery to a recycling or disposal site may be stored outside without being in a covered receptacle if it is stored so that it does not create a rodent harborage problem. 5-501.113 Covering Receptacles. Receptacles and waste handling units for REFUSE, recyclables, and returnables (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shall be kept covered: (A) Inside the FOOD ESTABLISHMENT if the receptacles and units: (1) Contain FOOD residue and are not in continuous use; or (2) After they are filled; and (B) With tight-fitting lids or doors if kept outside the FOOD ESTABLISHMENT. 5-501.115 Maintaining Refuse Areas and Enclosures. A storage area and enclosure for REFUSE, recyclables, or returnables shall be maintained free of unnecessary items, as specified under S 6-501.114, and clean.