

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 09/11/2025
NAME OF PROVIDER OR SUPPLIER Benbrook Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received food that was appetizing, appealing, and proper temperature prior to serving. The facility failed to ensure milk was at a safe temperature before serving. The facility failed to ensure the dinner roll item was appealing and appetizing food item. The facility failed to ensure the baked potatoes were appealing texture. This failure could result in residents' not being provided food that is nutritious and appealing, resulting in a decreased quality of life. Findings include: Record review of Resident #16's face sheet dated 09/11/2025, revealed a [AGE] year-old woman admitted on [DATE] from a psychiatric hospital. She was admitted with primary diagnoses chronic obstructive pulmonary disease and other pertinent diagnoses including post-traumatic stress disorder, anxiety disorder, adult financial abuse (confirmed, subsequent encounter), adult sexual abuse (confirmed, subsequent encounter), adult physical abuse (confirmed, subsequent encounter), and hypertension. Record review of Resident #16's MDS dated [DATE] revealed the resident had a BIMS (brief interview for mental status - tool used to assess cognitive function, and scores range from 0 to 15) of 15. Record review of Resident #83's face sheet dated 09/11/2025 revealed a [AGE] year-old female, admitted on [DATE] with primary diagnosis of fibromyalgia (chronic condition that causes widespread pain in muscles and soft tissues in the body) and other pertinent admitting diagnoses including type 2 diabetes mellitus with diabetic neuropathy, type 2 diabetes mellitus without complications, morbid (severe) obesity due to excess calories, pure hypercholesterolemia, major depressive disorder, generalized anxiety disorder, heart failure, and hypertension. Record review of Resident #83's MDS dated [DATE] revealed a BIMS of 13. Record review of Resident #35's face sheet dated 09/11/2025 revealed a [AGE] year-old male, admitted on [DATE] with primary diagnosis of vascular dementia, unspecified severity, with other behavioral disturbance. Other diagnoses include COPD, chronic kidney disease stage 3, cognitive communication deficit, dysphagia, cerebral infarction, unspecified, metabolic encephalopathy, generalized anxiety disorder, unspecified lack of coordination. Record review of Resident 35's MDS dated [DATE] revealed a BIMS of 05. Record review of Resident 35's dietary profile dated 09/03/2025 revealed the resident's current texture of food was mechanical soft. Record review of resident 35's dental visit dated 08/08/2025 revealed he had been getting fitted for dentures and was missing 17 teeth. During an interview on 09/09/2025 at 10:48AM with Resident #16, she described the food as having no flavor and discussed her meals were cold and she could ask to have her food heated up but there's many residents asking. During a brief observation and interview on 09/09/2025 at 10:29AM with Resident 35, he said cold when asked how the food at the facility was. Observation and interview on 09/09/2025 at 12:24 PM with Resident #83 and Resident #35 while they dined for lunch revealed Resident 35 was given a baked potato with shredded cheese and sour cream, a slice of white bread, and dessert for lunch. Resident #83 said that Resident #35 typically gets a baked potato as a substitute for his meals, and his teeth (dentures) did not fit right. Resident 35 pointed to his teeth, revealing he was missing many teeth. During an interview on 09/09/2025 at 1:20PM with Resident #83, she stated she had a concern with the food at the facility. She said she was told if she ate in the dining room the food would be warm. She described the baked potatoes as half cooked and (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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	they are hard. During a confidential resident council meeting on 09/10/2025 at 10:30AM it was revealed that residents mentioned the food being cold, and many residents eat in their rooms, and the food was cold when they receive it. Residents discussed milk being a warmer temperature when received. During an observation of temperature checks for resident's lunch meal on 09/10/2025 at 12:00PM, resident drink temperatures had not been checked. At 12:25PM, before the meal tray cart left the kitchen, this surveyor asked what the temperatures for the resident's drinks were. Temperature checks with the DM revealed the orange juice was 64 F and the milk was 67 F. At this time, the DM had all orange juice and milk cups on the meal tray carts disposed and replaced. During an interview on 09/10/2025 at 11:20 AM with the DM revealed she alternates the dinner rolls item, and residents do receive other dinner roll and not just white bread slices. She explained that she orders dinner rolls but sometimes the vendor would be out of stock, and she has discussed this with the registered dietitian and ADM. The DM stated she would not like a slice of white bread instead of a dinner roll. She stated many residents complain of the slice of white bread and residents have the right to get what they want (an actual dinner roll). Observation on 09/10/2025 at 1:22PM of the lunch test tray, included BBQ chicken, a dinner roll, pasta salad, and lemon cake. A baked potato with shredded cheese was added as requested. The food was warm and palatable. The center of the baked potato was edible but not as soft as the outer edges, requiring more time to masticate without teeth. An interview on 09/11/2025 at 2:30PM with the registered dietitian revealed residents occasionally complain about food being cold but the facility recently purchased new insulated top and bottom plate covers. When asked if there was an issue with food orders, she stated the food vendor runs out of stock. She said the DM calls and informs her of what the truck did not provide and discuss alternatives until they receive the items. She discussed the food vendor truck did not deliver dinner rolls, so sliced white bread was used as a substitute. She stated the dietary staff try not to use sliced white bread and other options they could use include cornbread. Record review of the facility's Resident Food Preferences policy, revised July 2017 reflected: Policy Statement Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to diet will only be ordered with the resident's or representative's consent. Policy Interpretation and Implementation1. Upon the resident's admission (or within seventy-two (72) hours after his/her admission) the dietitian or nursing staff will identify a resident's food preferences. 1. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. 2. Nursing staff will document the residents' food and eating preferences. 3. The dietitian and nursing staff, assisted by the physician, will identify any nutritional issues and dietary recommendations that might be in conflict with the resident's food preferences. 4. The dietitian will discuss with the resident or representative the rationale of any prescribed therapeutic diet. The physician and dietitian will communicate the risks and benefits of specialized therapeutic vs. liberalized diets. 5. Therapeutic diets will be ordered only after the resident/representative agrees with and consents to such a diet. 6. The resident has the right not to comply with therapeutic diets. 7. The food services department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night. 8. The facility's quality assessment and performance improvement (QAPI) committee will periodically review issues related to food preferences and meals to try to identify more widespread concerns about meal offerings, food preparation, etc.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen.1. The facility failed to ensure the stand-by freezer food items were dated, labeled, and secured.2. The facility failed to ensure the stand-by refrigerator food items were dated, labeled, and secured.3. The facility failed to ensure the dry storage food items were dated, labeled, and procured.4. The facility failed to ensure that canned good food items were free of dents.5. The facility failed to ensure that held food items were covered prior to serving. These failures could place residents at risk for foodborne illness and foodborne intoxication. Findings included: Observation on 09/09/2025 at 7:45AM upon entrance to the kitchen revealed an uncovered metal tin of butter with a pastry brush inside the tin, sitting on the stove top griddle. Observation on 09/09/2025 at 7:46AM of the standby freezer revealed:- An unsealed bag of frozen pizza dated 9-3-25 and with no use by date. Ice crystals forming on the pizzas. - A unlabeled Ziploc bag of chicken tenders dated 9-3, with no use by date. - A box with an unsealed bag of frozen hamburger patties, with no opened on or use by date. Observation on 09/09/2025 at 7:49AM of the standby refrigerator revealed:- An opened bag of shredded mozzarella cheese dated 9-3, with no use by date.- An open bag of shredded cheddar cheese dated 9-3, with no use by date.- An unsealed Ziploc bag with half a yellow onion, dated 9-4 and no use by date- A large, opened container of pickles dated 3.5.25, with no use by date. Observation on 09/09/2025 at 7:53AM on the kitchen's spice rack revealed an unsealed bottle of Paprika seasoning. At this time, an interview with the DM revealed the pizza in the stand-by freezer were used on Saturday (09/06/2025) and the box was dated with the delivery date. The DM acknowledged the ice crystals formation on the pizzas due to the unsealed bag and stated the pizzas were contaminated and no good. The DM further stated that the unsealed bottle of paprika seasoning can be contaminated. Observation on 09/09/2025 at 7:56AM of the dry storage closet revealed:- An opened and 1/2 used jar of concord grape jelly, with no use by date. Text on the label of the jar stated REFRIGERATE AFTER OPENING.- An opened and used bottle of yellow mustard, dated 8/6/25 with no use by date. Text on the label of the bottle stated BEST IF USED BY MAY 19 2025 and REFRIGERATE AFTER OPENING - One can of tomato soup, undated. - One can of pinto beans, undated. - One dented can of baked beans. At this time, an interview with the DM revealed she was not aware the labels stated the jelly and mustard were to be refrigerator after opening. She stated the problem with dented cans were that the metal can come off, the canned food items can go bad and contaminate food. Observation on 09/09/2025 at 11:22AM of the facilities kitchen revealed cooked bread rolls sat on top of the stove top, uncovered. The meal tray carts were prepared with trays, dessert food item, and drinks including milk and orange juice. An interview with the DM on 09/10/2025 at 11:58AM revealed all dietary staff members were responsible for labeling and dating for items, including opened on dates and use by dates. The DM stated food items were used within 3 days after opening. She stated the importance of dating food items was that they could go bad, and residents could get sick (if they eat food items past use-by date). When asked if there was an issue with the uncovered bread rolls, the DM stated there can be cross contamination. The DM explained temperature for hot held food items must be held at a minimum of 135 F and cold food items must be held at 40 F or lower. During an observation of temperature checks for resident's lunch meal on 09/10/2025 at 12:00PM, resident drink temperatures had not been checked. At 12:25PM, before the meal tray cart left the kitchen, this surveyor asked what the temperatures for the resident's drinks were. Temperature checks with the DM revealed the orange juice was 64 F and the milk was 67 F. At this time, the DM had all orange juice and milk cups on the meal tray carts disposed and replaced. An interview with the Registered Dietitian on 09/11/2025 at 2:30PM revealed she works with the dietary staff and staff are expected to follow the expectations and regulations for dating and labeling food items. She explained the procedure to dating and labeling included the food item, the (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	date used, and the use by date. She stated she expects opened food items to be covered and sealed. The registered dietitian stated holding temperature for hot food items was 135 F and for cold food items was 40 F. When asked how to keep resident drinks within holding temperatures prior to serving, she explained that was what the refrigerators and ice was for. She stated the importance of these expectations was for food safety, quality of food, and ultimately for resident safety. Record review of the facility's Food Receiving and Storage Policy, revised October 2017, reflected: Policy Statement Foods shall be received and stored in a manner that complies with safe food handling practices. Policy Interpretation and Implementation .7. Dry foods that are stored in bins will be labeled and dated (use by date). Such foods will be rotated using a first in - first out system. 8. All foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date). 11. The freezer must keep frozen foods frozen solid. Wrappers of frozen foods must stay intact until thawing. Record review of the U.S. FDA Food Code 2022 reflected: 3-302.12 Food Storage Containers, Identified with Common Name of Food: Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food. Section 3-501.17 . Commercial processed food: Open and hold cold . B . 1. The day the original container is opened in the food establishment shall be counted as Day 1. 2. The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety . C. 2. Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (A) of this section. 3. Marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded as specified under (B) of this section. Definitions 3 . Food Receiving and Storage - When food, food products or beverages are delivered to the nursing home, facility staff must inspect these items for safe transport and quality upon receipt and ensure their proper storage, keeping track of when to discard perishable foods and covering, labeling, and dating all PHF/TCS foods stored in the refrigerator or freezer as indicated. 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57 C (135 F) or above. (2) At 5 C (41 F) or less.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide a clean, functional, homelike environment for 2 of 4 shower rooms, 4 of 10 Residents (Resident 10, 53, 59, 78) reviewed for sanitary, functional, and homelike environment, as evidenced by: 1. Residents #10 and #53 had a broken toilet on 9-10-2025, causing the odor of human waste for over a week, forcing the residents to go to the shower room to use a toilet. When the shower room was in use, the residents had to wait to use a toilet. 2. The facility failed to maintain functional plumbing in the 100-Hall shower room, in which the water did not get hotter than 76.5 degrees Fahrenheit. 3. The facility failed to maintain functional plumbing in the 200 Hall Shower room, which had broken shower faucets, and the water could only be adjusted in the back by turning the main shower valves hot and cold. 4. The facility failed to repair a plumbing leak in 2 resident rooms, rooms [ROOM NUMBERS]. These failures could place residents at risk for a lack of hygiene and a decreased quality of life. Findings included: Resident #10 Record review of Resident #10's face sheet, dated 9-11-2025, revealed a [AGE] year-old male had been admitted to the facility on [DATE]. His diagnoses included Rhabdomyolysis (the breakdown of muscle tissue, leading to the release of harmful substances into the bloodstream), Schizoaffective Disorder (a mental health condition associated with hallucinations or delusions with mood disorders), Anxiety Disorder, Major Depressive Disorder, and Hepatitis C (a viral infection that causes inflammation of the liver). Record review of Resident #10's quarterly MDS, dated [DATE], indicated he had a BIMS score of 14 revealing he was cognitively intact. Resident #10's functional ability revealed he needed supervision or touching assistance to toilet transfer and toileting hygiene. Record review of Resident #10's care plan dated 7-24-2025, and revised on 9-9-2025, indicated he had a potential for pressure ulcers D/T being incontinent and immobile. In an observation and interview, on 9-10-2025 at 12:00 PM, Resident #10 was observed to be in his room sitting in a wheelchair. The toilet, in Resident #10's room, had a large black plastic bag over it. The toilet smelled of human waste. When the black plastic bag was lifted and the toilet lid was lifted, the toilet had brown liquid substance appearing to be human waste in it. Resident #10 stated his toilet had been broken for 3 weeks. Resident #10 said he was told by the maintenance department a week ago that a new toilet had been ordered for his bathroom. Resident #10 said not having his toilet working caused him to feel depressed as he had to roll his wheelchair into the shower room and use the toilet in there. Resident #10 said if someone was using the shower room, when he needed to use a toilet, he would have to hold it until the shower room was not in use. Resident #53 Record review of Resident #53's face sheet, dated 9-11-2025, revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses of intracerebral hemorrhage (a medical condition where bleeding occurs within the brain tissue itself), hepatitis C, muscle wasting and atrophy (a decrease in muscle mass and strength, resulting from a lack of use), and traumatic brain injury (an injury to the brain caused by an external force, such as a blow, bump, or jolt to the head). A record review of Resident #53's quarterly MDS, dated [DATE], revealed a BIMS score of 12, which indicated he was cognitively moderately impaired. Resident #53's functional ability revealed he needed supervision or touching assistance to toilet transfer and toileting hygiene. In an observation and interview, on 9-10-2025 at 12:10 PM, it was revealed that Resident #53 shared the same toilet as Resident #10. Resident #53 stated it made it harder on him to use a restroom as he had to go to a shower room to use a toilet. Resident #53 said it made him feel like shit not to have been able to have a working toilet in his room. In an interview on 9-11-2025 at 2:20 PM, it was revealed that CNA A had worked at the facility for a month and had worked the hallway where Residents #10 and #53 resided. CNA A said their toilet had been broken for 1.5 weeks. CNA A said she was told by the maintenance department on 9-6-2025 that a replacement toilet had been ordered for Resident #10 and Resident #53. CNA A said she believed not having a (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	working toilet, in a resident's room, would make them feel like they would not want to live in that room and feel bad. CNA A thought it was the maintenance department's responsibility to keep working toilets in resident's rooms. In an interview, on 9-11-2025 at 4:00 PM, it was revealed that CNA B had worked at the facility for 3 years and worked the hallway that Resident #10 & #53 resided on. CNA B said Resident #10's & Resident #53's toilet had been broken for a month. CNA B said the two residents must go to a shower room to use a toilet. CNA B said this can cause Resident # 10 & #53 a problem, if another resident was using the shower room, because they would not be able to enter the shower room to use the toilet. CNA B said Resident #10 had complained to her about his toilet being broken for so long and said it caused residents to feel mad and frustrated when they cannot use their own toilet. CNA B said the maintenance department was responsible for fixing or replacing broken toilets. CNA B said the maintenance department has claimed Resident #10's & 53's toilet had been repaired, at times, when in fact, it had not. CNA B said there has been a high turnover in the maintenance department and that has affected the repair or replacement of resident's appliances. In an interview, on 09/11/25 at 4:15 PM, it was revealed the Maintenance Director had worked at the facility for 2 months. The Maintenance Director said all staff members were responsible for reporting broken appliances and the maintenance department was responsible for repairing or replacing them. The Maintenance Director said that when he took over as Maintenance Director, the facility had several problems with water leaking and plumbing issues. The Maintenance Director stated that he had placed Resident #10 & Resident #53's toilets in out-of-order status on 09/03/25, as he had not yet been able to replace them. The Maintenance Director said the effect on residents having a broken toilet would cause them to be upset, as it would upset him not having a working toilet at his home. In an interview, on 9-11-2025 at 7:30 PM, the Administrator revealed it was the responsibility of all staff members to report a broken toilet to the maintenance department as soon as they discovered it was broken. The Administrator said it was up to the maintenance department to fix broken toilets timely. The Administrator said the facility had 3 broken toilets the previous week and did not have a spare one in stock to replace for Resident #10 and #53. The Administrator said these types of toilets are tankless toilets and it takes time to order and receive them. The Administrator's expectation was to keep a spare toilet on hand at the facility to be able to change a broken one out timely. The Administrator said the risk to a resident, not having a working toilet in his room, would be a dignity issue and cause frustration. Resident #6 Record review of Resident #6's face sheet, dated 09/10/25, revealed a [AGE] year-old female who was readmitted to the facility on [DATE] with a primary diagnosis of other specified myopathies- this is a group of diseases that primarily affect the skeletal muscles, leading to muscle weakness and dysfunction. Record review of Resident #6's quarterly MDS dated [DATE] reflected a BIMS of 14, indicating cognitively intact. MDS also indicated that Resident #6 was dependent on staff for showers. Record Review of Resident #6's care plan initiated on 04/04/23, revealed Resident #6 had ADL self-care performance deficit related to weakness. The goal was to maintain the current level of function in ADLs through the next review date. The intervention was to provide skin care to keep the skin clean and prevent skin breakdown. In an interview with Resident #6 on 09/09/25 at 10:56 AM, revealed she had been at the facility for 2 years. She said the 100 Hall shower was always cold and had not worked well since she has lived at the facility. She said she preferred the shower on the 200 Hall because at least the water was hot, but you need staff to help you turn it on in the back. She said turning [faucets] do not work, turns on only from the back of shower. She said, for 2 years they have been doing that, this place is old, and they have been having issues with maintenance. She said her other choices were to shower in the woman's unit where the shower pressure was like using a low pressure water peak or on 100 hall shower which was cold. She said it takes turning the water on 30 minutes in advance to get a warm shower in the 100 Hall Shower room. Resident #12 Record review of Resident #12's face sheet, dated 09/10/25, revealed, revealed a [AGE] year-old male readmitted to the facility on 08/31/25 with a primary diagnosis of type 2 diabetes mellitus (uncontrolled blood sugar diseases) with unspecified complications. Record review (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of Resident #12 quarterly MDS dated [DATE], reflected a BIMS score of 14 indicating cognitively intact. MDS also indicated that Resident #12 required supervision for showers/bathe self. Record Review of Resident #12's care plan initiated 12/13/24, revealed Resident #12 had ADL self-care performance deficit related to impaired balance. The goal was to improve the current level of function in ADLs through the next review date. The intervention included personal hygiene: The resident requires set-up assistance by staff with personal hygiene and oral care. Resident #22 Record review of Resident #22's face sheet, dated 09/10/25, revealed, revealed a [AGE] year-old male admitted to the facility on [DATE] with a primary diagnosis of unspecified intracranial injury with loss of consciousness of unspecified duration sequela (Brain injury that caused a loss of consciousness). Record review of Resident #22's quarterly MDS dated [DATE], reflected a BIMS score of 12 indicating moderate cognitive impairment. MDS also indicated that Resident #22 required partial/moderate assistance for showers/bathe self with the helper does less than half the effort. Record Review of Resident #22's care plan initiated on 05/20/25 revealed Resident #22 had ADL self-care performance deficit related to Traumatic Brain Injury. The goal was to maintain the current level of function in ADLs through the next review date. The intervention was to provide partial /moderate assistance for tub/shower transfer. In an interview with Resident #12 and Resident # 22 who were roommates on 09/09/25 at 10:37 AM, they stated the 100 shower is cold and the 200 shower is too hot because they cannot turn the faucet without getting out the shower and going around to adjust the water using the valve in the back. Resident #12 said he was Forced to use the 100 Hall cold shower because of the broken faucets in the 200 Hall shower close to his room. Resident #59 Record review of Resident # 59's face sheet, dated 09/10/25, revealed she was a [AGE] year-old female admitted to the facility on [DATE] with a primary diagnosis of hereditary and idiopathic neuropathy (this is a hereditary peripheral nerve pain without an identifiable cause). Record review of Resident #59's quarterly MDS dated [DATE] revealed a BIMS score of 13, indicating the resident's cognition was intact. The MDS also revealed Resident #59 required supervision during showers, with staff providing verbal cues as residents complete the activity. Record Review of Resident #59's care plan initiated on 07/11/25 revealed Resident #59 was resistant to care (showers and meals). The goal was that the residents would cooperate with care through the next review date. The intervention was to provide consistency in care to promote comfort with ADLs and maintain consistency in timing of ADLs, caregivers and routine, as much as possible. Resident #78 Record review of Resident #78's face sheet, dated 09/10/25, revealed, revealed a [AGE] year-old female admitted to the facility on [DATE] with a primary diagnosis of Sequelae of cerebral infraction (this a brain swelling complications related to stroke). Record review of Resident #78's quarterly MDS dated [DATE] revealed a BIMS score of 13, indicating the resident's cognition was intact. The MDS also revealed Resident #78 required partial/moderate assistance for showers with the helper does less than half the effort. Record Review of Resident #78's care plan initiated on 04/21/25, revealed Resident #78 had impaired circulation related to elevated cholesterol. The goal was to be free of symptoms of poor circulation. The intervention included inspecting foot/ankle, calf skin during shower days and weekly skin assessments. In an interview with Resident #59 and Resident #78 who were roommates on 09/09/25 at 09:53 AM, revealed the shower on 100 hallway was always cold. Resident #59 said the water did not get hot even after running the water for 30 minutes. She said she did not like cold showers, so she just used the 200 Hall shower which required staff to turn on the water for her. Resident #78 said the 200-hall shower was not user friendly because the faucets were broken, and she could not adjust the water temperature without calling staff into the shower room to adjust the temperature and water pressure using the valve in the back panel of the shower. Resident #59 and Resident # 78 said the 200 Hall Shower room had a hole cut open in the back of the shower wall. They said it had been like that since they admitted to the facility. Resident #59 and Resident # 78 said it was very inconvenient and frustrating that they could not adjust the water temperature to their liking while showering. Resident #59 said the shower head was better since they replaced it two (continued on next page)		

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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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weeks ago, but the faucets were not fixed. Resident #59 showed pictures of the shower head that was attached with what appeared like string or white tape. In an observation and interview of 200 Hall Shower room on 09/09/25 at 10:22 AM, revealed a large shower room, one shower area and a toilet. The faucet for the shower did not work when turned on, it just spun around. CNA H explained the shower faucets did not work. She said they used the valves in the back to turn the water on. She said maybe maintenance created the hole in wall tile so that they can use the valves to adjust the water temperature. She said she worked in the women's unit and did not work on the 200 Hallway, so she was not aware how it affected the residents. In an interview with CNA I and CNA J on 09/09/25 at 10:28 AM, they stated they had notified management and maintenance 3 weeks ago and even a week ago about the issues in the shower rooms. The CNA's said maintenance changed out the shower heads, but the faucets are still not working well without having to use the [NAME] in the back to adjust the water pressure and temperature. CNA I and CNA J said the only other option was to take residents on the man's unit shower because the 100-hall shower has been running cold and some residents complain that the water was cold. CNA I and CNA J said the risk of having to adjust water with the valve in the back was that the water gets too hot and could burn the residents. CNA I said that some of the independent residents like to shower on their own and if they did not adjust the water temperature correctly, they could burn themselves. In an Observation and interview on 09/09/2025 at 10:27 am with Maintenance Director in room [ROOM NUMBER] revealed water pooled underneath the sink, on the floor close to the window on B side, and on the floor near and inside the closet. A fan was on the floor blowing and was plugged in near the sink with the cord in the water. A blanket was on the floor underneath the sink. The Maintenance Director stated he realized there was a leak two days ago and was not sure where it was coming from. He said the leak was found under the sink and the far wall in the bedroom. He explained when he saw the water, he brought in a fan. He stated he had not fixed the leak because he had to get the water dried first. The maintenance director stated he thought the leak was from the shower but noticed there was still a leak the next day. He explained residents were to be moved to another room when their rooms flood but he had not moved the residents this room because he was waiting to see where the leak was from. The maintenance director stated the water on the ground was a hazard for residents because they can slip and fall. He further stated the fan sitting in the water was a risk because it can electrocute you. In an observation and interview with the Maintenance Director, on 09/09/25 from 12:05 PM -12:30 PM, revealed he had worked in the facility for two months. He checked the hot water temperature in the 100 Hall shower room showing a reading result of 76.5 degrees Fahrenheit. He said he was not aware of the shower issues. He said the only thing he was aware of was that the shower heads were broken, and they had been replaced last week. The maintenance Director said he believed when they were running the generator the water heater may have been affected causing cooler water temperatures in the 100 Hall shower. The Maintenance Director tried to enter the 200 Hall Shower, and he did not know the code. Resident #39 gave him the code as he walked by the shower room. Upon entry to the 200 Hall shower room, the Maintenance Director tried to turn the water on using the faucet, but it kept spinning around. He then pressed a button on the shower head and water came out; however, he could not adjust the temperature with the faucets. The Maintenance Director said the staff and residents do not need to adjust the temperature of the water using the Valves in the back of the shower because the shower head had a button that activated the water flow. He said he would replace the faucets so that they can start working. He said the staff may have rounded them by spinning them. He tested the hot water temperature in 200 hall showers, and the reading was 103 degrees Fahrenheit. He said all staff should utilize the TELS (a platform/software that the facility uses to track work orders) to report things that needed to be fixed. He said the TELS-priorities were urgent matters and that was what he fixed first. The Maintenance Director said the risk to cold shower in 100 Hall was that the shower would be cold and the risk of adjusting water using the valves was water circulation. In an interview with the DON on 09/11/25 at 6:42 PM she said nursing complained and notified maintenance about the showers. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/11/2025
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She said she expected the staff to use TELS to report anything broken but a lot of them will notify management, or maintenance in passing and then management will put the orders in TELS. The DON said if water was too hot, they could burn themselves. She said if the shower was cold, it would be their preference if they liked cold showers. Record review of facility TELS work order summary from 08/01/25 to 09/12/25 did not reflect work orders for hot water issues in shower room on 100 hall and faucets not working in 200 hall shower rooms. Review of the policy titled Bath, Shower, revised 02/18, reflected Policy: Be sure that the bath area is at a comfortable temperature for the resident. Record review of the facility's Maintenance Policy, dated 2001 and revised on 12-2009, titled: Maintenance Service states: Maintenance Service Policy Statement: Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: a. maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. d. maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order. 3. The maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety for 2 of 8 rooms (room [ROOM NUMBER] and 201) and for 4 of 8 Residents (Resident #12, # 22, 59 and #78) reviewed for refrigerators in the rooms. 1.Facility failed to monitor refrigerator temperature on 09/05/25, 09/06/25, 09/07/25, 09/08/25, and 09/09/25 in room [ROOM NUMBER] and room [ROOM NUMBER] 2.Facility failed to monitor and did not put thermometers or maintain temperature logs in Resident #59's and Resident #78's refrigerators. 3.Facility failed to monitor temperature and/or maintain temperature logs for Resident #12's and Resident #22's refrigerators. These failures could affect residents by placing them at risk for food-borne illnesses. Finding included: 1.Observation in room [ROOM NUMBER] on 09/09/25 at 08:46 AM revealed two personal refrigerators in the room. The temperature log was attached to the two refrigerator doors. The temp logs were missing entries for 09/05/25, 09/06/25, 09/07/25, 09/08/25, and 09/09/25. The refrigerators belonged to a resident in the hospital and was not available for interview. 2.Observation in room [ROOM NUMBER] on 09/09/25 at 09:09 AM revealed one personal refrigerator in the room. The temperature log was attached to the refrigerator door. The temp log was missing entries for 09/05/25, 09/06/25, 09/07/25, 09/08/25, and 09/09/25. The refrigerator belonged to a non-interviewable resident. 3.Observation and interview on 09/09/25 at 09:53 AM revealed Resident #59 and Resident #78 had two personal refrigerators in their room. They both said they bought them two months ago. Both residents opened their refrigerators and revealed no thermometer inside each refrigerator. Resident #78 stated she can feel from the door coolness and by looking at the icicles formed on the inside of the fridge to know that it was working and cool enough to keep her food fresh. Both residents said no one had checked their refrigerators or kept a log. They both said they cleaned out their own refrigerators and had no concerns. 4.Observation and interview on 09/09/25 at 10:37 AM revealed Resident #12 and Resident #22 both had personal refrigerators in their room. Both refrigerators had thermometers inside but there was no temp log. Resident #12 and Resident #22 said their temp was checked once a week. They said they clean out their own refrigerators. In an interview with CNA H on 09/10/25 at 5:21 PM, revealed she was not aware who was responsible for checking the refrigerator temps. She said maybe housekeeping was responsible or maintenance. In an interview with LVN G on 09/10/25 at 17:22 PM, revealed the 10 pm to 6 AM shift was responsible for checking the refrigerator temperatures in the medication room, but she was not aware who was responsible for the refrigerators in the rooms. She said that she had been working at the facility for 1 year and was never told that she was responsible for monitoring refrigerator temperatures in the rooms. She said it was most likely maintenance who was responsible. She said the reason for checking temps was to make sure that the temperature was correct, and that the food being kept is in good condition. Interview with the DON on 09/11/25 at 10:45 AM, revealed the night shift nursing staff monitored and documented the temperature in the med room refrigerators. She said all departments were responsible for refrigerators monitoring. The DON said the department heads are supposed to monitor the temp logs during their angel rounds and bring any issues to the meetings daily. She said the risk to the residents was not knowing the temperature of refrigerator and residents eating the food could cause gastric illness. Interview with maintenance on 09/11/25 at 12:05 PM revealed the nursing department was responsible for monitoring refrigerator temperatures in the rooms. He said he was new to the job, and he would double check on the frequency, but he believed it was checked daily. He said monitoring (continued on next page)		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of fridge temps was done for food safety. In an Interview with the Administrator on 09/11/25 at 03:34 PM, revealed he was not aware Resident #59 and Resident #78 had no thermometers inside their refrigerators because had he known, he would have put thermometers in them. He said he had thermometers in his office and that the surveyor should let him know which rooms were missing thermometers because it was a food safety concern, not knowing which residents didn't have thermometers in their fridges to monitor their fridge temperatures. He said temperatures in fridges are expected to be checked daily by nursing staff. He said it was a food safety concern. Record Review of the Facility policy titled Foods Brought by family/visitors revised 10/2017 revealed Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. The nursing and/or food service staff will discard any foods prepared for the residents that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates) The facility policy did not address temperature checks would be completed. Review of the Food and Drug Administration Food Code, dated 2022, reflected, .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility must properly dispose of garbage and rubbish in accordance with current state laws for 1 of 1 dumpster reviewed for garbage disposal. The facility failed to ensure all garbage items were placed into the dumpster and the dumpster doors were closed and secured. This failure could place residents at risk of infection and result in a pest infestation from improperly disposed garbage. Findings included: Observation on 09/09/2025 at 8:10AM of the facility's dumpster and dumpster area revealed a commercial-size dumpster 1/2 full of garbage. The left- and right-side doors were open. On the ground of the left side of the dumpster were 4 full plastic garbage bags, 2 partially filled plastic garbage bags, and 2 empty cardboard boxes. Laying on the ground in the dumpster area were 2 mattresses. Interview on 09/10/2025 at 3:34PM with the ADM revealed all staff use the dumpster and expected all doors on the dumpster to be closed. During an interview on 09/11/2025 at 8:00PM with the ADM, he stated generally all staff are responsible for making sure trash was inside the dumpster and the lids were closed. He explained the importance of that was to ensure that it does not cause issues like attract insects or other things that can cause undesirable issues. Record review of the U.S. FDA Food Code 2022 reflected: 5-501.15 Outside Receptacles. Proper storage and disposal of garbage and refuse are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage or breeding place for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be a possible source of contamination of food, equipment, and utensils. Storage areas for garbage and refuse containers must be constructed so that they can be thoroughly cleaned in order to avoid creating an attractant or harborage for insects or rodents. In addition, such storage areas must be large enough to accommodate all the containers necessitated by the operation in order to prevent scattering of the garbage and refuse. All containers must be maintained in good repair and cleaned as necessary in order to store garbage and refuse under sanitary conditions as well as to prevent the breeding of flies. Garbage containers should be available wherever garbage is generated to aid in the proper disposal of refuse. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident's right to be free from verbal abuse for 1 of 4 residents (Resident #49) reviewed for abuse. The facility failed to ensure Resident #49 was free from verbal abuse by Resident #87 on 8/29/25 and 9/6/25. This could place residents at risk of abuse and psychosocial harm. Findings included: Record review of Resident #49's admission record, dated 09/10/2025, revealed a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included bipolar disorder (serious mental illness that causes mood swings, changes in energy, thinking, behavior, and sleep), anxiety disorder, and unspecified Intellectual Disabilities (limitations on intelligence, learning and everyday abilities). Record review of Resident #49's Annual MDS assessment, dated 06/26/2025, revealed a BIMS score of 13, indicating intact cognition. Record review of Resident #49's nursing progress notes, dated 09/06/2025, written by LVN M, revealed [Resident #49] was out smoking when [Resident #87] became verbally aggressive with him. He threatens to knock his teeth out and throw his w/c on top of him. He then called him a [NAME]. Immediately separated and emotional support provided. Assisted to room where coffee and snack was given. Will continue to monitor. Vs 96.8, 20, 72, 128/77, 97%. Record review of Resident #87's admission record, dated 09/10/2025, revealed a [AGE] year-old-male who admitted to the facility on [DATE] with diagnoses that included unspecified dementia (brain disease that alters brain function and causes a cognitive decline) and unspecified psychosis (symptoms that happen when a person is disconnected from reality). Record review of Resident #87's admission MDS, dated [DATE], revealed a BIMS score of 14, indicating intact cognition. Record review of Resident #87's care plan, initiated 07/07/2025, revealed [Resident #87] is verbally aggressive r/t Dementia. [Resident #87] initiated verbal aggression towards another resident. Interventions included: - administer medications as ordered and monitor/document side effects and effectiveness- assess resident's coping skills and support system- psychiatric consult as indicated- when the resident becomes agitated: intervene before agitation escalates; guide away from source of distress. Record review of Resident #87's nursing progress note written by LVN D on 08/29/2025 revealed Res was calling another res names and picking on him out at the smoke area the issue was made aware to this nurse. This nurse went out to the smoke area and approached the res and educated reminded him how he wouldn't like to be treated that way and people have feelings it's not okay to talk to them in that way. Res understood he then apologized to the res and the nurse for his behavior and requested for a cigar in exchange for better behavior. Other res responded and handed him one before the nurse could make a deal. Both res continued to be nice and talk and laugh outside. Fluids and snacks provided at bedside. Continue to monitor. Record review of Resident #87's nursing progress note written by LVN M on 09/06/2025 revealed Up in D/R getting a cup of coffee when he saw resident [#49] and called him a [NAME]. redirected back to room where breakfast was waiting. Will continue to monitor. Record review of Resident #87's nursing progress note written by LVN M on 09/06/2025 revealed Another resident had witnessed verbal aggression toward another resident and called 911. He wanted a cigarette and become verbally aggressive with [Resident #49]. He threatens to knock his teeth down his throat and then throw his W/C on top of him. He also called him a [NAME]. Immediately separated and redirected to room where son was waiting on him. Vs 98.6, 18, 74, 128/74, 97%. Record review of Resident #87's nursing progress note written by LVN D on 09/08/2025 revealed Res relocated to room [number], family and MD notified. Res took all his belongings with him. Observation and interview on 09/09/2025 at 9:25 am, Resident #87 was in his room, lying in bed and appeared well groomed. When asked about the incident with Resident #49, Resident #87 stated he called him a faggot. Resident #87 stated Resident #49 had not made him mad, and they were not fighting or arguing. Resident #87 stated he just called him what he was and said he don't like me and I don't like (continued on next page)		

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Centers for Medicare & Medicaid Services

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No. 0938-0391

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	him. That is how it is. Resident #87 stated the police came up and told him to stay away from Resident #49 and leave him alone. Resident #87 stated he moved rooms yesterday (09/08/2025) but he did not know why. Interview on 09/09/2025 at 12:34 pm, the Administrator stated Resident #87 had a behavior contract in place and was issued a discharge notice on Friday. He stated with behavior contracts, the first time a behavior occurs was when the contract was given, unless it was severe harm, then if a second occurrence a 30 day discharge notice would be given, and if a third incident occurred, then an immediate discharge notice would be given. The Administrator stated he does go by the provider letter for guidance on reporting abuse to HHSC. He stated many factors like intent, cognition, anything physical, and most verbal if they were cursing, and someone saying it was abuse would be reportable. He stated he expected all staff to report any instance to him and it was not up to them on what was reportable. He stated the other thing that helped was part of the provider letter said to contact police and depending on what the police did about that incident, he would report. Observation and interview on 09/10/2025 at 10:57 am, Resident #49 was up in his wheelchair in the dining room. When asked about the incident, he stated Resident #87 had cussed him out and staff had moved his room. Resident #49 stated Resident #87 would get close to him and put his fist in his face and called him a gay faggot. He stated Resident #87 never hit him but tried to, and called him names. Resident #49 stated he told the nurses, and they told Resident #87 to stop. Resident #49 stated for the past 2 days he had been doing fine and felt safe. Attempted interview on 09/10/2025 at 3:15 pm with LVN D was unsuccessful. Interview on 09/10/2025 at 3:23 pm, LVN M stated she worked only weekends. She stated she did not see an incident between Resident #49 and Resident #87, but one of the residents did and called the police. She stated Residents #49 and #87 were bickering in the courtyard and she did not actually see it, but it was reported to her by the weekend supervisor. She stated she did not think the weekend supervisor saw the incident because a resident had reported it. LVN M stated Resident #87 wanted a cigarette from Resident #49, who said no, so Resident #87 got mad and threatened to knock his teeth out, throw his w/c on top of him and called him a faggot. She said there were no staff witnesses, and she completed the incident report. LVN M said she had never witnessed any other incidents between the two residents before. Interview on 09/11/2025 at 9:07 am, LVN D stated she worked morning shifts Monday through Friday. LVN D stated Resident #49 was in the hallway and Resident #87 was headed toward the smoking area and called Resident #49 a faggot. She said no physical contact was made and she had known that Resident #87 had done that pretty frequently, but this was the first time she witnessed it. She said she was in another resident's room, and as soon as she heard them getting loud she left the room and split Resident #49 and #87 up. She said Resident #87 went outside; she talked with Resident #49 and then went outside to Resident #87 to educate him not to use those words. LVN D stated while she was outside talking to Resident #87, Resident #49 called the police and that was when the Administrator took over. She stated she documented the incident in the progress notes. Surveyor asked LVN D to show where in the EHR it was documented this happened on 09/05/25, LVN pulled up the note dated 8/29/25. She stated she knew it was one of those days. She stated she did not complete an incident report or witness statement. She said she kept Resident #49 and Resident #87 separated on her shift the week of 8/29/25 through 9/5/25 and Resident #87 stayed in bed most of the morning that week. She stated Resident #87 was moved to a different hall on 09/08/25 but did not know why he moved. LVN D stated she was supposed to report all abuse to the abuse coordinator immediately. Interview on 09/11/2025 at 11:15 am, the Administrator stated he reported the incident because he got a call that police were at the facility and he walked back to talk to the residents involved, the nurse and other onlookers. He stated he thought another resident had called the police and she was saying he's going to hit somebody so that triggered him to report (to HHSC). The Administrator stated he read the note dated 08/29/2025 written by LVN D, and the way it read was like adults arguing. When Surveyor asked for clarification on which incident the initial reportable to HHSC was for on 09/06/25, the Administrator was not able to provide an explanation. When asked if the incident on 8/29/25 should (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 09/11/2025
NAME OF PROVIDER OR SUPPLIER Benbrook Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have been reported, he stated it read like adults arguing. He stated if there was a separate incident, maybe that's why they moved Resident #87 over the past weekend. Interview on 09/11/25 at 7:37 pm, the Administrator stated he had no new information related to the incident. He stated reporting to the state agency (HHSC) was to ensure guidelines were followed and incidents were handled appropriately, if not something could fall through the cracks and the outcome could be worse. He stated if staff witnessed abuse and did not report to him, the risk for verbal abuse could be lasting psychological harm that may not be noticed. He stated he expected staff to document incidents in the EHR and monitor residents after an incident. He stated residents could be monitored one to one or have every 15 minutes and would be monitored by the staff assigned to the hall. Record review of facility policy titled, Abuse Investigation and Reporting revised July 2017, revealed in part: All 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.		

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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, interviews and record reviews, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials including to the State Survey Agency in accordance with State law through established procedures, for 2 of 4 residents (Resident #49) reviewed for abuse. The facility failed to ensure a resident-to-resident altercation that occurred on 08/29/25 was reported to the State Survey Agency. This could place residents at risk of abuse. Findings included:Record review of Resident #49's admission record, dated 09/10/2025, revealed a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included bipolar disorder (serious mental illness that causes mood swings, changes in energy, thinking, behavior, and sleep), anxiety disorder, and unspecified Intellectual Disabilities (limitations on intelligence, learning and everyday abilities). Record review of Resident #49's Annual MDS assessment, dated 06/26/2025, revealed a BIMS score of 13, indicating intact cognition. Record review of Resident #49's nursing progress notes, dated 09/06/2025, written by LVN M, revealed [Resident #49] was out smoking when [Resident #87] became verbally aggressive with him. He threatens to knock his teeth out and throw his w/c on top of him. He then called him a [NAME]. Immediately separated and emotional support provided. Assisted to room where coffee and snack was given. Will continue to monitor. Vs 96.8, 20, 72, 128/77, 97%. Record review of Resident #87's admission record, dated 09/10/2025, revealed a [AGE] year-old-male who admitted to the facility on [DATE] with diagnoses that included unspecified dementia (brain disease that alters brain function and causes a cognitive decline) and unspecified psychosis (symptoms that happen when a person is disconnected from reality).Record review of Resident #87's admission MDS, dated [DATE], revealed a BIMS score of 14, indicating intact cognition.Record review of Resident #87's care plan, initiated 07/07/2025, revealed [Resident #87] is verbally aggressive r/t Dementia. [Resident #87] initiated verbal aggression towards another resident. Interventions included: - administer medications as ordered and monitor/document side effects and effectiveness- assess resident's coping skills and support system- psychiatric consult as indicated- when the resident becomes agitated: intervene before agitation escalates; guide away from source of distress. Record review of Resident #87's nursing progress note written by LVN D on 08/29/2025 revealed Res was calling another res names and picking on him out at the smoke area the issue was made aware to this nurse. This nurse went out to the smoke area and approached the res and educated reminded him how he wouldn't like to be treated that way and people have feelings it's not okay to talk to them in that way. Res understood he then apologized to the res and the nurse for his behavior and requested for a cigar in exchange for better behavior. Other res responded and handed him one before the nurse could make a deal. Both res continued to be nice and talk and laugh outside. Fluids and snacks provided at bedside. Continue to monitor.Record review of Resident #87's nursing progress note written by LVN M on 09/06/2025 revealed Up in D/R getting a cup of coffee when he saw resident [#49] and called him a [NAME]. redirected back to room where breakfast was waiting. Will continue to monitor.Record review of Resident #87's nursing progress note written by LVN M on 09/06/2025 revealed Another resident had witnessed verbal aggression toward another resident and called 911. He wanted a cigarette and become verbally aggressive with [Resident #49]. He threatens to knock his teeth down his throat and the throw his W/C on top of him. He also called him a [NAME]. Immediately separated and redirected to room where son was waiting on him. Vs 98.6, 18, 74, 128/74, 97%.Record review of intake (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	worksheet, priority date 09/06/2025, revealed date incident occurred was 09/05/2025 and Resident #49 called the police stating Resident #87 was cursing him in the hallway. LVN D witnessed the event, redirected Resident #87 and completed assessments. Further review revealed police called for incident by resident. No incident number given to administrator or staff. No actions taken by police. Observation and interview on 09/09/2025 at 9:25 am, Resident #87 was in his room, lying in bed and appeared well groomed. When asked about the incident with Resident #49, Resident #87 stated he called him a faggot. Resident #87 stated Resident #49 had not made him mad, and they were not fighting or arguing. Resident #87 stated he just called him what he was and said he don't like me and I don't like him. That is how it is. Resident #87 stated the police came up and told him to stay away from Resident #49 and leave him alone. Resident #87 stated he moved rooms yesterday (09/08/2025) but he did not know why. Interview on 09/09/2025 at 12:34 pm, the Administrator stated Resident #87 had a behavior contract in place and was issued a discharge notice on Friday. He stated with behavior contracts, the first time a behavior occurs was when the contract was given, unless it was severe harm, then if a second occurrence a 30 day discharge notice would be given, and if a third incident occurred, then an immediate discharge notice would be given. The Administrator stated he does go by the provider letter for guidance on reporting abuse to HHSC. He stated many factors like intent, cognition, anything physical, and most verbal if they were cursing, and someone saying it was abuse would be reportable. He stated he expected all staff to report any instance to him and it was not up to them on what was reportable. He stated the other thing that helped was part of the provider letter said to contact police and depending on what the police did about that incident, he would report. Observation and interview on 09/10/2025 at 10:57 am, Resident #49 was up in his wheelchair in the dining room. When asked about the incident, he stated Resident #87 had cussed him out and staff had moved his room. Resident #49 stated Resident #87 would get close to him and put his fist in his face and called him a gay faggot. He stated Resident #87 never hit him but tried to, and called him names. Resident #49 stated he told the nurses, and they told Resident #87 to stop. Resident #49 stated for the past 2 days he had been doing fine and felt safe. Attempted interview on 09/10/2025 at 3:15 pm with LVN D was unsuccessful. Interview on 09/10/2025 at 3:23 pm, LVN M stated she worked only weekends. She stated she did not see an incident between Resident #49 and Resident #87, but one of the residents did and called the police. She stated Residents #49 and #87 were bickering in the courtyard and she did not actually see it, but it was reported to her by the weekend supervisor. She stated she did not think the weekend supervisor saw the incident because a resident had reported it. LVN M stated Resident #87 wanted a cigarette from Resident #49, who said no, so Resident #87 got mad and threatened to knock his teeth out, throw his w/c on top of him and called him a faggot. She said there were no staff witnesses, and she completed the incident report. LVN M said she had never witnessed any other incidents between the two residents before. Interview on 09/11/2025 at 9:07 am, LVN D stated she worked morning shifts Monday through Friday. LVN D stated Resident #49 was in the hallway and Resident #87 was headed toward the smoking area and called Resident #49 a faggot. She said no physical contact was made and she had known that Resident #87 had done that pretty frequently, but this was the first time she witnessed it. She said she was in another resident's room, and as soon as she heard them getting loud she left the room and split Resident #49 and #87 up. She said Resident #87 went outside; she talked with Resident #49 and then went outside to Resident #87 to educate him not to use those words. LVN D stated while she was outside talking to Resident #87, Resident #49 called the police and that was when the Administrator took over. She stated she documented the incident in the progress notes. Surveyor asked LVN D to show where in the EHR it was documented this happened on 09/05/25, LVN pulled up the note dated 8/29/25. She stated she knew it was one of those days. She stated she did not complete an incident report or witness statement. She said she kept Resident #49 and Resident #87 separated on her shift the week of 8/29/25 through 9/5/25 and Resident #87 stayed in bed most of the morning that week. She stated Resident #87 was moved to a different hall on 09/08/25 but did not (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Benbrook Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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	know why he moved. LVN D stated she was supposed to report all abuse to the abuse coordinator immediately. Interview on 09/11/2025 at 11:15 am, the Administrator stated he reported the incident because he got a call that police were at the facility and he walked back to talk to the residents involved, the nurse and other onlookers. He stated he thought another resident had called the police and she was saying he's going to hit somebody so that triggered him to report (to HHSC). The Administrator stated he read the note dated 08/29/2025 written by LVN D, and the way it read was like adults arguing. When Surveyor asked for clarification on which incident the initial reportable to HHSC was for on 09/06/25, the Administrator was not able to provide an explanation. When asked if the incident on 8/29/25 should have been reported, he stated it read like adults arguing. He stated if there was a separate incident, maybe that's why they moved Resident #87 over the past weekend. Interview on 09/11/25 at 7:37 pm, the Administrator stated he had no new information related to the incident. He stated reporting to the state agency (HHSC) was to ensure guidelines were followed and incidents were handled appropriately, if not something could fall through the cracks and the outcome could be worse. He stated if staff witnessed abuse and did not report to him, the risk for verbal abuse could be lasting psychological harm that may not be noticed. He stated he expected staff to document incidents in the EHR and monitor residents after an incident. He stated residents could be monitored one to one or have every 15 minutes and would be monitored by the staff assigned to the hall. Record review of facility policy titled, Abuse Investigation and Reporting revised July 2017, revealed in part: All 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; b. The local/State Ombudsman; c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's attending physician; and g. The facility medical director. 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview and record review, the facility failed to complete and implement a comprehensive person-centered care plan for each resident to meet the resident's medical, nursing, therapeutic, and psychosocial needs in order to attain or maintain the resident's highest practicable well-being for one resident (Resident #16) of seven residents reviewed for care plans. The facility failed to complete care plans addressing Resident #16's history of abuse and PTSD. This failure could affect residents by placing them at risk for not receiving care to maintain and/or reach their highest practicable mental and psychosocial well-being. Findings included: Record review of Resident #16's face sheet dated 09/11/2025, revealed a [AGE] year-old woman admitted on [DATE] from a psychiatric hospital. She was admitted with primary diagnoses chronic obstructive pulmonary disease and other pertinent diagnoses including post-traumatic stress disorder (mental health condition that can develop after experiencing or witnessing a traumatic event), anxiety disorder, adult financial abuse (confirmed, subsequent encounter), adult sexual abuse (confirmed, subsequent encounter), adult physical abuse (confirmed, subsequent encounter), and hypertension. Record review of Resident #16's MDS dated [DATE] revealed the resident had a BIMS (brief interview for mental status - tool used to assess cognitive function, and scores range from 0 to 15) of 15 . Record review of Resident #16's history and physical dated 07/26/2025 reflected: Presenting Problems and History of Present Illness: CC (chief complaint): Depression, Suicidal ideations with intent and plan HPI: History is taken from the patient, patient's old medical record is review in detail. Patient endorses depressed mood, anhedonia, severe anxiety, hopelessness, helplessness, guilt, low self-esteem, decreased energy level, worthlessness, struggling with negative thoughts, impaired sleep and appetite. Patient lacks motivation and has problems with concentration. Patient has active suicidal ideation. Patient w/ pmhx financial sexual emotional physical abuse presented with SI W Plan/intent presented after assault at home by roommate, reporting neck pain. uses w/c to ambulate/Cane. Labs k 3.2 otherwise unremarked. neck workup/imaging clear. Psychiatric and Substance Abuse History: PTSD Medical History: COPD/emphysema, HTN/high BP, chronic pain History of head, neck and back surgeries. Psychiatric: The patient has complaints of mood, memory, orientation, depression, suicidal ideation, homicidal ideation. Active Medical Diagnosis: COPD/emphysema, HTN/high BP, chronic pain, Suicidal ideation, Anxiety, Depression, PTSD. Recommendations: I will recommend symptomatic and supportive care. I will recommend suicidal watch and fall precautions. I will also recommend preventive care including flu shot as needed. Patient was counseled to abstain from smoking, have offered medications to assist with nicotine withdrawal. I will also recommend avoiding illicit drugs and smoking and limit alcohol use. Extensive number of diagnosis or management options were considered as detailed above. Treatment of psychiatric problem as per the psychiatrist. Record review of Resident #16's Comprehensive Care Plan initiated 08/06/2025, reflected:- Focus of the resident uses antidepressants - Focus of the resident is a smoker; interventions include instructing resident about facility policy on smoking and observe clothing and skin for signs of cigarette burns; with a goal of the resident will not suffer injury from unsafe smoking practices through the review date. Upon further record review of Resident 16's Comprehensive Care Plan, all other care areas/focus/problems were initiated on 09/09/2025, including:- I have hx of financial, sexually, physically abused per admission H & P records.- I chose to have FULL CODE.- The resident uses antipsychotic medications r/t Behavior management, PTSD.- The resident has a mood problem r/t Admission, PTSD, hx of abuse, depression.- The resident has COPD. Record review of Resident #16's Trauma Informed Care Assessment, dated 08/06/2025 revealed the resident answered No to all questions asked. Record review of Resident #16's orders, dated 09/11/2025, reflected: (Psych Company) May Provide Psychological Services. Med Management May Provide Psychiatric Services; (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the order was made on 08/12/2025. Record review of Resident #16's Multidisciplinary Care Conference dated 08/14/2025 revealed the meeting occurred 08/14/2025 at 13:00 (1:00PM), with dietary staff, social worker, and MDS staff. The document indicated that the resident and family member/responsible party were not present. The remaining document was uncomplete, with no information regarding the resident's problem/needs nor evaluation/goals. Observation and interview with Resident #16 on 09/09/2025 at 10:48AM revealed Resident #16 did not know who the social worker was and had no consultations since admitting. Resident #16 discussed she had seen physical therapy and said her physical therapist had her wearing ankle weights when she should not do weight bearing exercises, and her ankle weights were used on her in her past (related to her history of abuse). She further stated being listened to (by facility staff) was hard. Resident did not appear or sound distressed. The resident was well groomed and dressed and was able to be mobile in her wheelchair. During an interview on 09/10/2025 at 2:15PM with Resident #16, she revealed that she had told staff about her (abuse) history but that staff had not formally asked her about it. Resident #16 stated she wanted to see psych services; she said she was told somebody (from psych services) was supposed to come but had not. The resident did not say who told her psych was supposed to come and see her. During an interview on 09/11/2025 at 8:50AM with the DON, she stated care plans were a group effort, she (DON) and nursing initiate baseline care plans but the interdisciplinary team had sections they were responsible for in the comprehensive care plan. She stated care plans include various care areas like acute conditions, medical diagnoses, DNR or full code, discharge plans, medications, monitoring, behaviors, secure units, and diets. She stated when a residents admitted with trauma history, staff do not always find out right away. She explained if a resident admits from psych (hospital), staff know right off the bat and sometimes they will not know any triggers early on. If a resident admits from a hospital, psych is not focused on. The DON further discussed when a residents admitted from psych, staff gets the resident into psych services and care plan specific behaviors. The DON discussed Resident #16 had not opened up to her about her history of abuse to her but she was aware of the history; the resident had discussed her family member's death with the DON. The DON stated she was aware of some of the resident's trauma history when she was admitted , but not all of it. An interview on 09/11/2025 at 10:29AM with the SW revealed she was responsible for care areas like DNR or full code status, discharge plans, and behaviors for care plans; she stated trauma needs to be documented. The SW said she does not do baseline care plans but was responsible for comprehensive care plan and estimated comprehensive care plans must be completed within 5-7 days (of admit) but was not sure. When completing the comprehensive care plan, she explained she tries to review as much as she can and put what she needs in there, ask further questions with her initial assessments, especially with code status, she looks at behaviors and previous behaviors because residents may not have them when they first get here. She usually uses records and information from when she speaks new admits for initial assessments. The SW explained that she did the trauma informed care assessment with Resident #16. She explained she asked about the resident's depression and if she had been involved with traumatic events, and the resident looked down and thought about it, and then said no to the SW. The SW said the resident would not discuss anything with her. Since the assessment, the SW had not tried to ask again because she did not want to push it and the resident seemed to have been doing well. When asked why the resident had not seen psych services, the SW responded she hasn't?; the SW discussed Resident #16 had been referred to speak with the psychologist . When asked why the things discussed were not in Resident #16's care plan, she stated she had thought she put it in there. The SW further explained she reviewed the resident's records and meant to put the resident's history in her care plan; she said she did not know why it was not in her care plans and may have overlooked it (completing the care plan). The SW said she reviewed Resident #16's hospital papers and talked with the resident, took notes on the hospital records, noted her trauma, and put it into her care plan, and resident's code status and discharge (plan). She explained that was how she typically does it and does not know how she (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	missed it. She said the resident's history should be care planned. During an interview on 09/11/2025 at 6:52PM with the DON, she stated care plan conference helped to get to truly know their residents and comprehensive care plans should be completed within 7 days. During an interview on 09/11/2025 at 8:00PM with the ADM, he stated he expected staff to complete comprehensive care plans when required. When discussing Resident #16's comprehensive care plan being completed on 09/09/2025, he stated that it was a problem (the length of time between Resident #16's admit date and comprehensive care plan completion date) because care plans ensure how care is supposed to be provided for the resident. Care Plans, Comprehensive Person-Centered Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 3. The IDT includes: a. the attending physician; b. a registered nurse who has responsibility for the resident; c. a member of the food and nutrition services staff; d. the resident and the resident's legal representative (to the extent practicable); and e. other appropriate staff or professionals as determined by the resident's needs or as requested by the resident. 4. Each resident's comprehensive care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: a. participate in the planning process. 5. The resident will be informed of his or her right to participate in his or her treatment. 6. The care planning process will: a. facilitate resident and/or representative involvement. 7. The comprehensive, person-centered care plan will: a. include measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. incorporate identified problem areas; d. incorporate risk factors associated with identified problems; e. build on the resident's strengths; f. reflect the resident's expressed wishes regarding care and treatment goals; g. aid in preventing or reducing decline in the resident's functional status and/or functional levels; h. enhance the optimal functioning of the resident by focusing on a rehabilitative program; [NAME]. reflect currently recognized standards of practice for problem areas and conditions. 8. Areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. 9. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. 10. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. a. When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers. 11. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). 14. The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals will be documented in the resident's clinical record in accordance with established policies.		

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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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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 interview and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one (Resident #83) of one resident reviewed for quality of care. The facility failed to monitor Resident #83's blood glucose levels before administering insulin. This failure could place residents at risk for not receiving appropriate care and treatment and decreased quality of life. Findings included: Record review of Resident #83's face sheet dated 09/11/2025 revealed a [AGE] year old female, admitted on [DATE] with primary diagnosis of fibromyalgia and other pertinent admitting diagnoses including type 2 diabetes mellitus with diabetic neuropathy, type 2 diabetes mellitus without complications, morbid (severe) obesity due to excess calories, pure hypercholesterolemia, major depressive disorder, generalized anxiety disorder, heart failure, and hypertension. Record review of Resident #83's MDS dated [DATE] revealed a BIMS of 13. Record review of Resident #83's blood glucose levels from 06/01/2025-07/03/2025 and 08/22/2025-09/09/2025 revealed the resident blood glucose levels consistently above 100 mg/dL (the upper limit). Record review of Resident #83's care plan last revised on 03/20/2025 reflected: Focus - The resident has altered endocrine status (specify) r/t Goal - The resident will maintain blood glucose levels below (specify) through the review date Interventions - Dietary consult for nutritional regimen and ongoing monitoring.; Fasting Blood Glucose (SPECIFY FREQ) as ordered by MD.; Monitor/document/report PRN for s/sx of hyperglycemia.; Monitor/document/report PRN s/sx of hypoglycemia.; take meds as ordered. Record review of Resident #83's insulin injection orders reflected:- Insulin Glargine Subcutaneous Solution (Insulin Glargine); Directions: inject 45 milliliter subcutaneously at bedtime for DM; Start date: 8/27/2024; End Date: 8/27/2024- Lantus SoloStar 100 UNIT/ML Solution pen-injector; Directions: Inject 45 unit subcutaneously at bedtime for diabetes inject 45u sub Q at bedtime; Start date: 8/28/2024; End date 7/4/2025- Lantus SoloStar 100 UNIT/ML Solution pen-injector; Directions: Inject 55 unit subcutaneously one time a day at bedtime for diabetes mellitus type 2; Start date: 7/4/2025; End date 9/8/2025- HumuLIN 70/30 Subcutaneous Suspension (70-30) 100 UNIT/ML (Insulin NPH Isophane & Reg (Human)); Directions: 35 unite subcutaneously two times a day for diabetes mellitus monitoring; Start date: 9/8/2025; End date: Indefinite Record review of Resident #83's medication administration summary for July 2025 revealed Resident #83's blood glucose was monitored and recorded before the medication was administered on July 1-3, 2025. Her blood glucose levels were not monitored for the remainder of the month. Record review of Resident #83's medication administration summary for August 2025 revealed Resident #83's blood glucose was not monitored between August 1-21, 2025. Her blood glucose began to resume monitoring on August 22, 2025. During an interview on 09/09/2025 at 1:20PM with Resident #83 she stated she had been receiving Lantus (long acting) insulin, and it was different than the insulin she used while she lived at home, Novolog 70/30 (rapid-acting) insulin. She stated she did not know why she was given Lantus, but she told her doctor it was not working and that her doctor was finally switching her insulin after a year of being at the facility. An interview with on 09/11/2025 at 4:56PM with LVN C revealed she had administered insulin to Resident #83. She explained she checked the resident's blood glucose level before administering insulin. She stated she was monitoring Resident #83's blood glucose levels after the medication was administered because she had a new order for her insulin, but normally after insulin was given she just monitors for signs and symptoms. LVN C stated before giving long acting insulin, she checked blood glucose level. She said it was best practice to monitor blood glucose levels before and after giving insulin because blood glucose levels could suddenly drop or the insulin may not be effective. LVN C stated she had not seen Resident #83's order say to check blood glucose levels before and after giving insulin, but if the orders did she would. She stated it would be beneficial to check blood glucose levels before and after administering insulin. During an interview on 09/11/2025 (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/11/2025
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 6:41PM with the DON, she stated she expected staff to check orders and make sure they give insulin as prescribed. She stated blood glucose levels were checked if ordered by the physician. If the resident's care plan says to monitor blood glucose levels and it was not in the physician order, the DON stated staff have to follow the physician order. If a resident had fluctuating blood glucose levels, she expected staff to still follow the physician's order (of not monitoring). The DON said nurses verify and check the physicians orders. The DON stated the difference in the levels can cause a risk of hypoglycemic episodes.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview, and record review, the facility failed to provide appropriate services to prevent complications of enteral feeding for 1 of 1 resident (Resident #8) observed for medication administration via gastrostomy tube. 1. LVN D did not raise the head of bed during medication administration and water flush via G-tube for Resident # 8. Resident #8 was laid flat on his back. 2. LVN D did not clean the syringe and plunger before placing it in the sealed bag after administering medications via G-tube to Resident #8. 3. Facility failed to obtain orders to elevate the head of bed to at least 30-45 degrees up for Resident #8 who received continuous feedings via G-tube. 4. Facility failed to care plan to elevate the head of bed to at least 30-45 degrees up for Resident #8 who received continuous feedings via G-tube. These failures could place residents at risk for aspiration and interactions between the formula and various medications. Findings included: Record review of Resident #8's face sheet dated 09/10/25 indicated Resident #8 was a [AGE] year-old male with an initial admission on [DATE] and readmitted to the facility on [DATE] with a primary diagnosis of Traumatic subdural hemorrhage without loss of consciousness (injury to the brain that caused bleeding). His secondary diagnoses include gastrostomy status (this is a feeding tube that is placed through the abdominal cavity area into the stomach for nutritional purpose and medication for individuals who have difficulty swallowing), gastro-esophageal reflux diseases without esophagitis (this is non erosive reflux of stomach acid backflowing into the esophagus), protein-calorie malnutrition, and dysphagia (difficulty swallowing). Record review of Resident #8's Quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #8 had a BIMS score of 8, indicating mild cognitive impairment. The MDS indicated he had a feeding tube and received 501 cc/day or more fluid through his g-tube. The MDS did not indicate the total amount of Resident #8's total calories obtained through tube feeding. Record review of Resident #8's care plan revised 05/20/25 indicated Resident #8 had swallowing problems related to dysphagia. The goal was to not have injury related to aspiration. The intervention was that all staff would be informed of residents' special dietary and safety needs. Further review of the care plan initiated 12/13/24 indicated Resident #8 had fluid overload related to brain injury. The intervention was to provide pillows; raise HOB as needed to facilitate breathing, increased comfort. Record review of Resident #8's September 2025 physician orders on 09/10/25 reflected the following:- [Brand Name of formular] at 66 cc/hr X 20 hours administered through her G-tube with down time from 8 am to 12 pm starting on 08/16/25.-SOB when lying flat. Every shift for monitoring. Starting 08/19/25- Levetiracetam Oral Tablet 500 MG (Levetiracetam) Give 1 tablet via G-Tube two times a day for anticonvulsants. Starting 04/28/25. Further review of the orders did not indicate orders to elevate the head of bed to at least 30-45 degrees for a resident with g-tube feedings. During an observation and interview on 09/10/25 at 08:09 AM, it was revealed Resident #8 in his bed. LVN D raised the bed up for height comfort, she then laid the head of the bed down and administered 30 cc of water, then medication Levetiracetam (which had been crushed and dissolved in water), and another 30 cc of water after medication administration via gastrostomy tube to Resident #8. LVN D did not clean the 60cc syringe and plunger after the medication was administered, LVN D placed the syringe and plunger back into the sealed bag. LVN D stated she forgot to raise the head of Resident #8 bed up during medication administration. She said not raising the head up when administering medication via the g-tube can cause the risk of aspiration. LVN D said she should have washed the syringe and plunger after the (continued on next page)		

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Centers for Medicare & Medicaid Services

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Form Approved OMB
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication administration before placing it in the sealed bag for infection control. During an interview on 09/11/25 at 09:12 AM the DON said when medications are administered via gastrostomy tube, they expected the nurses to raise the head of bed prior medication administration via G-tube per policy and to wash out the syringe and plunger after medication administration prior to replacing them into the storage bag. The syringe and plunger were to be changed every 24 hours. The DON said not raising the head was bad, could cause a risk for aspiration and to not wash out the syringe and plunger would be an infection control issue. DON stated she had completed in-services for medications. In an interview on 09/11/25 at 6:42 PM, the DON said the expectation was that a resident on continuous feeds should have orders to elevate HOB at least 30 degrees up. She said she was not sure why Resident #8 did not have orders or care plan to elevate his bed while receiving feedings via G-tube. She said it was the responsibility of the nurse to check orders and herself and the ADON were responsible for monitoring that orders and care plan were accurate. She said the potential risk was aspiration. Record review of facility Inservice completed on 01/20/25 included topics of Medication administration, Medication rooms, Medication rights, Counting Narcotics at the beginning and end of shift with nurse led by DON revealed 13 staff including MA's, Med tech's, Nurses, and LVN D completed the Inservice. Record review of facility policy titled, Enteral Feedings-Safety Precautions revision date November 2018, revealed. The facility will remain current in and follow accepted best practices in enteral nutrition. Elevate the head of the bed (HOB) to at least 30 during tube feeding and at least 1 hour after feeding. If elevating the HOB is medically contraindicated, use the reverse Trendelenburg position. Symptoms of esophageal complications (e.g., stricture, fistula, ulcers):1. Pain;2. Difficulty swallowing; and3. Difficulty breathing		

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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** Number of residents sampled: Number of residents cited: Based on observations, interviews, and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the medication cart for 1 of 3 medication carts (Med Cart B) reviewed for storage of medication. 1.LVN E failed to ensure Med Cart B was kept locked and under direct observation where residents and unauthorized staff could access it outside room [ROOM NUMBER]. These failures could give access to unauthorized persons, as well as medications may not be maintained at their best therapeutic level. Findings included: 1. Observation and interview on 09/10/25 from 08:20 AM to 08:27 AM, revealed Med Cart B outside room [ROOM NUMBER]. Med Cart B was unlocked and unattended with the lock mechanism out (indicating it was unlocked). The door to room [ROOM NUMBER] was open and staff was not in the room. At 08:27 LVN E walked towards the cart from down the 100-foyer area and revealed Med Cart B belonged to her. She did not say why she left the medication cart unlocked and unattended. LVN E said the expectation was that the medication cart would be locked and secure when not in use. She said the risk was someone could get into the cart when unlocked. In an interview on 09/11/25 at 6:42 PM, the DON stated the expectation was that staff would follow medication safety policy and procedures and lock and secure the medication cart when not in use. She said all nursing staff were responsible for securing medications when not in use. She said the potential risk of unsecured med cart was medication safety. Interview on 08/07/25 at 3:49 PM with the Administrator revealed the expectation was that all staff would follow company policies and procedures and always keep the residents safe. Record review the facility's policy Storage of Medications, revision date April 2007, reflected 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.)containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport suchitems shall not be left unattended if open or otherwise potentially available to others.		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure required in-service training for nurse aides was completed for 2 of 5 CNA's (CNA K and CNA L) reviewed for training. The facility failed to ensure nurse aides received no less than 12 hours of training annually. This failure could place residents at risk of abuse, neglect, and exploitation and receiving poor quality of care by untrained staff. Findings included: Record review of personnel files for CNA K revealed a hire date of 03/20/2014. Record review of personnel files for CNA L revealed a hire date of 08/30/2024. Review of in-services revealed CNA K and CNA L did not have the required 12 hours of annual training. Interview on 09/11/2025 at 5:57 pm, the Administrator stated they could not provide the required training for all the CNAs. He stated they were going to change their training program where everyone would complete the required training on their anniversary date. He stated they will still have monthly and annual in-services. He stated the risk to residents being cared for by untrained staff was failure to follow and complete policies and procedures in an effective way. Interview on 09/11/2025 at 6:41 pm, the DON stated the Administrator, and the DON were responsible to ensure CNAs had the required training annually. She stated staff should be trained upon orientation, annually and as needed. She said trainings were monitored by corporate, and they were implementing a new process where an active employee roster would be printed out and the employee would sign. Record review of facility policy titled, In-Service Training, All staff revised August 2022, revealed the following: All staff must participate in initial orientation and annual in-service training. 6. Required training topics include the following: a. Effective communication with residents and family (direct care staff); b. Resident rights and responsibilities; c. Preventing abuse, neglect, exploitation, and misappropriation of resident property including: (1) activities that constitute abuse, neglect, exploitation or misappropriation of resident property; (2) procedures for reporting incidences of abuse, neglect, exploitation or misappropriation of resident property; and (3) dementia management and resident abuse prevention. d. Elements and goals of the facility QAPI program; e. The infection prevention and control program standards, policies and procedures; f. Behavioral health; and g. The compliance and ethics program standards, policies and procedures.		