

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455798	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/20/2025
NAME OF PROVIDER OR SUPPLIER  Bedford Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  2001 Forest Ridge Dr Bedford, TX 76021	

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)
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51047</p> <p>Based on interviews and record review the facility failed to develop and implement a baseline care within 48 hours of admission that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care for 1 of 4 residents (Resident #1) reviewed for baseline care plans.</p> <p>The facility failed to create a baseline care plan for Resident #1 within 48 hours of admission that addressed the resident's need for indwelling catheter care.</p> <p>This failure could place the resident at risk of infection, a lack of continuity of care and communication among nursing home staff, reduced resident satisfaction of care, and reduced safeguards against adverse events that are most likely to occur right after admission.</p> <p>Findings included:</p> <p>Review of Resident #1 face sheet, dated 2/20/2025, revealed that Resident #1 was a [AGE] year-old male admitted on [DATE] with diagnoses of acute kidney failure and depression.</p> <p>Review of Resident #1 physician orders, dated 2/13/2025, revealed that there were orders for maintaining indwelling Foley catheter, providing catheter care every shift and as needed.</p> <p>Record review of care plan for Resident #1 on 2/18/2025 revealed no information or interventions about resident's acute kidney failure diagnosis or plan for indwelling catheter care and maintenance .</p> <p>Observation on 2/20/2025 at 1:00pm, RN A went in Resident #1's room to change the catheter collection bag for Resident #1. Resident #1 had a Foley catheter that needed the collection bag to be changed due to the catheter tube appearing cloudy.</p> <p>Interview on 2/20/2025 at 3:03pm with the DON revealed that the baseline care plan should be done within 48 hours after admission. The interdisciplinary team (IDT) including the ADON, the dietitian, the administration, the social worker, the activity director, and the therapy manager were responsible for developing a baseline care plan. The ADON then will review everything and finalize the baseline care plan . The DON said that the risk of not having a baseline care plan was that residents would not be cared for effective and had their needs met.</p> <p>(continued on next page)</p>

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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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Care Planning policy, dated January 2024, revealed that the purpose of a care plan was to ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. It also stated that:</p> <p>The Facility will develop a person-centered Baseline Care Plan for each resident within 48 hours of admission. The Baseline Care Plan will include at least the following information:</p> <ul style="list-style-type: none"> <li>A. Initial goals based on admission orders</li> <li>B. Physician orders</li> <li>C. Dietary orders</li> <li>D. Therapy services</li> <li>E. Social services</li> <li>F. PASARR recommendations, if applicable</li> </ul>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51047</p> <p>Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 24 residents (Resident #2) reviewed for comprehensive care plans.</p> <p>Resident #2's care plan did not address the resident's need to receive enteral feeding provided by the facility with goals or interventions.</p> <p>This deficient practice could result in a loss of quality of life due to residents receiving improper care.</p> <p>Findings included:</p> <p>Record review of Resident #2's face sheet, dated 2/20/2025, revealed Resident #2 was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included hemiplegia (paralysis of one side of body) and hemiparesis (one-sided muscle weakness) affecting dominant left side, type 2 diabetes, and acute kidney failure. The resident was discharged from the facility on 2/11/2025.</p> <p>Record review of Resident #2's Admission MDS, dated [DATE], indicated that the resident's nutritional approach while he was a resident of the facility should be via feeding tube.</p> <p>Record review of Resident #2's orders, dated 1/17/2025, revealed that there were orders related to enteral feedings. The orders included providing bolus enteral feeding five times a day, flushing of g-tube, and cleansing of g-tube every shift. There was also an order of NPO (nothing by mouth) dated 1/27/2025.</p> <p>Record review of Resident #2's Comprehensive Care plan, dated 1/17/2025, revealed there was no care plan related to resident's enteral feeding with specific goals and interventions .</p> <p>In an interview with the DON on 2/20/2025 at 3:00pm, she stated that the enteral feeding should be included in the Comprehensive Care Plan. She stated that the IDT met and developed a comprehensive care plan. The DON then will finalize the comprehensive care plan. She stated that a comprehensive care plan was important because everybody can provide care for a resident by looking at it and make sure that a resident received proper care with a detailed care plan. She stated that she was not sure why the enteral feeding was not included in Resident #2's comprehensive care plan.</p> <p>Record review of facility's policy titled Care Planning, dated January 2024, the policy stated that each resident's Comprehensive Care Plan will describe . the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The Comprehensive Care Plan must be completed within 7 days after completion of the Comprehensive Admission Assessment and must be periodically reviewed and revised by a team of qualified persons after each assessment, including the comprehensive and quarterly review assessments.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51047</b></p> <p>Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control measure designed to provide a safe, sanitary environment to help prevent the development and transmission of communicable diseases and infections for 1 of 5 (Resident #1) residents reviewed for infection control.</p> <p>RN A and ADON B failed to put on Personal Protective Equipment (PPE) while providing catheter care on Resident #1, who was on Enhanced Barrier Precaution (EBP).</p> <p>RN A failed to perform aseptic technique when performing catheter care for Resident #1.</p> <p>This deficient practice could place residents and nursing staff at risk of transmission of communicable diseases and infections.</p> <p>Findings included:</p> <p>Review of Resident #1's face sheet, dated 2/20/2025, revealed that Resident #1 was a [AGE] year-old male admitted on [DATE] with diagnoses of acute kidney failure and depression.</p> <p>Review of Resident #1's physician orders, dated 2/13/2025, revealed that EBP should be practiced during care related to indwelling catheter. The order stated that Staff members will wear a clean gown and gloves while performing high contact resident care activities to include: Dressing, Bathing/ Showering, transferring, providing hygiene, changing linens, changing briefs or toileting assistance, and/or caring for indwelling medical devices like central lines, catheters, feeding tube, tracheostomy/ventilator.</p> <p>Observation on 2/20/2025 at 1:00pm, RN A went in Resident #1's room with a new catheter bag to replace the old catheter bag. There was a sign at the door marking EBP. He performed hand hygiene, did not wear a gown, proceeded to greet Resident #1 to inform him that he was going to change the catheter bag to a new one. He put on gloves, emptied the collection bag in a urinal, and started to remove the old tubing from the catheter port when he was struggling to remove it. He then proceeded to the bathroom to empty the urinal in the toilet and flushed. He removed his gloves, performed hand hygiene, and informed the state surveyor he's going to get a different pair of gloves of his size. He came back in the room, with ADON B, both performed hand hygiene, wore gloves but they did not wear a gown. ADON B assisted RN A in removing the old collection bag tube from the port. RN A attached the new inlet tube to the catheter port without performing aseptic technique, not wiping both the inlet tube and catheter port with alcohol wipe. He discarded the old collection bag in the trash, performed hand hygiene, and left Resident #1's room.</p> <p>In an interview on 2/20/2025 at 1:24pm with ADON B, he confirmed that this resident was on EBP and he stated both he and RN A should have worn a gown before performing the procedure. He stated the risk of not wearing PPE was transmission of infection. He also stated that he came in to help RN A remove the old tubing and he forgot to wear PPE. He did not notice if RN A performed aseptic technique, but he stated an alcohol wipe should be used to wipe the new inlet tube and the catheter port.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 2/20/2025 at 1:30pm, RN A stated that he forgot to wear a gown while providing catheter care to Resident #1. He also stated he did not wipe the port and the inlet tube with alcohol wipe before attaching the tube to the port. He said the risk of not wearing PPE and performing aseptic technique was transmission of infection.</p> <p>In an interview on 2/20/2025 at 3:00pm, the DON stated that the purpose of wearing PPE while providing care for a resident on EBP was to prevent transmission of diseases and infection. She stated she was shocked to learn that ADON B and RN A did not wear PPE while providing catheter care to Resident #1 because they both have been in-serviced about infection control. She also stated that aseptic technique should be used while providing catheter care and changing catheter collection bag. She stated RN A was supposed to wipe the catheter port and the inlet tube with alcohol wipes before attaching them.</p> <p>Review of facility's Catheter care manual, dated 6/2020, section Collection bag stated that aseptic technique must be used to change the drainage bag. The catheter-tubing junction must be disinfected with an alcohol or chlorhexidine (CHG) sponge prior to connecting the new drainage bag.</p> <p>Review of facility's Standard and Enhanced Precaution Policy, dated April 2024, revealed that Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities . such as presence of indwelling devices (e.g., urinary catheter, feeding tube, endotracheal or tracheostomy tube, vascular catheters) and wounds or presence of unhealed pressure ulcers.</p> <p>For residents whom EBP are indicated, EBP should be used when performing high-contact resident care activities such as Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator.</p>		