

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 11/17/2025
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one of two residents (Resident #1) reviewed for catheter and incontinence care. The facility failed to ensure CNA B provided appropriate perineal care for Resident #1 when he failed to pull back the foreskin and failed to clean the resident's penial shaft during incontinence care on 11/17/25. This failure could place residents at risk for not receiving appropriate care to address their incontinence and could increase the risk of urinary tract infections. Findings included: Record review of Resident #1's quarterly MDS assessment, dated 08/29/25, reflected a [AGE] year-old male with an admission date of 07/26/24. He had a BIMS score of 15 which indicated he was cognitively intact. He was dependent on staff for toileting hygiene and was always incontinent of urine and bowel. Diagnosis included diabetes, hemiplegia (paralysis on one side of the body), and viral hepatitis (liver inflammation due to viral infection). Record review of Resident #1's care plan, initiated on 09/10/24, reflected, [Resident #] has bowel and bladder incontinence related to disease process, impaired mobility. Interventions. Check the resident how often 2 hours and as required for incontinence. Wash, rinse and dry perineum (the diamond-shaped area of soft tissue between the anus and the genitals) . In an interview with Resident #1 on 11/17/25 at 09:30 a.m. he stated he was waiting for the CNA to come and change him. He stated he knew he had a bowel movement. He stated they changed him last around 05:00 a.m. In an observation and interview on 11/17/25 at 09:35 a.m. CNA A entered Resident #1's room. CNA A put on a gown and gloves and a few minutes later CNA B entered the room and told her she was there to help. CNA B put on a gown and gloves. Both CNAs unfastened the residents brief revealing he had a large amount of bowel movement that had oozed upward into his groin area. CNA B proceeded to wipe down each groin with several wipes changing wipes with each swipe. She then wiped under his scrotum changing the wipes but did not clean his penile shaft or pull back the foreskin to clean the meatus area (opening in the penis where urine comes out). CNA B removed her gloves and put on clean gloves without performing hand hygiene. Both staff then rolled the resident onto his side. CNA A then wiped from front to back changing the wipes each time until the bowel movement was removed. CNA B then placed a clean brief under the resident and both staff rolled the resident over onto his back. The resident stated he did not think they got all of the bowel movement from his groin area. CNA B then used 4 wipes to continue cleaning the bowel movement from his groin area, pushing it downward toward the clean brief. Both staff then fastened the brief. In an interview on 11/17/225 at 10:20 a.m. with CNA B she stated she knew she missed some steps during care. She stated she did not clean the resident's penis or pull back his foreskin. She stated the risk of not performing proper incontinence care was infection and possible urinary tract infections. In an interview on 11/17/25 at 11:10 a.m. with CNA A she stated the risk of not cleaning the resident penis could cause skin problems as well as infections. She stated they were supposed to clean all of the areas anytime they did incontinence care. In an interview with the DON on 11/17/225 at 11:15 a.m. she stated any time the staff did incontinence care on a male they were supposed to clean the penis and if they were uncircumcised they had to pull the foreskin back to clean around the meatus. She stated failure to do perform correct incontinence care could lead to an increased risk of urinary tract infections. She stated they would be starting peri-care skills checks immediately. Record review of the facility's policy titled, Perineal Care, dated June 2020, reflected, ,Put on gloves. Wash the pubic area. For male residents. Wash the penis from the ureteral opening or tip of the penis. Pull back the foreskin on uncircumcised males and clean under it. Wash the scrotum, pay attention to skin folds, rinse and dry. Wash, rinse and dry buttocks and peri-anal area without contaminating perineal area.</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>(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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain an Infection Prevention and Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 2 Residents (Resident #1 and Resident #2) observed for infection control. 1.The facility failed to ensure CNA A and CNA B performed hand hygiene during incontinence care to Resident #1 and CNA B failed to perform hand hygiene prior to leaving the resident's room on 11/17/25. 2.The facility failed to ensure CNA C and CNA D performed hand hygiene during incontinence care to Resident #2 on 11/17/25. Findings included: 1. Record review of Resident #1's Face Sheet dated 11/17/25 reflected a [AGE] year-old male with an admission date of 07/26/24. Diagnosis included diabetes, hemiplegia (paralysis on one side of the body), and viral hepatitis (liver inflammation due to viral infection). In an observation on 11/17/25 at 09:35 a.m. CNA A entered Resident #1's room with a gown on. She then put on gloves without performing hand hygiene. Within a few minutes, CNA B entered the room and told her she was there to help. CNA B had put on a gown and gloves prior to entering the room. Both CNAs unfastened the residents brief revealing he had a large amount of bowel movement that had oozed upward into his groin area. CNA B proceeded to wipe down each groin with several wipes changing wipes with each swipe. She then wiped under his scrotum changing the wipes but did not clean his penile shaft or pull back the foreskin to clean the meatus area. CNA B removed her gloves and put on clean gloves without performing hand hygiene. Both staff then rolled the resident onto his side. CNA A then wiped from front to back changing the wipes each time until the bowel movement was removed. CNA B then placed a clean brief under the resident while CNA A changed her gloves but did not perform hand hygiene. Both staff rolled the resident over and the resident stated he did not think they got all of the bowel movement from his groin area. CNA B then used 4 wipes to continue cleaning the bowel movement from his groin area, pushing it downward toward the clean brief. Both staff then fastened the brief. CNA B then changed her gloves but did not perform hand hygiene and assisted CNA A with pulling the resident up in the bed and repositioning. Both staff gathered the trash and removed their gloves. CNA B washed her hands while CNA A left the room with the trash without performing had hygiene. CNA A walked down the hallway to deposit the trash in the soiled linen room. In an interview on 11/17/225 at 10:20 a.m. with CNA B she stated she knew she missed some steps during care. She stated she failed to perform hand hygiene between glove changes. She stated she should have sanitized her hands after cleaning him, before placing the clean brief on him and then pulling him up in the bed. She stated the risk of not performing hand hygiene was infection and possible urinary tract infections. In an interview on 11/17/25 at 11:10 a.m. with CNA A she stated she was supposed to perform hand hygiene before care, after glove changes and before she left the resident's room. She stated she did not do hand hygiene after she changed her gloves and did not wash her hands before she left the room. She stated the risk of not performing hand hygiene were infections and urinary tract infections. 2. Record review of Resident #2's Face Sheet dated 11/17/25 reflected a [AGE] year-old female with an admission date of 09/10/24. Diagnoses included seizures, hemiplegia (paralysis on one side of the body) and mild cognitive impairment. In an observation on 11/17/25 at 10:05 a.m. CNA C and CNA D revealed both staff Resident #2's doorway sanitizing their hands, putting on gowns and gloves. Both staff then entered Resident #2's room to provide incontinent care. Both staff unfastened the residents' brief. CNA C spread the labia and wiped down the middle using one wipe per swipe, wiped across the pubic area and down each groin changing the wipes each time. Staff rolled the resident over and CNA C wiped the resident from front to back. While wearing the same gloves used to provide peri care, CNA C placed a clean brief under the resident and rolled her back and fastened the brief. Staff then repositioned the resident, covered her up still wearing soiled gloves. Both staff then removed their gloves and gowns and washed their hands. In an interview with CNAs C and D on 11/17/25 at 10:10 a.m. both stated they were supposed to perform hand hygiene before incontinent care and once they finished. CNA C then stated she should have also performed glove change and hand hygiene when she finished cleaning the resident, before putting on the clean brief and repositioning her. They both stated the risk of not performing hand hygiene and glove changes was the spread of germs and infections. In an interview with the DON on 11/17/225 at 11:15 a.m. she stated it was the expectation for the staff to perform hand hygiene before care, after each glove change, and before leaving the room. She stated they were also to change their gloves when soiled, before moving to</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident bedside was adequately equipped to allow all residents to call for staff assistance through a communication system that would relay the call directly to a staff member or a centralized staff work area for one of five residents (Resident#3) reviewed for residents' call system. The facility failed on 11/16/25 to ensure the call light system was inaccessible for Resident #3. The call light was out of reach and under the positioning rail. This failure could place residents at risk of not having a means of directly contacting caregivers in an emergency or when they needed support for daily living. Findings included: Record review of Resident #3's face sheet undated reflected Resident #3 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of Metabolic Encephalopathy (brain dysfunction caused by a systemic illness or metabolic imbalance that affects brain function), glaucoma (group of eye diseases that can cause vision loss and blindness by damaging a nerve in the back of your eye called the optic nerve) and heart failure. Record review of Resident #3's quarterly MDS assessment dated [DATE] reflected Resident #3 had a BIMS of 15 indicating she was cognitively intact. Resident #3 required partial/moderate assistance with ADLs of transfers and toileting. Resident #3 was frequently incontinent of bowel/bladder. Record review of Resident #3's comprehensive care plan reflected Resident #3 revised on 09/24/25 had an actual fall with injury due to poor balance and unsteady gait. Resident #3 is at risk for falls related to gait/balance problems. Intervention included Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Observation and Interview on 11/16/25 at 2:13 PM revealed Resident #3 was yelling and calling out from her room for help. There was no facility staff in the hall. Resident #3 was lying in her bed and her call button was under the right positioning side rail. Resident #3 stated she needed help and told surveyor thank you I had no way of getting help other than yelling out. Resident #3 stated she could not use her call button if it was not near her and she needed assistance. She stated she was dependent on staff for assistance and was bed bound. Interview and observation on 11/16/25 at 2:16 PM with Med Aide E revealed Resident #3's call button was not within reach and should have been within reach. Observation revealed Med Aide E moved the call button within reach of Resident #3. Resident #3 stated she needed assistance from a nurse. Interview on 11/16/25 at 2:18 PM with LVN F revealed Resident #3's call button should be within reach of resident to use when she needs assistance from staff. LVN F stated Resident #3 was dependent on staff for assistance. Interview on 11/17/25 at 11:21 AM with DON revealed call buttons should be within reach of residents so they can get assistance and help when needed. She stated the risk to a resident not having a call button within reach could be a delay in getting assistance from staff. Review of facility's policy Communication - Call System last revised June 2020 reflected To provide a mechanism for residents to promptly communicate to nursing staff. The facility will provide a call system to enable residents to alert the nursing staff from their rooms. Call cords will be placed within the resident's reach in the resident's room.'</p>		