

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 09/13/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48177</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free from neglect for two of three residents (Resident #127 and Resident #56) reviewed for abuse, neglect, and exploitation.</p> <p>1. The facility failed to provide timely transportation for Resident #127 when he was finished with his medical appointment, being wheelchair bound, offsite from the facility. On 9-10-2024 Resident #127 was not picked up by a transportation driver for over 4 hours causing him to miss his lunch meal, pain medication time for Tramadol PRN every 4 hours (which the resident could have received at 11:00 AM but did not), causing psychosocial harm (resident was crying and felt abandoned which was exacerbated due to the resident's post-traumatic stress disorder).</p> <p>2. The facility failed to provide timely transportation for Resident #56 on 09-09-2024 due to the van lift malfunction and required his appointment to be rescheduled. The facility failed to provide timely transportation for Resident #56 on 09-10-2024 and was approximately an hour late for his appointment.</p> <p>A IJ was identified on 9-11-2024. The IJ template was provided to the facility on [DATE] at 3:33 PM. While the IJ was removed on 9-11-2024, the facility remained out of compliance at a severity level of no actual harm and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>This failure placed residents at risk for neglect causing pain, mental anguish, or emotional distress.</p> <p>Findings included:</p> <p>Review of Resident #127's face sheet dated 9-11-2024, reflected the resident was a [AGE] year-old male with an admitted [DATE]. His diagnoses include fracture of the left femur (a break in the left thighbone), anxiety disorder, type 2 diabetes, PTSD (a mental disorder that develops in some people who have experienced a shocking, scary, or dangerous events), COPD (lung disease making it difficult to breath), and a history of falling.</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
---	-------	-----------

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 09/13/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #127's Comprehensive MDS assessment dated [DATE] reflected a BIMS score of 11 indicating moderate mental impairment. Resident #127's functional abilities revealed he required Substantial/maximal assistance (where the helper does more than half the effort. Helper lifts or holds the trunk or limbs and provides more than half the effort) from a sitting position to a standing position and not attempted due to medical condition or safety concerns to car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.</p> <p>Review of Resident #127's Care Plan dated 9-11-2024 indicated he was at risk for skin breakdowns causing redness, blisters, bruises, discoloration, was care planned for pain management stating to anticipate Resident #127's need for pain relief and respond immediately, was on psychotropic medication for PTSD, and had wound management which encouraged Resident #127 to elevate his legs to be free of infection.</p> <p>Review of Resident #127's MAR revealed Resident# 127 was ordered for pain management PRN every 4 hours for Tramadol oral tablet and Tylenol 2 tablets.</p> <p>In an observation on 9-10-2024 at 1:30 PM, Resident #127 was entering the facility, being pushed in a wheelchair, by a family friend in an upset mood. The family friend #1 pushed Resident #127 into his bedroom.</p> <p>In an observation and interview on 9-10-2024 at 1:37 PM, it was revealed, by family friend #1, that Resident #127 just returned from his doctor's appointment because the transportation driver never returned to pick Resident #127 up when his appointment was completed. Family friend #1 said he was very upset with the facility. Family friend #1 stated Resident #127 finished his appointment at the orthopedic surgeon's office at 9:15 AM, the doctor's staff called Driver B to pick up Resident #127 at 9:15 AM, and by 1:09 PM no one had come to pick Resident #127 up. Family friend #1 said after waiting for hours Resident #127 began to get upset, get hungry, and cry because no one had come to pick him up. Family friend #1 said Resident #127 started getting weak sitting in his wheelchair for so long that he started to slide out of it. Family friend #1 said he then called Resident #127's Family Member #1 at 1:09 PM to let her know the situation. Family friend #1 said he was told by Resident #127's Family Member #1 to transport Resident #127 back to the facility as this was ridiculous for no one to come in over 4 hours to pick Resident #127 up.</p> <p>In an observation and interview on 9-10-2024 at 3:08 PM, Resident #127 was lying in his bed tilted up in a 45-degree angle and said he was kept waiting at his doctor's office today for over 4 hours after his appointment was completed. Resident #127 began crying and was visibly upset saying he felt abandoned by the facility. Resident #127 said he felt pain while he was waiting to be picked up as he dealt with psoriasis over his entire buttocks area and between his legs in his crouch area. Resident #127 said his pain level got to a level 10 while waiting to be picked up. Resident #127 said when he sat for long periods of time it made his psoriasis affected areas painful. Resident #127 stated his normal pain level was a 0.</p> <p>(continued on next page)</p>

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 09/13/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview with Resident #127's Family Member #1 on 9-10-2024 at 3:10 PM it was revealed that the driver never came back to the doctor's office to pick up Resident #127 this morning for over 4 hours. Resident #127's Family Member #1 said she paid family friend #1 to keep Resident #127 company when she could not be with Resident #127 because she worked on a job. Resident #127's Family Member #1 said family friend #1 does not transport Resident #127 but the facility does. Resident #127's Family Member #1 said after Resident #127 waited for over 4 hours to be picked up he became upset, started feeling weak, got in pain, and was hungry. Resident #127's Family Member #1 said after a 4 hour wait, she asked family friend #1 if he would bring Resident #127 back to the facility. Resident #127's Family Member #1 said this has happened before on medical appointments but could not name specific times.</p> <p>In an interview on 9-10-2024 at 2:05 PM the Transportation Manager revealed she has worked at the facility since 12-2023. The Transportation Manager said the facility use to outsource driving residents but due to budget cuts and unreliable service, the facility uses 1 van and 2 inhouse drivers. The Transportation Manager said the facility brought residents to their medical appointments including dialysis. The Transportation Manager said transportation has been a problem since she has worked at the facility because the nursing staff haven't had the residents dressed on time or haven't had the necessary paperwork ready, and the facility only has one van servicing the entire facility. The Transportation Manager said the reason Resident #127 wasn't picked up this morning for 4 hours, after his appointment was finished, was that Driver B was picking up and dropping off other residents. The Transportation Manager said the concern for residents who are not picked up from their appointments timely was that some of them could have been diabetic or have other medical problems they may have needed help with. She stated that the facility tried to outsource transportation for Resident #127 but the resident would have to wait longer. The Transportation Manager said in her opinion the facility needed more transportation vehicles and drivers to meet the demand of the facility. The Transportation Manager said the facility did not keep a transportation log of when residents arrived at appointments nor when they were picked up from the facility. The Transportation Manager said she was told by the Administrator to not outsource any driving for the facility due to budget cuts. Resident #56 also had an appointment with an orthopedic.</p> <p>In an interview with the Orthopedic Doctor's Office Staff for Resident #127 on 9-10-2024 at 4:53 PM, it was revealed that Resident #127 completed his medical appointment on 9-10-2024 at 9:12 AM and the staff called Driver B, at that time, to pick up Resident #127. The Orthopedic Doctor's Office Staff for Resident #127 said they made a 2nd call to Driver B at 10:26 AM telling her Resident #127 was ready to be picked up. The Orthopedic Doctor's Office Staff for Resident #127 said at 11:50 AM Driver B called them saying she was on her way to pick up Resident #127.</p> <p>In an interview with Driver B on 9-11-2024 at 11:10 AM, it was revealed she has worked at the facility since 8-14-2024. Driver B said there was only 1 van and 2 drivers for the entire facility. Driver B said the facility does not provide a facility phone to keep in touch with the facility, the doctor's office, or the residents. Driver B said the reason she was so late in picking up Resident #127 yesterday was because the facility had her going to so many appointments for other residents, she could not pick Resident #127 up timely. Driver B said she did not get back to Resident #127's location to around 1:00 PM. Driver B said picking up residents for their medical appointments and bringing them back to the facility has been a problem since she has worked at the facility. Driver B said the concern for residents being picked up late from their appointments was when they sit so long there could be potential health risk as they may be feeling weak from dialysis appointment or may need something to eat.</p> <p>(continued on next page)</p>

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 09/13/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In interview with Driver B on 09/11/2024 at 11:07 AM she stated that she left late for Resident #56's appointment because Resident #56 was not ready when she arrived to transport him. She stated this was an ongoing issue that she has reported to her the Transportation Manager. She stated that Resident #56's appointment was at 9:15 AM but she was not able to leave the facility until 9 or 10 AM and returned Resident #56 to the facility around 11 AM. She stated that Resident #56 was late to his appointment but was seen by the doctor.</p> <p>In interview with Driver A on 09/13/2024 at 8:48 AM, he stated that it was his first day on the job on 09/09/2024. He stated that he recalled leaving the facility with Resident #56 to transport him to his appointment around 2:30 PM that day. He stated that he could not get the lift to lower at the doctor's appointment and called DRIVER B to trouble-shoot. He stated it took too long and Resident #56's Family Member #3 had to reschedule his appointment. He stated that Resident #56's Family Member #3 had a right to be mad about missing his appointment. He stated it was important for residents at the facility to be at their appointments timely for resident care.</p> <p>2.</p> <p>Review of Resident #56's Face Sheet, dated 09/11/2024, revealed he was a [AGE] year-old male readmitted to the facility from an acute care hospital on 08/27/2024. Relevant diagnoses included right femur fracture (bone break,) cerebral infarction (disrupted blood flow to the brain,) hypertension (high blood pressure,) type 2 diabetes (insulin resistance,) and history of falling (result of gravity (from vertical to a horizontal position with gravitational force considerations.)</p> <p>Review of Resident #56's Comprehensive Care Plan, dated 09/10/2024, revealed he had an ADL Self Care Performance Deficit related to debility and required partial/moderate assistance for transfers. He was at risk for falls and had a fall without injury on 09/01/2024. Additionally, Resident #56 had diabetes and required medication and monitoring for side effects and effectiveness. Resident #56 had a potential risk for skin breakdown, had occasional forgetfulness, and was on anticoagulant therapy.</p> <p>Review of Resident #56's Admission MDS dated [DATE] revealed he was severely cognitively impaired and had a BIMS score of 06. He was dependent where helper does all the effort for car transfers and required partial/moderate assistance for toileting. No current or prior device aids (wheelchair, lift, walker, etc) were documented.</p> <p>In interview with Resident #56 and his Family Member #3 on 09/10/2024 at 4:31 PM he did not recall specifics of his transportation and asked me to defer to his Family Member #3 for information.</p> <p>In an interview with Resident #56's Family Member #3 on 09/10/224 at 4:31 PM she stated that she has had transportation issues on 09/09/2024 and 09/10/2024. She stated on 09/09/2024, he missed his appointment because the wheelchair van lift malfunctioned, and he was not able to get out of the van on time to make his appointment. She stated on 09/10/2024 he was an hour late to his appointment and almost missed that appointment, but the doctor was nice enough to take him late. She stated she was infuriated that she cannot depend on the facility to take Resident #56 to his appointments on time. She stated that Resident #56's dementia had progressed so much he cannot keep track of his own schedule and she needs to trust the facility to reliably take him to his appointments for his overall healing and wellbeing.</p> <p>(continued on next page)</p>		

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 09/13/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview with facility Transportation Manager on 09/10/2024 at 4:38 PM she stated she was not sure about the specifics of Resident #56's transportation information and requested to review her documentation.</p> <p>In interview with facility Transportation Manager on 09/11/2024 at 10:36 AM she stated that on 09/09/2024 the transportation driver for Resident #56 was Driver A, but it was his first day on the job. She stated that Resident #56 successfully was loaded into the van, but Driver A had issues getting Resident #56 out of the van once they arrived at the doctor's office. She stated the resident's appointment was missed and had to be rescheduled for a later date. She stated on 09/10/2024 the transportation driver was Driver B. She stated that she was aware that Driver B ran behind yesterday but was not sure of the specifics. She stated she was not authorized by the Administrator to use third party transportation because of costs but having only one van was not cutting it.</p> <p>Record review of the facility's Abuse and Neglect Policy dated 10-24-2022 stated:</p> <p>Purpose - To ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements.</p> <p>Policy</p> <p>I. Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, and misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property .</p> <p>III. The Administrator is responsible for coordinating and implementing the Facility's abuse prevention policies, procedures, training programs, and systems .</p> <p>Procedure</p> <p>III. Training A. Covered individuals will be trained through orientation and on-going training sessions, no less than annually, on the following topics: i. Who is a covered individual responsible for reporting ii. Abuse prevention iii. Identification and recognition of signs and symptoms of abuse/neglect iv. Protection of residents during an abuse investigation v. Investigation vi. Reporting and documentation of abuse and neglect without fear of reprisal .</p> <p>Prevention</p> <p>B. Supervisors shall immediately intervene, correct, and report identified situations where abuse, neglect or misappropriation of resident property is at risk for occurring .</p> <p>E. The Facility maintains adequate staffing on all shifts to ensure that the needs of each resident are met .</p> <p>Identification</p> <p>(continued on next page)</p>		

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 09/13/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>ii. Physical Neglect a. Malnutrition and dehydration (unexplained weight loss) b. Poor hygiene c. Inappropriate clothing (soiled, tattered, poor fitting, lacking, inappropriate for season) d. Decayed teeth e. Improper use/administration of medication; f. Inadequate provision of care g. Caregiver indifference to resident's personal care and needs h. Failure to provide privacy.</p> <p>i. Leaving someone unattended who needs supervision .</p> <p>iii. Possible Signs and Symptoms of Psychological Abuse or Neglect</p> <p>a. Resident clings to caregiver/abuser</p> <p>b. Paranoia .</p> <p>IX. Reporting/Response</p> <p>A. Facility Staff are Mandatory Reporters i. Facility owners, operators, employees, managers, agents, and contractors are obligated by the Elder Justice Act and any state specific regulations to report known or suspected instances of abuse of elder or dependent adults .</p> <p>H. Appropriate professional and licensing boards will be notified when a Facility Staff member is found to have committed abuse, neglect, or mistreatment of residents.</p> <p>On 9-11-2024 at 3:30 PM, the Administrator and the DON were notified that an Immediate Jeopardy had been identified concerning Resident #127 not being picked up for over 4 hours away from the facility. The Administrator stated he did not know anything about it. The IJ template was provided to the facility on [DATE] at 3:33 PM. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy.</p> <p>The facility's Plan of Removal for the Immediate Jeopardy was accepted on 9-12-2024 at 11:48 AM and reflected the following:</p> <p>F600</p> <p>On 9/11/2024 during a Full book survey at [Facility Name] at [Facility Address]. HHSC surveyor provided an IJ Template notification that the Survey Agency has determined that the conditions at the center constitute immediate jeopardy to resident health. The facility allegedly failed to provide services. Facility failed to provide transportation from MD appointment back to facility in a timely manner, Resident#127 was left for 4 hours at a doctor's appointment without transportation back to facility, resulting in the resident missing regular mealtimes, and experiencing psychosocial harm.</p> <p>The notification of the alleged immediate jeopardy states as follows:</p> <p>Resident #127 was left for four hours at a doctor's appointment without transportation back to the facility, resulting in the resident missing pain medication, not meeting regular mealtimes, and experiencing psychosocial harm.</p> <p>Identify residents who could be affected.</p> <p>(continued on next page)</p>		

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 09/13/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>All residents who go out on scheduled appointments and are transported via facility transportation have the potential to be affected.</p> <p>Identify responsible staff/ what action taken.</p> <ol style="list-style-type: none"> 1. Director of Nurses/Administrator and ADON re-educated by the Regional Clinical Nurse on the facility policy on abuse/neglect and resident rights. With a completion date of 9/11/2024. 2. DON/ADON's educated by Regional Clinical Nurse on procedure for patients out on appointments which includes follow up if resident is out of facility on MD appointment greater than 3 hours, Nurse is to call MD office to follow up to ascertain patient status. With completion date of 9/11/2024 3. All licensed nurses RN and LVN educated by DON/ADON's on Abuse/neglect, resident rights, change in condition, and procedure for patients out on appointments which includes follow up if resident is out of facility on MD appointment greater than 3 hours, Nurse is to call MD office to follow up to ascertain patient status. With completion date of 9/11/2024 4. Training for all licensed nurses RN and LVN's, follow up for patients out on MD appointment by DON/ADON's with completion date of 9/11/2024. 5. All licensed staff RN/LVN in serviced on use of transportation log, which will be at every nursing station. Completion date of 9/11/2024 6. Facility driver and transportation coordinator educated on the following procedural change by Administrator. Facility driver to immediately notify transportation coordinator if unable to pick up resident/patient from appointment within an hour. The coordinator will immediately schedule with alternate vendor for immediate pick up/drop off. The Transportation coordinator will immediately notify Administrator/Director of Nursing/ Assistant Director of Nursing of the status of patient. Completion by 9/12/2024 7. All staff in-serviced on abuse/neglect, resident rights by administrator/DON with completion date of 9/11/2024. 8. Resident # 127 head to toe assessment completed by RN with no adverse findings. Pain assessment, skin assessment, trauma assessment all completed with no adverse findings. Social worker followed up with patient and no adverse findings. Primary MD, [Physician] notified. All completed on 9/11/2024. <p>In-Service conducted.</p> <ol style="list-style-type: none"> 1. Director of Nurses/Administrator and ADON re-educated by the Regional Clinical Nurse on the facility policy on abuse/neglect and resident rights. With a completion date of 9/11/2024. 2. DON/ADON's educated by Regional Clinical Nurse on procedure for patients out on appointments which includes follow up if resident is out of facility on MD appointment greater than 3 hours, Nurse is to call MD office to follow up to ascertain patient status. With completion date of 9/11/2024 <p>(continued on next page)</p>		

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 09/13/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>3. Facility driver and transportation coordinator educated on the following procedural change by Administrator. Facility driver to immediately notify transportation coordinator if unable to pick up resident/patient from appointment within the hour. The coordinator will immediately schedule with alternate vendor for immediate pick up/ drop off. The transportation coordinator will immediately notify Administrator/ Director of Nursing of the status of patient. Completion date 9/12/2024.</p> <p>4. All licensed nurses RN and LVN educated by DON/ADON's on Abuse/neglect, resident rights, change in condition, and procedure for patients out on appointments which includes follow up if resident is out of facility on MD appointment greater than 3 hours, Nurse is to call MD office to follow up to ascertain patient status. With completion date of 9/11/2024</p> <p>5. Training for all licensed nurses RN and LVN's, follow up for patients out on MD appointment by DON/ADON's with completion date of 9/11/2024.</p> <p>6. All staff in-serviced on abuse/neglect, resident rights by administrator/DON with completion date of 9/11/2024.</p> <p>7. All licensed staff in-serviced on use of transportation log, which will be at every nurse's station, with completion date of 9/11/2024.</p> <p>Implementation of Changes</p> <p>Director of Nursing, Assistant Director of Nursing/Administrator re-educated on facility policy on abuse/neglect and resident rights by Completed on 9/11/2024 by Regional Nurse Consultant</p> <p>Director of Nursing, Assistant Director of Nursing educated by Regional Clinical Nurse on procedure for patients out on MD appointments which includes follow up if resident is out of facility on MD appointment greater than 3 hours, Nurse is to call MD office to follow up to ascertain patient status. With completion date of 9/11/2024.</p> <p>Facility driver and transportation coordinator educated on the following procedural change by Administrator. Facility driver to immediately notify transportation coordinator if unable to pick up resident/patient from appointment within the hour. The coordinator will immediately schedule with alternate vendor for immediate pick up/ drop off. The transportation coordinator will immediately notify Administrator/ Director of Nursing of the status of the patient. Completion dated 9/12/2024.</p> <p>All Licensed staff RN, LVN educated by Director of Nursing/Assistant director of Nursing on procedure for patients out on MD appointments, which includes follow up if resident is out of facility greater than 3 hours, Nurse is to call MD office to follow up to ascertain patient status. With Completion date of 9/11/2024.</p> <p>All licensed staff in-serviced on transportation log, to be kept at every nurse's station.</p> <p>(continued on next page)</p>

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 09/13/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The changes were started by the Regional Nurse Consultant. The changes were implemented effective on 9/11/2024 and training to be completed on 9/12/2024. Staff will not be allowed to work until they have been fully re-educated. All new hires will be educated on Abuse/neglect, resident rights, and procedure for patients out on MD appointments, which includes follow up if patient is out greater than 3 hours, Nurse to call MD office to follow up and ascertain patient status, prior to working the floor. The Director of Nursing will ensure competency through signing of in service, verbalization of understanding and completion of transportation log. The Director of Nursing will complete an audit of all outside appointments daily x 30 days then weekly thereafter.</p> <p>Monitoring</p> <p>The Administrator/Director of Nursing/Assistant Director of Nursing/Regional Nurse Consultant will be responsible for monitoring the implementation and effectiveness of in-service on 9/11/2024.</p> <p>The Director of Nursing/Assistant Director of Nursing/Regional Nurse Consultant will monitor/review all outside MD appointments and follow up daily x4 weeks, then weekly thereafter and report any adverse finding during QAPI.</p> <p>Director of Nursing/Assistant Director of Nursing will conduct a daily audit of transportation to outside appointments daily x4 weeks, then weekly thereafter and report any adverse findings during QAPI.</p> <p>Involvement of Medical Director</p> <p>The Medical Director met with the Interdisciplinary team on 9/11/2024 and conducted an Ad HOC QAPI regarding ensuring patients transferred back to facility from outside appointment in timely manner. The Medical Director was notified about the immediate Jeopardy on 9/11/2024, the Plan of removal was reviewed and accepted by Medical Director.</p> <p>Involvement of QA</p> <p>An Ad Hoc QAPI meeting was held with the Medical Director, facility administrator, director of nursing, to review the plan of removal on 9/11/24.</p> <p>Who is responsible for the implementation of the process?</p> <p>The Director of Nursing and Administrator will be responsible for the implementation of New Process. The New Process/ system was started on 9/11/2024.</p> <p>Please accept this letter as our plan of removal for the determination of Immediate Jeopardy issued on 9/11/2024.</p> <p>Monitoring the facilities Plan of Removal included the following:</p> <p>(continued on next page)</p>		

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 09/13/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 9-12-2024 at 10:30 AM, it was revealed that LVN C had worked at the facility for [AGE] years on the 6:00 AM to 2:00 PM shift. LVN C said she was in-serviced on transportation which covered keeping a special log for resident's name, time of appointment, time of pickup from the appointment, who the doctor was, and what was the resident seeing the doctor for. LVN C said the charge nurses would be responsible to ensure the residents are dressed, have their medications, have their paperwork for their appointments, and have eaten breakfast. LVN C stated the nurses would also enter this information in PCC. LVN C stated if a resident has not returned within 3 hours of leaving the facility, the nurse would contact the doctor's office to see if the appointment is finished and then would contact the driver to be picked up. LVN C said the potential risk to a resident, not being picked up timely, was it could be a potential for a lot of things such as they could be diabetic, they could get tired and may be a fall risk, and there could be incidents in the van or at the doctor's office. LVN C said the charge nurses would oversee the tracking of transportation and would make entries into Nursing Notes in PCC.</p> <p>In an interview on 9-12-2024 at 10:50 AM, LVN D said she had worked at the facility for 3 months on the 6:00 AM-2:00 PM shift and had been in-serviced on transportation. LVN D said the in-service included: the incident concerning Resident #127, the nurses were responsible for documenting in the transportation log when residents leave for appointments and put the information into PCC. LVN D stated if a resident was transported and gone for over 3 hours, the nurses were to call the doctor's office to see if the resident has been seen. LVN D stated the nurses were responsible for tracking getting to an appointment and returning to the facility. LVN D said the risk to the resident not being timely transported was they could miss a treatment, appointments, and cause them not to get medicines on time.</p> <p>In an interview on 9-12-2024 at 11:00 AM, LVN E revealed she had worked at the facility for 6 years and was working the 6:00 AM - 2:00 PM shift. LVN E said she had been in-serviced on transportation. LVN E said there were new protocols put in place as the nurses were to check the transportation schedule and see what residents were on the schedule for that day. LVN E said there was a paper log where nurses enter patients name, destination, time of appointment, how the resident transports (stretcher, wheelchair, walk), and if the driver was from the facility or outsourced. LVN E said that the nurses were to call the doctor's office to see if there was a hold up or if the resident was waiting to be picked up. LVN E said the nurses will call the dialysis facility if a resident was over an hour late in getting back to the facility. LVN E said the risk to residents that were not picked up timely from appointments could be their blood sugar dropping, not getting medicines on time, and not getting fed. LVN E said the nurses were the primary ones to keep track of appointments by entering it into a paper transportation log and into PCC. LVN E said if a resident is over 30 minutes to an hour late getting back to the facility, she will check on them.</p> <p>In an interview with the DON on 9-12-2024 at 11:25 AM revealed the DON was in-serviced on transportation follow-up and what to educate the nurses on by following up and keeping track of the resident's appointments. The DON said now they have a monitoring tool in the transportation log. Resident's name, who is transporting, what time the resident is leaving and what time they return. The DON said to ensure this type of neglect does not happen again the facility has been sent a 2nd van to help with the transportation workload. The DON stated the DON, ADON, and Administrator will oversee monitoring the licensed nurses for effective follow-up. The DON stated the reason Resident #127 being left for over 4 hours at a medical appointment, without being picked up, was an IJ was complacency. The DON said she was just blown away with it.</p> <p>(continued on next page)</p>		

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 09/13/2024
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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview with the Administrator on 9-12-2024 at 11:40 AM it was revealed he was in-serviced by the Corporate Nurse to make sure facility van drivers notify the Transportation Manager when they are running an hour late or more, in picking up a resident, so the Transportation Manager can notify an outsourced driving service. The Administrator said he was in-serviced on abuse, neglect, resident rights, and a decision was made that licensed nurses have been trained in completing a transportation log when a resident has not returned from a medical appointment within 3 hours of leaving the facility. The Administrator said the DON and the ADONs would oversee the licensed nurses to ensure residents were followed up on when being transported. The Administrator said the reason this IJ was called was because the State alleged a resident was not picked up from a doctor's appointment, after the appointment was over, for 4 hours. The Administrator said the facility does not have a transportation policy.</p> <p>In an interview with the Transportation Manager on 9-12-2024 at 12:45 PM reflected the new protocol for was more communication between the drivers and the facility. The Transportation Manager stated if a resident was going to be more than one hour late to an appointment the driver will notify the Transportation Manager who in turn would notify the nurses who work the hallway where the resident lives in. After that, the Transportation Manager said the nurses notify the DON, ADON, and the Administrator. The Transportation Manager said to ensure resident were not left waiting for long periods of time, after an appointment is finished, the facility will call the residents on their cell phones and the nurses will follow-up with the residents.</p>		

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 09/13/2024
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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48177</p> <p>Based observation, interview, 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 one (Resident #48) of seven residents observed for infection control.</p> <p>The facility failed to ensure Resident #48's foley bag was not lying on the floor detached from the bed.</p> <p>This failure could affect residents and place them at risk of illness and exposure to diseases.</p> <p>Findings include:</p> <p>Record review of Resident #48's Face Sheet dated 9-13-2024 reflected an [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of [NAME] Nile Virus (a neurological disease contracted from mosquitoes causing headache, body aches, joint pains, vomiting, diarrhea, or rash) with Encephalitis (a serious condition that causes the brain to swell due to inflammation), Enteropathogenic Escherichia Coli Infection (a bacterial pathogen that adheres to intestinal epithelial cells, causing diarrhea), and Myocardial Infarction (heart attack).</p> <p>Record review of Resident #48's MDS revealed a BIMS score of 4 indicating severe cognitive impairment. Resident #48's functional abilities of his MDS revealed his that his toileting hygiene: (The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement .) which indicated he was a code of 1 (Dependent - Helper does all the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.)</p> <p>Record review of Resident #48's care plan dated 9-13-2024 stated Resident #48 has an indwelling Foley Catheter 16FR 10cc bulb to bedside drainage Catheter: Obstructive Uropathy (a structural or functional hindrance of normal urine flow) .and to Check tubing for kinks and maintain the drainage bag off the floor.</p> <p>In an observation and interview on 9-10-2024 at 12:15 PM, Resident #48 was observed lying in bed with an indwelling catheter and the foley bag attached lying flat on the floor. Resident #48 said he did not know the foley bag was on the floor and he cannot control his bowel or bladder movement. Resident #48's Family Member #2 said she had been in Resident #48's bedroom for 45 minutes and the foley bag has been on the floor the entire time.</p> <p>In an observation and interview on 9-10-2024 at 12:25 PM LVN C was shown Resident #48's foley bag lying flat on the floor. LVN C said that is not good and left the room and came back wearing protective gloves to provide infection control and reattach the foley bag.</p> <p>In an interview on 9-10-2024, LVN C revealed she has worked at the facility for [AGE] years. LVN C said the concern for foley bags being on the floor was that it was an infection control issue, and it should not be on the floor. LVN C stated she works the hallway that includes Resident #48.</p> <p>(continued on next page)</p>		

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 09/13/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 9-10-2024 at 1:16 PM CNA K said the problem with a catheter foley bag being on the floor was that it was on the floor. CNA K said she did rounds to ensure foley bags were not on the floor. CNA K said if she would have walked in and saw a foley bag on the floor she would have told a charge nurse.</p> <p>In an interview on 9-13-2024 at 3:00 PM, the DON revealed her expectations were that foley bags be kept off floors. The DON said it was the nursing staff's responsibility to ensure foley bags are kept off floors, but the CNAs can pick them up. The DON said the potential risk to residents having an attached foley bag was infections, germs, and stuff.</p> <p>Record review of the facilities Catheter Care Policy dated 6-2020 reflected the following:</p> <p>Catheter - Care of Nursing Manual - Nursing Care Policy No. - NP - 260 Confidential and Proprietary Information.</p> <p>Purpose:</p> <p>To prevent catheter-associated urinary tract infections while ensuring that residents are not given in dwelling catheters unless medically necessary. Policy I. Each resident who is incontinent of urine is identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible .</p> <p>Procedure:</p> <p>III. Proper Techniques for Urinary Catheter Maintenance</p> <p>D. Urinary Flow-an unobstructed flow of urine should be maintained. In order to achieve a free flow of urine:</p> <p>i. Collection bags should always be kept below the level of the bladder, including during transport, avoiding contact with the floor .</p>		