

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: 455798	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
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)		
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 observation, interview, and record review, the facility failed to store, prepare, and handle food in accordance with professional standards for food safety in the facility's only kitchen. The facility failed to ensure walk-in freezer food items were dated, labeled, and secured. The facility failed to ensure that canned good food items were free of dents. The facility failed to ensure the walk-in refrigerator food items were dated, labeled, and secured. The facility failed to ensure staff followed food safety and sanitation protocols to prevent cross contamination. These failures could place residents at risk for foodborne illness and foodborne intoxication. Findings included: During an initial brief tour of the facility's only kitchen on 12/09/2025 from 7:31 AM to 7:57 AM, revealed the following: walk-in freezer - An unsealed clear bag of hot dog, with an illegible date- An unsealed bag of chicken legs in an open box, dated 12/8/2025 and labeled open- An unsealed bag of chicken legs in an open box, dated 11/20/2025- An open and unsealed box of cinnamon roll dough, undated canned good items (dry storage)- Dented can of grape jelly, dated 10-27-25- Dented can of tomato sauce, dated 9-30-25- Dented can of Champinones (mushrooms), dated 11-25-25walk-in refrigerator - An unsealed tub of sour cream, labeled opened 10/28/25 and use by 11/29/25- A large bag of pepper jack cheese cubes, undated and with manufacturer best by date 11/25/2025- Dietary Aide X in the walk-in cooler touching various products while wearing used food grade gloves. The gloves appeared to have seasonings on them. During an interview on 12/09/2025 at 7:56 AM with the Dietary Aide revealed the gloves she was wearing in the walk-in refrigerator were the same gloves used to prepare raw chicken. She said she was supposed to take them off and wash her hands because she does not want to contaminate anything else. During an interview on 12/09/2025 at 1:02 PM with the Dietary Supervisor, she said it was important food items in bag were sealed after opening because of contamination from other objects. She said it was important for frozen food items to be sealed because they can be freezer burnt. The Dietary Supervisor said the risk of canned good items was they could create a broken seal and cause contamination and botulism (foodborne illness caused by bacteria that creates botulinum toxins; consumption can lead to respiratory and muscular paralysis). Record review of the facility's Dietary Department policy, revised October 24, 2022, reflected: PurposeTo ensure that the dietary department has the requisite organization to meet the nutritional needs of residents. Policy.ProcedureI. The primary objectives of the dietary department include:.C. Maintenance of standards for sanitation and safety;D. Maintenance of standards for quality of food;E. Procurement, production and service with economical use of labor and food.H. Provision of effective supervision and training of food service personnel.V. Employee Hygiene During Food Preparation and ServiceA. Employees should never use bare hand contact with any foods, ready to eat or otherwise.Staff should maintain nails that are clean and neat, and wearing intact disposable gloves in good condition that are changed appropriately to reduce the spread of infection. Disposable gloves are a single use item and should be discarded between and after each use. See Policy No. - IC - 21 - Hand Hygiene. Record review of the U.S. FDA Food Code 2022 reflected: 3-101.11 Safe, Unadulterated, and Honestly Presented. 3-201.11 Compliance with Food Law. A primary line of defense in ensuring that food meets the requirements of S 3-101.11 is to obtain food from approved sources, the implications (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting and processing, they do not fall victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted and pitted or dented cans may also present a serious potential hazard.3-304 Preventing Contamination from Equipment, Utensils, and Linens. 3-304.15 Gloves, Use Limitation. (A) If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.3-501.17 . Commercial processed food: . 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 FDA Food Code 2022 Chapter 3. Food Chapter 3 - 29 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. (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 . D. (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.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assure resident assessments were accurate and reflected the resident's current medical status for 1 (Resident #72) of 8 residents reviewed for assessment accuracy. The facility failed to ensure Resident #72 was not misdiagnosed with Type 1 Diabetes Mellitus and the MDS reflected accurate diagnoses. This failure could lead to residents receiving inappropriate treatments based on misdiagnoses, and the facility could receive funds based on inaccurate diagnoses. Findings included: Record review of Resident #72's face sheet revealed an [AGE] year-old woman, admitted on [DATE] with a primary diagnosis of Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (decline in cognitive function). On 10/1/2024, Resident #72 was diagnosed with Type 1 Diabetes Mellitus (chronic autoimmune disease that occurs when the body's immune system attacks and destroys insulin-producing cells in the pancreas, leading to little or no insulin production. Record review of Resident #72's quarterly MDS dated [DATE] revealed Resident #72 had a BIMs (Brief Interview for Mental Status, cognitive assessment tool) of 0 (indication that the resident had severe cognitive difficulties) and an active diagnosis of Diabetes Mellitus. Record review of Resident #72's annual MDS dated [DATE] revealed Resident #72's active diagnoses did not include Diabetes Mellitus. Record review of Resident #72's blood sugar graph, dated 12/1/2023 through 12/10/2025, did not reveal any blood glucose readings. Record review of Resident #72's order summary, dated 12/11/2025, did not reveal active orders for Diabetes Mellitus. Record review of Resident #72's Care Plan, dated 12/11/2025, did not reveal a plan of care for the Type 1 Diabetes Mellitus diagnosis. During an interview on 12/11/2025 at 10:24 AM with LVN G, he stated the only way Resident #72 could have gotten a diagnosis for Type 1 Diabetes mellitus was from a doctor's order for a new diagnosis or if she was at the hospital. He said he put the diagnosis in Resident #72's chart. After reviewing Resident #72's records, LVN G said he could not find anything indicating where the diagnosis came from and that it was an error. He said he got an order to have that diagnosis discontinued today and two MDS' had to be modified. LVN G stated correct diagnoses were important because it was what helped doctors and plan of care; it helps make sure residents were taken care of and get medical and social services. He further stated that a wrong diagnosis can be a risk of wrong orders for residents, and wrong medications could be given. During an interview on 12/11/2025 at 11:21 AM with LVN I, she stated correct diagnoses were important because they need to be right on the MDS, so they (facility) do not receive benefits from it (incorrect diagnosis). She further stated the risk of a wrong diagnosis could be that the doctor would identify Resident #72's was not receiving anything (medication) for diabetes mellitus and go ahead and give Resident #72 metformin (insulin medication). During an interview on 12/11/2025 at 11:57 AM with the RN J, she stated the correct diagnoses were important so that the facility does not get paid for it and get accurate assessments (of residents). She did not think there was a risk of an incorrect diagnosis for Resident #72 since they were not actively doing anything for the diagnosis, and said the risk was minimal if any. RN J said she would hope the doctor questioned the diagnosis before prescribing medication for Type 1 Diabetes Mellitus. Record review of the facility's RAI Process policy, revised 8/22/2024, reflected: Purpose To ensure that the Resident Assessment Instrument (RAI) is used, in accordance with specified format and timeframes, in conducting comprehensive assessments as part of an ongoing process through which the facility identifies each resident's preferences and goals of care, functional and health status, strengths and needs, as well as offering guidance for further assessment once problems have been identified. III. Each MDS section will be completed by the responsible individual. B. Each resident's assessment will be coordinated by and certified as complete by a registered nurse, and all individuals who complete a portion of the assessment will sign and certify to the accuracy of the portion of the assessment he or she completed. C. All information recorded within the MDS Assessment must reflect the resident's status at the time of the Assessment Reference Date (ARD).		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were able to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that it was not possible, or the resident preferences indicated otherwise for one (Resident #1) of five residents reviewed for quality of care. The facility failed to weigh Resident #1 at admission per facility policy and physician's orders. These failures could place residents at risk for decreased nutritional and weight status and a decline in health. Findings included: Record review of Resident #1's admission MDS dated [DATE], reflected a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (a group of diseases that affect how the body uses blood sugar), muscle wasting, and atrial fibrillation (an irregular and often rapid heartbeat). The MDS reflected Resident #1's weight as 0 pounds. The MDS reflected a BIMS of 13, indicating intact cognition. Record review of Resident #1's care plan initiated on 12/11/2025, reflected Resident #1 required treatment for atrial fibrillation with an intervention that Resident #1 was to be monitored for loss of appetite. Record review of Resident #1's physician orders, written by Physician F with start date 12/04/2025, reflected Resident is at risk for malnutrition related to diagnosis: Longstanding Persistent Atrial Fibrillation, weigh weekly x 4 weeks, and monthly thereafter. Dietician to consult as needed, per orders. On 12/09/25, a record review of weights in Resident #1's electronic health record revealed a weight of 0.0 pounds completed on 12/03/2025. No other weights were present at that time. Record review of Resident #1's Skilled Evaluations for December 2025 reflected her weight as 0.0 pounds. In an interview on 12/09/25 at 01:50 pm, Resident #1 stated, they have never weighed me. She stated, I used to be about 182 pounds, and the hospital had me at 192 pounds, but I don't think that is right. In an interview on 12/11/25 at 11:20 am, ADON A stated that she was the nurse providing care to Resident #1 and on 12/10/25 she had struck out Resident #1's weight in the electronic weight record and indicated incorrect documentation when she realized that Resident #1's weight had been recorded as 0.0 pounds which was, obviously not correct. She stated she thought that the nurse who had documented 0.0 pounds in Resident #1's record had placed the accurate weight on a different resident on accident, however she did not know what other resident's chart or what nurse had made the entry. She stated the facility policy for checking weights was upon admit, every week times 4 weeks, then monthly unless it is determined to be needed more often. She stated that Restorative Aides are responsible for checking weights and that the DON was responsible for documenting the weights and identifying and responding to changes in weight. She stated the facility DON had quit last week and that ADON B would be taking over the responsibility but that she was still in training. She reported that the risk of a resident's weight not being checked according to the policy or physician order would be, the weight helps us get a baseline to monitor gains and losses. She stated she believed that the therapy department was responsible for training the Restorative Aides on checking weights. In an interview on 12/11/25 at 11:25 am, RN C stated she was remaining in the building this week as the facility DON had quit last week. She read from the facility policy that residents are to have their weights checked upon admission, every week for four weeks, and then monthly and as needed unless indicated more frequently by a physician's order. She stated that the Restorative Aides are responsible for taking residents' weights and receiving training on this from the therapy department. She stated that the Restorative Aides give the weights to the DON who documents them and identifies and responds to changes in weights or inaccuracies. She stated she thought therapy was responsible for this training. She did not state why Resident #1's weight had not been recorded. In an interview on 12/11/25 at 12:45 pm, ADON B stated that the DON monitored and documented resident's weights but that the DON quit last week and she (ADON B) was now beginning to take that over the responsibility. She stated that Restorative Aides check resident's weights upon (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission, readmission, weekly x 4 weeks, then monthly or more often as determined needed. She stated that the facility's restorative aides are knowledgeable of this. She stated she was aware of the restorative aides receiving training on weights from another restorative aide who had come from a sister facility around September 2025. ADON B stated the risk of a resident's weight not being checked per policy or order was that we could have weight gain that could be detrimental to the patient or unnecessary weight loss. There are some things we can treat if we know. She stated she did not know why Resident #1s' weight had not been checked. In a review of Resident #1s electronic weight record on 12/11/25 at 01:15 pm, a new (not previously present) entry dated 12/3/25 by ADON A reflected Resident #1s weight as 187 pounds. In an interview on 12/11/25 at 01:09 pm, ADON A reported she had entered Resident #1's weight on 12/11/25 as 187 pounds for 12/3/25 when she found the list of residents' weights sitting on the desk of the DON who quit last week. She declined to provide this list to the surveyor but stated that the spreadsheet could be obtained from the DOR. In an interview and observation on 12/11/25 at 01:20 pm, the DOR stated that Restorative Aides take residents' weights and have received training from another restorative aide who came in from another facility in September or October of 2025. She stated that once a Restorative Aide checked a resident's weight, they would write it down on a piece and then type it into a shared file spreadsheet that the DON had access to. She stated that the DON who quit last week had been responsible for entering those weights into the electronic health record. She reported that the DON would enter the weekly, monthly, admission, as needed, and all weights into the electronic health record. She stated she believed that Resident #1 was on more frequent weight checks because of congestive heart failure. She stated that if Resident #1's weight had not done by the restorative aide, that the DON would have communicated that to her and she would have had a restorative aide check the weight. She stated that by looking at the shared file spreadsheet she noted that Resident #1's weekly weight was done this week, but she was not sure about the admission weight. She provided a spread sheet from the shared file and for Resident #1 a weight was entered under a column dated 12/1/25-12/5/25, and she stated this was a concern because the exact date could not be identified. She stated that this shared file could be altered at any time by anyone with access, and there were no time-stamps or ability to track edits. In an interview on 12/11/25 at 01:45 am, Restorative Aide E stated she was responsible for checking Resident #1s weight upon admission. She stated she did check Resident #1s weight using a mechanical lift and sling, and that she gave this weight to the DOR. She was adamant that she did this weight on 12/1/25. In an interview on 12/11/25 at 2:07 pm, the ADM stated that Residents' weights were to be checked for every admission per their policy and for CHF patients. He stated that the Restorative Aides check the weights and give them to the DON who evaluates the weights for discrepancies or concerns. He stated that the DON enters them into the electronic health record. He stated that if a resident's weight was not checked, anything that is not done for the patient could possibly have a negative outcome. The expectation is to get the weight. The facility policy titled, Assessment and Management of Resident Weights with revised date of 06/2020 stated, Weights are obtained upon admission and/or re-admission, then weekly for four (4) weeks and monthly thereafter. Additional weights may be obtained at the discretion of the licensed nurse or the interdisciplinary team (IDT).		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide complete, accurately documented and readily accessible information in 1 (Resident #7) of 1 resident reviewed for identifiable information. The facility failed to provide the original, complete, and accurate handwritten notes taken during a meeting with Resident #7, Resident #7's family, the DON, and SW. This failure places residents at a risk of inaccurate orders that could lead to negative effects in their clinical, functional, mental, and psychosocial care. Findings included: Record review of Resident #7's face sheet revealed an [AGE] year old woman, admitted on [DATE], with a primary diagnosis of Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side (paralysis or weakness to the left side of the body due to a stroke). Other pertinent diagnoses include Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (decline in cognitive function). Record review of Resident #7's MDS, dated [DATE] revealed the resident had a BIMS of 13 (indication that the resident had intact cognitive function). Record review of Resident #7's progress note, dated 11/25/2025, reflected: Resident's [family] is requesting that resident's tramadol be reduced to be only to bed time and for the gabapentin to be discontinued due to it being ineffective, NP notified. Record review Resident #7's order summary, dated 12/09/2025, reflected: Gabapentin Oral Capsule 300 MG (Gabapentin) Give 1 capsule by mouth at bedtime for pain Give 1 capsule PO QHS for pain Order Date: 9/23/2025 tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 1 tablet by mouth every 8 hours as needed for pain Order Date: 11/28/2025. The order summary did not show an active order for Tylenol. During an interview on 12/08/2025 at 12:15 PM with Resident #7's RP, they stated the family requested that the facility stop the Gabapentin because it was not having any effect on Resident #7's ankle pain. The RP stated they were in contact with the ADM, DON, ADON, and social worker, and they requested a meeting with us (Resident #7, RP, family) to discuss the issue. The RP said there was a meeting last Wednesday (12/03/2025) in Resident #7's room. The RP said based on last week's (12/03/2025) meeting, Tylenol and Tramadol will be administered as needed for pain. During an interview with Resident #7 on 12/11/2025 at 9:00AM, she revealed the Gabapentin does not work for her pain and she does not want Tramadol due to it making her drowsy. Resident #7 said she did not talk about the medications in last week's meeting and said her family communicates with the facility staff; Resident #7 prefers her family to be talked to about her care and medications. Resident #7 said she had pain in her ankle last night and did not call staff because she knew they would suggest Tramadol and she refused the Gabapentin. During an interview on 12/11/2025 at 11:33 AM with RN H, she stated Resident #7 complained of pain was prescribed Gabapentin. She said the Gabapentin did not help much, so Resident #7 was prescribed Tramadol. RN H said the Tramadol was too much, making Resident #7 drowsy and now the Tramadol was PRN. Since Tramadol has been changed to PRN, Resident #7 does not ask for it, and had refused it. RN H said if residents do not like their medication, she was to contact the provider (doctor or nurse practitioner). During an interview on 12/11/2025 at 12:21 PM with LVN I, she revealed there had been a meeting with the DON, SW and Resident #7 at Resident #7's bedside regarding care. RN I stated the SW told her that the DON had the SW document the conversation. At this time, this surveyor requested a copy of the note. This surveyor did not receive the note. During an interview on 12/11/2025 at 1:45 PM with the ADM, stated there was a meeting on 11/28/2025 with Resident #7 and a family member. He stated it was a meeting to address grievances. He said the family wanted to discontinue Resident #7's medication order for Tramadol and the Gabapentin was not effective. The ADM indicated he was aware that the family did not want Resident #7 to take Gabapentin. He stated he asked the family to come into the facility so they could resolve the grievance, so the family and facility could be on the same page. The ADM stated the grievance was resolved by changing the Tramadol to be used as (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed. He said the family has not voiced concerns since that meeting. The ADM stated Resident #7's family was very involved with her care and Resident #7 wanted her family involved; and even though Resident #7 had dementia, she had a BIMs of 13 and was able to make her own decisions. Record review of the grievance concern, dated 11/28/2025, reflected: Concern: . [Family] voiced concerned about [Resident #7's] pain medication, thinks that she may be receiving a high dose, requested clarification on the medication dosage, and also for changes to the medication. Response: Team met with resident and [family members] to clarify medication concern, MD notified, medication was clarified and concern was resolved. During an interview on 12/11/2025 at 2:29 PM with Med Aide K, he stated Resident #7's family told him the Gabapentin was not working to treat pain, and that was when Tramadol was prescribed by the nurse practitioner or doctor. He said Resident #7 was sleeper from the Tramadol, and the scheduled medication was discontinued. He said Resident #7 refused Gabapentin, but sometimes takes it, and in the last week she had not taken Tramadol. Med Aide K did not indicate if Gabapentin was supposed to be discontinued, only that Tramadol was scheduled for as needed. During an interview on 12/11/2025 at 3:15 PM with the SW, she showed this surveyor the handwritten note, on her phone, from the meeting with Resident #7 and her family from the week prior. The SW said the meeting was last Monday (12/01/2025) or Tuesday (12/02/2025) with the DON, Resident #7, Resident #7's family, and her. She said the meeting was maybe later than 4 PM. The handwritten note as written, to discontinue the Gabapentin and PRN (as needed) the Tylenol or Tramadol. The medication adjustments per the family requests included a pain patch and brace at night. This surveyor requested the handwritten note to be emailed; the SW said she would email it to the surveyor. The SW said the DON was going to type up the handwritten note since she was a SW and does not do medications. Record review of the SW's hand written note (via screenshot) provided by the ADM and interview on 12/11/2025 at 3:41 PM, the screenshot showed an image of a handwritten note that reflected: [Resident X] - [Resident X room number] - A 4 pm mtg- Med adjustments - family request- Pain patch- w/ brace @ nightuse tramadol or tylenolAt this time, this surveyor requested the original handwritten note to be sent to this surveyor, with the note to discontinue the Gabapentin. The ADM said the note he sent was the note the SW sent to him, indicating it was the original note. This surveyor explained the SW showed a handwritten note stating to discontinue the Gabapentin order; the ADM asked if this surveyor saw the note or had the note, indicating this surveyor did not have proof or see the note mention Gabapentin. This surveyor explained the handwritten note was from a meeting the week prior, and the ADM denied there be a meeting the week prior. He indicated that because he did not initiate the meeting, the meeting did not happen. The ADM refused to give the SW's full handwritten note from the meeting with Resident #7, her family, the DON, and SW. Upon a closer review of the screenshot of the handwritten note, the screenshot revealed the full handwritten note in the camera roll below the partial handwritten note and reflected: [Resident X] - [Resident X room number] - A 4 pm mtg- Med adjustments - family request- Pain patch- w/ brace @ night- DC: gabapentinuse tramadol or tylenol PRNThe full handwritten note showed the discrepancy of DC: gabapentin right above use tramadol or tylenol PRN. During an interview on 12/11/2025 at 5:35PM with the SW, she revealed she wrote the notes for the DON during the meeting in the prior week. She recalled the discussion about the plan for the pain patch, the brace, and Tramadol and Tylenol being prn. When asked if the note said to discontinue the Gabapentin, the SW said, I don't know. When asked to show the handwritten note on her phone again, she said I deleted it, I thought we were done with it. The SW said she did recall discussing Gabapentin in the meeting. She said she did not email the handwritten note because she cannot send it from her personal email. This surveyor asked the SW to look at the screenshot with the full handwritten note and partial handwritten note and to identify the discrepancy. The SW said, Gabapentin is there and Gabapentin is not there. When asked if she knew why there was a discrepancy, she said no. When asked what the risk of records not being kept accurately was, she stated missed information. [NAME] an interview on 12/11/2025 at 5:48 PM with RN C, she identified the discrepancies between (continued on next page)		

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 12/11/2025
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)		
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the full handwritten note and partial handwritten note. When asked why the discrepancy was an issue, she stated she did not know why the Gabapentin was an issue. She said DONs and nurses take their own notes; she discussed part of nurse's responsibilities include taking their own notes and not having another staff member take notes. RN C stated I have never experienced this, never had this issue before. I didn't see anything. I heard her [SW] say to [the ADM] do I send it to you or work email and [the ADM] said send to me. It's not their character. During an interview on 12/11/2025 at 6:08 PM with the ADM, he was asked what the discrepancies between the full handwritten note and partial handwritten note was and would not verbally state what the discrepancy was. The ADM said, That was there and that wasn't there. I'm repeating myself. He said, whatever was forwarded to me was forwarded to you. When asked why discrepancy was a risk, the ADM said, I don't have an answer for your question because I don't know what risk you are talking about. When asked the what the risk associated with inaccurate records was, he stated That was a voluntary note she provided. I don't know. When asked what the risk was if the partial handwritten note going forward as an order, the ADM stated Ma'am, I don't know if I have an answer. Record review of the facility's Documentation - Nursing policy, date revised 01/2025, reflected: PurposeTo provide documentation of resident status and care given by nursing staff. PolicyNursing documentation will be concise, clear, pertinent, accurate and evidence based. Narrativecharting, as outlined in specific policies and procedures, will be used for initial treatments orprocedures. Documentation for subsequent and/or routine care and procedures may be completedby exception. Checklists, flow charts, and other documentation tools will be used as appropriate.Nursing documentation will not contain error-prone abbreviations.Nursing staff will not falsify or improperly correct nursing documentation.ProcedureI. Nursing DocumentationA. admission nursing assessments completed by individual assessment on the day ofadmission.- If the time required to complete the admission nursing assessment crosses amidnight, the admission is considered completed as of the date and time theassessment was initiated as long as it is completed within 4 hours of that starttime.B. Minimum data set (MDS) completion as per CMS and Medicare guidelines.C. The Licensed Nurse will review the Plan of Care on a weekly basis and document theresident's response and progress towards the goal.D. Any communications with family, durable power of attorney (DPOA), or physician is to benoted in nurse's notes.E. All laboratory data will be dated, timed, and initialed when received and initially reviewedby a licensed.- This notation may be made on the laboratory results page.- The date, time, and signature of the licensed nurse reviewing the laboratory dataand the disposition of that information shall be noted in the nurse's notes.F. Nurse's notes are dated, timed, and signed when written.G. Nurse's notes addressing the resident leaving the facility will document when and withwhom, and time of return, along with any medications sent.H. Medication administration records and treatment administration records are completedwith each medication or treatment completed.I. Glucose measuring is documented as per physician's order.J. Treatments completed and documented as per physician's order.K. Documentation will be completed by the end of the assigned shift.		