STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675868	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hereford Nursing & Rehabilitation	231 Kingwood St Hereford, TX 79045

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48161 Based on observation, interview and record review, the facility failed to ensure each resident had a right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 of 14 residents (Resident #4) reviewed for accommodation of needs. Resident #4's call light was not within her reach. This failure could place residents at risk of not having their needs met and a decline in their quality of care and life. Findings included: Record review of Resident #4's face sheet, dated 07/17/2024, revealed a [AGE] year-old female admitted on [DATE] with diagnoses that included, but were not limited to, parkinsonism (slowed movements, tremors), urinary tract infection, dementia (memory loss), anxiety disorder, neuromuscular dysfunction of bladder (incomplete bladder emptying), and a history of falling. Record review of Resident #4's quarterly MDS, dated [DATE], revealed a BIMS score of 00 out of 15 which indicated Resident #4 had severe cognitive impairment. Resident #4 required extensive two-person staff assistance with toileting hygiene, upper and lower body dressing, and personal hygiene. Record review of Resident #4's care plan, dated 05/07/2024, revealed, in part, Resident #4 had urinary/bowel incontinence with interventions to keep call light in easy reach and remind resident to call for assistance when urgency to eliminate was noted. Resident #4 was at risk for injuries from falling related to physical mobility and generalized weakness with interventions to ensure call light was in reach and answered promptly. During an observation and interview on 07/17/2024 at 8:34 AM, Resident #4 was sitting in her recliner in the middle of her room, she had a blanket covering her body. Resident #4 stated she needed to go to the bathroom. Observation of Resident #4's private room revealed that her designated call light located closest to her bed was on the floor. A second call light for that room that would have been designated for a roommate was located on Resident #4's bed out of reach from Resident #4. When asked about how long she was in the recliner needing help, Resident #4 did not answer the question. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and observation on 07/17/2024 at 8:43 AM, CNA B stated that Resident #4 could not transfer herself and that she and another aide transferred her into her recliner. CNA B walked into Resident #4's room and noticed the call light was not in residents reach. CNA B apologized to surveyor for the call light being on the bed and not near Resident #4. CNA B stated that a possible negative outcome for not having the call light in reach could be that a resident could fall and would not be able to call for help. In an interview on 07/17/2024 at 9:40 AM, LVN A stated that it was protocol for call lights to be in reach of residents and the negative outcome for a resident not having a call light in reach would be that a resident could try to get up on their own and could hurt themselves. In an interview on 07/17/2024 at 2:37 PM, the ADON stated that it was protocol when residents were transferred from their bed to a chair in their room that the call light was to be placed near the resident. The ADON stated that the possible negative outcome for a call light out of reach of a resident could be that they could fall and need help. In an interview on 07/17/2024 at 2:40 PM, the DON stated that staff had been inserviced on call light placement and that a possible negative outcome for a resident that was not able to reach their call light could be that the resident would need help and not be able to call for help. Record Review of the policy titled Call light-use of dated 12/2017 revealed the following in part: .It is the policy of this home to ensure residents have a call light win reach that they are physically able to access and that have been instructed on its use. .All nursing personnel must be aware of call lights at all times. .When providing care to residents, be sure to position the call light conveniently for the resident to use. Tell the resident where the call light is and show him/her how to use the call light. .Be sure call lights are placed near the resident, never on the floor or bedside stand.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48161 Based on observation, interview, and record review the facility failed to attempt to use appropriate alternatives prior to installing a side or bed rail, assess the resident for risk of entrapment from bed rails prior to installation, and review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation for1 of 14 (Resident #13) residents reviewed for bed rails. Resident #13 had (1) one-third bed rail, on the right side of her bed with no documentation of resident consent, or safety assessment prior to installation. This failure could place residents at risk of injury, hinder residents from getting out of bed, and/or cause a decline in resident's ability to engage in activities of daily living. Findings included: Record Review of Resident #13's Face Sheet dated July 16, 2024revealed that a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that include but not limited to weakness, cognitive communication deficit, unspecified dementia (memory loss) and major depressive order. Record Review of Resident #13's Quarterly MDS assessment dated [DATE] revealed Resident #13 had a BIMS score of 01 indicating that resident had severe cognitive impairment. The MDS revealed that Resident #13 required a 2 person assist with lying to sitting on side of bed, sitting to standing and chair to bed transfer. Record Review of Resident #13's Care plan dated 5/01/2024 revealed the following with no documentation relating to side/bed rail use. Focus: Dementia with cognitive impairment Interventions: Reorient resident as needed. Focus: Limited physical mobility Interventions: Provide supportive care, assistance with mobility as needed. Record Review of Resident #13's clinical record dated 10/09/2023 revealed physician's standing orders of side rails to be used when assessment revealed necessary. Record Review of Resident #13's clinical record under Assessments revealed no documentation of bed rail safety assessment for 1/3 size bed rails. Record Review of Resident #13's clinical record under Assessments revealed an assessment was completed on 10/09/2023 for 1/8 size bed rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Resident #13's clinical record for bed rail consents revealed no documentation of a signed bed rail consent for 1/3 size bed rails. Observation on 07/16/2024 at 10:42AM of Resident #13's bed revealed (1) 1/3 size bed rail on the right side of bed. Observation on 07/17/2024 at 8:30 AM of Resident #13's bed revealed bed rail was no longer on the bed. In an interview on 07/17/2024 at 9:40 AM, LVN A stated that assessment and consents were required for bed rail use. LVN A stated she did know that the bed rail had been taken off the bed but stated that maintenance was responsible for bed rails installation and removal. LVN A stated that a possible negative outcome for bedrails being used without assessments could be that it could cause entrapment, or a resident could try to crawl over the bed rail and get hurt. LVN A stated she did not know what size bed rails were on Resident #13's bed. In an interview/observation on 07/17/2024 at 2:00 PM, Resident #13 was sitting in her recliner. When asked about the bed rails being on her bed, Resident #13 waved her hands back and forth to the side saying, it doesn't matter. Resident #13 was bilingual and to ensure she understood surveyor, CNA C entered the room and relayed the question in Spanish concerning the bed rails. CNA C stated that that Resident #13 didn't care if bedrails were on or off the bed. In an interview on 07/17/2024 at 2:06 PM, the MS stated that he was directed by ADON to take bed rails off the bed on 07/16/2024. The MS stated that the bed rail on Resident #13's bed was 1/3 in size. In an interview on 07/17/2024 at 2:38 PM, the ADON stated she directed MS to take the bed rail off the bed because the family requested the removal. The ADON stated she did not know what size of bed rail was on Resident #13's bed. The ADON stated that a possible negative outcome for having bed rails on the bed was that a resident could be stuck in the bed. In an interview on 07/17/2024 at 2:40 PM, the DON stated that she did not know what size of the bed rails that were on the bed and stated that a possible negative outcome for unneeded bed rails on the bed would be that the resident wouldn't be able to get out of bed. Record Review of facility policy title Bed Rails dated November 8, 2016, revealed the following: Assessment-Prior to use of a bed rail the resident will be assessed to ensure the proper rail is utilized for the resident's need. The facility will re-evaluate the use of the rail on a periodic basis. Based on the resident assessment, the interdisciplinary team will make the determination for the plan of care as it relates to bed rail. Consent-The resident or resident representative will provide consent for the use of rails prior to installation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47854 Based on observation, interview, and record review; the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles for 1 of 2 medication carts (Hall 200) and 1 of 1 medication room reviewed for drug labeling and storage and expired drugs. 4.5 pills were loose in the bottom of medication cart drawers of Hall 200 Medication cart. Medication room revealed a medication for Resident #36 that expired in June of 2023. These failures could result in residents not receiving an accurate dose of medication as well as not being maintained at their best therapeutic level. Findings included: Observation and interview on 07/16/2024 at 10:26 AM of medication room revealed a medication for Resident #36 that had an expiration date of 06/2023. LVN D stated that the medication was discontinued and was not sure why the medication was still in the medication room. LVN D was unable to give a negative outcome for having expired medication in the medication room. Observation on 07/16/2024 at 10:46 AM revealed 4.5 pills were found loose on the bottom of the medication cart drawers for medication cart for 200 Hall. MA was not able to identify any of the medications. Interview on 07/16/2024 at 10:54 AM, MA stated that the negative outcome for having lose medication could result in the resident not receiving their medications. Interview on 07/17/2024 at 11:11 AM with DON, requested policy for medication storage. DON was asked what a negative outcome would be for having loose medications in the medication cart. DON stated, missed dose. No further information was provided by DON. Record review of facility provided policy, titled Storage of Medications, revised April 2007, revealed the following: 1. Drugs and biological shall be stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. . 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility provided policy, titled Labeling of Medication Containers, revised April 2007, revealed the following: Policy Statement All medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations. Record review of facility provided policy, titled Drug Destruction Policy, revised May 9, 2010, revealed the following: It is the policy of this facility to destroy dangerous and controlled medications according to the State of Texas law. .3. Nursing staff will submit to Director of Nursing any medication and any applicable log that has expired, been discontinued by physician or that had been prescribed to a resident who no longer resides at the facility. 48221

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48161 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with the professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure freezer items were properly stored, labeled, and dated. 2. The facility failed to ensure pantry foods were properly stored, labeled, and dated. These failures could place residents who ate food served by the kitchen at risk of food-borne illness. Findings included: In an observation of the walk-in pantry on [DATE] at 8:50 AM the following was observed: 1. (4) graham cracker pie crusts in a package, not sealed and open to air with no date or label. 2. (1) open gallon of Big Chief Imitation Vanilla Flavor expiration date [DATE], with no open date. In an observation of the freezer on [DATE] at 8:55 AM the following was observed: 1. (1) box of hamburger patties with approximately 20 patties in the box, open to air with no open date. A small amount of freezer burn on the top patties was observed. In an interview on [DATE] at 9:15 AM, the DC stated all employees were responsible for disposing of expired foods or foods that were not any good. The DC stated that the negative outcome for not throwing away expired items would be that residents could get sick. The DC stated that all employees were also responsible for labeling and sealing any items in the dry food area, refrigerator, and freezer area. In an interview on [DATE] at 9:20 AM, the DS stated that she and her employees were responsible for ensuring foods were labeled and sealed. The DS stated that all employees were responsible for disposing of expired items. The DS said that a possible negative outcome for expired or open foods would be that a resident could get sick or contact pathogens and that not sealing or labeling foods properly could cause freezer burn on the foods. In an interview/observation on [DATE] at 9:30 AM, the DS removed the open pie crusts from the shelf in the Dry Pantry and told Surveyor that she did not know when the item was opened as it was not labeled. Record review of facility provided policy (no date) titled Labeling and Dating Food stated in part: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When the food item is removed from the original box, each item must be dated, or container must be dated. Once you open a food item, you must date it the day it was opened. Record review of facility provided policy (not date) titled Dry Storage and Supplies stated in part: Open packages of food are stored in closed containers with tight covers and dated as to when opened. Record review of facility provided policy (not date) Food Safety stated in part: Food is to be tightly wrapped or sealed and covered. Opened food shall be labeled, dated and stored properly. Do not keep potentially hazardous food past the labeled expiration date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47854 Based on 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 4 (LVN D, LVN E, CNA G, and CNA H) of 4 staff members and 2 of 2 residents (Resident #2 and Resident #45) in that: LVN E did not don PPE gown before administering ordered medications via Peg-tube to Resident #2 LVN E did not don PPE gown before administrating Foley Catheter Care, Incontinent Care, and Wound Care-Stage 3 pressure ulcer to coccyx on Resident #45 CNA G did not don PPE gown before assisting LVN E with Foley Catheter Care, Incontinent Care and Wound Care Stage 3 pressure ulcer to coccyx on Resident #45 CNA H did not don PPE gown before, assisting LVN E with Foley Catheter Care, Incontinent Care, and Wound Care-Stage 3 pressure ulcer to coccyx on Resident #45 LVN D did not don PPE gown before administering liquid feeding via Peg-tube to Resident #2 These deficient practices have the potential to affect all residents in the facility by exposing them to care that could lead to the spread of viral infections, secondary infections, communicable diseases. Findings include: Observation on 7/17/24 at 8:50AM revealed LVN E did not don PPE gown for the administration of ordered medications for Resident #2's PEG-tube. PPE gown was not present inside room or in hallway outside the door of Resident #2's room. Record review of Resident #2's Admission Record states Resident #2 is a 48 y/o female admitted to facility on 7/1/2007. Medical diagnoses include a diagnosis of Cerebral Palsy. Care Plan dated 7/9/24 states Resident requires total assist with ADL needs, is incontinent of bowel and bladder, must maintain nutritional status via tube feeding related to inability to swallow, and receives all medications, feedings, and fluids via peg tube. Observation on 7/17/24 at 9:33AM revealed that LVN E, CNA G, and CNA H did not don PPE gowns during Foley catheter care, Incontinent bowel care followed by Wound care for Stage 3 pressure ulcer to coccyx for Resident #45. No gowns were used in any of the procedures performed. No gowns were in Resident #45's room or in the hallway outside Resident #45's door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #45 Admission Record states Resident #45 is a 61 y/o male initially admitted to facility on 2/8/24. Medical diagnoses include Pressure Ulcer of Sacral Region Stage 3 and Obstructive and Reflux Uropathy. Care Plan dated 5/28/24 states; Resident is incontinent of bladder and requires an indwelling Foley catheter, Sacral pressure ulcer stage 3, needs staff assistance for ADLs, and 2 staff members to transfer. Observation on 7/17/24 at 11:45AM revealed LVN D did not don PPE gown, before administration of ordered feeding for Resident #2 via her Peg-tube. PPE gown was not present inside room or in hallway outside her room. Interview on 7/17/24 at 11:55AM LVN D stated she had not been told to wear a gown as part of PPE when using Peg-tube for feeding residents. She did not know what Enhanced Barrier Protection (EBP) meant. She stated a negative outcome of not donning a PPE gown during care is that germs can spread. Interview on 7/17/24 at 1:01PM CNA G stated she had never been told to wear a gown when changing or assisting with any resident care. She did not know what Enhanced Barrier Precautions (EBP) were. She stated a negative outcome of not donning a PPE gown could be Spread of Infection. Interview on 7/17/24 at 1:08PM CNA H stated she had heard talk about wearing a gown, she could not remember who had told her. She stated a negative outcome of not donning a PPE gown ring resident care could be, Infection to the resident. Interview on 7/17/24 at 1:28PM Charge Nurse LVN A stated she had never heard of Enhanced Barrier Precautions (EBP). She did not remember an in-service on EBP being done. She stated a negative outcome of not donning a PPE gown during resident care could be, Possibility of getting bacteria on clothes and transferring. Interview on 7/17/24 at 1:33PM DON stated she was not aware of EBP policy. She was not aware of any in-service or training for staff. When asked what a possible negative outcome could be for not donning a PPE gown during resident care she first stated, I don't know. Administrator was in room and stated to her, Organisms if there are any, and she repeated to Surveyor, Organisms if there are any. Interview on 7/17/24 at 1:38PM with Administrator. He stated he was aware of EBP policy. He stated there had been an in-service on it and he would find it. He stated he had gotten a resignation from facilities former DON who had been at facility for [AGE] years, on March 31, 2024. The current DON started in April of 2024. Current DON may not have known about EBP policy he stated. When asked what a possible negative outcome could be for not donning a PPE gown during resident care he stated, Possibility of transfer of organisms. Interview with LVN E attempted. Tried to contact by phone on 7/17/24 at1:45PM, 1:46PM and 7/18/24 at 9:49AM. Left Voicemails requesting call back. Unable to contact LVN E and she was not working at facility after 12:00PM on 716/24. Did not work through 7/18/24. Record review of facility provided policies, procedures, CMS, and CDC updates received, and in-service: Inservice Titled 'Infection Control, Don & Doffing, Enhanced Barrier Precaution-catheter/wound/peg-tube,' (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	which included: Record review of facility provided Inservice document titled CMS OSO-24-08-NH Dated March 20,2024 effective April 1, 2024, revealed the following: .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO's) that employs targeted gown and glove use during high contact resident care activities.' .Examples of chronic wounds include, but not limited to pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. .Indwelling medical device examples include central lines, urinary catheters, feeding tubes .EBP is employed when performing the following: Providing hygiene, Changing briefs or assisting with toileting, Device care or use .urinary catheter, feeding tube, wound care any skin opening requiring a dressing. Record Review of Facility provided Inservice document titled; 'CDC Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDRO's)' updated July 12, 2022, under Key Points revealed: 2. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. 4. Effective implementation of EBP requires staff training on proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at point of care. Record review of Facility provided Policy Titled: 'Enteral and Parenteral Feeding' dated 12/02/2017 under Procedure revealed: 12. Standard precautions, clean techniques, applicable nursing policies, and manufacturer's recommendations are followed by nursing personnel when dealing with nutrition support residents. DON and/or designee are responsible for training and monitoring of nursing personnel on Nutritional Support procedures, documentation, and orders. Record review of Facility provided Policy Titled: 'Administering Medications' dated December 2012 under Policy and implementation revealed: 22. Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic techniques, gloves, isolation precautions, etc.) for the administration of medications as applicable. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Facility Policy Titled: 'Perineal Care Male' dated December 8, 2009, under Gather Supplies revealed: Gather needed supplies: i. Washcloths or Pre-moistened cleaning wipes ii. Towels iii. Soap or no-rinse perineal cleanser iv. Clean wash basin(s) or comfortably warm water v. Clean, disposable examination gloves vi. Overbed table vii. Disposable plastic bags for trash and linen viii. Incontinence pad(s) or brief ix. Additional supplies as needed if heavy soiling is present, i.e., toilet paper. Record review of Facility provided Policy Titled: 'Catheter Care dated February 13, 2007, under Procedure revealed: 1. Gather Supplies: a. Gloves b. Pre-moistened no-rinse disposable wash cloths c. Or wash cloths and basin (if using soap and water) Record review of Facility provided Policy Titled: 'Infection Control Plan': Overview dated 2018 under Facility Assessment revealed: At least annually and on an as needed basis the facility will conduct a facility wide assessment to determine the resources needed to maintain and efficient and up to date infection control program. The facility assessment can assist in determining the types of residents being cared for, what is needed to care for those residents, and what education facility staff need. 48221