

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: 675868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Hereford Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 231 Kingwood St Hereford, TX 79045	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure residents have the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive for 1 of 15 (Resident #19) reviewed for Resident Rights. The facility failed to ensure Resident #19 had a DNR in place which was signed by a physician and dated by the notary public. This failure could cause the loss of valuable time when dealing with a Resident's medical emergency and possible unwarranted death. Findings included: Review of Resident #19's admission record reflected Resident #19 was a [AGE] year-old female who was admitted to the facility on [DATE] with a diagnosis of Alzheimer's Disease, unspecified, Type 2 Diabetes Mellitus with Diabetic Polyneuropathy, Type 2 Diabetes Mellitus with Hypoglycemia without coma, Adult Failure to Thrive, Anxiety Disorder, unspecified, Covid-19, Insomnia, and Major Depressive Disorder, Single Episode, unspecified. Review of Resident #19's Quarterly MDS dated [DATE] revealed she required partial to moderate assistance with all elements of self-care and mobility. She had an indwelling catheter related to neuromuscular dysfunction of the bladder and was occasionally incontinent of bowel. Resident #19 had no nutritional issues with swallowing of liquids and solid foods but indicated some discomfort when chewing solid foods. Resident #19 received constant oxygen via nasal cannula at 2-5 Lt./min. to keep oxygen saturation rates above 90% related to hypoxia and received Hospice services twice per week related to Diabetes Mellitus, Unknown Sepsis and Chronic Kidney Disease. Resident #19 had a BIMS score of 04, indicating severe cognitive impairment. Review of Resident #19's care plan dated 08/05/2025 reflected Resident #19 has an order for Do Not Resuscitate (DNR) with a Goal of Resident/Responsible Party decision for DNR will be honored over the next 90 days and an Intervention of In absence of blood pressure, pulse, respiration, CPR will not be initiated, notify MD of change of condition and Resident will be maintained at a level of comfort as ordered by physician. Review of Resident #19's physician orders revealed her active comfort medications were Fentanyl Transdermal Patch 72-Hour, 25MCG/HR, apply one patch transdermal every 72-hours for Pain and remove per schedule, and Morphine Sulfate (Concentrate) Oral Solution 20MG/ML, give 0.1ml. by mouth every 4 hours as needed for pain level 7-10. Review of Resident #19's DNR revealed it was signed by the resident on 07/14/2021. The DNR was also signed by two witnesses on 07/14/2021 and notarized. The notary's signature and seal were not dated, and the DNR was not signed and dated by a physician. An interview with LVN A on 08/07/2025 at 10:28AM reflected Resident #19's DNR was not valid as it was not signed by a physician. She stated if the resident went into cardiac arrest, she would have to ask the DON for clarification of the DNR and how to proceed with Resident #19's care. An interview with the DON on 08/07/2025 at 10:35AM reflected the DNR was not valid as it was not signed by a physician and the notary had not dated her signature and seal. She stated if the resident went into cardiac arrest, the facility would have to send her to the ER via ambulance. The DON stated staff give EMS personnel the resident's code status while they prepare the resident for transport to the hospital. She stated the negative outcome of not having the DNR signed and dated by the physician and notary would be the loss of valuable life-saving time while (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 675868
		If continuation sheet Page 1 of 16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Hereford Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 231 Kingwood St Hereford, TX 79045	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's representative was called to discuss the resident's code status wishes. An interview with the Administrator on 08/07/2025 at 11:21AM reflected Resident #19's DNR was not valid due to no signature and date by a physician, and the notary had not dated her signature and seal. He stated the facility had a book at the nurse's station with all the resident's code statuses and if Resident #19 had a red page in the book it indicated Do Not Resuscitate. If the book had a green page for the resident, it indicated the resident had requested CPR as a life-saving measure. He stated if Resident #19 went into cardiac arrest, staff would refer to the book instead of the resident's chart to determine the resident's code status. He stated he would not assume what would happen if Resident #19 went into cardiac arrest, since the DNR was not signed and dated by the physician and notary. The Administrator stated the resident's current sheet in the code status book would be invalid for these reasons. Review of the facility's undated policy Advance Directives Policy and Acknowledgment revealed the following: It is the Health Care Center's policy to provide all residents and/or responsible party members with information relating to an individual's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical treatment, and the right to formulate Advance Directives. The Health Care Center respects the implementation of such rights and will follow all physicians' orders respecting such rights. Without physician's orders, Health Care Center's staff may be required to institute interventions that differ from the Advance Directive. The Health Care Center will clearly document in each resident's chart whether the resident has executed an Advanced Directive, and if so, what the directives will be. The Health Care Center will not discriminate against an individual based on whether the resident has executed an Advanced Directive. The Health Care Center agrees to provide the resident and/or responsible party with information regarding; Decisions concerning medical care, including the right to accept and refuse treatment when made in accordance with stated law. Valid Advance Directives made in accordance with stated law. If the resident has an invalid Advance Directive or no Advance Directive and the resident or the resident representative wishes to refuse, withhold, or withdraw life-sustaining medical treatment, such decisions shall be made consistent with state law and in conjunction with the Health Care Center's staff, management staff, and the attending physician. Full consideration shall be given to the applicable state law as interpreted by the Legal Department. Review of the facility's Code Status Listing Policy dated 01/28/2017 revealed the following: The facility will provide residents the opportunity to file an Advance Directive document declaring the resident/family/responsible party's end of life wishes and will provide education on options available. Procedure: Resident will be informed of their opportunity to file an Advance Directive document upon admission. The facility will utilize a colored sheet of paper at the front of each resident's chart to assist the staff in quickly identifying code status. Resident/family/responsible party electing DNR will have a red sheet. Resident/family/responsible party electing Full Code (CPR) will have a green sheet. Interdisciplinary team will discuss Advance Directive with the resident/family/responsible party during care plan meetings annually, when there is a significant positive change or a significant deterioration in the resident's clinical condition.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Hereford Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 231 Kingwood St Hereford, TX 79045	
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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property for 2 (Resident #8 and Resident #30) of 15 residents reviewed for abuse, neglect, exploitation, and misappropriation of resident property.1. The facility failed to implement their policy titled Abuse/Neglect and report Resident #8's black eye to state authorities.2. The facility failed to implement their policy titled Abuse/Neglect and report Resident #30's missing diamond ring to state authorities.This failure placed residents at increased risk of abuse, neglect, exploitation and misappropriation of their property.Findings Included:1. Record review of Resident #8's admission record dated 08/06/25 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning) and dementia (a group of thinking and social symptoms that interferes with daily functioning) in other diseases classified elsewhere mild with mood disturbance.Record review of Resident #8's quarterly MDS completed on 06/16/25 revealed a BIMS score of 8 which indicated moderate cognitive impairment. Resident #8 was noted to require setup or clean-up assistance or supervision/touching assistance across all ADLs.Record review of Resident #8's care plan completed on 06/17/25 revealed he was not able to measure his pain on a pain scale from 0-10 due to cognitive impairment and he had limited physical mobility. Resident #8 was noted to have Dementia with cognitive impairment as evidence by: Memory problems.Record review of Resident #8's orders revealed the following: Aspirin EC Tablet Delayed Release 81 MG (Aspirin) Give 1 tablet by mouth one time a day related to ACUTE COMBINED SYSTOLIC (CONGESTIVE) AND DIASTOLIC (CONGETSTIVE) HEART FAILURE. with start date of 11/27/24. Clopidogrel Bisulfate Tablet 75 MG Give 1 tablet by mouth one time a day for blood clot prevention related to ACUTE COMBINED SYSTOLIC (CONGESTIVE) AND DIASTOLIC (CONGESTIVE) HEART FAILURE. with start date of 11/27/24.Record review of Resident #8's progress notes from 07/07/25 to 08/07/25 revealed the following note written by LVN D on 07/31/25 at 12:41 PM: [Initials of dialysis center] called concerning black eye to resident explained it was from a shower head that fell onto his eye.Further review revealed no other progress notes were found pertaining to the black eye.Record review of incident by incident report for May-July of 2025 revealed Resident #8 had a bruise incident on 07/30/25.Record review of incident report found in EHR under Clinical and Risk Management revealed the following: . Bruise Date 7/30/2025 11:00 (AM)Resident: [Name of Resident #8]Incident Location: ShowerPerson Preparing Report: [Name of LVN A]Incident DescriptionNursing Description: Resident noticed with a bruise to right eye underneath. Resident noted earlier was self showering in shower and then noted with bruise. Resident denies falling. No other injuries noted.Resident Description: I don't knowWas this incident witnessed: N .Description: Resident noted to go in shower and shower self, Showerhead is a removeable sprayer and comes off the wall.Injuries Observed at Time of IncidentInjury Type BruiseInjury Location 4) FaceLevel of Pain:Numerical: 0 .Mental Status Lack of Safety Awareness .Agencies/People NotifiedPhysician . 7/30/2025 11:05 (AM)DON/RN . 7/30/25 15:49 (03:49 PM)Family Member . 7/30/2025 11:10 (AM)During an observation and interview on 08/06/25 at 09:18 AM LVN A stated when a resident has an injury nurses document in the EHR under Clinical and Risk Management. She demonstrated how to find incident reports in the EHR.During an observation and interview on 08/06/25 at 09:45 Resident #8 was standing near the nurses' station. He had fading, yellowish, green bruising approximately the size of a quarter underneath his right eye. He stated no one hit him. When asked about the bruise he stated a garlic was growing above his right eyebrow (gestured to the area) and it slid down his face. He also mentioned that his right ear was falling. When asked directly if a shower head had fallen on his eye, he stated it had not.2. Record (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Hereford Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 231 Kingwood St Hereford, TX 79045	
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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident #30's admission record dated 08/06/25 revealed a [AGE] year-old female most recently admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), and other signs and symptoms involving cognitive functions and awareness. Record review of Resident #30's admission MDS completed on 07/15/25 revealed a BIMS score of 10 which indicated moderately impaired cognition. Record review of Resident #30's care plan completed on 07/15/25 revealed she had impaired communication due to cognitive impairment. Resident #30 was noted to have dementia with cognitive impairment. Record review of Resident #30's progress notes from 07/06/25 to 08/06/25 revealed no mention of her missing diamond ring. It did reveal the following progress note written by LVN D on 08/02/25 at 09:06 AM: resident is slapping and hitting staff and other residents. making accusations that staff and other residents are stealing her stuff. Record review of incident by incident report for May-July 2025 revealed no mention of Resident #30's ring or any incident of misappropriation of resident property. Record review of grievance for the last three months revealed a grievance written by ADM on 07/28/25 regarding Resident #30's missing ring. During an observation and interview on 08/05/25 at 11:06 AM Resident #30 wheeled herself in her wheelchair down the hall to speak to this surveyor. She stated she had a diamond ring stolen. She stated it was a diamond solitaire and it was given to her by a family member. She stated she did not know who took it but she did know it was missing. During an interview on 08/05/25 at 02:49 PM Resident #30's family member stated Resident #30's diamond solitaire ring disappeared on 07/28/25. He stated the ring was on her finger and in a ring keeper with her two wedding diamond rings and a gold band. He stated the ring keeper was a plastic ring that went through all of her rings to keep them together and on her finger. During an observation and interview on 08/06/25 at 10:21 AM Resident #30 was seated in her wheelchair at the nurses' station. She had a gold band and a larger silver ring with purple stones in it on her finger but no ring keeper. She stated the ring with the purple stones was fake. She stated she was very sad her diamond ring had been stolen. During an interview on 08/06/25 at 10:33 AM Resident #30's family member stated after her diamond solitaire ring was stolen, he cut the ring protector and took her other two diamond rings home leaving her with the gold band only. He stated the silver ring with the purple stones was his way of giving her something pretty to wear that was not valuable. He stated he visited Resident #30 on 07/26/25 and her diamond solitaire ring was on her finger with her other rings inside the ring keeper. He stated he visited her on 07/28/25 and the ring was not on her finger, but the other three rings (gold band and two wedding diamond rings) were still inside the ring keeper on her finger. He stated someone would have had to cut the band of the diamond solitaire ring to get it out of the ring keeper and off her finger. He stated as soon as he noticed the diamond solitaire ring was missing, he told MDS LVN and she went and got [first name of ADM]. He stated ADM called the owner of the local pawn shop regarding Resident #30's missing ring. During an interview on 08/07/25 at 09:17 AM CNA B stated when a resident had an injury of unknown origin or a new bruise, she reported the injury to her charge nurse and ADM. She stated she had been trained and was regularly trained on reporting injuries of unknown origin to her charge nurse and ADM. CNA B stated if a resident told her they were missing personal property she would report it to her charge nurse and DON. She stated she had been trained on this procedure. She stated she heard about Resident #30's missing ring when ADM asked staff if they had seen the ring. She stated she was not working the day Resident #8 acquired his black eye and she was told by the CNA going off the night shift that it happened due to a fall. CNA B stated residents could be hurt more than we see if injuries and missing property were not properly reported. During an interview on 08/07/25 at 09:29 AM LVN A stated if a CNA drew her attention to, or she noticed on her own an injury of unknown origin on a resident she would notify the physician, DON, and ADM. She stated she had been trained and was regularly trained on this procedure. LVN A stated, Once a month we go through the reporting process. She stated a possible negative outcome for a (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Hereford Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 231 Kingwood St Hereford, TX 79045	
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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident if injuries of unknown origin were not properly reported was, If they have a bruise we don't know if they fell, or it was caused by an object or something. Sometimes the bruises cause blood clots, and they could have a fracture or something and we don't take care of it. She stated she did not see the shower head fall on Resident #8's eye. She stated Resident #8 had been in the shower by himself. She stated, When staff are not looking, he will go in there by himself to shower and we knew he was in there because he opened the door to tell us he needed a towel. LVN A stated later in the day she noticed the bruise to Resident #8's right eye. She stated when she first interviewed him and filled out the incident report, he told her he did not know how it happened. She stated later when she spoke to him about it again, he told her the shower head fell on his eye. LVN A stated she forgot to document that conversation anywhere. She stated when a resident's property went missing the procedure was to report to DON and ADM. LVN A stated she had been trained on this procedure probably every month. She stated she heard about Resident #30's missing ring when ADM was asking staff if they had seen the ring. LVN A stated a possible negative outcome of not reporting residents missing property was, This is their home and if we don't report it, and it is valuable to the resident, they will feel neglected that we didn't do anything about it. During an interview on 08/07/25 at 09:46 PM DON stated she expects her staff to report injuries of unknown origin and missing resident property to her. She stated, We investigate it. She stated staff had been trained on these reporting procedures at hire and about every 6 months during in-services. She stated she did not think there was a negative outcome to a resident if an injury of unknown origin was not reported to the state. She stated Resident #8 was in the shower with an aide and the aide believed he hit himself with the shower head. She stated she was not sure which aide was with him in the shower. DON stated it was not okay for staff to assume what happened with an injury of unknown origin. She stated Resident #8 told her the shower head bruised his eye. When asked where she documented that conversation she stated, I haven't completed his note on his event report yet, but it would be in there. DON stated she did not know of a possible negative outcome of not reporting resident's missing property to the state. She stated Resident #30's family member told her about the missing diamond ring. She stated ADM was notified and he investigated. DON stated ADM wrote a grievance regarding the ring and that was why it was not reported to the state. DON stated ADM was usually responsible for reporting incidents to the state. During an interview on 08/07/25 at 09:59 AM MDS LVN stated she had been trained 3-4 times a year on reporting injuries of unknown origin and missing resident property. She stated a resident could be negatively impacted if an injury of unknown origin was not reported. MDS LVN stated, It could affect their health, it could affect their mobility. She stated staff might not give proper care to the resident if they were unaware of the injury. MDS LVN stated if a resident's missing property was reported to her, she would tell DON and ADM. She stated there was a clause in the admission packet that stated the facility was not responsible for lost or stolen property. She stated at admission the residents and families were encouraged not to bring items of value to the facility. She stated if misappropriation of resident property was not reported the resident and the family could be upset. She stated Resident #30's family member reported the missing diamond ring to her and she immediately let DON and ADM know. She stated she and ADM went to Resident #30's room and began to search everywhere for the ring. MDS LVN stated ADM and DON were responsible for reporting misappropriated resident property to the state. During an interview on 08/07/25 at 10:33 AM ADM stated he expected his staff to report injuries of unknown origin and missing resident property to him or the charge nurse. He stated staff were trained on reporting procedure at hire and biannually. He stated he would not speculate on something that had not happened. ADM stated Resident #8 was fine when he went into the shower and had a black eye when he came out. He stated he would speculate on that because Resident #8 was tall and the shower head is right there, and he probably turned and bumped his head on it (the shower head). He stated he looked for Resident #30's ring and wrote a grievance. ADM stated he spoke to staff who worked the days the ring disappeared, but he did not document any of those conversations or his search for the ring. He stated he called the owner of the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Hereford Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 231 Kingwood St Hereford, TX 79045	
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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	local pawn shop and described the ring and asked for a call if it came into the pawn shop, but he did not document his call to the pawn shop. He stated he told Resident #30's family member to file a police report. ADM stated he did not know he was supposed to report Resident #8's black eye and Resident #30's missing ring to the state. ADM stated, Do I need to report it when a resident loses their glasses? Because glasses cost a lot more than that diamond ring, I guarantee. He stated he was responsible for reporting incidents to the state. During exit conference on 08/07/25 at 01:35 PM after preliminary findings were read, ADM stated, I guess I'll start reporting lost pajamas and lost glasses, then. Record review of facility policy titled Abuse/Neglect and dated 11/15/2016 revealed the following: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. Misappropriation of resident property: means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Injury of Unknown Source any injury to a resident where: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and The injury is suspicious because of the extent of the injury or the location of the injury. All reports of abuse or suspicion of abuse/neglect or potentially criminal behavior will be investigated as per facility protocol. Investigations will be reviewed by the facility administrator and/or Abuse Preventionist within 24 hours of complaint. Appropriate notification to state and home office will be the responsibility of the administrator and per policy. The facility will be responsible to identify, correct, and intervene in situations of possible abuse/neglect. The facility has in place a method to identify events such as suspicious bruising of residents. Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report the allegation to HHSC. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation. Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist. All allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injuries of unknown source will be investigated. 1. The administrator in consultation with the Risk Management Department will be responsible for investigating and reporting cases to the HHSC. The Abuse Preventionist and/or administrator will conduct a thorough investigation of the incident(s).		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Hereford Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 231 Kingwood St Hereford, TX 79045	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 2 (Resident #8 and Resident #30) of 15 residents reviewed for reporting abuse, neglect, exploitation, and misappropriation of resident property.1. The facility failed to report Resident #8's black eye to state authorities.2. The facility failed to report Resident #30's missing diamond ring to state authorities. These failures could place residents at risk of continued abuse/misappropriation of property in the facility. Findings Included: 1. Record review of Resident #8's admission record dated 08/06/25 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning) and dementia (a group of thinking and social symptoms that interferes with daily functioning) in other diseases classified elsewhere mild with mood disturbance. Record review of Resident #8's quarterly MDS completed on 06/16/25 revealed a BIMS score of 8 which indicated moderate cognitive impairment. Resident #8 was noted to require setup or clean-up assistance or supervision/touching assistance across all ADLs. Record review of Resident #8's care plan completed on 06/17/25 revealed he was not able to measure his pain on a pain scale from 0-10 due to cognitive impairment and he had limited physical mobility. Resident #8 was noted to have Dementia with cognitive impairment as evidence by: Memory problems. Record review of Resident #8's orders revealed the following: Aspirin EC Tablet Delayed Release 81 MG (Aspirin) Give 1 tablet by mouth one time a day related to ACUTE COMBINED SYSTOLIC (CONGESTIVE) AND DIASTOLIC (CONGETSTIVE) HEART FAILURE. with start date of 11/27/24. Clopidogrel Bisulfate Tablet 75 MG Give 1 tablet by mouth one time a day for blood clot prevention related to ACUTE COMBINED SYSTOLIC (CONGESTIVE) AND DIASTOLIC (CONGESTIVE) HEART FAILURE. with start date of 11/27/24. Record review of Resident #8's progress notes from 07/07/25 to 08/07/25 revealed the following note written by LVN D on 07/31/25 at 12:41 PM: [Initials of dialysis center] called concerning black eye to resident explained it was from a shower head that fell onto his eye. Further review revealed no other progress notes were found pertaining to the black eye. Record review of incident by incident report for May-July of 2025 revealed Resident #8 had a bruise incident on 07/30/25. Record review of incident report found in EHR under Clinical and Risk Management revealed the following: . Bruise Date 7/30/2025 11:00 (AM) Resident: [Name of Resident #8] Incident Location: Shower Person Preparing Report: [Name of LVN A] Incident Description Nursing Description: Resident noticed with a bruise to right eye underneath. Resident noted earlier was self showering in shower and then noted with bruise. Resident denies falling. No other injuries noted. Resident Description: I don't know Was this incident witnessed: N . Description: Resident noted to go in shower and shower self, Showerhead is a removeable sprayer and comes off the wall. Injuries Observed at Time of Incident Injury Type Bruise Injury Location 4) Face Level of Pain: Numerical: 0 . Mental Status Lack of Safety Awareness . Agencies/People Notified Physician . 7/30/2025 11:05 (AM) DON/RN . 7/30/25 15:49 (03:49 PM) Family Member . 7/30/2025 11:10 (AM) During an observation and interview on 08/06/25 at 09:18 AM LVN A stated when a resident has an injury nurses document in the EHR under Clinical and Risk Management. She demonstrated how to (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Hereford Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 231 Kingwood St Hereford, TX 79045	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	find incident reports in the EHR.During an observation and interview on 08/06/25 at 09:45 Resident #8 was standing near the nurses' station. He had fading, yellowish, green bruising approximately the size of a quarter underneath his right eye. He stated no one hit him. When asked about the bruise he stated a garlic was growing above his right eyebrow (gestured to the area) and it slid down his face. He also mentioned that his right ear was falling. When asked directly if a shower head had fallen on his eye, he stated it had not.2. Record review of Resident #30's admission record dated 08/06/25 revealed a [AGE] year-old female most recently admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), and other signs and symptoms involving cognitive functions and awareness.Record review of Resident #30's admission MDS completed on 07/15/25 revealed a BIMS score of 10 which indicated moderately impaired cognition.Record review of Resident #30's care plan completed on 07/15/25 revealed she had impaired communication due to cognitive impairment. Resident #30 was noted to have dementia with cognitive impairment Record review of Resident #30's progress notes from 07/06/25 to 08/06/25 revealed no mention of her missing diamond ring. It did reveal the following progress note written by LVN D on 08/02/25 at 09:06 AM: resident is slapping and hitting staff and other residents. making accusations that staff and other residents are stealing her stuff.Record review of incident by incident report for May-July 2025 revealed no mention of Resident #30's ring or any incident of misappropriation of resident property.Record review of grievance for the last three months revealed a grievance written by ADM on 07/28/25 regarding Resident #30's missing ring.During an observation and interview on 08/05/25 at 11:06 AM Resident #30 wheeled herself in her wheelchair down the hall to speak to this surveyor. She stated she had a diamond ring stolen. She stated it was a diamond solitaire and it was given to her by a family member. She stated she did not know who took it but she did know it was missing.During an interview on 08/05/25 at 02:49 PM Resident #30's family member stated Resident #30's diamond solitaire ring disappeared on 07/28/25. He stated the ring was on her finger and in a ring keeper with her two wedding diamond rings and a gold band. He stated the ring keeper was a plastic ring that went through all of her rings to keep them together and on her finger.During an observation and interview on 08/06/25 at 10:21 AM Resident #30 was seated in her wheelchair at the nurses' station. She had a gold band and a larger silver ring with purple stones in it on her finger but no ring keeper. She stated the ring with the purple stones was fake. She stated she was very sad her diamond ring had been stolen.During an interview on 08/06/25 at 10:33 AM Resident #30's family member stated after her diamond solitaire ring was stolen, he cut the ring protector and took her other two diamond rings home leaving her with the gold band only. He stated the silver ring with the purple stones was his way of giving her something pretty to wear that was not valuable. He stated he visited Resident #30 on 07/26/25 and her diamond solitaire ring was on her finger with her other rings inside the ring keeper. He stated he visited her on 07/28/25 and the ring was not on her finger, but the other three rings (gold band and two wedding diamond rings) were still inside the ring keeper on her finger. He stated someone would have had to cut the band of the diamond solitaire ring to get it out of the ring keeper and off her finger. He stated as soon as he noticed the diamond solitaire ring was missing, he told MDS LVN and she went and got [first name of ADM]. He stated ADM called the owner of the local pawn shop regarding Resident #30's missing ring.During an interview on 08/07/25 at 09:46 PM DON stated she did not think there was a negative outcome to a resident if an injury of unknown origin was not reported to the state. DON stated she did not know of a possible negative outcome of not reporting resident's missing property to the state. DON stated ADM wrote a grievance regarding the ring and that was why it was not reported to the state. DON stated ADM was usually responsible for reporting incidents to the state.During an interview on 08/07/25 at 09:59 AM MDS LVN stated Resident #30's family member reported the missing diamond ring to her and she immediately let DON and ADM know. She stated ADM and DON were responsible for reporting (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Hereford Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 231 Kingwood St Hereford, TX 79045	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	misappropriated resident property to the state. During an interview on 08/07/25 at 10:33 AM ADM stated Resident #8 was fine when he went into the shower and had a black eye when he came out. He stated, I will speculate on that. ADM stated Resident #8 was tall and the shower head is right there, and he probably turned and bumped his head on it (the shower head). He stated he looked for Resident #30's ring and wrote a grievance. He stated he told Resident #30's family member to file a police report. ADM stated he did not know he was supposed to report Resident #8's black eye and Resident #30's missing ring to the state. ADM stated, Do I need to report it when a resident loses their glasses? Because glasses cost a lot more than that diamond ring, I guarantee. He stated he was responsible for reporting incidents to the state. During exit conference on 08/07/25 at 01:35 PM after preliminary findings were read, ADM stated, I guess I'll start reporting lost pajamas and lost glasses, then. Record review of facility policy titled Abuse/Neglect and dated 11/15/2016 revealed the following: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Misappropriation of resident property: means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Injury of Unknown Source any injury to a resident where: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and The injury is suspicious because of the extent of the injury or the location of the injury. Appropriate notification to state and home office will be the responsibility of the administrator and per policy. The facility will be responsible to identify, correct, and intervene in situations of possible abuse/neglect. The facility has in place a method to identify events such as suspicious bruising of residents. Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services. Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report the allegation to HHSC. If the allegation does not involve abuse or serious bodily injury, the report must be made within 24 hours of the allegation. 1. The administrator in consultation with the Risk Management Department will be responsible for investigating and reporting cases to the HHSC.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Hereford Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 231 Kingwood St Hereford, TX 79045	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to, in response to allegations of abuse, neglect, exploitation, or mistreatment, have evidence that all alleged violations are thoroughly investigated for 2 (Resident #8 and Resident #30) of 15 residents reviewed for investigating abuse, neglect, exploitation, and misappropriation of resident property.1. The facility failed to complete a thorough investigation of Resident #8's injury of unknown source (black eye).2. The facility failed to complete a thorough investigation of misappropriation of Resident #30's property (missing diamond ring).These failures could place residents at risk of continued abuse/misappropriation of property in the facility.Findings Included:1. Record review of Resident #8's admission record dated 08/06/25 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning) and dementia (a group of thinking and social symptoms that interferes with daily functioning) in other diseases classified elsewhere mild with mood disturbance.Record review of Resident #8's quarterly MDS completed on 06/16/25 revealed a BIMS score of 8 which indicated moderate cognitive impairment. Resident #8 was noted to require setup or clean-up assistance or supervision/touching assistance across all ADLs.Record review of Resident #8's care plan completed on 06/17/25 revealed he was not able to measure his pain on a pain scale from 0-10 due to cognitive impairment and he had limited physical mobility. Resident #8 was noted to have Dementia with cognitive impairment as evidence by: Memory problems.Record review of Resident #8's orders revealed the following: Aspirin EC Tablet Delayed Release 81 MG (Aspirin) Give 1 tablet by mouth one time a day related to ACUTE COMBINED SYSTOLIC (CONGESTIVE) AND DIASTOLIC (CONGETSTIVE) HEART FAILURE. with start date of 11/27/24. Clopidogrel Bisulfate Tablet 75 MG Give 1 tablet by mouth one time a day for blood clot prevention related to ACUTE COMBINED SYSTOLIC (CONGESTIVE) AND DIASTOLIC (CONGESTIVE) HEART FAILURE. with start date of 11/27/24.Record review of Resident #8's progress notes from 07/07/25 to 08/07/25 revealed the following note written by LVN D on 07/31/25 at 12:41 PM: [Initials of dialysis center] called concerning black eye to resident explained it was from a shower head that fell onto his eye.Further review revealed no other progress notes were found pertaining to the black eye.Record review of incident by incident report for May-July of 2025 revealed Resident #8 had a bruise incident on 07/30/25.Record review of incident report found in EHR under Clinical and Risk Management revealed the following: . Bruise Date 7/30/2025 11:00 (AM)Resident: [Name of Resident #8]Incident Location: ShowerPerson Preparing Report: [Name of LVN A]Incident DescriptionNursing Description: Resident noticed with a bruise to right eye underneath. Resident noted earlier was self showering in shower and then noted with bruise. Resident denies falling. No other injuries noted.Resident Description: I don't knowWas this incident witnessed: N .Description: Resident noted to go in shower and shower self, Showerhead is a removeable sprayer and comes off the wall.Injuries Observed at Time of IncidentInjury Type BruiseInjury Location 4) FaceLevel of Pain:Numerical: 0 .Mental Status Lack of Safety Awareness .Agencies/People NotifiedPhysician . 7/30/2025 11:05 (AM)DON/RN . 7/30/25 15:49 (03:49 PM)Family Member . 7/30/2025 11:10 (AM)During an observation and interview on 08/06/25 at 09:18 AM LVN A stated when a resident has an injury nurses document in the EHR under Clinical and Risk Management. She demonstrated how to find incident reports in the EHR.During an observation and interview on 08/06/25 at 09:45 Resident #8 was standing near the nurses' station. He had fading, yellowish, green bruising approximately the size of a quarter underneath his right eye. He stated no one hit him. When asked about the bruise he stated a garlic was growing above his right eyebrow (gestured to the area) and it slid down his face. He also mentioned that his right ear was falling. When asked directly if a shower head had fallen on his eye, he stated it had not.2. Record review of Resident #30's admission record dated 08/06/25 revealed a (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Hereford Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 231 Kingwood St Hereford, TX 79045	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[AGE] year-old female most recently admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), and other signs and symptoms involving cognitive functions and awareness. Record review of Resident #30's admission MDS completed on 07/15/25 revealed a BIMS score of 10 which indicated moderately impaired cognition. Record review of Resident #30's care plan completed on 07/15/25 revealed she had impaired communication due to cognitive impairment. Resident #30 was noted to have dementia with cognitive impairment. Record review of Resident #30's progress notes from 07/06/25 to 08/06/25 revealed no mention of her missing diamond ring. It did reveal the following progress note written by LVN D on 08/02/25 at 09:06 AM: resident is slapping and hitting staff and other residents. making accusations that staff and other residents are stealing her stuff. Record review of incident by incident report for May-July 2025 revealed no mention of Resident #30's ring or any incident of misappropriation of resident property. Record review of grievance for the last three months revealed a grievance written by ADM on 07/28/25 regarding Resident #30's missing ring. During an observation and interview on 08/05/25 at 11:06 AM Resident #30 wheeled herself in her wheelchair down the hall to speak to this surveyor. She stated she had a diamond ring stolen. She stated it was a diamond solitaire and it was given to her by a family member. She stated she did not know who took it but she did know it was missing. During an interview on 08/05/25 at 02:49 PM Resident #30's family member stated Resident #30's diamond solitaire ring disappeared on 07/28/25. He stated the ring was on her finger and in a ring keeper with her two wedding diamond rings and a gold band. He stated the ring keeper was a plastic ring that went through all of her rings to keep them together and on her finger. During an observation and interview on 08/06/25 at 10:21 AM Resident #30 was seated in her wheelchair at the nurses' station. She had a gold band and a larger silver ring with purple stones in it on her finger but no ring keeper. She stated the ring with the purple stones was fake. She stated she was very sad her diamond ring had been stolen. During an interview on 08/06/25 at 10:33 AM Resident #30's family member stated after her diamond solitaire ring was stolen, he cut the ring protector and took her other two diamond rings home leaving her with the gold band only. He stated the silver ring with the purple stones was his way of giving her something pretty to wear that was not valuable. He stated he visited Resident #30 on 07/26/25 and her diamond solitaire ring was on her finger with her other rings inside the ring keeper. He stated he visited her on 07/28/25 and the ring was not on her finger, but the other three rings (gold band and two wedding diamond rings) were still inside the ring keeper on her finger. He stated someone would have had to cut the band of the diamond solitaire ring to get it out of the ring keeper and off her finger. He stated as soon as he noticed the diamond solitaire ring was missing, he told MDS LVN and she went and got [first name of ADM]. He stated ADM called the owner of the local pawn shop regarding Resident #30's missing ring. During an interview on 08/07/25 at 09:29 AM LVN A stated she did not see the shower head fall on Resident #8's eye. She stated Resident #8 had been in the shower by himself. She stated, When staff are not looking, he will go in there by himself to shower and we knew he was in there because he opened the door to tell us he needed a towel. LVN A stated later in the day she noticed the bruise to Resident #8's right eye. She stated when she first interviewed him and filled out the incident report, he told her he did not know how it happened. She stated later when she spoke to him about it again, he told her the shower head fell on his eye. LVN A stated she forgot to document that conversation anywhere. During an interview on 08/07/25 at 09:46 PM DON stated she expects her staff to report injuries of unknown origin and missing resident property to her. She stated, We investigate it. She stated Resident #8 was in the shower with an aide and the aide believed he hit himself with the shower head. She stated she was not sure which aide was with him in the shower. DON stated it was not okay for staff to assume what happened with an injury of unknown origin. She stated Resident #8 told her the shower head bruised his eye. When asked where she documented that conversation she (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Hereford Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 231 Kingwood St Hereford, TX 79045	
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated, I haven't completed his note on his event report yet, but it would be in there. She stated staff were to report missing resident property to her and we do an investigation. Seh stat4ed Resident #30's family member told her about the missing diamond ring. She stated ADM was notified and he investigated. DON stated ADM wrote a grievance regarding the ring.During an interview on 08/07/25 at 09:59 AM MDS LVN stated Resident #30's family member reported the missing diamond ring to her and she immediately let DON and ADM know. She stated she and ADM went to Resident #30's room and began to search everywhere for the ring. During an interview on 08/07/25 at 10:33 AM ADM stated Resident #8 was fine when he went into the shower and had a black eye when he came out. He stated Resident #8 was tall and the shower head is right there, and he probably turned and bumped his head on it (the shower head). He stated he looked for Resident #30's ring and wrote a grievance. ADM stated he spoke to staff who worked the days the ring disappeared, but he did not document any of those conversations or his search for the ring. He stated he called the owner of the local pawn shop and described the ring and asked for a call if it came into the pawn shop, but he did not document his call to the pawn shop. He stated he told Resident #30's family member to file a police report. Record review of facility policy titled Abuse/Neglect and dated 11/15/2016 revealed the following: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation . The facility will provide and ensure the promotion and protection of resident rights. It is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property abuse and situations that may constitute abuse or neglect to any resident in the facility. Misappropriation of resident property: means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Injury of Unknown Source any injury to a resident where: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and The injury is suspicious because of the extent of the injury or the location of the injury . All reports of abuse or suspicion of abuse/neglect or potentially criminal behavior will be investigated as per facility protocol. Investigations will be reviewed by the facility administrator and/or Abuse Preventionist within 24 hours of complaint. Comprehensive investigations will be the responsibility of the administrator and/or Abuse Preventionist. All allegations of abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property and injuries of unknown source will be investigated. 1. The administrator in consultation with the Risk Management Department will be responsible for investigating and reporting cases to the HHSC. The Abuse Preventionist and/or administrator will conduct a thorough investigation of the incident(s).		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Hereford Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 231 Kingwood St Hereford, TX 79045	
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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete a significant change assessment within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition for 2 (Resident #4 and Resident #39) of 15 residents reviewed for timing of assessments.1. The facility failed to complete Resident #4's significant change MDS within 14 days of her admission to hospice care on 07/16/25.2. The facility failed to complete Resident #39's significant change MDS within 14 days of her admission to hospice care on 12/26/24.These failures could place residents at risk of not receiving necessary care/coordination of care.Findings Included:1. Record review of Resident #4's admission record dated 08/06/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Alzheimer's disease. Her admission record did not mention hospice.Record review of Resident #4's significant change MDS assessment completed on 08/05/25 revealed a BIMS score of 3 which indicated severely impaired cognition. Resident #4 was noted to be receiving hospice care While a Resident. The RN signature at Z0500 which indicated the assessment was complete was DON's signature.Record review of Resident #4's care plan completed on 05/14/25 revealed Resident #4 was on hospice and required hospice as evidenced by terminal illness.Record review of Resident #4's order summary dated 08/06/25 revealed no mention of hospice.Record review of Resident #4's hospice paperwork under the miscellaneous tab in her EHR revealed a certification for hospice care signed by her physician on 07/14/25 with an election date and effective date of 07/16/25. A voice order for hospice care was noted from Resident #4's attending physician on 07/16/25 at 09:30 AM.2. Record review of Resident #39's admission record dated 08/06/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Alzheimer's disease, anxiety disorder, and Parkinsonism. Her admission record revealed her primary payer was Hospice Medicaid and listed the name of her hospice care provider.Record review of Resident #39's quarterly MDS completed 07/23/25 revealed a BIMS of 3 which indicated severely impaired cognition. Resident #39 was noted to be receiving hospice care While a Resident. The RN signature at Z0500 which indicated the assessment was complete was DON's signature.Record review of Resident #39's significant change MDS completed on 01/20/25 revealed a BIMS of 3 which indicated severely impaired cognition. Resident #39 was noted to be receiving hospice care While a Resident. The RN signature at Z0500 which indicated the assessment was complete was DON's signature.Record review of Resident #39's care plan completed on 06/03/25 revealed she required hospice as evidence by terminal illness.Record review of Resident #39's order summary dated 08/06/25 revealed one mention of hospice as noted in the following order: Ativan Oral Tablet 0.5 MG (Lorazepam) Give 0.5 mg by mouth every 4 hours as needed for anxiety/hospice related to ANXIETY DISORDER, UNSPECIFIED (F41.9) for 365 Days. Start date of order was 07/30/25.Record review of Resident #39's hospice paperwork under the miscellaneous tab in her EHR revealed a certification for hospice care with an election date of 12/26/24 and effective date of 12/26/24. A voice order for hospice care was noted from Resident #39's attending physician on 12/26/24 at 10:00 AM.During an interview on 08/07/25 at 09:29 AM LVN A stated MDS LVN was responsible for completing MDS assessments timely. She stated a possible negative outcome of a MDS assessment not being completed timely was staff would not have the correct information regarding resident care.During an interview on 08/07/25 at 09:46 AM DON stated MDS LVN was responsible for completing MDS assessments timely. She stated she (DON) signed off on the assessments as complete because she was an RN. DON stated MDS LVN sent her (DON) an email or came to her (DON's) office to let her know which MDS assessments were ready to be signed as completed. She stated she did not know why Resident #4 and Resident #39's significant change assessments were not signed as completed within the 14-day time frame provided by the RAI manual. She stated she could not think of a negative outcome to a (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Hereford Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 231 Kingwood St Hereford, TX 79045	
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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident if a significant change MDS was not completed timely. She stated it would affect facility funding which could, in turn, affect resident care negatively. During an observation and interview on 08/07/25 at 09:59 MDS LVN stated she was responsible for ensuring MDS assessments were completed timely. She stated the policy she followed when completing MDS assessments was the RAI. MDS LVN stated residents could be negatively impacted if a significant change MDS was not completed timely. She stated staff's ability to give the proper care to that resident could be negatively impacted. MDS LVN stated when an MDS assessment was ready for DON's signature she would let DON know. She demonstrated how DON could go into EHR and see which assessments were ready for her signature. MDS LVN stated she believed Resident #4 and Resident #39's significant change MDS assessments were completed timely. She stated the work for the assessments was completed within the 14 days allowed and it did not matter what date DON signed the assessments as complete. During an interview on 08/07/25 at 10:33 AM ADM stated MDS LVN was responsible for ensuring MDS assessments were completed timely. He stated, I'm not gonna speculate on what didn't happen regarding a possible negative outcome for residents when MDS assessments were not completed timely. Record review of the Long-Term Care Facility RAI 3.0 User's Manual Version 1.18.11 dated October 2023 revealed a chart on page 38 with the following: Assessment Type. Significant Change. MDS Completion Date. no later than 14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days). Significant Change in Status Assessment . Must be completed (item Z0500B) within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Hereford Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 231 Kingwood St Hereford, TX 79045	
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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and 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 3 of 15 residents (Residents #37, #35, and #40) reviewed for infection control. CNA C failed to utilize clean gloves while performing incontinence care for Resident #37. LVN D failed to disinfect the blood pressure cuff between uses for Resident #35 and Resident #40. These failures could place residents at risk for cross contamination and infection. The findings included: 1. Resident #37 Record review of Resident #37 undated face sheet revealed a [AGE] year-old female originally admitted on [DATE]. Resident #37 had a medical history of type two diabetes, muscle weakness, and chronic kidney disease. Record review of Resident #37's annual MDS dated [DATE] revealed the following: *Section C- Cognitive Patterns, revealed a BIMS score of 13, which indicated Resident #37 was cognitively intact. *Section H- Bladder and bowel revealed resident was frequently incontinent of bowel and bladder. During an incontinence care observation on 8/05/2025 at 11:10 AM, CNA C placed a bag of clean wipes and clean gloves on a table in Resident #37's room. CNA C proceeded with incontinence care for Resident #37's and reached into the clean bag with contaminated gloves to grab the wipes. While reaching into the clean bag with contaminated gloves, CNA C picked up the clean gloves with the contaminated gloves and placed them back into the bag. CNA C changed gloves, washed her hands with soap and water, and donned on contaminated gloves from the bag and finished incontinence care for Resident #37. During an interview on 8/6/2025 at 1:54pm with CNA C, she stated the infection preventionist was the DON. She stated she had been trained on infection control and her last training was approximately a month ago. She stated she had been trained to change her gloves during incontinence care. She stated if clean gloves were touched with contaminated gloves, those gloves should be thrown away and new ones should be used. She stated she did not notice she had grabbed the clean gloves with contaminated gloves, she believed she had only grabbed the wipes. She stated the potential negative outcome of using contaminated gloves during incontinence care could be spreading infection. She stated they had been trained to put the clean gloves and wipes in one bag and the clean brief in another bag. 2. During a medication administration observation on 8/6/2025 at 8:05AM LVN D used a blood pressure cuff to take Resident #35's blood pressure. At 8:16 AM, LVN D used the same blood pressure cuff to take Resident #40's blood pressure. No sanitation of equipment was conducted before or after using the blood pressure cuff on Resident #35 or Resident #40. During an interview on 8/6/2025 at 1:39pm with LVN D she stated she had been trained on infection control and her last training was this past summer. She stated the infection preventionist was the DON. She stated she had been trained to disinfect the blood pressure cuff between residents. She stated the potential negative outcome of not disinfecting the blood pressure cuff before and after use could be spreading skin disease, cold, flu, bacteria or viruses. She stated she did not disinfect the blood pressure because she had a bad habit of not doing so. During an interview on 8/7/2025 at 9:54AM with the ADM, he stated the DON was the infection preventionist. He stated infection control was monitored by doing walkarounds and having staff do return demonstrations. He stated staff are also in-service on infection control and the last in-service was last month. He stated staff are trained to place a set of gloves with one bag with the wipes and then another set of gloves with the clean brief, that way they stay clean in between glove changes. He stated he was not aware of staff mixing clean gloves with contaminated gloves. The ADM stated staff had been trained on disinfecting the blood pressure cuff after each use. He stated that his expectation was for staff to disinfect the blood pressure cuff after use, with the appropriate wipes and allow the blood pressure cuff to dry completely before using on another resident. He stated his expectations of staff are to follow the policy. He stated the potential negative outcome of not following infection control practices could be (continued on next page)		

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: 675868	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Hereford Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 231 Kingwood St Hereford, TX 79045	
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 - Few	possible infections. During an interview on 8/07/2025 at 10:08 AM with the DON, she stated she was the infection preventionist. She stated staff are trained on infection control twice a year and yearly through competencies. She stated the last training was on 7/01/2025. She stated she was not aware staff was contaminating clean gloves during incontinence care. She stated staff are trained to have two bags, one with the wipes and one with the gloves that way after they change their gloves and wash their hands, they can don clean gloves. She stated staff have been trained to disinfect the blood pressure cuff after each resident use. She stated she was not aware staff had not been disinfecting the blood pressure cuff after using it on residents. She stated the potential negative outcome of staff not following infection control could be cross contamination and risk for infection. Record review of undated facility policy titled Remember Care begins and Ends with Washing your hands revealed; 2. Gather supplies, keeping the blue gloves and clean brief in the bag by themselves.If contamination occurs while performing the skill, start over from the very beginning. If contamination of your work area occurs, start over from the beginning.Bag 1: Blue gloves, brief. Bag 2: Wipes, gloves (4-5[pair]), towel/blue pad. Record review of facility policy titled Infection Control- Precautions- Categories and Notices effective date 12/2017, revealed; f. Resident- Care Equipment.If use of common items is unavoidable, the adequately clean and disinfect them before use for another resident.		