STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E004	A. Building B. Wing	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedford CO Nursing Home	1229 County Farm Road Bedford, VA 24523

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of practice during a medication pass on one of three units (100 unit). The findings include: A nurse documented that the medication Eliquis was administered to Resident #61 (R61) during an 8:00 a.m. medication pass when the medicine was omitted. The Eliquis was not administered to Resident #61 until 8/15/23 at 9:20 a.m. A medication pass observation was conducted 8/15/23 at 7:57 a.m., with licensed practical nurse (LPN #2) administering medications to R61. The medication Eliquis was omitted and not administered to R61 during the 8:00 a.m. medication pass. R61's clinical record documented a physician's order dated 7/3/23 for Eliquis 5 mg to be administered twice per day (at 8:00 a.m. and 8:00 p.m.) due to personal history of pulmonary embolism. On 8/15/23 at 8:53 a.m., LPN #2 was interviewed about the omitted Eliquis during R61's 8:00 a.m. medication pass. LPN #2 stated the Eliquis was not in the medication cart. LPN #2 stated that she had not yet checked to see if the medicine was available in the back-up supply. On 8/15/23 at 9:00 a.m., R61's medication administration record (MAR) was reviewed to determine the if there was an alternate time scheduled for the Eliquis administration. Upon this MAR review, R61's Eliquis was already signed off as given on 8/15/23 at 8:00 a.m. On 8/15/23 at 9:14 a.m., LPN #2 was asked if she had administered the Eliquis since it was signed off on the MAR. LPN #2 stated that she had not administered the Eliquis because she had not yet checked the back-up supply. When asked why the medicine had already been signed off on the MAR as given, LPN #2 stated, I might have signed it off by mistake. LPN #2 stated if the medicine was not in the back-up supply, she would take that off the MAR. On 8/15/23 at 9:20 a.m., LPN #2 went to the back-up supply, obtained a 5 mg dose of Eliquis and administered the Eliquis to R#61. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/23 at 1:30 p.m., the director of nursing (DON) was interviewed about LPN #2 documenting the Eliquis as administered when it had not actually been given. The DON stated that the medication record should not have been signed off until after the medication was given. The DON stated that the Eliquis should have been obtained from the back-up supply, administered as scheduled at 8:00 a.m., and documentation made after giving the medicine. On 8/15/23 at 2:30 p.m., the DON stated she checked R61's electronic health record and LPN #2 signed off the MAR indicating the Eliquis was administered on 8/15/23 at 8:20 a.m. The facility's policy titled Administering Medications (revised April 2019) documented, Medications are administered in a safe and timely manner, and as prescribed .The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones .As required or indicated for a medication, the individual administering the medication records in the resident's medical record .The date and time the medication was administered . The Lippincott Manual of Nursing Practice 11th edition documents on page 15 that common departures from standards of care include, .Failure to administer medications properly and in a timely fashion or to report and administer omitted doses appropriately . (1) These findings were reviewed with the administrator and director of nursing during a meeting on 8/15/23 at 3:30 p.m. with no other information provided prior to the end of the survey. (1) Nettina, [NAME] M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/[NAME] & [NAME], 2019.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview, and clinical record review, the facility staff failed to follow physician orders for one of twenty-four residents in the survey sample (Resident #10). The findings include: Resident #10 (R10) was observed during dining without food items cut in bite-sized pieces as ordered by the physician. R10 was admitted to the facility with diagnoses that included multiple sclerosis, dysphagia, dementia, psychotic disturbance, affective mood disorder, anxiety, depression, bipolar disorder, hypertension, history of urinary tract infections and history of COVID-19. The minimum data set (MDS) dated [DATE] assessed R10 with severely impaired cognitive skills. R10's clinical record documented a nursing note on 3/15/23 stating, Resident choking and coughing with each bite of food .MD .notified of choking episode, order to continue mechanical soft diet but cut meals into bite sized pieces. A physician's progress note dated 3/15/23 documented, Seen today for choking. Speech therapist witnessed him choking repeated on a 'honeybun' at breakfast .Patient with no c/o [complaints] but does not understand what I'm asking . Other staff report he can eat an egg salad sandwich without difficulty, but apparently 'gobbles' large bite of honey bun leading to choking . combination problem of somewhat impaired swallowing with behavioral problem with continuing to stuff food in his mouth despite incomplete swallowing. Previous attempts to downgrade diet to pureed led to refusal to eat and precipitous weight loss .will continue mech [mechanical] soft diet, but cut all foods into small pieces; staff to support patient in regulating intake of bites until he has cleared his previous bite. R10's clinical record documented a physician's order dated 3/15/23 for regular mechanical soft diet with nectar thick liquids, fortified foods and instructions for small bite sized pieces. On 8/15/23 at 8:19 a.m., R10 was observed eating breakfast in the dining room with three staff members supervising/assisting residents with meals. R10 was holding and eating a half section of a cinnamon bun. The bun was not cut into bite sized pieces. On R10's plate was an egg sandwich and a Nutrigrain bar. The sandwich and the Nutrigrain bar were not cut into pieces. On 8/15/23 at 8:26 a.m., R10 had finished the cinnamon bun and a staff person was observed cutting the egg sandwich in half. R10 did not eat the sandwich or Nutrigrain bar during this meal observation. On 8/15/23 at 1:00 p.m., R10 was observed in the dining room finishing his lunch. R10's food items were not cut into bite sized pieces as ordered. On R10's plate was a partially eaten cinnamon bun and a minced chicken sandwich cut in half with potato tots. R10's meal tickets for the 8/15/23 breakfast and lunch included the instruction for, .Small bite sized pieces . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/23 at 1:03 p.m., the certified nurses' aide (CNA #1) caring for R10 and assisting residents in the dining room was interviewed. CNA #1 stated that she had cut the cinnamon buns in half and the Nutrigrain bar was usually cut in half. CNA #1 stated that R10 does good with it .he likes finger foods. CNA #1 stated R10 usually ate the cinnamon bun first with meals and that the foods were usually cut when served. On 8/15/23 at 1:09 p.m., the therapy director (other staff #1) was interviewed about R10. The rehab director stated a speech therapy evaluation was conducted on 3/31/23 and that R10 had been on the speech therapy caseload since then. On 8/15/23 at 2:12 p.m., the speech therapist (other staff #2) was interviewed about R10. The speech therapist stated R10 had been seen by speech since 3/31/23. The speech therapist stated that she had observed R10 eating a cinnamon bun with appropriate bite sizes and sufficient swallowing. The speech therapist stated that R10 had a history of dysphagia and the initial speech evaluation recommended the mechanical soft diet and nectar thick liquids but did not mention bite sized pieces. The speech therapist stated that the order for the bite sized pieces came from the provider and was not a recommendation from speech therapy. On 8/15/23 at 2:24 p.m., the director of nursing (DON) was interviewed about R10's order for bite sized food pieces. The DON stated the food items were supposed to be cut up per the physician's order. The DON stated the meal was supposed to match the meal ticket. The DON stated that staff assisting residents in the dining room were expected to cut food items as ordered. The DON stated R10 ate meals in the dining room with staff members present during meals. The DON stated R10 had experienced no further choking episodes since the 3/10/23 incident. On 8/16/23 at 8:09 a.m., the dietary manager (other staff #3) was interviewed. The dietary manager stated the kitchen provided the mechanical soft textured, hand-held food items per order but that staff serving the meals were expected to cut foods if needed. This finding was reviewed with the administrator and director of nursing during a meeting on 8/16/23 at 10:10 a.m. with no further information provided prior to the end of the survey.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28106 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure a medication error rate of less than five percent. Medication pass observations revealed four errors out of thirty three opportunities resulting in a 12.5% error rate. 1. Resident #69 (R69) Administration instructions were not followed, and the wrong dose of Flovent was administered. 2. Resident #61 (R61) extended release Metoprolol was crushed prior to administering, and Eliquis was not administered timely. The Findings Include: 1. During a medication pass and pour observation conducted on 815/23 at 8:00 AM, license practical nurse (LPN #1) began pulling medications out of the medication cart for R69 and handing the medications to this surveyor to document. One of the medications pulled from the medication cart was Flovent inhaler 44 MCG (micrograms). The label on the Flovent read Rinse and spit. LPN #1 administered Flovent to R69 and did not instruct R69 to rinse and spit after inhaling the medication. After the medication pass was completed with R69, LPN #1 was asked about instructing R69 to rinse and spit after administering the Flovent, pointing out the instructions written on the Flovent label. LPN #1 verbalized that she had forgotten to instruct R69 to rinse and spit. Physician's orders were then reviewed to verify accuracy of medications given. R69's Flovent order read in part Flovent inhaler; 110 mcg [.] 1 puff; inhalation diagnosis; Unspecified asthma [.]. On 8/15/23 at 9:09 AM, LPN #1 was interviewed regarding the discrepancy of the dose of Flovent given (44 MCG) and the dose ordered (110 MCG). LPN #1 reviewed the order then pulled the Flovent from the medication cart and agreed with the discrepancy. LPN #1 then reviewed the medication cart to see if there was another bottle of Flovent but did not find any other Flovent. LPN #1 said that the Flovent was what the pharmacy had sent and she would clarify with the physician. On 8/15/23 at 3:30 PM, the above information was presented to the director of nursing (DON) and administrator. A facility policy titled Administering Medications read in part: 10. The individual administering the medication checks the label THREE (3) [sic] times to verify the right resident, right medication, right dosage, right time and method of administration before giving the medication. No other information was presented prior to exit on 8/15/23. 21875 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Extended-release metoprolol was crushed prior to administration to Resident #61 (R61). The medication Eliquis, ordered to be administered at 8:00 a.m., was omitted during the medication pass and not administered until 9:20 a.m. A medication pass observation was conducted 8/15/23 at 7:57 a.m., with licensed practical nurse (LPN #2) administering medications to R61. Included in medications administered was a half tablet of metoprolol 25 milligrams (mg) extended-release (ER). The extended-release metoprolol was crushed with other oral medications and administered to R61. Instructions on the metoprolol pharmacy label stated, Do not crush. The medication Eliquis was omitted and not administered during the 8:00 a.m. medication pass. R61's clinical record documented a physician's order dated 7/3/23 for Eliquis 5 mg to be administered twice per day (at 8:00 a.m. and 8:00 p.m.) due to personal history of pulmonary embolism. R61's clinical record documented a physician's order dated 7/3/23 for metoprolol extended-release 24-hour, 12.5 mg orally once per at 8:00 a.m. for treatment of hypertension. The prescription order for the metoprolol extended-release documented not to crush the medication. On 8/15/23 at 8:15 a.m., LPN #2 was interviewed about crushing the extended-release metoprolol. LPN #2 stated, I crushed it with the other meds. LPN #2 stated that the pill was cut in half already from the pharmacy. On 8/15/23 at 8:53 a.m., LPN #2 was interviewed about the omitted Eliquis during R61's 8:00 a.m. medication pass. LPN #2 stated the Eliquis was not in the medication cart. LPN #2 stated that she had not checked yet to see if the medicine was available in the back-up supply. Review of R61's medication administration record (MAR) documented Eliquis 5 mg was administered on 8/15/23 at 8:00 a.m. On 8/15/23 at 9:14 a.m., LPN #2 was asked if she obtained and administered the Eliquis since it was signed off on the MAR. LPN #2 stated that she had not administered the Eliquis because she had not yet checked the back-up supply. At this time LPN #2 went to the back-up supply and obtained a 5 mg dose of Eliquis. LPN #2 administered the Eliquis to R61 on 8/15/23 at 9:20 a.m. LPN #2 offered no explanation of why the Eliquis was not retrieved and administered during the 8:00 a.m. medication pass. On 8/15/23 at 1:30 p.m., the director of nursing (DON) was interviewed about the late administration of Eliquis to R61. The DON stated medications were expected to be given within 60 minutes prior to or after the scheduled administration time. The DON stated the Eliquis should have been obtained from the back-up supply and administered as scheduled at 8:00 a.m. The facility's policy titled Administering Medications (revised April 2019) documented, .Medications are administered in accordance with prescriber orders, including any required time frame .Medication administration times are determined by resident need and benefit, not staff convenience .Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) . The Nursing 2022 Drug Handbook documents on page 971 regarding extended-release metoprolol, . Extended-release tablets may be cut in half on scored line, but never crushed or chewed . (1) (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nursing 2022 Drug Handbook documents on page 136 regarding administration of Eliquis, .Patient who doesn't take dose at the scheduled time should take the dose as soon as possible on the same day, then resume twice-daily administration . (1) These findings were reviewed with the administrator and director of nursing during a meeting on 8/15/23 at 3:30 p.m. with no other information presented prior to the end of the survey. (1) Woods, [NAME] Dabrow. Nursing 2022 Drug Handbook. Philadelphia: Wolters Kluwer, 2022.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on observation, staff interview, and clinical record review, the facility staff failed to provide an adaptive cup for one of twenty-four residents in the survey sample (Resident #180). The findings include: Resident #180 (R180) was not provided a two-handled sip cup as recommended by therapy and ordered by the physician. R180 was admitted to the facility with diagnoses that included Lewy body neurocognitive disorder, urinary tract infection, proctitis, anxiety, bipolar disorder, hypertension, asthma, depression and hypothyroidism. The minimum data set (MDS) dated [DATE] assessed R180 with moderately impaired cognitive skills and with limited/impaired vision. R180's clinical record documented a rehabilitation therapy order signed by the physician on 11/9/22 for adaptive equipment that included a two-handled mug for meals. On 8/16/23 at 8:12 a.m., R180 was in bed with her breakfast tray in front of her on the over-bed table. R180 had a single handled standard mug of orange juice. R10's meal ticket included instructions for a 2 Handle Sip Cup. There was no two-handled sip cup provided on the tray. On 8/16/23 at 8:18 a.m., the certified nurses' aide (CNA #1) caring for R180 was interviewed about the two-handled sip cup. CNA #1 stated that she usually set-up R10's tray, let the resident eat/do what she could for herself and provided assistance as needed. CNA #1 stated she was not aware of the requirement for a two-handled sip cup. CNA #1 stated, I don't know where that came from. On 8/16/23 at 8:25 a.m., the dietary manager (other staff #3) was interviewed about R180's two-handled sip cup. The dietary manager stated the adaptive cups were provided on the beverage cart during meals. The dietary manager stated the aides serving meal trays were responsible for pouring juices/drinks into the appropriate cups. The dietary manager went to the beverage cart on R180's unit and displayed that two-handled sip cups were available on the beverage cart. On 8/16/23 at 9:27 a.m., the therapy director (other staff #1) was interviewed about R180's adaptive cup. The therapy director reviewed R180's record and stated the adaptive cup was a recommendation from therapy, made in November 2022, for assistance with fluid intake, along with a segmented plate. R180's plan of care (revised 8/3/23) documented the potential for impaired nutrition related to dementia, encephalopathy, anxiety, and legal blindness, as well as the risk for weight loss due to poor intake. Interventions to maintain parameters of nutrition included providing adaptive equipment for meals as needed. This finding was reviewed with the administrator and director of nursing during a meeting on 8/16/23 at 10:10 a.m. with no further information presented prior to the end of the survey.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 21875 Based on facility document review and staff interview, the facility staff failed to submit payroll data prior to the deadline for quarter January 1 through March 31, 2023. The findings include: The PBJ (payroll-based journal) data report for the facility's fiscal year quarter 2 (1/1/23 through 3/31/23) documented no data regarding excessively low weekend staffing, RN (registered nurse) hours or licensed nursing coverage 24 hours per day. On 8/16/23 at 9:40 a.m., the business office manager (other staff #4) and the administrator were interviewed about the missing PBJ data for March quarter 2023. The business office manager stated she usually gathered data, placed in a zip file and then posted to the website. The business office manager stated when the posting was complete, she usually got a submission verification. The business office manager stated for March 2023 quarter, she did not get a submission confirmation after sending the data. The business office manager stated that she did not realize the data posting did not go through until after deadline for submission. The business office manager stated she attempted to call and submit the data after the cut-off date but was told there was no grace period. The business office manager stated the cut-off date was either 5/15/23 or 5/16/23. The business office manager stated she did not know why the submission did not process but was unable to resubmit the data because it was beyond the submission deadline. The administrator stated the initial data submission attempt was prior to the deadline and he did not know why the submission was not successful. This finding was reviewed with the administrator and director of nursing during a meeting on 8/16/23 at 10:10 a.m. with no other information presented prior to the end of the survey.