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 ______	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CO NURSING HOME	1229 COUNTY FARM ROAD BEDFORD, VA 24523

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicaid standard survey was conducted 6/20/17 through 6/22/17. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. No complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this ninety certified bed facility was 88 at the time of the survey. The survey sample consisted of fifteen current resident reviews (Residents 1 through 15) and three closed record reviews (Residents 16 through 18).	F 000		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 279		7/31/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/30/2017

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.

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 ______	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CO NURSING HOME	**1229 COUNTY FARM ROAD BEDFORD, VA 24523**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record	F 279	F0279 Comprehensive Care Plan	

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 ______	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CO NURSING HOME	1229 COUNTY FARM ROAD BEDFORD, VA 24523

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 2 review, the facility staff failed to develop a comprehensive care plan for one of 18 residents in the survey sample. Resident #1 had no care plan developed regarding impaired vision. The findings include: Resident #1 was admitted to the facility on 7/18/16 with diagnoses that included dementia, diabetes and high blood pressure. The minimum data set (MDS) dated 5/19/17 assessed Resident #1 with short and long-term memory problems and severely impaired cognitive skills. Section B1000 of Resident #1's MDS dated 5/19/17 indicated the resident had highly impaired vision and used corrective lenses. The care area assessment summary of this MDS included vision as a triggered care area requiring development of a care plan and indicated a decision by the facility to proceed with a plan of care for vision. Resident #1's plan of care (revised 6/1/17) included no problems, goals and/or interventions regarding impaired vision. The plan made no mention of the resident's need or use of glasses. On 6/21/17 at 1:30 p.m. the registered nurse (RN #1) responsible for care plan development was interviewed about Resident #1's care plan. RN #1 reviewed the care plan and stated she did not see anything on the plan about vision. On 6/21/17 at 1:45 p.m. RN #1 stated she checked with the social worker who completed the vision assessment and stated there should have been a plan developed addressing impaired vision. These findings were reviewed with the administrator and director of nursing on 6/21/17	F 279	Failure to double check CAA's resulted in an incomplete care plan for vision on resident #18. Resident #18's care plan has been updated to include vision. All residents are potentially affected by the deficient practice. A 100% review of all CAA's and care plans will be completed to ensure compliance with the regulations. Any errors found will be corrected. The Interdisciplinary Team will be re-educated regarding the correct procedure to follow for CAA's and care plans. Five residents MDS/CAA's will be audited weekly for 2 months to ensure that all CAA's are appropriately addressed in the care plan. Non-compliance will be reported to the QA Performance Improvement Committee. C. Morgan RN DON will be responsible for implementing the plan of correction.	

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 ______	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CO NURSING HOME	**1229 COUNTY FARM ROAD** **BEDFORD, VA 24523**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 3 at 1:50 p.m.	F 279		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and	F 309		7/31/17

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 ______	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CO NURSING HOME	1229 COUNTY FARM ROAD BEDFORD, VA 24523

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 4 preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to follow a physician's order for one of 18 residents in the survey sample. Resident #9 was administered two sprays in each nostril of the medication Flonase (fluticasone propionate) when the physician's order required one spray in each nostril. The findings include: Resident #9 was admitted to the facility on 10/19/13 with diagnoses that included COPD (chronic obstructive pulmonary disease), anxiety, dementia and peripheral vascular disease. The minimum data set (MDS) dated 3/31/17 assessed Resident #9 as cognitively intact. A medication pass observation was conducted on 6/21/17 at 7:20 a.m. with licensed practical nurse (LPN) #1 administering medications to Resident #9. During this observation LPN #1 administered two sprays in each nostril of the medication Flonase 50 mcg (micrograms) spray. Resident #9's clinical record documented a physician's order dated 2/2/17 for Flonase (fluticasone) spray 50 mcg/actuation with instructions for one puff to be administered in each nostril twice daily for the treatment of allergic rhinitis. On 6/21/17 at 8:10 a.m. LPN #1 was interviewed about administering two sprays of Flonase in each nostril instead of the ordered one spray. When asked if she administered two sprays in each nostril for Resident #9, LPN #1 stated, "Yes." LPN #1 reviewed the physician's order and	F 309	F309 Provide Care/Services for highest well being Failure to follow facility policy on medication administration of nasal sprays. This resulted in failure to follow physician's order for amount of medication to be administered. The nurse making the error received re-education on proper administration of nasal sprays on 6/21/2017. All residents with orders for administration of nasal sprays have potential to be affected by this deficient practice. All licensed nurses will be re-educated on proper medication administration of nasal sprays. The facility will identify all residents with current orders for nasal sprays. Two medication observations will be completed weekly for two months on identified residents when receiving their nasal spray medications. Non-compliance will be reported to the QA Performance Improvement Committee. C. Morgan RN DON will be responsible for implementing the plan of correction.	

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 ______	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CO NURSING HOME	**1229 COUNTY FARM ROAD** **BEDFORD, VA 24523**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 5 stated the order required one spray to be administered in each nostril. The Nursing 2017 Drug Handbook on pages 654 and 655 describes Flonase (fluticasone propionate) as a corticosteroid used to treat nasal symptoms of seasonal allergies. (1) These findings were reviewed with the administrator and director of nursing on 6/21/17 at 1:50 p.m. (1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.	F 309		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident;	F 514		7/31/17

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 ___	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CO NURSING HOME	**1229 COUNTY FARM ROAD BEDFORD, VA 24523**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 6 (ii) A record of the resident’s assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician’s, nurse’s, and other licensed professional’s progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for one of 18 residents in the survey sample. Weekly assessments of Resident #1's pressure sore were not documented in the resident's clinical record. The findings include: Resident #1 was admitted to the facility on 7/18/16 with diagnoses that included dementia, diabetes and high blood pressure. The minimum data set (MDS) dated 5/19/17 assessed Resident #1 with short and long-term memory problems and severely impaired cognitive skills. Resident #1's clinical record documented the physician assessed the resident with a "new pressure blister" measuring 2 cm x 2 cm (length by width in centimeters) on 4/26/17. Nursing notes documented as assessment of the resident's left heel on 5/1/17, 5/19/17 and	F 514	F0514 Resident Records-Complete/Accurate/Accessible Failure to use a comprehensive assessment format to describe pressure injuries resulted in an incomplete clinical assessment on Resident #1's pressure injury. Wound nurse received re-education on pressure injury documentation on 6/21/2017. All residents developing pressure injuries have the potentially to be affected by this deficient practice. Resident #1's pressure injury is healed. A comprehensive assessment tool has been developed to more appropriately describe a pressure injury. Upon the occurrence of the development of a pressure injury, the wound will be assessed initially and every (7) days thereafter until healed. The	

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 ______	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CO NURSING HOME	1229 COUNTY FARM ROAD BEDFORD, VA 24523

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 7 5/23/17. A note on 6/13/17 documented the skin on Resident #1's left heel was "intact." Weekly skin assessments in the clinical record documented no assessment of the resident's left heel wound. On 6/21/17 at 11:15 a.m. the licensed practical nurse (LPN #2) responsible for wound care was interviewed about ongoing assessments for Resident #1's left heel wound. LPN #2 stated she assessed Resident #1's left heel wound weekly and documented her assessments in her QA (quality assurance) log. LPN #2 stated she brought her QA log to wound meetings and discussed the status and any needed interventions. LPN #2 presented copies of weekly assessments on a QA log form of Resident #1's left heel wound. The assessments were dated 4/26/17, 5/4/17, 5/11/17, 5/18/17, 5/25/17, 6/8/17 and 6/15/17. The assessments included the location of the wound, wound appearance, measurements and treatments in place. When asked why these assessments were not part of Resident #1's clinical record, LPN #2 stated the assessments were to be scanned and entered into the record "at some point." LPN #2 stated she kept the logs in her office and used the information during wound meetings and daily staff meetings. The facility's policy titled Pressure Injury Treatment Procedure (undated) stated, "Residents with pressure injuries will be assessed by a licensed nurse weekly using the pressure injury observation record. A narrative nurse's note may be completed to include additional information. The wound care nurse or designee will assess, measure and document on all pressure ulcers weekly..."	F 514	assessment will be included in the resident's clinical record. All pressure injuries will be reviewed for a complete assessment weekly. (100% review for 2 months). Non-compliance will be reported to the QA Performance Improvement Committee. C. Morgan RN DON will be responsible for implementing the plan of correction.	

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 ______	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEDFORD CO NURSING HOME	**1229 COUNTY FARM ROAD** **BEDFORD, VA 24523**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 8 These findings were reviewed with the administrator and director of nursing on 6/21/17 at 1:50 p.m.	F 514		