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 _____	09/05/2019

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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 9/3/19 through 9/5/19. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 09/03/2019 through 09/05/2019. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 81 at the time of the survey. The survey sample consisted of 19 current Resident reviews and two (2) closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		10/8/19

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

Electronically Signed | 09/19/2019

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure a dignified dining experience in the dining room for one of 20 residents on the second unit, Resident #9. Resident #9, who needed to be fed by staff, was kept waiting for seventeen minutes while all the other residents at the table and in the dining room were served and ate their meal. The findings include: At approximately 8:00 a.m., on 09/04/19, observations of the breakfast meal in the second	F 550	F550 1. Current staff ensure that resident #9 is served with tray at same time as the other resident's at the table. Resident #9 is being assisted with meal by a nursing staff member at the same time as the other residents at the table. 2. An audit was completed by Director of Nursing/Designee to identify any current residents who require full assistance with meals to ensure staff are delivering trays in timely manner to all residents sitting at	

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F 550	Continued From page 2 unit dining room began. Each resident on the unit had an assigned seat at one of the tables, with three to six residents at each table. There were approximately 20 residents in the dining room for the breakfast meal observation. As residents began to arrive at a table, they were asked for their drink choices and then served their breakfast meal. During the observation there were 4 certified nursing assistants (CNA) and 1 activity assistant who were providing feeding assistance to the residents who required assistance. At 08:30 a.m., three residents were observed seated at a table near the entry to the dining room. Two of the residents at the table were served their breakfast and two staff members sat at the table feeding both of the residents. Resident #9 at the table required assistance with eating and was not served her food until 08:47 a.m., waiting approximately 17 minutes for her breakfast. Resident #9 was the last resident in the dining room of approximately 20 residents to receive her breakfast. Resident #9 was admitted to the facility on 06/19/19 with diagnosis that included dementia with behavioral disturbance, depression, dysphasia, macular degeneration, and gastro-esophageal reflux disease (GERD). The minimum data set (MDS) dated 06/28/19, which was the admission assessment, assessed Resident #9 as severely cognitive impaired for daily decision making with a score of 3 out of 15. Section G - Functional Status of the MDS assessed Resident #9 as requiring extensive assistance, with one person physical assistance with eating.	F 550	the same table and that staff is providing assistance to all the residents at one table with no wait time. 3. Director of Nursing/Designee will educate current staff to deliver trays to one table at a time and ensure all residents including those needing assistance, eat at the same time. Director of Nursing or Designee will observe meal times 5x a week for 4 weeks to ensure staff are delivering trays to one table at a time and that assistance is provided to all residents that require being fed at that table. Any issue will be addressed immediately at the time of identification. 4. Director of Nursing/Designee to present results in QA x 3 months for recommendations.	

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F 550	Continued From page 3 On 09/04/19 at 2:00 p.m., the certified nursing assistant (CNA #4) who provided assistance to Resident #9 was interviewed about the breakfast service. CNA #4 stated, "we normally have enough help to feed everyone, I don't know what happened today." CNA #4 stated she was concerned Resident #9 was the last to receive her meal. CNA #4 stated Resident #9 required assistance and encouragement with eating. CNA #4 stated "we can only feed one person at a time and we were doing the best we could this morning." These findings were reviewed with the administrator, director of nursing and social services director during a meeting on 09/04/19 at 4:30 p.m.	F 550		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657		10/8/19

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F 657	Continued From page 4 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, facility staff failed to review and revise comprehensive care plans (CCP) for three of 21 residents in the survey sample. Facility staff did not update for an edema sleeve, bunny boots, body pillow, to elevate legs when sitting for edema, and no tennis shoe to right foot for Resident #12, aspiration precautions for Resident #50, and discontinuation of anticoagulant therapy for Resident #15. Findings included: 1. Resident #12 was admitted to the facility on 06/11/2018 with diagnoses including, but not limited to: Alzheimer's Disease, Bipolar Disease, Dementia, and Polyneuropathy. The most recent MDS (minimum data set) was an annual review with an ARD (assessment reference date) of 06/05/2019. Resident #12 was assessed as moderately impaired in his short and long term memory and daily decision making skills. Resident #12's clinical record was reviewed on 09/04/2019 at approximately 8:30 a.m. During this review, the POS (physician order sheet),	F 657	F657 1. The Comprehensive Care Plans for resident #12, #50 and #15 updated appropriately. 2. An audit was conducted by Director of Nursing and/or Designee to ensure all Comprehensive Care Plans were updated with current MD orders. Corrections were made as necessary. 3. Director of Nursing/Designee will educate licensed staff that Comprehensive Care Plan must be updated with any new orders. Also that Comprehensive Care Plan will be updated for any discontinued orders. Director of Nursing or Designee will ensure weekly x 4 weeks that the Comprehensive Care Plan has been reviewed within 24-72 hours after all new orders and all discontinued orders. Any issue will be addressed immediately at the time of identification. 4. Director of Nursing/Designee to present results in QA x 3 months for	

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F 657	Continued From page 5 dated 08/04/2019 - 09/04/2019 included the following under treatments: "...03/27/2019...Edema sleeve to LEFT arm: On in AM, remove at HS. Three Times A Day...05/21/2019...Bunny Boots while in bed for protection...06/11/2019...Body pillow when in bed for positioning...06/25/2019...Elevate legs above the level of the heart when sitting r/t [related to] Edema...06/27/2019...NO TENNIS SHOE TO RIGHT FOOT. Resident to wear gripper sock or soft slipper only...08/13/2019...Float heels while in bed..." Subsequent review of the CCP included: "...Problem Start Date: 12/13/2018, Category: ADL [activities of daily living] Functional / Rehabilitation Potential, Potential for decline in ADLs r/t dementia and anxiety, Edited: 03/21/2019...Approach Start Date: 12/13/2018, Edema gloves and sleeve to left hand on in am off at hs as tolerated until edema resolves. Created: 12/13/2018...Problem Start Date: 06/29/2018, Category: Pressure Ulcer, Resident is at risk for pressure ulcer due to reduced activity and chairfast. Edited: 06/27/2019...Approach Start Date: 06/29/2018, Pressure reducing cushion / mattress to bed and chair. Created: 06/29/2018..." The CCP was not updated to reflect that the edema glove was discontinued and only an edema sleeve was ordered. No documentation in CCP was located to indicate the use of bunny boots, body pillow, elevation of legs related to edema, or no tennis shoe to right foot. RN #1 (registered nurse), MDS Coordinator was interviewed on 09/04/2019 at 2:50 p.m. regarding Resident #12's CCP. RN #1 stated, "Yes, I am	F 657	recommedations.	

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F 657	Continued From page 6	F 657		

the only one that updates care plans. I update them every three months or with any changes. I am alerted of changes during morning stand-up, through clinical and printing new orders each day. I know during June I was out in the hospital and didn't return to work until July. I know they had another agency nurse come in right before I came back, but I don't know who was designated to make changes while I was out." RN #1 reviewed the physician orders and current CCP. RN #1 stated, "You are right. It isn't there. Let me check in the computer and make sure you have everything."

On 09/05/2019 at 8:40 a.m., the Administrator relayed a message from the MDS coordinator. The Administrator stated, "The information you have is correct."

The Administrator and DON (director of nursing) were informed of the above findings during and end of day meeting with the survey team on 09/04/2019. No further information was received prior to the exit conference on 09/05/2019.

2. Resident #50 was admitted to the facility on 6/7/17. Diagnoses for Resident #50 included Glaucoma, diabetes, dementia, and pneumonia. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/24/19. Resident #50 was assessed as having short-term memory loss and moderately impaired cognitive skills.

On 09/03/19 at 3:37 PM, an interview was conducted with Resident #50's husband. During the interview the husband mentioned that Resident #50 needed to be fed and sit up for an hour after eating due to having had aspiration pneumonia in March.

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F 657	Continued From page 7	F 657		

Review of Resident #50's physician's orders evidenced an active order dated 3/17/19 for "Aspiration Precautions."

Review of Resident #50's care plan indicated that a care plan for nutrition was in place but did not evidence the care plan had been revised to reflect that Resident #50 had been placed on aspiration precautions.

On 09/04/19 at 11:02 AM, the MDS coordinator (registered nurse, RN #1) was interviewed regarding up dating Resident #50's care plan. RN #1 reviewed the care plan and stated that she did review the care plan for nutrition on 5/2/19 around the time of aspiration precautions and thought she had updated the care plan but must have not submitted the information into the system properly.

On 09/04/19 at 4:30 PM, the above information was present to the director of nursing and administrator.

No other information was presented prior to exit conference on 9/5/19.

3. Resident #15 was originally admitted on 05/04/18 with diagnoses that included Alzheimer' disease, acute embolism and thrombosis of deep veins - left lower extremity, edema, bipolar disorder, cardiac murmur, depression, hypertension and constipation. The most recent minimum data set (MDS) dated 06/10/19 was a quarterly assessment and assessed Resident #15 has having long and short term memory problems, moderately impaired for daily decision making and have continuous periods of inattention and disorganized thinking.

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Resident #15's clinical record was reviewed on 09/03/19 at 2:40 p.m. Observed on the current physician orders was the following order: "Eliquis (apixaban) tablet: 2.5 mg (milligrams); amt: 1; oral, DX: Acute embolism and thrombosis of unspecified deep veins of left lower extremity. Twice a day: 09:00, 17:00. Start Date 05/09/2019, End Date: 08/22/19 (DC date)." A review of the electronic medication record (E-MAR) documented the resident last received the medication on 08/21/19.

A review of Resident #15's progress notes documented the following nursing notes: "08/22/19 13:47. [Name of Physician Assistant], in to see resident this shift, Order to D/C (discontinue) Eliquis and ordered Doppler to both lower extremities... Signed by [Name of LPN]."

A review of Resident #15's comprehensive care plan (CCP) documented the following: "Problem Start Date: 03/25/19. Resident is prescribed anticoagulant therapy (Eliquis). Edited: 06/26/19." The care plan included goals and interventions for the use of the anticoagulant. Resident #15's CCP had not been reviewed and revised to reflect the changes in the plan of care.

On 09/04/19 at 01:55 p.m., the minimum data set coordinator (RN #1) who was responsible for the updating the care plans was interviewed. RN #1 reviewed Resident #15's orders and CCP and stated the anticoagulant care plan should have been reviewed and revised since the Eliquis had been discontinued on 08/22/19. RN #1 stated the unit managers reviewed the 24-hour report and changes are discussed during the morning staff meeting, however she could not say if she was or

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F 657	Continued From page 9 was not notified regarding the change. RN #1 stated it was an oversight the care plan was not updated accordingly. These findings were reviewed with the administrator, director of nursing and social services director during a meeting on 09/04/19 at 4:30 p.m.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of care for two of 21 residents in the survey sample. Treatment records for Resident #22 and #74 were signed off by nursing indicating application of physician ordered devices when the items were not actually in use. The findings include: 1. Resident #22 was admitted to the facility on 7/14/09 with a re-admission on 9/19/16. Diagnoses for Resident #22 included peripheral vascular disease, generalized edema, dementia, atrial flutter, dermatitis, diverticulitis, heart disease and diabetes. The minimum data set (MDS) dated 6/21/19 assessed Resident #22 with severely impaired cognitive skills and as requiring total assistance of one person for dressing.	F 658	F658 1. Nurse made corrections to ETAR while surveyors were in the building. 2. An audit was conducted by Director of Nursing/Designee to identify any current residents that have orders for TED hose, brace or adaptive equipment that requires nurse signature for accurate entries in the resident's medical record. 3. Director of Nursing/Designee will educate nurses on making prompt, accurate entries in a resident's medical record. Director of Nursing/Designee will audit EMARs/TARs for prompt and accurate entries 5x week for 4 weeks. 4. Director of Nursing/Designee to present	10/8/19

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F 658	Continued From page 10 Resident #22's clinical record documented a physician's order dated 7/11/17 for TED support hose on each morning and off each evening for treatment of edema. The clinical record also documented a physician's order dated 11/16/18 for resident to wear WHFO (wrist/hand/finger orthosis) brace to right hand as tolerated. On 9/4/19 at 8:00 a.m., Resident #22 was observed in the dining room without the hand brace in use. On 9/4/19 at 9:30 a.m., Resident #22 was observed in his wheelchair in his room. The resident had no hand brace in place or TED support hose in use on either leg. On 9/4/19 at 9:45 a.m., the certified nurses' aide (CNA #2) caring for Resident #22 was interviewed about the TED hose and hand brace. CNA #2 stated the resident was already out of bed and dressed when she came to work at 7:00 a.m. CNA #2 stated the resident was supposed to have the brace on his right hand and was to wear the TED hose during the day. CNA #2 stated the 11:00 p.m. to 7:00 a.m. shift got Resident #22 dressed and must not have put on the TED hose or the brace on the right hand. On 9/4/19 at 9:47 a.m., accompanied by CNA #2, Resident #22 was observed in his room without the hand brace or TED support hose in place. CNA #2 located the TED support hose in the resident's dresser drawer and the hand brace on top of the television table. Resident #22's clinical record was reviewed further on 9/4/19 at 10:00 a.m. The clinical record documented licensed practical nurse (LPN #3) had already signed off the resident's treatment record for 9/4/19 indicating the hand	F 658	results in QA x 3 months for recommendations.	

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brace and TED support hose were in use by the resident when the items had not been applied.

2. Resident #74 was admitted to the facility on 12/28/16 with diagnoses that included mood disorder, insomnia, hypothyroidism, constipation, dementia, depression and anxiety. The minimum data set (MDS) dated 8/7/19 assessed Resident #74 with short and long-term memory problems, moderately impaired cognitive skills and as requiring extensive assistance of one person for dressing.

Resident #74's clinical record documented a physician's order dated 9/21/17 for compression hose to be on each morning and off at bedtime for the management of edema.

On 9/4/19 at 9:45 a.m., Resident #74 was observed in his wheelchair in the dining room. The resident had on tennis shoes, crew socks and no compression hose. Resident #74 was observed again in the dining room on 9/4/19 at 10:21 a.m. without compression hose in use.

On 9/4/19 at 10:23 a.m., the certified nurses' aide (CNA #2) caring of Resident #74 was interviewed about Resident #74's compression hose. CNA #2 stated Resident #22 was already up and dressed when she started work at 7:00 a.m. CNA #2 stated Resident #22 was "an early riser" and the 11:00 p.m. to 7:00 a.m. shift got him up and dressed. On 9/4/19 at 10:25 a.m., accompanied by CNA #2, Resident #74 was observed in his room. The resident's feet were observed after CNA #2 removed his shoes/socks. The resident had indented skin around each lower leg where the top of the crew socks were positioned. CNA #2 located the resident's compression hose in the

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F 658	Continued From page 12	F 658		

dresser drawer.

Resident #74's clinical record was reviewed further on 9/4/19 at 10:05 a.m. The clinical record documented licensed practical nurse (LPN #3) had already signed off the resident's treatment record for 9/4/19 indicating the compression hose were in use by the resident when the hose had not actually been applied.

On 9/4/19 at 10:47 a.m., LPN #3 was interviewed about how the treatment records for Resident #22 and #74 were signed off when the physician ordered items were not in place. LPN #3 stated she already signed off the treatment records for 9/4/19 indicating the hose/brace were in place. LPN #3 stated she had not actually verified placement of the items but was hoping her CNA had applied the devices as ordered. LPN #3 stated she signed off the record before checking to see if the ordered items were actually in place. LPN #3 stated the signing off was just a habit and she should have made sure the items were in place before signing the treatment record.

The facility's policy titled Specific Medication Administration Procedures (effective 6/9/15) documented nurses were required to sign off the treatment administration records or medication administration records after administration or application of treatments as indicated.

The Lippincott Manual of Nursing Practice 10th edition states on pages 16 and 17 concerning common departures for standards of care, "Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to assess the patient properly or in a timely fashion,

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F 658	Continued From page 13 follow physician orders, follow appropriate nursing measures, communicate information about the patient, adhere to facility policy or procedure, document appropriate information in the medical record...Failure to monitor or observe a patient's clinical status adequately...Failure to perform a nursing treatment or procedure properly...Failure to make prompt, accurate entries in a patient's medical record..." (1) These findings were reviewed with the administrator and director of nursing during a meeting on 9/4/19 at 4:30 p.m. (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.	F 658		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical document review, facility staff failed to follow physician orders for 5 of 21 residents in the survey sample. Facility staff did not apply an edema sleeve for Resident #12, failed to apply geri sleeves for Resident #50, failed to notify the physician of elevated blood sugars for Resident	F 684	F684 1. Edema sleeve was applied to resident #12. Arm protectors applied to resident #50. Physician was notified of elevated blood sugars for resident #46. TED hose were applied as ordered to residents #22	10/8/19

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F 684	Continued From page 14 #46 and failed to apply TED (compression) stockings for Residents #22 and #74. Findings included: 1. Resident #12 was admitted to the facility on 06/11/2018 with diagnoses including, but not limited to: Alzheimer's Disease, Bipolar Disease, Dementia, and Polyneuropathy. The most recent MDS (minimum data set) was an annual review with an ARD (assessment reference date) of 06/05/2019. Resident #12 was assessed as moderately impaired in his short and long term memory and daily decision making skills. Resident #12's clinical record was reviewed on 09/04/2019 at approximately 8:30 a.m. During this review, the POS (physician order sheet), dated 08/04/2019 - 09/04/2019 included the following under treatments: "...03/27/2019...Edema sleeve to LEFT arm: On in AM, remove at HS. Three Times A Day..." On 09/04/19, Resident #12 was observed with a long sleeve shirt in place at 10:08 a.m. and again at 1:00 p.m. LPN #1 (licensed practical nurse) interviewed at 1:05 p.m. regarding edema sleeve. LPN #1 stated, "No, he doesn't have it on. I looked all over for it this morning and couldn't find it. I checked in laundry and that is where it is. He feeds himself and gets food all over it. We rinse it out at night, but it doesn't get all the food out, so we have to send to laundry. It takes them time to catch up sometimes. We could get a second sleeve." The Administrator and DON (director of nursing)	F 684	and #74. 2. An audit was conducted by Director of Nursing/Designee to identify any current residents that have orders for TED hose, edema and geri-sleeves, and audit was completed for residents with blood sugar checks to validate that NP or MD was notified of blood sugars outside of specified parameters from 7/1/2019 to current. 3. Director of Nursing/Designee will educate nursing staff on residents with active orders for TED hose, edema and geri-sleeves. Nurses will be educated on any current resident with active orders for blood sugar checks and when to notify the physician. The Director of Nursing/Designee will perform an audit 5x week for 4 weeks to ensure residents have TED hose, edema and geri-sleeves in place as ordered. Director of Nursing/Designee will perform an audit 5x week for 4 weeks that physicians are notified for any blood sugars that are outside of specified parameters. 4. Director of Nursing/Designee to present results in QA x 3 months for recommendations.	

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were informed of the above finding during a meeting with the survey team on 09/04/2019. No further information was received prior to the exit conference on 09/05/2019.
2. Resident #50 was admitted to the facility on 6/7/17. Diagnoses for Resident #50 included Glaucoma, diabetes, dementia, and pneumonia. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 7/24/19. Resident #50 was assessed as having short-term memory loss and moderately impaired cognitive skills.

On 9/3/19 Resident #50 physician orders were reviewed and included an active order dated 6/28/19 that read "Bilateral arm protectors on when OOB [out of bed] every shift." This order was also added to Resident #50's active care plan as an intervention on 5/6/19.

On 9/4/19 at 7:45 AM, Resident #50 was observed in the dining room without arm protectors in place.

At 9:40 AM Resident #50's husband was in Resident #50's room along side Resident #50 who was sitting up in a chair. Resident #50's husband was asked if the certified nursing assistants (CNA) put on arm protectors. Resident #50's husband stated that he had not seen the aides put on arm protectors but had seen the aides put on leg protectors. Resident #50 arms evidenced an older skin tear to the right forearm.

On 09/04/19 at 9:51 AM, CNA #1 (assigned to Resident #50) was interviewed. CNA #1 was not aware of Resident #50 needing arm protectors. CNA #1 went down to Resident #50's room to

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look for the arm protectors but was not able to find any. CNA #1 then reviewed the physician's order with Resident #50's nurse (license practical nurse, LPN #2). After reviewing the order LPN #2, and CNA #1 went back to Resident #50's room to look for the arm protectors, but were unable to find any. LPN #2 stated that she would get some arm protectors and put them on Resident #50.

On 09/04/19 at 4:30 PM, the above information was presented to the director of nursing and administrator.

No other information was presented prior to exit conference on 9/5/19.

3. Resident #22 was admitted to the facility on 7/14/09 with a re-admission on 9/19/16. Diagnoses for Resident #22 included peripheral vascular disease, generalized edema, dementia, atrial flutter, dermatitis, diverticulitis, heart disease and diabetes. The minimum data set (MDS) dated 6/21/19 assessed Resident #22 with severely impaired cognitive skills and as requiring total assistance for dressing.

Resident #22's clinical record documented a physician's order dated 7/11/17 for TED support hose on each morning and off each evening for treatment of edema.

On 9/4/19 at 9:30 a.m., Resident #22 was observed in his wheelchair in his room. The resident had protective booties on his feet but no TED support hose in use on either leg.

On 9/4/19 at 9:45 a.m., the certified nurses' aide (CNA #2) caring for Resident #22 was interviewed about the TED hose. CNA #2 stated

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the resident was already out of bed and dressed when she came to work at 7:00 a.m. CNA #2 stated the resident was supposed to wear the TED hose during the day. CNA #2 stated the 11:00 p.m. to 7:00 a.m. shift got Resident #22 dressed and must not have put on the TED hose. On 9/4/19 at 9:47 a.m., accompanied by CNA #2, Resident #22 was observed in his room without TED support hose in place. CNA #2 located the support hose in the resident's dresser drawer.

On 9/5/19 at 8:15 a.m., the licensed practical nurse (LPN #3) caring of Resident #22 was interviewed about the support hose. LPN #3 stated the night shift aide should have applied the TED hose when dressing the resident for the day.

This finding was reviewed with the administrator and director of nursing during a meeting on 9/4/19 at 4:30 p.m.

4. Resident #74 was admitted to the facility on 12/28/16 with diagnoses that included mood disorder, insomnia, hypothyroidism, constipation, dementia, depression and anxiety. The minimum data set (MDS) dated 8/7/19 assessed Resident #74 with short and long-term memory problems, moderately impaired cognitive skills and as requiring the extensive assistance of one person for dressing.

Resident #74's clinical record documented a physician's order dated 9/21/17 for compression hose to be on each morning and off at bedtime for the management of edema.

On 9/4/19 at 9:45 a.m., Resident #74 was observed in his wheelchair in the dining room. The resident had on tennis shoes, crew socks

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and no compression hose. Resident #74 was observed again in the dining room on 9/4/19 at 10:21 a.m. without compression hose in use.

On 9/4/19 at 10:23 a.m., the certified nurses' aide (CNA #2) caring of Resident #74 was interviewed about Resident #74's compression hose. CNA #2 stated Resident #22 was already up and dressed when she started work at 7:00 a.m. CNA #2 stated Resident #22 was "an early riser" and the 11:00 p.m. to 7:00 a.m. shift got him up and must not have applied the compression hose. On 9/4/19 at 10:25 a.m., accompanied by CNA #2, Resident #74 was observed in his room. The resident's feet were observed after CNA #2 removed his shoes/socks. The resident had indented skin around each lower leg where the top of the crew socks were positioned. CNA #2 located the resident's compression hose in the dresser drawer.

Resident #74's plan of care (revised 8/15/19) documented the resident was at risk of ADL (activities of daily living) decline. Interventions to prevent functional decline in the included compression hose on each morning and off at each bedtime.

This finding was reviewed with the administrator and director of nursing during a meeting on 9/4/19 at 4:30 p.m.

5. Resident #46 was admitted to the facility on 2/6/11 with a re-admission on 2/20/19. Diagnoses for Resident #46 included diabetes, cerebrovascular disease with hemiplegia/hemiparesis, respiratory infection, cellulitis, bronchitis, history of femur fracture, dementia, depression and urinary tract infection.

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The minimum data set (MDS) dated 7/15/19 assessed Resident #46 as cognitively intact.

Resident #46's clinical record documented a physician's order dated 5/30/19 requiring notification to the physician of any blood sugar results greater than 400. The record documented a physician's order dated 6/20/19 for blood sugar checks to be done before each meal and at bedtime.

Resident #46's medication administration record documented the resident's blood sugar was assessed at greater than 400 on the follow dates/times. Blood sugar readings are listed in milligrams per deciliter (mg/dL).

7/2/19 at 11:30 a.m. = 426
7/3/19 at 11:30 a.m. = 417
7/3/19 at 4:30 p.m. = 413
7/4/19 at 4:30 p.m. = 450
7/5/19 at 4:30 p.m. = 458

There was no notification to the physician of these elevated blood sugar readings as required by the physician's order.

On 9/4/19 at 1:12 p.m., the licensed practical nurse (LPN #3) caring for Resident #46 was interviewed about any notification regarding the elevated blood sugars on 7/3/19 through 7/5/19. LPN #3 stated notification to the physician would be documented in the nursing notes. LPN #3 reviewed Resident #46's clinical record and stated she did not find notification to the physician regarding the elevated blood sugar readings.

On 9/4/19 at 1:30 p.m., the director of nursing (DON) was interviewed about notification to the

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F 684	Continued From page 20 physician of Resident #46's elevated blood sugar readings. The DON stated nurses were to notify the physician as ordered regarding the elevated blood sugar readings and obtain a physician's order for any needed insulin. The DON stated nurses were expected to document notification in the clinical record. Resident #46's plan of care (revised 7/25/19) listed the resident was at risk of altered blood glucose levels. Included in interventions to prevent hyperglycemia were, "Administer medications as ordered. Evaluate/record/report effectiveness/adverse side effects...Monitor blood glucose as ordered...Observe for signs of hyperglycemia or hypoglycemia..." These findings were reviewed with the administrator and director of nursing during a meeting on 9/4/19 at 4:30 p.m.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and	F 688		10/8/19

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F 688	Continued From page 21 assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to apply a physician ordered hand brace for one of 21 residents in the survey sample (Resident #22). The findings include: Resident #22 was admitted to the facility on 7/14/09 with a re-admission on 9/19/16. Diagnoses for Resident #22 included peripheral vascular disease, generalized edema, dementia, atrial flutter, dermatitis, diverticulitis, heart disease and diabetes. The minimum data set (MDS) dated 6/21/19 assessed Resident #22 with severely impaired cognitive skills and as requiring total assistance for dressing. Resident #22's clinical record documented a physician's order dated 11/16/18 for resident to wear a WHFO (wrist/hand/finger orthosis) brace to right hand as tolerated. On 9/4/19 at 8:00 a.m., Resident #22 was observed in the dining room without the hand brace in place. On 9/4/19 at 9:30 a.m., Resident #22 was observed in his room with no hand brace in place on his right hand. On 9/4/19 at 9:45 a.m., the certified nurses' aide (CNA #2) caring of Resident #22 was interviewed about the hand brace. CNA #2 stated the resident was already in his chair and dressed when she arrived at work at 7:00 a.m. CNA #2 stated the 11:00 p.m. to 7:00 a.m. shift got	F 688	F688 1. Hand brace was applied to resident #22 while surveyors were in the building. 2. An audit was completed by Director of Nursing/Designee to identify any current residents that have orders for hand braces with no other incidents identified. 3. Director of Nursing or Designee will educate nurses on residents with active orders for braces. The Director of Nursing and/or Designee will perform an audit 5x week for 4 weeks to ensure residents have braces in place as ordered. 4. Director of Nursing/Designee to present results in QA x 3 months for recommendations.	

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F 688	Continued From page 22 Resident #22 up and should have made sure the brace was on when getting the resident dressed. On 9/4/19 at 9:47 a.m., accompanied by CNA #2, Resident #22 was observed in his room without the brace in place. CNA #2 located the brace on top of the resident's television table. CNA #2 stated the brace was supposed to be on the resident's right hand. On 9/5/19 at 8:14 a.m., the licensed practical nurse (LPN #3) caring for Resident #22 was interviewed about the hand brace. LPN #3 stated the resident was not able to open his fingers on the right hand as well as the left hand. LPN #3 stated the brace was ordered for proper positioning of the resident's hand/wrist/fingers and should have been in use. Resident #22's plan of care (revised 7/18/19) listed the resident had a potential for decline in activities of daily living. Included in interventions to prevent a decline in function was, "Resident to wear WHFO brace to right hand as tolerated." There was no documentation indicating any refusals by the resident to wear the hand brace. This finding was reviewed with the administrator and director of nursing during a meeting on 9/4/19 at 4:30 p.m.	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		10/8/19

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F 689	Continued From page 23 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to use footrest and a foot board/plate on a wheelchair to prevent accidents resulting in a clavicle fracture for one of 21 residents in the survey sample, Resident #15; and failed to ensure physician orders and ensure an assessment was completed for the use of a Broda specialized wheelchair, for one of 21 residents sample, Resident #37. The findings include: 1. Resident #15 was originally admitted on 05/04/18 with diagnoses that included Alzheimer' disease, acute embolism and thrombosis of deep veins - left lower extremity, edema, bipolar disorder, cardiac murmur, depression, hypertension and constipation. The most recent minimum data set (MDS) dated 06/10/19 was a quarterly assessment and assessed Resident #15 has having long and short term memory problems, moderately impaired for daily decision making and have continuous periods of inattention and disorganized thinking. Section G - Functional Status on the MDS assessed Resident #15 as requiring extensive assistance, with one person physical assistance for bed mobility, total dependence, with one personal physical assistance for toileting, hygiene, dressing, locomotion, and transfers. On 09/03/19 at 11:15 a.m., during the initial tour, Resident #15's daughter was interviewed regarding Resident #15's quality of life and care	F 689	F689 1. Foot board in place on w/c for resident #15. An assessment was completed for the use of the Broda wheelchair for resident #37. 2. An audit was conducted by the Director of Nursing/Designee to identify any current residents who have foot boards in use to ensure proper use, proper placement and the function of the devices. Corrections were made as necessary. An audit was conducted by the Director of Nursing/Designee to ensure an assessment is updated and current for all residents with a Broda wheelchair. 3. Director of Nursing/Designee will educate the current nursing staff on the use of foot boards, the proper placement and when placement is indicated. Director of Nursing and/or Designee will observe foot boards 5x week for 4 weeks to ensure appropriate use, proper placement and proper function. Director of Nursing and/or Designee will monitor any resident with a new intervention for a Broada chair to ensure that an appropriate assessment has been completed weekly x 4 weeks. Any issues will be addressed immediately. 4. Director of Nursing/Designee to present results in QA x 3 months for	

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BEDFORD CO NURSING HOME	1229 COUNTY FARM ROAD BEDFORD, VA 24523

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since being admitted at the facility. The daughter stated Resident #15 had recently had a fall resulting in a hematoma and bruising. She stated this past weekend we were notified that she has a fractured clavicle from the last fall. Resident #15's daughter was asked if she knew how the fall occurred. She stated she was told the resident fell out of the wheelchair. Resident #15's daughter pointed towards the wheelchair and stated "I do see they have placed a larger footboard on the bottom of the wheelchair. I always thought the other one was too small."

Resident #15's clinical record was reviewed on 09/04/19 at 1:45 p.m. Observed were the following nurses' notes:

"08/21/19 18:48 Nurse was off unit when CNA notified writer of fall event. Nurse assessed resident and noted large hematoma to right side of forehead with minimal bleeding from small laceration. Nurse noted CNA had applied ice compact for swelling and to control bleeding prior to nurse arrival. Resident denied pain during assessment. [Name of Physician], DON (director of nursing) and family notified of fall. Per MD (Doctor) instructions, resident was sent to ER (emergency room) for an evaluation..."

"08/21/19 23:36 Writer spoke with [Name of ER Nurse]. Writer was informed that resident had head and spine CT with no fractures. Resident has large hematoma to right forehead where Derma-Bond was applied for adhesiveness. Writer instructed to hold Eliquis for 24 hours and notified MD r/t (related to fall) history and to continue or D/C (discontinue) medication. Resident arrived in good spirit and alert, oriented to baseline. Resident is able to express pain and

recommendations.

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discomfort to staff. Will continue to monitor."

"08/22/19 13:47 [Name of Physician Assistant] into see resident this shift, Order to d/c Eliquis and ordered Doppler to both lower extremities. Rp [name] notified at this time."

"08/22/19 22:26 Resident continues s/p fall...resident slides down in chair daily. Staff adjusted resident several times today. PT (physical therapy) eval (evaluation) in place for positioning."

"08/26/19 6:36 observed resident right shoulder swollen bruised uneven bilateral denies pain and discomfort, will notify MD."

"08/26/19 15:57 MD was informed of swelling and bruising to (R) shoulder. Resident was seen by MD. MD did not want F/U (follow-up) x-ray at this time d/t (due to) resident denies pain in area. Will continue to monitor."

"08/26/19 22:21 Nurse noted bruising to right shoulder per shift possibly r/t S/P fall. No grimace, noted pain or discomfort. Will continue to monitor."

"08/27/19 6:13 Continues with noted bruising to right shoulder. No c/o pain. No s/s of distress. Resting quietly throughout shift."

"08/28/19 10:55 Weekly Standards of Care meeting held today with IDT (interdisciplinary) team present, discussed Fall on 08/21/19 out of chair, hematoma to right forehead, small laceration and sent to ER for eval per orders. Derma-bond applied in ED, CT can of head and spine completed with negative results received.

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Intervention PT and OT eval. No other issues noted. Continue current POC (plan of care)."

"08/29/19 6:39 Weekly Skin Assessment completed. Fading bruising continues to right shoulder...Will continue to monitor."

"08/29/19 19:36 Resident noted to have swelling and bruising to right shoulder. Resident was seen by MD today and x-ray ordered r/t recent fall. RP notified [name]. facility awaiting results."

"08/30/19 14:22 X-ray results obtained and show a non-displaced acute fx (fracture) through the distal clavicle and that the AC joint is well maintained. MD was notified and gave an order for a non-urgent follow-up with Ortho in 7-10 days. Resident continues to deny pain, ROM is WNL, bruising continues. This nurse left message for residents RP to call facility. Will continue to monitor resident for pain and discomfort."

A review of the 08/30/19 x-ray documented: "Right Shoulder 2 View. History: related to fall. Findings: internal and external rotation views show nondisplaced acute fracture through the distal end of the right clavicle. The AC joint is well maintained..."

On 09/04/19 at 2:30 p.m., MDS coordinator (RN #1) who documented the note on 08/28/19 regarding the "Weekly Standards of Care" meeting was interviewed. RN #1 stated after the IDT discussed that due to Resident #15 having falls on 06/20/19, 07/16/19 and 8/21/19 the IDT felt is was best to have a PT/OT evaluation to assist with possible other fall interventions.

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On 09/04/19 at 2:45 p.m., the rehab manager (OS #2) was interviewed regarding the PT/OT evaluation. OS #2 provided a copy of the evaluation that took place on 08/29/19. Observed on the OT evaluation was the following: "Patient referred to skilled OT services due to recent fall out of wheelchair. Patient is an 88 year old female resident at [name of facility]. Patient referred to skilled OT services due to recent fall out of wheelchair on 08/21/19 caused by not having foot rests and back plate on wheelchair. Intervention in place at this time to place footrests on and back plate on when resident in wheelchair." OS #2 stated the evaluation determined Resident #15 required a new larger footboard to be placed behind the legs of the wheelchair to ensure the resident's legs did not touch the ground which would cause her to fall forward. OS #2 stated the new foot board was installed and education was given to staff.

On 09/04/19 at 3:15 p.m., the director of nursing (DON) was asked to see the charge nurse and CNA who were on duty on 8/21/19 the day of the fall incident. The DON stated the charge nurse, was a contract nurse and her contract had recently ended, therefore she was not available. The DON stated from her understanding of the fall incident, the CNA was transporting the resident from the dining room back to her room and the resident's feet dropped down on the carpet and halted the chair causing the resident to fall out of the wheelchair. The DON was asked if there were footrests and/or a foot board/plate on the wheelchair at the time of the transport and DON stated she did not believe there was.

On 09/04/19 at 3:17 p.m., the certified nursing assistant (CNA #3) who witnessed the fall

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incident was interviewed. CNA #3 stated she was taking Resident #15 to her room after dinner to get ready for bed. CNA #3 stated "I asked her to hold her feet up and while we were going down the hall she placed her feet on the floor and this stopped the wheelchair causing her (Resident #15) to fall forward out of the chair onto the floor. CNA #3 was asked if there was supposed to be footrests and/or a foot board/plate on the wheelchair. CNA #3 stated "yes, but I don't know why they weren't on there at the time." CNA #3 stated "I received report from the first shift CNA and I don't think the footrests and foot board were on the wheelchair at the time I received report." CNA #3 was asked if she knew the foot rests and foot board/plate were supposed to be on the wheelchair why did she not place them prior to transporting Resident #15. CNA #3 stated "you're right, it's everyone's responsibility. I should have put them on, but I don't know why they weren't on. It will probably get me in trouble."

The above findings were reviewed with the administrator, director of nursing and social services director during a meeting on 09/04/19 at 4:30 p.m. On 09/05/19 at 8:30 a.m., the administrator and director of nursing were advised of the concern of harm for Resident #15 related to the fall incident which took place on 08/21/19 resulting in a fractured right clavicle.

On 09/05/19 at 8:35 a.m., the occupational therapist (OS #3) who completed the OT evaluation was interviewed. OS #3 stated when she received the referral she was told it was because the resident had fallen out of the wheelchair because the staff did not have the footrests and foot board/plate on the wheelchair at the time of the incident. OS #3 stated when

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she assessed Resident #15 she determined a larger, wider foot board would be better because Resident #15 leans forward and slides down in the wheelchair. OS #3 stated the larger, wider foot board would prevent the resident's feet from dropping down on the floor. OS #3 was asked if Resident #15 was able to propel or assist with any of locomotion and transfers. OS #3 stated "no she requires total assistance." A review of the OT evaluation form documented the following: "Patient is a total assist with all ADLs (activities of living) and functional mobility."

On 09/05/19 at 8:40 a.m., CNA #5 who routinely provides care during first shift was interviewed. CNA #5 stated Resident #15 does require the footrests and foot board. CNA #5 stated Resident #15 is gotten up by the third shift staff and dressed for the day. CNA #5 stated because Resident #15 stays up in the wheelchair for so long during the day, that she usually lays her down after lunch at which time the footrests and foot board are removed for a safe transfer from the chair to the bed. CNA #5 stated someone on second shift would have gotten Resident #15 up for dinner at which time they should have installed the footrests and foot board to transport her to and from the dining room for dinner.

No additional information was provided to the survey team prior to the exit conference on 09/05/19 at 10:30 a.m.

2. Resident #37 was admitted to the facility on 07/08/19 with diagnoses that included hospice care, chronic kidney disease - stage 3, hyperlipidemia, vascular dementia, dysphasia, chronic pain, depression, edema and gastro-esophageal reflux disease (GERD). The

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minimum data set (MDS) dated 07/15/19 was the admission assessment and assessed Resident #37 as severally impaired for daily decision making with a score of 5 out of 15. Section G - Functional Status assessed Resident #37 total dependence, with two person physical assistance for transfers and total dependence with one person physical assistance for locomotion, dressing, toileting, hygiene.

On 09/04/19 at 8:00 a.m., Resident #37 was observed being transported to the second unit dining room in a Broda specialized chair.

On 09/04/19 at 9:45 a.m., the certified nursing assistant (CNA #4) who routinely provides care for Resident #37 was interviewed about the use of the Broda chair. CNA #4 stated the resident used the Broda chair whenever she was out of bed.

Resident #37's clinical record was reviewed on 09/04/19 at 10:17 a.m.,. Observed documented in the nurses' notes was the following:

"08/20/19 13:58 At 1PM while sitting in the dining room waiting to be taken back to her room resident fell out of her Broda chair face first. She was attempting to get up out of her chair unsafely. When writer came into dining room resident was lying in her right side of the floor next to chair. Writer and supervisor assessed resident, ROM was performed and resident stated that she had pain in her neck and the back of her head. She also stated that her shoulder and coccyx area were hurting as well. There was strong grip in both hands and PEARL. Vital signs were obtained and within normal limits. On call [Name of Nurse Practitioner] was notified and

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informed of fall and resident stating she has having pain in her neck, back of head, shoulder and coccyx area. She gave verbal order to send resident to ER for further evaluation. Daughter [name] was notified at 1:24PM and stated she would meet her mother at the hospital. Writer called in report to [name of ER nurse]."

"08/20/19 16:26 Weekly Standards of Care meeting held with IDT team present to discuss fall without injury. Intervention added to Use Broda Chair until therapy evals. Continue current POC."

A review of the comprehensive care plan documented the Broda chair as an intervention on the "Falls" care plan dated 07/25/19. The clinical record did not document physician orders for the use of Broda chair.

On 09/04/19 at 1:30 p.m., the MDS coordinator (RN #1) who documented the 08/20/19 "Weekly Standards of Care" note was interviewed about the PT/OT evaluation for the Broda chair. RN #1 stated the referral was made because of concerns with positioning after Resident #37 had the fall from the Broda chair. RN #1 stated she was not sure if an initial evaluation was made by PT/OT when Resident #37 was admitted.

On 09/04/19 at 1:47 p.m., the Rehab Manager (OS #2) was interviewed regarding an evaluation for the Broda chair. OS #2 stated the in-house therapy did not complete the evaluation because hospice wanted to have their own independent PT/OT come in and complete the evaluation.

On 09/04/19 at 3:30 p.m. the director of nursing (DON) was asked if an order was needed for a

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Broda chair. The DON stated the resident had been admitted with the chair on the day of admission. She was asked again if the Broda chair required an a physician's order and she stated she would have to check into this since Resident #37 was admitted on Hospice and the Broda chair came with her. The DON was asked if there had been a therapy evaluation for the Broda chair. The DON stated "No, we have had conversations with Hospice about having an evaluation completed, however hospice did not want to use our in-house therapy department and stated they would provide their own independent therapy evaluation." The DON was asked if she could provide documentation regarding the conversations with hospice related to the therapy evaluation for the Broda chair. The DON stated the Social Services Director should have more information regarding Resident #37 because she was receiving hospice services.

On 09/04/19 at 3:45 p.m., the social services director (LPN #4) was interviewed regarding if the had been a therapy evaluation completion on the Broda chair. She stated she was not sure if there had been an initial evaluation completed at admission. LPN #4 stated she would contact hospice and provide the information.

09/04/19 at 4:15 p.m., LPN #4 provided a fax cover sheet from the [Hospice Provider] which documented the resident was admitted to the facility with the Broda chair on 07/08/19. Additional information provided were copies of physical therapy notes which documented the initial PT evaluation for the Broda chair did not take place until 08/25/19. The PT evaluation documented the following: "PT services necessary to help identify and establish proper

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F 689	Continued From page 33 positioning of patient in Broda chair, as it is unclear if she is being positioned incorrectly or if she was attempting self-mobility which led to her fall..." These findings were reviewed with the administrator, director of nursing and social services director during a meeting on 09/04/19 at 4:30 p.m. No additional information was provided prior to the exit conference on 09/05/19 at 10:30 a.m.	F 689		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation staff interview, and facility document review, the facility staff failed to store	F 812	F0812	10/8/19

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F 812	Continued From page 34 and prepare food in a sanitary manner. Seventeen 0.5 oz. (ounce) cartons of Lactaid milk, with expired discard dates, were stored and available for use in the main kitchen's walk-in refrigerator. The findings include: On 09/03/19 at 10:35 a.m., accompanied by the dietary manager, the facility's main kitchen was inspected. Stored in the walk-in refrigerator were seventeen 0.5 oz (ounce) cartons of Lactaid milk with the discard date of 08/22/19. On 09/03/19 at 10:45 a.m., the dietary manager was interviewed about the seventeen 0.5 oz cartons of expired Lactaid milk. The dietary manager stated kitchen employees were supposed to check the walk-in refrigerator daily for expired items and discard them as needed. The dietary manager stated the item was originally ordered for one specific resident, however it was later determined the resident did not drink milk and currently there were not any other residents in the facility who requested or required Lactaid milk. The dietary manager was asked for a policy regarding food storage and expired items. The dietary manager stated the facility did not have a policy directly related to expired items, because it was food safety knowledge that all foods with an expired discard date should be discarded and not stored and available for use. The dietary manager stated the expectation was when the dietary staff observed expired items they would discard the items immediately and not keep those items beyond the expiration date. The dietary manager presented a policy titled "Date Marking" (revised 4/10/19) documented "before you place anything in the	F 812	1. Expired Lactaid milk was discarded on 9/3/2019. 2. An audit was conducted on 9/3/2019 by the Dietary Manager to identify the expiration date on remaining foods in the refrigerator with no other issues noted. 3. Dietary Manager educated by Administrator on disposal of expired items in walk-in refrigerator on 9/3/2019. Dietary Manager will educate Dietary staff on disposal of expired items. Dietary Manager/Designee will Audit items in refrigerator 3 times week for expiration date compliance. Dietary Manager will turn in weekly audit to Administrator or Director of Nursing for 4 weeks. 4. Director of Nursing/Designee to present results in QA x 3 months for recommendations.	

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F 812	Continued From page 35 refrigerator or cooler it must be labeled and dated." This policy did not directly address food items with an labeled with an expired/discard date. These findings were reviewed with the administrator, director of nursing and social services director during a meeting on 09/04/19 at 4:30 p.m.	F 812		
F 880 SS=C	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		10/8/19

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(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:

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 _____	09/05/2019

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 880	Continued From page 37 Based on review of the facility's Infection Prevention and Control Program, the Antimicrobial Stewardship Program, and staff interview, the facility failed to ensure both programs were reviewed and approved by the Medical Director, and failed to ensure both programs were formally adopted as facility policy. The findings were: 1. During review of the facility's Infection Prevention and Control Program (IPCP), it was noted there was no documentation indicating the program had been reviewed by the Medical Director, or that it had been formally adopted as facility policy. At approximately 9:45 a.m. on 9/4/19, the facility's Administrator was asked if he could provide any evidence that the IPCP had been reviewed by the Medical Director and formally adopted as facility policy. At 2:00 p.m. on 9/4/19, the Administrator stated that he was unable to find any evidence the IPCP had been reviewed by the Medical Director, or that it had been formally adopted as facility policy. 2. During review of the facility's Antimicrobial Stewardship Program, it was noted the program was provided by the facility's pharmaceutical provider. The program included a cover sheet from the pharmaceutical provider which noted the following: "(Name) Pharmacy is happy to provide you with tools to help you create and maintain your Antibiotic Stewardship Program (ASP)...Enclosed are six sample policies your facility may use for your Antibiotic Stewardship Program."	F 880	F880 1. Infection Control and Antimicrobial Stewardship Program were reviewed and formally adopted on 9/16/2019 by the Administrator, Director of Nursing and Medical Director. 2. Policy and procedure manual will be reviewed for adoption by Administrator, Director of Nursing, Medical Director and IDT. 3. Administrator will in-service IDT as well as Medical Director on annual review of policy and procedures manual. 4. Director of Nursing/Designee to present results in QA x 3 months for recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 38	F 880		

There were 12 additional pages, each titled "ANTIMICROBIAL STEWARDSHIP PROGRAM," encompassing the six sample policies mentioned in the cover sheet. At the bottom of each of the 12 pages was the notation "ASCP Sample Policy."

At 8:45 a.m. on 9/5/19, the facility's Administrator was asked if the Antimicrobial Stewardship Program had been reviewed and adopted as facility policy. The Administrator said the Antimicrobial Stewardship Program had not been formally adopted as policy by the facility. "It is on my list to have adopted, along with the Infection Prevention and Control Policy," he said.

During an end of day meeting at 4:00 p.m. on 9/4/19, which included the Administrator, Director of Nursing (DON), and the survey team, the Administrator and DON were advised that the Infection Control Program was under consideration by the survey team.