State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0026	A. BUILDING: ______ B. WING ______	08/05/2021

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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial state licensure inspection was conducted 8/3/21 through 8/5/21. Corrections are required for compliance with Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this ninety certified bed facility was seventy at the time of the inspection. The survey sample consisted of eighteen current resident reviews and one closed record review.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Regulations for the Licensure of Nursing Facilities. 12VAC5-371-370 A Cross reference to F584 12VAC5-371-250 F Cross reference to F657 12VAC5-371-220 A, B Cross reference to F658 12VAC5-371-360 A, E Cross reference to F849	F 001	F584 1) In room 211 on Unit 2, the entrance door has been repaired and painted, the restroom door has been repaired and painted and the wall beside the bed has been repaired and painted. 2) An audit was completed by Support Services Supervisor of all rooms in facility to identify any other rooms needing repair to doors or walls. Needed repairs have been scheduled. 3) Administrator has educated Support Services Supervisor that all resident rooms are to be free from damage to doors or walls and any repairs need to be scheduled using TELS system and prioritized.	8/27/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/13/21

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F 001	Continued From page 1	F 001	4) Administrator or designee will audit 5 rooms a week x 4 weeks to ensure rooms are not in need of repair; repairs will be scheduled as needed. Process will be reviewed in QA committee x 3 months for recommendations. F657 1) The comprehensive care plan for resident #36 code status has been reviewed and updated. 2) An audit was conducted by the MDS Coordinator to ensure all comprehensive care plans reflect the appropriate code status for each resident. No discrepancies identified. 3) the DON educated the MDS Coordinator all care plans must be reviewed and revised for appropriate code status change. 4) QA/Education Nurse and/or Designee will audit 5 care plans a week x 4 weeks for appropriate code status. Corrections will be made for any identified variances and appropriate staff will be re-educated. Process will be reviewed in QA committee x 3 months for recommendations. F658 1) the ICAPS for resident #67 was clarified with physician and the order updated in the EMR. 2) An audit was conducted by the Nursing Supervisor to ensure all residents	

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F 001	Continued From page 2	F 001	medications directly match physician orders in the EMR. All identified discrepancies were corrected. 3) QA/Education Nurse educated staff nurses to ensure medications directly match the physician's order prior to administration. 4) QA/Education and or Designee will audit 7 residents a week x 4 weeks to ensure there are no discrepancies between the medication ordered and the medication provided by the pharmacy. Variances will be investigated and attending physician will be notified for clarification. Process will be reviewed in QA committee x 3 months for recommendations. F849 1) Records of weekly hospice visits were provided to the facility for resident #14 by hospice provider. 2) An audit of all hospice residents has been completed by Nursing Supervisors to ensure records of weekly visits are provided to facility with credentials of person conducting visit. Corrections were made as necessary. 3) SW educated all hospice providers, in person or via phone, records of weekly visits are to be provided to the facility in a timely manner with credentials of person conducting visit.	

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F 001	Continued From page 3	F 001	4) QA/Education nurse and or designee will audit 4 hospice residents a week x 4 weeks to ensure records of weekly visits are provided to the facility. Variances will be investigated and corrected and hospice provider notified of concerns. Process will be reviewed in QA committee x 3 months for recommendations.	