STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215246	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedford Court Healthcare Cent.	3701 International Drive Silver Spring, MD 20906

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 42783 Based on review of the facility policy and interviews it was determined that the facility failed to ensure that grievance forms were accessible. This was found to be evident for 1 (Resident #244) out of 1 Resident reviewed for the grievance policy. The findings include: A review of a formal complaint MD00203191 filed with the Office of Healthcare Quality was conducted on 12/05/24 at 10:00 AM. The complainant stated that verbal grievances were filed by the Social Service Director on behalf of the complainant and Resident #244. The complainant also reported that a request to receive a copy of the written grievances was denied in accordance with the facility's policy. On 12/05/24 at 10:32 AM review of grievance forms confirmed Resident #244 had 2 investigated grievance forms. During an interview conducted on 12/05/24 at 11:10 AM, the Social Service Director stated that she filed the grievances on behalf of the complainant and Resident #244. The Social Service Director stated that the complainant requested a copy of the grievance forms investigated, however the request was denied because the grievance forms were an internal document not for the public view which was in accordance with the facility's policy. This Surveyor requested a copy of the grievance policy. On 12/05/24 at 11:19 AM, the Surveyor reviewed the facility's grievance policy which stated in Action Step #5 section c stated The SSC (Social Service Coordinator) / designee will: Make grievance reports readily accessible to residents, family, and team members. During an interview conducted on 12/05/24 at 12:22 PM, the Surveyor and Nursing Home Administrator (NHA) reviewed the grievance policy provided by the Social Service Director. The NHA confirmed that the facility's grievance policy stated that the facility would make the grievance policy accessible to residents, family, and team members. The NHA further stated that she would educate the Social Service Director on the facility's grievance policy.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42783 Based on record review and interview of staff it was determined that the facility failed to ensure Activities of Daily Living (ADL) was provided. This was found to be evident for 1 (Resident #244) out of 14 Residents reviewed for ADL care. The findings include: A review of a formal complaint MD00203191 filed with the Office of Healthcare Quality was conducted on 12/05/24 at 10:00 AM. The complainant stated that Resident #244 had not received showers as scheduled during his/her stay at the facility. A review of Resident #244's medical records conducted on 12/05/24 at 10:22 AM confirmed the resident shower days were scheduled for Tuesday and Friday evenings. According to the National Institute of Health (NIH) Activities of Daily Living (ADL) are basic self-care tasks which include toileting, dressing, bathing or showering, getting in/out of bed or chairs, and walking. A review of the Resident's medical record revealed Resident #244 was admitted to the facility on [DATE]. A further review of the resident's ADL task form for Bathing revealed the resident received a bed bath on 12/21/23 and 12/28/23 and a shower on 1/1/24. During an interview conducted on 12/05/24 at 10:32 AM, the NHA acknowledged that the resident did not receive bed baths and showers per the facility policy because the Bathing order was scheduled as needed in error.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50504 Based on observation, record review and interview, it was determined the facility failed to 1) obtain physician orders for residents to receive Continuous Positive Airway Pressure (CPAP) treatment and 2) maintain Quality of Care. This was evident for 3 (Resident #17, #8 and #292) of 24 residents reviewed during the annual survey The findings include: 1) CPAP treatment, which stands for Continuous Positive Airway Pressure, is a therapy that uses a machine to deliver pressurized air through a mask worn while sleeping, keeping the airway open and preventing breathing interruptions caused by sleep apnea. On 12/04/24 at 09:30AM during rounds the surveyor observed a CPAP machine sitting on Resident #17's bedside table. The resident stated he/she had problems sleeping so the machine was used at night. They put it on every night so I could sleep On 12/05/24 at 07:37 AM a review of Resident #17 clinical record confirmed that the resident had been receiving CPAP treatment at night. This was evident in a progress note dated 11/10/24 by Staff #17. Further review of the clinical record revealed no evidence of a physician's order for the CPAP treatment. On 12/05/24 at 08:56 AM in an interview with the Director of Nursing (DON) the surveyor enquired whether a physician order was required for a resident to receive CPAP treatment. The DON replied, who is the resident, tell me and I will get back to you? The surveyor gave the name of the resident to the DON. On 12/05/24 at 10:15AM the DON informed the surveyor that a physician's order was obtained for Resident #17's CPAP treatment and a copy of the order dated 12/5/24 was given to the surveyor. The Physician's order stated Apply CPAP at time of sleep in the night and remove in the AM every evening and night shift. Assist resident applying and removing CPAP. The order was confirmed in Resident#17's electronic chart by the surveyor. 51491 2a) During an observation on 12/04/24 at 12:41 PM Resident #8 was observed sitting in a wheelchair with another resident at the table. Resident #8 was slumped forward sleeping with a stream of drool draining from the resident's mouth onto the resident's lap. A plate of food was placed in front of the Resident and no food had been eaten. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/04/24 at 12:51 PM Resident #8 was observed still sitting in a wheelchair with another resident at the table. Resident #8 was still slumped forward sleeping with a stream of drool draining from his mouth onto his lap. A plate of food was placed in front of him/her and no food had been eaten. No assistance was provided from the staff. The surveyor attempted to awaken the resident by saying the resident's name but received no response. A Geriatric Nursing Assistant (GNA) (#9) came over to assist. The GNA had to say the Resident's name loudly and shake his/her shoulders to awaken him/her. The Resident appeared groggy and struggled to keep his/her head held up. The GNA had the resident taken back to his/her room. During an observation on 12/05/24 at 08:47 AM, Resident #8 was asleep in bed with a food tray set up in front of him/her. The resident would wake to verbal stimuli from the Surveyor but would fall back to sleep, with no assistance being provided or offered by staff, During an observation on 12/05/24 at 10:07 AM Resident is awake and in bed, breakfast tray still on table. The resident was still in the t-shirt he slept in. The resident appears very thin. During an observation on 12/05/24 at 12:38 PM Resident #8 was again observed slumped over and asleep in a wheelchair for lunch, no food had been delivered yet. The resident sat at a table in the corner alone and had wet spots on his/her shirt from drool. During the continued observation the Surveyors returned to the dining room at 12:47 PM. The Resident was still slumped forward sleeping. The Resident now had a plate of food in front of him/her. The Surveyors left the dining room and located the Assistant Director of Nursing (ADON). The Surveyors explained their concern with the ADON. The Surveyors and the ADON returned to the dining room and found the Resident still asleep, slumped forward and his/her food was untouched. The ADON woke the Resident by calling his/her name loudly and shaking his/her shoulders. The Resident responded but appeared groggy with difficulty lifting his/her head. There was visible drool on the napkin that lay on the Resident's lap. The MDS (Minimum Data Set) is a health status screening and assessment tool used for all residents of long-term care nursing facilities. The MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid-certified nursing homes. This process provides a comprehensive assessment of each Resident's functional capabilities and helps nursing home staff identify health problems. A Care Plan is used in nursing facilities to summarize a resident's health conditions and care needs. It is used to ensure resident's needs are met and consistent care is provided to the resident based on those needs. During a Medical Record Review on 12/06/24 at 08:41 AM it was revealed the Resident has had a 6.04% weight loss; the Residents weight was 122.5 pounds on 11/09/24 and 115.1 on 12/02/24. An additional record review showed the Resident's Minimum Data Set (MDS) in Section GG Functional Abilities identified the Resident as needing Supervision or touching assistance while eating and the helper provides verbal cues and/or touching/steadying and/or contact guard assistance as residence completes activity. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Service Evaluation and Health Assessment for Resident #8 identifies the Resident as I am dependent with assistance of helpers with eating. On the Resident's care plan, it states I require supervision or touching assistance with eating which was initiated on 11/13/2024. During a review of a Nutrition/Dietary on 12/09/24 at 8:33 AM, a note on 12/6/2024 at 07:04 AM was discovered and the Dietician identified the Resident as severely underweight noted with significant weight loss. During an observation on 12/10/24 at 09:18 AM, Resident #8 was sitting up in bed, falling asleep while eating. No facility staff in the room. During an observation on 12/11/24 at 10:09 AM Resident sitting up in bed, holding a piece of bacon in his hand, and falling asleep, no facility staff was with the resident, and food was running down the Resident's chin and spilled onto the napkin sitting on the Resident's chest. During a Medical Record Review on 12/11/24 at 12:56 PM, it was revealed that the resident has had additional weight loss. The Resident's weight was 122.5 pounds on 11/09/24 and 111.8 pounds on 12/10/24 for an 8.73% weight loss. 2b.) A hip abduction pillow is a soft but firm foam pillow that is placed between the thighs and strapped onto the patient's legs while they are in a resting position. This aids in keeping the body stable and prevents an abducting motion that could cause pain or further injury post-surgery. During a medical chart review on 12/10/24 at 07:57 AM it was revealed the Resident has had a Left femur fracture and had had surgery on his left hip. There was a doctor's order for the Abduction Pillow while in bed every shift which was ordered on 11/08/24. The Resident ' s Care Plan interventions included using the Abduction Pillow when in bed which was initiated on 11/13/24. During an observation on 12/10/24 at 10:17 AM LPN #18 showed the resident had Pressure-relieving boots on as ordered and it was noted the Resident did not have the abduction pillow in place. The pillow was observed on the floor in the corner of the room. During an observation on 12/11/24 at 12:56 PM, it was discovered that Resident #8 was asleep in bed, the Resident did not have the abduction pillow in place, it was sitting on the floor in the corner of the room. During an interview on 12/12/24 at 06:40 AM, the Surveyor asked RN #3 if Resident #8 had the abduction pillow in place. RN #3 reported, It should be, the evening shift does it. The Surveyor advised the order is scheduled for all three shifts when the Resident is in bed and RN #3 confirmed their initials as the last one to sign off the order. During an interview and observation with the Nursing Home Administrator (NHA) on 12/12/24 at 06:48 AM, the NHA was taken into the Resident's room and explained concerns about the order being signed off but the adduction pillow was not on the Resident. The abduction pillow was sitting on the floor in the corner of the resident's room. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Treatment Administration Record (TAR) on 12/12/24 at 07:10 AM it was revealed that the order for the Abduction Pillow to be on when the patient was in bed had been signed off as complete for every shift that occurred from 12/04/24 through 12/12/24. During an observation of Resident #8 on 12/12/24 at 09:12 AM, it was discovered the Abduction Pillow is no longer in the corner of the room. The Abduction Pillow was found on the Resident while he/she was lying in bed. 2c) During an observation on 12/04/24 at 7:58 AM the daughter of Resident #292 advised Registered Nurse (RN) #3 that the Resident was vomiting. The RN returned to the nursing station without any intervention or assessment of the Resident. During an interview with the daughter conducted on 12/04/24 at 08:08 AM she reported that Resident #292 had been having lots of pain and was now vomiting. During an interview with Licensed Practical Nurse (LPN) #6 on 12/04/24 at 08:10 AM, the Surveyors made LPN #6 aware of Resident #292 complaining of pain and vomiting. The LPN reported that RN # 3 had left and that the nurse for that area was on the way. During an interview on 12/04/24 at 8:42 AM, LPN #13 stated she arrived at the facility at 8:15 AM. When asked if she received a report on Resident #292, the LPN stated that RN #3 reported that the Resident had complained of pain and wanted Gabapentin. She further stated that the RN reported that the medication had not been ordered during RN #3's night shift. The LPN did not report that the RN notified her that Resident #292 had vomited. During an interview with the Nursing Home Administrator (NHA) on 12/04/24 at 09:22 AM, the NHA reported that when a nurse is running late, the facility expects the nurse assigned to remain on duty until the oncoming nurse arrives and relieves the nurse of their duties. The NHA further stated that the Assistant Director of Nursing (ADON) can also fill the staffing vacancies as needed. The NHA confirmed she was not aware that RN #3 left the facility before being relieved of his duties by the late oncoming nurse and that the middle hallway was unattended until the oncoming nurse arrived. During an interview on 12/06/24 at 06:26 AM, RN #3 stated he did not return to Resident #292 after being advised that the resident had vomited. The RN reported that he told the Geriatric Nursing Assistant #9 GNA about the Resident vomiting before leaving. When asked why the RN told the GNA about the vomiting resident and why he did not assess the Resident, the RN advised I don't have an answer. The RN confirmed he gave a verbal report over the telephone to LPN #13 and left a written report inside the medication cart. During an interview on 12/06/24 at 07:16 AM, GNA #9 reported becoming aware of Resident #292 concerns by the daughter in the hallway. The GNA #9 advised she assisted the resident to the bathroom. During an interview on 12/06/24 AM at 0950, the Resident's daughter reported no nurse came in to care for her mother for about an hour. LPN #13 was the first nurse that came into her room after the Resident vomited. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of staff clock time reports it was revealed that RN #3 clocked out at 08:03 AM and LPN #13 clocked in at 08:34 AM to fill her role as the nurse in the middle hall.