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	03/20/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to verify the accuracy of hospital discharge paperwork prior to placing admission medication orders for newly admitted residents. This was evident for 1 (Resident #40) out of 20 residents reviewed during the survey.The findings include: On 03/18/2026 at 11:44 AM, the surveyor began reviewing a complaint that stated Resident #40 received incorrect medication on the first 4 days of their stay.On 03/18/2026 at 12:02 PM, record review revealed that Resident #40 was admitted to the facility from the hospital on [DATE]. Discharge paperwork from the hospital dated 02/20/2026 reflected that the resident was prescribed the following medication at the hospital: Eliquis (blood thinner) 5 mg by mouth twice daily, amiodarone (blood pressure medication) 200 mg 1 tablet by mouth once daily, and Buspirone (anxiety medication) 5 mg take 1 tablet by mouth twice daily.Facility records indicated that orders were entered for Eliquis (blood thinner) 5 mg by mouth once daily with a start date of 02/21/2026 and a discontinue date of 02/25/2026, and was administered as ordered. Amiodarone 200 mg by mouth twice daily was also ordered with a start date of 02/21/2026 and a discontinue date of 02/25/2026, and was administered as ordered. Additionally, Losartan Potassium (blood pressure medication) 50 mg by mouth once daily was ordered and administered from 02/21/2026 through 02/27/2026; however, this medication was not listed on the hospital discharge medication list. Buspirone administration began on 02/27/2026.In an interview on 03/18/2026 at 1:03 PM, the Medical Director (Staff #9) recalled that a medication error had occurred involving the above medications for Resident #40. Staff #9 indicated that these errors were corrected once discovered by nursing staff and that the corrections had been made by the time he evaluated the resident. On 03/19/2026 at 9:19 AM, an interview with the Director of Nursing revealed that the facility had received the resident's hospital discharge summary from a prior hospitalization on 07/18/2025. However, the Director of Nursing also stated that nursing staff had misread the date and did not identify the error. The error was corrected after it was identified by a family member four days after admission during which the resident had been receiving incorrect medication. On 03/19/2026 at 10:55 AM, the surveyor reviewed the hospital discharge paperwork from 07/18/2025 and confirmed the error.

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

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	03/20/2026

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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and staff interview, it was determined that the facility failed to ensure that controlled substances were consistently accounted for and documented through the required dual nurse signatures during shift-to-shift narcotic counts. This was evident for 2 (Choice and Independent) out of 3 units during the facility's recertification survey.The findings include:On 03/17/2026 at 9:18 AM, following an observation of a medication pass conducted by the surveyor on the choice unit with Licensed Practical Nurse (LPN) #7, the surveyor reviewed the narcotic control book and identified a missing signature for the incoming nurse on 03/13/2026 for the 3:00 PM to 11:00 PM shift, as well as a missing signature for the outgoing nurse for the 11:00 PM to 7:00 AM shift. LPN #17 was requested to participate in a concurrent review of the narcotic book and she confirmed the date and the absence of the required signatures. On 03/17/2026 at 9:20 AM, during an interview with LPN #7, when asked for the expectation regarding signing in the narcotic book, she stated that at the beginning of each shift, narcotics are counted jointly by the outgoing and incoming nurses, and both nurses are expected to sign the narcotic book to validate that the count was completed. When asked why the signatures were missing, LPN #7 stated that the incoming nurse experienced a family emergency, and a nurse from another unit assisted with the narcotic count. LPN #7 further stated that although the count was completed and report was given, the assisting nurse failed to sign the narcotic book. LPN #7 indicated that she would follow up with LPN #17, who assisted with the count, to determine why the signature was omitted and to request completion of the documentation.On 03/18/2026 at 8:36 AM, following an observation of a medication pass conducted by the surveyor on Independence unit with LPN #21, the surveyor reviewed the narcotic binder and identified three missing signatures. These included a missing signature for the incoming nurse on 03/01/2026 for the 3:00 PM to 11:00 PM shift, a missing signature for the outgoing nurse on the same date for the 11:00 PM to 7:00 AM shift, and a missing signature for the incoming nurse on 03/04/2026 for the 11:00 PM to 7:00 AM shift. LPN #21 reviewed the narcotic binder and confirmed the missing signatures. On 03/18/2026 at 8:38 AM, during an interview, LPN #21, when she was asked about the facility's expectation for signing the narcotic book, LPN #21 stated that both the outgoing and incoming nurses are required to sign to verify that the narcotics were counted.On 03/18/2026 at 8:42 AM, LPN #7 approached the surveyor and reported that LPN #17 had subsequently signed the narcotic book while present in the facility for her shift on the night of 03/17/2026.On 03/19/2026 at 7:29 AM, during an interview with the Director of Nursing (DON), when asked for the expectation regarding signing the narcotic book, she stated that the expectation was for two nurses (the outgoing nurse and the incoming nurse) to sign the narcotic book after jointly counting and verifying that all controlled medications are accounted for. The DON further stated that the presence of two signatures serves as documentation that the narcotic count was completed. When the DON was informed of the identified missing signatures, she acknowledged the findings.