

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>51491</p> <p>Based on observation and interviews with residents and staff, it was determined that the facility failed to respect a resident's dignity. This was evident in 1 (Resident #8) out of 6 residents observed for dignity.</p> <p>The findings include:</p> <p>During an observation on 12/04/24 at 12:41 PM Resident #8 was observed sitting in a wheelchair with another resident at the dining room table. Resident #8 was slumped forward asleep with a stream of drool draining from the resident's mouth onto the resident's lap. A plate of food was sitting in front of the resident on the dining room table and no food had been eaten.</p> <p>During continued observation on 12/04/24 at 12:52 PM Resident #8 was observed sitting in a wheelchair asleep. No assistance was being provided by 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 the resident's shoulders to awaken. The resident appeared groggy and would not hold his/her head up. The GNA stated that she would take the Resident to his/her room.</p> <p>During an observation on 12/05/24 at 12:38 PM Resident #8 was observed slumped over sleeping in his/her wheelchair at lunch, no food had been delivered yet. The resident was sitting at a table in the corner alone and had wet spots on his/her shirt from drool.</p> <p>During an observation on 12/05/24 at 12:41 PM Resident #8 was slumped over sleeping. No attempts to awaken or any other assistance had been given to the resident. No food had been delivered to the Resident.</p> <p>During the continued observation the Surveyors returned to the dining room at 12:47 PM. The Resident was still slumped forward asleep. The Resident now had a plate of food in front of him/her.</p> <p>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.</p> <p>(continued on next page)</p>

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:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>The ADON stated, This is unacceptable. The ADON advised the surveyors that she would have someone to sit with the resident during his/her meals.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0577</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>50504</p> <p>Based on observations and interview, it was determined the facility failed to ensure that the location of the most recent state survey results and plan of correction were posted in a place readily accessible to residents, family members and visitors. This was evident during the facility's recertification survey.</p> <p>The findings include:</p> <p>The surveyor's observations of the facility on 12/05/24 at 8:00AM and 12/6/24 at 7:30AM did not reveal any posted notification indicating where the recent state survey results and plan of correction were located.</p> <p>On 12/09/24 at 07:56 AM in an interview, the Nursing Home Administrator confirmed that the facility failed to post a sign indicating where the most recent survey inspection was located. The Administrator stated I will take care of that right now</p> <p>After the surveyor's intervention, on 12/09/24 at 09:54 AM the surveyor observed a sign which revealed the location of the recent state survey inspection results, posted in a place easily accessible to any person, on a table in front of the nurse's station.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>50502</p> <p>Based on record review and interview, it was determined that the facility failed to provide evidence that an advance directive was offered to the residents. This was evident for 2 (Resident #22 and #37) of 4 residents reviewed for advance directives during the recertification survey.</p> <p>The findings include:</p> <p>An advance directive is a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor. It is a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity.</p> <p>A Medical Orders for Life-Sustaining Treatment (MOLST) is a medical order form that documents a patient's wishes for end-of-life care.</p> <p>A Brief Interview for Mental Status (BIMS) is a brief cognitive screening measure that focuses on orientation and short-term word recall.</p> <p>On 12/5/24 at 7:45 AM, a review of Resident #22 and Resident #37's paper charts revealed capacity forms that were completed on 11/14/24 which indicated that they were both capable. Further review of their paper and electronic health records revealed no evidence that an advance directive was offered to the residents.</p> <p>On 12/5/24 at 8:13 AM, during an interview with the Social Worker, she stated that Resident #22 and Resident #37 had no advance directives in the charts. The Social worker also discussed the process when the facility had new admission, she stated that she made sure the resident was seen within 24 hours and if it was a Friday admission, she saw the resident on a Monday. She added that she checked the capacity and went over the home situation to have an idea of the discharge planning. She also stated that she checked if BIMS was conducted by nursing staff and redid if needed. She also checked the MOLST and asked the resident if they had an advance directive and if the resident had one, she would ask the family to bring to the facility and followed up the resident representative after a week, if there was none, she stated that she asked the resident to complete a surrogate form to determine the decision maker. She further stated that she offered the residents or the resident representatives to formulate an advance directive, however, she confirmed that she did not document it in the medical records.</p> <p>On 12/6/24 at 7:36 AM, a record review revealed that the Social worker documented these progress notes to the following residents after surveyors' intervention:</p> <p>- Resident #37, 12/5/2024 13:42 Discussed Advance Directives with resident. Resident states he/she has informally appointed his/her son but has not put anything in writing. Resident accepted a copy of the advance directives to review with his/her son.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Resident #22, 12/5/2024 13:46 Spoke with resident about advance directives. Resident states he/she believes he/she has documents but will discuss with family. Resident declined a copy of the advance directives.</p> <p>On 12/12/24 at 10:20 AM, the facility was made aware of the concern with advance directives during the exit meeting.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>50502</p> <p>Based on record review and interview, it was determined that the facility failed to develop and implement a comprehensive care plan for the use of a splint. This was evident for 1 (Resident #37) of 32 residents reviewed for care planning during the recertification survey.</p> <p>The findings include:</p> <p>A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care.</p> <p>On 12/4/24 at 11:32 AM, Resident #37 was observed sitting in the wheelchair and was noted with left arm weakness, his/her arm was supported by a half lap board arm rest attached to the wheelchair, a plastic splint was also noted on the windowsill.</p> <p>On 12/5/24 at 10:02, a review of the physician orders revealed the following:</p> <ul style="list-style-type: none"> <li>- Start Left upper extremity rigidity splint during day shift. (Can be removed during therapy) every day shift, this order was written on 11/18/2024</li> <li>- Start Left upper extremity soft brace Elbow QHS (Once a day at bedtime) every evening shift , this order was written on 11/18/2024</li> </ul> <p>On 12/6/24 at 12:30 PM, a review of Resident #37's care plan revealed no evidence that a care plan was formulated for splint use since 11/18/2024.</p> <p>On 12/9/24 at 9:05 AM, the Nursing Home Administrator (NHA) confirmed that there was no splint care plan in Resident #37's medical record.</p> <p>On 12/9/24 at 9:28 AM, during an interview with the acting Director of Nursing (DON), she revealed the process of how the care plan was formulated. She stated that the nurse who completed the admission assessment initiated the new resident's care plan. She added that when there were changes to the care plan that needed to be made, the DON, NHA, Social Worker and the Resident Assessment Coordinator would update the resident's care plan. The Acting DON was notified that Resident #37 was started on a splint to the left arm on 11/18/2024, however, the care plan was never formulated.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50504</p> <p>Based on medical record review, and staff interview, it was determined the facility staff failed to review and revise the interdisciplinary care plans to reveal accurate interventions to meet the needs of the residents. This was evident for 1 (Residents #17) of 24 residents selected for investigation during the survey process.</p> <p>The findings include:</p> <p>A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care</p> <p>A peripherally inserted central catheter (PICC) line is a thin, flexible tube that is inserted into a vein in the arm or neck and threaded into a large vein in the chest. A PICC line can be used for many types of intravenous treatments.</p> <p>Resident #17 was admitted to the facility on [DATE] with physician orders for intravenous (IV) antibiotic treatment via PICC line for Osteomyelitis.</p> <p>On 12/5/24 at 8:16AM in an interview, Resident #17 informed the surveyor that his/her antibiotic treatment ended about 2 weeks ago and he/she no longer had a PICC line.</p> <p>On 12/6/24 at 9:37AM a review of Resident #17's medical record revealed that resident received antibiotic via PICC line four times a day from 10/4/24 to 11/7/24. The medical record also revealed that the PICC line was removed on 11/7/24 after completion of the antibiotic treatment.</p> <p>Further, a review of the Resident#17's plan of care revealed interventions initiated on 10/5/24 for PICC line care remained active after the PICC line was removed. The Care plan stated the resident is receiving IV antibiotic therapy through PICC line r/t Osteomyelitis. Change PICC site gauze dressing/securement device as ordered. Flush PICC as ordered</p> <p>On 12/05/24 10:15AM in an interviewed the DON confirmed that the care plan interventions should have been discontinued after the PICC line was removed. The surveyor was given a copy of an updated care plan for Resident # 17 with the interventions for the PICC line discontinued.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>50504</p> <p>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</p> <p>The findings include:</p> <p>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.</p> <p>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</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>51491</p> <p>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.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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,</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 abduction pillow was not on the Resident. The abduction pillow was sitting on the floor in the corner of the resident's room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>48393</p> <p>Based on observations, clinical record review, and staff interviews it was determined that the facility failed to maintain oxygen therapy equipment according to professional standards of practice. This was found to be evident for 2 (#24 and #11) out of 2 residents reviewed for respiratory care during the annual survey.</p> <p>The findings include:</p> <p>1) During an observation on 12/04/24 at 11:09 AM, Resident #24's oxygen tubing and the humidification bottle were not labeled.</p> <p>On 12/05/24 at 09:17 AM, review of Resident #11's clinical record revealed the following physician orders:</p> <p>Date 04/26/2024 O2 (oxygen) via NC (nasal cannula) at 3L/min (liters per minute) for chronic obstructive pulmonary disease (COPD)</p> <p>Date 08/16/2022 Change humidifier bottle weekly and PRN (as needed) secondary to pt (patient) on oxygen every night shift every Wednesday and as needed</p> <p>During a second observation on 12/05/24 at 08:30 AM, Resident 24's oxygen tubing and the humidification bottle were not labeled.</p> <p>On 12/06/24 at 11:25 AM, an interview with Licensed Practical Nurse (LPN) #6 revealed that oxygen tubing and humidification bottles should be changed on 11pm - 7am shift every week according to physician orders and labeled. LPN #6 stated that when the oxygen tubing and humidification bottle is changed, the date is written on the humidification bottle. LPN #6 further stated that he/she assumes both the oxygen tubing and humidification bottle are changed on the date written on the humidification bottle.</p> <p>Resident #24's oxygen tubing and humidification bottle were observed together with LPN #6 who confirmed that there was no date / label on the humidification bottle and stated that he/she did not know when the oxygen tubing or humidification bottle was changed. LPN #6 further stated, I will change the oxygen tubing and humidification bottle and label them now.</p> <p>During a follow up interview with the Assistant Director of Nursing (ADON) on 12/09/2024 at 11:26 AM, the ADON stated that it is the expectation of nursing staff to change a resident's oxygen tubing and humidification bottle according to physician orders and label the oxygen tubing and humidifier bottle when it is changed.</p> <p>On 12/06/24 11:38 AM, an interview was conducted with the Nursing Home Administrator (NHA) and Regional Director of Clinical Care at which time the surveyor discussed the concerns regarding unlabeled oxygen therapy equipment.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2) During an observation on 12/05/24 at 07:59 AM, Resident #11's oxygen tubing and the humidification bottle were not labeled.</p> <p>On 12/05/24 at 09:17 AM, review of Resident #11's clinical record revealed the following physician orders:</p> <p>Date 10/01/2021 Change oxygen humidifier bottle every week every night shift every 7 day(s)</p> <p>Date 10/01/2021 Change oxygen tubing every week and prn (as needed) every night shift every 7 day(s)</p> <p>During a second observation on 12/06/24 at 11:12 AM, Resident 11's oxygen tubing and the humidification bottle were not labeled.</p> <p>On 12/06/24 at 11:25 AM, an interview with Licensed Practical Nurse (LPN) #6 revealed that oxygen tubing and humidification bottles should be changed on 11pm -7am shift every week according to physician orders and labeled. LPN #6 stated that when the oxygen tubing and humidification bottle is changed, the date is written on the humidification bottle. LPN #6 further stated that he/she assumes both the oxygen tubing and humidification bottle are changed on the date written on the humidification bottle.</p> <p>Resident #11's oxygen tubing and humidification bottle were observed together with LPN #6 who confirmed that there was no date / label on the humidification bottle and stated that he/she did not know when the oxygen tubing or humidification bottle was changed. LPN #6 further stated, I will change the oxygen tubing and humidification bottle and label them now.</p> <p>During a follow up interview with the Assistant Director of Nursing (ADON) on 12/09/2024 at 11:26 AM, the ADON stated that it is the expectation of nursing staff to change a resident's oxygen tubing and humidification bottle according to physician orders and label the oxygen tubing and humidifier bottle when it is changed.</p> <p>On 12/06/24 11:38 AM, an interview was conducted with the Nursing Home Administrator (NHA) and Regional Director of Clinical Care at which time the surveyor discussed the concerns regarding unlabeled oxygen therapy equipment.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42783</b></p> <p>Based on observations and staff interviews it was determined that the facility failed to maintain a safe and effective system for securing medication. This was found to be evident for 3 out of 3 medication carts observed during the re-certification survey.</p> <p>The findings include:</p> <p>During a random tour of the nursing unit conducted on 12/06/24 at 6:12 AM, the surveyors observed an unattended medication cart unlocked. The surveyors were able to open each drawer that contained prescribed and over the counter medications. In addition, the laptop was open to resident names. The medications were labeled with resident names and room numbers. During the continued observation the Surveyors observed RN #3 exit resident room [ROOM NUMBER].</p> <p>During an interview conducted on 12/06/24 at 6:16 AM, RN #3 apologized for leaving his medication cart unattended and unlocked as well as the laptop open to resident names. The RN stated that he had a rough night but that the facility's policy was to always lock your medication cart when unattended as well as lock the screen on the laptop.</p> <p>On 12/06/2024 at 8:10 AM, during an interview this surveyor advised the NHA of the observation of the unlocked med cart.</p> <p>On 12/09/2024 at 6:22 AM the surveyors observed an unattended medication cart unlocked. The surveyors were able to open each drawer that contained prescribed and over the counter medications. The medications were labeled with resident names and room numbers. During the continued observation, Licensed Practical Nurse (LPN) 12 was observed exiting resident room [ROOM NUMBER].</p> <p>During an interview conducted on 12/09/2024 at 6:26 AM, the NHA and Regional Director of Clinical Care #1 observed the unlocked med cart and stated they would educate the LPN and staff on unattended unlocked med carts.</p> <p>During a random observation conducted on 12/09/2024 at 10:09 AM, the surveyor observed a medication cart unattended and unlocked. The surveyors were able to open each drawer that contained prescribed and over the counter medications. The surveyor then went to the NHA and Regional Director of Clinical Care #1 and advised another medication cart was unlocked. Both the NHA and Regional followed the surveyor back to the unattended unlocked medication cart and observed LPN #18 exit resident room [ROOM NUMBER] from down the hallway. The LPN returned to the unlocked medication cart and locked his cart.</p> <p>During an interview conducted on 12/09/24 at 10:14 AM, the LPN stated the facility's policy is to always lock your assigned medication cart when unattended. The NHA stated she has educated the nursing staff and would continue the education.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51491</p> <p>Based on observations and interviews with facility staff, it was determined that the facility failed to store and prepare food in a manner that maintains professional standards of food service safety. This practice had the potential to affect all residents eating food prepared by the facility kitchens.</p> <p>The findings include:</p> <p>During observations in the Dining Room Kitchen on [DATE] at 08:15 AM, the following items were found: 1 metal container with a lid containing cooked ham labeled with a prepared date of [DATE] and a use by date of [DATE], 1 unlabeled and undated pack of cheese in clear plastic wrap, 1 undated plastic container labeled Rice Krispies, 1 5-pound plastic container of Creamy Peanut Butter that had an open date of ,d+[DATE] with no year written on the lid but had no expiration date identified. There was also 1 container of Old Bay seasoning that was labeled with an open date of [DATE] and a use-by date of [DATE].</p> <p>During an interview with the Lead Dietary Aide #2 On [DATE] at 08:15 AM, the Lead Dietary Aide acknowledged the pack was some type of cheese but was unable to identify it and was unsure when it was opened or when it would expire. The Lead Dietary Aide further stated I didn't know what expiration date to put for the cereal so it's not labeled yet. We are waiting for the manager to advise a date on expirations. The Lead Dietary Aide reported that things are not labeled because I don't know the correct date to put. The Lead Dietary Aide observed the expired Old Bay Seasoning, acknowledged the seasoning had expired, and explained it should have been disposed of once it expired.</p> <p>During the initial tour of the Main Kitchen on [DATE] at 8:30 AM conducted with the lead Cook, several items were found opened with no label showing the expiration date. The following foods identified were:</p> <p>Foods found in the refrigerators opened and with no expiration date:</p> <p>A plastic container containing Roasted Peppers had a label with a prepared date of [DATE] and no expiration date.</p> <p>Three undated aluminum pans filled with muffins with no label or dates.</p> <p>Cookie dough wrapped in plastic wrap in a metal pan with no label or dates.</p> <p>Tomato sauce in a plastic container with no label or dates.</p> <p>Pearl Onion in a blue bag with no label or dates.</p> <p>Wholesome Farms Sour Cream 5-pound plastic container in the refrigerator with no label or dates.</p> <p>Ken's Essentials Classic Caesar Dressing gallon plastic container with no label or dates.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Sysco Classic Mint Jelly 4-pound glass jar in refrigerator with no label or dates.</p> <p>Ken's Fat-Free Italian Dressing 1 Gallon plastic container with no label or dates.</p> <p>Ken's Deluxe Thousand Island Dressing 1 Gallon plastic with no label or dates.</p> <p>Sysco Imperial [NAME] French Dressing 1 Gallon plastic container with no label or dates.</p> <p>Plastic Container with a Facility label labeled as Honey mustard in a gallon container with no label or dates.</p> <p>Block &amp; Barrel Mild Banana Pepper Rings ,d+[DATE] Crinkle Cut 1 gallon container with no label or dates.</p> <p>[NAME] Premium Capers Non-Pareille Crunchy &amp; Briny 1 Quart Glass jar with no label or dates.</p> <p>Ken's Table Side Caesar Dressing gallon plastic container with no label or dates.</p> <p>Ken's Ranch gallon plastic container with no label or dates.</p> <p>Bag of shredded carrots open, top loosely folded over with no label or dates.</p> <p>5 dressing dispensers unlabeled with dressing in the dispensers with no label or dates.</p> <p>Apple pie -,d+[DATE] pie in an aluminum pie pan dated as prepped on [DATE], with no expiration date or label.</p> <p>Pecan Pie -,d+[DATE] pie in an aluminum pie pan dated as prepped on [DATE], with no expiration date or label.</p> <p>King's Hawaiian Original Sweet Roll's pack of 24 rolls has been opened with no label or dates.</p> <p>La Catalina Blueberries opened with no label or dates.</p> <p>Jello in a metal container with no label or dates</p> <p>Land O Lakes Half and Half opened with no label or dates.</p> <p>Two Containers of Minor's Zesty Orange Sauce half a gallon plastic containers with no label or dates.</p> <p>Sweet Baby Ray's Barbeque Sauce gallon plastic container opened with no label or dates.</p> <p>[NAME] Wild Swedish Lingonberries 14.2 oz jar with no label or dates.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Additionally, there were two expired items found in the refrigerator, 1 plastic container of [NAME] Bananas [NAME] with a prepared date of [DATE] and an expiration date of [DATE] and 1 14.2-ounce jar of [NAME] Wild Swedish Lingonberries with an opened date of ,d+[DATE] with no year written and an expiration date of , d+[DATE] with no year written.</p> <p>During an interview with Lead [NAME] #1 on [DATE] at 08:47 AM, the Lead [NAME] agreed the items were expired and should have been disposed of and would be thrown out.</p> <p>During the continued tour foods were found on the counters and freezers opened and with no expiration date including:</p> <p>On the counters, there was 1 [NAME] Mayo 12 FL oz plastic container with no label or dates,</p> <p>2 House Recipe Fancy Tomato Ketchup 24 oz plastic containers with no label or dates and 1 glass bottle of A.1. Original sauce glass bottle with no label or dates.</p> <p>In the freezer, there was 1 bag of biscuits that laid in a pan with no label or dates, 1 unwrapped pita that sat in a container with no lid, label, or dates, 1 pie crust opened with no label or dates,</p> <p>4 metal containers of muffins covered with aluminum foil, with no dates on three and one with a date of [DATE], 3 pizzas in an opened bag open to air with no label or dates, 1 large bag of biscuits in a tied bag in the freezer with no label or dates, pearl onions in a blue bag with no label or dates, pierogies classic cheddar 6-pound bag with no label or dates.</p> <p>Meat was found in a sealed bag in the freezer and did not have a label or expiration date. The Lead [NAME] #1 was unable to identify what was in the package and advised it was some kind of meat.</p> <p>During the tour, the surveyors observed a sign posted on a refrigerator that stated Make sure all open items in this refrigerator have a label with the following information - item description, item opened date, item expiration date, initials of team member who wrote the labels. There are no exceptions.</p> <p>An observation of the outside walk-in freezer was conducted on [DATE] at 8:58 AM. There was a plastic 12-quart container with no lid that sat on the bottom shelf of the freezer rack. The container had several prepackaged unidentified items and some ravioli wrapped loosely in a bag. A light brown sticky substance had leaked into the container and onto several of the food items.</p> <p>During observations of each refrigerator and freezer in the Main Kitchen during the initial tour, it was discovered that none of the refrigerators and freezers had internal temperature monitoring devices in place and the logs to record the temperatures were incomplete.</p> <p>During an interview with Lead [NAME] #1 on [DATE] at 08:36 AM, the Lead [NAME] reported he didn ' t know a device was needed to measure the internal temperatures and that the staff used the external thermometer to monitor the temperatures.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the Dining Service Director on [DATE] at 9:46 AM, the Dining Service Director was made aware of the issues with the unlabeled items, expired items, the lack of internal temperature monitoring, and the incomplete records of the refrigerator and freezer temperatures. The Director stated that the facility follows a health code for the time that open foods can be kept. The Director reported he was having staffing issues but there's no excuse for the findings.</p> <p>During a follow-up interview conducted on [DATE] at approximately 11:15 PM, the Director of Dining advised the Surveyors that thermometers had been ordered for each refrigerator and freezer.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dispose of garbage and refuse properly.</p> <p>51491</p> <p>Based on observations and interviews, it was determined that the facility failed to properly dispose of waste in the kitchen area in a manner to prevent contamination and the attraction of pests. This was evident for 1 out of 2 kitchen areas in the facility.</p> <p>The findings include:</p> <p>During the initial tour of the main kitchen on 12/04/24 at 8:36 AM, the Surveyors observed a pile of 14 empty boxes that lay on the floor beside the doorway. The pile of boxes blocked the doors of the free-standing refrigerator, freezer, and holding warmer. An observation of the trash can beside the door was overfull and would not allow the lid to completely close. Several Sysco Classic Sliced [NAME] Potatoes cans were visible on top of the trash holding the lid open.</p> <p>During an interview on 12/04/24 at 08:40 AM, Lead [NAME] #1 said the trash should not be there and needs to be cleaned up.</p> <p>During an interview conducted on 12/04/24 at 9:46 AM, the Dining Service Director stated that the boxes should not have been piled on the floor and the trash overfilled and stated there was no excuse.</p> <p>During an observation with the Dining Service Director of the dumpster area on 12/06/24 at 10:24 AM, it was discovered that trash was not disposed of properly. The area was fenced in with trash scattered over several areas. Trash was found lying around the dumpster, against the fence, and other parts of the dumpster area, trash included disposable cups, papers, and carry-out trays. There is also a heavy buildup of dried leaves around the dumpster area. A cart with two bags of trash was noted sitting beside the dumpster waiting to be thrown out and a stack of boxes was sitting beside the dumpster.</p> <p>During an interview with the Dining Service Director on 12/06/24 at 10:26 AM, he advised he was going to have someone come to clean up and throw away the trash left beside the dumpster. The Director stopped to tell a passing dietary employee to make sure the trash is thrown away because it can attract rodents.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>50502</p> <p>Based on observation, record review and interview, it was determined that the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 2 (Resident #3 and #8) of 24 residents reviewed the recertification survey.</p> <p>The findings include:</p> <p>A fever is a body temperature of 100.4 F (38 C) or higher, as measured by a thermometer.</p> <p>On 12/4/24 at 10:49 AM, Resident #3 was observed lying in bed and complained of pain in the left leg with a score of 10/10. The resident was also observed grabbing his/ her left leg and was grimacing. The assigned Licensed Practical Nurse (LPN #8) was made aware and stated that he/she will administer the routine Tylenol order.</p> <p>On 12/9/24 at 8:44 AM, a review of the active pain medication orders and Medication Administration Record (MAR) revealed:</p> <ol style="list-style-type: none"> <li>1. Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth three times a day for Leg Pain</li> <li>2. Tylenol Oral Tablet 325 MG (Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for Pain</li> <li>3. Ibuprofen Oral Tablet 200 MG (Ibuprofen) Give 2 tablet via G-Tube every 4 hours as needed for fever. However, this medication was administered on the following dates for pain instead of fever.</li> </ol> <p>November 5- pain score 3/10</p> <p>December 5- pain score 3/10</p> <p>December 6- pain score 3/10</p> <p>December 7- pain score 4/10</p> <p>December 8- pain score 3/10</p> <p>On 12/09/24 at 10:00 AM, a review of Resident #3's vital signs record revealed no temperatures above 100.4 F on the following dates:</p> <p>12/5/2024 15:14 97.7 F</p> <p>12/6/2024 14:41 97.7 F</p> <p>12/7/2024 13:44 97.7 F</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12/8/2024 14:14 97.6 F</p> <p>On 12/09/24 at 10:04 AM, a review of Resident #3's progress notes did not indicate any episodes of fever from December 4 through 8, 2024.</p> <p>On 12/10/24 at 7:35 AM, in an interview with LPN #3, he/she described the pain management process. He/she stated that he/she would ask an alert/oriented resident if he/she was in pain and asked the pain level and if the resident was confused, the nurses would use the non-verbal signs of pain such as facial grimacing. He/she confirmed that the nurses should administer the pain medication as ordered and would let the doctor know if resident is not on any pain medication.</p> <p>On 12/10/24 at 8:46 AM, during an interview with the Director of Nursing (DON), she stated that nurses were expected to assess the resident's pain and to document in the Treatment Administration Record (TAR) and in the progress notes. She added that the indication should be followed by the nurses when pain medications were administered. The ADON was made aware that Resident #3 was given Ibuprofen for four days for fever, however the resident did not have any episodes of elevated temperature on December 5,6,7 and 8. She stated that she would let the doctor know to clarify the order because Ibuprofen was supposed to be for breakthrough pain.</p> <p>On 12/10/24 at 10:15 AM, the DON gave the surveyor a copy of the clarification order for the Ibuprofen. The order was written on 12/10/24 at 10:00 am, it read, Clarification order. Ibuprofen oral tablet 200 mg tablet. Give 2 tablet by mouth every 4 hours as needed for Breakthrough pain. Discontinue previous order.</p> <p>51491</p> <p>During a medical record review on 12/10/2024 at 7:17 AM it was discovered that Physician's orders were placed for Resident #8; however, the order did not transmit to the Treatment Administration Record (TAR) for daily monitoring of an Antipsychotic medication, Behavior monitoring, Anticoagulant and an Antidepressant medication as listed below:</p> <p>1. Resident #8 ordered Risperdal 1 mg twice a day for psychosis which started on 11/13/24 and the Resident should be monitored for side effects that were not identified on the daily task form, the TAR. The order stated, Antipsychotic Medication - monitor for dry mouth, constipation, blurred vision, disorientation/confusion, difficulty urinating, hypotension, dark urine, yellow skin, Nausea and vomiting, Lethargy Drooling, Tremors, Disturbed Gait Increased Agitation, Restlessness, involuntary movement of mouth or tongue (Document Y if monitored and none of the above observed. N if monitored and any of the above was observed, select chart code other/see nurses notes and progress note findings every shift for behavior.)</p> <p>A review of The Service Evaluation and Health Assessment 3c conducted on 12/10/24 at 7:33 AM showed the Resident's Anti-psychotic care plan and listed an intervention as monitoring for side effects and effectiveness.</p> <p>The Resident's Care plan identified the resident as being on antipsychotic medication, an antidepressant medication, and an anticoagulant medication. The Care plan lists interventions to monitor for side effects and effectiveness of the medication during every shift, anticoagulant therapy monitor for side effects and effectiveness.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident #8 had a history of Schizophrenia and Depression. The order was placed to monitor the Resident's behaviors but was not transmitted for daily monitoring on the TAR. The order read Behaviors monitor for the following restlessness, (agitation) hitting, increase in complaints, biting, kicking, spitting, cussing, racial slurs, elopement, stealing, delusions, hallucinations, psychosis, aggression, refusing care. (Document Y if monitored and none of the above observed. N if monitored and any of the above was observed, select chart code other/see nurses notes and progress note findings every shift for every shift to monitor behavior.)</p> <p>3. Resident #8 had an order for Lovenox 40 mg an Anticoagulant medication to prevent blood clots. Daily monitoring was not transmitted to the TAR. The Order identified, Anticoagulant medication - monitor for discolored urine, black tarry stools sudden severe, headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and/or V/S, SOB, Nose bleeds. (Document Y if monitored and none of the above observed. N if monitored and any of the above was observed, select chart code other/see nurses notes and progress note findings every shift on Anticoagulant every shift for anticoagulant</p> <p>4. Resident #8 was ordered Mirtazapine 7.5mg for bipolar disorder. The order identified the need for daily monitoring, but it was not transferred to the TAR. Antidepressant medication - monitor for drowsiness, blurred vision, dizziness, nausea, fatigue, trouble sleeping, dry mouth, hallucinations, other unusual changes in mood or behavior (Document Y if monitored and none of the above observed. N if monitored and any of the above was observed, select chart code other/see nurses notes and progress note findings every shift).</p> <p>A review of the resident's diagnoses conducted on 12/11/24 at 8:05 AM confirmed that the resident does not have a diagnosis of Bipolar.</p> <p>A review Medication Administration Record conducted on 12/11/24 at 8:11 AM revealed a medication indication discrepancy for Mirtazapine for bipolar disorder.</p> <p>During an interview on 12/11/24 at 11:43 AM, the Assistant Director of Nursing (ADON) confirmed that Resident #8 did not have a diagnosis of BiPolar disorder. The ADON stated the order for Mirtazapine 7.5 mg was incorrectly documented and that the medication's true indication was for an appetite stimulant.</p> <p>The ADON further stated that the medication orders for the antipsychotic, antidepressant, behaviors, and anticoagulant failed to transmit to the TAR due to a missed step by the nurses who placed the orders in the Resident ' s medical record. The ADON confirmed that as a result the resident had not been monitored for the side effects of the medications.</p> <p>During a follow-up interview with the ADON on 12/11/24 at 12:26 PM a copy of the revised orders was provided to ensure the order would populate to the TAR to allow documentation of the daily monitoring of antipsychotic, antidepressant, behaviors, and anticoagulant medications.</p> <p>A review of Resident #8's TAR conducted on 12/11/24 at 12:33 PM confirmed monitoring tools are now listed for antipsychotic, antidepressant, behaviors, and anticoagulant medications.</p> <p>On 12/12/24 at 9:07 AM the ADON provided the surveyors with a revised medication order summary that now showed Mirtazapine 7.5 mg indication was for an appetite stimulant.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident #8's medical record conducted on 12/12/24 at 9:33 AM revealed the Resident had wound care being provided by [NAME] Wound Physicians. The Initial Wound Evaluation and Management Summary dated 11/18/24 included using Pressure-relieving boots for an unstageable deep tissue injury (DTI) of the right heel.</p> <p>The [NAME] Wound Doctors Wound Evaluation and Management Summary from 12/09/24 also listed using Pressure-relieving boots in their recommendations of care for the healing wound.</p> <p>A review of the TAR conducted on 12/12/24 at 9:40 AM did not reveal an order for the use of pressure-relieving boots.</p> <p>During an interview on 12/12/24 at 09:56 AM, the Surveyors and the ADON reviewed Resident #8's plan of care and recommendation in the wound care summary. The ADON was asked to describe how these plans of care are added to the Resident ' s orders. The ADON advised they take the order to the resident's doctor for approval and then the task is added to the TAR for the staff to complete as ordered. The Surveyor and ADON reviewed the Resident's TAR. The ADON confirmed there was no order for the pressure-relieving boots listed on the TAR.</p> <p>The ADON returned on 12/12/24 at 10:57 AM and provided the surveyors with an order summary and TAR for the use of pressure-relieving boots to bilateral lower extremities while in bed every shift for wound care management.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>50502</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on interview and record review, it was determined the facility failed to ensure the required staff members were present for each of the monthly Quality Assurance (QA) Committee meetings. This was evident during a review of the Quality Assurance and Performance Improvement (QAPI) program during the recertification survey.</p> <p>The findings include:</p> <p>On 12/11/24 at 9:59 AM, an interview with the Nursing Home Administrator (NHA) was conducted to review the facility's quality assurance activities. Copies of the attendance sheets for the past 6 months' QA meetings were requested.</p> <p>On 12/11/24 at 3:31 PM, a review attendance sheets for the following months revealed:</p> <ul style="list-style-type: none"> <li>- May: no Director of Nursing (DON), Infection Preventionist (IP), Medical Director (MD)</li> <li>- June: no DON and IP</li> <li>- July: no DON, IP and MD</li> </ul> <p>On 12/12/24 at 7:44 AM, the NHA and the General Manager (GM) were notified of the concern related to the required members of the QA committee attending the meeting.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  215246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/12/2024
NAME OF PROVIDER OR SUPPLIER  Bedford Court Healthcare Cent.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50504</p> <p>Based on observations, and interviews, it was determined that the facility failed to 1) keep a sanitary environment and 2) ensure the facility's equipment was functional. This was evident in the laundry room and for 1 (Resident #8) out of 14 resident rooms observed during the facility's recertification survey.</p> <p>The findings include:</p> <p>1) On 12/06/24 at 07:50 AM the surveyor did a tour of the laundry room with Staff#15. The surveyor observed the floor tiles in the room with the washing machines were visually dirty with dark colored residue scattered throughout the flooring and an accumulation of dirt between the three washing machines. The wall below the shelf housing the chemicals for the washing machines was peeled and visibly damaged. Also, the wall above the eye wash station had scattered areas of a brown colored substance. Staff #15 acknowledged the surveyor's findings.</p> <p>On 12/06/24 at 8:11AM the surveyor did a walk through with the Housekeeping Supervisor, Staff #16 who confirmed the findings. Staff #16 stated that damage to one of the walls was caused by leakage from the unit housing the chemicals for the washing machine.</p> <p>12/06/24 at 08:34 AM the Surveyor informed the administrator of the findings. No comment was offered.</p> <p>51491</p> <p>2) During an observation conducted on 12/04/24 at 10:42 AM, it was discovered the toilet paper holder wall mount was broken in room [ROOM NUMBER]. One arm mount was missing off the wall and the roll holder was missing. One arm mount remained attached to the wall.</p> <p>During an interview with the Nursing Home Administrator (NHA) on 12/09/24 at 11:45 AM, the broken dispenser was shown to the NHA. She advised she would check to see if it had been reported. The NHA further stated all maintenance concerns are entered as a work order into their electronic program, TELS. The NHA confirmed that the holder is still broken.</p> <p>During an interview with the NHA on 12/10/24 at 08:43 AM she reported the request had not already been submitted into the system, so she/he entered the work order request (#16900) into TELS.</p> <p>During a Review of the work order, it was revealed that work order #16900 was submitted on 12/10/24 at 5:05 AM by the NHA.</p>