

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2025
NAME OF PROVIDER OR SUPPLIER Bedford Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 136 Donahoe Manor Road Bedford, PA 15522	

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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and observations, as well as interviews with staff, it was determined that the facility failed to maintain the confidentiality of medical information for one of 25 residents reviewed (Resident 46).</p> <p>Findings include:</p> <p>The facility's policy regarding general dose preparation and medication administration, dated February 14, 2025, indicated that employees are to observe each resident's privacy and rights in accordance with applicable law (including blocking unnecessary access to the Medication Administration Record).</p> <p>Observations during medication administration on July 2, 2025, at 8:04 a.m. revealed that Registered Nurse 1 walked away from the medication cart in the hallway between rooms [ROOM NUMBERS] to administer medications to Resident 46 in room [ROOM NUMBER], and left the laptop on top of the medication cart open and the Medication Administration Record (MAR) for Resident 46 was visible to staff, residents, and visitors in the hallway.</p> <p>Interview with Registered Nurse 1 on July 2, 2025, at 8:16 a.m. confirmed that he did not minimize or close the laptop screen to protect Resident 46's confidential medical information from being viewed by unauthorized people and he should have.</p> <p>Interview with the Director of Nursing on July 2, 2025, at 11:09 a.m. confirmed that laptop screens with confidential medical information should not be left open and visible to staff, residents, and visitors in the hallway.</p> <p>28 Pa. Code 201.29(a) Resident Rights.</p> <p>28 Pa. Code 211.5(b) Clinical Records.</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
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on review of policies and personnel files, as well as staff interviews, it was determined that the facility failed to ensure that the status of nursing licenses was checked with the State Board of Nursing for two of two nurses reviewed (Registered Nurse 2, Licensed Practical Nurse 3), and failed to complete a Nurse Aide Registry verification for one of three nurse aides reviewed (Nurse Aide 4).</p> <p>Findings include:</p> <p>The facility's policy regarding Abuse, neglect, exploitation, and Misappropriation Prevention prom, dated February 14, 2025, indicated that the facility would conduct employee background checks and would not knowingly employ or otherwise engage any individuals who have had a finding entered into the State Nurse Aide Registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or have a disciplinary action in effect against his or her professional license by a state licensure body as a result finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.</p> <p>The personnel file for Registered Nurse 2 revealed a start date of June 25, 2025. However, there was no documented evidence that her license was verified with the state board.</p> <p>The personnel file for Licensed Practical Nurse 3 revealed a start date of May 12, 2025. However, there was no documented evidence that her license was verified with the state board.</p> <p>The personnel file for Nurse Aide 4 revealed a start date of June 23, 2025. However, there was no documented evidence that the nurse aide's standing on the Pennsylvania Nurse Aide Registry was verified until June 28, 2025.</p> <p>Interview with the Human Resources/Payroll Director on July 2, 2025, at 10:57 a.m. confirmed that Registered Nurse 2's start date was June 25, 2025, and that the license was not verified with the State Board of Nursing, but used a contracted company to perform background/licensure checks. She confirmed that License Practical Nurse 3's start date was May 12, 2025, and that the license was not verified with the State Board of Nursing, but used a contracted company to perform background/licensure checks. She also confirmed that Nurse Aide 4 had a start date of June 23, 2025, and that there was no documented evidence that a registry verification was completed prior to her start date, but used an contracted company to perform background/registry checks.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on facility policy, clinical record reviews, and resident and staff interviews, it was determined that the facility failed to follow physician's orders related to bowel protocols for one of 25 residents reviewed (Resident 45).</p> <p>Findings include:</p> <p>A facility policy for bowel protocol, dated February 14, 2025, indicated that the facility was to ensure that residents are free from complications secondary to constipation. This would be accomplished through adequate assessment tracking, and treatment as indicated. The evening shift nurse would provide medication as ordered according to the following bowel protocol: Give Milk of Magnesia (MOM - an oral laxative) one time if there is no bowel movement after three days at bedtime. If Milk of Magnesia is ineffective, on day four, give a Dulcolax suppository (a laxative inserted rectally). If both Milk of Magnesia and Dulcolax suppository are ineffective, on day five give a saline enema (a liquid inserted rectally to stimulate a bowel movement). The day shift nurse would monitor the daily bowel record to ensure the residents had received successful bowel care results. The day shift supervisor would assess the resident and notify the physician for the residents that did not have successful results for other means of providing bowel relief.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 45, dated May 18, 2025, indicated that the resident was cognitively intact, was frequently incontinent of bowel and urine and required partial to moderate assistance for transfers from chair to bed, sitting and standing, and toilet hygiene. A care plan, dated May 15, 2025, for Resident 45 indicated that she was at risk for complications with the gastrointestinal system due to constipation.</p> <p>Interview with Resident 45 on June 30, 2025, at 10:33 a.m. revealed that she had recently been constipated.</p> <p>Physician's orders for Resident 45, dated May 14, 2025, included orders for staff to administer 30 milliliters (ml) of Milk of Magnesia as needed for no bowel movement after three days; a 10 milligram (mg) Dulcolax suppository as needed if Milk of Magnesia was not effective, to be administered on Day 4 if no bowel movement; and to administer a saline enema as needed if Milk of Magnesia and Dulcolax suppository are ineffective, to be administered on Day 5 of no bowel movement.</p> <p>Review of the bowel record for Resident 45, dated March 2025, indicated that the resident did not have a bowel movement on June 3 through June 8, 2025, a total of six days.</p> <p>Review of the Medication Administration Record (MAR) for Resident 45, dated June 2025, indicated that 30 ml of Milk of Magnesia was administered to the resident on June 6 with ineffective results. Review of the MAR revealed no documented evidence that Dulcolax was administered when Milk of Magnesia was ineffective on Day 4 of not having a bowel movement as ordered, and no documented evidence that a saline enema was administered on Day 5 of no bowel movement, as ordered.</p> <p>Interview with the Director of Nursing on July 2, 2025, at 10:15 a.m. confirmed that bowel protocol was not followed for Resident 45 on the above-mentioned dates.</p> <p>(continued on next page)</p>		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code 211.12(d)(5) Nursing Services.

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's recommendations for brace application were followed for one of 25 residents reviewed (Resident 25).</p> <p>Findings include:</p> <p>A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 25, dated May 21, 2025, indicated that the resident was cognitively impaired, required moderate assistance for dressing and hygiene, and utilized a walker and a wheelchair.</p> <p>Interview with Resident 25 on June 30, 2025, at 1:29 p.m. revealed that he was to receive a back brace after he had fallen at the facility and broke his back, but he never received it.</p> <p>Hospital discharge records for Resident 25, dated January 5, 2025, revealed that the resident was to have a TLSO Brace (a brace that supports the back and pelvis area to reduce pain and prevent further injury) due to a back fracture.</p> <p>A nursing note for Resident 25, dated January 7, 2025, at 11:27 a.m., revealed that the hospital recommended the TLSO brace, but they did not require a specific company. The facility was unable to obtain a TLSO brace from one medical supplier and another supplier would not be able to provide the brace in a timely manner. The physical therapy department was to obtain a TLSO brace for the resident.</p> <p>Nursing Note for Resident 25, dated January 7, 2025, at 12:15 p.m., revealed that therapy was not able to obtain a TLSO brace and that his daughter would like him to be seen by a brain and spine specialist to obtain his brace.</p> <p>Interview with the Nursing Home Administrator on July 2, 2025, at 1:38 p.m. revealed that Resident 25 did not receive his TLSO brace because his daughter was to take the resident to a brain and spine specialist and purchase the brace but never did.</p> <p>Interview with the Director of Therapy on July 2, 2025, at 12:50 p.m. revealed that she would have been able to purchase the correct brace for Resident 25 and was told not to purchase it. Physical therapy was delayed for several months since he did not have the brace for support.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing services.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on review of clinical record reviews, as well as observations and staff interviews, it was determined that the facility failed to complete safety assessments for three of 25 residents reviewed (Residents 9, 17, 36) who used an air mattress.</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 9, dated May 30, 2025, revealed that the resident was cognitively impaired, required assistance with daily care needs, had a Stage 3 pressure ulcer (pressure wound that forms as a result of prolonged pressure involving the fat layers beneath the skin), and had diagnoses that included dementia and Parkinson's Disease (a degenerative brain condition that affects muscle control and movement). Physician's orders for Resident 9, dated December 3, 2024, included an order for the resident to have a low air flow mattress (an inflated mattress for pressure relief) to promote skin integrity.</p> <p>Observations on June 30, 2025, at 11:11 a.m. revealed that Resident 9's bed was equipped with an air mattress; however, there was no documented evidence in the resident's clinical record that the use of an air mattress was assessed for potential safety hazards prior to being placed on the resident's bed.</p> <p>Interview with the Director of Nursing on July 2, 2025, at 1:30 p.m. confirmed that Resident 9 did not have an air mattress safety assessment completed regarding potential safety hazards prior to the air mattress being placed on the resident's bed.</p> <p>A quarterly MDS assessment for Resident 17, dated May 5, 2025, revealed that the resident was cognitively impaired, required extensive assistance with daily care needs, and had diagnoses that included Parkinson's (a progressive neurological disease that affects movement), stroke, sarcopenia (a medical condition where there is a loss of muscle mass).</p> <p>Observations on June 30, 2025, at 12:13 p.m. revealed that Resident 17's bed was equipped with an air mattress; however, there was no documented evidence in the resident's clinical record that the use of an air mattress was assessed for potential safety hazards prior to being placed on the resident's bed.</p> <p>Interview with the Director of Nursing on July 2, 2025, at 10:15 a.m. confirmed that Resident 17 did not have an air mattress safety assessment completed regarding potential safety hazards prior to the air mattress being placed on the resident's bed.</p> <p>A quarterly MDS assessment for Resident 36, dated May 31, 2025, revealed that the resident was cognitively intact, required extensive assistance with daily care needs, and had diagnoses that included a hip fracture and contractures (a shortening and hardening of muscles and tendons) of the left hand and right hip.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observations on June 30, 2025, at 11:13 a.m. revealed that Resident 36's bed was equipped with an air mattress; however, there was no documented evidence in the resident's clinical record that the use of an air mattress was assessed for potential safety hazards prior to being placed on the resident's bed.</p> <p>Interview with the Director of Nursing on July 2, 2025, at 10:55 a.m. confirmed that Resident 36 did not have an air mattress safety assessment completed regarding potential safety hazards prior to the air mattress being place on the resident's bed.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for one of 25 residents reviewed (Resident 17).</p> <p>Findings include:</p> <p>The facility's policy regarding medication administration, dated February 14, 2025, indicated that documentation of narcotic administration will be done in accordance with applicable law including documenting necessary medication administration treatment information on appropriate forms.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a residents abilities and care needs) for Resident 17, dated May 5, 2025, revealed that the resident was cognitively impaired, required extensive assistance with daily care needs, and had diagnosis of Parkinson's (a progressive neurological disease that affects movement), stroke, sarcopenia (a medical condition where there is a loss of muscle mass).</p> <p>Physician's orders for Resident 17, dated September 9, 2024, included an order for the resident to receive 5-325 milligram (mg) of oxycodone-acetaminophen (a narcotic pain medication) to be administered every four hours as needed for pain.</p> <p>Review of the controlled drug record (tracks each dose of a controlled medication) for Resident 17 for May and June 2025 revealed that a 5-325 mg dose of oxycodone-acetaminophen was signed out on May 9, 2025, at 6:30 p.m.; June 4, 2025, at 5:11 a.m.; June 13, 2025, at 5:30 a.m.; and June 16, 2025 at 6:36 p.m. However, a review of the resident's Medication Administration Record (MAR) revealed no documented evidence that the medication was actually administered to the resident on the dates and times listed.</p> <p>Interview with the Director of Nursing on July 2, 2025, at 10:15 a.m. confirmed that there was no documentation of medication administration on the MAR for Resident 17 on the above dates and times and there should have been.</p> <p>28 Pa. Code 211.9(a)(h) Pharmacy Services.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>Based on review of facility policies and clinical record reviews, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from unnecessary psychotropic medications (medications that affect the mind, emotions and behavior), by failing to ensure that non-pharmacological (non-medication) behavioral interventions (individualized, non-pharmacological approaches to care) were attempted prior to the administration of as needed antianxiety medications (psychotropic medication used to treat anxiety) for one of 25 residents reviewed (Resident 47).</p> <p>Findings include:</p> <p>The facility's policy regarding psychoactive/psychotropic medication use (any medication that affects brain activities associated with mental processes and behavior), dated February 14, 2025, indicated that psychotropic medication management for the resident will involve identifying person-centered non-pharmacological interventions (unless contraindicated) to minimize or discontinue the use of psychotropic medications.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 47, dated April 25, 2025, indicated that the resident was cognitively impaired, was dependent on staff for care needs, received antianxiety medications, and had diagnoses that included restlessness/agitation and dementia.</p> <p>Physician's orders for Resident 47, dated May 28, 2025, included an order for the resident to receive 0.5 milligrams (mg) of Ativan (Lorazepam) (an antianxiety medication) every four hours as needed for anxiety.</p> <p>Review of the Medication Administration Record (MAR) for Resident 47 for May and June 2025 revealed that the resident was administered 0.5 mg of Ativan on May 30 at 11:25 a.m., May 31 at 2:23 p.m., June 11 at 6:30 p.m., June 16 at 9:25 a.m., and June 25 at 3:21 p.m. There was no documented evidence that non-pharmacological behavioral interventions were attempted prior to administering Ativan on the above-mentioned dates and times.</p> <p>Interview with the Director of Nursing on July 1, 2025, at 2:52 p.m. confirmed that non-pharmacological interventions should have been attempted prior to the administration of as needed Ativan to Resident 47 on the above-mentioned dates and times.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on review of facility policies, manufacturer's instructions, and clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain a medication error rate of less than five percent.</p> <p>Findings include:</p> <p>The facility's policy regarding general dose preparation and medication administration, dated February 14, 2025, indicated that facility staff should crush oral medications only in accordance with pharmacy guidelines. Exceptions to Should Not Crush medications may occur when the physician/prescriber orders are documented in the medical record including a statement explaining why crushing the medication will not adversely affect the resident. The facility is to follow manufacturer medication administration guidelines.</p> <p>Manufacturer's instructions for Oxycontin extended-release tables, dated May 2024, included instructions to swallow the tablets whole. Do not break, crush, chew or dissolve the tablets. Doing so can release all the drug at once increasing the risk for overdose. The medication label included instructions to take whole and do not crush.</p> <p>Observations during medication administration on July 2, 2025, revealed that two medication administration errors were made during 29 opportunities for error, resulting in a medication administration error rate of 6.90 percent.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 46, dated June 13, 2025, indicated that the resident was cognitively impaired, was dependent on staff for care needs, had presence of pain and was taking an opioid (medication used for pain that has the potential to be abused) for pain, and had diagnoses that included a hip fracture, fracture of the right humerus, asthma, and respiratory failure (blood does not have enough oxygen and causes difficulty breathing).</p> <p>Physician's orders for Resident 46, dated June 23, 2025, included an order for the resident to receive 15 milligrams (mg) of Oxycontin ER (Extended-Release) (an opioid) every 12 hours for pain.</p> <p>Observations of medication administration on July 2, 2025, at 8:04 a.m. revealed that Registered Nurse 1 crushed the extended-release tablet of Oxycontin prior to administering the medication to Resident 46.</p> <p>Physician's orders for Resident 46, dated June 7, 2025, included an order for the resident to receive 100 micrograms-5 micrograms of Dulera (Mometasone Furoate-Formoterol Fumarate Dihydrate) (medication used to prevent or control symptoms caused by asthma) with instructions to inhale two puffs daily.</p> <p>Observations of medication administration on July 2, 2025, at 8:04 a.m. revealed that Registered Nurse 1 administered the two puffs of Dulera to Resident 46 and gave him a drink of water following administration. Manufacturer's instructions for Dulera, dated September 2024, included instructions to prevent dryness, hoarseness, and oral yeast infections from developing, gargle/rinse mouth with water and spit out after each use. Do not swallow the rinse water.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that medications were properly secured in the medication cart.</p> <p>Findings include:</p> <p>The facility's policy regarding general dose preparation and medication administration, dated February 14, 2025, indicated that the facility should ensure that medication carts are always locked when out of sight or unattended.</p> <p>Observations during medication administration on July 2, 2025, at 8:04 a.m. revealed that Registered Nurse 1 walked away from the medication cart in the hallway between rooms [ROOM NUMBERS] to administer medications to Resident 46 in room [ROOM NUMBER] and left the medication cart unlocked, unattended, and out of sight in the hallway when he entered the resident's room.</p> <p>Interview with Registered Nurse 1 on July 2, 2025, at 8:16 a.m. confirmed that the medication cart was not locked, and it should have been.</p> <p>Interview with the Director of Nursing on July 2, 2025, at 11:09 a.m. confirmed that the medication cart should have been locked when unattended.</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy Services.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		