STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E004	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedford CO Nursing Home	1229 County Farm Road Bedford, VA 24523

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on staff interview and clinical record review, the facility staff failed to ensure an accurate clinical record for the one resident in the survey sample (Resident #1). The findings include: Resident #1 (R1) was admitted to the facility with diagnoses that included congestive heart failure, ischemic heart disease, chronic kidney disease, peripheral artery disease, dementia, hypertension, anxiety, history of myocardial infarction and osteoarthritis. The minimum data set (MDS) dated [DATE] assessed R1 with severely impaired cognitive skills. R1's closed clinical record documented a physician's order dated [DATE] changing the resident's resuscitation status from full code (requiring cardiopulmonary resuscitation) to do not resuscitate (DNR). R1's electronic health record viewed on [DATE] documented the resident's code status as do not intubate (DNI) and did not reflect the DNR status ordered on [DATE] that was in place of the time of R1's death on [DATE]. R1's face sheet, printed from the electronic health record, listed the inaccurate DNI status at the top of the form beside the resident' name. R1's clinical record documented the resident was previously listed as full code and included no orders for the do not intubate status. On [DATE] at 8:50 a.m., the social worker (other staff #1) responsible for updating the code status in clinical records was interviewed about R1. The social worker stated the R1's electronic record displayed the incorrect code status. The social worker stated R1's code status was changed on [DATE] from full code to DNR. The social worker stated the wrong selection was made on the electronic health record screen with do not intubate selected instead of do not resuscitate. The social worker stated R1 never had an order for a do not intubate status. This finding was reviewed with the administrator and assistant director of nursing on [DATE] at 10:00 a.m. with no further information presented prior to the end of the survey.

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