PRINTED: 01/02/2024 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495303	B. WING		C 09/13/2023
	ROVIDER OR SUPPLIER VERS HEALTH & REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2960 CHELSEA ROAD WEST POINT, VA 23181	03/13/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETION
F 000	INITIAL COMMENTS	3	F 00	00	
	survey was conducted 9-13-23. Two compliance (V/A) and VA00059675 Survey (V/A) Significant corrections compliance with 42 Control Term Care requirements.	s are required for CFR Part 483 Federal Long			
F 552 SS=D	of 4 Resident reviews Right to be Informed	s. /Make Treatment Decisions	F 55	52	10/24/23
	The resident has the participate in, his or h §483.10(c)(1) The rig language that he or s her total health status his or her medical co §483.10(c)(4) The rig advance, of the care of care giver or profe §483.10(c)(5) The rig	ght to be informed, in to be furnished and the type ssional that will furnish care.			
I ABORATORY	professional, of the ricare, of treatment an treatment options an option he or she pref This REQUIREMENty:	isks and benefits of proposed d treatment alternatives or d to choose the alternative or	35	TITLE	(X6) DATE

Electronically Signed 10/16/2023

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) BUILDING (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X9) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X8) MULTIPLE CONSTRUCTION (X8) PROVIDER/SUPPLIER/CLIA (X9) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SUPPL		(X3) DATE SURVEY COMPLETED			
		495303	B. WING		C 09/13/2023
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	09/13/2023
				2960 CHELSEA ROAD	
THREE RI	VERS HEALTH & REHA	AB CENTER		WEST POINT, VA 23181	
(X4) ID		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION SHOUL	, , ,
PREFIX TAG	,	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF	
F 552	Continued From pag	ge 1	F 55	2	
	Based on staff inter	view, Ombudsman interview,		Resident #2 no longer resides in	the
	family interview, faci	lity documentation review,		facility.	
		v, and in the course of a		All residents that have stop dates	s for
		ion, the facility staff failed to		medications have the ability to be	
		resident's responsible party		affected. A 14-day look back has be	
		notified of a change in		completed on all current residents w	
		sident (Residents #2) in a		medication stop dates to ensure the	
	survey sample of for	ur (4) residents.		provider has been contacted for	
	.			verification of discontinuance of the	
		e facility discontinued all of the		as well as notifying the resident and	
	resident's cardiac, antihypertensive, and blood Responsible Representative. A 14-day				
	_	s after 30 days, and did not		look back was performed for all new	
	notify the physician,	se following medications		admissions/re-admissions for the pa days to ensure orders to follow up w	
		Diltiazem, Metoprolol, and		specialist were carried out.	iui a
		lation (blood thinner)		3. Licensed Nursing staff have been	,
		onset atrial fibrillation.		educated on verifying all orders with	
	medication for new c	Shoct athar hormation.		dates and the need to follow up with	-
	The findings include	d·		specialist, as well as notifying the re	
	The infamge molade	u.		and/or Responsible Representative	
	Resident #2 was add	mitted to the facility on		changes. The facility providers were	
		hospital. Diagnoses		educated by their Chief Medical Offi	
		atrial fibrillation, aortic valve		September 19th, 2023 regarding pro	
	stenosis, aortic valve	e insufficiency, likely acute		documentation, care planning, and	
	heart attack, long ter	rm use of anticoagulants,		medical utilization. The providers w	ere
	hypertension, high c	holesterol, mild protein		also reeducated on a detailed review	v of
	calorie malnutrition,	and dementia.		admission orders, including follow-u	p
				appointments, review of diagnosis, a	and
		recent Minimum Data Set		medications required for treatment.	
		ssment reference date (ARD)		4. The Director of Nursing/designed	; will
		oded as a 5-day admission		review six residents per week to	
		ent #2 was coded as having a		determine that any discontinuance of	of
		ental Status (BIMS) score of		orders have been verified by the	
		5, revealing significant		healthcare provider, any orders to se	
		t. Resident #2 was also		specialist have been carried through	and
		extensive assistance to		resident and/or Responsible	. [
		ce on staff to perform		Representative have been notified for	
		ng, such as bed mobility,		weeks. All results and trends will be	!
	transferring, locomo	tion, and toileting.		reviewed at the monthly Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495303	B. WING				C / 13/2023
NAME OF P	ROVIDER OR SUPPLIER	10000		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	09	113/2023
	(0.1.5 <u>2.1.</u> 0.1. 00. 1.2.2.1.				960 CHELSEA ROAD		
THREE RI	VERS HEALTH & REHA	B CENTER			EST POINT, VA 23181		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PRECEDED BY FULL PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	TION SHOULD BE COMPLE THE APPROPRIATE DATE	
F 552	following: Resident #2 was disc the nursing facility wi with rapid ventricular The resident was issi new orders for all me doctor after being sta hospital doctor's inter follow-up with the resident was incomposed to the nursing facility, nursing facility to hon orders were for the form Schedule appointment (PCP) (name given) a visit within one week. Schedule appointment (name given) as soo one month. Apixaban - anticoagu Diltiazem - antihypert Metoprolol - antihypert Metoprolol - antihypert Metoprolol - antihypert Metoprolol - antihypert Calcium - supplement Vitamin D-3 - supplement Vitamin B-12 - supple Multivitamin - supplement Prilosec - gastric refle	charged from the hospital to the new onset atrial fibrillation response on 07/03/2023. The dications from a hospitalist abilized in the hospital. The nation was for the resident to sident's PCP and Cardiology and continue those orders. It in the after rehabilitation. Those online after rehabilitation. Those oblowing: Int with Primary Care Doctor has soon as possible for a second as possible for a second and the tensive of the property of the	F	552	Assurance Performance Improvement meeting to determine compliance and ongoing auditing. Areas of variance w be investigated and appropriate action will be taken to minimize recurrence.		
	Miralax - constipation	1					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		1 ' '			(X3) DATE SURVEY COMPLETED	
		495303	B. WING				13/2023
	ROVIDER OR SUPPLIER VERS HEALTH & REHAM			2	PTREET ADDRESS, CITY, STATE, ZIP CODE 960 CHELSEA ROAD VEST POINT, VA 23181	1 03/	13/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 552	that the Atorvastatin f administered one time admission, 07/04/202 same day for an unkr document reveals the discontinuance. The discontinued after 30 discontinued on 08/03/2 dose, and the other 2 a.m. dose on 08/03/2 The following 3 cardia restarted while Resid facility, prior to rehos 11:30 a.m., on 08/14/stroke. 1. Diltiazem (antihype workload on the vess milligrams (mg) one to 2. Metoprolol (antihype workload on the vess milligrams (mg) one to 2.	2's clinical record revealed for high cholesterol was only to e on the day after 13, and discontinued on that hown reason as no e reason for the 13 cardiac medications were days of use with Diltiazem 12/2023 after the 8:00 a.m. It medications after the 8:00 a.m. It medications were not ent #2 was in the nursing potalization, at approximately 12023 (11 days later) with a 14 certensive) - reduces 15 els and heart, 240 ime per day at 8:00 a.m.	F	552	DEFICIENCY		
	prevents blood clots theart attack and strokday at 8:00 a.m., and It is notable to mention orders were continue During interviews, it wappointments ordered	gulant) - blood thinner, from forming and causing se, 5 mg one tablet twice per 9:00 p.m. In that all other 30-day d in the nursing facility. In that follow-up d for PCP, and Cardiology cheduled, nor were those					

B. WING		l l	
		1 ,	C 09/13/2023
	STREET ADDRESS, CITY, STATE, ZIP COD 2960 CHELSEA ROAD WEST POINT, VA 23181		J 9 /13/2023
ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
c er er			
	PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) F 552 C ee	PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 552 C C C EF C C C C C C C C C C C C C

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(>	X3) DATE S COMPL	
				· · ·		С	;
		495303	B. WING _			09/1	3/2023
	ROVIDER OR SUPPLIER VERS HEALTH & REHAE	3 CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2960 CHELSEA ROAD WEST POINT, VA 23181			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORE X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	E	(X5) COMPLETION DATE
F 552	On 09/13/2023 at append of day debrief, the were made aware of	gs and stated she had vide. proximately 2:00 p.m., at the le Administrator and DON the failure of staff to notify of the discontinuance of Resident #2.		552			10/24/23
SS=D	S483.21 Comprehens Planning §483.21 (a) Baseline (§483.21(a) Baseline (§483.21(a)(1) The faci implement a baseline that includes the instreffective and personthat meet professiona The baseline care platicity and personthat meet professiona (i) Be developed with admission. (ii) Include the minimunecessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recomm	Care Plans cility must develop and care plan for each resident ructions needed to provide centered care of the resident al standards of quality care. an must- in 48 hours of a resident's um healthcare information or care for a resident ted to- d on admission orders.					10/24/23

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			(X3) DATE SURVEY COMPLETED			
		495303	B. WING _			C 09/13/2023
	ROVIDER OR SUPPLIER VERS HEALTH & REHAI	B CENTER	•	STREET ADDRESS, CITY, STATE, ZI 2960 CHELSEA ROAD WEST POINT, VA 23181	P CODE	33/10/2020
(X4) ID PREFIX TAG						
F 655	admission. (ii) Meets the requirer (b) of this section (exthis section). §483.21(a)(3) The faresident and their report the baseline care plimited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the form behalf of the faciliti(iv) Any updated inform of the comprehensive This REQUIREMENT by: Based on staff intervity family interview, facilic clinical record review complaint investigation develop and implement cardiac treatment for and #1) in a survey s 1. For Resident #2, this implement a cardiac admitting diagnosis of heart attack, with carnew cardiac medication. 2. For Resident #1, the provide a baseline cardiac shall associated skin dama inguinal dialysis shuring the section of the section of the comprehensive cardiac medication.	ments set forth in paragraph cepting paragraph (b)(2)(i) of accility must provide the presentative with a summary plan that includes but is not accility and personnel acting by. If the resident the present acting by the presentation based on the details accare plan, as necessary. It is not met as evidenced be accility and personnel acting by the present acting t	F6	1. Resident #1 and #2 in the facility. 2. The Director of Nursin reviewed the baseline canewly admitted residents comprehensive care plans been created. The review baseline care plans incluinstructions needed to properson-centered care for current and potential needs. The Director of Nursin reeducate all licensed nursing review the baseline care admitted resident's weeks the review will ensure be include the instructions reindividualized care for the	ng/designee has are plans of all is for whom the in has not yet it was to ensure the rovide effective in the residents eds. Ing/designee will urses on policy line Care Plans ing/designee will plans of all new lay, for six week aseline care planeeded to provi	s re II wly ss. ans

Facility ID: VA0202

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		3) DATE SURVEY COMPLETED
		495303	B. WING			C 09/13/2023
	ROVIDER OR SUPPLIER VERS HEALTH & REHAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2960 CHELSEA ROAD WEST POINT, VA 23181	I	09/13/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 655	The findings included 1. Resident #2 was a 07/03/2023 from the lincluded, new onset a stenosis, aortic valve heart attack, long terr hypertension, high ch calorie malnutrition, a Resident #2's most re (MDS) with an assess of 07/10/2023 was co assessment. Resident Brief Interview of Mer out of a possible 15, a cognitive impairment. coded as requiring excomplete dependency activities of daily living transferring, locomotic Hospital records from 07/03/2023 were revifollowing: Resident #2 was discounted the nursing facility with with rapid ventricular. The resident was issued no orders for all medoctor after being state hospital doctor's interfollow-up with the resident on the nursing facility, to the nursing facility, to the nursing facility,	dmitted to the facility on nospital. Diagnoses strial fibrillation, aortic valve insufficiency, likely acute in use of anticoagulants, olesterol, mild protein ind dementia. The cent Minimum Data Set sement reference date (ARD) ded as a 5-day admission to #2 was coded as having a stall Status (BIMS) score of 6 revealing significant. Resident #2 was also tensive assistance to be on staff to perform 100, such as bed mobility, on, and toileting. The company of the hospital to the new onset atrial fibrillation response on 07/03/2023. The dications from a hospitalist bilized in the hospital. The stion was for the resident to ident's PCP and Cardiology do continue those orders. Linuity of care for discharge and ultimately from the ne after rehabilitation. Those	F 65	results and trends will be reviewed Quality Assurance and Performa Improvement meeting to determit compliance and ongoing auditing of variance will be investigated a appropriate actions will be taken minimize recurrence.	nce ne j. Areas nd	

PRINTED: 01/02/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		405202		_			0	
NAME OF D		495303	B. WING		TREET ARRESTON OUTV. OTATE 7/D OORE	09/	13/2023	
	ROVIDER OR SUPPLIER VERS HEALTH & REHAE	3 CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 960 CHELSEA ROAD VEST POINT, VA 23181			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 655	Continued From page	÷ 8	F	655				
	(PCP) (name given) a visit within one week. Schedule appointmen (name given) as soor one month. Apixaban - anticoagu Diltiazem - antihypert Metoprolol - antihypert Metoprolol - antihypert Atorvastatin - lowers Vitamin D-3 - supplem Calcium - supplement Vitamin B-12 - supplem Multivitamin - supplement Prilosec - gastric reflumiralax - constipation Review of Resident # that the Atorvastatin fadministered one time admission, 07/04/202 same day for an unkridocument reveals the discontinued after 30 discontinued on 08/03 dose, and the other 2 a.m. dose on 08/03/2 The following 3 cardia restarted while Residifacility, prior to rehosp	at with Cardiology Doctor as possible for visit within lant ensive rtensive high cholesterol nent t ement ax 2's clinical record revealed or high cholesterol was only e on the day after 3, and discontinued on that hown reason as no e reason for the 3 cardiac medications were days of use with Diltiazem 2/2023 after the 8:00 a.m. medications after the 8:00						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			ATE SURVEY OMPLETED			
		495303	B. WING		١,	C 09/13/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2960 CHELSEA ROAD WEST POINT, VA 23181	<u> </u>	39/13/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 655	Continued From pag	ge 9	F 6	55		
	workload on the ves milligrams (mg) one 2. Metoprolol (antihy workload on the ves half tablet two times 9:00 p.m. 3. Apixaban (anticoa prevents blood clots heart attack and stroday at 8:00 a.m., and It is notable to mentiorders were continued During interviews it appointments ordered doctors were never a doctors contacted all	rime per day at 8:00 a.m. repertensive) - reduces sels and heart, 25 mg one per day and 8:00a.m., and rigulant) - blood thinner, from forming and causing ske, 5 mg one tablet twice per d 9:00 p.m. on that all other 30-day ed in the nursing facility. was found that the follow-up ed for PCP and Cardiology scheduled, nor were those rout continuing the cardiac mily was also not contacted ct that the cardiac				
	Record (MAR/TAR) August 2023, and re indicating the Diltiaz administered through	Treatment Administration was reviewed for July and vealed nursing signatures em medication had been the morning of 08/02/2023, iac drugs were administered of 08/03/2023.				
	revealed no focus, n primary diagnosis of anticoagulant therap	olan was reviewed and or interventions for the atrial fibrillation, by, heart attack, and cardiac tt, nor follow-up appointment				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495303	B. WING _			C 9/13/2023
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, 2 2960 CHELSEA ROAD WEST POINT, VA 23181		9/13/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION : ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 655	involved in the care Nursing progress not revealed no notes do had been discontinual family was ever made discontinuance. On 09/13/2023 at 11 Nursing (DON) was room and stated she medications had not doctor and family we being discontinued	tor. The family was not planning process. Ites were reviewed, and ocumenting the medication ed, nor that the doctor, or le aware of the 100 a.m., the Director of interviewed in the conference had been unaware that been given, nor that the ere not notified of medications by staff. The DON was a new and recently been hired. The is a conference during the able to be reached until the rivey. At that time, she was made and stated she had by ide. In proximately 2:00 p.m., at the he Administrator and DON if the failure of staff to develop rediac care plan for the In was provided. Ithe facility staff did not have plan for moisture large (MASD), care for any placement site, and and knee after hospitalization.	F	655		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	I' '		3) DATE SURVEY COMPLETED	
		495303	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2960 CHELSEA ROAD WEST POINT, VA 23181		09/13/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 655	Resident #1 was ad 03/09/2023 with diag kidney failure, effusi acute embolism of le pain, hypertension, insufficiency, stroke. Resident #1's most Assessment (MDS) Reference Date (AR a 5-day admission a Resident #1 as need assistance with toile The resident was als points on a BIMS, in impairment. The res frequently incontiner. Review of Resident on 03/10/2023, "(Rewounds left knee surgery" "baseline initiated" The resident's care revealed a care plar impairment; however resident had actual 03/23/2023, nor doeknee after knee surges sutures in her neck. of a femoral artery dresident's inguinal of assessments in the these. There were nof care and treatment actually experienced.	mitted to the facility on gnoses including, acute on left knee, diabetes type 2, eft femoral vein, left knee hypothyroidism, venous and breast cancer. Trecent Minimum Data Set with an Assessment and by of 03/15/2023. Which was seessment. The MDS coded ding extensive to total staff ting, hygiene, and bathing. So coded as 10 of 15 possible dicating mild cognitive ident was coded as not of bowel and bladder. #1's progress notes indicated sident name) has surgical two small incisions from knee care plan has been plan was reviewed, and a for potential for skin r, does not indicate the MASD found by staff on so it mention sutures to her gery in the hospital, nor There was also no mention ialysis shunt placed in the rease (groin) area, and no clinical record regarding to interventions, nor mention and of any of the 4 skin issues at by Resident #1 in the care have required an active	F 6	55			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		IDENTIFICATION NUMBER		PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED C 09/13/2023	
	NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2960 CHELSEA ROAD WEST POINT, VA 23181		311312023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 655	medication administrate treatment administrate reviewed and reveal (3 days after admissionations on 03/12/2 saline and leave operations on 03/12/2 saline and leave operations of the record during the 19 indication of suture resident's stay. The National Institute guidance on sutured standard of practice be removed in 7 day extremities overlying sutures are left in to remove them with a and could increase standard dialysis shutten and increases the clinical records finguinal dialysis shutten.	cian orders, assessments, ration record (MAR), and ation record (TAR), were led the only skin care orders sion) received for the 2 suture 1023 to clean with normal en to air. No assessments of skin exists in the clinical 1-day stay, nor is there any removal orders during the 1-day stay, and states as a 1, sutures on the neck should 1/2, and in the lower 1/2 a joint 12 to 14 days. If 1/2 to 14 days. If 1/2 to 14 days. If 1/2 to 19 days at the site. Issments were ever placed in 1/2 to 14 days and femoral 1/2 to 14 days. If 1/2 to 14 days are tissue at the site. Issments were ever placed in 1/2 to	F 65	55			
	associated skin dam buttocks." No other form was not comple ordered for the MAS resident's 4-day stay another facility on 03 Activities of daily livi reviewed and reveal	before being transferred to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495303	B. WING			C 09/13/2023	
	ROVIDER OR SUPPLIER VERS HEALTH & REHAR	3 CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2960 CHELSEA ROAD WEST POINT, VA 23181			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 655 F 658 SS=D	times daily during the Staff stated the facility Incontinent Residents provided approximate and PRN (as needed wet incontinent briefs stated the expectation care immediately after Resident #1 was not care as many times a evidenced by the MA 10 days in the facility. The facility Administra (DON) were made and the end-of-day debried No additional information surveyor. Services Provided McCFR(s): 483.21(b)(3) Compr. The services provided as outlined by the continuation of the services provided as outlined	ented as provided multiple resident's stay. y policy on Perineal Care for s, was that care would be ely every 2 hours every shift), which included removal of , and cleansing. Staff further in is to give incontinence or every incontinent episode. afforded timely incontinence is was needed, as SD actually acquired after ator and Director of Nursing over of the above findings at if on 09/13/2023. Ition was provided to the elect Professional Standards (i)	F 6			10/24/23	
	by: Based on staff interv family interview, facili clinical record review, complaint investigation	is not met as evidenced iew, Ombudsman interview, ty documentation review, and in the course of a on, the facility staff failed to conal standards of nursing ents (Residents #2 and #1)		Resident #2 no longer resides in the facility. All residents that have stop dates for medications have the ability to be affected. A 14-day look back has been completed on all current residents with medication stop dates to ensure the	or 1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495303	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	49000	B: Willo _	СТІ	REET ADDRESS, CITY, STATE, ZIP CODE	09/	13/2023
NAME OF PI	ROVIDER OR SUPPLIER						
THREE RI	VERS HEALTH & REHA	B CENTER			60 CHELSEA ROAD		
				WE	EST POINT, VA 23181		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From pag	e 14	F 6	58			
F 658	1. For Resident #2, the all the resident's card blood thinning medic onset atrial fibrillation the family and doctor not obtain follow-up a resident's doctors as did not develop nor in plan for cardiac treat. 2. For Resident #1, provide incontinence moisture associated further failed to care inguinal dialysis shur sutures in the neck at The findings included. 1. Resident #2, was 07/03/2023 from the included, new onset stenosis, aortic valve heart attack, long-ter hypertension, high chalorie malnutrition, at Resident #2's most resident #2	the facility staff discontinued diac, antihypertensive, and ations after 30 days for new in. They also failed to notify of the discontinuance, did appointments with the ordered by a physician, and implement a nursing care ment. Ithe facility staff did not care timely resulting in skin damage (MASD), and for, and care plan for int placement site, MASD, and ind knee after hospitalization. Ithe facility staff did not care timely resulting in skin damage (MASD), and for, and care plan for int placement site, MASD, and individual to the facility on hospital. Diagnoses atrial fibrillation, aortic valve insufficiency, likely acute in use of anticoagulants, nolesterol, mild protein	F 6	58	provider has been contacted for verification of discontinuance of the ord as well as notifying the resident and/or Responsible Representative. A 14-day look back was performed for all new admissions/re-admissions for the past days to ensure orders to follow up with specialist were carried out. 3. Licensed Nursing staff have been educated on verifying all orders with states and the need to follow up with a specialist, as well as notifying the resid and/or Responsible Representative of changes. The facility providers were educated by their Chief Medical Officer September 19th, 2023 regarding propedocumentation, care planning, and medical utilization. The providers were also reeducated on a detailed review of admission orders, including follow-up appointments, review of diagnosis, and medications required for treatment. 4. The Director of Nursing/designee wireview six residents per week to determine that any discontinuance of orders have been verified by the healthcare provider, any orders to see specialist have been carried through at resident and/or Responsible Representative have been notified for second the provider of the provid	30 a op lent any on er f ii	
	of 07/03/2023 was co assessment. Resider brief interview of mer out of a possible 15, cognitive impairment coded as requiring ex complete dependence	oded as a 5-day admission int #2 was coded as having a intal status (BIMS) score of 6 revealing significant . Resident #2 was also extensive assistance to be on staff to perform g, such as bed mobility,			weeks. All results and trends will be reviewed at the monthly Quality Assurance Performance Improvement meeting to determine compliance and ongoing auditing. Areas of variance wil investigated and appropriate actions w be taken to minimize recurrence.	l be	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION G	COMPI	(X3) DATE SURVEY COMPLETED			
	495303 B. WING		001					
	ROVIDER OR SUPPLIER VERS HEALTH & REHAL			STREET ADDRESS, CITY, STATE, ZIP CODE 2960 CHELSEA ROAD WEST POINT, VA 23181	09/	09/13/2023		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 658	Continued From page	e 15	F 65	8				
	Hospital records from 07/03/2023 were revifollowing:	n 06/26/2023 through ewed and revealed the						
	the nursing facility with rapid ventricular. The resident was issued new orders for all medoctor after being stated hospital doctor's interfollow-up with the resident of the nursing facility, nursing facility to homorders were for the formal schedule appointment (PCP) (name given) a visit within one week. Schedule appointment (name given) as soo	nt with Primary Care Doctor as soon as possible for a						
	one month. Apixaban - anticoagu Diltiazem - antihypert Metoprolol - antihype Atorvastatin - lowers Vitamin D-3 - suppler Calcium - supplemen Vitamin B-12 - supple Multivitamin - suppler Iron - supplement	ensive rtensive high cholesterol ment t ement						
	Prilosec - gastric reflu Miralax - constipation							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495303	B. WING		C 09/13/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2960 CHELSEA ROAD WEST POINT, VA 23181	09/13/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 658	Continued From pag	e 16	F 6	58	
	that the atorvastatin administered one tim administered one tim admission, 07/04/20 same day for an unk document reveals th discontinuance. The discontinued after 30 discontinued on 08/0 dose, and the other a.m. dose on 08/03/2 The following 3 card restarted while Resid facility, prior to rehos 11:30 a.m., on 08/14 stroke. 1. Diltiazem (antihyp workload on the vesimilligrams (mg) one 2. Metoprolol (antihy workload on the vesimilligrams (mg) one 3. Apixaban (anticoa prevents blood clots heart attack and stroday at 8:00 a.m., and It is notable to mentiorders were continued.	23, and discontinued on the nown reason as no e reason for the 3 cardiac medications were 0 days of use with Diltiazem 12/2023 after the 8:00 a.m. 2 medications after the 8:00 2023. ac medications were not dent #2 was in the nursing spitalization, at approximately 1/2023 (11 days later) with a sertensive) - reduces sels and heart, 240 time per day at 8:00 a.m. pertensive) - reduces sels and heart, 25 mg one per day and 8:00 a.m., and gulant) - blood thinner, from forming and causing ke, 5 mg one tablet twice per			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495303	B. WING _		C 09/13/2023		
	ROVIDER OR SUPPLIER VERS HEALTH & REHA	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2960 CHELSEA ROAD WEST POINT, VA 23181	<u>'</u>	5571672025	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 658		oout discontinuing the cardiac mily was also not contacted ct that the cardiac	F 6	58			
	Record (MAR/TAR) August 2023, and re indicating the Diltiaz administered through and the other 2 card up through the morn Guidance for the add Apixaban/Eliquis is g Institutes of Health (-					
	clots. Stopping Apixe thrombotic events, li pulmonary embolus. Resident #2's care p	olan was reviewed and or interventions for the					
	anticoagulant therap medication treatmen Nursing progress no revealed no notes do medication had been doctor, or family was discontinuance.	tes were reviewed, and cardiac tes were reviewed, and coumenting that the discontinued, nor that the sever made aware of the					
	drugs were discontir	023, the day after the cardiac nued, "No aspirin will be on ull code." After that note,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED			
		495303	B. WING _			09/13/2023		
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2960 CHELSEA ROAD WEST POINT, VA 23181		03/13/2023		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 658	until the time of discissymptoms) indicated made aware of the comedications by staff Vital sign records an reviewed and reveal discharge 08/14/202 the hospital for strok resident's pulse was per minute, and blocomon the morning of direction of the morning of the mor	g physician progress notes harge (for stroke like I the physician was never liscontinuance of the cardiac	F 6	,				
	were told that Residestroke. Discharge records fr treatment on 08/16/2 "stroke." Resident #2 family and hospice s On 09/13/2023 at 11 Nursing (DON) was room and stated she medications had not appointments had no	om the hospital after 2023 indicated diagnosis of 2 was discharged home with services. :00 a.m., the Director of interviewed in the conference was not aware the been given, the ot been set, there was no or that the doctor and family						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495303	B. WING _			C 09/13/2023
	ROVIDER OR SUPPLIER VERS HEALTH & REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 2960 CHELSEA ROAD WEST POINT, VA 23181	ı	09/13/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 658	member and had re- Administrator was a survey and was not time of exit of the su made aware of findi nothing further to pri On 09/13/2023 at ag end of day debrief, t were made aware o care plans, set follow family and doctors of discontinuance. No further information 2. For Resident #1, provide incontinence moisture associated further failed to care placement site, and after hospitalization. The findings include Resident #1 was ad 03/09/2023 with diag kidney failure, effusi acute embolism of le pain, hypertension, insufficiency, stroke Resident #1's most Assessment (MDS) Reference Date (AR 5-day admission ass	f. The DON was a new staff cently been hired. The ta conference during the able to be reached until the rivey. At that time she was ngs and stated she had ovide. Oproximately 2:00 p.m., at the he Administrator and DON of the failure of staff to develop of the failure of staff to develop of the facility staff did not be care timely resulting in skin damage (MASD), and for inguinal dialysis shunt sutures in the neck and knee did: mitted to the facility on gnoses including, acute on left knee, diabetes type 2, left femoral vein, left knee hypothyroidism, venous	F 6	58		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495303	B. WING_			C
	ROVIDER OR SUPPLIER VERS HEALTH & REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 2960 CHELSEA ROAD WEST POINT, VA 23181		09/13/2023
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F 658	The resident was also points on a Brief Inter (BIMS), indicating more resident was coded bowel and bladder. Review of Resident on 03/10/2023, "(Rewounds left knee surgery""baseline initiated" The resident's care prevealed a care plant impairment; however indicate the resident staff on 03/23/2023, to her knee after knes utures in her neck. of a femoral artery does not care and treatment actually experienced plan, which would have treatment care plan. Resident #1's physical medication administrative and reveal (3 days after admission locations on 03/12/2 saline and leave oper those 2 areas of the record during the 19	ting, hygiene, and bathing. so coded as 10 of 15 possible erview for Mental Status ild cognitive impairment. The as frequently incontinent of #1's progress notes indicated sident name) has surgical two small incisions from knee care plan has been plan was reviewed and for potential for skin r, the care plan does not had actual MASD found by nor does it mention sutures be surgery in the hospital, nor There was also no mention ialysis shunt placed in the rease (groin) area, and no clinical record regarding to interventions, nor mention at of any of the 4 skin issues are pare required an active	F 6	58		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495303	B. WING		C 09/13/2023	
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2960 CHELSEA ROAD WEST POINT, VA 23181	03/13/2023	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION	
F 658	guidance on sutured standard of practice be removed in 7 day extremities overlying sutures are left in to remove them with a and could increase. No orders nor assess the clinical records inguinal dialysis should be considered for the first skin impair record occurred on evaluation documer associated skin dan buttocks." No other the form was not coordered for the MAS resident's 4-day state another facility on 0. Activities of daily living reviewed and reveating were documented a however, not document the facility of the staff stated the facility on the staff staff stated the facility on the staff staff stated the facility of the staff staf	tes of Health (NIH) gives d wounds, and states as a , sutures on the neck should ys, and in the lower g a joint 12 to 14 days. If o long, it may be difficult to potential to reinjure the area, scar tissue at the site. Sesments were ever placed in for the MASD, and femoral ant area. The ment note in the clinical 03/23/2023, which was a skin at, described "moisture mage (MASD)" "right and left information was given and mpleted. No treatments were ED for the rest of the y before being transferred to 3/27/2023. The mage (ADL) records were led that hygiene and bathing is being provided daily; mented as provided multiple	F 6:	58		
	wet incontinent brie stated the expectati care immediately af	rs, and cleansing. Staff further on is to give incontinence ter every incontinent episode. t afforded timely incontinence				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495303	B. WING			C 1 13/2023
	ROVIDER OR SUPPLIER VERS HEALTH & REHAL	3 CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2960 CHELSEA ROAD WEST POINT, VA 23181	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	10 days in the facility The facility Administra (DON) were made av the end-of-day debrie	s was needed, as SD actually acquired after ator and Director of Nursing ware of the above findings at	F6	558		
F 677 SS=D	S483.24(a)(2) A reside out activities of daily be services to maintain appresental and oral hydrogen and oral hydrogen and oral hydrogen acomplaint investigate ensure incontinence provided timely for 1 four (4) residents in the incontinence care time associated skin dama failed to care for inguisite, and sutures in the hospitalization. The findings included Resident #1 was admost 03/09/2023 with diagonal services of daily a resident #1 was admost 03/09/2023 with diagonal services of daily and service	iew, facility document I review, and in the course of tion, the facility staff failed to and wound care was resident (Resident #1) of the survey sample. facility staff did not provide tely resulting in moisture tage (MASD), and further tinal dialysis shunt placement the neck and knee after	F6	1. Resident #1 no longer resides in a facility. 2. All residents requiring assistance activities of daily living have the poter to be affected by this deficient practic An audit was performed to determine is at risk for incontinence. Orders for barrier cream have been placed for a residents at risk. 3. Facility licensed and certified Nursestaff will be reeducated on the identification and treatment of Moistur Associated Skin Damage and the init of topical treatment. Facility licensed certified nursing staff will be reeducated on policy and procedure for Activities Daily Living (ADL's) to include the importance of providing and documer incontinence care to minimize impairs	with Itial e. who I ing re ation and ed of	10/24/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	10000	 		STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	13/2023	
NAME OF T	TOVIDER OR SOLT EIER				, , ,			
THREE RI	VERS HEALTH & REHAE	B CENTER			2960 CHELSEA ROAD			
				١	WEST POINT, VA 23181			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 677	Continued From page	e 23	F 6	677	,			
	acute embolism of lef	t femoral vein, left knee			skin integrity. Weekly skin observation	S		
		ypothyroidism, venous			will be completed and documented by			
	insufficiency, stroke,	* * · · · · *			licensed nursing staff to identify areas skin impairment.	of		
	Resident #1's most re	ecent Minimum Data Set			4. Director of Nursing/designee will au	ıdit		
	Assessment (MDS) w	vith an Assessment			six incontinent residents weekly to ens	ure		
	Reference Date (ARD	0) of 03/15/2023 was a			proper incontinences care was provide			
	5-day admission asse	essment. The MDS coded			and appropriate treatment was ordered	Ł		
		ng extensive to total staff			and initiated for six weeks. All results	and		
		ng, hygiene, and bathing.			trends will be reviewed at the Quality			
		coded as 10 of 15 possible			Assurance Performance Improvement			
	•	view for Mental Status			meeting to determine compliance and			
		d cognitive impairment. The			ongoing auditing. Areas of variance w			
		s frequently incontinent of			be investigated and appropriate action	S		
	bowel and bladder.				will be taken to minimize recurrence.			
	on 03/10/2023, "(Res	1's progress notes indicated ident name) has surgical wo small incisions from knee						
	surgery""baseline c							
	initiated"							
	The resident's care pl	lan was reviewed and						
	•	, does not indicate the						
		IASD found by staff on						
		it mention sutures to her						
	· ·	ery in the hospital, nor						
		here was also no mention						
	of a femoral artery dia							
		al crease (groin) area, and no						
		linical record regarding						
		interventions, nor mention						
		t of any of the 4 skin issues						
		by Resident #1 in the care						
	plan, which would have							
	treatment care plan.							
	Resident #1's physici	an orders, assessments,						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495303	B. WING _			C 09/13/2023
NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2960 CHELSEA ROAD WEST POINT, VA 23181	· · · · · · · · · · · · · · · · · · ·	03/13/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 677	treatment administr reviewed and reveal (3 days after admissionations on 03/12/2 saline and leave op those 2 areas of the record during the 19 indication of suture Resident #1's stay. The National Institut guidance on suturestandard of practice be removed in 7 day extremities overlying sutures are left in to remove them with a and could increase. No orders nor assess the clinical records inguinal dialysis should be removed on evaluation document associated skin dark buttocks." No other	tration record (MAR), and ation record (TAR), were aled the only skin care orders sion) received for the 2 suture 2023 to clean with normal en to air. No assessments of e skin exists in the clinical 3-day stay, nor is there any removal orders during tes of Health (NIH) gives d wounds, and states as a e, sutures on the neck should ys, and in the lower g a joint 12 to 14 days. If so long it may be difficult to potential to reinjure the area, scar tissue at the site.	F 6	,		
	#1's 4-day stay before another facility on 0 Activities of daily live reviewed and reveal were documented as	ing (ADL) records were led that hygiene and bathing is being provided daily; nented as provided multiple				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2960 CHELSEA ROAD WEST POINT, VA 23181	09/	13/2023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 760 SS=G	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 6			10/24/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495303 B. WING				C 09/13/2023		
NAME OF PROVIDER OR SUPPLIER				SI	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	13/2023
While of Thoribert of Contract					960 CHELSEA ROAD		
THREE RI	VERS HEALTH & REHAE	3 CENTER			/EST POINT, VA 23181		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 760	F 760 Continued From page 26		F 7	760			
	REGULATORY OR LSC IDENTIFYING INFORMATION)				look back was performed for all new admissions/re-admissions for the past days to ensure orders to follow up with specialist were carried out. 3. Licensed Nursing staff have been educated on verifying all orders with stadates and the need to follow up with a specialist, as well as notifying the resid and/or Responsible Representative of changes. The facility providers were educated by their Chief Medical Officer September 19th, 2023 regarding proper documentation, care planning, and medical utilization. The providers were also reeducated on a detailed review of admission orders, including follow-up appointments, review of diagnosis, and medications required for treatment. 4. The Director of Nursing/designee will review six residents per week to determine that any discontinuance of orders have been verified by the healthcare provider, any orders to see specialist have been carried through an resident and/or Responsible Representative have been notified for sweeks. All results and trends will be reviewed at the monthly Quality Assurance Performance Improvement meeting to determine compliance and ongoing auditing. Areas of variance will investigated and appropriate actions we be taken to minimize recurrence.	a op ent any on er f I II and six	
	Apixaban - anticoagulant Diltiazem - antihypertensive						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495303	B. WING		C 09/13/2023		
NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2960 CHELSEA ROAD WEST POINT, VA 23181		09/13/2023		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	BE COMPLETION		
F 760	that the Atorvastatir administered one ti after admission, anday for an unknown reveals the reason cardiac medications Diltiazem (antihype (antihypertensive) ways of use with Dil 08/02/2023 after the other 2 medications after the 8:00 a.m. of the following 3 cardiates are the same of the following 3 cardiates are the following 3 cardiates are the same of the following 3 cardiates are the following 3	ement ent ent element ement element el	F 76				
	workload on the ve	ypertensive) - reduces ssels and heart, 25 mg, one s per day and 8:00 a.m., and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		TE SURVEY MPLETED	
		495303	495303 B. WING		C 09/13/2023		
NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP COIL 2960 CHELSEA ROAD WEST POINT, VA 23181			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 760	prevents blood clots heart attack and stroper day at 8:00 a.m., It is notable to mention orders were continued. During interviews it wappointments ordered doctors were never stoctors contacted about medications. The fand and alerted that the odiscontinued. Guidance for the admandalerted that the odiscontinued. Guidance for the admandalerted that the odiscontinued. National Institutes of Apixaban/Eliquis is goinstitutes of Health (National Institutes of Apixaban reduces the clots. Stopping Apixathrombotic events, like pulmonary embolus. Resident #2's care prevealed no focus, no primary diagnosis of anticoagulant therapy medication treatment. Nursing progress not revealed no notes do medication had been	gulant) - blood thinner, from forming and causing ke, 5 mg, one tablet twice and 9:00 p.m. on that all other 30-day and in the nursing facility. was found that the follow-up of for PCP, and Cardiology acheduled, nor were those rout continuing the cardiac only was also not contacted cardiac medications were ninistration of iven by The National NIH), and is as follows: Health & Medline.gov erisk of strokes and blood aban will increase the risk of the stroke, heart attack, and and was reviewed and for interventions for the atrial fibrillation, y, heart attack, and cardiac the swere reviewed, and	F 76	50			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495303 B. WING				1	C 13/2023	
NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH & REHAB CENTER				2960	ET ADDRESS, CITY, STATE, ZIP CODE CHELSEA ROAD T POINT, VA 23181	1 03/	13/2023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 760	REGULATORY OR LSC IDENTIFYING INFORMATION)		F	760	DEFICIENCY)		
	called the hospital en report of the condition told that Resident #2 Discharge records fro treatment on 08/16/20	023 indicated diagnosis of					
	"stroke." Ultimately, Resident #2 was discharged home with family and hospice services. On 09/13/2023 at 11:00 a.m., the Director of Nursing (DON) was interviewed in the conference room and stated she had been unaware that						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495303	B. WING			C
NAME OF PROVIDER OR SUPPLIER THREE RIVERS HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2960 CHELSEA ROAD WEST POINT, VA 23181		09/13/2023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 760	medications had not be doctor and family wer being discontinued by notified at that time of DON was a new staff been hired. The Admiconference during the be reached until the tithat time, she was may and stated she had not on 09/13/2023 at appthe end-of-day debried	been given, nor that the e not notified of medications of staff. The DON was for harm to Resident #2. The member and had recently nistrator was at a survey and was not able to the edications of the findings of thing further to provide. Droximately 2:00 p.m., during for the Administrator and the failure of staff to edications resulting in the form.	F	760		