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THREE RIVERS HEALTH & REHAB CENTER	2960 CHELSEA ROAD WEST POINT, VA 23181

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted on 9-12-23 through 9-13-23. Two complaints were investigated during the survey (VA00058473 Substantiated, and VA00059675 Substantiated). Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 60 certified bed facility was 55 at the time of the survey. The sample consisted of 4 Resident reviews.	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by:	F 552		10/24/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/16/2023

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F 552	Continued From page 1 Based on staff interview, Ombudsman interview, family interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure a demented resident's responsible party and physician were notified of a change in treatment for one resident (Residents #2) in a survey sample of four (4) residents. For Resident #2, the facility discontinued all of the resident's cardiac, antihypertensive, and blood thinning medications after 30 days, and did not notify the physician, nor family of the discontinuance. These following medications were discontinued: Diltiazem, Metoprolol, and Apixaban anticoagulation (blood thinner) medication for new onset atrial fibrillation. The findings included: Resident #2 was admitted to the facility on 07/03/2023 from the hospital. Diagnoses included, new onset atrial fibrillation, aortic valve stenosis, aortic valve insufficiency, likely acute heart attack, long term use of anticoagulants, hypertension, high cholesterol, mild protein calorie malnutrition, and dementia. Resident #2's most recent Minimum Data Set (MDS) with an assessment reference date (ARD) of 07/10/2023 was coded as a 5-day admission assessment. Resident #2 was coded as having a Brief Interview of Mental Status (BIMS) score of 6 out of a possible 15, revealing significant cognitive impairment. Resident #2 was also coded as requiring extensive assistance to complete dependence on staff to perform activities of daily living, such as bed mobility, transferring, locomotion, and toileting.	F 552	1. Resident #2 no longer resides in the facility. 2. 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 provider has been contacted for verification of discontinuance of the order 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 30 days to ensure orders to follow up with a specialist were carried out. 3. Licensed Nursing staff have been educated on verifying all orders with stop dates and the need to follow up with a specialist, as well as notifying the resident and/or Responsible Representative of any changes. The facility providers were educated by their Chief Medical Officer on 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 a specialist have been carried through and resident and/or Responsible Representative have been notified for six weeks. All results and trends will be reviewed at the monthly Quality	

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F 552	Continued From page 2 Hospital records from 06/26/2023 through 07/03/2023 were reviewed and revealed the following: Resident #2 was discharged from the hospital to the nursing facility with new onset atrial fibrillation with rapid ventricular response on 07/03/2023. The resident was issued the customary 30-day new orders for all medications from a hospitalist doctor after being stabilized in the hospital. The hospital doctor's intention was for the resident to follow-up with the resident's PCP and Cardiology doctors to monitor and continue those orders. This provides for continuity of care for discharge to the nursing facility, and ultimately from the nursing facility to home after rehabilitation. Those orders were for the following: Schedule appointment with Primary Care Doctor (PCP) (name given) as soon as possible for a visit within one week. Schedule appointment with Cardiology Doctor (name given) as soon as possible for visit within one month. Apixaban - anticoagulant Diltiazem - antihypertensive Metoprolol - antihypertensive Atorvastatin - lowers high cholesterol Vitamin D-3 - supplement Calcium - supplement Vitamin B-12 - supplement Multivitamin - supplement Iron - supplement Prilosec - gastric reflux Miralax - constipation	F 552	Assurance Performance Improvement meeting to determine compliance and ongoing auditing. Areas of variance will be investigated and appropriate actions will be taken to minimize recurrence.	

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Review of Resident #2's clinical record revealed that the Atorvastatin for high cholesterol was only administered one time on the day after admission, 07/04/2023, and discontinued on that same day for an unknown reason as no document reveals the reason for the discontinuance. The 3 cardiac medications were discontinued after 30 days of use with Diltiazem discontinued on 08/02/2023 after the 8:00 a.m. dose, and the other 2 medications after the 8:00 a.m. dose on 08/03/2023.

The following 3 cardiac medications were not restarted while Resident #2 was in the nursing facility, prior to rehospitalization, at approximately 11:30 a.m., on 08/14/2023 (11 days later) with a stroke.

1. Diltiazem (antihypertensive) - reduces workload on the vessels and heart, 240 milligrams (mg) one time per day at 8:00 a.m.

2. Metoprolol (antihypertensive) - reduces workload on the vessels and heart, 25 mg one half tablet two times per day and 8:00 a.m., and 9:00 p.m.

3. Apixaban (anticoagulant) - blood thinner, prevents blood clots from forming and causing heart attack and stroke, 5 mg one tablet twice per day at 8:00 a.m., and 9:00 p.m.

It is notable to mention that all other 30-day orders were continued in the nursing facility.

During interviews, it was found that the follow-up appointments ordered for PCP, and Cardiology doctors were never scheduled, nor were those

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F 552	Continued From page 4	F 552		

doctors contacted about continuing the cardiac medications. The family was also not contacted and alerted to the fact that the cardiac medications were discontinued.

The Medication and Treatment Administration Record (MAR/TAR) was reviewed for July and August 2023, and revealed nursing signatures indicating the Diltiazem medication had been administered through the morning of 08/02/2023, and the other 2 cardiac drugs were administered up through the morning of 08/03/2023.

Nursing progress notes were reviewed, and revealed no notes documenting the medication had been discontinued, nor that the doctor, or family was ever made aware of the discontinuance.

Physician's progress notes were reviewed and revealed on 08/04/2023, the day after the cardiac drugs were discontinued, "No aspirin will be on Eliquis for A-fib" ..."full code".... After that note, none of the following physician progress notes until the time of discharge (for stroke like symptoms) indicated that the physician was never made aware of the discontinuance of the cardiac medications by staff for Resident #2.

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 medications had not been given, nor that the doctor and family were not notified of medications being discontinued by staff`. The DON was a new staff member and had recently been hired. The Administrator was at a conference during the survey and was not able to be reached until the time of exit of the survey. At that time, she was

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F 552	Continued From page 5 made aware of findings and stated she had nothing further to provide. On 09/13/2023 at approximately 2:00 p.m., at the end of day debrief, the Administrator and DON were made aware of the failure of staff to notify the doctor and family of the discontinuance of cardiac treatment for Resident #2. No further information was provided.	F 552		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655		10/24/23

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F 655	Continued From page 6 admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, Ombudsman interview, family interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to develop and implement a baseline care plan for cardiac treatment for two residents (Residents #2 and #1) in a survey sample of four (4) Residents. 1. For Resident #2, the facility did not develop nor implement a cardiac care plan for the primary admitting diagnosis of new onset atrial fibrillation, heart attack, with cardiac doctor oversight, and new cardiac medication therapy. 2. For Resident #1, the facility staff did not provide a baseline care plan for moisture associated skin damage (MASD), care for inguinal dialysis shunt placement site, and sutures in the neck and knee after hospitalization.	F 655	1. Resident #1 and #2 no longer reside in the facility. 2. The Director of Nursing/designee has reviewed the baseline care plans of all newly admitted residents for whom the comprehensive care plan has not yet been created. The review was to ensure baseline care plans include the instructions needed to provide effective person-centered care for the residents current and potential needs. 3. The Director of Nursing/designee will reeducate all licensed nurses on policy and procedure for Baseline Care Plans. 4. The Director of Nursing/designee will review the baseline care plans of all newly admitted resident's weekly, for six weeks. The review will ensure baseline care plans include the instructions needed to provide individualized care for the resident. All	

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F 655	Continued From page 7 The findings included: 1. Resident #2 was admitted to the facility on 07/03/2023 from the hospital. Diagnoses included, new onset atrial fibrillation, aortic valve stenosis, aortic valve insufficiency, likely acute heart attack, long term use of anticoagulants, hypertension, high cholesterol, mild protein calorie malnutrition, and dementia. Resident #2's most recent Minimum Data Set (MDS) with an assessment reference date (ARD) of 07/10/2023 was coded as a 5-day admission assessment. Resident #2 was coded as having a Brief Interview of Mental Status (BIMS) score of 6 out of a possible 15, revealing significant cognitive impairment. Resident #2 was also coded as requiring extensive assistance to complete dependence on staff to perform activities of daily living, such as bed mobility, transferring, locomotion, and toileting. Hospital records from 06/26/2023 through 07/03/2023 were reviewed and revealed the following: Resident #2 was discharged from the hospital to the nursing facility with new onset atrial fibrillation with rapid ventricular response on 07/03/2023. The resident was issued the customary 30-day new orders for all medications from a hospitalist doctor after being stabilized in the hospital. The hospital doctor's intention was for the resident to follow-up with the resident's PCP and Cardiology doctors to monitor and continue those orders. This provides for continuity of care for discharge to the nursing facility, and ultimately from the nursing facility to home after rehabilitation. Those orders were for the following:	F 655	results and trends will be reviewed at the Quality Assurance and Performance Improvement meeting to determine compliance and ongoing auditing. Areas of variance will be investigated and appropriate actions will be taken to minimize recurrence.	

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Schedule appointment with Primary Care Doctor (PCP) (name given) as soon as possible for a visit within one week.
Schedule appointment with Cardiology Doctor (name given) as soon as possible for visit within one month.

Apixaban - anticoagulant
Diltiazem - antihypertensive
Metoprolol - antihypertensive
Atorvastatin - lowers high cholesterol

Vitamin D-3 - supplement
Calcium - supplement
Vitamin B-12 - supplement
Multivitamin - supplement
Iron - supplement

Prilosec - gastric reflux
Miralax - constipation

Review of Resident #2's clinical record revealed that the Atorvastatin for high cholesterol was only administered one time on the day after admission, 07/04/2023, and discontinued on that same day for an unknown reason as no document reveals the reason for the discontinuance. The 3 cardiac medications were discontinued after 30 days of use with Diltiazem discontinued on 08/02/2023 after the 8:00 a.m. dose, and the other 2 medications after the 8:00 a.m. dose on 08/03/2023.

The following 3 cardiac medications were not restarted while Resident #2 was in the nursing facility, prior to rehospitalization, at approximately 11:30 a.m., on 08/14/2023 (11 days later) with a stroke.

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1. Diltiazem (antihypertensive) - reduces workload on the vessels and heart, 240 milligrams (mg) one time per day at 8:00 a.m.

2. Metoprolol (antihypertensive) - reduces workload on the vessels and heart, 25 mg one half tablet two times per day and 8:00a.m., and 9:00 p.m.

3. Apixaban (anticoagulant) - blood thinner, prevents blood clots from forming and causing heart attack and stroke, 5 mg one tablet twice per day at 8:00 a.m., and 9:00 p.m.

It is notable to mention that all other 30-day orders were continued in the nursing facility.

During interviews it was found that the follow-up appointments ordered for PCP and Cardiology doctors were never scheduled, nor were those doctors contacted about continuing the cardiac medications. The family was also not contacted and alerted to the fact that the cardiac medications were discontinued.

The Medication and Treatment Administration Record (MAR/TAR) was reviewed for July and August 2023, and revealed nursing signatures indicating the Diltiazem medication had been administered through the morning of 08/02/2023, and the other 2 cardiac drugs were administered through the morning of 08/03/2023.

Resident #2's care plan was reviewed and revealed no focus, nor interventions for the primary diagnosis of atrial fibrillation, anticoagulant therapy, heart attack, and cardiac medication treatment, nor follow-up appointment

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with the cardiac doctor. The family was not involved in the care planning process.

Nursing progress notes were reviewed, and revealed no notes documenting the medication had been discontinued, nor that the doctor, or family was ever made aware of the discontinuance.

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 medications had not been given, nor that the doctor and family were not notified of medications being discontinued by staff. The DON was a new staff member and had recently been hired. The Administrator was at a conference during the survey and was not able to be reached until the time of exit of the survey. At that time, she was made aware of findings and stated she had nothing further to provide.

On 09/13/2023 at approximately 2:00 p.m., at the end of day debrief, the Administrator and DON were made aware of the failure of staff to develop and implement a cardiac care plan for the resident.

No further information was provided.

2. For Resident #1, the facility staff did not provide a baseline care plan for moisture associated skin damage (MASD), care for inguinal dialysis shunt placement site, and sutures in the neck and knee after hospitalization.

The Findings included:

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Resident #1 was admitted to the facility on 03/09/2023 with diagnoses including, acute kidney failure, effusion left knee, diabetes type 2, acute embolism of left femoral vein, left knee pain, hypertension, hypothyroidism, venous insufficiency, stroke, and breast cancer.

Resident #1's most recent Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 03/15/2023. which was a 5-day admission assessment. The MDS coded Resident #1 as needing extensive to total staff assistance with toileting, hygiene, and bathing. The resident was also coded as 10 of 15 possible points on a BIMS, indicating mild cognitive impairment. The resident was coded as frequently incontinent of bowel and bladder.

Review of Resident #1's progress notes indicated on 03/10/2023, "(Resident name) has surgical wounds.. left knee.. two small incisions from knee surgery"..."baseline care plan has been initiated..."

The resident's care plan was reviewed, and revealed a care plan for potential for skin impairment; however, does not indicate the resident had actual MASD found by staff on 03/23/2023, nor does it mention sutures to her knee after knee surgery in the hospital, nor sutures in her neck. There was also no mention of a femoral artery dialysis shunt placed in the resident's inguinal crease (groin) area, and no assessments in the clinical record regarding these. There were no interventions, nor mention of care and treatment of any of the 4 skin issues actually experienced by Resident #1 in the care plan, which would have required an active treatment care plan.

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Resident #1's physician orders, assessments, medication administration record (MAR), and treatment administration record (TAR), were reviewed and revealed the only skin care orders (3 days after admission) received for the 2 suture locations on 03/12/2023 to clean with normal saline and leave open to air. No assessments of those 2 areas of the skin exists in the clinical record during the 19-day stay, nor is there any indication of suture removal orders during the resident's stay.

The National Institutes of Health (NIH) gives guidance on sutured wounds, and states as a standard of practice, sutures on the neck should be removed in 7 days, and in the lower extremities overlying a joint 12 to 14 days. If sutures are left in too long it may be difficult to remove them with a potential to reinjure the area, and could increase scar tissue at the site.

No orders nor assessments were ever placed in the clinical records for the MASD, and femoral inguinal dialysis shunt area.

The first skin impairment note in the clinical record occurred on 03/23/2023, which was a skin evaluation document, described "moisture associated skin damage (MASD)" "right and left buttocks." No other information was given and the form was not completed. No treatments were ordered for the MASD for the rest of the resident's 4-day stay before being transferred to another facility on 03/27/2023.

Activities of daily living (ADL) records were reviewed and revealed that hygiene and bathing were documented as being provided daily;

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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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 13 however, not documented as provided multiple times daily during the resident's stay. Staff stated the facility policy on Perineal Care for Incontinent Residents, was that care would be provided approximately every 2 hours every shift and PRN (as needed), which included removal of wet incontinent briefs, and cleansing. Staff further stated the expectation is to give incontinence care immediately after every incontinent episode. Resident #1 was not afforded timely incontinence care as many times as was needed, as evidenced by the MASD actually acquired after 10 days in the facility. The facility Administrator and Director of Nursing (DON) were made aware of the above findings at the end-of-day debrief on 09/13/2023. No additional information was provided to the surveyor.	F 655		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, Ombudsman interview, family interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to maintain the professional standards of nursing practice for two residents (Residents #2 and #1) in a survey sample of four (4) Residents.	F 658	1. Resident #2 no longer resides in the facility. 2. 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	10/24/23

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F 658	Continued From page 14 1. For Resident #2, the facility staff discontinued all the resident's cardiac, antihypertensive, and blood thinning medications after 30 days for new onset atrial fibrillation. They also failed to notify the family and doctor of the discontinuance, did not obtain follow-up appointments with the resident's doctors as ordered by a physician, and did not develop nor implement a nursing care plan for cardiac treatment. 2. For Resident #1, the facility staff did not provide incontinence care timely resulting in moisture associated skin damage (MASD), and further failed to care for, and care plan for inguinal dialysis shunt placement site, MASD, and sutures in the neck and knee after hospitalization. The findings included: 1. Resident #2, was admitted to the facility on 07/03/2023 from the hospital. Diagnoses included, new onset atrial fibrillation, aortic valve stenosis, aortic valve insufficiency, likely acute heart attack, long-term use of anticoagulants, hypertension, high cholesterol, mild protein calorie malnutrition, and dementia. Resident #2's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD of 07/03/2023 was coded as a 5-day admission assessment. Resident #2 was coded as having a brief interview of mental status (BIMS) score of 6 out of a possible 15, revealing significant cognitive impairment. Resident #2 was also coded as requiring extensive assistance to complete dependence on staff to perform activities of daily living, such as bed mobility, transferring, locomotion, and toileting.	F 658	provider has been contacted for verification of discontinuance of the order 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 30 days to ensure orders to follow up with a specialist were carried out. 3. Licensed Nursing staff have been educated on verifying all orders with stop dates and the need to follow up with a specialist, as well as notifying the resident and/or Responsible Representative of any changes. The facility providers were educated by their Chief Medical Officer on 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 a specialist have been carried through and resident and/or Responsible Representative have been notified for six 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 will be investigated and appropriate actions will be taken to minimize recurrence.	

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Hospital records from 06/26/2023 through 07/03/2023 were reviewed and revealed the following:

Resident #2 was discharged from the hospital to the nursing facility with new onset atrial fibrillation with rapid ventricular response on 07/03/2023. The resident was issued the customary 30-day new orders for all medications from a hospitalist doctor after being stabilized in the hospital. The hospital doctor's intention was for the resident to follow-up with the resident's PCP, and cardiology doctors to monitor and continue those orders. This provides for continuity of care for discharge to the nursing facility, and ultimately from the nursing facility to home after rehabilitation. Those orders were for the following:

Schedule appointment with Primary Care Doctor (PCP) (name given) as soon as possible for a visit within one week.
Schedule appointment with Cardiology Doctor (name given) as soon as possible for visit within one month.

Apixaban - anticoagulant
Diltiazem - antihypertensive
Metoprolol - antihypertensive
Atorvastatin - lowers high cholesterol

Vitamin D-3 - supplement
Calcium - supplement
Vitamin B-12 - supplement
Multivitamin - supplement
Iron - supplement

Prilosec - gastric reflux
Miralax - constipation

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Review of Resident #2's clinical record revealed that the atorvastatin for high cholesterol was only administered one time on the day after admission, 07/04/2023, and discontinued on the same day for an unknown reason as no document reveals the reason for the discontinuance. The 3 cardiac medications were discontinued after 30 days of use with Diltiazem discontinued on 08/02/2023 after the 8:00 a.m. dose, and the other 2 medications after the 8:00 a.m. dose on 08/03/2023.

The following 3 cardiac medications were not restarted while Resident #2 was in the nursing facility, prior to rehospitalization, at approximately 11:30 a.m., on 08/14/2023 (11 days later) with a stroke.

1. Diltiazem (antihypertensive) - reduces workload on the vessels and heart, 240 milligrams (mg) one time per day at 8:00 a.m.

2. Metoprolol (antihypertensive) - reduces workload on the vessels and heart, 25 mg one half tablet two times per day and 8:00 a.m., and 9:00 p.m.

3. Apixaban (anticoagulant) - blood thinner, prevents blood clots from forming and causing heart attack and stroke, 5 mg one tablet twice per day at 8:00 a.m., and 9:00 p.m.

It is notable to mention that all other 30-day orders were continued in the nursing facility.

During interviews, it was found that the follow-up appointments ordered for PCP, and cardiology doctors were never scheduled, nor were those

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doctors contacted about discontinuing the cardiac medications. The family was also not contacted and alerted to the fact that the cardiac medications were discontinued.

The Medication and Treatment Administration Record (MAR/TAR) was reviewed for July and August 2023, and revealed nursing signatures indicating the Diltiazem medication had been administered through the morning of 08/02/2023, and the other 2 cardiac drugs were administered up through the morning of 08/03/2023.

Guidance for the administration of Apixaban/Eliquis is given by The National Institutes of Health (NIH) (National Institutes of Health & Medline.gov), and is as follows:

Apixaban reduces the risk of strokes and blood clots. Stopping Apixaban will increase the risk of thrombotic events, like stroke, heart attack and pulmonary embolus.

Resident #2's care plan was reviewed and revealed no focus, nor interventions for the primary diagnosis of atrial fibrillation, anticoagulant therapy, heart attack, and cardiac medication treatment.

Nursing progress notes were reviewed, and revealed no notes documenting that the medication had been discontinued, nor that the doctor, or family was ever made aware of the discontinuance.

Physician's progress notes were reviewed and revealed on 08/04/2023, the day after the cardiac drugs were discontinued, "No aspirin will be on Eliquis for A-fib" ..."full code." After that note,

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none of the following physician progress notes until the time of discharge (for stroke like symptoms) indicated the physician was never made aware of the discontinuance of the cardiac medications by staff for Resident #2.

Vital sign records and progress notes were reviewed and revealed that on the day of discharge 08/14/2023, Resident #2 went back to the hospital for stroke like symptoms. The resident's pulse was between 80 and 130 beats per minute, and blood pressure was 130/78.

On the morning of discharge, 08/14/2023, Resident #2 went back to the hospital. The nursing notes indicated between 9:30 a.m., and 11:37 a.m., the resident was experiencing "irregular pulse, altered level of consciousness, weakness/hemiparesis, leaning in wheel chair, slurred speech, and 911." Emergency services was called to transfer the resident to the hospital. At 6:36 p.m., the progress notes documented the facility staff called the hospital emergency room to get a report of the condition of the resident and were told that Resident #2 was admitted for a stroke.

Discharge records from the hospital after treatment on 08/16/2023 indicated diagnosis of "stroke." 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 was not aware the medications had not been given, the appointments had not been set, there was no cardiac care plan, nor that the doctor and family were not notified of medications being

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discontinued by staff. The DON was a new staff member and had recently been hired. The Administrator was at a conference during the survey and was not able to be reached until the time of exit of the survey. At that time she was made aware of findings and stated she had nothing further to provide.

On 09/13/2023 at approximately 2:00 p.m., at the end of day debrief, the Administrator and DON were made aware of the failure of staff to develop care plans, set follow up appointments, and notify family and doctors of cardiac medication discontinuance.

No further information was provided.

2. For Resident #1, the facility staff did not provide incontinence care timely resulting in moisture associated skin damage (MASD), and further failed to care for inguinal dialysis shunt placement site, and sutures in the neck and knee after hospitalization.

The findings included:

Resident #1 was admitted to the facility on 03/09/2023 with diagnoses including, acute kidney failure, effusion left knee, diabetes type 2, acute embolism of left femoral vein, left knee pain, hypertension, hypothyroidism, venous insufficiency, stroke, and breast cancer.

Resident #1's most recent Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 03/15/2023 was a 5-day admission assessment. The MDS coded Resident #1 as needing extensive to total staff

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assistance with toileting, hygiene, and bathing. The resident was also coded as 10 of 15 possible points on a Brief Interview for Mental Status (BIMS), indicating mild cognitive impairment. The resident was coded as frequently incontinent of bowel and bladder.

Review of Resident #1's progress notes indicated on 03/10/2023, "(Resident name) has surgical wounds.. left knee.. two small incisions from knee surgery"..."baseline care plan has been initiated..."

The resident's care plan was reviewed and revealed a care plan for potential for skin impairment; however, the care plan does not indicate the resident had actual MASD found by staff on 03/23/2023, nor does it mention sutures to her knee after knee surgery in the hospital, nor sutures in her neck. There was also no mention of a femoral artery dialysis shunt placed in the resident's inguinal crease (groin) area, and no assessments in the clinical record regarding these. There were no interventions, nor mention of care and treatment of any of the 4 skin issues actually experienced by Resident #1 in the care plan, which would have required an active treatment care plan.

Resident #1's physician orders, assessments, medication administration record (MAR), and treatment administration record (TAR), were reviewed and revealed the only skin care orders (3 days after admission) received for the 2 suture locations on 03/12/2023 to clean with normal saline and leave open to air. No assessments of those 2 areas of the skin exists in the clinical record during the 19-day stay, nor is there any indication of suture removal orders during the

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resident's stay.

The National Institutes of Health (NIH) gives guidance on sutured wounds, and states as a standard of practice, sutures on the neck should be removed in 7 days, and in the lower extremities overlying a joint 12 to 14 days. If sutures are left in too long, it may be difficult to remove them with a potential to reinjure the area, and could increase scar tissue at the site.

No orders nor assessments were ever placed in the clinical records for the MASD, and femoral inguinal dialysis shunt area.

The first skin impairment note in the clinical record occurred on 03/23/2023, which was a skin evaluation document, described "moisture associated skin damage (MASD)" "right and left buttocks." No other information was given and the form was not completed. No treatments were ordered for the MASD for the rest of the resident's 4-day stay before being transferred to another facility on 03/27/2023.

Activities of daily living (ADL) records were reviewed and revealed that hygiene and bathing were documented as being provided daily; however, not documented as provided multiple times daily during the resident's stay.

Staff stated the facility policy on Perineal Care for Incontinent Residents, was that care would be provided approximately every 2 hours every shift and as needed (PRN), which included removal of wet incontinent briefs, and cleansing. Staff further stated the expectation is to give incontinence care immediately after every incontinent episode. Resident #1 was not afforded timely incontinence

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F 658	Continued From page 22 care as many times as was needed, as evidenced by the MASD actually acquired after 10 days in the facility. The facility Administrator and Director of Nursing (DON) were made aware of the above findings at the end-of-day debrief on 09/13/2023. No additional information was provided to the surveyor.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure incontinence and wound care was provided timely for 1 resident (Resident #1) of four (4) residents in the survey sample. For Resident #1, the facility staff did not provide incontinence care timely resulting in moisture associated skin damage (MASD), and further failed to care for inguinal dialysis shunt placement site, and sutures in the neck and knee after hospitalization. The findings included: Resident #1 was admitted to the facility on 03/09/2023 with diagnoses including, acute kidney failure, effusion left knee, diabetes type 2,	F 677	1. Resident #1 no longer resides in the facility. 2. All residents requiring assistance with activities of daily living have the potential to be affected by this deficient practice. An audit was performed to determine who is at risk for incontinence. Orders for barrier cream have been placed for all residents at risk. 3. Facility licensed and certified Nursing staff will be reeducated on the identification and treatment of Moisture Associated Skin Damage and the initiation of topical treatment. Facility licensed and certified nursing staff will be reeducated on policy and procedure for Activities of Daily Living (ADL's) to include the importance of providing and documenting incontinence care to minimize impaired	10/24/23

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F 677	Continued From page 23 acute embolism of left femoral vein, left knee pain, hypertension, hypothyroidism, venous insufficiency, stroke, and breast cancer. Resident #1's most recent Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 03/15/2023 was a 5-day admission assessment. The MDS coded Resident #1 as needing extensive to total staff assistance with toileting, hygiene, and bathing. Resident #1 was also coded as 10 of 15 possible points on a Brief Interview for Mental Status (BIMS), indicating mild cognitive impairment. The resident was coded as frequently incontinent of bowel and bladder. Review of Resident #1's progress notes indicated on 03/10/2023, "(Resident name) has surgical wounds.. left knee.. two small incisions from knee surgery"..."baseline care plan has been initiated..." The resident's care plan was reviewed and revealed a care plan for potential for skin impairment; however, does not indicate the resident had actual MASD found by staff on 03/23/2023, nor does it mention sutures to her knee after knee surgery in the hospital, nor sutures in her neck. There was also no mention of a femoral artery dialysis shunt placed in Resident #1's inguinal crease (groin) area, and no assessments in the clinical record regarding these. There were no interventions, nor mention of care and treatment of any of the 4 skin issues actually experienced by Resident #1 in the care plan, which would have required an active treatment care plan. Resident #1's physician orders, assessments,	F 677	skin integrity. Weekly skin observations will be completed and documented by licensed nursing staff to identify areas of skin impairment. 4. Director of Nursing/designee will audit six incontinent residents weekly to ensure proper incontinences care was provided and appropriate treatment was ordered and initiated for six weeks. All results and trends will be reviewed at the Quality Assurance Performance Improvement meeting to determine compliance and ongoing auditing. Areas of variance will be investigated and appropriate actions will be taken to minimize recurrence.	

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medication administration record (MAR), and treatment administration record (TAR), were reviewed and revealed the only skin care orders (3 days after admission) received for the 2 suture locations on 03/12/2023 to clean with normal saline and leave open to air. No assessments of those 2 areas of the skin exists in the clinical record during the 19-day stay, nor is there any indication of suture removal orders during Resident #1's stay.

The National Institutes of Health (NIH) gives guidance on sutured wounds, and states as a standard of practice, sutures on the neck should be removed in 7 days, and in the lower extremities overlying a joint 12 to 14 days. If sutures are left in too long it may be difficult to remove them with a potential to reinjure the area, and could increase scar tissue at the site.

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Activities of daily living (ADL) records were reviewed and revealed that hygiene and bathing were documented as being provided daily; however, not documented as provided multiple times daily during the resident's stay.

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F 677	Continued From page 25 Staff stated the facility policy on Perineal Care for Incontinent Residents, was that care would be provided approximately every 2 hours every shift and as needed (PRN), which included removal of wet incontinent briefs, and cleansing. Staff further stated the expectation is to give incontinence care immediately after every incontinent episode. Resident #1 was not afforded timely incontinence care as many times as was needed, as evidenced by the MASD actually acquired after 10 days in the facility. The facility Administrator and Director of Nursing (DON) were made aware of the above findings at the end-of-day debrief on 09/13/2023. No additional information was provided to the surveyor.	F 677		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, Ombudsman interview, family interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure one resident (Resident #2) was free from significant medication errors in a survey sample of four (4) residents, resulting in harm. For Resident #2, the facility discontinued all of the resident's cardiac, antihypertensive, and blood thinning medications after 30 days resulting in	F 760	1. Resident #2 no longer resides in the facility. 2. 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 provider has been contacted for verification of discontinuance of the order as well as notifying the resident and/or Responsible Representative. A 14-day	10/24/23

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F 760	Continued From page 26 hospitalization for a stroke. The medications were Diltiazem, Metoprolol, and Apixaban anticoagulation (blood thinner) medication for new onset atrial fibrillation. The findings included: Resident #2 was admitted to the facility on 07/03/2023 from the hospital. Diagnoses included, new onset atrial fibrillation, aortic valve stenosis, aortic valve insufficiency, likely acute heart attack, long term use of anticoagulants, hypertension, high cholesterol, mild protein calorie malnutrition, and dementia. Hospital records from 06/26/2023 through 07/03/2023 were reviewed and revealed the following: Resident #2 was discharged from the hospital to the nursing facility with new onset atrial fibrillation with rapid ventricular response on 07/03/2023. The resident was issued the customary 30-day new orders for all medications from a hospitalist doctor after being stabilized in the hospital. This provides for continuity of care for discharge to the nursing facility, and ultimately from the nursing facility to home after rehabilitation. Those orders were for the following: Schedule appointment with Primary Care Doctor (PCP) (name given) as soon as possible for a visit within one week. Schedule appointment with Cardiology Doctor (name given) as soon as possible for visit within one month. Apixaban - anticoagulant Diltiazem - antihypertensive	F 760	look back was performed for all new admissions/re-admissions for the past 30 days to ensure orders to follow up with a specialist were carried out. 3. Licensed Nursing staff have been educated on verifying all orders with stop dates and the need to follow up with a specialist, as well as notifying the resident and/or Responsible Representative of any changes. The facility providers were educated by their Chief Medical Officer on 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 a specialist have been carried through and resident and/or Responsible Representative have been notified for six 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 will be investigated and appropriate actions will be taken to minimize recurrence.	

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Metoprolol - antihypertensive
Atorvastatin - lowers high cholesterol

Vitamin D-3 - supplement
Calcium - supplement
Vitamin B-12 - supplement
Multivitamin - supplement
Iron - supplement

Prilosec - gastric reflux
Miralax - constipation

Review of Resident #2's clinical record revealed that the Atorvastatin for high cholesterol was only administered one time on 07/04/2023, the day after admission, and discontinued on that same day for an unknown reason as no document reveals the reason for the discontinuance. The 3 cardiac medications, Apixaban (anticoagulant), Diltiazem (antihypertensive), and Metoprolol (antihypertensive) were discontinued after 30 days of use with Diltiazem discontinued on 08/02/2023 after the 8:00 a.m. dose, and the other 2 medications, Apixaban and Metoprolol, after the 8:00 a.m. dose on 08/03/2023.

The following 3 cardiac medications were not restarted while Resident #2 was in the nursing facility, prior to rehospitalization, at approximately 11:30 a.m., on 08/14/2023 (11 days later) with a stroke.

1. Diltiazem (antihypertensive) - reduces workload on the vessels and heart, 240 mg, one time per day at 8:00 a.m.

2. Metoprolol (antihypertensive) - reduces workload on the vessels and heart, 25 mg, one half tablet two times per day and 8:00 a.m., and

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9:00 p.m.

3. Apixaban (anticoagulant) - blood thinner, prevents blood clots from forming and causing heart attack and stroke, 5 mg, one tablet twice per day at 8:00 a.m., and 9:00 p.m.

It is notable to mention that all other 30-day orders were continued in the nursing facility.

During interviews it was found that the follow-up appointments ordered for PCP, and Cardiology doctors were never scheduled, nor were those doctors contacted about continuing the cardiac medications. The family was also not contacted and alerted that the cardiac medications were discontinued.

Guidance for the administration of Apixaban/Eliquis is given by The National Institutes of Health (NIH), and is as follows:

National Institutes of Health & Medline.gov
Apixaban reduces the risk of strokes and blood clots. Stopping Apixaban will increase the risk of thrombotic events, like stroke, heart attack, and pulmonary embolus.

Resident #2's care plan was reviewed and revealed no focus, nor interventions for the primary diagnosis of atrial fibrillation, anticoagulant therapy, heart attack, and cardiac medication treatment.

Nursing progress notes were reviewed, and revealed no notes documenting that the medication had been discontinued, nor that the doctor, or family was ever made aware of the discontinuance.

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Physician's progress notes were reviewed and revealed on 08/04/2023, the day after the cardiac drugs were discontinued, "No aspirin will be on Eliquis for A-fib" ..."full code." After that note, none of the following physician progress notes until the time of discharge for stroke like symptoms indicated the physician was never made aware of the discontinuance of the cardiac medications by staff for Resident #2.

Vital sign records and progress notes were reviewed and revealed on the day of discharge, 08/14/2023, back to the hospital for stroke like symptoms, Resident #2's pulse was between 80 and 130 beats per minute, and blood pressure was 130/78.

On 08/14/2023, the morning of discharge back to the hospital, between 9:30 a.m. and 11:37 a.m., nursing notes indicated that the Resident #2 was experiencing "irregular pulse, altered level of consciousness, weakness/hemiparesis, leaning in wheel chair, slurred speech, and 911." Emergency services was called to transfer Resident #2 to the hospital. At 6:36 p.m., the progress notes documented the facility staff called the hospital emergency room to get a report of the condition of the resident and were told that Resident #2 was admitted for a stroke.

Discharge records from the hospital after treatment on 08/16/2023 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

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medications had not been given, nor that the doctor and family were not notified of medications being discontinued by staff. The DON was notified at that time of harm to Resident #2. The DON was a new staff member and had recently been hired. The Administrator was at a conference during the survey and was not able to be reached until the time of exit of the survey. At that time, she was made aware of the findings and stated she had nothing further to provide.

On 09/13/2023 at approximately 2:00 p.m., during the end-of-day debrief, the Administrator and DON were made aware of the failure of staff to administer cardiac medications resulting in hospitalization and harm.

No further information was provided.