STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345499	A. BUILDING _____ B. WING _____	C 12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITCHFORD FALLS HEALTHCARE & REHABILITATION CENTER	8200 LITCHFORD ROAD RALEIGH, NC 27615

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F 000	INITIAL COMMENTS An onsite complaint investigation was conducted from 12/10/24 through 12/13/24. Additional information was obtained offsite on 12/16/24. The credible allegation of immediate jeopardy removal was validated on 12/17/24. Therefore, the exit date was changed to 12/17/24. The following intakes were investigated: NC00220746, NC00221270, NC00224836, NC00224859 and NC00225047. Intake NC00225047 resulted in immediate jeopardy. 3 of the 22 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity of J CFR 483.45 at tag F756 at a scope and severity of J CFR 483.45 at tag F760 at a scope and severity of J The tag F760 constituted Substandard Quality of Care. Immediate Jeopardy began on 10/28/24 (for F580 and F760) and on 11/13/24 (for F756) and was removed on 12/14/24. A partial extended survey was conducted.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580		1/17/25

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

Electronically Signed | 01/13/2025

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F 580	Continued From page 1	F 580		

representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement

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F 580	Continued From page 2 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on facility staff interviews, physicians' interviews, and facility and hospital record reviews, the facility failed to immediately consult with the resident's Medical Doctor (MD) for order clarification when there was a lapse in the resident's coverage of an oral anticoagulant medication (Eliquis). Eliquis is a prescription medication used to reduce the risk of stroke and blood clots in people who have atrial fibrillation (a type of irregular heartbeat). Eliquis was discontinued 11 days before Resident #6 returned for a one-month Vascular follow-up appointment by an outside provider due to a recent diagnosis of bilateral lower extremity deep vein thrombosis (or DVTs, a condition where a blood clot forms in a deep vein, typically in the legs). The facility failed to clarify with either the Vascular consultant or Resident #6's physician as to whether the Eliquis needed to be continued until the next Vascular consult on 11/8/24. This occurred for 1 of 1 resident reviewed for notification of change (Resident #6) with a history of strokes, DVTs, pulmonary embolism (or PE, a condition where a blood clot travels to the lungs), and atrial fibrillation. Resident #6 was admitted to the hospital on 12/3/24 due to a change in mental status with diagnoses which included an acute middle cerebral artery (MCA) stroke. An MCA stroke occurs when blood flow through the middle cerebral artery in the brain is interrupted. Resident #6 remained hospitalized as of the date of the review (12/17/24).	F 580	The creation and submission of this allegation of compliance does not constitute an admission by this provider of any wrongful did, or of any violation of regulation. It is solely created to demonstrate our good faith attempt to continue to provide a quality of life for our residents. F580 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #6 is no longer in the facility. Identification of other residents having the potential to be affected by the same deficient practice: 100% audit of all current residents discontinued/stopped medication in the last 30 days completed on 12/13/2024, by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinator (1 or #2) to identify any other medication that was discontinued/stopped/ran-out without consultation with an attending physician. Any resident(s) identified with a discontinued order without attending physician consultation, the Director of nursing will inform the physician for appropriate measures and or interventions and implement the	

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F 580	Continued From page 3 Immediate jeopardy began on 10/28/24 when Resident #6's Eliquis was discontinued without consulting with the physician. Immediate jeopardy was removed on 12/14/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the completion of education and monitoring systems are in place. The findings included: Resident #6 was admitted to the hospital on 2/13/24 after sustaining a left distal fibular fracture (a break in the small bone of the lower leg near the ankle) from a fall. The resident's hospital Discharge Summary dated 2/20/24 noted she was on chronic anticoagulation due to atrial fibrillation and a history of DVT and PE. Resident #6's hospital Discharge Medication List included 5 milligrams (mg) Eliquis to be administered as one tablet by mouth twice daily. She was discharged from the hospital and admitted to the facility on 2/20/24. A review of Resident #6's February 2024 through September 2024 Physician Orders revealed the resident's medication regimen continued to include 5 mg Eliquis administered by mouth two times a day from 2/20/24 to 9/17/24. On 9/17/24, a venous doppler ultrasound study was conducted of Resident #6's left lower extremity due to the resident's complaint of pain in her left lower extremity and history of frequent DVTs. The Radiology Results read in part,	F 580	interventions as ordered. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur Effective 12/13/2024, facility employees will ensure any changes in medication or treatment, to include discontinuation of medication such as Eliquis, will be reported to the physician prior to the discontinuation to ensure appropriate medical intervention/assessment is implemented to prevent possible negative consequences that may result from abruptly discontinuing medication such as Eliquis. This systemic modification will be accomplished by implementing the following measures: Effective 12/13/2024, licensed nurse on duty will inform the resident; consult with the resident□s physician; and notify, the resident representative when there is; a significant change in the resident□s physical, mental, or psychosocial status, a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). This notification will be documented on each resident□s electronic medical records by the licensed nurse on duty. Effective 12/13/2024, the facility□s clinical team, which includes Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1 Unit coordinator #2, and/or Admission	

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F 580	Continued From page 4 "Impression: Findings are consistent with deep venous thrombosis [DVT] ...Clinical Follow-up is recommended." A Health Status Note dated 9/17/24 at 2:54 PM reported Resident #6's MD was informed of the radiology results. A new physician's order was received to discontinue the resident's Eliquis and initiate the administration of 40 mg enoxaparin (an injectable anticoagulant used for the treatment of DVTs) to be administered subcutaneously (under the skin) every 12 hours to prevent blood clotting. The physician also ordered a Vascular consult for Resident #6 at that time. Resident #6 was seen for an outside Vascular consultation on 9/27/24. Upon her return to the facility, paperwork provided from the consultation included a Doctor's Order Consult Request. A notation made on this form indicated the reason for the consultation was due to concerns for blood clots given the resident's positive history and bilateral leg pain. The "Consultation Findings" indicated a bilateral lower extremity (BLE) venous duplex (ultrasound) was conducted with a diagnosis of "Bilateral lower extremity non-occlusive DVTs [a condition where veins are partially blocked, allowing some blood to flow around the clots]." The "Recommendations" read as follows: "Compression stockings ...daily (on in AM, off in PM) and Eliquis 5 mg BID [twice daily] x 30 days and follow-up in 1 month with a repeat BLE venous duplex [ultrasound to be completed at the next visit] to check on the status of the thrombi [clots]. Patient may need to be on low anticoagulation indefinitely with her history of DVT/PE." The Doctor's Order Consult Request form also noted the resident's 1 monthly follow-up	F 580	nurse initiated a process for reviewing clinical documentation for the last 24 hours and physician orders written in the last 24 hours (including orders to discontinue medication), or from the last clinical meeting to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. Any negative findings will be addressed promptly. The nursing administrative team will review the clinical documentation and physician orders written on Friday, Saturday, and/or Sunday at the next clinical meeting on the following Monday. 100% education of all licensed nurses to include full time, part time, and as needed licensed nurses will be completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and/or Unit Coordinators (1, #2). The emphasis of this education will be the importance of notifying an attending physician and the party responsible in a timely manner for any change in condition, change of treatment/intervention and discontinuation of medication. The education emphasized that an attending physician should be consulted before medication ran out/stopped for proper intervention. This education will be completed by 12/13/2024, any licensed nurses not educated by 12/13/2024 will	

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appointment was scheduled for 11/4/24 at 3:00 PM. The form was signed by the Vascular clinic Nurse Practitioner #1 (NP #1).

Upon Resident #6's return to the facility on 9/27/24, a physician's order was received and transcribed by Nurse #1 into the resident's electronic medical record (EMR) to re-start her Eliquis as 5 mg administered as one tablet by mouth twice daily for 30 days. The order for Eliquis included a start date of 9/28/24 and an end date of 10/28/24. A physician's order was also received and transcribed into Resident #6's EMR for the enoxaparin to be discontinued as of 9/27/24.

A telephone interview was conducted on 12/16/24 at 7:56 PM with Nurse #1. Nurse #1 was identified as having transcribed the order for Resident #6's Eliquis on 9/27/24 upon the resident's return from her Vascular consultation. When asked, the nurse recalled Resident #6 but could not remember any specifics related to the orders transcribed into the resident's EMR on 9/27/24. When asked, Nurse #1 reported if she had any questions on the resident's paperwork from the consult, she would have told the Unit Manager. The nurse reported it was her understanding that the Unit Manager was responsible for any follow-up deemed necessary regarding the physician's orders.

A telephone interview was conducted on 12/16/24 at 1:56 PM with the facility's former Unit Manager. During the interview, the Unit Manager reported she did not recall any specific details about the paperwork returned from Resident #6's Vascular consultation or the orders received on 9/27/24. When asked, the Unit Manager stated she was not be allowed to work until educated.
Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (1, #2) will monitor and track the completion of this education and will complete this education for any newly hired licensed nurses during the new hire orientation effective 12/13/2024
100% education of all current clinical leadership team members to include Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1, Unit coordinator #2 and/or Admission nurse completed by the Regional Director of Clinical services. The emphasis of this education includes, but is not limited to, the importance of ensuring residents discontinued medication and other changes of condition is reviewed in the daily clinical meeting to ensure the attending physician was consulted before the medication ran out/stopped or discontinued. This education will be completed by 12/13/2024, any clinical team member not educated by 12/13/24, will not be allowed to work until educated. This education is added to a new hire orientation for all clinical team members effective 12/13/2024.

Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur:

Effective 01/13/2025, DON and/or ADON will monitor compliance with notification of changes to physician and or responsible party by reviewing the daily clinical meeting reports to ensure completion,

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F 580	Continued From page 6 not certain the facility had a set process in place to receive and address the recommendations made by outside consultants. Upon further inquiry as to whether she recalled seeing the Doctor's Order Consult Request from Resident #6's Vascular consult on 11/8/24, the Unit Manager stated she did not. A review of the resident's September 2024 Medication Administration Record (MAR) revealed Resident #6 began to receive 5 mg Eliquis administered as one tablet by mouth twice daily on 9/28/24 in accordance with the physician's order. A Health Status Note dated 10/28/24 at 3:25 PM and authored by the facility's Director of Nursing (DON) reported Resident #6's managed care program "notified facility about resident's upcoming Vascular appointment scheduled for 11/4/24, stating that the [family member] would like to reschedule due to a conflicting event ...Awaiting time and date for rescheduled appt [appointment]." A telephone interview was conducted on 12/16/24 at 3:42 PM with the facility's former Director of Nursing (DON), who was currently working as the facility's Assistant Director of Nursing (ADON). During the interview, the ADON was asked about her 10/28/24 notation which indicated she was informed Resident #6's family wished to reschedule the Vascular consultation. When asked if she realized Resident #6 would no longer be receiving Eliquis after 10/28/24, the ADON responded by saying, "No ...not at that moment." The ADON added if she had realized at the time that the resident would be without an anticoagulant until her next Vascular consult	F 580	timely notification to physician and responsible party for any item identified to meet notification requirements. Any issues identified during this monitoring process will be addressed promptly. This monitoring process will be conducted daily Monday to Friday for two weeks, weekly for two more weeks, then monthly for three months or until a pattern of compliance is maintained. Effective 01/13/2025, Director of Nursing will report findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance. Compliance date: 01/17/2025.	

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appointment, she would have called the MD to clarify the order for the Eliquis. Upon further inquiry, the ADON was asked what the nursing staff should do if there was a question on an order for a medication such as Eliquis. The ADON responded by saying she would have wanted the nursing staff to notify Resident #6's physician that the resident would be without this pertinent drug (Eliquis) and to see what he wanted to do.

A review of Resident #6's October 2024 and November 2024 MARs revealed the resident received her last dose of Eliquis on the morning of 10/28/24. No other doses of Eliquis were documented as administered on the resident's MARs from 10/28/24 to 11/8/24. This represented an 11-day lapse in the administration of Eliquis to Resident #6.

On 11/8/24 at 2:00 PM, Resident #6 was seen for her outside Vascular consultation and follow-up due to her bilateral DVTs. The Doctor's Order Consult Request form provided to the facility upon conclusion of this follow-up reported the resident's thrombi were unchanged. The Consultation Findings for her "Diagnosis" indicated the resident had chronic bilateral lower extremity DVTs. The "Recommendations" on the consult form read in part: " ...Eliquis 5 mg BID [twice daily] po [by mouth] x 90 days #2 refills. Referral for hematology due to history of multiple DVTs and PE."

A review of Resident #6's physician's orders and her November / December 2024 MARs revealed no orders were transcribed into the resident's EMR for Eliquis. No doses of Eliquis were documented as administered to the resident from

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11/8/24 up to the date of her discharge to the hospital on 12/3/24.

Resident #6's EMR included a Skilled Nursing Facility (SNF) to Hospital Transfer form dated 12/3/24 at 6:50 PM. The transfer form reported Resident #6 was sent out to the hospital for evaluation and treatment due to a change in mental status and possible stroke.

A review of the resident's hospital Admission Note's History and Physical dated 12/3/24 at 11:36 PM was conducted. The note indicated Resident #6 was transported to the hospital via Emergency Medical Services (EMS) and presented with altered mental status, garbled speech, and confusion. The notes reported the resident had a history of stroke with left sided deficits. Resident #6's History of Present Illness also included, in part, atrial fibrillation not on anticoagulation and DVT with IVC filter (a small device that prevents blood clots from traveling from the legs to the lungs). The Emergency Room notes reported a computerized tomography (CT) scan of the head showed an acute to subacute ischemic event (a situation where a stroke was caused by blocked blood flow to the brain) involving the left posterior temporal lobe (a part of the brain for understanding language, learning, and remembering verbal information) and temporal parietal junction (a region of the human brain that is involved in many higher-order cognitive and motor functions). The resident was reported to have atrial fibrillation and noted she was not currently on anticoagulation. The hospital record also indicated Resident #6 was previously on Eliquis, but it been discontinued without her family being aware of the reason for the discontinuation of it. Resident #6 remained

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hospitalized as of the date of the review (12/17/24).

A telephone interview was conducted on 12/13/24 at 12:12 PM with the Vascular MD from the outside consulting clinic. He reported the NP who saw Resident #6 on 9/27/24 was no longer employed by the Vascular clinic. When asked, the MD stated he would have wanted the facility to call his office if there was any question as to whether the Eliquis should have been continued until her follow-up appointment on 11/8/24. During the interview, the MD reported the lapse in Eliquis administration (from 10/28/24 to 11/8/24) was "definitely not an intentional lapse."

A telephone interview was conducted on 12/13/24 at 10:13 AM with Resident #6's Medical Doctor (MD) at the facility. During the interview, the MD stated he felt the "crux of the problem" was that the 9/27/24 order was written for a 30-day period. He reported that ideally, he would have thought the Eliquis should have been continued until her scheduled follow-up appointment. The MD reported if he had been called about the Eliquis being discontinued on 10/28/24, he would have asked the facility to call the Vascular consultant to see what he/she recommended. The MD added, "I commonly do that kind of thing."

The Administrator was notified of immediate jeopardy at F580 on 12/13/24 at 2:30 PM.

The facility provided the following credible allegation of immediate jeopardy removal.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

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Review of Resident #6's clinical documentation indicates; on 9/27/24 Resident #6 had a vascular appointment. The consultation resulted in recommendation to resume Apixaban (Eliquis) 5mg twice daily for 30 days. The order was transcribed onto the facility Electronic Health records and implemented as ordered. Medication was ordered to start on 9/28/2024 with the stop date of 10/28/24. Resident #6 was ordered to have a follow up appointment in 30 days. The consultation form indicated that residents' follow up appointments to be 11/4/2024 at 3pm. No indication that the attending physician was consulted regarding what to do about running out of Eliquis prior to the scheduled appointment.

Review of facility clinical documentation dated 10/8/24 indicate Resident #6's daughter requested for the Vascular appointment to be rescheduled due to conflict of interest. The appointment was rescheduled for 11/8/2024. No indication that the attending physician was consulted regarding what to do about running out of Eliquis prior to the scheduled appointment.

Resident #6 went to the follow up Vascular appointment on 11/8/2024. The Vascular physician ordered Eliquis 5mg to be restarted twice daily for 30 days.

Review of Resident #6 Electronic Health Records from 10/28/2024 to 11/08/2024 indicated that no orders for Eliquis were transcribed onto the facility's Electronic Health Records. No indication the attending physician was notified when Eliquis run out on 10/28/2024. Resident #6 was sent to the acute care hospital on 12/3/2024 due to altered mental status.

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Review of Resident #6 Documentation on Resident #6's Medication Administration Records (MARs) revealed she did not receive this oral anticoagulant from 10/28/24 to 11/08/2024 after the medication was stopped after 30 days' supply run out. No indication on Resident #6's clinical records that the Attending physician was consulted before medication ran out on 10/28/24.

Resident #6 is no longer in the facility.

The Governing body led by the Vice President of Operation, the facility Administrator, Regional Director of Clinical Services, and Director of Nursing conducted the root cause analysis on 12/13/2024, to identify the causative factor for this alleged noncompliance.

The Root Cause Analysis (RCA) identified the alleged noncompliance resulted from the failure of the facility employee to administer Eliquis and for DVT prevention per physician order. The RCA further identified that facility staff also failed to consult the physician when Resident #6 was running out of Eliquis before the scheduled appointment that took place on 11/8/24.

The governing body put forth the following plan for identification for those residents who are likely to suffer a serious adverse outcome as a result of the alleged noncompliance and implemented the measures below to alter the process to prevent a serious adverse outcome from occurring.

100% audit of all current residents discontinued/stopped medication in the last 30 days completed on 12/13/2024, by the Director of

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Nursing, Assistant Director of Nursing, and/or Unit Coordinator (1 or #2) to identify any other medication that was discontinued/stopped/ran-out without consultation with an attending physician. Any resident(s) identified with a discontinued order without attending physician consultation, the Director of nursing will inform the physician for appropriate measures and or interventions and implement the interventions as ordered.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

Effective 12/13/2024, facility employees will ensure any changes in medication or treatment, to include discontinuation of medication such as Eliquis, will be reported to the physician prior to the discontinuation to ensure appropriate medical intervention/assessment is implemented to prevent possible negative consequences that may result from abruptly discontinuing medication such as Eliquis. This systemic modification will be accomplished by implementing the following measures:

Effective 12/13/2024, licensed nurse on duty will inform the resident; consult with the resident's physician; and notify, the resident representative when there is; a significant change in the resident's physical, mental, or psychosocial status, a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment). This notification will be documented on each resident's electronic medical records by the licensed nurse on duty.

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Effective 12/13/2024, the facility's clinical team, which includes Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1 Unit coordinator #2, and/or Admission nurse initiated a process for reviewing clinical documentation for the last 24 hours and physician orders written in the last 24 hours (including orders to discontinue medication), or from the last clinical meeting to ensure any needed notification of changes to the physician, and/or responsible party was done in a timely manner. This systemic process will take place Monday through Friday. Any identified issues will be addressed promptly. This process will be incorporated into the daily clinical meeting. Any negative findings will be addressed promptly. The nursing administrative team will review the clinical documentation and physician orders written on Friday, Saturday, and/or Sunday at the next clinical meeting on the following Monday.

100% education of all licensed nurses to include full time, part time, and as needed licensed nurses will be completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and/or Unit Coordinators (1, #2). The emphasis of this education will be the importance of notifying an attending physician and the party responsible in a timely manner for any change in condition, change of treatment/intervention and discontinuation of medication. The education emphasized that an attending physician should be consulted before medication ran out/stopped for proper intervention. This education will be completed by 12/13/2024, any licensed nurses not educated by 12/13/2024 will not be allowed to work until educated. Director of Nursing,

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Assistant Director of Nursing, and/or Unit Coordinators (1, #2) will monitor and track the completion of this education and will complete this education for any newly hired licensed nurses during the new hire orientation effective 12/13/2024

100% education of all current clinical leadership team members to include Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1, Unit coordinator #2 and/or Admission nurse completed by the Regional Director of Clinical services. The emphasis of this education includes, but is not limited to, the importance of ensuring residents' discontinued medication and other changes of condition is reviewed in the daily clinical meeting to ensure the attending physician was consulted before the medication ran out/stopped or discontinued. This education will be completed by 12/13/2024, any clinical team member not educated by 12/13/24, will not be allowed to work until educated. This education is added to a new hire orientation for all clinical team members effective 12/13/2024.

Alleged immediate jeopardy removal date: 12/14/24

A validation of IJ removal plan was conducted on 12/17/24. A review of the audits conducted for current residents with discontinued/stopped medication within the last 30 days revealed they were completed as planned. All licensed nurses assigned to a hall within the facility were interviewed regarding the in-service education received. Additionally, sign-in sheets documented the education provided and the nursing staff who received it. When asked, the

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F 580	Continued From page 15 nursing staff was able to describe the education provided on the facility's procedures regarding the notification of the resident's provider and resident or Responsible Party (RP). The nurses consistently verbalized an understanding of the need to consult with the MD and notify the resident/RP when there was a significant change in the resident's medication (including medication discontinuation) and/or in the resident's condition. The IJ removal date of 12/14/24 was validated.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on facility staff interviews, physicians' interviews, and facility and hospital record reviews, the facility failed to initiate the use of compression stockings for 1 of 1 resident reviewed (Resident #6) with a history of deep vein thrombosis or DVTs (a condition where a blood clot forms in a deep vein such as the legs), pulmonary embolism or PE (a condition where a blood clot travels to the lungs) and atrial fibrillation (a type of irregular heartbeat). The findings included:	F 684	F684 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #6 is no longer in the facility. Identification of other residents having the potential to be affected by the same deficient practice: 100% audit of current residents who have had medical appointments in the last 30 days was completed by the Director of Nursing and/or Assistant Director of	1/16/25

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F 684	Continued From page 16 Resident #6 was admitted to the hospital on 2/13/24 after sustaining a left distal fibular fracture (a break in the small bone of the lower leg near the ankle) from a fall. She was discharged from the hospital and admitted to the facility on 2/20/24. Her diagnoses included a personal history of DVTs, PE and atrial fibrillation. On 9/17/24, a venous doppler ultrasound study was conducted of Resident #6's left lower extremity due to the resident's complaint of pain in her left lower extremity and history of frequent DVTs. The Radiology Results read in part, "Impression: Findings are consistent with deep venous thrombosis [DVT] ...Clinical Follow-up is recommended." A Health Status Note dated 9/17/24 at 2:54 PM reported Resident #6's Medical Doctor was informed of the radiology results. The physician ordered a Vascular consult for Resident #6 at that time. Resident #6 was seen for an outside Vascular consultation on 9/27/24. Upon her return to the facility, paperwork provided from the consultation included a Doctor's Order Consult Request. The "Consultation Findings" indicated a bilateral lower extremity (BLE) venous duplex (ultrasound) was conducted with a diagnosis of "Bilateral lower extremity non-occlusive DVTs [a condition where veins are partially blocked, allowing some blood to flow around the clots]." The "Recommendations" read in part: "Compression stockings ...daily (on in AM, off in PM)..." Upon Resident #6's return to the facility on 9/27/24, the recommendation to initiate compression stockings was not transcribed into	F 684	Nursing on 12/13/2024 to validate any orders/recommendation from the consulting physician were transcribed to the facility electronic health records and implemented as ordered. No other resident identified with any deficiency. Findings of this audit are documented on a appointment consultation audit tool located in the facility compliance binder. 100% audit of current residents orders completed by the Director of Nursing and/or Assistant Director of Nursing on 12/13/2024 to validate any resident with an order for compression stockings is implemented based on the physician orders. Findings of this audit are documented on a compression stocking audit tool located in the facility compliance binder. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur Effective 12/13/24, a licensed nurse on duty will review a consultation report for any resident who returned from medical appointment while on duty and transcribe any orders in facility electronic health records, to include orders for compression stockings, if any. Effective 12/13/24 nursing employees will apply compression stockings based on physician orders and document the application and removal in each resident s clinical record. Effective 12/13/2024, the facility s clinical team, which includes Director of Nursing, Assistant Director of Nursing, Medical	

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F 684	Continued From page 17 the resident's electronic medical record (EMR). A telephone interview was conducted on 12/16/24 at 7:56 PM with Nurse #1. Nurse #1 was identified as having worked on 9/27/24 at the time of Resident #6's return from the Vascular consultation. When asked, the nurse recalled Resident #6 but could not remember any specifics related to the orders transcribed into her EMR on 9/27/24. Nurse #1 stated she did recall the resident had a change in her medications after the Vascular consult, but did not recall seeing an order for compression stockings to be initiated for Resident #6. The resident's physician's orders, September 2024 Medication Administration Record (MAR), and September 2024 Treatment Administration Record (TAR) revealed there were no orders for compression stockings to be applied for Resident #6. The resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 10/18/24. The MDS indicated Resident #6 had severely impaired cognition. She was dependent on staff for all her Activities of Daily Living (ADL), except for requiring only set-up or clean up assistance with meals and partial to moderate assistance for personal hygiene. The diagnoses section of the MDS assessment included atrial fibrillation as an active diagnosis. The section of the MDS related to medications indicated Resident #6 received an anticoagulant medication. Resident #6's most recent care plan included the following area of focus, in part: -Anticoagulant: The resident is at risk for	F 684	records coordinator, Unit coordinator #1 Unit coordinator #2, and/or Admission nurse initiated a process for reviewing clinical documentation to include the review of medical appointments ordered and/or scheduled in the last 24 hours or from the last held clinical meeting to ensure the appointment is scheduled and take place as ordered. The review will also validate the consultation form from a completed medical appointment is reviewed for any orders/recommendation and ensure such orders are transcribed onto the facility□s electronic health records. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly, and appropriate actions will be implemented by the DON, ADON, and/or Unit coordinator #1/#2 Findings of this systemic change will be documented on the daily clinical report form and maintained in the daily clinical meeting binder. 100% education of all current clinical leadership team members to include Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1, Unit coordinator #2 and/or Admission nurse completed by the Regional Clinical Director. The emphasis of this education includes, but is not limited to, the importance of ensuring residents□ medical appointments is reviewed in the daily clinical meeting to ensure ordered appointments are scheduled, completed, and the consultation forms from the completed appointments are reviewed for any new	

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F 684	Continued From page 18 bleeding, hemorrhage, excessive bruising, and complications related to anticoagulant use secondary to atrial fibrillation, DVT (Date Initiated 9/6/24; Revision on 10/24/24). The interventions included the administration of medications as ordered (Date Initiated 9/5/24). The interventions did not include compression stockings. Resident #6's physician's orders and October / November 2024 MARs revealed there were no orders for compression stockings to be applied for this resident. On 11/8/24 at 2:00 PM, Resident #6 was seen for her outside Vascular consultation and follow-up for her bilateral DVTs. The Doctor's Order Consult Request form provided to the facility upon conclusion of this follow-up reported the resident's thrombi were unchanged. The resident's diagnosis indicated she had chronic bilateral lower extremity DVTs. The "Recommendations" on Resident #6's consult form included, in part: "Compression stockings ...daily (on in morning off in evening) ..." Resident #6's physician's orders and her November / December 2024 MARs revealed no orders were transcribed into the resident's EMR for the compression stockings. A review of the resident's most recent Kardex (not dated) revealed it did not include a note to indicate Resident #6 was supposed to use compression stockings. The Kardex is an electronic resource utilized by Nursing Assistants (NAs) to provide a summary of the resident's care needs. A telephone interview was conducted on 12/16/24 at 1:42 PM with Nurse #2. Nurse #2 was the nurse identified as having been assigned to care	F 684	orders and recommendations. The education also covered the importance of applying and removing compression stockings as ordered by the physician. This education will be completed by 12/13/2024, any clinical team member not educated by 12/13/24, will not be allowed to work until educated. This education is added to a new hire orientation for all clinical team members effective 12/13/2024. The Assistant Director of Nursing will provide 100% education of all licensed nurses and Medication aids, to include full time, part time, and as needed nursing employees. The emphasis of this education includes but is not limited to; the importance of ensuring the consultation forms for residents who returned from the medical appointment while on duty are reviewed for any new orders/recommendation and transcribe such orders/recommendation onto resident□s electronic medical records and implement such physician order, to include orders for compression stocking This education will be completed by 12/13/24. Any licensed nurses and/or medication aid not educated by 12/13/24 will not be allowed to work until educated. Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (1, 2) will monitor and track the completion of this education and will complete this education for any newly hired licensed nurses and/or medication aides during the new hire orientation effective 12/13/2024. Monitoring of corrective actions to ensure	

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F 684	Continued From page 19 for Resident #6 at the time she returned from her 11/8/24 Vascular consultation. Upon inquiry, the nurse stated paperwork from outside consultations was usually given to the hall nurse. However, Nurse #2 reiterated she was not given any papers from the Vascular consultation on this occasion. A telephone interview was conducted on 12/16/24 at 1:56 PM with the facility's former Unit Manager. During the interview, the Unit Manager was asked what the facility's process was for addressing any recommendations made by outside consultations. The Unit Manager reported that she herself would sometimes have to put the orders into the resident's EMR if the hall nurse did not. When asked if she was given the Doctor's Order Consult Request form upon Resident #6's return from her Vascular consult on 11/8/24, the Unit Manager stated she did not recall. A telephone interview was conducted on 12/16/24 at 10:49 AM with the facility's Administrator. During the interview, the Administrator was asked who would have been responsible to review and transcribe the Vascular consultation recommendations / MD orders into the Resident #6's EMR after her consultations. The Administrator reported the hall nurse would have had the initial responsibility for this task. However, he added the Unit Manager was responsible as a second check to ensure this task had been completed. An interview was conducted on 12/12/24 at 1:50 PM with Nursing Assistant (NA) #1. During the interview, the NA stated she has worked full time at the facility for several months and was typically assigned to care for Resident #6. When asked,	F 684	that the deficient practice is being corrected and will not recur: Effective 01/13/2025, DON and/or ADON will monitor compliance with order transcription to include compression stockings by reviewing the daily clinical meeting reports to ensure completion and validate that the clinical team cross referenced consultation forms from previous appointment with orders entered into the facility EHR for accuracy. This will be done daily Monday through Friday for two weeks, weekly for two weeks, then monthly for three months or until a pattern of compliance is maintained. Effective 01/13/2025, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (1, #2) will complete the compression sticking monitoring process. This monitoring process will be accomplished by completing observation for three randomly selected residents with orders for compression stockings to ensure they are applied and removed based on the physician orders. This monitoring process will be completed daily (Monday through Friday) for two weeks, weekly for two more weeks, then monthly for three months, or until the pattern of compliance is established. Any negative findings will be addressed by the Director of nursing promptly. This monitoring process will be documented on a compression stocking observation monitoring tool located in the facility compliance binder. Effective 01/13/2025, Director of Nursing will report findings of this monitoring	

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NA #1 reported Resident #6 did not wear compression stockings. Upon further inquiry, the NA stated a resident's Kardex would note if he/she was supposed to wear compression stockings.

An interview was conducted 12/12/24 at 1:30 PM with Nurse #3. Nurse #3 was identified as having frequently cared for Resident #6. When asked, Nurse #3 stated she did not recall compression stockings being used for Resident #6. Upon further inquiry, the nurse stated if a resident had an order to use compression stockings, she thought the order would typically be documented on the resident's MAR.

An interview was conducted on 12/13/24 at 8:45 AM with the facility's Assistant Director of Nursing (ADON). During the interview, the ADON was asked to describe what she would have expected to be done to implement the Vascular consult's recommendation for Resident #6 to use compression stockings. The ADON reported that once the resident came back from her outside Vascular consult, the nurse should have reviewed the new orders, called the provider for approval of the order, and then transcribed the order into Resident #6's EMR. She stated that once the order was put into the EMR, it would typically show up on the resident's Treatment Administration Record (TAR) for the nurse to document its completion. The order would also be put on the resident's Kardex so the NA caring for Resident #6 would know that he/she needed to assist the resident with the compression stockings.

A telephone interview was conducted on 12/13/24 at 12:12 PM with the Vascular MD. During the

process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan monthly for three months, or until a pattern of compliance is maintained. The QAPI committee can modify this plan to ensure the facility remains in substantial compliance.

Compliance date: 01/16/2025

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F 684	Continued From page 21 interview, the MD was asked about the recommendation made to utilize compression stockings for Resident #6. He stated that although compression stockings were primarily used to prevent chronic edema, they also served another purpose. The MD explained that compressing the veins in the leg would lower the risk of venous stasis (a condition where blood flow in the veins is slowed or stagnant) and DVT.	F 684		
F 756 SS=J	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to	F 756		1/16/25

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F 756	Continued From page 22 be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews, consultant pharmacist and physician interviews, and facility and hospital record reviews, the consultant pharmacist failed to urgently report an irregularity related to the omission of Eliquis (an oral anticoagulant medication) for 1 of 1 resident reviewed for a significant medication error (Resident #6) with a history of strokes, deep vein thrombosis (or DVTs, a condition where a blood clot forms in a deep vein, typically in the legs), pulmonary embolism (or PE, a condition where a blood clot travels to the lungs), and atrial fibrillation (a type of irregular heartbeat). Eliquis is a prescription medication used to reduce the risk of stroke and blood clots in people who have atrial fibrillation. Resident #6 was initially seen for a Vascular consultation on 9/27/24 with a follow-up consultation conducted on 11/8/24. Both consultations recommended the resident be treated with Eliquis. The consultant pharmacist completed a monthly Medication Regimen Review (MRR) on 11/13/24. While the pharmacist identified there was a lapse in Eliquis coverage for Resident #6, she failed to notify the facility of this lapse until 11/20/24. A Physician Recommendation was not completed related to	F 756	F756 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #6 is no longer in the facility. Identification of other residents having the potential to be affected by the same deficient practice: 100% audit of current residents who have had medical appointments in the last 30 days was completed by the Director of Nursing and/or Assistant Director of Nursing on 12/5/2024 to validate any orders/recommendation from the consulting physician were transcribed to the facility electronic health records and implemented as ordered. No other resident identified with any deficiency. Findings of this audit are documented on a appointment consultation audit tool located in the facility compliance binder. 100% of all consulting pharmacist nursing recommendations and MD recommendations for current residents given in the last 30 days were audited on	

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F 756	Continued From page 23 the omission of Eliquis for this resident. On 12/3/24, Resident #6 was admitted to the hospital due to a change in mental status with diagnoses which included an acute middle cerebral artery (MCA) stroke. An MCA stroke occurs when blood flow through the middle cerebral artery in the brain is interrupted. Resident #6 remained hospitalized as of the date of the review (12/17/24). Immediate jeopardy began on 11/13/24 when the facility's consultant pharmacist completed a monthly MRR, identified the omission of Eliquis from Resident #6's medication regimen, but failed to urgently address this issue with either the physician or the facility. Immediate jeopardy was removed on 12/14/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the completion of education and monitoring systems are in place. The findings included: On 9/17/24, a venous doppler ultrasound study was conducted of Resident #6's left lower extremity due to the resident's complaint of pain in her left lower extremity and history of frequent DVTs. The Radiology Results read in part, "Impression: Findings are consistent with deep venous thrombosis [DVT] of the left common femoral, deep femoral and proximal superficial femoral veins of indeterminate age. Clinical Follow-up is recommended." A Health Status Note dated 9/17/24 at 2:54 PM reported Resident #6's Medical Doctor (MD) was	F 756	12/13/2024 by the Director of Nursing, Assistant Director of Nursing, and/or Admission nurse to identify any other recommendations that were not transcribed/implemented/acted upon correctly in the facility. The audit also focusses on ensuring any medication irregularities were reported to the attending physician and acted upon timely. Findings of this audit are documented on the pharmacy recommendation tool order audit tool located in the facility compliance binder. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Effective 12/13/2024, the licensed pharmacist will review each resident drug regimen monthly and report any irregularities to the attending physician and the Director of Nursing to be acted upon in a timely manner. The consultant pharmacist will accomplish this systemic change by addressing any medication irregularities on a physician recommendation form that will be provided to the attending physician for review. Findings of this systemic change will be documented on the Monthly pharmacy consultation review form and maintained in the Pharmacy binder. Effective 12/13/2024, the facility□s clinical team, which includes Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1 Unit coordinator #2, and/or Admission nurse initiated a process for reviewing	

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F 756	Continued From page 24 informed of the radiology results. A new physician's order was received to discontinue the resident's Eliquis and initiate the administration of 40 mg enoxaparin (an injectable anticoagulant used for the treatment of DVTs) to be administered subcutaneously (under the skin) every 12 hours to prevent blood clotting. The physician also ordered a Vascular consult for Resident #6 at that time. Resident #6 was seen for an outside Vascular consultation on 9/27/24. Upon her return to the facility, paperwork provided from the consultation included a Doctor's Order Consult Request. A notation made on this form indicated the reason for the consultation was due to concerns for blood clots given the resident's positive history and bilateral leg pain. The "Consultation Findings" indicated a bilateral lower extremity (BLE) venous duplex (ultrasound) was conducted with a diagnosis of "Bilateral lower extremity non-occlusive DVTs [a condition where veins are partially blocked, allowing some blood to flow around the clots]." The "Recommendations" read in part, "...Eliquis 5 mg BID [twice daily] x 30 days and follow-up in 1 month with a repeat BLE venous duplex [ultrasound to be completed at the next visit] to check on the status of the thrombi [clots]. Patient may need to be on low anticoagulation indefinitely with her history of DVT/PE." The Doctor's Order Consult Request form also noted the resident's one-month follow-up appointment was scheduled for 11/4/24 at 3:00 PM. The form was signed by the Vascular clinic Nurse Practitioner #1 (NP #1). Upon Resident #6's return to the facility on 9/27/24, a physician's order was received and transcribed by Nurse #1 into the resident's	F 756	pharmacy recommendations completed by the licensed pharmacist to ensure the recommendations to include any irregularities on drug regimen are reported to the attending physician and acted upon in a timely manner. This systemic process will take place within three days or receipt of pharmacy consultation reports. Any identified issues will be addressed promptly, and appropriate actions will be implemented by the DON, ADON, and/or Unit coordinator #1/#2 Findings of this systemic change will be documented on the Monthly pharmacy consultation review form and maintained in the Pharmacy binder. 100% education of all current clinical leadership team members to include Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1, Unit coordinator #2 and/or Admission nurse completed by the facility administrator. The emphasis of this education includes, but is not limited to, the importance of reviewing all pharmacy recommendations and implementing the recommendation in a timely manner. This education will be completed by 12/13/2024, any clinical team member not educated by 12/13/24, will not be allowed to work until educated. This education is added to a new hire orientation for all clinical team members effective 12/13/2024. Facility Administrator will monitor and track the completion of this education and will complete this education for any newly hired Clinical leader during the new hire orientation effective 12/13/2024.	

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F 756	Continued From page 25 electronic medical record (EMR) to re-start her Eliquis as 5 mg administered as one tablet by mouth twice daily for 30 days. The order for Eliquis included a start date of 9/28/24 and an end date of 10/28/24. The resident's order for enoxaparin was discontinued as of 9/27/24. A physician's order was received and transcribed appropriately for Resident #6's enoxaparin to be discontinued as of 9/27/24. A review of the resident's September 2024 Medication Administration Record (MAR) revealed Resident #6 began to receive 5 mg Eliquis administered as one tablet by mouth twice daily on 9/28/24 in accordance with the physician's order. A review of the resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 10/18/24. The MDS indicated Resident #6 had severely impaired cognition. The diagnoses section of the MDS assessment included atrial fibrillation as an active diagnosis. The section of the MDS related to medications indicated Resident #6 received an anticoagulant medication. A review of Resident #6's October 2024 and November 2024 MARs revealed the resident received her last dose of Eliquis on the morning of 10/28/24. No other doses of Eliquis were documented as administered on the resident's MARs from 10/28/24 to 11/8/24. On 11/8/24 at 2:00 PM, Resident #6 was seen at her outside Vascular consultation and follow-up for her bilateral DVTs. The Doctor's Order Consult Request form provided to the facility upon conclusion of this follow-up reported the	F 756	The facility Administrator conducted a phone in-service education to the facility medical director, attending physician, and the licensed pharmacist who provide services to the facility on 12/13/2024. The emphasis of this education includes, but is not limited to, the importance of ensuring any medication irregularity is communicated to the attending physician timely for proper follow through. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Effective 01/13/2025, the facility Administrator completes the monitoring process for follow ups on pharmacy consultant reports. This monitoring process will be accomplished by reviewing the completion of follow ups for all pharmacy consultant reports to ensure follow ups were completed timely for all pharmacy consultants reported for the previous month. This monitoring process will be completed monthly for three months, then quarterly, or until the pattern of compliance is established. Any negative findings will be addressed by the Administrator and/or Director of nursing promptly. This monitoring process will be documented on a pharmacy consultant review monitoring tool located in the facility compliance binder. Effective 01/13/2025, the Director of Nursing and/or Assistant Director of Nursing will report the findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for	

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F 756	Continued From page 26 resident's thrombi were unchanged. The resident's diagnosis indicated she had chronic bilateral lower extremity DVTs and her medications/treatments were noted as 5 mg Eliquis to be administered by mouth twice a day for 90 days with 2 refills. The "Recommendations" on the consult form included, in part: "Eliquis 5 mg BID [twice daily] po [by mouth] x 90 days #2 refills. Referral for hematology due to history of multiple DVTs and PE." A follow-up Vascular appointment was recommended in 6 months. A review of Resident #6's physician's orders and her November 2024 MAR revealed the recommendations from the 11/8/24 Vascular consultation were not transcribed into the resident's EMR. No doses of Eliquis were documented as administered to the resident from 11/8/24 to 11/13/24. Resident #6's EMR included a monthly consultant pharmacist Medication Regimen Review (MRR) dated 11/13/24 at 1:27 PM. The MRR included the following, in part: " ...New Meds / Changes: reviewed ... Notes / Recommendations: DON [Director of Nursing] x 2." The MRR progress note did not address the omission of an anticoagulant for this resident. As of 11/13/24, Resident #6 had been without an anticoagulant medication (such as Eliquis) for 16 days. A telephone interview was conducted on 12/12/24 at 2:08 PM with the facility's consultant pharmacist. At the time of the interview, the pharmacist said she did have electronic access to the facility's EMRs so she was able to review Resident #6's November MRR. When asked if she had a concern about the discontinuation of	F 756	recommendations and/or modifications, monthly for three months, or until the pattern of compliance is archived. Compliance Date: 01/16/2025	

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the resident's Eliquis as of 10/28/24, the pharmacist stated she noticed the resident had a Vascular consultation on 11/8/24. She was also aware of the discontinuation of Resident #6's Eliquis. The pharmacist then reported she, "made a recommendation on 11/13 to the DON" inquiring if the Eliquis should be re-started. Upon further inquiry, the pharmacist stated the recommendation she made would have been sent to the facility's DON and Administrator in an email dated 11/20/24, along with her consultation report and all the physician and nursing recommendations for the month of November. When asked about the delay in sending this recommendation to the facility, the pharmacist acknowledged that she could have sent an "urgent request" to the DON or physician to alert them of the Eliquis discontinuation.

Upon request, the Assistant Director of Nursing (ADON) provided a copy of the consultant pharmacist's "Nursing Summary Report" dated 11/19/24 and received via email on 11/20/24. The heading of the Nursing Summary Report read, in part: "Please review this report for possible updates for your Nursing system. These findings were noted by the consultant pharmacist on their most recent visit." There were 5 recommendations on page 3 (of 6) of the Nursing Summary Report. The second recommendation on this page was a notation (dated 11/13/24) that addressed the omission of Resident #6's Eliquis. The notation read, "Medium Priority. Resident had a consult with Vascular [Name of Clinic] on 11/8/24. They recommended starting Eliquis 5 mg BID x 9 months. Should Eliquis be restarted?"

A review of Resident #6's physician orders and

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her November/December 2024 MARs revealed the Eliquis was not re-initiated for this resident. No doses of Eliquis were administered to Resident #6 up to the date of the resident's discharge to the hospital on 12/3/24. A total of 36 days had elapsed from 10/28/24 to 12/3/24 without Resident #6 receiving an anticoagulant (such as Eliquis).

Resident #6's EMR included a Skilled Nursing Facility (SNF) to Hospital Transfer form dated 12/3/24 at 6:50 PM. The transfer form reported Resident #6 was sent out to the hospital for evaluation and treatment due to a change in mental status and possible stroke.

Resident #6's EMR included a Skilled Nursing Facility (SNF) to Hospital Transfer form dated 12/3/24 at 6:50 PM. The transfer form reported Resident #6 was sent out to the hospital for evaluation and treatment due to a change in mental status and possible stroke.

A review of the resident's hospital Admission Note's History and Physical dated 12/3/24 at 11:36 PM was conducted. The note indicated Resident #6 was transported to the hospital via Emergency Medical Services (EMS) and presented with altered mental status, garbled speech, and confusion. The notes reported the resident had a history of stroke with left sided deficits. Resident #6's History of Present Illness also included, in part, atrial fibrillation not on anticoagulation and DVT with IVC filter (a small device that prevents blood clots from traveling from the legs to the lungs). The Emergency Room notes reported a computerized tomography (CT) scan of the head showed an acute to subacute ischemic event (a situation where a

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stroke was caused by blocked blood flow to the brain) involving the left posterior temporal lobe (a part of the brain for understanding language, learning, and remembering verbal information) and temporal parietal junction (a region of the human brain that is involved in many higher-order cognitive and motor functions). The resident was reported to have atrial fibrillation and noted she was not currently on anticoagulation. The hospital record also indicated Resident #6 was previously on Eliquis, but it been discontinued without her family being aware of the reason for the discontinuation of it. Resident #6 remained hospitalized as of the date of the review (12/17/24).

An interview was conducted on 12/13/24 at 8:19 AM with the facility's Administrator, DON (who started her position on 11/20/24), and the facility's former DON (who was currently working as the facility's ADON). The Regional Director of Clinical Operations joined the interview shortly after it began. During the interview, the ADON and Administrator confirmed they both received the consultant pharmacist's report sent via email on 11/20/24. However, they both agreed the report wasn't as timely as they would have expected and in the "snapshot," there were no urgent needs mentioned. The ADON stated she would always look at the snapshot first so these issues would be addressed first. She reported the Physician Recommendations and Nursing Recommendations were typically separated and given to either the MD or the appropriate nursing staff to take care of. However, the ADON noted she did not see the pharmacist's recommendation for Resident #6's Eliquis in amongst the recommendations for other residents until she specifically looked back for it.

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When the Administrator, DON, and ADON were asked if the omission of Resident #6's Eliquis would have been considered an urgent issue that needed to be addressed, they each said, "Yes." The Administrator added, any urgent issue should have been addressed by any means. He further stated, "Urgent means right now."

A telephone interview was conducted on 12/13/24 at 12:12 PM with the Vascular MD who oversaw NP #1. He reported the NP who saw Resident #6 on 9/27/24 was no longer employed by the Vascular clinic. When asked, the MD stated the lapse in Eliquis administration was "definitely not an intentional lapse." Upon review of the 11/8/24 consultation notes, the MD reported it appeared the provider wanted to write a prescription with a longer duration on 11/8/24 so Resident #6 had coverage for 6 more months. Upon further review of the consultation notes, the MD also reported a referral to hematology was made for this resident. Overall, the MD stated the 11/8/24 Vascular consult recommendations were what he would have reasonably expected.

A telephone interview was conducted on 12/13/24 at 10:13 AM with Resident #6's MD at the facility. During the interview, the MD stated he felt the "crux of the problem" was that the 9/27/24 order was written for a 30-day period. He reported that ideally, he would have thought the Eliquis should have been continued until her scheduled follow-up appointment. When asked, the MD added that he didn't know why the 11/8/24 order for Eliquis was missed. He stated that there are a few medications which are particularly important to continue, and these would include antiseizure medications and blood thinners (anticoagulants). The MD was also asked what he would have

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wanted the consultant pharmacist to do when she identified that Resident #6's Eliquis had been discontinued. He reported the pharmacist should have called someone at the facility and alerted them to the discontinuation of Eliquis when she noticed it.

The Administrator was notified of immediate jeopardy on 12/12/24 at 5:30 PM.

The facility provided the following credible allegation of Immediate Jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

Review of Resident #6's clinical documentation indicates; on 9/27/24 Resident #6 had a vascular appointment. The consultation resulted in recommendation to resume Apixaban (Eliquis) 5mg twice daily for 30 days. The order was transcribed onto the facility Electronic Health records and implemented as ordered. Medication was ordered to start on 9/28/2024 with the stop date of 10/28/24. Resident #6 was ordered to have a follow up appointment in 30 days. The consultation form indicated that resident's follow up appointments to be 11/4/2024 at 3pm.

Review of facility clinical documentation dated 10/8/24 indicate Resident #6's daughter requested for the Vascular appointment to be rescheduled due to conflict of interest. The appointment was rescheduled for 11/8/2024.

Resident #6 went to the follow up Vascular appointment on 11/8/2024. The Vascular physician ordered Eliquis 5mg to be restarted

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twice daily for 30 days.
Review of Resident #6 Electronic Health Records from 11/8/2024 to 12/3/2024 indicated that no orders for Eliquis were transcribed onto the facility's Electronic Health Records. Resident #6 was sent to the acute care hospital on 12/3/2024 due to altered mental status.

Review of Resident #6 Documentation on Resident #6's Medication Administration Records (MARs) revealed she did not receive this oral anticoagulant from 10/28/24 up to the date of her discharge to the hospital on 12/3/24.

Review of the licensed pharmacist-nursing summary report dated 11/13/2024, completed during monthly resident's drug regimen reviews indicated a notation that Resident #6 had a consultation with Vascular solutions on 11/8/24, the recommendation questioned whether the Eliquis should be restarted per recommendation. The facility received the pharmacy recommendation on 11/20/2024. No indication that the pharmacy recommendation was sent to the physician for review and/or followed up by the facility.

Resident #6 is no longer in the facility.

The Governing body led by the Vice President of Operation, the facility Administrator, Regional Director of Clinical Services, and Director of Nursing conducted the root cause analysis on 12/12/2024, to identify the causative factor for this alleged noncompliance, to include failure to report the medication irregularities to the attending physician and implement recommendation by the licensed pharmacist given on 11/13/24, and implemented appropriate measures to correct

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and prevent the reoccurrences.

The governing body put forth the following plan for identification for those residents who are likely to suffer a serious adverse outcome as a result of the alleged noncompliance and implemented the measures below to alter the process to prevent a serious adverse outcome from occurring.

100% audit of current residents who have had medical appointments in the last 30 days was completed by the Director of Nursing and/or Assistant Director of Nursing on 12/5/2024 to validate any orders/recommendation from the consulting physician were transcribed to the facility electronic health records and implemented as ordered. No other resident identified with any deficiency. Findings of this audit are documented on a "appointment consultation audit tool" located in the facility compliance binder.

100% of all consulting pharmacist nursing recommendations and MD recommendations for current residents given in the last 30 days were audited on 12/13/2024 by the Director of Nursing, Assistant Director of Nursing, and/or Admission nurse to identify any other recommendations that were not transcribed/implemented/acted upon correctly in the facility. The audit also focusses on ensuring any medication irregularities were reported to the attending physician and acted upon timely. Findings of this audit are documented on the pharmacy recommendation tool order audit tool located in the facility compliance binder.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and

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when the action will be complete:

Effective 12/13/2024, the licensed pharmacist will review each resident drug regimen monthly and report any irregularities to the attending physician and the Director of Nursing to be acted upon in a timely manner. The consultant pharmacist will accomplish this systemic change by addressing any medication irregularities on a physician recommendation form that will be provided to the attending physician for review. Findings of this systemic change will be documented on the Monthly pharmacy consultation review form and maintained in the Pharmacy binder.

Effective 12/13/2024, the facility's clinical team, which includes Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1 Unit coordinator #2, and/or Admission nurse initiated a process for reviewing pharmacy recommendations completed by the licensed pharmacist to ensure the recommendations to include any irregularities on drug regimen are reported to the attending physician and acted upon in a timely manner. This systemic process will take place within three days or receipt of pharmacy consultation reports. Any identified issues will be addressed promptly, and appropriate actions will be implemented by the DON, ADON, and/or Unit coordinator #1/#2 Findings of this systemic change will be documented on the Monthly pharmacy consultation review form and maintained in the Pharmacy binder.

100% education of all current clinical leadership team members to include Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1, Unit coordinator

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#2 and/or Admission nurse completed by the facility administrator. The emphasis of this education includes, but is not limited to, the importance of reviewing all pharmacy recommendations and implementing the recommendation in a timely manner. This education will be completed by 12/13/2024, any clinical team member not educated by 12/13/24, will not be allowed to work until educated. This education is added to a new hire orientation for all clinical team members effective 12/13/2024. Facility Administrator will monitor and track the completion of this education and will complete this education for any newly hired Clinical leader during the new hire orientation effective 12/13/2024.

The facility Administrator conducted a phone Inservice education to the facility medical director, attending physician, and the licensed pharmacist who provide services to the facility on 12/13/2024. The emphasis of this education includes, but is not limited to, the importance of ensuring any medication irregularity is communicated to the attending physician timely for proper follow through.

Alleged immediate jeopardy removal date: 12/14/24

A validation of the IJ removal plan was conducted on 12/17/24. The facility provided documentation of the audits conducted for current residents who had medical appointments in the last 30 days and the validation check of any new orders prompted by the recommendations. These audits were completed as planned. Documentation was also reviewed of the education provided to the clinical leadership team members related to the

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F 756	Continued From page 36 importance of a timely review to ensure the pharmacy recommendations made by the consultant pharmacist are promptly addressed. Also, the facility's Administrator held in-service (via telephone) with the facility's Medical Doctors and consulting pharmacist on 12/13/24 to encourage the coordination of reporting and addressing any medication irregularities identified by the pharmacist. The IJ removal date of 12/14/24 was validated.	F 756		
F 760 SS=J	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 facility staff interviews, physicians' interviews, and facility and hospital record reviews, the facility failed to provide an uninterrupted course of Eliquis (an oral anticoagulant or blood thinner used to reduce the risk of stroke and blood clots in people who have atrial fibrillation) when the medication was discontinued 11 days before Resident #6 returned for a one-month follow-up from an outside Vascular consultation. The resident was seen for the follow-up Vascular consultation on 11/8/24. At that time, the facility failed to transcribe an order for the Eliquis into her electronic medical record (EMR), which resulted in the resident missing this medication for a total of 36 days until she was discharged to the hospital on 12/3/24. This occurred for 1 of 1 resident reviewed (Resident #6) with a history of strokes, deep vein thrombosis (or DVTs, a condition where a blood	F 760	F760 Corrective actions accomplished for those residents found to be affected by the deficient practice: Resident #6 is no longer in the facility. Identification of other residents having the potential to be affected by the same deficient practice: 100% audit of current residents who have had medical appointments in the last 30 days was completed by the Director of Nursing and/or Assistant Director of Nursing on 12/13/2024 to validate any orders/recommendation from the consulting physician were transcribed to the facility electronic health records and implemented as ordered. No other resident identified with any deficiency.	1/16/25

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F 760	Continued From page 37 clot forms in a deep vein, typically in the legs), pulmonary embolism (or PE, a condition where a blood clot travels to the lungs), and atrial fibrillation (a type of irregular heartbeat). Resident #6 was admitted to the hospital on 12/3/24 due to a change in mental status with diagnoses which included an acute middle cerebral artery (MCA) stroke. An MCA stroke occurs when blood flow through the middle cerebral artery in the brain is interrupted. Resident #6 remained hospitalized as of the date of the review (12/17/24). Immediate jeopardy began on 10/28/24 when Resident #6's Eliquis was discontinued from Resident #6's medication orders. Immediate jeopardy was removed on 12/14/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the completion of education and monitoring systems are in place. The findings included: Resident #6 was admitted to the hospital on 2/13/24 after sustaining a left distal fibular fracture (a break in the small bone of the lower leg near the ankle) from a fall. The resident's discharge medical history noted she was on chronic anticoagulation due to atrial fibrillation and a history of DVT and PE. Resident #6's discharge medication list included 5 milligrams (mg) Eliquis to be administered as one tablet by mouth twice daily. She was discharged from the hospital and admitted to the facility on 2/20/24.	F 760	Findings of this audit are documented on a appointment consultation audit tool located in the facility compliance binder. 100% audit of current residents medication discontinues in the last 30 days was completed by the Director of Nursing and/or Assistant Director of Nursing on 12/13/2024 to validate any discontinued medication that was done based on the physician orders to ensure such actions are done based on the medical guidance to prevent significant medication error. Findings of this audit are documented on a discontinued medication audit tool located in the facility compliance binder. Measures/systemic changes will be put into place to ensure that the deficient practice does not recur Effective 12/13/24, a licensed nurse on duty will review a consultation report for any resident who returned from medical appointment while on duty and transcribe any orders in facility electronic health records. Effective 12/13/24 employees will administer medication based on physician orders, to include Eliquis, to treat a specific condition as diagnosed, and document the administration of such medication in each resident s clinical record. Effective 12/13/2024, the facility s clinical team, which includes Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1 Unit coordinator #2, and/or Admission	

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F 760	Continued From page 38 A review of Resident #6's February 2024 through August 2024 Physician Orders revealed the resident's medication regimen continued to include 5 mg Eliquis administered by mouth two times a day from 2/20/24 to 9/17/24 due to her diagnosis of atrial fibrillation. On 9/17/24, a venous doppler ultrasound study was conducted of Resident #6's left lower extremity due to the resident's complaint of pain in her left lower extremity and history of frequent DVTs. The Radiology Results read in part, "Impression: Findings are consistent with deep venous thrombosis [DVT] ...Clinical Follow-up is recommended." A Health Status Note dated 9/17/24 at 2:54 PM reported Resident #6's Medical Doctor (MD) was informed of the radiology results. A new physician's order was received to discontinue the resident's Eliquis and initiate the administration of 40 mg enoxaparin (an injectable anticoagulant used for the treatment of DVTs) to be administered subcutaneously (under the skin) every 12 hours to prevent blood clotting. The physician also ordered a Vascular consult for Resident #6 at that time. Resident #6 was seen for an outside Vascular consultation on 9/27/24. Upon her return to the facility, paperwork provided from the consultation included a Doctor's Order Consult Request. A notation made on this form indicated the reason for the consultation was due to concerns for blood clots given the resident's positive history and bilateral leg pain. The "Consultation Findings" indicated a bilateral lower extremity (BLE) venous duplex (ultrasound) was conducted with a diagnosis of "Bilateral lower extremity	F 760	nurse initiated a process for reviewing clinical documentation to include the review of medical appointments ordered and/or scheduled in the last 24 hours or from the last held clinical meeting to ensure the appointment is scheduled and take place as ordered. The review will also validate the consultation form from a completed medical appointment is reviewed for any orders/recommendation and ensure such orders are transcribed onto the facility□s electronic health records. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly, and appropriate actions will be implemented by the DON, ADON, and/or Unit coordinator #1/#2 Findings of this systemic change will be documented on the daily clinical report form and maintained in the daily clinical meeting binder. 100% education of all current clinical leadership team members to include Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1, Unit coordinator #2 and/or Admission nurse completed by the Regional Clinical Director. The emphasis of this education includes, but is not limited to, the importance of ensuring residents□ medical appointments is reviewed in the daily clinical meeting to ensure ordered appointments are scheduled, completed, and the consultation forms from the completed appointments are reviewed for any new orders and recommendations. The education also covered the importance of	

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F 760	Continued From page 39 non-occlusive DVTs [a condition where veins are partially blocked, allowing some blood to flow around the clots]." The "Recommendations" read as follows: "Compression stockings ...daily (on in AM, off in PM) and Eliquis 5 mg BID [twice daily] x 30 days and follow-up in 1 month with a repeat BLE venous duplex [ultrasound to be completed at the next visit] to check on the status of the thrombi [clots]. Patient may need to be on low anticoagulation indefinitely with her history of DVT/PE." The Doctor's Order Consult Request form also noted the resident's 1 monthly follow-up appointment was scheduled for 11/4/24 at 3:00 PM. The form was signed by Nurse Practitioner #1 (NP #1) with an additional notation which read, "Reviewed by Attending Physician." Upon Resident #6's return to the facility on 9/27/24, a physician's order was received and transcribed by Nurse #1 into the resident's EMR to re-start her Eliquis as 5 mg administered as one tablet by mouth twice daily for 30 days. The order for Eliquis included a start date of 9/28/24 and an end date of 10/28/24. A physician's order was received and transcribed appropriately for Resident #6's enoxaparin to be discontinued as of 9/27/24. A telephone interview was conducted on 12/16/24 at 7:56 PM with Nurse #1. Nurse #1 was identified as having transcribed the order for Resident #6's Eliquis on 9/27/24 upon her return from the Vascular consultation. When asked, the nurse recalled Resident #6 but could not remember any specifics related to the orders transcribed into her EMR on 9/27/24. Nurse #1 stated she did recall the resident was put back on her usual dose of Eliquis after the injectable enoxaparin was discontinued. The nurse	F 760	reviewing all medication discontinues in the last 24 hours or from the last held clinical meeting to validate any discontinued medication was done based on the physician orders to prevent significant medication errors. This education will be completed by 12/13/2024, any clinical team member not educated by 12/13/24, will not be allowed to work until educated. This education is added to a new hire orientation for all clinical team members effective 12/13/2024. Assistant Director of Nursing provide will provide 100% education of all licensed nurses and Medication aides, to include full time, part time, and as needed nursing employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (1, #2). The emphasis of this education includes but is not limited to: 1. The importance of administering medication to include Eliquis, and other medications per physician order. 2. The importance of consulting the attending physician before medication stopped/discontinued, such as Eliquis, to avoid the possible serious consequences that can happen when abruptly stopping the medication. 3. The importance of ensuring each resident is assigned to a licensed nurse to oversee his/her care including provision for assessing, monitoring, and addressing a change in condition. 4. The importance of ensuring the consultation forms for residents who returned from the medical appointment	

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F 760	Continued From page 40 reported if she had any questions on the recommendations or orders put on the resident's paperwork from the consult, she would have told the Unit Manager. Nurse #1 reported the Unit Manager was responsible for any follow-up deemed necessary for the physician's orders. Upon inquiry, the nurse stated that usually when a resident returned from an outside appointment, the Unit Manager would review the consultation paperwork, and she would often be the staff member who put any new or changed physician's orders into the resident's EMR. A review of the resident's September 2024 Medication Administration Record (MAR) revealed Resident #6 began to receive 5 mg Eliquis administered as one tablet by mouth twice daily on 9/28/24 in accordance with the physician's order. A review of the resident's most recent Minimum Data Set (MDS) was a quarterly assessment dated 10/18/24. The MDS indicated Resident #6 had severely impaired cognition. The diagnoses section of the MDS assessment included atrial fibrillation as an active diagnosis. The section of the MDS related to medications indicated Resident #6 received an anticoagulant medication. Resident #6's most recent care plan included the following area of focus, in part: --Anticoagulant: The resident is at risk for bleeding, hemorrhage, excessive bruising, and complications related to anticoagulant use secondary to atrial fibrillation, DVT (Date Initiated 9/6/24; Revision on 10/24/24). The interventions included the administration of medications as ordered (Date Initiated 9/5/24).	F 760	while on duty are reviewed for any new orders/recommendation and transcribe such orders/recommendation onto resident□s electronic medical records and implement such per physician order. This education will be completed by 12/13/24. Any licensed nurses and/or medication aide not educated by 12/13/24 will not be allowed to work until educated. Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (1, 2) will monitor and track the completion of this education and will complete this education for any newly hired licensed nurses and/or medication aides during the new hire orientation effective 12/13/2024. Monitoring of corrective actions to ensure that the deficient practice is being corrected and will not recur: Effective 01/13/2025, DON and/or ADON will monitor compliance with order transcription to include Eliquis by reviewing the daily clinical meeting reports to ensure completion and validate that the clinical team cross referenced consultation forms from previous appointment with orders entered into the facility EHR for accuracy. This will be done daily Monday through Friday for two weeks, weekly for two weeks, then monthly for three months or until a pattern of compliance is maintained. Effective 01/13/2025, the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (1, #2) will complete discontinued medication monitoring process. This monitoring	

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F 760	Continued From page 41 A review of Resident #6's October 2024 and November 2024 MARs revealed the resident received her last dose of Eliquis on the morning of 10/28/24. No other doses of Eliquis were documented as administered on the resident's MARs from 10/28/24 to 11/8/24. A Health Status Note dated 10/28/24 at 3:25 PM and authored by the facility's Director of Nursing (DON) reported Resident #6's managed care program "notified facility about resident's upcoming Vascular appointment scheduled for 11/4/24, stating that the [family member] would like to reschedule due to a conflicting event ... Awaiting time and date for rescheduled appt [appointment]." A telephone interview was conducted on 12/16/24 at 3:42 PM with the facility's former Director of Nursing (DON), who was currently working as the facility's Assistant Director of Nursing (ADON). During the interview, the ADON was asked about her 10/28/24 notation which indicated she was informed that Resident #6's family wished to reschedule the Vascular consultation. When asked if she realized that Resident #6 would no longer be receiving Eliquis after 10/28/24, the ADON responded by saying, "No ...not at that moment." On 11/8/24 at 2:00 PM, Resident #6 was seen for her outside Vascular consultation and follow-up for her bilateral DVTs. The Doctor's Order Consult Request form provided to the facility upon conclusion of this follow-up reported the resident's thrombi were unchanged. The resident's diagnosis indicated she had chronic bilateral lower extremity DVTs. Resident #6's	F 760	process will be accomplished by reviewing three randomly selected residents medication orders to validate any discontinued medication that was done based on the physician orders and based on the medical guidance to prevent significant medication errors. This will be done daily Monday through Friday for two weeks, weekly for two weeks, then monthly for three months or until a pattern of compliance is maintained. Effective 01/13/2025, the Director of Nursing and/or Assistant Director of Nursing will report the findings of this monitoring process to the facility Quality Assurance and Performance Improvement Committee (QAPI), for recommendations and/or modifications, monthly for three months, or until the pattern of compliance is archived. Compliance Date: 01/16/2025	

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medications/treatments were noted as 5 mg Eliquis to be administered by mouth twice a day for 90 days with 2 refills. The "Recommendations" on the consult form read as follows: "Compression stockings ...daily (on in morning off in evening), Eliquis 5 mg BID [twice daily] po [by mouth] x 90 days #2 refills. Referral for hematology due to history of multiple DVTs and PE." A follow-up Vascular appointment was recommended in 6 months.

A review of Resident #6's physician's orders and her November / December 2024 MARs revealed no orders were transcribed into the resident's EMR for Eliquis. No doses of Eliquis were documented as administered to the resident from 11/8/24 up to the date of her discharge to the hospital on 12/3/24.

A telephone interview was conducted on 12/16/24 at 1:42 PM with Nurse #2. Nurse #2 was the nurse identified to have been assigned to care for Resident #6 at the time she returned from her 11/8/24 Vascular consultation. During the telephone interview, Nurse #2 reported she recalled Resident #6 having an appointment on 11/8/24 but she didn't remember seeing the resident until she went to the resident's room to pass medications around 9:30 PM. Nurse #2 stated, "Nobody gave me any reports." Upon further inquiry, the nurse stated paperwork from outside consultations was usually given to the hall nurse. However, Nurse #2 reiterated she was not given any papers from the Vascular consultation on this occasion.

A telephone interview was conducted on 12/16/24 at 1:56 PM with the facility's former Unit Manager. During the interview, the Unit Manager was asked

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what the facility's process was for addressing any recommendations made by outside consultations. The Unit Manager reported that she herself would sometimes have to put the orders into the resident's EMR if the hall nurse did not. Upon further inquiry, the Unit Manager stated that sometimes a resident would not come back with the Doctor's Order Consult Request form sent with them to the consultation. If that was the case, the facility would then have to call the consulting provider to try to obtain the form and the information shared on it. When asked if she was given the Doctor's Order Consult Request form upon Resident #6's return from her Vascular consult on 11/8/24, the Unit Manager stated she did not recall.

A telephone interview was conducted on 12/16/24 at 10:49 AM with the facility's Administrator. During the interview, the Administrator was asked who would have been responsible to review and transcribe the Vascular consultation recommendations / MD orders into the Resident #6's EMR after her Vascular consultation on 11/8/24. The Administrator reported the hall nurse would have had the initial responsibility for this task. However, he added the Unit Manager was responsible as a second check to ensure this task had been completed.

Resident #6's EMR included a Skilled Nursing Facility (SNF) to Hospital Transfer form dated 12/3/24 at 6:50 PM. The transfer form reported Resident #6 was sent out to the hospital for evaluation and treatment due to a change in mental status and possible stroke.

A review of the resident's hospital Admission Note's History and Physical dated 12/3/24 at

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11:36 PM was conducted. The note indicated Resident #6 was transported to the hospital via Emergency Medical Services (EMS) and presented with altered mental status, garbled speech, and confusion. The notes reported the resident had a history of stroke with left sided deficits. Resident #6's History of Present Illness also included, in part, atrial fibrillation not on anticoagulation and DVT with IVC filter (a small device that prevents blood clots from traveling from the legs to the lungs). The Emergency Room notes reported a computerized tomography (CT) scan of the head showed an acute to subacute ischemic event (a situation where a stroke was caused by blocked blood flow to the brain) involving the left posterior temporal lobe (a part of the brain for understanding language, learning, and remembering verbal information) and temporal parietal junction (a region of the human brain that is involved in many higher-order cognitive and motor functions). The resident was reported to have atrial fibrillation and noted she was not currently on anticoagulation. The hospital record also indicated Resident #6 was previously on Eliquis, but it been discontinued without her family being aware of the reason for the discontinuation of it. Resident #6 remained hospitalized as of the date of the review (12/17/24).

A telephone interview was conducted on 12/13/24 at 12:12 PM with the Vascular MD who oversaw NP #1. He reported the NP who saw Resident #6 on 9/27/24 was no longer employed by the Vascular clinic. When asked, the MD stated the lapse in Eliquis administration was "definitely not an intentional lapse." He reported it appeared to him to be a "logistical" issue having to do with the timing of the next month's appointment. Upon

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review of the 11/8/24 consultation notes, the MD reported it appeared the provider wanted to write a prescription with a longer duration on 11/8/24 so she had coverage for 6 more months. Upon review of the consultation notes, the MD also noted a referral to hematology was made for this resident. Overall, the MD stated the 11/8/24 Vascular consult recommendations were what he would reasonably expect.

A telephone interview was conducted on 12/13/24 at 10:13 AM with Resident #6's MD at the facility. During the interview, the MD stated he felt the "crux of the problem" was that the 9/27/24 order was written for a 30-day period. He reported that ideally, he would have thought the Eliquis should have been continued until her scheduled follow-up appointment. When asked, the MD added that he didn't know why the 11/8/24 order for Eliquis was missed. He stated that there are a few medications which are particularly important to continue, and these would include antiseizure medications and blood thinners (anticoagulants).

The Administrator was notified of immediate jeopardy on 12/12/24 at 5:30 PM.

The facility provided the following credible allegation of Immediate Jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

Review of Resident #6's clinical documentation indicates; on 9/27/24 Resident #6 had a vascular appointment. The consultation resulted in recommendation to resume Eliquis 5mg twice daily for 30 days. The order was transcribed onto

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the facility Electronic Health records and implemented as ordered. Medication was ordered to start on 9/28/2024 with the stop date of 10/28/24. Resident #6 was ordered to have a follow up appointment in 30 days. The consultation form indicated that residents' follow up appointments to be 11/4/2024 at 3pm. No indication that the attending physician was consulted regarding what to do about running out of Eliquis prior to the scheduled appointment.

Review of facility clinical documentation dated 10/8/24 indicate Resident #6's daughter requested for the Vascular appointment to be rescheduled due to conflict of interest. The appointment was rescheduled for 11/8/2024. No indication that the attending physician was consulted regarding what to do about running out of Eliquis prior to the scheduled appointment.

Resident #6 went to the follow up Vascular appointment on 11/8/2024. The Vascular physician ordered Eliquis 5mg to be restarted twice daily for 30 days.

Review of Resident #6 Electronic Health Records from 11/8/2024 to 12/3/2024 indicated that no orders for Eliquis was transcribed onto the facility's Electronic Health Records. Resident #6 was sent to the acute care hospital on 12/3/2024 due to altered mental status.

Review of Resident #6 Documentation on Resident #6's Medication Administration Records (MARs) revealed she did not receive this oral anticoagulant from 10/28/24 up to the date of her discharge to the hospital on 12/3/24.
Review of the licensed pharmacist-nursing summary report dated 11/13/2024, completed

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during monthly resident's drug regimen reviews indicated a notation that Resident #6 had a consultation with Vascular solutions on 11/8/24, the recommendation questioned whether the Eliquis should be restarted per recommendation. No indication that the pharmacy recommendation was followed up by the facility.

Resident #6 is no longer in the facility.

The Governing body led by the Vice President of Operation, the facility Administrator, Regional Director of Clinical Services, and Director of Nursing conducted the root cause analysis (RCA) on 12/13/2024, to identify the causative factor for this alleged noncompliance and implemented appropriate measures to correct and prevent the reoccurrences.

The Root Cause Analysis (RCA) identified the alleged noncompliance resulted from the failure of the facility employee to administer Eliquis and apply compression stockings for DVT prevention per physician order. The RCA further identified that facility staff also failed to consult the physician when Resident #6 was running out of Eliquis before the scheduled appointment that took place on 11/8/24.

The RCA further identified that the significant medication error resulted from the failure of the facility licensed nurses to follow the professional standard of practice on transcribing physician order for Resident #6 ordered by the outside Vascular consultant on 11/8/2024. The RCA further concluded that the failure to transcribe the ordered medication by the outside vascular consultant resulted from lack of systemic approach on reviewing outside appointments to

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F 760	Continued From page 48 validate all recommendations are carried out effectively and timely. The governing body put forth the following plan for identification for those residents who are likely to suffer a serious adverse outcome as a result of the alleged noncompliance and implemented the measures below to alter the process to prevent a serious adverse outcome from occurring. 100% audit of current residents who have had medical appointments in the last 30 days was completed by the Director of Nursing and/or Assistant Director of Nursing on 12/13/2024 to validate any orders/recommendation from the consulting physician were transcribed to the facility electronic health records and implemented as ordered. No other resident identified with any deficiency. Findings of this audit are documented on a "appointment consultation audit tool" located in the facility compliance binder. 100% audit of current residents' medication discontinues in the last 30 days was completed by the Director of Nursing and/or Assistant Director of Nursing on 12/13/2024 to validate any discontinued medication that was done based on the physician orders to ensure such actions are done based on the medical guidance to prevent significant medication error. Findings of this audit are documented on a "discontinued medication audit tool" located in the facility compliance binder. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:	F 760		

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Effective 12/13/24, a licensed nurse on duty will review a consultation report for any resident who returned from medical appointment while on duty and transcribe any orders in facility electronic health records.
Effective 12/13/24 employees will administer medication based on physician orders, to include Eliquis, to treat a specific condition as diagnosed, and document the administration of such medication in each resident's clinical record.

Effective 12/13/2024, the facility's clinical team, which includes Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1 Unit coordinator #2, and/or Admission nurse initiated a process for reviewing clinical documentation to include the review of medical appointments ordered and/or scheduled in the last 24 hours or from the last held clinical meeting to ensure the appointment is scheduled and take place as ordered. The review will also validate the consultation form from a completed medical appointment is reviewed for any orders/recommendation and ensure such orders are transcribed onto the facility's electronic health records. This systemic process will take place daily (Monday through Friday). Any identified issues will be addressed promptly, and appropriate actions will be implemented by the DON, ADON, and/or Unit coordinator #1/#2 Findings of this systemic change will be documented on the daily clinical report form and maintained in the daily clinical meeting binder.

100% education of all current clinical leadership team members to include Director of Nursing, Assistant Director of Nursing, Medical records coordinator, Unit coordinator #1, Unit coordinator #2 and/or Admission nurse completed by the

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Regional Clinical Director. The emphasis of this education includes, but is not limited to, the importance of ensuring residents' medical appointments is reviewed in the daily clinical meeting to ensure ordered appointments are scheduled, completed, and the consultation forms from the completed appointments are reviewed for any new orders and recommendations. The education also covered the importance of reviewing all medication discontinues in the last 24 hours or from the last held clinical meeting to validate any discontinued medication was done based on the physician orders to prevent significant medication errors. This education will be completed by 12/13/2024, any clinical team member not educated by 12/13/24, will not be allowed to work until educated. This education is added to a new hire orientation for all clinical team members effective 12/13/2024.

Assistant Director of Nursing provide will provide 100% education of all licensed nurses and Medication aides, to include full time, part time, and as needed nursing employees will be completed by the Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (1, #2). The emphasis of this education includes but is not limited to:
1. The importance of administering medication to include Eliquis, and other medications per physician order.
2. The importance of consulting the attending physician before medication stopped/discontinued, such as Eliquis, to avoid the possible serious consequences that can happen when abruptly stopping the medication.
3. The importance of ensuring each resident is assigned to a licensed nurse to oversee his/her care including provision for assessing,

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monitoring, and addressing a change in condition.
4. The importance of ensuring the consultation forms for residents who returned from the medical appointment while on duty are reviewed for any new orders/recommendation and transcribe such orders/recommendation onto resident's electronic medical records and implement such per physician order.

This education will be completed by 12/13/24. Any licensed nurses and/or medication aide not educated by 12/13/24 will not be allowed to work until educated. Director of Nursing, Assistant Director of Nursing, and/or Unit Coordinators (1, 2) will monitor and track the completion of this education and will complete this education for any newly hired licensed nurses and/or medication aides during the new hire orientation effective 12/13/2024.

Alleged immediate jeopardy removal date: 12/14/24

A validation of IJ removal plan was conducted on 12/17/24. A review of the audits conducted for current residents who had medical appointments in the last 30 days and for current residents' medication discontinuation in the last 30 days revealed they were completed as planned. All nurses and one Medication Aide (MA) assigned to a hall within the facility were interviewed in regard to the in-service education received. Additionally, sign-in sheets documented the education provided and the nursing staff who received it. When asked, the nursing staff was able to describe the education provided on the facility's procedures and the process employed to review a resident's paperwork upon his/her return from an outside consultation. The nurses verbalized

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F 760	Continued From page 52 an understanding of the need to notify the resident's physician and RP of any new recommendations made and to transcribe the new orders into the electronic medical record. They were also able to consistently describe the need for communication with several other departments, including the resident's physician, the transportation department (for follow-up appointments), and medical records. The IJ removal date of 12/14/24 was validated.	F 760		