

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335823	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Helen Hayes Hospital R H C F		STREET ADDRESS, CITY, STATE, ZIP CODE 51 N Rt 9w West Haverstraw, NY 10993	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>51902</p> <p>Based on observation, interview, and record review conducted during the Recertification Survey from 2/4/2025-2/7/2025, the facility did not ensure the development within 48 hours of baseline care plans for each resident that included the minimum healthcare information necessary to meet resident needs for and 1 of 1 resident (Resident #15) reviewed for hospitalization and 1 of 1 resident (Resident #169) reviewed for Anticoagulant Use. Specifically, for Resident #15 and Resident #169 the baseline care plan did not address the use of physician prescribed anticoagulants (medications to prevent or treat blood clots).</p> <p>The Findings are:</p> <p>The policy titled Anticoagulant Management dated 7/8/2020 documented the facility will ensure the safe use of anticoagulants in the entire hospital by monitoring for bleeding or hospital acquired thromboembolism and adjust or discontinue anticoagulant therapy following evidence-based guidelines.</p> <p>Resident #15 was admitted with diagnosis of Pneumonia, Atrial Fibrillation, and Chronic Obstructive Pulmonary Disease</p> <p>The 11/6/24 Physician Order documented Apixaban 2.5 mg (an anticoagulant) twice daily for Atrial Fibrillation.</p> <p>There was no documented evidence in the 11/6/24 Baseline Care Plan to address the use of anticoagulants or the instructions needed to provide effective care that included measurable goals and/or interventions related to risk for bleeding/bruising.</p> <p>51647</p> <p>Resident #169 was admitted with diagnoses including Congestive Heart Failure, Atrial Fibrillation (irregular heartbeat), and Pulmonary Embolism.</p> <p>The 2/3/25 Physician Order documented Apixaban 2.5 mg (an anticoagulant) twice daily for Deep Vein Thrombosis Prophylaxis.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There was no documented evidence in the 2/3/25 Baseline Care Plan to address the use of anticoagulants or the instructions needed to provide effective care that included measurable goals and/or interventions related to risk for bleeding/bruising.</p> <p>During an interview and observation on 2/5/25 at 4:16 PM the Administrator stated there were no anticoagulant baseline care plans in the computer system but they stated in the resident baseline care plan there was a section titled Knowledge-Based and in that section it stated to monitor for bleeding. When the administrator attempted to view the baseline care plan interventions in the regular viewable settings where all nurses and certified nursing aides could view the plan, it could not be seen outside of the administrator's computer view. The Administrator stated they were not sure why the interventions did not transfer over into the all-viewer system.</p> <p>During an interview on 2/05/25 at 4:21 PM the Assistant Director of Nursing stated the admission nurse was responsible for creating and/or putting baseline care plans in the system. The Assistant Director of Nursing, stated care plans were updated once a week and reviewed weekly and as needed. The Assistant Director of Nursing was asked how staff would have been able to know what interventions or monitoring was needed for anticoagulants and the Assistant Director of Nursing stated, staff would have known what interventions to put in place based on the medication's prescribed, registered nurse critical thinking, and the residents condition.</p> <p>10 NYCRR 415.11</p>		