STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495357	A. BUILDING _____ B. WING _____	C 08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 24016

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E 000	Initial Comments An unannounced Emergency Preparedness Survey was conducted 8/22/23 to 8/25/2023. The facility was in substatial compliance with 42 CFR Part 483.73, Requirement for Long Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 8/22/2023 through 8/25/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey: 1. VA00057514- Noncompliant with regulations with deficient practice cited. 2. VA00055064- Noncompliant with regulations with deficient practice cited. Life Safety Code Survey/Report will follow. The census is this 70 certified bed facility was 62 at the time of the survey. The survey sample consisted of 16 current resident reviews and 5 closed record reviews.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		

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

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F 657	Continued From page 1 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed to ensure care plan meetings were held in a timely manner for one of 21 residents, Resident #221. The findings included: For Resident #221 the facility staff failed to hold care plan meetings after each minimum data set (MDS) assessment. Resident #221's face sheet listed diagnoses which included but not limited to dementia, anxiety, depression, psychotic disturbance, hypertension, arteriosclerotic heart disease and	F 657	1. Resident was discharged from facility on 12/6/22. 2. An audit will be conducted on all residents to ensure care plan meetings have been held following the most recent MDS assessment schedule. Audit will be completed by 9/29/2023. 3. Education will be provided to the social worker that care plan meetings will be held for each resident based off their MDS assessment dates. Once a care plan meeting has been held, the social worker/Designee will enter a progress note into resident's electronic chart. Education will be completed by 10/02/2023. 4. The DON/Designee will ensure Care Plan meetings have been held based off MDS Assessment date and that a progress note has been entered. This process will be monitored weekly x4weeks. DON/Designee will review and discuss in quarterly QA meeting.	

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F 657	Continued From page 2	F 657		

hypothyroidism.

Resident #221's most recent MDS with an assessment reference date (ARD) of 09/26/22 assigned the resident a brief interview for mental status score of 8 out of 15 in section C, cognitive patterns. This indicates that the resident was moderately cognitively impaired.

Resident #221's clinical record was reviewed and contained "Care Plan Conference Summary" forms dated 11/03/21, 01/26/22, 04/20/22, 07/20/22, 10/12/22 and 11/09/22. Resident #221's clinical record contained care plan progress notes dated 01/20/21, 02/16/21, 06/09/21 and 11/03/21. There was no documentation for care plan meetings from 02/16/21 until 06/09/21 and from 06/09/21 until 11/30/21.

This surveyor spoke with the director of nursing (DON) on 08/24/23 at 11:30 am regarding Resident #221's care plan meetings. DON stated that MDS coordinator gives the social worker (SW) the ARD for each MDS, then SW schedules the care plan meetings. Surveyor asked the DON why there were no care plan meetings from 02/16/21 until 06/09/21 and from 06/09/21 until 11/30/21, and DON stated, "We were between social workers at that time."

This surveyor requested and was provided with a facility policy entitled "RI (resident assessment instrument) and Plan of Care" which read in part, "Procedure: 10. A plan of care for resident will be completed to meet the assessed needs of the resident within 7 days of completion of the RI-i.e., no later than 21 days of admission. A comprehensive care plan will be developed by the Interdisciplinary Team and include participation of

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F 657	Continued From page 3 a nurse aide with responsibility for the resident, a member of food and nutrition services staff, the resident and/or their representative. If participation of the resident and their representative is determined not to be practicable for the development of the care plan, written explanation will be provided in the resident's medical record. XI. The plan of care is reviewed and evaluated within time references, but no less than every 90 days." The concern of not having care plan meetings was discussed with the administrator and DON on 08/25/23 at 3:50 pm. No further information was provided prior to exit.	F 657		
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 staff interview and clinical record review the facility staff failed to follow physician's orders for one of 21 residents, Resident #221. The findings included: For Resident #221, the facility staff failed to change the administration times for the	F 684	1. Resident was discharged from facility on 12/6/22. 2. An audit will be conducted on residents to ensure there are no active orders to change administration times. Audit will be completed by 9/29/2023. 3. Education will be provided to the charge nurses to ensure all physician orders, requesting change in administration times are carried out as ordered. Education will be completed by 9/29/2023. 4. The DON/Designee will ensure that all physician orders requesting change in administration times are carried out as prescribed 5xweekly for 4weeks. DON/Designee will review and discuss in quarterly QA meeting.	

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F 684	Continued From page 4	F 684		

medication Voltaren gel per the physician's order.

Resident #221's face sheet listed diagnoses which included but not limited to dementia, anxiety, depression, psychotic disturbance, hypertension, arteriosclerotic heart disease and hypothyroidism.

Resident #221's most recent MDS with an assessment reference date (ARD) of 09/26/22 assigned the resident a brief interview for mental status score of 8 out of 15 in section C, cognitive patterns. This indicates that the resident was moderately cognitively impaired.

Resident #221's clinical record contained a physician's order summary for April 2022, which read in part "03/25/22 Change admin times on the Voltaren gel to 6 a, 12 noon, and 9 Per daughter request thank you."

Resident #221's "Treatment Administration History" for April 2022 contained an entry which read in part, "Order: Voltaren Arthritis Pain (diclofenac sodium) [OTC] gel 1 %; Amount to Administer: 1 Application; topical. Frequency: Three Times a Day. Start Date: 04/18/22." This entry contained administration times of 9:00 am, 1:00 pm, and 5:00 pm.

Surveyor spoke with the director of nursing (DON) on 08/24/23 regarding Resident #221's Voltaren gel administration times. DON stated the order was entered under "general" which is considered a "FYI (for your information)." Surveyor asked DON if the administration times should have been changed, and DON stated they should have.

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F 684	Continued From page 5 The concern of not changing the administration times per the physician's orders was discussed with the administrator and DON on 08/25/23 at 3:50 pm. No further information was provided prior to exit.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, facility staff failed to ensure the resident received adequate supervision and assistance devices to prevent accidents for one of 21 residents in the survey sample, Resident # 222. The findings: For Resident #222, one facility staff member transferred the resident from the bed to a chair instead of utilizing a mechanical lift with two+ staff members as required per the resident's care plan. During the transfer, the resident sat on her right lower leg which caused discomfort. An X-ray two days after the incident was negative for fracture. A subsequent X-ray three days after the incident indicated the resident had a tibial fracture.	F 689	1. Resident was discharged from facility on 06/06/2023 2. An audit will be conducted to review care plans for all residents and ensure the proper way to transfer is listed. Care plans will be updated as needed. An audit will be conducted to ensure CNAs are required to review all residents requiring mechanical lift transfers during their ADL documentation. Audit will be completed by 9/29/2023. 3. Education will be provided to nurses that care plans will reflect if a resident requires mechanical lift for transfers. Education will be provided to CNAs that they will be required to review and acknowledge during ADL Documentation if a resident requires a mechanical lift. Education will be completed by 10/02/2023. 4. The DON/Designee will monitor 4xweekly for 4 weeks, that Care plans are updated for any changes in transfer statues and that CNAs are acknowledging transfer requirements during their ADL documentation. DON/Designee will review and discuss in quarterly QA meeting.	

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Resident #222's diagnoses included but were not limited to multiple sclerosis, adult failure to thrive, anxiety disorder, narcolepsy (chronic sleep disorder), dysphagia and other speech disturbances, neuralgia and neuritis (inflammation and nerve pain), age-related osteoporosis, insomnia and unspecified voice and resonance disorder. The resident's care plan included but was not limited to a problem category of falls with a start date of 05/12/22 and an approach which read, "Hoyer lift for transfer w/ 2 person assist" with a start date of 05/12/22. Another problem category of toileting, with the same start date, read for the approach, "Provide assistance for toileting as needed, uses hoyer lift for transfer, assist her on/off bedpan as needed. Keep call light in reach and encourage use".

Resident #222's clinical record contained a licensed practical nurse (LPN #4) progress note that read on 12/24/22 at 9:33 p.m., "Resident LOA for night with family. Left facility at 2000 (8:00 p.m.) picked up by daughter. Resident transferred to mobile chair by CNA (certified nursing assistant). Right knee mis [sic] positioned on side while placing in chair. Leg was then straightened into chair properly. Resident C/O (complained of) pain to right knee. This nurse inspected knee and noted intact skin, no swelling or redness to affected area. ROM (range of motion) normal to BIL (bilateral) knees. PRN (as needed) Moprhine [sic] given at 1950 (7:50 p.m.) d/t (due to) pain. Family arrived to pick resident up and was notified. This nurse told RP (responsible party) that hospice will be notified when rsd (resident) returns 12/25/22 and further action taken by (name of hospice omitted) if necessary. Overnight medications for 12/25

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given to RP. Narcotics signed out by this nurse and RP." The next progress note by LPN #1 was dated 12/25/22 at 10:00 a.m. and read, "Resident's RP called and stated resident's right leg was swollen with blisters and painful. Daughter called hospice and made aware. Hospice went to RP's house and ordered prednisone and antibiotic and X-ray. Resident on her way back here. Order for X-ray transcribed." LPN #4 wrote on 12/25/22 at 10:16 p.m. that Resident #222's right leg was warm to touch, swollen, red with large, intact fluid filled blisters. The resident's vital signs were shared with the hospice nurse and were blood pressure = 170/86, pulse = 111, respirations = 18, temperature = 99.4, and 96% oxygen saturation on room air. Pedal pulses were present bilaterally. Vital signs were reassessed one hour later and were blood pressure = 145/82, pulse = 90, respirations = 18, temperature = 98.9, and oxygen saturation = 99% on room air. The second set of vital signs and the resident's increased pain were shared with the hospice nurse. New orders from the provider for increased pain medication both scheduled (every 4 hours) and as needed (every 2 hours), a steroid daily, an antibiotic twice a day for seven days. The LPN called hospice for clarification on antibiotic order due to resident's allergy. The resident's RP was made aware of the resident's condition and new medication orders.

On 12/26/22 at 11:26 a.m., LPN #1's progress note read the X-ray was done that morning with "results negative for injury." The facility's medical doctor assessed Resident #222 with medications, labs and Doppler studies of the right lower extremity ordered. A message was left for the resident's RP to call back.

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An imaging report dated 12/26/22 read a two view TIB/FIB X-ray was completed. The findings read that the two views "show no acute fracture or dislocation. There are degenerative changes of the knee as well as ankle joints. Postoperative changes are seen along the distal tibia and fibula. The alignment is anatomic and hardwares are intact. The soft tissues are normal." The impression read, "1. There is no acute fracture or dislocation. 2. There are degenerative changes and stable postoperative changes."

LPN #4 was interviewed in person and reported CNA #2 was familiar with Resident #222 and was getting the resident out of bed and into a chair in preparation for going home with family for the holiday on 12/24/22. LPN #4 reported that although the resident had difficulty verbalizing, the nurse heard and understood the resident tell CNA #2 she would rather be lifted manually, without the Hoyer lift. The CNA denied needing the nurse's help with the transfer. LPN #4 left the room and when she returned, she witnessed the resident's right leg below the knee was underneath her body weight in the chair for approximately 4 to 5 seconds at the most. LPN #4 assisted CNA #2, who was holding Resident #222, to straighten the resident's leg. Resident #222 made a "little grimace and sound" when she sat in the chair on her right lower leg. When LPN #4 assessed the resident's knee and leg there were no open wounds, no swelling or discoloration. The resident moaned and cried with range of motion and the nurse stated since crying was a frequent behavior for the resident, it was difficult to determine whether the crying was from pain or not. LPN #4 administered pain medication in case the resident was experiencing pain. The resident's family arrived to take her

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home and LPN #4 informed them of the incident with her right leg and showed the family her leg which did not look unusual at the time. The nurse told the family to "let us know' if they had any problems at home. The resident's family transferred Resident #222 from the chair at the facility and into the car prior to leaving for home. LPN #4 reported one of the family members was a registered nurse and facility staff would normally ask if they wanted help with the transfer into the car, but the nurse did not recall anyone at the facility assisted the family with transferring Resident #222 into the car. When LPN #4 returned on 12/25/22 at 3:00 p.m., Resident #222 had returned to the facility earlier than expected due to the resident's leg pain. LPN #4 (evening shift) and LPN #1 (day shift) observed the resident's right lower leg together, noting discoloration and blisters. LPN #1 reported to LPN #4 that when the family brought the resident back to the facility, the family denied anything happening while the resident was with them at home (i.e., denied applying creams, heating/cooling or applying anything at all).

CNA #2 was on leave and not available for interview.

LPN #1 was interviewed on 08/24/23 at 11:00 a.m. and stated that on day shift, they always used the Hoyer lift to transfer Resident #222 and even with lift, it could take three people to support her extremities because she was so flaccid. The resident did not like the lift and that was why she would stay in bed some days. LPN #1 stated she did not know how anyone could transfer her by themselves; she was dead weight. Resident #222's family transferred her by themselves all the time.

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F 689	Continued From page 10 The resident's medical doctor who provided care to Resident #222 was interviewed in person on 08/24/23 at 10:20 a.m. He reported assessing the resident on 12/26/22 and noted significant bruises localized to right lower leg with soft tissue swelling and blisters. The X-ray at the facility on 12/26/22 was negative. The resident's family took Resident #222 to the emergency room on 12/27/22 where a subsequent X-ray indicated a tibial fracture and possible nondisplaced fracture of the patella. The physician stated the hospital consulted orthopedics and dermatology who described the wound as "traumatic blisters from the fracture." Due to the resident being a hospice patient, the family decided not to treat the fracture; a brace was applied. During a summary meeting with the administrator and DON on 8/24/23 at approximately 3:30 p.m., the DON reported her expectation was that staff would document in the clinical record the resident's refusal to have a Hoyer Lift transfer prior to transferring her without the lift. The DON acknowledged there was no clinical record documentation of the resident refusing the Hoyer Lift on 12/24/22 and there was documentation the resident was transferred by one person. The DON acknowledged Resident #222's care plan noted the resident required two+ persons with Hoyer lift for transfers. No further information was provided prior to the exit conference.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 692		

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F 692	Continued From page 11 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, resident observation and clinical record review, the facility staff failed to ensure that residents maintain acceptable parameters of nutrition for one of 23 residents in the survey sample, resident # 46. For resident # 46, the facility staff failed to follow the recommendations of the Registered Dietician (RD) to obtain another weight, and then do weekly weights if an actual weight loss is confirmed.. Additionally, the facility staff failed to ensure that resident # 46's weight loss was addressed by the physician. Resident # 46's diagnoses list included but was not limited to, Type II diabetes mellitus, gastro esophageal reflux disease, vitamin deficiency unspecified, mild protein calorie malnutrition, and chronic kidney disease.	F 692	1. Resident was discharged from facility on 8/27/2023 2. An audit will be conducted by DON/designee to review weights of current residents. The audit will be reviewed by the Registered dietitian and Physician. The Registered dietitian will make recommendations and the Physician will address any concerns at that time. DON/Designee will ensure all recommendations and orders are completed. Audit will be completed by 9/29/2023. 3. Education will be provided to nursing staff that weights will be monitored by DON/Designee and Registered Dietitian. The Physician will review the recommendations by the Registered Dietitian and address any concerns. The nurses will be responsible for ensuring that orders are completed. Education will be completed by 10/02/2023. 4. The DON/Designee will monitor the recommendations made by the Registered Dietitian and ensure Physician has addressed. DON/Designee will monitor weekly x4weeks that Recommendations and orders have been carried out. DON/Designee will review and discuss in quarterly QA meeting.	

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	495357	A. BUILDING _____ B. WING _____	C 08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF THE VALLEY	650 NORTH JEFFERSON STREET ROANOKE, VA 24016

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The most recent annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/11/23 assigned resident # 46 a brief interview for mental status (BIMS) score of 14 indicating mild cognitive impairment. Under Section K, Swallowing and Nutritional Status, resident # 46 was coded as weighing 118 pounds with no significant weight loss over the last six months.

A review of resident # 46's clinical record revealed the following resident weights:
8/4/23 102.8 pounds
7/3/23 118 pounds
6/5/23 120.1 pounds

A progress note by the RD dated 8/4/23 read, "RD referral due to wt [weight] loss. Wt. noted to go from 118 (7/3) to 102.8 (8/4). Reweight is pending. Currently on diabetic diet, po [by mouth] intake (approximately) 75%, which is slightly decreased from last RD review (7/14), but not enough to cause wt loss of this magnitude. No changes recommended at this time until reweight obtained. If reweight confirms wt loss, recommend adding to weekly weights for 4 weeks for closer monitoring. There was no reweight documented in the clinical record.

The surveyor observed resident # 46 during the lunch meal on 8/23/23 at 1:48 PM. Lunch tray was at bedside and was untouched. Resident stated they didn't have much of an appetite and that the food provided, "ain' t much good." Surveyor asked resident if they would like something different and they declined. On 8/24/23 at 9:22 AM surveyor observed resident in their room. When asked if they ate breakfast,

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they stated they did not. Resident stated they "might" eat a grilled cheese sandwich if it was hot. Resident ate a few bites of the sandwich. At 12:36 surveyor visited the resident during the lunch meal again. Resident was lying in bed with the lunch tray at bedside untouched. Resident stated, "no" when asked if they were going to eat.

On 8/24/23 12:36 surveyor interviewed Licensed Practical Nurse (LPN) #2. When asked about resident # 46 not eating they stated, "(name omitted) usually goes to the dining room but (omitted) is just going downhill lately."

On 8/24/23 at 2:34 PM surveyor interview Certified Nursing Assistant #1. They stated that resident # 46 not eating is "not normal but (resident) hasn't been feeling well. (Resident) used to come to the dining room and eat good. I don't know what happened."

8/24/23 at 3:45 PM surveyor interviewed the Director of Nursing (DON). Surveyor asked where re-weights would be documented, and if they would expect the re-weight to have been done and documented by now. They stated they would see if it were on the nurse's flow sheet, and just not in the record yet. They stated they would expect the reweight to have been done by now. The DON returned at approximately 4:30 PM and stated resident # 46's re-weight was not done on 8/4/23. Resident was weighed at this time and the weight was 105 pounds. The DON states that the weekly weights should have been ordered based on the RD recommendations. The DON stated that they had made a progress note about the weight loss on 8/4/23 but did not follow up to make sure the reweight was done timely. They indicated that they had notified the physician and

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resident # 46's responsible party of the weight loss according to their note. Surveyor asked for a copy of resident #46's meal percentages and the facility policy for weight loss.

On 8/25/23 the surveyor interviewed the DON. They stated, "we don't have (omitted) meal percentages. It wasn't set up correctly in Matrix (electronic medical record). It was set up for them to just review and not enter the amount of what he actually ate. I spoke to (responsible party) this morning and (they) are coming today. (They) said (their) (parent) is tired and is just done. We have ordered Boost (nutritional supplement), labs and daily weights for five days."

Surveyor was unable to locate any evidence in the record to indicate the physician had addressed or acknowledged resident # 46's weight loss.

On 8/25/23 at 11:30 AM surveyor met with RD. Surveyor asked if they would have expected that the reweight, they asked for on 8/4/23 for resident #46 would have been done before 8/24/23 and they stated "yes, I would have." The DON was present and also acknowledged that the weight loss should have been addressed before 8/24/23. DON stated there is no facility policy for weight loss. Surveyor asked what the process was to follow up on weights and they stated, "The process is that weights are reviewed in a weekly high-risk meeting and this one fell through the cracks."

On 08/25/23 03:47 PM the survey team met with the Administrator and the DON, and this concern was discussed.

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F 692	Continued From page 15 No further information was provided to the survey team prior to the exit conference.	F 692		
F 756 SS=D	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 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	F 756	1. Pharmacy recommendation was reviewed and addressed by Medical Provider 8/27/23. 2. An audit will be completed on all residents to ensure all pharmacy recommendations x60days have been addressed by the physician. Audit will be completed by 9/29/2023. 3. Education will be provided to nursing staff that all pharmacy recommendations will be reviewed and addressed by physician. The physician will give pharmacy recommendations to DON/Designee and DON/Designee will review and address any new orders with nursing staff. Education will be completed by 10/02/2023. 4. The DON/Designee will monitor pharmacy recommendations weekly x4weeks to ensure that the Physician has addressed, and that the recommendation has been carried out by nursing staff. DON/Designee will review and discuss in quarterly QA meeting.	

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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 interview, facility document review and record review, the facility staff failed to ensure the physician reviewed the pharmacy recommendations for one of 21 residents in the survey sample, Resident #4.

The findings:

The facility staff failed to ensure Resident #4's Medication Regimen Reviews (MRRs) was addressed by a medical provider.

Resident #4's face sheet listed diagnoses included but were not limited to dementia, Alzheimer's disease with late onset, glaucoma, Bipolar II disorder, and traumatic subdural hemorrhage. The resident's minimum data set with an assessment reference date of 08/16/23 coded the resident a having a brief interview for mental status of 04 out of 15. Resident #4 was assessed as requiring assistance with bed mobility, transfers, dressing, toileting, and personal hygiene.

Resident #4's clinical documentation included a pharmacy review for 03/14/23. The document read to see the pharmacist's review however the review was not found in the clinical record. The director of nursing (DON) was asked about the pharmacy recommendation and on 08/25/23 provided a pharmacy consultation report dated 03/14/23 which read, "Please evaluate the continued use of prednisolone and taper to the

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lowest dose that reduces symptoms or discontinue." The document was signed by the pharmacist but had no signatures by the physician or the DON. The DON reported being unable to locate the document with physician signature/acknowledgment of pharmacist's recommendation and whether the physician agreed or declined the recommendation. The DON acknowledged Resident #4 remained on the same dose of prednisolone without tapering or discontinuation of the medication. The DON provided a referral form showing Resident #4 had an appointment on 04/16/23 which ordered a continuation of the prednisolone.

During a summary meeting with the administrator and DON on 08/25/23 at 3:47 p.m., the concern regarding there being no evidence a provider reviewed the pharmacist's identified irregularity was discussed. No further information was provider prior to the exit conference.