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	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of the Valley	650 North Jefferson Street Roanoke, VA 24016

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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 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 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 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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 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 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. 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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 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 [DATE] 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.