STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING _____ B. WING _____	04/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	300 MAIN ST S VELVA, ND 58790

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Standard Medicare/Medicaid recertification survey started on 04/07/19 and concluded 04/10/19.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		5/15/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/28/2019

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F 578	Continued From page 1 individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to ensure the resident's right to request, refuse, and/or discontinue treatment for 1 of 16 sampled residents (Resident #25) reviewed for advance directives. Failure to discuss the resident's advance care planning wishes, including resuscitation status, procure physician's orders reflective of the resident's wishes, and ensure the resident's medical record reflected his/her wishes regarding life-sustaining procedures limited the facility's ability to communicate to direct care staff and emergency personnel the residents' wishes in the event of a medical emergency. Findings include: Review of the facility policy titled "Advance Care Planning and Advance Directives" occurred on 04/10/19. This policy, dated April 2016, stated, ". . . Admission or Re-admission: . . . 3. Social services will inform resident/healthcare decision-maker that a meeting will be set up within the week to begin discussions about their wishes in regards to advance care planning. . . . 5. If an advance directive has been formulated, a copy will be scanned in [electronic health record]. 6. As necessary, physicians will be contacted for	F 578	Preparation and execution of this response and plan of correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purpose of any allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual. Tag 578 1. Resident # 1 Advance Directive has been reviewed and updated per Resident/Family wishes. 2. All residents have the potential of being affected. 3. All residents on admission date will meet with Social Services or designee to discuss advance directive with resident/family on admission to facility. HIM has an admission checklist that is completed with each new admission we	

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F 578	Continued From page 2 orders that reflect the resident's wishes. . . ." Review of Resident #1's medical record occurred on April 7-9, 2019. The facility admitted Resident #1 in July 2018 and diagnoses included stroke, chronic kidney disease, and dementia. The record contained an Advance Directive, signed by Resident #1 on 02/27/13. The directive included the name of Resident #1's medical Power of Attorney (POA) and stated, ". . . my life shall not be artificially prolonged under the circumstances set forth below, . . . If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, . . ." Resident #1's face sheet (pertinent resident information, including emergency contacts and POA) failed to note the resident had an advance directive. The record lacked evidence of a discussion with the resident and medical POA regarding what her current wishes entailed, including resuscitation. The record lacked a physician's order related to life-sustaining procedures. During an interview on 04/09/19 at 4:19 p.m., an administrative staff member (#3) agreed staff should note advance directive information on the resident's face sheet so they are aware of the resident's wishes.	F 578	have included Advance Directives to monitor compliance. 4. Social Service Director or designee will audit residents chart to ensure advance directives are properly addressed in each residents chart. Health Information Management Director or Designee will audit all new resident admissions paperwork to ensure Advance Directives are set up in the residents chart. Health Information Director or designee will audit daily Monday thought Friday resident charts to show Advance Directive are current for one month, weekly for one month, and monthly for four months. Quality Assurance committee will review and monitor admission audits during monthly quality meetings. Quality Assurance committee will ensure compliance. 5. Completion Date 5/15/19	
F 644	Coordination of PASARR and Assessments	F 644		5/15/19

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F 644 SS=D	Continued From page 3 CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures For Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 3 sampled residents (Resident #3) reviewed for PASARR with a newly added diagnosis of mental illness. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with resident's needs. Findings include:	F 644	Tag 644 1. Resident #3 status change for the Pasarr was completed. 2. All residents who have a newly diagnosis of mental illness can be affected. 3. Nursing Department will inform Social Services of an newly diagnosis of mental illness added to the residents chart. 4. Systemic Change: DNS or designee will audit and give Social Services a copy of all new psychotropic medication and/or a newly diagnosis of mental illness to ensure PASARR screenings are updated. DNS or designee will audit new orders of	

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F 644	Continued From page 4 The North Dakota PASARR Provider Manual page 13 states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend [contracted service provider for screening process] to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and the condition later emerged or was discovered . . . " Review of Resident #3's medical record occurred on all days of survey. The record showed the initial PASARR completed in 07/08/16 identified no diagnosis of a major mental illness (MMI) and no PASARR II needed. The facility added a diagnosis of unspecified psychosis not due to a substance or known physiological condition on 03/02/18. The record lacked evidence of an updated Level I screening/change in status assessment with the added diagnosis. During an interview on 04/04/19 at 2:48 p.m., an administrative staff member (#3) agreed the staff failed to complete the required Level I PASARR rescreening after the diagnosis of a MMI (unspecified psychosis).	F 644	psychotropic medication and newly diagnosis of mental illness weekly for four weeks, then bi-weekly for four weeks, and then monthly for four months to ensure quality. Quality Assurance committee will review and monitor Pasarr audits during monthly quality meetings. Quality Assurance committee will ensure compliance. 5. Completion Date 5/15/19	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		5/15/19

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F 656	Continued From page 5 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656		

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F 656	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.16), policy review, and staff interview, the facility failed to develop a comprehensive care plan for 1 of 3 residents (Resident #24) reviewed for unnecessary medications on an antidepressant. Failure to develop a care plan that includes care and services for residents with depression may negatively impact the resident's quality of life. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual, October 2018, page D-4 defined the 9-Item Patient Health Questionnaire (PHQ-9©) as "A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder." Page D-10, stated, ". . . In addition, PHQ-9© Total Severity Score can be used to track changes in severity over time. Total Severity Score can be interpreted as follows: 1-4: minimal depression 5-9: mild depression . . ." Review of the facility policy titled "Care Plan" occurred on 04/10/19. This policy, dated November 2016, stated, ". . . Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals . . . Through the use of departmental assessments, the Resident Assessment Instrument and review of the	F 656	Tag 656 1. Resident #24 care plan has been updated to include depression. 2. All residents have the potential of being affected. 3. All staff meeting will be on 4/30/19 to re-educate staff care plans and how we need to ensure they are person-centered for each resident. Care plans are being reviewed Monday through Friday to ensure accuracy. Nursing Department is responsible to update care plan at appropriate time to ensure problem/preferences are current. 4. Social Services Director or designee will audit/monitor one care plan a day Monday through Friday to ensure compliance. Care Plan audit will be completed daily for one month, bi-weekly for one month, and then monthly for four month. The Care Plan audit will include accuracy of diagnosis written within the care plan. Quality Assurance committee will review and monitor Care Plan audit during monthly quality meetings. Quality Assurance committee will ensure compliance. 5. Completion Date 5/15/19	

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F 656	Continued From page 7 physician's orders, any problems, needs and concerns identified will be addressed. . . ." Review of Resident #24's medical record occurred on 04/10/19. Diagnoses included major depressive disorder. Medications included Sertraline (antidepressant) 200 milligrams daily, started on 12/4/18. Resident #24's admission Minimum Data Set (MDS), dated 12/11/18, and quarterly MDS, dated 02/26/19, showed the PHQ-9© mood questionnaire identified a Total Severity Score for depression of 3 and 8 respectively. The admission Care Area Assessment (CAA) for psychotropic drug use, dated 12/14/18, stated, ". . . takes an antidepressant which was started after his CVA [stroke] about three years ago. . . ." The care plan failed to address the problem of depression. During an interview on 04/10/19 at 1:00 p.m., an administrative staff member (#3) stated she would include depression under "moods" on the care plan and agreed staff did not develop a care plan for Resident #24's depression. Failure to care plan depression as a problem and develop goals and interventions may have contributed to Resident #24's worsening symptoms of depression as reflected on the quarterly MDS.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 658		5/15/19

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F 658	Continued From page 8 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow professional standards of practice when priming insulin pens for 2 of 2 residents (Resident #34 and #36) observed during insulin administration. Failure to prime insulin pens prior to administration may result in the resident receiving an inaccurate amount of insulin. Finding include: Review of the facility policy/procedure titled "Insulin Pens" occurred on 04/10/19. This policy, dated March 2018, stated, ". . . 10. Turn the dosage knob to '2' units to prime the pen. 11. Hold the pen with needle pointing upwards, press the button until at least a drop of insulin appears. 12. Dial in the ordered dose of units. . . ." - Review of Resident #34's medical record occurred on 04/09/19 and identified a physician's order for Novolog Flex Pen (a rapid-acting insulin) 27 units, prior to meals. Observation of medication pass occurred on 04/09/19 at 11:34 a.m. A nurse (#1) dialed Resident #34's Novolog Flex Pen to 27 units and administered the insulin to Resident #34. The nurse failed to prime the insulin pen prior to administration. - Review of Resident #36's medical record occurred on 04/09/19 and identified a physician's order for Novolog Flex Pen 10 units prior to	F 658	Tag 658 1. Licensed Nurses for resident #34 and #36 we re-educated to ensure understand/competency of priming the insulin pen prior to giving insulin. 2. All inulin depended residents have the potential of being affected. 3. All Licensed Nurses will be re-educated on proper procedure of how to prime and insulin pen prior to giving the insulin to the resident. Licensed Nurses will complete an insulin competency to show understanding. 4. DNS or designee will do an insulin administration audit three times a week for one month, weekly for one month, bi-monthly for four months. Quality Assurance committee will review and monitor insulin administration audit during monthly quality meetings. Quality Assurance committee will ensure compliance. 5. Completion Date 5/15/19	

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F 658	Continued From page 9 meals. Observation of medication pass occurred on 04/10/19 at 11:45 a.m. A nurse (#1) dialed Resident #36's Novolog Flex Pen to 10 units and administered the insulin to Resident #36. The nurse failed to prime the insulin pen prior to administration. During an interview on 04/10/19 at 11:36 a.m., an administrative nurse (#2) confirmed staff are to prime the insulin pen prior to administration.	F 658		
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 observation, record review, review of facility policy, and family and staff interview, the facility failed to provide care and services in a manner to maintain the highest practicable well-being for 2 of 5 sampled residents (Resident's #7 and #8) observed improperly positioned in a Rock 'N Go wheelchair. Failure to assess, monitor, and properly position residents in their wheelchair placed the residents at risk for increased fatigue, pain, discomfort, skin breakdown, aspiration, and falls.	F 684	Tag 684 1. 4-23-19 Physical Therapist and Occupational Therapist re-evaluated residents #7 and #8 for proper wheelchair positioning. 2. All residents in a wheelchair have the potential of being affected. 3. All Staff Meeting is being held on 4-30-19 staff will be re-educated by Physical Therapist and Occupational Therapist on proper positioning of resident while sitting in a wheelchair.	5/15/19

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F 684	Continued From page 10 Findings include: Review of the facility policy titled "MOBILITY SUPPORT AND POSITIONING: POSITIONING" occurred on 04/10/19. This policy, revised October 2017, stated, ". . . PURPOSE: To position those residents unable to position/reposition independently in a manner which prevents formation of contractures, provides comfort and maintains skin integrity. To provide proper body alignment for residents in wheelchairs . . . Wheelchair Position . . . Proper alignment starts with proper pelvic positioning. Keeps the pelvis symmetrical, equal weight bearing on both sides of the buttocks . . . Hips are centered between the armrests and buttocks against the back rest: you can place hand or two-finger widths between the residents hips and armrests . . . Resident is upright positioning and weight bearing equally at hips (does not lean to one side) . . . Adjust the footrests so that the resident's knees are parallel to the thigh and the thigh is parallel to the floor. If the knees are lower than the hips the resident will slide to the floor . . . feet are flat on the foot rests . . . contact your Occupational Therapist for wheelchair positioning assessment . . . without intervention, the resident is at risk for contractures and skin problems . . . Therapists can assist with adaptive equipment and wheelchair selection if there is difficulty correctly positioning the resident . . ." - Review of Resident #7's medical record occurred on all days of survey. The current care plan showed the resident required total assistance with all activities of daily living (ADLs), required a positioning wedge on right side, and leans when sitting.	F 684	Systemic Change: Nursing Department will receive orders for Physical Therapy or Occupational Therapy to evaluate resident on admission or change of condition/mobility for proper positioning in wheelchair. 4. DNS or designee will audit resident wheelchair positioning daily for one week, weekly for three weeks, bi-weekly for one month, and monthly for four months. Quality Assurance committee will review and monitor wheelchair placement audit during monthly quality meetings. Quality Assurance committee will ensure compliance. 5. Completion Date 5/15/19	

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F 684	Continued From page 11 Observations for Resident #7's positioning while in her Rock 'N Go wheelchair included the following: * 04/07/19 at 12:09 p.m. - The resident seated with hips to the left and head leaned firmly against the right shoulder panel with no supportive/adaptive device in place. Staff fed the resident dinner while seated in this position. * 04/07/19 at 4:47 p.m. - The resident seated with hips slid forward towards the front of the seat and head leaned firmly against the right shoulder panel with no supportive/adaptive device in place. The resident's spouse present during observation and stated, "they usually have a blue wedge on her right side but they don't have it in place now." * 04/08/19 at 8:39 a.m. - The resident seated with hips slid forward towards the front of the seat with a positioning wedge located on the right side and the resident's head tilted over the upper edge of the positioning wedge. Staff fed the resident breakfast in this position. * 04/09/19 at 9:07 a.m. - The resident seated with positioning wedge located on the right side and head tilted over the upper edge of the positioning wedge. Staff fed the resident breakfast in this position. - Review of Resident #8's medical record occurred on all days of survey. The current care plan showed the resident required total assistance with ADL's and required blue padding around leg pedals to help with positioning of feet in the wheelchair. Observations for Resident #8's positioning while in her Rock 'N Go wheelchair included the	F 684		

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	355109	A. BUILDING _____ B. WING _____	04/10/2019

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F 684	Continued From page 12 following: * 04/07/19 at 11:50 a.m. - The resident seated with hips slid forward towards the front of the seat and head leaned firmly against the right shoulder panel. One of the resident's feet rested on the floor in between the wheelchair pedals. The padding on the foot pedals lacked proper placement. * 04/07/19 at 12:41 p.m. - The resident seated with hips to the left and head leaned firmly against the right shoulder panel. Staff fed the resident dinner in this position. * 04/08/19 at 8:20 a.m. - The resident seated with hips to the left and head leaned firmly against the right shoulder panel. Staff fed the resident breakfast in this position. * 04/09/19 at 9:03 a.m. - The resident seated with hips slid forward towards the front of the seat and head leaned firmly against the right shoulder panel. Staff fed the resident breakfast in this position. The facility staff failed to assess and to provide proper body alignment and upright positioning for Resident's #7 and #8 while seated in their Rock 'N Go wheelchairs. During an interview on 04/09/19 at 11:25 a.m., a therapy staff member (#4) acknowledged formal assessments are not completed unless ordered and nursing staff make the determination on wheelchairs and adaptive devices.	F 684		
F 756 SS=E	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	F 756		5/15/19

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F 756	Continued From page 13 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 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 record review, policy review, and staff	F 756	Tag 756	

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F 756	Continued From page 14 interview, the facility failed to ensure the pharmacist conducting the monthly drug regimen reviews documented irregularities on a separate, written report and sent each report to the attending physician, the medical director, and the director of nursing for 5 of 5 residents (Resident #12, #23, #24, #30, and #33) reviewed for unnecessary medications. Failure to complete individual reports for each resident identified with an irregularity and distribute the drug regimen reviews (DRRs) in a timely manner does not ensure confidentiality of resident information and may delay action on recommendations from the pharmacist. Findings include: Review of the facility policy titled "Drug Regimen Review" occurred on 04/10/19. This policy, dated October 2018, stated, ". . . Definitions: Drug Regimen Review is a process that includes both medication reconciliation and a review of all medications (Rx [prescription], OTC [over-the-counter], vitamins, herbals, etc.) a resident is currently using to identify and prevent potentially clinically significant medication issues. . . . Monthly Drug Regimen Review: . . . 2. The DRR will identify the following: * Review of medications to assure that doses and duration are appropriate . . . ; * Monitoring of medications for efficacy and adverse consequences; * Potential medication irregularities and response to these irregularities; * Medication-related errors; and, * Gradual dose reduction. 3. The pharmacist will complete a written report noting any drug irregularities or issues of concern	F 756	1. Residents #23,#33,#12,#24,#30 have been reviewed with a response by the residents physician. 2. All residents have the potential of being affected. 3. All Staff Meeting is being held on 4-30-19 staff will be re-educated on the regulation and requirement for Drug regimen review and reporting irregularities to the attending physician. Systemic Change: Pharmacist will be noting any irregularities during the review be documented on a separate, written report that is sent to the attending physician and the facilities medical director and the centers Director of Nursing. Director of Nursing will ensure that the attending physician and medical director review Pharmacist drug regimen review and responded in a timely manner. 4. DNS or designee will audit monthly for six months the facilities Drug Regimen Review provided by the Consultant Pharmacist. Audit will show that the attending physician reviewed and responded. Quality Assurance committee will review and monitor Monthly Pharmacy audit during monthly quality meetings. Quality Assurance committee will ensure compliance. 5. Completion Date 5/15/19	

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F 756	Continued From page 15 for each resident reviewed. . . . 6. Drug irregularities will be reported to the medical director and attending physician by the director of nursing services or designee. The location must designate someone to ensure that these reports have been acted upon within 30 calendar days of the review and have been documented. 7. The consultant pharmacy report will be scanned into [the storage area for scanned paper documents in each resident's electronic medical record] upon receipt, under the document type Pharmacy Consultant Report. . . ." Review of the DRR process occurred on April 9-10, 2019 for Resident #12, #23, #24, #30, and #33. On 04/09/19, an administrative nurse (#2) provided the consultant pharmacist's DRR form for March but was unable to locate the DRR forms for January and February. On the morning of 04/10/19, the nurse presented copies of the consultant pharmacist's DRR for January and February. Both January and February's forms lacked responses from the physician, or if applicable the director of nursing. The DRRs, completed on the following dates, listed irregularities and/or requests for information for the following residents: * 01/18/19 - Resident #23 and 13 other residents * 02/20/19 - Resident #23, #33, and 13 other residents * 03/29/19 - Resident #12, #24, #30, and 13 other residents The consulting pharmacist documented the irregularities for the above residents on one DRR form each month versus completing a separate report for each resident. Failure to have a	F 756		

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F 756	Continued From page 16 separate written report to send to each resident's attending physician does not maintain the resident's confidentiality, nor enable the facility to add the DRR with the physician or nursing response into each resident's medical record. During an interview on 04/10/19 at 02:11 p.m., an administrative nurse (#2) stated regarding the January and February DRRs, the facility "did not receive them or they were missed,." and she planned to give them to the nurse practitioner tomorrow during rounds. The nurse agreed the pharmacist did not write the January - March DRR irregularities on an individual form for each resident.	F 756		