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OUR LADY OF HOPE HEALTH CENTER	13700 NORTH GAYTON ROAD RICHMOND, VA 23233

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 12/7/2021 through 12/9/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 12/7/21 through 12/9/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 75 certified facility was 60 at the time of the survey. The survey sample consisted of 30 current record reviews and 2 closed record reviews.	F 000	The filing of this plan of correction does not constitute that the deficiencies alleged to in fact occurred. This plan of correction is filed as evidence of Our Lady of Hopes desire to comply with the requirements of participation and to continue to provide high-quality resident care.	12/29/21
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 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).	F 657	**F 657 Care Plan Timing and Revision** 1. Resident #28's comprehensive care plan was updated with post-fall review 2. An audit of residents with falls was conducted by the DON/Designee to ensure that the comprehensive care plan has been updated to reflect the post-fall review. 3. LPN/RN re-education on the updating of the comprehensive care plan to reflect the post-fall review.	12/29/21

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

Paul Jones | ADMINISTRATOR | 12/20/21

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.

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F 657	Continued From page 1 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 observation, resident interview, clinical record review, facility document review and staff interview, it was determined facility staff failed to review the comprehensive care plan for one of 32 residents in the survey sample, Resident #28. On 11/14/21 Resident #28 sustained a fall. The residents comprehensive care plan was not reviewed or revised to address the residents 11/14/21 fall. The findings include: Resident #28 was admitted to the facility with diagnoses that included but were not limited to atrial fibrillation (1), pneumonia (2), and chronic respiratory failure with hypoxia (3). Resident #28's most recent MDS (minimum data set), a 5-day assessment with an ARD (assessment reference date) of 12/03/2021, coded Resident #28 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14-being cognitively intact for making daily decisions. Section J of the assessment documented Resident #28 having a fall in the month prior to entry and no falls since admission/entry or	F 657	4. An audit will be accomplished weekly x 3 months to ensure post-fall review is documented within the comprehensive care plan. The findings of the audit will be submitted monthly by the Director of Nursing to QAPI for review and recommendation. 5. Compliance Date: 12/29/2021	

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reentry.

On 12/7/2021 at approximately 11:30 a.m., an observation was made of Resident #28 in their room. At that time an interview was conducted with Resident #28. Resident #28 stated that they had one recent fall but did not remember the exact date. Resident #28 stated that they were not injured and had not fallen since then.

The progress notes for Resident #28 documented in part,

- "11/14/2021 12:38 AM 3-11 (3:00 p.m.-11:00 p.m.) Resident skilled service for/t [sic] A-fib (atrial fibrillation) with RVR (rapid ventricular response), fall. Resident A & O x3 (alert and oriented to person, place and time) and able to make needs known. 1 (one) person assist with adl's (activities of daily living) and transfers. Continent of bowel and bladder. No c/o (complaints of) pain or s/s (signs or symptoms) of resp. (respiratory) distress. Resident in bed resting, call bell in reach. Will continue to monitor."

The clinical record documented a fall assessment risk tool completed on 10/19/2021 and 11/29/2021 which assessed Resident #28 being a high fall risk.

The comprehensive care plan for Resident #28 documented in part, "Problem Start Date: 10/25/2021 Category: Falls I am at risk for falls due to recent syncope (4), muscle weakness, unsteady gait, hx (history) of falls, and use of cardiac and opiod medications." Under "Goal" it documented, "...I will have no falls within this review period. Created 10/25/2021." The care plan failed to evidence documentation of a review

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completed after the fall documented on 11/14/2021.

On 12/7/2021 at approximately 3:18 p.m., a request was made via written list to ASM (administrative staff member) #1, the executive director for the fall investigation for Resident #28 and the care plan addressing falls.

The fall investigation for Resident #28 documented in part, "Date: 11/14/2021; Time 06:40 PM; Shift 3-11...Location Residents room; This resident lost her balance while transferring, wittnessed [sic] by staff member. Will continue to have her work with therapy for strenghtening [sic] and transfers; Event Type Fall; Actions Taken Fall Evaluation, if applicable (NF-96), Physician Notified, Responsible Party Notified, Vital signs taken and charted." The document failed to evidence a review of the comprehensive care plan for Resident #28.

On 12/8/2021 at 1:55 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that the MDS coordinator and the director of nursing reviewed and revised the care plans. LPN #1 stated that the purpose of the care plan was to guide them how to care for the resident. LPN #1 stated that a fall would warrant a review of the care plan to make sure they had all of the appropriate interventions in place to prevent another fall.

On 12/8/2021 at 2:15 p.m., an interview was conducted with RN (registered nurse) #2, MDS coordinator. RN #2 stated that they completed the MDS assessment and revised the care plan in relation to items triggered on the assessment. RN #2 stated that the care plan should be

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updated after a fall and would have been updated by the nurse caring for the resident at the time. RN #2 stated that the purpose of the care plan was to direct patient centered care. RN #2 reviewed the fall care plan for Resident #28 provided by the facility and stated that there was no review after the fall on 11/14/2021.

On 12/9/2021 at approximately 8:30 a.m., a request was made to ASM #1 for the facility policy regarding reviewing the care plan.

The facility policy, "Comprehensive Person-Centered Care Planning" dated revised 11/15/2017 documented in part, "...The Care Planning/Interdisciplinary Team are responsible for the review and updating of the care plans: When requested by the resident/resident representative; When there has been a significant change in the resident's condition; When the desired outcome is not met..."

On 12/8/2021 at approximately 4:15 p.m., ASM #1, the executive director was made aware of the findings.

No further information was provided prior to exit.

References:

1. Atrial fibrillation
A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html>.

2. Pneumonia
An infection in one or both of the lungs. Many

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F 657	Continued From page 5 germs, such as bacteria, viruses, and fungi, can cause pneumonia. You can also get pneumonia by inhaling a liquid or chemical. This information was obtained from the website: <https://medlineplus.gov/pneumonia.html> 3. Chronic respiratory failure When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. 4. Syncope Fainting. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/003092.htm.	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, clinical record review, facility document review and staff interview, it was determined facility staff failed to store respiratory equipment in a sanitary manner for two of 32 residents in the survey sample, Resident #28 and Resident #62.	F 695	**F 695 Respiratory/Tracheostomy Care and Suctioning** 1. The incentive spirometer for resident #62, and the nebulizer for resident #28 were removed, sanitized, and replaced in a resealable storage container. 2. An audit of residents with incentive spirometers and nebulizers was conducted by the DON to ensure that the devices had been stored in a sanitary manner to reflect the interventions provided. 3. LPN/RN re-education was provided on ensuring nebulizers and incentive spirometers are stored in a sanitary manner.	12/29/21

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F 695	Continued From page 6 The facility staff failed to store nebulizer equipment in a sanitary manner for Resident #28 and failed to store an incentive spirometer in a sanitary manner for Resident #62. The findings include: 1. The facility staff failed to store nebulizer (1) equipment in a sanitary manner for Resident #28. Resident #28 was admitted to the facility with diagnoses that included but were not limited to congestive heart failure (2) and chronic respiratory failure with hypoxia (3). Resident #28's most recent MDS (minimum data set), a 5-day assessment with an ARD (assessment reference date) of 12/03/2021, coded Resident #28 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions. On 12/7/2021 at approximately 11:30 a.m., an observation was made of Resident #28 in their room. A nebulizer machine was observed on the dresser in Resident #28's room, with a mask and medication delivery cup attached to tubing lying on the dresser surface draped across the nebulizer machine. At that time an interview was conducted with Resident #28. Resident #28 stated that the nurses administered medication in the nebulizer for breathing. Additional observations of Resident #28's room on 12/7/2021 at 1:32 p.m. and 12/7/2021 at 3:41 p.m. revealed the nebulizer mask and medication delivery cup attached to tubing lying on the dresser surface draped across the nebulizer machine.	F 695	4. An audit will be accomplished weekly x 3 months to ensure nebulizers and incentive spirometers are stored in a sanitary manner. The findings of the audit will be submitted monthly by the Director of Nursing to QAPI for review and recommendation. 5. Compliance Date: 12/29/21	

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On 12/8/2021 at 8:45 a.m., observation revealed the nebulizer mask and medication delivery cup inside of a plastic bag on the dresser.

The physician orders for Resident #28 documented, "12/06/2021 Albuterol Sulfate solution for nebulization 2.5 mg (milligram)/3 ml (milliliter) 0.083% every 4 (four) hours- prn (as needed)..."

The eMAR (electronic medication administration record) dated 12/1/2021-12/8/2021 documented Resident #28 received Albuterol Sulfate solution by nebulizer on 12/3/2021 at 5:00 p.m., 12/4/2021 and 12/5/2021 at 9:00 a.m. and 5:00 p.m., and 12/6/2021 at 9:00 a.m.

The comprehensive care plan for Resident #28 documented in part, "Problem: Risk for respiratory distress due to: anemia, CHF (congestive heart failure), HTN (hypertension), allergic rhinitis, refuses medications, Pneumonia. Start Date: 10/25/2021. Last Reviewed/Revised 11/30/2021 08:50 AM."

On 12/8/2021 at 1:55 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that nebulizers were cleaned after use and stored in plastic bags with the residents name and the date on them. LPN #1 stated that they were stored this way to prevent dust from getting on them. LPN #1 stated that they checked them periodically to ensure they were stored properly and the bags were changed. When LPN #1 was made aware of the observations of Resident #28's nebulizer on 11/7/2021 at 11:30 a.m., 1:32 p.m. and 3:41 p.m., LPN #1stated that they were not sure when the

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bag was placed in the room but it [nebulizer mask and tubing] should have been stored in the bag when not in use.

On 12/8/2021 at 9:40 a.m., ASM (administrative staff member) #1, the executive director provided a written document stating that the facility followed Lippincott as a standard of practice.

On 12/9/2021 at approximately 8:30 a.m., a request was made to ASM #1 for the facility policy regarding reviewing storage of nebulizer equipment.

On 12/9/2021 at 8:40 a.m., ASM #1 stated that they did not have a policy regarding storage of nebulizers or incentive spirometers.

According to The Lippincott Manual of Nursing Practice 10th Edition, 2014, page 236, Procedure Guidelines 10-11 documented in part, "Follow-up phase 1. Record medication used and description of secretions. 2. Disassemble and clean nebulizer after each use. Keep this equipment in the patient's room. The equipment is changed according to facility policy. Each patient has own breathing circuit (nebulizer, tubing and mouthpiece). Through proper cleaning, sterilization, and storage of equipment, organisms can be prevented from entering the lungs."

On 12/8/2021 at approximately 4:15 p.m., ASM #1, the executive director was made aware of the findings.

No further information was provided prior to exit.

References:

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1. Nebulizer
- "a device used to aerosolize medications for delivery to patients." Taken from Encyclopedia & Dictionary of Medicine, Nursing & Allied Health -Seventh Edition, Miller-Keane, page 1182.

2. Congestive heart failure
A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html

3. Respiratory failure
When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

2. The facility staff failed to store an incentive spirometer (1) in a sanitary manner for Resident #62.

Resident #62 was admitted to the facility with diagnoses that included but were not limited to diabetes (2) and hypertension. Resident #62's most recent MDS (minimum data set), a 5-day assessment with an ARD (assessment reference date) of 11/27/2021, coded Resident #62 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions.

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Section O coded Resident #62 as receiving respiratory therapy during the assessment period.

On 12/7/2021 at approximately 12:25 p.m., an observation was made of Resident #62 in their room. An incentive spirometer was observed uncovered with the mouthpiece touching the surface of the dresser in the room. At that time an interview was conducted with Resident #62. Resident #62 stated that they used the spirometer when staff asked them to.

Additional observations of Resident #62's room on 12/7/2021 at 3:43 p.m. revealed the incentive spirometer uncovered on top of the dresser with the mouthpiece touching the surface of the dresser in the room. On 12/8/2021 at 8:45 a.m., the incentive spirometer was observed on the nightstand beside Resident #62's bed uncovered.

The physician orders for Resident #62 documented, "11/23/2021 Rehab [rehabilitation] Potential: PT/OT/RT/ST (physical therapy, occupational therapy, respiratory therapy, speech therapy)..."

The progress notes for Resident #62 documented in part the following:
- "12/08/2021 01:52 PM. Met with resident for 30 minutes coaching IS (incentive spirometer). Provided a visual cue to remind her and to document. Spo2 (oxygen saturation) 94%, HR (heart rate) 63."
- "12/07/2021 01:15 PM. Met with resident for 30 minutes coaching IS. Spo2 96% HR 67."
- "12/06/2021 01:37 PM. Met with resident for 30 minutes coaching IS. Spo2 92% HR 68."
- "11/30/2021 02:29 PM. Met with resident for 30 minutes coaching IS. Spo2 92% HR 60."

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- "11/29/2021 02:21 PM. Met with resident for 30 minutes coaching IS. Spo2 92% HR 60."
- "11/26/2021 12:44 PM. Met with resident for 30 minutes coaching IS. Spo2 93% HR 56."
- "11/24/2021 01:12 PM. Met with resident for 30 minutes assessing respiratory status and coaching IS. Spo2 96% HR 44. Informed PA (physician's assistant) of low heart rate."

The comprehensive care plan for Resident #62 documented in part, "Problem: Risk for respiratory distress due to: HTN (hypertension). Start Date: 11/29/2021. Last Reviewed/Revised 11/29/2021 12:11 p.m."

On 12/8/2021 at 1:55 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that incentive spirometers were cleaned after use and stored in plastic bags with the residents name and the date on them. LPN #1 stated that they were stored this way to prevent dust from getting on them. LPN #1 stated that they checked them periodically to ensure they were stored properly and the bags were changed. LPN #1 observed the uncovered incentive spirometer on the nightstand beside Resident #62's bed and stated that it should be in a bag and they would let the nurse caring for the resident know to take care of it.

On 12/8/2021 at 9:40 a.m., ASM (administrative staff member) #1, the executive director provided a written document stating that the facility followed Lippincott as a standard of practice.

On 12/9/2021 at approximately 8:30 a.m., a request was made to ASM #1 for the facility policy regarding reviewing storage of incentive spirometers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495311	A. BUILDING _____ B. WING _____	12/09/2021

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F 695	Continued From page 12	F 695		

On 12/9/2021 at 8:40 a.m., ASM #1 stated that they did not have a policy regarding storage of incentive spirometers.

According to Lippincott's Nursing Procedures (6th Edition) 2013. "Wash the mouthpiece in warm water and dry it. Avoid immersing the spirometer itself in water because water enhances bacterial growth and impairs the internal filter's effectiveness in preventing inhalation of extraneous material. Place the mouthpiece in a plastic storage bag between exercises, and label it and the spirometer, if applicable, with the patient's name to avoid inadvertent use by another patient. Keep the incentive spirometer within the patient's reach."

On 12/8/2021 at approximately 4:15 p.m., ASM #1, the executive director was made aware of the findings.

No further information was provided prior to exit.

References:

1. Incentive spirometer
Your health care provider may recommend that you use an incentive spirometer after surgery or when you have a lung illness, such as pneumonia. The spirometer is a device used to help you keep your lungs healthy. Using the incentive spirometer teaches you how to take slow deep breaths. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm

2. Diabetes mellitus

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F 695	Continued From page 13 A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.	F 695		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and employee record review, it was determined that the facility staff failed to ensure that training records reviewed included all the required annual training for one of 5 CNA [certified nursing assistant] records reviewed, CNA #1. The findings include: On 12/8/21 a review of 5 CNA (Certified Nursing Assistant) training / education records were reviewed. CNA #1 was hired on 5/16/11 and her most recent completed anniversary year for training and education was 5/16/20 to 5/16/21. A review of CNA #1's training records for 5/16/20 to 5/16/21 failed to evidence that any abuse training was provided.	F 730	**F 730 Nurse Aide Perform Review- 12 hr/yr In-Service** 1. C N A # 1 was provided abuse training. 2. An audit was completed for nursing staff to ensure yearly abuse training was completed. 3. Re- education was provided to Director of Nursing on ensuring that each nursing staff employee receives the required annual in-service training. 4. An Audit will be completed by the Administrator/Designee monthly x three months on nursing staff to ensure ongoing compliance with required annual in service training. The findings of the audit will be submitted by the Administrator/Designee to QAPI for review and recommendation. 5. Compliance Date: 12/29/21	12/29/21

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F 730	Continued From page 14 On 12/08/21 at 2:19 PM, an interview was conducted with ASM #1 (Administrative Staff Member) the Executive Director. He stated that he looked everywhere and contacted the former Administrator and searched for any ad hoc abuse training. He stated that none was found. He stated that the facility does not have a training/education coordinator due to the facility being only a 75 bed facility. He stated that (ASM #2, the Director of Nursing) manages most of the training. He stated there wasn't any evidence that abuse training was provided to this CNA during the anniversary year. A review of the facility policy, "Employee Training and Orientation" documented, "...3. Training required for Direct Care Staff/C.N.A.s: a. The Director of Nursing Services or designee will be responsible for ensuring that each C.N.A. or Nurse attends twelve (12) hours of in-service education per year. Dementia education and resident abuse prevention training will be provided annually...." No further information was provided by the end of the survey.	F 730		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812	**F 812 Food Procurement, Store/Prepare/Serve-Sanitary** 1. The grape jelly and walnut halves were removed from the food storage and disposed of. 2. An audit of the food storage was completed to ensure that no other expired food was present.	12/29/21

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F 812	Continued From page 15 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and facility document review, it was determined the facility staff failed to store, food in accordance with professional standards for food service safety. The facility staff failed to dispose of expired food during the facility task- kitchen observation on 12/7/21 at 9:45 AM. The findings include: On 12/7/21 at 9:45 AM, an observation was conducted in the main kitchen dry storage room with OSM (other staff member) #3, the director of dining services. A 32-ounce bag of walnut halves and pieces was torn open and uncovered, with plastic wrap at the bottom of the bag. On the spice rack, there was a 20-ounce grape jelly jar, one third full, the jelly was at room temperature and the label on the bottle documented "refrigerate after opening". An interview was conducted on 12/7/21 at 10:00 AM with OSM (other staff member) #3, the director of dining services. When asked if the walnuts should be opened, OSM #3 stated, "No,	F 812	3. Dietary staff was provided educated on identification and removal of expired products and proper containment of opened items within food storage. 4. An audit will be accomplished weekly x 3 months to ensure no expired items are present within the food storage. The findings of the audit will be submitted monthly by the Director of Nursing to QAPI for review and recommendation. 5. Compliance Date:12/29/21	

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F 812	Continued From page 16 they should be closed. It looks like someone was snacking." When asked about the grape jelly and the length of time out of the refrigerator, OSM #3 stated, "I'm not sure." When shown the label on the one third full jar of grape jelly, which documented to refrigerate after opening, OSM #3 stated, "That will be thrown away now." On 12/8/21 at 4:15 PM, ASM #1, the executive director was made aware of the above findings. The facility's "Dining Services" policy dated 11/11, documented in part, "Any opened food item must be stored in clearly labeled containers with a clearly labeled lid. Food supplies should be stored in a manner to ensure 'first in, first out' usage." No further information was provided prior to exit.	F 812		