STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PERPETUAL HELP	4560 PRINCESS ANNE ROAD VIRGINIA BEACH, VA 23462

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/12/21 through 10/14/21. Corrections are required for compliance with 42 CFR Part 483.73, Requirements for Long Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented,	E 006		11/28/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
11/12/2021

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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E 006	Continued From page 1 facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility document review the facility staff failed to have documentation that the Emergency Preparedness Plan included an updated facility Risk	E 006	E000 The filing of this plan of correction does not constitute an admission that the deficiencies alleged did in fact exist. This plan of correction is filed as evidence	

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E 006	Continued From page 2 Assessment to include their current population of COVID-19 resident's. The findings included: An interview was conducted with the Administrator and Assistant Administrator on 10/14/21 at approximately 3:30 p.m. The Administrator was asked if the facility's Emergency Preparedness Plan included the facility's current resident population to include the two (2) current COVID-19 positive cases in the building. The facility provided the Facility Resource Assessment document that was reviewed and update by the Quality Assessment Assurance (QAA) / Quality Assurance and Performance Improvement (QAPI) committee on 07/14/21. The assessment included the following documentation under special treatments: zero (0) for the number of residents who were on isolation or quarantine for active infectious disease. The Administrator said the risk assessment is an ongoing assessment that must be reviewed and revised as changes occur within the facility. The Administrator said the facility assessment should have been revised to include the (2) positive cases of COVID-19 that's currently in the building. The Administrator, Assistant Administrator, Director of Nursing and Dietary Manager were informed of the finding during a debriefing on 10/14/21 at approximately 6:15 p.m. The facility staff did not present any further information about the findings. The facility provided the Emergency Preparedness and Evacuation Plan with a revision date of 10/14/21. The purpose of an evacuation plan in this facility is to ensure the	E 006	of Our Lady of Perpetual Help□s desire to comply with the requirements of participation and to continue to provide high-quality resident care. E006 Corrective Action: - On 10-15-2021, the Facility Risk Assessment was updated to include the covid positive residents. Identifying Other Potential Residents: - All residents have a potential to be affected. Systemic Changes: - The Facility Risk Assessment will be reviewed monthly to identify changes to be made in the resident population statistics. Monitoring System: - Monthly reviews, with any changes will be presented to and reviewed by the Administrator or designee, monthly x 3 months. Results will be submitted for review by Quality Assurance Performance Improvement (QAPI) committee, monthly.	

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E 006	Continued From page 3 ongoing safety of our resident population if the facility and its management are presented with circumstance that provide untenable in the pursuit of continued care and rendering of service or pose an immediate threat to the life safely and well-being of facility occupants. Procedure: This plan will incorporate the following requirements: 7. Documentation of the facility's risk assessments and associated strategies. 11. Documentation that the policies and procedures were developed based on the facility and community-based risk assessment and communication plan, utilizing an all-hazards approach.	E 006		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/12/21 through 10/14/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint (VA00052135) was investigated during the survey. The census in this 30 certified bed facility was 26 at the time of the survey. The survey sample consisted of 18 current and 1 closed record.	F 000		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than	F 638		11/28/21

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F 638	Continued From page 4 once every 3 months. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility's staff failed to complete a quarterly Minimum Data Set (MDS) assessment at least every 92 days for one of 19 residents (Resident 5), in the survey sample. The findings included; Resident #5 was originally admitted to the facility 3/25/21 and the resident had never been discharged from the facility. The current diagnoses included; dementia, an anxiety disorder and hypothyroidism. The significant Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 5/12/21 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired for daily decision making. During the course of the survey 10/12/21 through 10/14/21, Resident #5's clinical record was reviewed. The most recent MDS assessment completed for the resident was a significant change assessment with an assessment reference date (ARD) of 5/12/21. On 10/14/21 at approximately 2:40 p.m., an interview was conducted with the MDS coordinator who reviewed Resident #5 MDS history. The MDS coordinator stated Resident #5 was currently in house and the last MDS assessment completed for her was dated	F 638	F000 The filing of this plan of correction does not constitute an admission that the deficiencies alleged did in fact exist. This plan of correction is filed as evidence of Our Lady of Perpetual Help□s desire to comply with the requirements of participation and to continue to provide high-quality resident care. F638 Corrective Action: - The Quarterly Assessment MDS was completed for resident #5 on 10/15/2021. Identifying Other Potential Residents: - A 100% audit of resident□s records was completed to determine if there were any other missing assessments. Systemic Changes: - A tracking document will be created for the purpose of establishing the resident□s assessment schedule, to identify and ensure timely completion of assessments. Monitoring System: - An audit of resident assessment schedules will be completed by the DON or designee, weekly X4 then monthly X3, to ensure completion of scheduled resident assessments. - Audits will be reviewed by the Administrator or designee and the results of those audits will be submitted for review by our Quality Assurance Performance Improvement (QAPI)	

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F 638	Continued From page 5 5/12/21. The MDS coordinator stated another MDS assessment should have been conducted one to ten days prior to 8/12/21 with the next assessment due in November. The MDS coordinator further stated she would conduct a facility audit to ensure all resident MDS assessments were current. The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. (CMS Resident Assessment Instrument Version 3.0 Manual, dated October 2019, Chapter 2, page 2-33) On 10/14/21 at approximately 4:10 p.m., the Director of Nursing stated the MDS coordinator had recently retired but she was meticulous about ensuring the MDS assessments were completely timely, she didn't understand how the resident's assessment was omitted. On 10/14/21 at approximately 6:00 p.m., the above findings were shared with the Administrator and the Director of Nursing. They were afforded the opportunity to present additional information but; they did not.	F 638	committee, monthly.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a	F 640		11/28/21

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F 640	Continued From page 6	F 640		

facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

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F 640	Continued From page 7 §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility staff failed to complete the required discharge Minimum Data Set (MDS) assessment within the required timeframe after a death in the facility for 1of 19 residents (Resident #9), in the survey sample. The findings included; Resident #9 was originally admitted to the facility 7/28/20 and had never been discharged from the facility. The current diagnoses included; dementia, depression and diabetes. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 05/26/2021 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired for daily decision making. On 10/13/21, during the finalization of the sample the Resident Assessment task triggered for review. It revealed the Centers for Medicare/Medicaid Services (CMS) identified Resident #9 hadn't had a MDS assessment submitted to the MDS databank for more than 120 calendar days. Review of the clinical record revealed a nurse's	F 640	F640 Corrective Action: - The discharge MDS assessment for resident #9 was completed on 10/14/2021 and transmitted on 10/15/2021. Identifying Other Potential Residents: - A 100% audit of resident□s records was completed to determine if there were any other missing assessments. Systemic Changes: - A tracking document will be created for the purpose of establishing the resident□s assessment schedule and to identify and ensure timely completion of assessments. Monitoring System: - An audit of resident assessment schedules will be completed by the DON or designee, weekly X4 then monthly X3, to ensure completion of scheduled resident assessments. - Audits will be reviewed by the Administrator or designee and the results of those audits will be submitted for review by our Quality Assurance Performance Improvement (QAPI) committee, monthly.	

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F 640	Continued From page 8	F 640		

dated 08/13/2021 at 06:25 a.m., which read; Resident pronounced at 0557. No heart rate or respirations found on auscultation for 1 full minute.

On 10/14/21 at approximately 2:40 p.m., an interview was conducted with the MDS coordinator who reviewed Resident #9's MDS history. The MDS coordinator stated the clinical record revealed Resident #9's death in the facility MDS Tracking Record was dated 8/13/21 and read "in process" The MDS coordinator stated that "in process" means the assessment was opened but not completed and transmitted to the CMS databank.

CMS's Resident Assessment Instrument Version 3.0 Manual, dated October 2019, Chapter 2, page 2-36 instructions read; the Death in Facility Tracking Record must be completed when the resident dies in the facility and it must be completed within 7 days after the resident's death, which is recorded in item A2000. Discharge Date (A2000 + 7 calendar days). The Tracking Record must be submitted within 14 days after the resident's death, which is recorded in item A2000, Discharge Date (A2000 + 14 calendar days).

On 10/14/21 at approximately 4:10 p.m., the Director of Nursing stated the MDS coordinator had recently retired but she was meticulous about ensuring the MDS assessments were completely timely, she didn't understand how the resident's assessment was omitted.

On 10/14/21 at approximately 6:00 p.m., the above findings were shared with the Administrator and the Director of Nursing. They were afforded

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F 640	Continued From page 9 the opportunity to present additional information but; they did not.	F 640		
F 657 SS=E	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). 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 clinical record reviews, staff interviews, facility documentation, and review of the facility's policy; the facility staff failed to review and revise the person-centered care plan as each resident's	F 657	F657 Corrective Action: - The Care Plan for resident #6 was updated. Resident #20 was no longer in	11/28/21

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F 657	Continued From page 10 condition changed for two of 19 residents (Resident #20 and #6) in the survey sample. The findings included: 1. The facility staff failed to review and revise Resident #20's person-centered care plan to include Hospice services and use oxygen (O2). Resident #20 was originally admitted to the facility 1/27/20 and readmitted 9/27/21 after an acute care hospital stay beginning 9/19/21. The current diagnoses included; COPD, COVID-19 diabetes and renal insufficiency. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/21/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #20's cognitive abilities for daily decision making were intact. Review of the clinical record revealed a physician's order dated 9/16/21 which read; oxygen (O2) at 2 Liters (L) per minute via Nasal Cannula (NC) as needed for Oxygen saturation (Sats) below 90% or dyspnea/shortness of breath (SOB); notify physician for sats below 90%, As Needed. 09/28/2021- O2 at 4 Liter per minute via NC as needed for Sats below 90% or dyspnea/SOB; notify MD for sats below 90%, As Needed. Review of the clinical record also revealed the following progress note dated 10/11/21 at 05:29 p.m., Resident admitted to (name of the agency) Hospice on 10/9/21. Comfort pack order	F 657	the facility. Identifying Other Potential Residents: - A 100% audit of all resident□s care plans was completed to ensure care plans were current / up-to-date, for all residents with psychoactive medications, oxygen use and hospice services. Systemic Changes: - DON and MDS Coordinator will jointly assume the responsibility to update care plans, with changes as they occur. Monitoring System: - An audit of resident□s care plans will be completed by the DON or designee, weekly X4 then monthly X3, to ensure care plans are current / up-to-date. - Audits will be reviewed by the Administrator or designee and the results of those audits will be submitted for review by our Quality Assurance Performance Improvement (QAPI) committee, monthly.	

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F 657	Continued From page 11 provided. Resident aware of admission. Review of Resident #20's person-centered care plan revealed no problem/goal/interventions for use of O2 or election of Hospice services therefore; and interview was conducted with the Director of Nursing on 10/14/21 at approximately 4:10 p.m. The Director of Nursing stated it was her responsibility to update the care plans but she had been on vacation and hadn't updated Resident #20's care plan to reflect the use of O2 and Hospice Services and neither had the Hospice agency provided the facility with their care plan. On 10/14/21 at approximately 6:00 p.m., the above findings were shared with the Administrator and the Director of Nursing. They were afforded the opportunity to present additional information but; they did not. 2. The facility staff failed to revise Resident #6's comprehensive person-centered care plan to include the use of psychotropic medication (Xanax). Resident #8 was admitted to the nursing facility on 01/25/21. Diagnosis for the resident included but not limited to Depression. Resident #8's Minimum Data Set (MDS-an assessment protocol) a quarter assessment with an Assessment Reference Date of 09/22/21 coded Resident #8's Brief Interview for Mental Status (BIMS) scored a 14 out of a possible score of 15 indicating no cognitive impairment for daily decision-making. The MDS coded the resident extensive assistance of one with bathing, limited assistance of one with bed mobility, dressing and toilet use, and no assistance required with transfer or eating with Activities of Daily (ADL)	F 657		

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	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PERPETUAL HELP	4560 PRINCESS ANNE ROAD VIRGINIA BEACH, VA 23462

(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 657	Continued From page 12	F 657		

care.

Resident #8's person-centered comprehensive care plan with a revision date 09/29/21 did not include the use of psychoactive medication Xanax.

The physician Order Sheet (POS) for October 2021 included the following order:
Xanax 0.25 mg daily as needed starting 04/26/21.

1. Review of May 2021 Medication Administration Record (MAR) revealed, PRN Xanax was administered on the following day: 05/13/21.

2. Review of June 2021 Medication Administration Record (MAR) revealed, PRN Xanax was administered on the following days: 06/01/21 and 06/22/21.

On 10/14/21 at approximately 3:00 p.m., an interviewed was conducted with the Administrator and Director of Nursing (DON). The DON said she update/revise the care plans. She said the Xanax was ordered when Resident #6's son passed away. She said at one time there was a care plan for the use of the medication Xanax but it was deleted.

The Administrator, Assistant Administrator, Director of Nursing and Dietary Manager were informed of the finding during a debriefing on 10/14/21 at approximately 6:15 p.m. The facility staff did not present any further information about the findings.

The facility's policy titled Comprehensive Person-Centered Care Planning - revision date 11/15/17. The comprehensive care plan will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 13 incorporate identified problem area and incorporate risk factors associated with identified problems. -The Care Planning/Interdisciplinary Team are responsible for the review and updating of the care plans. Definitions: -Xanax is used to treat anxiety disorder and anxiety caused by depression (https://www.drugs.com/xanax.html).	F 657		
F 684 SS=E	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 observations, clinical record review, staff interviews and facility document review the facility staff failed to apply bilateral hand rolls for 8 days for 1 of 19 residents in the survey sample with severe hand contractures, Resident #11. The findings included: Resident #11 was admitted to the facility on 8/18/21 with diagnoses to included but not limited to Bilateral Upper Extremity Contractures, Alzheimer's Disease and Osteoporosis.	F 684	F684 Corrective Action: - Hand Splints were applied to resident #11 on 10/14/2021 - Education was provided to LPN #1 on following specific physician□s orders with application of splints. - Education was provided for to the licensed nurses to include following physician orders and the residents plan of care.	11/28/21

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	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PERPETUAL HELP	4560 PRINCESS ANNE ROAD VIRGINIA BEACH, VA 23462

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F 684	Continued From page 14 Resident #11's most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 8/25/21. The Brief Interview for Mental Status (BIMS) was not completed because the resident was coded as rarely or never understood. Resident #11 was coded as having long and short term memory problems and severely impaired for task of daily living. Under Section G Functional Status G0400. Functional Limitation in Range of Motion Resident #11 was coded as having Upper Extremity Impairment on both sides. On 10/13/21 at 10:37 a.m., Resident #11 was observed in a private room lying in bed with her personal sitter at her side. The resident was severe bilateral hand contractures with to the point that her fingers were pressing into the palm of her hands. There was signage instructions with a diagram of hand rolls on the closet door which read : 6 to 8 hours/day during daytime. Resident #11 was observed with no hand rolls in place to either hand. On 10/13/21 at 11:45 a.m., Resident #11 was observed still lying in bed with no hand rolls in place to either hand. On 10/13/21 at 1:20 p.m., Resident #11 was once again observed still lying in bed with no hand rolls in place to either hand. 10/13/21 at 1:25 p.m., an interview was conducted with Resident #11's personal sitter. Resident #11's personal sitter was asked about the resident's hand rolls. The personal sitter stated, "They haven't been on today. It's been almost a week since I've seen them on her, they	F 684	Identifying Other Potential Residents: - All residents with orders for the application of splints have the potential to be affected. - A 100% audit of all resident□s orders was completed to determine if there were orders for the application of splints. Systemic Changes: - The Charge Nurse will perform the application of the hand splints, as directed by a physician□s order. Monitoring System: - An audit of residents with orders for splints will be completed by the DON or designee, weekly X4 then monthly X3, to ensure compliance with the application, based on the orders given by the physician. - Audits will be reviewed by the Administrator or designee and the results of those audits will be submitted for review by our Quality Assurance Performance Improvement (QAPI) committee, monthly.	

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	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PERPETUAL HELP	4560 PRINCESS ANNE ROAD VIRGINIA BEACH, VA 23462

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F 684	Continued From page 15	F 684		

may be in laundry. The staff usually put them on her, but they come off a lot. The therapy lady that made them for her is no longer here. I'm here with her usually everyday from 7 am to 3 pm." The personal sitter found one hand roll in resident's top dresser drawer, but was unable to locate the second one.

Resident #11's Physical Orders were reviewed and are documented in part, as follows:

Use bilateral hand rolls during daytime. ON at 0800 and OFF at 1400 (2 p.m.) Special Instructions: Contractions. Start Date: 11/30/2020.

Resident #11's Comprehensive Care Plan revised on 9/4/21 was reviewed and is documented in part, as follows:

Problem: Category: ADL (Activities of Daily Living) Functional/Rehabilitation Potential Name (Resident #11) has limited in range of motion related to contractures in bilateral upper and lower extremities.

Approach: Inspect skin before and after hand rolls. Observe and report any red or broken areas, Refer to diagram for placement.

On 10/13/21 at 2:30 p.m., an interview was conducted with the Director of Nursing (DON) regarding Resident #11's hand rolls. The DON stated, "I would expected for the staff to follow her plan of care and have the splints on her. If we are missing one we can get another one for her that's not a problem."

On 10/14/21 at 11:03 a.m., Resident #11 was

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	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PERPETUAL HELP	4560 PRINCESS ANNE ROAD VIRGINIA BEACH, VA 23462

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F 684	Continued From page 16 observed in bed with her hand rolls in place to both hands. The facility was unable to provide a policy related to the facility expectations for the use of hand rolls or splinting devices to aide with contractures. On 10/14/21 at 5:57 p.m., a Pre-Exit Debriefing was held with the Administrator, the Assistant Administrator, the Director of Nursing and the Food Services Director were the above information was shared. Prior to exit no further information was shared.	F 684		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and clinical record review the facility staff failed to ensure 1 of 19 residents (Resident #18) in the survey sample who were unable to carry out activities of daily living (ADL) receives the necessary services to maintain toenail care. The findings included:	F 687	F687 Corrective Action: - Nail care was provided to resident #18 on 10/14/2021, by the Podiatrist. - Education was provided to the licensed nurses and C.N.A.□s to evaluate the need for hygiene and grooming of toenails and fingernails.	11/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 687	Continued From page 17 The facility staff failed to ensure that podiatry services was provided to Resident #18. Resident #18 was originally admitted to the facility on 03/18/19. Diagnosis for Resident #18 included but not limited to Dementia without behavioral disturbance. Resident #18's Minimum Data Set (MDS-an assessment protocol) a quarter assessment with an Assessment Reference Date of 08/25/21 coded Resident #18's Brief Interview for Mental Status (BIMS) scored a 03 out of a possible score of 15 indicating severe cognitive impairment. The MDS coded the resident total dependence of two with transfer, total dependence of one with toilet use, personal hygiene and bathing, extensive assistance of one with bed mobility and dressing and supervision for (ADL) care. Resident #18's person centered care plan with a revision date 09/01/21 documented resident is at risk for further interruption in skin integrity related to mobility impairments. One intervention/approach to manage goal include the License Practical Nurse (LPN) to document weekly skin/nail assessment under observations, as per schedule. During the review of Resident #18's active Order Summary Report included the following order with a start date of 11/09/19: may have podiatry as needed. On 10/13/21 at approximately 11:16 a.m., Resident #18 was observed lying in bed with both feet uncovered. The resident's great toenails were long and thick with rigged edges. Resident #18 stated, "My toenails need to be cut, are you	F 687	Identifying Other Potential Residents: - A 100% audit of all resident□s nails was completed to determine if there were any others requiring nail care. Systemic Changes: - Nail Care will be assessed by the Licensed Nurse, weekly. - Resident□s will be placed on a routine schedule for podiatry services. Monitoring System: - An audit of the weekly assessments will be completed by the DON or designee, weekly X4 then monthly X3, to determine compliance with proper foot / nail care. - Audits will be reviewed by the Administrator or designee and the results of those audits will be submitted for review by our Quality Assurance Performance Improvement (QAPI) committee, monthly.	

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	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PERPETUAL HELP	4560 PRINCESS ANNE ROAD VIRGINIA BEACH, VA 23462

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F 687	Continued From page 18	F 687		

able to cut them for me?" On the same day at approximately 4:45 p.m., License Practical Nurse (LPN) #2 was asked to assess Resident #18's toenails. After assessing Resident #18's toenails, she stated, "Yes, his toe nails need to be cut and trimmed, they are thick and long." When asked, who is responsible for accessing toenails to ensure podiatry services are provided as needed, she replied, "The Certified Nursing Assistant (CNA) should be checking daily while performing ADL care and they are to inform the nurse who will place the resident on the podiatry list. She said the nurses should be checking the resident's toenails weekly during skin check." The LPN said she be contact the podiatry to do a visit; hopefully tomorrow.

Review of Resident #18's progress note written by LPN #2 on 10/13/2021 at 05:04 p.m., included the following information: "Resident #18's toenails are long and need to be trimmed. A call was placed to (name of podiatrist), asked if he could see Resident #18 for toenail trimming; his bilateral great toe nails are thick, other toes nails are thin. The document also include the nurse did attempt to trim the thin nails but the resident stated, stop don't do that, that is enough." (Name of podiatrist) was made aware and states that he will be here tomorrow (10/14/21). Resident informed the podiatrist will be here tomorrow to provide toenail care.

On 10/14/21 at approximately 2:05 p.m., the facility provided a document written by the podiatrist on 10/14/21 that included the following: podiatry visit today for Resident #18. Physical exam revealed his toenails were elongated, dystrophic and discolored; toenails derided today.

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	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 687	Continued From page 19 A debriefing conference was conducted with the Administrator and Assistant Administrator on 10/14/21 at approximately 2:30 p.m. The facility did not present any further information about the findings. The facility's policy titled Personal Care and Service Delivery - revision date 01/01/09. It is the policy of this facility to promote and maintain the resident's highest level of functional independence while providing assistance with bathing, meals, mediations, bathroom and bedtime needs. Care and delivery shall be resident-centered to the maximum extent possible. Procedure include but not limited to: 17. Hygiene and grooming include trimming fingernails and toenails (certain medical conditions necessitate that this be done by a licensed health care professional).	F 687		
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 observations, clinical record reviews, and staff interviews; the facility staff failed to administer oxygen (O2) as ordered for one of 19	F 695	F695 Corrective Action: - The oxygen flow rate was adjusted for	11/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 20 residents (Resident #20) in the survey sample. The findings included: Resident #20 was originally admitted to the facility 1/27/20 and readmitted 9/27/21 after an acute care hospital stay beginning 9/19/21. The current diagnoses included; COPD, COVID-19 diabetes and renal insufficiency. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/21/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #20's cognitive abilities for daily decision making were intact. Review of the clinical record revealed a physician's order dated 9/16/21 which read; oxygen (O2) at 2 Liters (L) per minute via Nasal Cannula (NC) as needed for Oxygen saturation (Sats) below 90% or dyspnea/shortness of breath (SOB); notify physician for sats below 90%, As Needed. 09/28/2021- O2 at 4 Liter per minute via NC as needed for Sats below 90% or dyspnea/SOB; notify MD for sats below 90%, As Needed. 10/12/2021 07:05 a.m., Resident complained of back pain at 0430 and was given morphine 0.25. At 0545 she started yelling that she couldn't breath and no one was helping her. Pulse ox was 76-78 on 4 liters. She was yelling and moving about and saying that she needed to get out of here. Oxygen was increased to 5 liters. She was given 0.5 ml of morphine, 0.5mg of Ativan, and her rescue inhaler. She was repositioned in the bed so that he head was elevated better once	F 695	resident #20, to match the physician□s orders on 10/14/2021 - Education was provided to the nursing staff regarding following physician□s orders. Identifying Other Potential Residents: - All residents with orders for oxygen have the potential to be affected. - A 100% audit of all residents with orders for oxygen was completed to determine if the flow rate matched the physician orders. Systemic Changes: - Education was provided to the nursing staff on the need to monitor the oxygen flow rate at the beginning of their shift as well as periodically throughout the shift to ensure that the proper flow rate is maintained Monitoring System: - An audit of residents with orders for oxygen will be completed by the DON or designee, weekly X4 then monthly X3, to determine compliance with the proper flow rate being administered, as ordered by the physician. - Audits will be reviewed by the Administrator or designee and the results of those audits will be submitted for review by our Quality Assurance Performance Improvement (QAPI) committee, monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PERPETUAL HELP	4560 PRINCESS ANNE ROAD VIRGINIA BEACH, VA 23462

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F 695	Continued From page 21	F 695		

head of bed put up. She was calming down by 0600 and her pulse ox was up to 86%. Hospice was called to update her condition.

ON 10/12/21 there was no order in the clinical record to increase the oxygen to 5 liter per minute.

Review of the clinical record also revealed the following progress note dated 10/11/21 at 05:29 p.m., Resident admitted to (name of the agency) Hospice on 10/9/21. Comfort pack order provided. Resident aware of admission.

On 10/13/21 at approximately 10:45 a.m., Resident #20 could be heard yelling out "I can't breathe". Observations were made of staff going in to assist the resident but she continued to yell out. On 10/13/21 at approximately 11:20 a.m. an interview was conducted with Resident #20. The resident stated her back hurt and she couldn't breathe. She was observed with an O2 mask on and the O2 concentrator reading was 5 1/2 Liters per minute according to Licensed Practical Nurse (LPN) #1.

On 10/13/2021 at approximately 12:30 p.m. a Hospice progress note was added to the clinical record by the facility's nurse. It read; Hospice in and saw resident. Resident is transitioning. New Oder to start Lorazepam 2mg/mL give 0.25 mL Sublingual every six hours routinely for anxiety/restlessness. Discontinue Remeron, Xanax, Bumex, Tramadol, Arthritis Tylenol, Trazadone, Proair, Pulmicort, and Lexapro. Increase oxygen to 5 ½ Liter per minute and Discontinue the left lower leg treatment. Responsible Party/Brother here and at bed side aware of status and new orders. Vital signs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PERPETUAL HELP	4560 PRINCESS ANNE ROAD VIRGINIA BEACH, VA 23462

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F 695	Continued From page 22 temperature 97.3, Heart rate 113, Respirations 20, O2 Sats on 89% 5 ½ Liter of O2 via face mask. On 10/13/21 at approximately 2:10 p.m. an observation was again made of Resident #20 at approximately se was with closed eyes, the O2 mask remained in place and the O2 concentrator remained at 5 1/2 Liters per minute. On 10/13/21 at approximately 3:20 p.m., the MDS coordinator presented an order for O2 at 5 1/2 liters per minute via facemask. At the time resident #20's O2 was increased to 5 ½ liter per minutes there was no order in the clinical record. On 10/14/21 at approximately 2:44 p.m., a progress note read; Brother came to visit this AM. Resident seen by Hospice NP and case manager today. New orders for resident to now receive routine morphine 0.75m and Lorazepam 0.5 Q3H. Also Atropine 2 drops Q3H. Residents O2 decreased to 4 Liters per hospice. Resident states she wants to be left alone. On 10/14/21 at approximately 2:45 p.m., an interview was conducted with the Hospice Nurse who stated they saw no improvement in the resident's respirations with the increased O2 therefore the oxygen had been decreased from 5.5 Liter per minute to 4 Liters per minute. On 10/14/21 at approximately 6:00 p.m., the above findings were shared with the Administrator and the Director of Nursing. They were afforded the opportunity to present additional information but; they did not.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PERPETUAL HELP	4560 PRINCESS ANNE ROAD VIRGINIA BEACH, VA 23462

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F 756	Continued From page 23	F 756		
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 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	F 756		11/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 756	Continued From page 24 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 clinical record review, staff interviews, and review of facility documents, the facility staff failed to ensure at least once a month a Licensed Pharmacist conduct a monthly Medication Regimen Review (MMR) for 5 of 19 residents (Resident #20, 13, 4, 6, and 2), in the survey sample. The findings included: 1. The facility staff failed to ensure Resident #20's drug regimen was reviewed at least once a month by a licensed pharmacist. Resident #20 was originally admitted to the facility 1/27/20 and readmitted 9/27/21 after an acute care hospital stay beginning 9/19/21. The current diagnoses included; COPD, COVID-19, diabetes and renal insufficiency. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/21/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #20's cognitive abilities for daily decision making were intact. The twelve month Pharmacist review for Resident #20 revealed an absence of a review for March 2021 and September 2021. An interview was conducted with The Director of Nursing on 10/14/21 at approximately 2:25 p.m. The Director of Nursing stated after reviewing the	F 756	F756 Corrective Action: - The Drug Regimen Reviews had been completed each month on resident□s #20, 13, 4, 6, and 2. - The pharmacy was notified that the records did not include a pharmacy progress note for resident #20 in March & September 2021, resident #13 in July & September 2021, resident #4, #6 and #2 in September 2021. Pharmacy will update medical records to reflect that the monthly reviews were completed on current residents that were identified, in the months stated. Identifying Other Potential Residents: - A 100% audit of all pharmacy reviews was completed to determine if there were any missing drug regimen reviews. Systemic Changes: - The documentation of the drug regimen reviews / recommendations will be reviewed by the DON or designee to ensure that each resident has had their completed reviews documented by the pharmacist, upon completion of the monthly review. Monitoring System: - An audit of the documentation of the resident□s drug regimen review will be completed by the DON or designee, monthly X3, to determine compliance with	

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F 756	Continued From page 25 clinical record that she didn't see the resident's drug regimen review for March 2021 and September 2021 but; the list of resident submitted to her from the Pharmacist for March 2021 and September 2021 indicated the resident was reviewed all twelve months. On 10/14/21 at approximately 6:00 p.m., the above findings were shared with the Administrator and the Director of Nursing. The Administrator stated the Pharmacist is required to document the monthly medication review in the electronic record and she understood the reviews were not all there but; she also had received documents from the Pharmacist indicating the monthly drug regimens were conducted as required. 2. The facility staff failed to ensure Resident #13's drug regimen was reviewed at least once a month by a licensed pharmacist. Resident #13 was originally admitted to the facility 12/16/19 and had never been discharged from the facility. The current diagnoses included; Parkinson's disease and an anxiety disorder. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 7/7/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #13's cognitive abilities for daily decision making were intact. The twelve month Pharmacist review for Resident #13 revealed an absence of a review for July 2021 and September 2021. An interview was conducted with The Director of	F 756	documentation of the completed resident reviews. - Audits will be reviewed by the Administrator or designee and the results of those audits will be submitted for review by our Quality Assurance Performance Improvement (QAPI) committee, monthly.	

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F 756	Continued From page 26	F 756		

Nursing on 10/14/21 at approximately 2:25 p.m. The Director of Nursing stated after reviewing the clinical record that she didn't see the resident's drug regimen review for July 2021 and September 2021 but; the list of resident submitted to her from the Pharmacist for July 2021 and September 2021 indicated the resident was reviewed all twelve months.

On 10/14/21 at approximately 6:00 p.m., the above findings were shared with the Administrator and the Director of Nursing. The Administrator stated the Pharmacist is required to document the monthly medication review in the electronic record and she understood the reviews were not all there but; she also had received documents from the Pharmacist indicating the monthly drug regimens were conducted as required.

3. Resident #4 was originally admitted to the facility on 04/27/21. Diagnosis for Resident #4 included but not limited to Type II Diabetes and Hypertension (high blood pressure). Resident #4's Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 07/21/21 coded the resident with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The MDS coded Resident #4 requiring extensive assistance of two with transfer, extensive assistance of one with toilet use, limited assistance of one with personal hygiene, dressing and bathing and supervision with set-up with bed mobility and eating for Activities of Daily Living (ADL) care.

Resident #4's comprehensive care plan documented the resident with history of hypertension. The goal set for the resident by the

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	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

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OUR LADY OF PERPETUAL HELP	4560 PRINCESS ANNE ROAD VIRGINIA BEACH, VA 23462

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F 756	Continued From page 27	F 756		

staff the resident will verbalize disease process and methods to control risk factors for hypertension and remain compliance with medication regimen. Some of the intervention/approaches to manage goal include but not limited resident provide monitor vital signs as ordered and encourage questions regarding disease and treatment and provide medications as ordered.

The comprehensive care plan also documented the resident with diabetes and is insulin dependent. The goal set for the resident by the staff the resident will have blood glucose ranging between 100-130 and absent of signs of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar). Some of the intervention/approaches to manage goal include but not limited documenting blood sugars in the Electric Medical Record (EMR), monitor blood sugar and provide medications as ordered.

Review of Resident #4's clinical record revealed the following pharmacy progress notes dated 05/04/21, 06/07/21, 07/08/21 and 08/09/21. The clinical record did not include a pharmacy progress note for September 2021.

An interview was conducted with the Administrator and Director of Nursing (DON) on 10/14/21 at approximately 4:00 p.m. When asked if Resident #4's clinical record provided evidence that the resident had a pharmacy review in September 2021, the Administrator replied, "No, the resident's chart was not audited to determine if the pharmacy documented in the progress note for September 2021 but we will start checking from now on."

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	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

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F 756	Continued From page 28 Definitions: -Type II Diabetes is an impairment in the way the body regulates and uses sugar (glucose) as a fuel (https://www.mayoclinic.org/diseases-conditions/type-2-diabetes/symptoms-causes/syc). 4. Resident #6 was admitted to the facility on 01/25/21. Diagnosis for Resident #6 included but not limited to Congestive Heart Failure (CHF) and Sarcoidosis of the lung. Resident #6's Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 09/22/21 coded the resident with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The MDS coded the resident requiring extensive assistance of one with bathing, limited assistance of one with bed mobility, dressing toilet use and personal hygiene and independent with transfer and eating for Activities of Daily Living (ADL) care. Resident #6's comprehensive care plan documented the resident with respiratory distress due to diagnosis of Sarcoidosis of the lung and CHF. The goal set for the resident by the staff the resident will maintain current health status with no sign and symptoms of respiratory distress. Some of the intervention/approaches to manage goal include but not limited to maintain head of bed (HOB) at least 45 degrees as needed and as tolerated by resident to facilitate breathing, pulmonary consult and administer medications as ordered. Review of Resident #6's clinical record revealed the following pharmacy progress notes dated	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

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F 756	Continued From page 29 02/05/21, 03/06/21, 04/14/21, 05/04/21, 06/07/21 and 07/08/21. The clinical record did not include a pharmacy progress note for September 2021. An interview was conducted with the Administrator and Director of Nursing (DON) on 10/14/21 at approximate 4:00 p.m. When asked if Resident #4's clinical record provided evidence that the resident had a pharmacy review in September 2021, the Administrator replied, "No, the resident's chart was not audited to determine if the pharmacy documented in the progress note for September 2021 but we will start checking from now on." On 10/14/21 at approximately 6:20 p.m., the facility provided the following email dated 10/14/21 at 6:07 p.m., from (name of pharmacy) that read: "I understand from our account manager that the pharmacy consultations were not documented by the consultant pharmacist in the EMR for (name of facility). The pharmacist has since retired. To correct the documentation (name of pharmacist) can enter late entries stating the medication regimen reviews were done, including the date done, by whom (the note will show him as the author but he will reference to (name of previous pharmacist), and whether any irregularities noted." The Administrator, Assistant Administrator, Director of Nursing and Dietary Manager were informed of the finding during a debriefing on 10/14/21 at approximately 6:15 p.m. The facility staff did not present any further information about the findings. Definitions: -Congestive Heart Failure occurs when the heart	F 756		

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	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

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F 756	Continued From page 30	F 756		

muscle doesn't pump blood as well as it should. When this happens, blood often backs up and fluid can build up in the lungs, causing shortness of breath (https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms-causes/syc).

-Sarcoidosis of the lung is a disease characterized by the growth of tiny collections of inflammatory cells (granulomas) in any part of your body - most commonly the lungs and lymph nodes. But it can also affect the eyes, skin, heart and other organs (https://www.mayoclinic.org/diseases-conditions/sarcoidosis/symptoms-causes).
5. The facility staff failed to provide drug regimen reviews once a month by a licensed pharmacist.

Resident #2 was admitted to the facility on 06/04/2019 with diagnoses which included osteoporosis, hypertension, anxiety disorder, insomnia, dementia and anemia. A review of the clinical records did not include a pharmacy review for the month of September 2021.

A physician order dated 10/14/2021 indicated Resident #2 was receiving the following medications and treatments: "Provide shower/bath 2 x weekly, provide regular diet, admit to home hospice care, administer flu vaccine annually between October 1 and October 31.

Medications provided to Resident #2 included: Synthroid tablet 112 mcg; amt 1 tablet oral once day (06:00 AM), Lexapro tablet 10 mg 1 tablet once a day (09:00 AM), trazaodone 50 mg give one tab PO QHS routinely at bedtime (07:00 PM)c, Ultracet -Schedule IV tablet 37.5-325 mg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

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F 756	Continued From page 31 one tab four times a day (9:00 AM, 01:00 PM, 05:00 PM, 09:00 PM), clonazepam Schedule IV tablet;v 0.5 mg; 1 tab oral three times a day (06:00 AM, 02:00 PM, 09:00 PM), and Depakote Sprinkles capsule 125 mg 1 cap oral BID for mood/behavioral disturbance twice a day (09:00 AM, 05:00 PM). Treatments: LPN to perform weekly skin and nail assessment on Friday 7-3 shift. Once a day on Friday (07:30 AM-03:30 PM). Monitor S/T (skin tear) 10/12/21 for signs and symptoms of infection Q shift until healed. Every shift, days, Evenings, Nights.' During an interview on 10/14/21 at 5:00 P.M. with the administrator she stated, she was aware that the pharmacy did not review all of the resident pharmacy reviews for the month of September 2021. A Pharmacy Policy revised 06/11/21 indicated: " Medication Regimen Review: This Policy 9:1 sets forth procedures relating to the medication regimen review (MRR) Procedure: 1. The Consultant Pharmacist will conduct MRR's if required under a Pharmacy Consultant Agreement and will make recommendations based on the information available in the residents' health record 5. The facility should independently review each resident's medication regimen directly from the resident's medical chart and with Interdisciplinary Care Team members, resident or Responsible Party, as needed.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		11/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PERPETUAL HELP	4560 PRINCESS ANNE ROAD VIRGINIA BEACH, VA 23462

(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 758	Continued From page 32 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PERPETUAL HELP	4560 PRINCESS ANNE ROAD VIRGINIA BEACH, VA 23462

(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 758	Continued From page 33 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews and facility documentation, the facility staff failed to do a Gradual Dose Reduction (GDR) for 1 out of 19 residents, Resident #6 in the survey sample who was receiving a PRN (as needed) psychotropic medication (Xanax). The findings included: The facility staff failed to ensure an as needed psychotropic medication (Xanax) was limited to 14 days for Resident #6. The physician or Nurse Practitioner (NP) did not do an evaluation of Resident #6 to extend the psychotropic medication pass 14 days without documenting the rational and duration in the resident's medical record. Resident #8 was admitted to the nursing facility on 01/25/21. Diagnosis for the resident included but not limited to Depression. Resident #8's Minimum Data Set (MDS-an assessment protocol) a quarter assessment with an Assessment Reference Date of 09/22/21 coded Resident #8's Brief Interview for Mental Status (BIMS) scored a 14 out of a possible score of 15 indicating no cognitive impairment for daily decision-making.	F 758	F758 Corrective Action: - The order for PRN Xanax on resident #6 was discontinued. - Education was provided to the prescribing practitioners on the need for a 14-day limit to any PRN psychotropic medication. - Education was provided to the licensed nurses to review the need for a 14-day limit on any PRN psychotropic medication, as they are taking orders from practitioners. Identifying Other Potential Residents: - A 100% audit of all resident□s orders was completed to determine if there were orders for PRN psychotropic medications, without a 14-day limit and stop date. Systemic Changes: - Orders for PRN psychotropics will not be entered into our eMAR system, without the stop date, from the ordering practitioner. Monitoring System: - An audit of residents with orders for PRN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 34 The MDS coded the resident extensive assistance of one with bathing, limited assistance of one with bed mobility, dressing and toilet use, and no assistance required with transfer or eating with Activities of Daily (ADL) care. The MDS under section "E" (Behaviors), coded Resident #8 for not exhibiting physical and verbal behaviors directed towards others 1-3 days each week. The resident was also coded for not having behaviors symptoms not directed toward others. Under section (E0800), for rejection of care was coded for not having behavior occurred 1-3 days each week. Resident #8's person-centered comprehensive care plan with a revision date 09/29/21 did not include the use of psychoactive medication Xanax. The physician Order Sheet (POS) for October 2021 included the following order: Xanax 0.25 mg daily as needed starting 04/26/21. 1. Review of May 2021 Medication Administration Record (MAR) revealed, PRN Xanax was administered on the following days: 05/13/21. 2. Review of June 2021 Medication Administration Record (MAR) revealed, PRN Xanax was administered on the following days: 06/01 and 06/22/21. On 10/14/21 at approximately 3:00 p.m., an interviewed was conducted with the Administrator and Director of Nursing (DON). The DON said the Xanax was ordered when Resident #6's son passed away. The DON reviewed Resident #6's Xanax order then stated, "The PRN Xanax order	F 758	psychotropic medications will be completed by the DON or designee, weekly X4 then monthly X3, to determine compliance with the 14-day limit and stop date by the physician. - Audits will be reviewed by the Administrator or designee and the results of those audits will be submitted for review by our Quality Assurance Performance Improvement (QAPI) committee, monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

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F 758	Continued From page 35 should have been written for 14 days then re-evaluated by the physician." The Administrator, Assistant Administrator, Director of Nursing and Dietary Manager were informed of the finding during a debriefing on 10/14/21 at approximately 6:15 p.m. The facility staff did not present any further information about the findings. A facility's policy titled Psychopharmacologic Medication -revision date 11/28/17. The policy will develop and maintain a system for assuring the proper use and monitoring of psychopharmacologic agents. Residents on psychopharmacologic agents require a physician's order for an appropriate diagnosis and a treatment plan. Procedure: Initiation of Psychopharmacologic Drug Therapy per physician read in part:as needed antipsychotic agent should only be used: 4. PRN for psychotropic medications are limited to 14 days unless the attending physician or prescribing practitioner believes it is necessary for the PRN order to extend beyond 14 days, he/she will document the rational in the resident's medical record and indicate the duration for the PRN order. Definitions: -Xanax is used to treat anxiety disorder and anxiety caused by depression (https://www.drugs.com/xanax.html).	F 758		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment.	F 838		11/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PERPETUAL HELP	4560 PRINCESS ANNE ROAD VIRGINIA BEACH, VA 23462

(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 838	Continued From page 36 The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical);	F 838		

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	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

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F 838	Continued From page 37 (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and the facility document review, the facility staff failed to document an ongoing facility wide risk assessment to include their current population of two (2) COVID-19 residents. The findings included: The facility had an outbreak of COVID-19 in the facility starting on 08/18/21. Resident cumulative COVID-19 cases totaled nine (9) with three (3) COVID-19 related deaths. Staff cumulative COVID-19 cases totaled ten (10), all staff recovered and no deaths. At the time of the survey, there were two (2) residents that were currently positive for COVID-19. The facility provided a document titled Infection	F 838	F838 Corrective Action: - On 10-15-2021, the Facility Risk Assessment was updated to include the covid positive residents. Identifying Other Potential Residents: - All residents have a potential to be affected. Systemic Changes: - The Facility Risk Assessment will be reviewed monthly to identify changes to be made in the resident population statistics. Monitoring System: - Monthly reviews, with any changes will	

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	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

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OUR LADY OF PERPETUAL HELP	4560 PRINCESS ANNE ROAD VIRGINIA BEACH, VA 23462

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F 838	Continued From page 38 Control Assessment and Response (ICAR) recommendation report dated 09/30/21 from the Virginia Beach Epidemiologist. The document included but not limited to the following information: "work with Virginia Department of Health (VDH) to conduct "Train the Trainer" exercises to increase the proportion of N-95 fit-tested employees, discontinue the re-use of mask while outside of crisis strategy and discontinue use of red biohazard bags for COVID-19 isolation waste." An interview was conducted with the Administrator on 10/14/21 at approximately 3:30 p.m. The Administrator was asked if the facility Wide-Assessment Plan was updated to include the facility's current resident population, the Administrator replied, "Yes." The facility Wide-Assessment Plan was reviewed with the Administrator. The assessment revealed the following documentation under special treatments: zero (0) for the number of residents who were on isolation or quarantine for active infectious disease. After the assessment was reviewed with the Administrator, the Administrator stated the facility assessment plan does not include the two (2) COVID-19 positive residents as part of the current resident population. She said the assessment plan is reviewed annual and do I realize the Facility Assessment is an ongoing assessment and must be revised as changes occur within the facility. The Administrator said the Facility Assessment Plan should have included the two (2) positive cases of COVID-19 as part of the current resident population. The Administrator, Assistant Administrator, Director of Nursing and Dietary Manager were informed of the finding during a debriefing on	F 838	be presented to and reviewed by the Administrator or designee, monthly x 3 months. Results will be submitted for review by our Quality Assurance Performance Improvement (QAPI) committee, monthly.	

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	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

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F 838	Continued From page 39 10/14/21 at approximately 6:15 p.m. The facility staff did not present any further information about the findings. The facility provided the Emergency Preparedness and Evacuation Plan with a revision date of 10/14/21. The purpose of an evacuation plan in this facility is to ensure the ongoing safety of our resident population if the facility and its management are presented with circumstance that provide untenable in the pursuit of continued care and rendering of service or pose an immediate threat to the life safely and well-being of facility occupants. Procedure: This plan will incorporate the following requirements: 7. Documentation of the facility's risk assessments and associated strategies. 11. Documentation that the policies and procedures were developed based on the facility and community-based risk assessment and communication plan, utilizing an all-hazards approach.	F 838		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		11/28/21

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F 842	Continued From page 40 §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when	F 842		

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	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

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F 842	Continued From page 41 there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews and facility document review the facility staff failed to ensure an accurate medical record for 1 of 19 residents in the survey sample to include applying and removing bilateral hand rolls for 8 days with severe hand contractures, Resident #11. The findings included: Resident #11 was admitted to the facility on 8/18/21 with diagnoses to included but not limited to Bilateral Upper Extremity Contractures, Alzheimer's Disease and Osteoporosis. Resident #11's most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date (ARD) of 8/25/21. The Brief Interview for Mental Status (BIMS) was not completed because the resident was coded as rarely or never understood. Resident #11 was	F 842	F842 Corrective Action: - Education was provided to LPN #1 on the necessity of documentation accuracy, in the resident□s medical record. - Education was provided for the licensed nurses to review the importance of completing thorough and accurate documentation in the resident□s medical records. Identifying Other Potential Residents: - All residents with orders for the application of splints have the potential to be affected. Systemic Changes: - The Charge Nurses will perform accurate and thorough documentation, following the completion of splint applications, as ordered by the physician.	

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	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

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F 842	Continued From page 42 coded as having long and short term memory problems and severely impaired for task of daily living. Under Section G Functional Status G0400. Functional Limitation in Range of Motion Resident #11 was coded as having Upper Extremity Impairment on both sides. On 10/13/21 at 10:37 a.m., Resident #11 was observed in a private room lying in bed with her personal sitter at her side. The resident was severe bilateral hand contractures with to the point that her fingers were pressing into the palm of her hands. There was signage instructions with a diagram of hand rolls on the closet door which read : 6 to 8 hours/day during daytime. Resident #11 was observed with no hand rolls in place to either hand. On 10/13/21 at 11:45 a.m., Resident #11 was observed still lying in bed with no hand rolls in place to either hand. On 10/13/21 at 1:20 p.m., Resident #11 was once again observed still lying in bed with no hand rolls in place to either hand. 10/13/21 at 1:25 p.m., an interview was conducted with Resident #11's personal sitter. Resident #11's personal sitter was asked about the resident's hand rolls. The personal sitter stated, "They haven't been on today. It's been almost a week since I've seen them on her, they may be in laundry. The staff usually put them on her, but they come off a lot. The therapy lady that made them for her is no longer here. I'm here with her usually everyday from 7 am to 3 p.m.." The personal sitter found one hand roll in resident's top dresser drawer, but was unable to locate the second one.	F 842	Monitoring System: - An audit of resident□s documentation for those with orders for splints will be completed, by the DON or designee, weekly X4 then monthly X3, to ensure accurate and complete documentation has occurred. - Audits will be reviewed by the Administrator or designee and the results of those audits will be submitted for review by our Quality Assurance Performance Improvement (QAPI) committee, monthly.	

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	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

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F 842	Continued From page 43	F 842		

Resident #11's Physical Orders were reviewed and are documented in part, as follows:

Use bilateral hand rolls during daytime. ON at 0800 and OFF at 1400 (2 p.m.) Special Instructions: Contractions. Start Date: 11/30/2020.

Resident #11's Comprehensive Care Plan revised on 9/4/21 was reviewed and is documented in part, as follows:

Problem: Category: ADL (Activities of Daily Living) Functional/Rehabilitation Potential Name (Resident #11) has limited in range of motion related to contractures in bilateral upper and lower extremities.

Approach: Inspect skin before and after hand rolls. Observe and report any red or broken areas, Refer to diagram for placement.

Resident #11's Medication Administration Record (MAR) dated 10/1/21 through 10/14/21 was reviewed and is documented in part, as follows:

Order: Use bilateral hand rolls during daytime. ON at 0800 and OFF at 14:00 (2:00 p.m.).
Frequency: Twice a day.
Special Instructions: Contractures.
Start/End Date: 11/3/2020-Open Ended.

From 10/6/21 through 10/13/21 the above order was signed off as being completed by Licensed Practical Nurse (LPN) #1 on Resident #11's MAR.

On 10/14/21 at 3:10 p.m., a phone interview was conducted with LPN #1 regarding Resident #11's

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	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

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F 842	Continued From page 44	F 842		

bilateral hand rolls. LPN #1 was asked about if she applied and removed Resident #11's bilateral hand rolls on her shift from 10/6/21 through 10/13/21. LPN #1 stated, "I just recently starting working on the day shift, I used to work nights. I was under the impression that the private sitter was applying them during the day when she came in and taking them off right before she left each day. I never put them on or removed them." LPN #1 was asked if Resident #11's MAR was accurate from 10/6/21 through 10/13/21 regarding the bilateral hand rolls that she had signed off as completing. LPN #1 stated, "No, I didn't put them on her or remove them. When I signed it off on the MAR I should have assured that the splints were on."

On 10/14/21 at 3:45 p.m., an interview was conducted with the Director of Nursing (DON) regarding Resident #11's inaccurate MAR from 10/6/21 through 10/13/21 for applying and removing her bilateral hand rolls. The DON stated, "It is the licensed nurse's responsibility to ensure what they are documenting in the clinical record is accurate. She (LPN #1) did tell me yesterday that she thought the sitter was applying the splints and removing them each day."

The facility policy titled "Electronic Medical Record" revised 1/5/2015 was reviewed and is documented in part, as follows:

Purpose: To ensure complete, accurate, and timely electronic medical records.
Definition of Terms: 1. Medical Record: The chronological documentation of health care and medical treatment given to a patient by professional members of the health care team. It is an accurate, prompt recording of their

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	49E256	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PERPETUAL HELP	4560 PRINCESS ANNE ROAD VIRGINIA BEACH, VA 23462

(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 842	Continued From page 45 observations including relevant information about the patient, the patient's progress and the results of treatment. Procedure: 2. Entries must be accurate, relevant, timely, and complete. On 10/14/21 at 5:57 p.m., a Pre-Exit Debriefing was held with the Administrator, the Assistant Administrator, the Director of Nursing and the Food Services Director were the above information was shared. Prior to exit no further information was shared.	F 842		