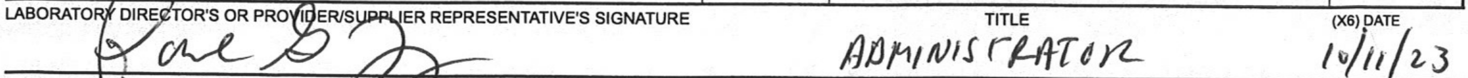
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495311	A. BUILDING ______ B. WING ______	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF HOPE HEALTH CENTER	13700 NORTH GAYTON ROAD RICHMOND, VA 23233

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 9/26/2023 through 9/27/2023. Two complaints were investigated during the survey (VA00059767- unsubstantiated with a related deficiency; and VA00059540- unsubstantiated with a related deficiency). Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 75 certified bed facility was 72 at the time of the survey. The survey sample consisted of six current resident reviews and two closed record reviews.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include	F 607	**F 607 Develop/Implement Abuse/Neglect Policies** 1. Resident #1 no longer resided in the facility. 2. An audit of current resident/ family grievance forms and email communication was conducted by the Executive Director to ensure that any allegations of abuse were investigated and reported according to the facility abuse policy. 3. Education was provided to the Administrator and Assistant Administrator regarding the facility abuse policy for investigating and reporting an allegation of abuse. 4. An audit will be accomplished weekly x 3 months by the Regional Director to ensure the proper implementation of the facility abuse policy for investigating and reporting an allegation of abuse.	10/17/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 10/11/23



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.

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 ______	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF HOPE HEALTH CENTER	13700 NORTH GAYTON ROAD RICHMOND, VA 23233

(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 607	Continued From page 1 but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility failed to implement their abuse policy for investigating and reporting an allegation of abuse when reported to the facility staff for one of eight residents in the survey sample, Resident #1. The findings include: For Resident #1 (R1), the facility staff failed to implement their abuse policy to investigate and report an allegation of abuse that was reported to the executive director via email on 9/22/2023. The facility policy "Right to Dignity Freedom from Abuse Neglect and Exploitation" revised 2/13/2023 documented in part, "... The Administrator or designee will immediately make an oral or written report of the allegation or of the first suspicion of abuse to the local social services department, to the adult protective services unit and to other agencies in accordance with established procedures. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, and misappropriation of resident's property, are reported immediately, but not later	F 607	5. Compliance Date: 10/17/2023.	

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 ______	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF HOPE HEALTH CENTER	13700 NORTH GAYTON ROAD RICHMOND, VA 23233

(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 607	Continued From page 2 than 2 hours after allegation is made if the events that cause the allegation involve abuse or results in serious bodily injury; or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The Administrator will report the results of the investigation within five (5) working days of the first report of the incident... The Administrator or Assistant Administrator is responsible for the coordination of a timely and thorough internal investigation. The investigation will include, but is not limited to, a physical assessment of the resident; resident, staff and witness interviews, reportable incident form and chart reviews as necessary, and/or psychosocial assessment if warranted. Adult Protective Services, the local Ombudsman, and/or police department will be contacted to assist in the investigation as appropriate. The Administrator or designee will complete an investigative report summarizing the internal investigation. The investigative report will include the individuals involved; a description of the occurrence including date, location and description of the incident; injury to the resident, immediate corrective action taken, mechanisms in place to prevent recurrence and documentation of report to appropriate agencies. If needed, the Administrator or designee will submit this investigative report to the Office of License and Certification within 5 working days of the initial report..." R1 no longer resided at the facility and could not be observed or interviewed during the survey dates. The record was reviewed as a closed record. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment	F 607		

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 ____	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF HOPE HEALTH CENTER	13700 NORTH GAYTON ROAD RICHMOND, VA 23233

(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 607	Continued From page 3 reference date) of 8/25/2023, the resident scored 12 out of 15 on the BIMS (brief interview for mental status) assessment, which indicated the resident was moderately impaired for making daily decisions. Review of the facility synopsis of events from 4/1/2023 through the present failed to evidence any events for R1. Review of R1's clinical record failed to evidence documentation of allegations of abuse by R1 or R1's family. On 9/27/2023 at 11:40 a.m., an interview was conducted with ASM (administrative staff member) #1, the executive director. ASM #1 stated that they had several meetings with R1's son to discuss their care and concerns when they were at the facility. He stated that R1's son had discussed concerns regarding obtaining medical records, having to pay a fee for the records, call bell response, R1's medications, the resident's room not being clean, the attitudes of some of the CNA's (certified nursing assistants) and the end of skilled services at the facility. When asked if he received any email correspondence from R1's son regarding concerns, he stated that he had not received any directly from the son but had received an email from (Name of Senator's) office on 9/22/2023 which had concerns that R1 was being discharged for retaliation purposes. He stated that he did not go through the email completely because the parts that he saw were saying that they were deceptive and covering up the truth. When asked about the allegation of being shaken after pushing the call bell on 9/15/2023, ASM #1 stated that he was not aware of any allegations of R1 being shaken by anyone	F 607		

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 _____	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF HOPE HEALTH CENTER	13700 NORTH GAYTON ROAD RICHMOND, VA 23233

(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 607	Continued From page 4	F 607		

and he did not believe that it took place in any way, shape or form but he would have reported the allegation if it were brought to his attention.

On 9/27/2023 at 12:45 p.m., ASM #1 provided a printed copy of the email addressed to them dated 9/22/2023 1:01 p.m. which documented in part, "... Attached is correspondence from (Name of R1's son) regarding his mother, (Name of R1), who was a resident at (Name of facility). We are forwarding this correspondence as a courtesy to the family..." The attached documented in part, "Statement of Problem. Patient/Resident: (Name of R1). I am writing to once again formally communicate my horror and concerns of multiple incidents of elder abuse, flagrant violations of Resident's rights (per the Code of Federal Regulation), and medical malpractice that my helpless (age and name of R1), has experienced while in the care of you and your staff at (Name of facility)... b. When staff did respond to her (in the absence of advocates), they spoke to her in a threatening and aggressive manner saying disrespectful things to her like: "What to you want now?" or "What is it now?". This was obviously done to intimidate her and make her feel scared to push the call button... e. My mom told me of one incident on 9/15/23 where she said: "A lady grabbed me and shook me one evening after I pushed the call." That is clear criminal assault... 6. Physical assault from caregivers. She told me that a lady grabbed me and shook me after I pushed the call button for help. Unexplained cuts, bruises, and injuries..."

On 9/27/2023 at 1:20 p.m., ASM #1, the executive director was made aware of the findings. ASM #1 stated that they did not send a report because the resident was already

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 ______	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF HOPE HEALTH CENTER	13700 NORTH GAYTON ROAD RICHMOND, VA 23233

(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 607	Continued From page 5 discharged from the facility when they received the email and they did not read it completely. He stated that they had met with the son and the long term care ombudsman on the day of discharge and no one had reported any allegations of abuse to them at that time and they would have reported it if they had. No further information was provided prior to exit. As of 10/2/2023, the State Agency had not received notification from the facility staff of the allegation of abuse.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609	**F 609 Reporting of Alleged Violation** 1. Resident #1 no longer resided in the facility. The Administrator provided the surveyor with a copy of the emailed document containing the allegation of abuse. 2. An audit of current resident/ family grievance forms and email communication was conducted by the Administrator to ensure that any allegations of abuse were investigated and reported to the State Survey Agency. 3. Education was provided to the Administrator and Assistant Administrator regarding the requirement to report allegations of abuse to the State Survey Agency. 4. An audit will be accomplished weekly x 3 months by the Regional Director to ensure the proper reporting of allegations of abuse to the State Survey Agency. 5. Compliance Date: 10/17/23.	10/17/23

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 ___	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF HOPE HEALTH CENTER	13700 NORTH GAYTON ROAD RICHMOND, VA 23233

(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 609	Continued From page 6 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility failed to report an allegation of abuse to the State Agency for one of eight residents in the survey sample, Resident #1. The findings include: For Resident #1 (R1), the facility staff failed to report an allegation of abuse to the State Agency that had been reported to the executive director via email on 9/22/2023. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/25/2023, the resident scored 12 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. R1 no longer resided at the facility and could not be observed during the survey dates. The record was reviewed as a closed record. Review of the facility synopsis of events from 4/1/2023 through the present failed to evidence any events for R1. Review of R1's clinical record failed to evidence documentation of allegations of abuse by R1 or	F 609		

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 ____	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF HOPE HEALTH CENTER	**13700 NORTH GAYTON ROAD RICHMOND, VA 23233**

(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 609	Continued From page 7	F 609		

R1's family.

On 9/27/2023 at 11:40 a.m., an interview was conducted with ASM (administrative staff member) #1, the executive director. ASM #1 stated that they had several meetings with R1's son to discuss their care and concerns when they were at the facility. He stated that R1's son had discussed concerns regarding obtaining medical records, having to pay a fee for the records, call bell response, R1's medications, the resident's room not being clean, the attitudes of some of the CNA's (certified nursing assistants) and the end of skilled services at the facility. When asked if he received any email correspondence from R1's son regarding concerns, he stated that he had not received any directly from the son but had received an email from (Name of Senator's) office on 9/22/2023 which had concerns that R1 was being discharged for retaliation purposes. He stated that he did not go through the email completely because the parts that he saw were saying that they were deceptive and covering up the truth. When asked about the allegation of being shaken after pushing the call bell on 9/15/2023, ASM #1 stated that he was not aware of any allegations of R1 being shaken by anyone and he did not believe that it took place in any way, shape or form but he would have reported the allegation if it were brought to his attention.

On 9/27/2023 at 12:45 p.m., ASM #1 provided a printed copy of the email sent to them dated 9/22/2023 1:01 p.m. which documented in part, "... Attached is correspondence from (Name of R1's son) regarding his mother, (Name of R1), who was a resident at (Name of facility). We are forwarding this correspondence as a courtesy to the family..." The attached documented in part,

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 ______	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF HOPE HEALTH CENTER	13700 NORTH GAYTON ROAD RICHMOND, VA 23233

(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 609	Continued From page 8 "Statement of Problem. Patient/Resident: (Name of R1). I am writing to once again formally communicate my horror and concerns of multiple incidents of elder abuse, flagrant violations of Resident's rights (per the Code of Federal Regulation), and medical malpractice that my helpless (age and name of R1), has experienced while in the care of you and your staff at (Name of facility)... b. When staff did respond to her (in the absence of advocates), they spoke to her in a threatening and aggressive manner saying disrespectful things to her like: "What to you want now?" or "What is it now?". This was obviously done to intimidate her and make her feel scared to push the call button... e. My mom told me of one incident on 9/15/23 where she said: "A lady grabbed me and shook me one evening after I pushed the call." That is clear criminal assault... 6. Physical assault from caregivers. She told me that a lady grabbed me and shook me after I pushed the call button for help. Unexplained cuts, bruises, and injuries..." The facility policy "Right to Dignity Freedom from Abuse Neglect and Exploitation" revised 2/13/2023 documented in part, "... The Administrator or designee will immediately make an oral or written report of the allegation or of the first suspicion of abuse to the local social services department, to the adult protective services unit and to other agencies in accordance with established procedures. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, and misappropriation of resident's property, are reported immediately, but not later than 2 hours after allegation is made if the events that cause the allegation involve abuse or results in serious bodily injury; or not later than 24 hours	F 609		

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 ______	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF HOPE HEALTH CENTER	13700 NORTH GAYTON ROAD RICHMOND, VA 23233

(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 609	Continued From page 9 if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. The Administrator will report the results of the investigation within five (5) working days of the first report of the incident..." On 9/27/2023 at 1:20 p.m., ASM #1, the executive director was made aware of the findings. ASM #1 stated that they did not send a report because the resident was already discharged from the facility when they received the email and they did not read it completely. He stated that they had met with the son and the long term care ombudsman on the day of discharge and no one had reported any allegations of abuse to them at that time and they would have reported it if they had. No further information was provided prior to exit. As of 10/2/2023, the State Agency had not received notification from the facility staff of the allegation of abuse.	F 609		
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.	F 657	**F 657 Care Plan Timing and Revision** 1. Resident #1 no longer resided in the facility. 2. A 100% audit of comprehensive care plans for current residents was conducted by the MDS Director to ensure the accuracy of the comprehensive care plan. 3. The nursing staff were educated on developing the comprehensive care plan.	10/17/23

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 ___	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF HOPE HEALTH CENTER	13700 NORTH GAYTON ROAD RICHMOND, VA 23233

(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 10 (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 review, staff interview and facility document review, it was determined the facility staff failed to review and revise the care plan for one of eight residents in the survey sample, Resident #1. The findings include: For Resident #1 (R1), the facility staff failed to review and revise the comprehensive care plan to evidence resident-centered preferences for care. On the most recent MDS (minimum data set) assessment, an admission assessment with an ARD (assessment reference date) of 8/25/2023, the resident scored 12 of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. Section G documented R1 requiring extensive assistance of one person for dressing, bathing and personal hygiene and extensive assistance of two persons	F 657	4. An Audit will be completed by the Administrator/designee monthly x three months to ensure the accuracy of the comprehensive care plan. The findings of the audit will be submitted by the Administrator/Designee to QAPI for review and recommendation. 5. Compliance Date: 10/17/23.	

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 ______	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF HOPE HEALTH CENTER	13700 NORTH GAYTON ROAD RICHMOND, VA 23233

(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 11	F 657		

for toileting.

The comprehensive care plan for R1 documented in part, "Problem Start Date: 08/28/2023. Category: ADLs (activities of daily living) Functional Status/Rehabilitation Potential. I have alteration in ADL function due to weakness associated with multiple compression fx's (fractures). Risk factors include: impaired mobility, anxiety. Created: 08/28/2023." The care plan failed to evidence resident-centered choices regarding preference for no male caregivers due to religious choices.

The dietary communication orders documented, "Muslim diet. 8/21/2023." and "No Pork. 9/2/2023."

The progress notes for R1 documented in part, "09/06/2023 01:17 pm Care plan meeting was held on Friday, September 1, 2023, with son, (Name of son), (Name of the executive director), (Name of the assistant director of nursing), (Name of occupational therapist), director of rehab services, and this writer [social worker]. Resident did not attend. Concerns and facility routines were discussed with son..."

Review of the clinical record failed to evidence documentation of the resident's preference for no male caregivers due to religious choices.

Review of the as worked schedules for nursing dated 8/21/2023-9/20/2023 documented female CNA (certified nursing assistant) staff assigned to care for R1 each shift.

On 9/26/2023 at 3:46 p.m., an interview was conducted with CNA (certified nursing assistant)

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 ______	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF HOPE HEALTH CENTER	13700 NORTH GAYTON ROAD RICHMOND, VA 23233

(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		

#2, scheduling coordinator. CNA #2 stated that R1 and their son had requested that only women provide care for them due to their religion. She stated that they did not have many male CNA's and that they communicated the request to the nurses verbally so that none were assigned to care for them.

On 9/26/2023 at 4:36 p.m., an interview was conducted with RN (registered nurse) #1, MDS coordinator. RN #1 stated that the purpose of the care plan was to identify the resident needs and used to provide individualized care to the residents. She stated that the comprehensive care plan was completed by MDS and included the care areas that were triggered by the MDS assessment and the interdisciplinary team updated the care plan as needed. She stated that she would expect that R1's preference to have female caregivers be addressed on the care plan and would expect the care plan to address cultural perspectives.

On 9/27/2023 at 11:18 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that they worked with R1 often. LPN #3 stated that they did not have any male CNA's working their shift so R1 only had female CNA's taking care of them. She stated that there was one shift when R1 was assigned a male nurse and the nursing supervisor had handled the situation accordingly.

On 9/27/2023 at 11:25 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that the care plan was developed by the MDS staff and nursing could add to it as needed. She stated that R1 and R1's son had requested

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 ____	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF HOPE HEALTH CENTER	13700 NORTH GAYTON ROAD RICHMOND, VA 23233

(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 13 to only have female caregivers and they had accommodated the request by assigning only females. She stated that they would expect to see the preference to have only female caregivers addressed on the care plan. The facility policy, "Comprehensive Person-Centered Care Planning" revised 11/15/2017 documented in part, "...All reasonable efforts will be made to incorporate the resident's personal and cultural preferences in developing goals of care..." On 9/27/2023 at 1:20 p.m., ASM #1, the executive director, was made aware of the findings. No further information was obtained prior to exit.	F 657		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced	F 711	**F 711 Physician Visits – Review Care/Notes/Other** 1. Resident # 2 no longer resided in the facility. 2. A 100% audit of physician visits and associated notes for current residents was conducted by the Administrator. 3. The Physician was educated regarding the requirement to write, sign, and date a progress note for each resident visit. 4. An audit will be completed weekly x 3 months by the Administrator/designee to ensure the physician has written, signed, and dated a note for each resident visit. The findings of the audit will be submitted monthly by the Administrator/Designee to QAPI for review and recommendation.	10/17/23

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 ____	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF HOPE HEALTH CENTER	13700 NORTH GAYTON ROAD RICHMOND, VA 23233

(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 711	Continued From page 14 by: Based on staff interview and clinical record review, it was determined that the physician failed to write, sign and date a progress note during a visit for one of eight residents in the survey sample; Resident #2. The findings include: Resident #2 was most recently admitted on 6/30/23 and discharged to home on 8/3/23. The resident had diagnoses of, but not limited to, high blood pressure and atrial fibrillation (a-fib). The resident was coded on the most recent MDS (Minimum Data Set), an admission assessment dated 7/5/23 coded the resident as being cognitively intact in ability to make daily life decisions, scoring a 13 out of a possible 15 on the BIMS (Brief Interview for Mental Status). A review of the clinical record revealed the resident was admitted on 6/30/23. The hospital discharge orders included Metoprolol Tartrate 100 mg (milligrams) twice daily (1). Admission orders to the facility dated 6/30/23 included Metoprolol Tartrate 100 mg, twice daily. A review of the clinical record revealed blood pressure readings were obtained from admission on 6/30/23 through 7/14/23. The lowest reading was on 6/30/2023 at 02:58 PM and was documented as 97/52. The highest reading was on 7/03/2023 at 01:31 AM and was documented as 133/70. On 7/14/23 the dose was changed and an order	F 711	5. Compliance Date: 10/17/23.	

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 ______	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF HOPE HEALTH CENTER	13700 NORTH GAYTON ROAD RICHMOND, VA 23233

(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 711	Continued From page 15	F 711		

was written for Metoprolol Tartrate 25 mg once daily.

A review of the clinical record failed to reveal any documentation by the physician regarding her assessment and rationale for lowering the dose of this medication.

On 9/26/23 at 1:50 PM, an interview was conducted with ASM #3 (Administrative Staff Member), the physician. She stated that she reviewed the blood pressures and noted that they were trending low, so she talked to the resident, who was awake, alert and oriented, regarding the blood pressure trending low, and wanted to reduced the dose of Metoprolol. She stated that the resident was in agreement. She stated that even after lowering the dose, the resident's blood pressure remained under control and was still low at times but she did not want to lower the dose any further because the resident needed the medication for a-fib. She stated that she probably should have wrote a note about her assessment of the resident's blood pressures and clinical decision to lower the dose.

On 9/27/23 at 11:37 AM, ASM #1 the Administrator was made aware of the findings. He stated that there was not a policy regarding physician requirements for documentation.

No further information was provided by the end of the survey.

Reference:
(1) Metoprolol is used to treat high blood pressure, angina, and heart failure.)
Information obtained from

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 ______	C 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF HOPE HEALTH CENTER	**13700 NORTH GAYTON ROAD** **RICHMOND, VA 23233**

(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 711	Continued From page 16 https://medlineplus.gov/druginfo/meds/a682864.html	F 711		