STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495311	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Hope Health Center	13700 North Gayton Road Richmond, VA 23233

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to implement the comprehensive care plan for one of eight residents in the survey sample, Resident #6. The findings include: For Resident #6 (R6), the facility staff failed to implement the comprehensive care plan to provide treatment to a pressure injury (1). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/28/24, the resident was assessed as having one unstageable deep tissue injury (2) that was not present on admission. The comprehensive care plan for R6 documented in part, Problem Start Date: 10/29/2024. I am at risk for pressure ulcers/impaired skin integrity due to: open lesion to the finger from ruptured gout nodule, incontinence, impaired mobility, skin tear to LLE (left lower extremity), edema, fragile skin due to fluid accumulation, right heel DTI (deep tissue injury). Edited: 10/31/2024. Under Approach it documented in part, . Treatment as ordered. Created: 10/29/2024 . The progress notes for R6 documented in part, - 10/28/2024 02:00 pm (Recorded as late entry on 11/01/2024 02:01 pm) DTI observed by therapy and was overheard speaking to son about floating resident's heal [sic] and possibly ordering bilateral heal [sic] protector boots. This writer was told and assessed the resident. It was noted that resident had DTI on right heal [sic] measuring 3.5x5.5cm (centimeter). Nurse made aware, and consult put in place for resident to be seen wound MD. Nursing care continues. - 10/29/2024 11:32 am Resident dx (diagnosed) with generalized weakness and declining last few weeks/months with AMS (altered mental status) possibly d/t (due to) UTI (urinary tract infection) on antibiotics .10/29 noted with right heel DTI . - 11/4/2024 12:54 am Resident continues skilled services r/t UTI, muscle weakness. Alert and oriented to self only, able to verbalize needs. No c/o (complaints of) pain or discomfort. Requires total assist x 1 w/ ADLs (activities of daily living). Air mattress in place and functioning. DTI to right heel remains, skin prep applied as ordered, heels floating . (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 11/4/2024 2:07 pm .PA (physician's assistant) assessed resident at bedside, note new wound care orders to right heel & RUE (right upper extremity) . The wound physician evaluation dated 11/11/24 documented in part, .Unstageable DTI with intact skin . Wound size (LxWxD): 3.5x3.8xnot measurable cm) .Wound progress: Improved evidenced by decreased surface area . The physician order's for R6 documented in part, Skin prep to right heel. Every shift Days, Evenings, Nights. Start Date: 11/07/2024. Review of the eTAR (electronic treatment administration record) for R6 dated 10/1-10/31/24 documented the heels floated when in bed beginning on 10/28/24 however it failed to evidence any treatment to the right heel DTI that was first observed on 10/28/24. Review of the eTAR for R6 dated 11/1-11/30/24 documented the heels floated when in bed each shift. It further documented a treatment of Betadine to the right heel every shift beginning on 11/4/24 through 11/7/24. The eTAR further documented the skin prep treatment beginning every shift on 11/7/24. On 12/6/24 at 9:26 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the purpose of the care plan was to promote interventions for caring for the resident. She stated that the care plan should be implemented for safety reasons and to promote care of the resident to get them back to their baseline functioning. On 2/6/24 at 10:32 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that there was an order placed for skin prep for R6's right heel on 11/1/24 but the order did not show on the eTAR. She stated that the staff that entered the order placed it under the general flow sheet so it did not trigger to show on the eTAR and staff would not have known that the treatment needed to be completed. ASM #2 stated that when the DTI was first observed on 10/28/24 the nurse should have contacted the physician and entered the order for the treatment if not already entered. She stated that the purpose of the care plan was to plan the residents care and ensure that it was centered to the residents needs at the facility. She stated that the care plan should be implemented, because it was the way to know how to care for the resident based on their needs. The facility policy Comprehensive Person-Centered Care Planning revised May 7, 2024, documented in part, .The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychological needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) process . On 12/6/24 at approximately 12:15 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the assistant administrator were made aware of the findings. No further information was provided prior to exit. Reference: (1) Pressure injury (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst.tage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm. (2) DTI- deep tissue injury Pressure sores that develop in the tissue deep below the skin. This is called a deep tissue injury. The area may be dark purple or maroon. There may be a blood-filled blister under the skin. This type of skin injury can quickly become a stage III or IV pressure sore. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to provide care and services to promote healing of a pressure injury for one of eight residents in the survey sample, Resident #6. The findings include: For Resident #6 (R6), the facility staff failed to evidence a treatment for a facility acquired deep tissue injury (1) first observed on 10/28/24 until 11/4/24. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/28/24, the resident was assessed as having one unstageable deep tissue injury that was not present on admission. The progress notes for R6 documented in part, - 10/28/2024 02:00 pm (Recorded as late entry on 11/01/2024 02:01 pm) DTI observed by therapy and was overheard speaking to son about floating resident's heal [sic] and possibly ordering bilateral heal [sic] protector boots. This writer was told and assessed the resident. It was noted that resident had DTI on right heal [sic] measuring 3.5x5.5cm (centimeter). Nurse made aware, and consult put in place for resident to be seen wound MD. Nursing care continues. - 10/29/2024 11:32 am Resident dx (diagnosed) with generalized weakness and declining last few weeks/months with AMS (altered mental status) possibly d/t (due to) UTI (urinary tract infection) on antibiotics .10/29 noted with right heel DTI . - 11/4/2024 12:54 am Resident continues skilled services r/t UTI, muscle weakness. Alert and oriented to self only, able to verbalize needs. No c/o (complaints of) pain or discomfort. Requires total assist x 1 w/ ADLs (activities of daily living). Air mattress in place and functioning. DTI to right heel remains, skin prep applied as ordered, heels floating . - 11/4/2024 2:07 pm .PA (physician's assistant) assessed resident at bedside, note new wound care orders to right heel & RUE (right upper extremity) . The wound physician evaluation dated 11/11/24 documented in part, .Unstageable DTI with intact skin . Wound size (LxWxD): 3.5x3.8xnot measurable cm) .Wound progress: Improved evidenced by decreased surface area . The physician order's for R6 documented in part, Skin prep to right heel. Every shift Days, Evenings, Nights. Start Date: 11/07/2024. Review of the eTAR (electronic treatment administration record) for R6 dated 10/1-10/31/24 documented the heels floated when in bed beginning on 10/28/24 however it failed to evidence any treatment to the right heel DTI that was first observed on 10/28/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the eTAR for R6 dated 11/1-11/30/24 documented the heels floated when in bed each shift. It further documented a treatment of Betadine to the right heel every shift beginning on 11/4/24 through 11/7/24. The eTAR further documented the skin prep treatment beginning every shift on 11/7/24. The comprehensive care plan for R6 documented in part, Problem Start Date: 10/29/2024. I am at risk for pressure ulcers (2)/impaired skin integrity due to: open lesion to the finger from ruptured gout nodule, incontinence, impaired mobility, skin tear to LLE (left lower extremity), edema, fragile skin due to fluid accumulation, right heel DTI (deep tissue injury). Edited: 10/31/2024. On 12/6/24 at 9:26 a.m., an interview was conducted with LPN (licensed practical nurse) #2 who stated that skin assessments were completed weekly on each resident. She stated that if a new pressure injury was observed they were not allowed to stage the wound, so they called the RN (registered nurse) to come assess the wound and stage it. She stated that if there was no RN in the building, they wrote a detailed note regarding the wound and described it without staging it until the RN could assess it. She stated that no matter if it were an LPN or RN the nurse contacted the physician and obtained a treatment order and documented the wound. On 2/6/24 at 10:32 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that there was an order placed for skin prep for R6's right heel on 11/1/24 but the order did not show on the eTAR. She stated that the staff that entered the order placed it under the general flow sheet so it did not trigger to show on the eTAR, and staff would not have known that the treatment needed to be completed. ASM #2 stated that when the DTI was first observed on 10/28/24 the nurse should have contacted the physician and entered the order for the treatment if not already entered. The facility policy Pressure Ulcer and Skin Care revised 4/24/24 documented in part, .Intervention: i. Initiate and document nursing interventions (examples: pressure reduction mattress, supportive devices, turning schedule, catheter to prevent further breakdown, etc.) ii. Obtain a treatment order and/or other specific physician orders On 12/6/24 at approximately 12:15 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the assistant administrator were made aware of the findings. No further information was provided prior to exit. Reference: (1) DTI- deep tissue injury Pressure sores that develop in the tissue deep below the skin. This is called a deep tissue injury. The area may be dark purple or maroon. There may be a blood-filled blister under the skin. This type of skin injury can quickly become a stage III or IV pressure sore. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm (2) Pressure injury (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst.tage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to report and follow post fall procedures for one of eight residents in the survey sample, Resident #8. The findings include: For Resident #8 (R8), the facility staff failed to report a fall that occurred on evening shift 8/28/24. There was no documentation completed until 9/2/24 after the resident was discovered to have a fractured femur (1) and an investigation for the injury was started. R8 was admitted to the facility with diagnoses that included but were not limited to multiple fractures of pelvis, repeated falls, disorders of bone density and structure, and protein-calorie malnutrition (2). On the most recent MDS (minimum data set), a 5-day assessment with an ARD (assessment reference date) of 9/19/24, the resident was assessed as having one fall with fracture in the past month. The nursing progress notes documented in part, - 08/28/2024 08:23 pm (Recorded as Late Entry on 09/02/2024 08:33 pm). Resident was noted on the bathroom floor at the last round of the shift. Writer was noted called in by the aide and assessed and was noted with no visible injuries and no skin tears or bruises. Resident was placed in her w/c (wheelchair) and assisted back to bed. No pain on transfer to w/c or in bed. Fall event to follow. - 08/29/2024 07:22 am Resident continues skilled services r/t (related to) multiple left pelvic fractures, muscle weakness. Resident is alert and oriented to self only. Denies any pain or discomfort .No s/s (signs or symptoms) of distress . - 08/29/2024 03:22 pm .No s/s of discomfort/distress noted. Will continue to monitor. - 08/30/2024 03:55 am .Denies any pain or discomfort .Bed kept in lowest position for safety. Resting in bed @ this time. No s/s of distress . - 08/30/2024 03:56 pm .ambulates by wheelchair .resident is watching television in day room, no c/o (complaints of) pain/discomfort noted at this time, will continue to monitor per my shift. - 08/30/2024 08:26 pm N.O.S (new orders) received from MD for x-ray of pelvis r/t f/u (follow up) pelvis fx (fracture) and check urinalysis w/ reflex to cx (culture). RP (responsible party) [Name of RP] notified. - 08/31/2024 03:19 am Resident medicated @ the end of previous shift w/ prn (as needed) Oxycodone/acetaminophen r/t c/o (complaints of) back/pelvic pain, has been effective .No s/s of distress . - 08/31/2024 01:49 pm .No s/s of discomfort/distress noted. Will continue to monitor. N/O for pelvic x-ray submitted, but not completed, so far. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 09/01/2024 02:41 am (Recorded as late entry on 09/24/2024 11:42 am) .No s/s of discomfort/distress noted. Will continue to monitor. - 09/01/2024 11:26 am F/U with [Name of imaging] about x-ray and was informed that they're supposed to be here sometime today. - 09/02/2024 09:53 am Resident being sent to [Name of hospital], per MD, for a R femur fx, per x-ray. She will be picked up by non-emergency transportation about 11:30. RP aware, Resident was given a PRN Oxycodone/Acetaminophen for pain before being picked up. - 09/06/2024 04:00 pm Resident is a re-admit from [Name of hospital] via stretcher .admitted for skilled services r/t surgical aftercare for rt femur hemiarthroplasty, multiple pelvic fractures, muscle weakness . The physician progress note dated 8/30/24 documented in part, .A [Age and sex of R8] who was admitted to the hospital from 8/10 until 8/15 with multiple fractures .As per physical therapist she has been having increased weakness and has been complaining of more pain and not participating much with therapy. Not much meaningful history available form the patient at this time .Physical Exam: .Moving all 4 extremities . Assessment and Plan: Generalized weakness, multiple falls. Continue with PT/OT (physical and occupational therapy). Family is planning to put her and [sic] memory care here after her skilled stay. At this time, she has increased pain, weakness, planning on repeat x-rays and a UA. Multiple fractures of the pelvis, found to have acute left superior and inferior pubic rami and left sacral fractures with diffuse osteopenia (3). Non-operative management per orthopedics, weightbearing as tolerated. Continue on Percocet 5/325 Q4 (every four hours) for pain, Pain worse for the last couple of days, we will repeat x-ray of the pelvis. Altered mental status, now improved, likely delirium. Osteopenia, seen on CT scan. I suspect she has osteoporosis (4) since she has a fragility fracture. Now on calcium and Vitamin D, discussed about starting bisphosphonates with her daughter, and at this time we have decided against it . The physician progress note dated 9/2/2024 documented in part, .Assessment and Plans: Right femoral neck fracture, she was complaining of increased pain while being transferred. She was also had [sic] some altered mental status, we repeated the x-ray of her pelvis, and it showed a deformed right femoral fracture which was age indeterminate. Reviewing her hospital records her right femoral x-ray was normal in the hospital, so this is likely a new fracture. We will send her to the ER for further evaluation and an ortho consult for possible surgery . The radiology report for R8 with an exam date of 09/01/2024 documented an impression of 1. Prominently deformed subcapital fracture of undetermined age right femur. 2. Moderate osteopenia. 3. Otherwise, negative pelvis exam. The comprehensive care plan for R8 documented in part, Problem Start Date: 08/22/2024. Category: Falls. I am at risk for falls due to impaired mobility, weakness and unsteady gait, opioid med use. Edited: 09/12/2024. The fall risk assessment for R8 dated 8/16/24 documented the resident being at risk for falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/6/24 at approximately 9:55 a.m., ASM (administrative staff member) #1, the administrator stated that the nurse who documented the late entry for the fall on 8/28/24, the nurse who sent R8 out to the hospital on 9/2/24 and the physician who examined R8 on 8/30/24 and 9/2/24 no longer worked at the facility and could not be interviewed. On 12/5/24 at 10:45 a.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated that they were able to see in the computer when a resident was a high fall risk, and the nurse told them in report also. CNA #1 stated that if a resident fell, they called the nurse to come assess the resident for injuries before getting them up and back in the chair or bed. On 12/6/24 at 9:26 a.m., an interview was conducted with LPN (licensed practical nurse) #2 who stated that when a resident had a fall, they assessed the resident for injuries, sent them to the hospital if needed, notified the physician and responsible party and documented the fall in the computer. LPN #2 stated if the fall was unwitnessed that neurochecks should be done in case the resident hit their head to assess for change in condition. On 2/6/24 at 10:32 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that R8's fall was discovered during her investigation of the fracture. She stated that R8 was admitted to the facility with existing pelvic fractures and a history of falls and was a fall risk. She stated that when the x-ray came back showing the femur fracture, she started an investigation because it was a potential injury of unknown origin but when interviewing the nursing staff who worked with R8, one of the nurses told her that R8 had the fall in the bathroom. She stated that the CNA had confirmed the fall, and the nurse had entered the progress note as a late entry. She stated that they had not completed a fall investigation because they were not aware of the fall until R8 was sent to the ER. She stated that R8 had not complained of any pain until 8/30/24 when the physical therapist reported it, and she was seen by the physician who ordered the x-rays. She stated that R8 was unable to tell them what happened, and she had educated staff on notifying the physician if the x-ray was not done in a timely manner. She stated that the x-ray was not ordered stat and was done within 24 hours which was the expectation, but the staff should have called the physician to see if they wanted the resident sent out for the x-ray prior. She stated that she had suspended the nurse for not reporting the fall and they were terminated the next day. She stated that she had educated most of the nursing staff but not all of them and had not done a formal plan of correction. She stated that the process the nurse should have followed was to immediately check vital signs, neurological checks, check for any injuries, call 911 if needed, notify the physician and RP, document the event in the medical record and update the care plan. She stated that this was not done for R8 and if it had been done it would have triggered the post fall observations and other assessments. She stated that R8 was still getting out of bed and participating with physical therapy. She stated that R8's pain was assessed and addressed by the physician when they first complained of it. The facility policy, Post Fall Evaluation and Intervention revised 6/11/21 documented in part, The nursing staff will evaluate falls by assessing causation and potential contributing factors and implementing appropriate interventions to prevent reoccurrence as part of quality assurance of the facility . A post fall assessment in the electronic record is to be completed after each fall in its entirety . On 12/6/24 at approximately 12:18 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, the assistant administrator were made aware of the above concern. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit. Reference: (1) femur fracture You had a fracture (break) in the femur in your leg. It is also called the thigh bone. You may have needed surgery to repair the bone. You may have had surgery called an open reduction internal fixation. In this surgery, your surgeon will make a cut to open your fracture. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm. (2) malnutrition Food provides the energy and nutrients you need to be healthy. If you don't get enough nutrients -- including proteins, carbohydrates, fats, vitamins, and minerals - you may suffer from malnutrition. This information was obtained from the website: https://medlineplus.gov/malnutrition.html (3) osteopenia is a condition that begins as you lose bone mass and your bones get weaker. This happens when the inside of your bones become brittle from a loss of calcium. It ' s very common as you age. This information was obtained from the website: https://familydoctor.org/condition/osteopenia/?adfree=true (4) osteoporosis is a disease in which your bones become weak and are likely to fracture (break). The disease can develop when your bone mineral density and bone mass decrease. It can also happen if the structure and strength of your bones change. Osteoporosis is called a silent disease because it doesn't usually cause symptoms. You may not even know you have the disease until you break a bone. This could happen with any bone, but it's most common in the bones of your hip, vertebrae in the spine, and wrist. This information was obtained from the website: https://medlineplus.gov/osteoporosis.html