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	04/17/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interview, staff interview and facility document review, the facility staff failed to follow professional standards of practice for one of eight residents in the medication administration observation and for one of 37 residents in the survey sample, Residents #65 and #78. The findings include:1. For Resident #65 (R65), the LPN (licensed practical nurse) #2 opened an extended-release (1) capsule of Tolterodine Tartrate (2) before administering the medication. R65 was admitted to the facility with diagnosis that included but not limited to an overactive bladder. On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/10/2026, R65 scored 6 (six) out of 15 on the BIMS (brief interview for mental status), indicating R65 was severely impaired of cognition for making daily decisions. On 04/15/2026 at approximately 8:38 a.m. an observation during the facility's medication administration observation, revealed LPN #2 preparing R65's medications. LPN #2 removed R65's medications of Zinc, Ascorbic Acid, Tolterodine Tartrate and Pro-Stat from the medication cart. She then dispensed one Zinc capsule, one Ascorbic Acid tablet, one Tolterodine Tartrate capsule into a medication cup and dispensed 30 milliliters of Pro-Stat into a separate medication cup. LPN #2 entered R65's room and informed R65 of the medications she was going to receive. After looking at the tablet and capsules in the medication cup, LPN #2 asked R65 if she wanted to take the medication whole. R65 stated that the medications were too large. LPN #2 asked R65 if she would like the medications crushed for easier consumption and R65 stated yes. LPN # 2 was observed crushing the Ascorbic Acid tablet, opening the Zinc and Tolterodine Tartrate capsules, emptying them into the medication cup with the crushed Ascorbic Acid tablet. She re-entered R65's room and administered all three medications to R65. Continued observations revealed that R65 consumed the Zinc, Ascorbic Acid and Tolterodine Tartrate. The physician order for R65 documented in part, Tolterodine Tartrate ER (extended release) Oral Capsule Extended Release 24 Hour 4 MG (milligrams) (Tolterodine Tartrate). Give 1 capsule by mouth one time a day related to overactive bladder. Order Date: 11/12/2025. On 04/16/2026 at approximately 11:09 a.m. an interview was conducted with LPN #2 regarding the administration of Tolterodine Tartrate to R65. When asked how she determines which medications can be crushed or opened before administering them to a resident she stated that she refers to a guide located on the medication cart. She also stated that she refers to the guide when she is not sure if a medication could be crushed or opened and it is sometimes on the physician's order. LPN #2 stated that extended-release medications should not be crushed or opened. Regarding R65's Tolterodine Tartrate, she stated that she should not have opened the capsule. (continued on next page)

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

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	04/17/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/15/2026 at approximately 12:10 p.m. a request was made to the DON (director of nursing) regarding the drug book used by the facility's nurses. The DON provided the Nursing 2025-2026 Drug Handbook by Wolters Kluwer. Review of the Nursing 2025-2026 Drug Handbook by Wolters Kluwer revealed the drug Tolterodine Tartrate. Under the heading Administration PO (by mouth) it documented in part, Have patient swallow extended-release capsule whole, don't crush or open capsules. On 04/16/2026 at 12:28 p.m. the DON was asked what professional standard the facility's nurses follow. She stated that the nurse's follow the professional standards by [NAME]. Oral Drug Administration: If the patient can't swallow a whole tablet or capsule, ask the pharmacist if the drug is available in liquid form or if it can be administered by another route. If not, ask him if you can crush the tablet or open the capsule and mix it with food. Keep in mind that many enteric-coated or time-release medications and gelatin capsules shouldn't be crushed. Remember to contact the doctor for an order to change the route of administration when necessary. Nursing procedures; Wolters Kluwer, [NAME], [NAME] & [NAME] P529-530. On 04/16/2026 at approximately 4:30 p.m. the Administrator and DON were made aware of the above findings. No further information was provided prior to exit. References: (1) Designed to slowly release a drug in the body over an extended period of time especially to reduce dosing frequency. This information was obtained from the website: https://www.merriam-webster.com/medical/extended-release. (2) Used to treat overactive bladder (a bladder condition that causes sudden urges to urinate that may be hard to control). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a699026.html. 2.a. The facility staff failed to meet professional standards by not administering pain medication for Resident #78. Resident #78 (R78) was admitted to the facility on [DATE] with diagnosis that included but were not limited to chronic pain, spondylosis, bipolar disorder, anxiety disorder and diabetes mellitus. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 4/13/26, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring moderate assist for bed mobility, transfer, hygiene and supervision for eating. A review of the comprehensive care plan dated 4/7/26 revealed, FOCUS: Resident has Chronic Pain issues related to spondylosis, verbalized lower back pain. Uses opioid medication for treatment of (continued on next page)

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	04/17/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain. INTERVENTIONS: Educate Resident / Representative on prescribed analgesics and / or anti-inflammatory medications. Administer pain medications per order, if non-medication interventions are ineffective. A review of the physician orders dated 4/8/26 revealed, Tramadol (opioid analgesic to relieve moderate to severe pain) (1) 50 mg (milligram), Give 1 tablet by mouth four times a day related to OTHER CHRONIC PAIN. A review of the progress note dated 4/7/26 at 9:03 PM revealed, Tramadol HCl Oral Tablet 50 MG,Give 1 tablet by mouth four times a day related to OTHER CHRONIC PAIN. New admit med not available, provider aware. A review of the progress note dated 4/8/26 at 9:00 AM revealed, Tramadol HCl Oral Tablet 50 MG, give 1 tablet by mouth four times a day related to OTHER CHRONIC PAIN, duplicate order. A review of the MAR (medication administration record) revealed Tramadol 50 mg not administered on 4/7/26 at 9:00 PM and 4/8/26 at 9:00 AM. A review of the facility's Omnicell Drug inventory list, identified Tramadol HCL 50 MG as available in their Omnicell. On 4/14/26 at 12:15 PM an interview was conducted with R78. Asked about pain management, R78 stated, my pain medication is frequently delayed. An interview was conducted on 4/15/26 at 3:45 PM with LPN (licensed practical nurse) #2. Asked to describe R78's pain medication regimen, LPN #2 stated, the first day she was assigned to me (4/8/26 day shift), the Tramadol had not been delivered yet, but the order was with the pharmacy. When that happens, the pharmacy will not give you a code to enter into Omnicell to give her Tramadol from our stock. An interview was conducted on 4/16/26 at 6:45 AM with LPN #3. Asked to describe R78's pain medication regimen, LPN #3 stated, she was admitted on my shift, the orders are sent to the pharmacy the Tramadol script was sent. When the pharmacy receives prescriptions, they will not give us a code for narcotics to pull from our Omnicell. Non-pharmacological interventions and non-narcotic medications are implemented. 2.b. For Resident #78, the facility staff failed to administer pain medication in the prescribed time frame. A request was made for the medication administration time audit report and copy of R78's narcotic sign out sheet for Tramadol 50 mg. A review of R78's Tramadol narcotic sign out sheet, evidenced Tramadol was pulled at the correct administration times of 10:00 AM, 1:00 PM, 6:00 PM and 10:00 PM. A review of R78's MAR revealed delayed administration time for Tramadol on 4/9/26 6:00 PM dose-2.5 hours late, 4/10/26 6:00 PM dose-1.5 hours late, 4/11/26 1:00 PM dose-2.75 hours late and 4/15/26 6:00 PM dose-1.75 hours late. An interview was conducted on 4/15/26 at 1:00 PM with LPN #1, when asked medication administration process, LPN #1 stated, the medication, dose, time, route, resident name and form are (continued on next page)

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	04/17/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verified. Asked the time frame for medication administration for scheduled doses, LPN #1 stated, an hour before and an hour after the scheduled time. An interview was conducted on 4/16/26 at 1:40 PM with the assistant director of nursing, who stated, according to the nurse's statements, they signed off in the narcotic books, but did not sign them off till later in the MAR. Asked if this followed professional standards of practice, the assistant director or nursing stated, no, the medications, especially narcotics, are to be signed off immediately. A review of the facility's Medication Administration policy revealed, Medications shall be removed from the pharmacy packaging and administered immediately (pre-pouring is not permitted); by the same authorized person; AND within 1 hour before or one hour after scheduled time. Professional practice standards should be utilized for all medication administration. Documentation in the MAR or eMAR shall occur immediately after administration and shall not be delayed or completed in advance. On 4/16/26 at 4:45 PM, the administrator and the director of nursing were made aware of the findings. No further information was provided prior to exit. References: 1. Tramadol (opioid analgesic to relieve moderate to severe pain). [NAME] Pocket Drug Guide for Nurses 2019.

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	04/17/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide complete and accurate documentation for two of 37 residents, Resident #78 and #75. The findings include: The facility failed to document Tramadol administered according to scheduled doses and differing from documented narcotic pull times for Resident #78.Resident #78 (R78) was admitted to the facility on [DATE] with diagnosis that included but were not limited to chronic pain, spondylosis, bipolar disorder, anxiety disorder and diabetes mellitus. The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 4/13/26, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring moderate assist for bed mobility, transfer, hygiene and supervision for eating. A review of the comprehensive care plan dated 4/7/26 revealed, FOCUS: Resident has Chronic Pain issues related to spondylosis, verbalized lower back pain. Uses opioid medication for treatment of pain. INTERVENTIONS: Educate Resident / Representative on prescribed analgesics and / or anti-inflammatory medications. Administer pain medications per order, if non-medication interventions are ineffective.A review of the physician orders dated 4/8/26 revealed, Tramadol (opioid analgesic to relieve moderate to severe pain) 50 mg (milligram), Give 1 tablet by mouth four times a day related to OTHER CHRONIC PAIN.A review of the progress note dated 4/7/26 at 9:03 PM revealed, Tramadol HCl Oral Tablet 50 MG,Give 1 tablet by mouth four times a day related to OTHER CHRONIC PAIN. New admit med not available, provider aware.A review of the progress note dated 4/8/26 at 9:00 AM revealed, Tramadol HCl Oral Tablet 50 MG, give 1 tablet by mouth four times a day related to OTHER CHRONIC PAIN, duplicate order.A review of the MAR (medication administration record) revealed Tramadol 50 mg not administered on 4/7/26 at 9:00 PM and 4/8/26 at 9:00 AM.On 4/14/26 at 12:15 PM an interview was conducted with R78. Asked about pain management, R78 stated, his pain medication is frequently delayed. An interview was conducted on 4/15/26 at 3:45 PM with LPN (licensed practical nurse) #2. Asked to describe R78's pain medication regimen, LPN #2 stated, the first day she was assigned to me (4/8/26 day shift), the Tramadol had not been delivered yet, but the order was with the pharmacy. When that happens, the pharmacy will not give you a code to enter into Omnicell to give her Tramadol from our stock.An interview was conducted on 4/16/26 at 6:45 AM with LPN #3. Asked to describe R78's pain medication regimen, LPN #3 stated, she was admitted on my shift, the orders are sent to the pharmacy the Tramadol script was sent. When the pharmacy receives prescriptions, they will not give us a code for narcotics to pull from our Omnicell. Non-pharmacological interventions and non-narcotic medications are implemented. A request was made for the medication administration time audit report and copy of R78's narcotic sign out sheet for Tramadol 50 mg.A review of R78's Tramadol narcotic sign out sheet, evidenced Tramadol was pulled at the correct administration times of 10:00 AM, 1:00 PM, 6:00 PM and 10:00 PM.A review of R78's MAR revealed delayed administration time for Tramadol on 4/9/26 6:00 PM dose- 2.5 hours late, 4/10/26 6:00 PM dose-1.5 hours late, 4/11/26 1:00 PM dose-2.75 hours late and 4/15/26 6:00 PM dose-1.75 hours late.An interview was conducted on 4/15/26 at 1:00 PM with LPN #1, when asked medication administration process, LPN #1 stated, the medication, dose, time, route, resident name and form are verified. Asked the time frame for medication administration for scheduled doses, LPN #1 stated, an hour before and an hour after the scheduled time.An interview was conducted on 4/16/26 at 1:40 PM with the assistant director of nursing, who stated, according to the nurse's statements, they signed off in the narcotic books, but did not sign them off till later in the MAR. Asked if this followed professional standards of practice, the assistant director or nursing stated, no, the medications, especially narcotics, are to be signed off (continued on next page)

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	04/17/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immediately. When asked if this differing documentation is evidence of a complete and accurate medical record, the assistant director of nursing, stated, no, it is not.On 4/16/26 at 4:45 PM, the administrator and the director of nursing were made aware of the findings. A review of the facility's Electronic Medical Record policy revealed, PURPOSE: To ensure complete, accurate and timely medical records.No further information was provided prior to exit. 2. The facility staff failed to evidence required clinical documentation after a resident is transferred to the hospital for Resident #75 (R75). R75 was transferred to the hospital on 3/8/26. R75's medical record was reviewed as part of the closed medical record task.R75 was admitted to the facility on [DATE] with diagnosis that included but were not limited to Pneumonia (PNA), Sepsis, Acute respiratory failure and CHF (congestive heart failure).The most recent MDS (minimum data set) assessment, a Medicare 5-day assessment, with an ARD (assessment reference date) of 2/23/26, coded the resident as scoring a 06 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section GG-functional abilities and goals coded the resident as requiring maximal assistance for mobility/transfers/bathing/dressing and hygiene. A review of the baseline care plan dated 2/19/26 revealed, FOCUS: Ineffective Airway Clearance Upper Respiratory Infection, PNA, shortness of breath, respiratory failure. INTERVENTIONS: Evaluate respiratory rate / effort, cough and shortness of breath.A review of the progress note dated 3/8/26 at 3:30 PM revealed, Functional decline (worsening function and/or mobility) Shortness of breath. Respiratory Status Evaluation: Shortness of breath Cough. Primary Care Provider responded with the following feedback: Recommendations: STAT chest x-ray, Mucinex 600mg twice a day x 7 days, Tylenol 325mg 2 tablets every 6 hours as needed for pain.No evidence of a progress note or eINTERACT (electronic Interventions To Reduce Acute Care Transfers) form documenting hospital transfer.On 4/16/26 at 12:50 PM, an interview was conducted with the director of nursing. The director of nursing stated, there is no evidence of clinical documentation sent with the resident to the hospital.On 4/16/26 at 4:50 PM, the administrator and director of nursing were made aware of the findings.No further information was provided prior to exit.