

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2026
NAME OF PROVIDER OR SUPPLIER Our Lady of Hope Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and staff interview, the facility staff failed to maintain one of one facility dumpster area in a sanitary manner. The findings include: On 4/14/2026 at approximately 11:30 a.m., an observation of the facility's dumpster area located behind the facility was conducted with the dietary manager. The observation revealed debris that had collected behind the dumpsters, which included a plastic garbage bag with trash inside, multiple loose medical gloves and a nail clipper on the ground. On 4/14/2026 at 11:45 a.m., an observation of the facility's dumpster area and interview was conducted with the maintenance director. Regarding maintaining the facility's dumpsters, the maintenance director stated the janitors maintained the area, but it is also a team effort with kitchen and dietary that should be done daily with a deep clean at least once a week. He agreed that the dumpster area needed cleaning. A review of the facility's Food Services Infection Control policy, revised 7/14/25, revealed regarding handling and disposing of trash and waste: placing all garbage into containers as soon as possible; and using appropriate control measures to eliminate insects and rodents. On 4/16/2026 at 4:30 p.m., Administrator, DON (director of nursing) and Infection Preventionist were made aware of the above findings. No further information was provided prior to exit.		

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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interview, and facility document review, it was determined that the facility staff failed to maintain one of one kitchens in a sanitary manner. The findings include: On 4/14/26 at 9:40 a.m., an observation was conducted in the kitchen with the following findings: in dry storage, two 32oz cartons of thick & easy thickened dairy beverage with use by date of 8/14/25. In a 12-quart plastic bin dated 3/6/26, with less than 1 quart marking of lentils there was a portion of the product's bag label on top of the lentils. Observation of the kitchen area, there was debris that could be either scraped or wiped away from the surface inside the mixing bowl, around the base of the stand mixer, and the base of the deli slicer. The dietary manager was present, when observation of twelve cleaned steam tray pans stacked ready for use were made with the third pan found wet on the outside. The dietary manager stated it was wet nesting (droplets of water observed on the inside and outside of the pan). There was a large utility fan on the kitchen floor with visible dust present on the front and back of the fan cage. An interview was conducted with the dietary manager at the end of the kitchen observation, and the dietary manager was taken to the dry storage room and showed the two 32oz cartons of thick & easy thickened dairy beverage with the use by date of 8/14/25. He stated the cartons had expired and should not have been in the dry storage available to use. He was then shown the label inside the plastic bin with the lentils. He stated it was a way to identify the product by placing its label inside the plastic storage bin. When asked about contamination, he responded they can take it out. The dietary manager was then shown the debris inside the food processor bowl, around the stand mixer base and deli slicer base. He stated the appliances needed to be cleaned. He observed the visible dust on the cage of the fan and stated that the utility fan needed to be cleaned. A review of the facility's Food Services Infection Control policy, revised 7/14/25, revealed, All food supplies and equipment used in the food service area meet accepted standards of safety and sanitation; regarding procedure and food storage, the policy revealed, checking all food items on a periodic basis for expiration dates; cleaning and sanitization of equipment, dishes, utensils, etc., thoroughly washing and drying all utensils, food contact surfaces, and equipment between preparation of food items; and insuring proper installation and maintenance of all equipment. On 4/16/2026 at 4:30 p.m., Administrator, DON (director of nursing) and Infection Preventionist were made aware of the above findings. No further information was provided prior to exit.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **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 evidence of required clinical documentation after a resident is transferred to the hospital for one of 37 residents in the survey sample, Resident #75. The findings include: 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. There was 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. A review of the facility's Transfer-Discharge Process policy revealed, Information will be provided to the receiving provider to include a minimum of the following: Contact information of the practitioner responsible for the care of the resident. Resident Representative information including contact information. Advance Directive information. All special instructions or precautions for ongoing care, as appropriate. Comprehensive care plan goals. All other necessary information, including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care. No further information was provided prior to exit.		

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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. 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. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 pain. INTERVENTIONS: Educate Resident / Representative on prescribed analgesics and / or (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on resident interview, staff interviews, facility document review and clinical record review, the facility staff failed to acquire medications for administration for one of nine residents in the survey sample, Resident #103 The findings include: For R103 the facility staff failed to administer the physician ordered medication Fish Oil Oral Capsule (supplement) on 6/2/26 and 6/7/26. A review of R103's clinical record revealed a physician's order dated 4/8/26 for Fish Oil Oral Capsule 1000 MG (milligrams) one time a day for supplement. A review of R103's June 2026 MAR (medication administration record) revealed the same physician's order for Fish Oil Oral capsule. On 6/2/26 and 6/7/26, the MAR documented the code, 9=Other/See Progress Notes. Nurses' notes dated 6/2/26 and 6/7/23 documented, Medication not available. A review of the facility backup medication supply list revealed it was not stocked in supply. An interview was conducted on 6/8/26 at 11:30 AM with R103 who stated, there is a problem with me receiving my medications here, I just don't understand it. The most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/13/26, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. An interview was conducted on 6/9/26 at 2:20 PM with LPN (Licensed Practical Nurse) #1. LPN #1 stated medications should be re-ordered from the pharmacy when seven pills are remaining. LPN #1 stated that when a medication is ordered and not available for administration, staff should check the emergency supply, call the pharmacy, notify the physician and the RP (responsible party). A review of the facility policy, Medication Shortage/Unavailable Medications, revealed, in part: upon discovery that facility has inadequate medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy. On 6/9/26 at 4:18 p.m., the Administrator and Director of Nursing were made aware of the above findings.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on clinical record review, staff interview, and facility document review, it was determined that the facility staff failed to act in a timely manner on the pharmacy medication regimen review for one of 37 residents in the survey sample, Residents #8. The findings include: For Resident #8 (R8), the facility staff failed to implement pharmacy recommendations that were approved by the attending physician on 3/19/2026 until 4/9/2026. On the most recent minimum data set (MDS), an admission assessment with an assessment reference date (ARD) of 3/17/2026, R8 was assessed as being moderately impaired for making daily decisions and receiving antipsychotic, antidepressant, anticoagulant and antibiotic medications while at the facility. The pharmacy consultation report for R8 dated 3/16/2026 documented in part, .Recommendation: Please attempt a gradual dose reduction of Quetiapine (1) to 12.5mg (milligram) every other night at bedtime for 7 days then discontinue . The report documented under the Physician's Response, I accept the recommendation(s) above, please implement the monitoring plan outlined below. Monitoring Plan: [left blank] . The physician and Director of Nursing signature was dated 3/19/2026. The physician orders for R8 documented a current order for Quetiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate) Give 12.5 mg by mouth at bedtime for depression related to Dementia in other diseases classified elsewhere, moderate, with other behavioral disturbance. Order Date: 04/10/2026. Review of the electronic medication administration record (eMAR) for R8 dated 3/1/2026-3/31/2026 documented the Quetiapine 12.5mg administered daily at bedtime through 3/31/2026. Review of the eMAR for R8 dated 4/1/2026-4/30/2026 documented the Quetiapine 12.5mg administered daily at bedtime through 4/8/2026. The eMAR further documented the Quetiapine order changed on 4/9/2026 to 12.5mg every other day for 7 days. The order was noted to be discontinued on 4/10/2026 with a new order that changed the Quetiapine back to the original 12.5mg daily at bedtime starting on 4/10/2026. The progress notes for R8 documented in part,- 03/16/2026 10:41 (AM) Pharmacy note. Note Text : Medication Review: This resident's medical record including electronic documentation was reviewed on this date. [x] See report for any noted irregularities and/or recommendations .- 03/19/2026 15:39 (3:39 PM) Note Text: Per pharm recommendation and MD approval, Oxycodone discontinued as well as GDR (gradual dose reduction) of Quetiapine 12.5mg every other night at HS (bedtime) for 7 days. RP (responsible party) made aware.- 04/09/2026 17:10 (5:10 PM) LATE ENTRY. Note Text: RP aware of medications risk and benefits. Also, aware of GDR attempt. Will like to further speak with physician about medication. MD aware.- 04/10/2026 17:56 (5:56 PM) Note Text: RP would like resident to stay on current dose with current frequency. Aware of risk and benefits of GDR attempts. MD aware and medication changed to previous dose.- 04/13/2025 11:45 (AM) . Today provider returned call to his son and provided update on his overall progress . Son does not want to GDR current low-dose quetiapine as pt is responding well, and provider agrees . On 4/16/2026 at 9:18 AM, an interview was conducted with the assistant director of nursing who stated that they had received the pharmacy recommendations for R8, and the physician had agreed to the GDR of the Quetiapine. She stated that the physician had stated that they were going to put the orders in for the medication change but did not and she became aware when the pharmacy had emailed her last week to check the status of the GDR. She stated that at that time she had called the physician who told them to proceed with the GDR, so they contacted the responsible party who initially had agreed but then changed his mind. She stated that R8's responsible party had requested the resident be placed back on the daily dosage because it had been prescribed in the hospital for sleeping and he did not want the medication to be (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changed. She stated that she had changed the order back to the original at that time. The facility policy Medication Regimen Review revised 6/1/24, documented in part, .The attending physician should document in the residents' health record that the identified irregularity has been reviewed and what, if any, action has been taken to address it . On 4/16/2026 at approximately 4:38 PM, the Administrator, the Director of Nursing and the Assistant Director of Nursing/infection preventionist were made aware of the findings. No further information was provided prior to exit. References: (1) Quetiapine is used to treat schizophrenia (a mental illness that affects how a person thinks, feels and behaves), bipolar disorder (a disease that causes depression, mania, and other abnormal moods) and major depressive disorder. Quetiapine is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain . This information was obtained from the website: Quetiapine: MedlinePlus Drug Information		

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NAME OF PROVIDER OR SUPPLIER Our Lady of Hope Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on clinical record review, staff interview, and facility document review, it was determined the facility staff failed to implement a complete immunization program for two of five record reviews for immunizations, Resident #1 and Resident #12. The findings include: 1. For Resident #1 (R1), the facility staff failed to administer the COVID-19 vaccine (1). Review of R1's clinical record documented under Immunizations the following information, COVID-19 Moderna Booster, Pending Immunization, Consent confirmed 10/1/2025, education provided 11/13/2025 .A Vaccination Summary for R1 dated 9/16/2025 documented in part, . COVID-19, Past Due .A Nursing Facility Influenza/Pneumonia Vaccines document for R1 dated 10/1/25 documented consent for the COVID-19 Monovalent Vaccine. The clinical record failed to evidence administration of the COVID-19 vaccine after the consent was given on 10/1/25. On 4/16/2026 at 9:18 AM, an interview was conducted with the infection preventionist who stated that R1 had consented to the Moderna COVID-19 vaccine back in the fall, but she thought that they did not have any in stock at that time. She stated that the former infection preventionist had resigned and it had fallen through the cracks and not been administered. The facility policy, Influenza, Pneumococcal, and Covid Immunizations revised July 2025 documented in part, . Each resident will be offered annual immunization against Influenza and Covid, unless medically contraindicated. The Influenza and Covid vaccines will be offered annually by the community during the Influenza season, October through March, unless otherwise recommended by the Centers for Disease Control and Prevention .On 4/16/2026 at 4:38 PM, the administrator, director of nursing and infection preventionist were made aware of the findings. No further information was provided prior to exit. Reference: (1) CDC recommends the 2025-2026 COVID-19 vaccine for people ages 6 months and older based on individual-based decision making. This includes people who have received a COVID-19 vaccine, people who have had COVID-19, and people with long COVID . This information was obtained from the website: Staying Up to Date with COVID-19 Vaccines Covid CDC2. For Resident #12 (R12), the facility staff failed to administer the COVID-19 vaccine. Review of R12's clinical record documented under Immunizations the following information, COVID-19 Moderna Booster, Pending Immunization, Consent confirmed 9/17/2025, education provided 9/19/2025 .A Vaccination Summary for R12 dated 9/16/2025 documented in part, . COVID-19, Past Due .A Nursing Facility Influenza/Pneumonia Vaccines document for R1 dated 9/17/25 documented consent for the COVID-19 Monovalent Vaccine 25-26 Moderna. The clinical record failed to evidence administration of the COVID-19 vaccine after the consent was given on 9/17/25. On 4/16/2026 at 9:18 AM, an interview was conducted with the infection preventionist who stated that R12 had consented to the Moderna COVID-19 vaccine back in the fall, but she thought that they did not have any in stock at that time. She stated that the former infection preventionist had resigned and it had fallen through the cracks and not been administered. On 4/16/2026 at 4:38 PM, the administrator, director of nursing and infection preventionist were made aware of the findings. No further information was provided prior to exit.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to post daily staffing for one of four days reviewed. The findings include: During the Sufficient and Competent Staffing facility task review started on 4/14/26 and ended on 4/17/26, a review of the daily staffing evidenced the following: On 4/14/26 at 8:00 AM the facility was entered for the survey. There was no evidence of staff posting in the main lobby, the lobby outside of the nursing care center or on the nursing station desk in the nursing care center. 11:00 and 3:30 PM checks of these areas did not reveal any staff posting. The daily staffing was posted correctly the remainder of the survey, 4/15/26, 4/16/26 and 4/17/26. On 4/14/26 at 3:45 PM, an interview was conducted with the Director of Nursing (DON). Asked where the staff posting is located, the DON stated, it is right here in this book. It is not posted, as a plastic frame was needed for it. The DON was referred to the regulations. On 4/15/26 at 8:15 AM, the Director of Nursing stated, the regulations were reviewed and the staff posting should be visible, it is in a frame now. On 4/16/26 at 4:45 PM, the Administrator and the Director of Nursing were made aware of the findings. According to the facility's Posting of Direct Care Staff policy which revealed, It is the policy of the Community to post daily, at the beginning of the shift, the number of licensed and unlicensed direct care staff directly responsible for resident care in the facility, facility name, current date, and resident census. No further information was provided prior to exit.		