STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49A007	A. BUILDING _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PEACE INC	751 HILLSDALE DRIVE CHARLOTTESVILLE, VA 22901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite on 08/23/22. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted 08/23/22. The facility was not in compliance with 42 CFR Part 483.80 infection control regulations, and/or the CMS and Centers for Disease Control (CDC) recommended practices for COVID-19. The census in this 32 certified bed facility was 29 at the time of the survey.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		10/5/22

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

Electronically Signed | 09/12/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 880	Continued From page 1	F 880		

providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

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F 880	Continued From page 2 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment for the prevention of COVID 19 during resident care and failed to ensure written policies and procedures included standard and transmission-based precautions to be followed to prevent spread of infections for COVID 19. Findings include: 1) On 08/23/22 at approximately 11:30 AM, CNA #4 (certified nursing assistant) was observed in an isolation resident room of a resident confirmed positive for COVID-19 (Resident #2). The CNA had on a KN95 mask, no gloves, no gown and no goggles or face shield. On the outside of the resident room was a sign that documented, "Stop No Visitors Please See the Nurse", there was a small isolation cart/drawers outside of the door with gowns, gloves, N95 masks, shields/goggles. 2) There was no signage anywhere that identified what type of isolation was in place for this room/residents, there was no signage regarding what type of PPE (personal protective equipment) was required prior to entry into the room and no signage regarding donning/doffing instructions of required PPE.	F 880	Corrective Action for Those Affected: The Director of Nursing ("DON") posted signage regarding the donning, doffing and disposal of all required appropriate PPE to enter the room on 8/23/2022. The DON also posted signage to indicate the type of isolation in place for the residents in the room on 8/23/2022. The staff member involved was counseled by the DON on 8/24/2022 regarding infection control practices, including hand hygiene and donning / doffing / disposing of PPE. Steps Taken to Identify Other Residents with the Potential to be Affected: All Nursing Center residents had the potential to be affected. Measures Put in Place/Systemic Changes to Prevent Recurrence: The Executive Director and DON will create a COVID-19 specific reference guide of applicable policies and procedures for staff use in the event of a COVID-19 outbreak. The guide will include isolation signage and instructions to post for donning/doffing/disposing of PPE. The DON or designee will educate all direct care staff on the guide. All staff will be required to demonstrate COVID-19	

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F 880	Continued From page 3 The CNA was observed assisting a resident in/toward the resident bathroom. The resident was in a wheelchair in the doorway of the bathroom, the CNA was with the resident. CNA #4 then came out of the bathroom and headed toward the resident's bed/living area. The CNA was asked from the doorway, which resident was she caring for. The CNA stated that she was caring for Resident #3 (a resident no longer on isolation and not currently positive with COVID-19). The CNA was asked if this was a COVID positive room, the CNA stated, "Yes" and stated that the COVID positive resident (Resident #2) was in the room (out of direct sight from the doorway), but that wasn't who she was working with. The CNA was asked what was supposed to be worn in that room while caring for residents since this was an isolation/COVID-19 room. The CNA stated, "full PPE while in the room." The CNA was asked what that included and the CNA stated, "...N95 mask, gown, gloves, goggles/or face shield...full PPE." The CNA was asked if there was a reason that she did not don the proper PPE (personal protective equipment) prior to entering a COVID positive room. The CNA stated that Resident #3 (non COVID resident) was going through the dirty laundry in the bathroom and was pulling items out and she (CNA #4) was trying to keep the resident from doing that. 3) The CNA then exited the room, did not wash or sanitize her hands, came into the hallway outside of the resident's room and opened the isolation cart to don PPE. At 12:15 PM, the DON (director of nursing) and the administrator were made aware of the above	F 880	isolation precautions including proper handwashing practices and appropriate donning/doffing/disposing of PPE. Training will be required of all direct care staff upon hire, annually, and as needed. The DON or designee is responsible for ensuring the outbreak response guide is implemented appropriately in the event of an outbreak. How Corrective Actions will be Monitored: The Executive Director or designee will audit the training records and report the results to the QAPI committee at the next regularly scheduled meeting for recommendation for continued follow-up, if any.	

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F 880	Continued From page 4	F 880		

observations and concerns. The administrator stated that she (CNA #4) knows what she should do/wear for those residents.

The policy for PPE was reviewed and documented, "...caring for a resident with COVID-19...wash hands after...wash hands immediately after gloves removed...between resident to resident contact...as indicated to avoid transfer of microorganisms to others and/or the environment...put on non sterile gloves...wear a mask and eye protection...to observe airborne precautions (wearing a N95 mask...) when caring for a resident with symptoms of a respiratory infection indicative of COVID-19...Residents with confirmed COVID-19, regardless of vaccinations status...All recommended COVID-19 PPE should be worn during care of residents..."

The facility policy did not indicate the specific PPE to be worn for a COVID-19 resident, did not address the appropriate donning/doffing techniques, did not address and/or specify disposal of such PPE and did not include information/education regarding signage for the specific type of isolation, specifically of COVID-19 residents.

On 08/23/22 at approximately 4:40 PM, the DON and administrator were again made aware of the above observations and concerns with infection control practices for the prevention of COVID-19.

No further information and/or documentation was presented prior to the exit conference on 08/23/22 at 5:00 PM.