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 ______	R **03/09/2023**

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	{E 000}	The submission of the Plan of Correction does not constitute agreement on the part of Our Lady of Peace that the deficiencies cited within the report represent deficient practices on the part of the community and its staff. The plan represents our ongoing pledge to provide quality care rendered in substantial compliance with regulatory requirements.	
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 01/10/23 through 01/12/23, was conducted on 03/07/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 32 certified bed facility was 27 at the time of the survey. The survey sample consisted of six current resident reviews (Residents #101 through #106).	{F 000}	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The treatment order for Resident #103 was corrected to show the correct frequency of dressing changes.	04/07/2023
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, the facility staff failed to follow physician orders for one of 6 residents and failed to follow care plan interventions for one of 6 residents. The findings include: 1. The facility staff were not completing dressing	{F 684}	How the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of all residents with physician orders for treatments was completed. Orders that were audited were corrected if needed. Systemic changes made to ensure that the deficient practice will not recur: Nurses were educated on the importance of correctly entering orders and on how to enter orders in EMR. The nurses will attach a copy of all new orders to the 24 hour report. The Unit Manager or designee will compare the written order to the EMR entry daily to ensure it is entered correctly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rachel [signature] | TITLE: LNHA/Executive Director | (X6) DATE: 04/09/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49A007	A. BUILDING ______ B. WING ______	R 03/09/2023

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
{F 684}	Continued From page 1 changes timely as ordered for Resident #103. 2. The facility staff were not following interventions according to the nutrition care plan for Resident #105. 1. Diagnoses for Resident #103 included: Dementia, anemia, glaucoma, and pressure ulcer. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 2/18/23. Resident #103 was assessed with a cognitive status of severely impaired. On 3/7/23 Resident #103's clinical record was reviewed. An active order dated 1/31/23 read in part "Cleanse open area to right and left buttocks. Apply Optifoam dressing to areas every two days..." Resident #103's treatment administration record (TAR) was reviewed for a time period of 2/25/23 through 3/7/23 and documented the nursing staff were completing dressing changes every three days. On 3/7/23 at 2:10 PM Resident #103's physician (other staff, OS #1) was interviewed via telephone for clarification of the order. OS #1 said that dressing changes for Resident #103 are supposed to be done every two days. On 3/7/23 at 3:15 PM licensed practical nurse (LPN #1) was interviewed. LPN #1 said that she had entered the order into the electronic chart based off a hand written order by hospice. LPN #1 then reviewed the hand written order and verified the order with what was entered into the electronic clinical record and realized that she	{F 684}	How to monitor to make sure the solutions are sustained: The findings of this audit will be reviewed and discussed at the monthly QA meeting. Any concerns identified will be corrected. Monthly reports will be submitted to the QAPI committee on a quarterly basis for four quarters with continued follow up, if any, at the recommendation of the QAPI committee.	

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 ____	R 03/09/2023

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
{F 684}	Continued From page 2 had entered the frequency of the dressing changes incorrectly to every three days. Resident #103's most current wound assessments were reviewed and indicated the right buttock pressure ulcer was down graded from a stage two to a stage one, while the left buttock pressure ulcer was healed as of 3/5/23. On 3/7/23 at 4:30 PM the above findings were presented to the administrator and director of nursing. No other information was presented prior to exit conference on 3/7/23. #2. The facility staff failed to follow interventions on the CCP (comprehensive care plan) for Resident #105 regarding nutrition intake records. Findings include: Resident #105's diagnoses included, but were not limited to: Alzheimer's dementia, TBI (traumatic brain injury), high blood pressure, muscle weakness, and depression. The most recent MDS (minimum data set) was a quarterly assessment dated 11/25/22. This MDS assessed the resident with short and long term memory impairment and severe impairment in daily decision makings skills. The resident was also assessed as requiring total assistance of one staff member for eating. The resident's most recent full MDS was an annual assessment dated 05/25/22. The CAAS (care area assessment summary) section of this MDS triggered the resident for nutrition.	{F 684}	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The order for nutritional supplements for Resident # 105 was corrected to include documentation of the percentages consumed. How the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of all residents with orders for nutritional supplements was completed. Orders that were found to not include the task to track percentages were corrected as needed.	04/07/2023

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 ______	R 03/09/2023

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
{F 684}	Continued From page 3 The resident's physician's orders were reviewed and revealed an order dated 02/01/23, which documented: "Do not obtain weights, do not obtain vitals signs monthly, Resident receiving hospice services..." The resident also had an order dated 02/09/23, which documented: "Ensure supplement...for weight loss once daily..." The resident's CCP (comprehensive care plan) was then reviewed and revealed the following: "...Nutrition Status...Monitor meal intake percentages collaborate with RD, MD/NP (Registered Dietitian, Medical Doctor/Nurse Practitioner), and hospice for interventions as needed (created: 02/13/23)...Supplement as ordered (created: 02/14/23)...Monitor and document intake (created: 06/29/22)..." On 03/07/23 at approximately 2:45 PM, the DON (Director of Nursing) was asked for assistance in locating intake records per the resident's CCP (above). The DON pulled up the MAR/TAR (medication/treatment administration records) for February and March 2023. The MARs showed the order for the supplement (Ensure) to be administered once daily, along with initials that it was administered and/or offered. The DON stated that they (staff) didn't document the amount of supplement consumed. The DON looked through the MARS/TARS and did not find any percentage and/or ml (milliliters) records to indicate what amount of the Ensure was consumed by the resident. The DON was asked if staff should be documenting the amount of Ensure consumed, the DON stated that it should be.	{F 684}	Systemic changes made to ensure that the deficient practice will not recur: Nurses were educated on adding a task to all nutritional supplements to document the percentage consumed. The nurses will attach a copy of all new orders for nutritional supplements to the 24 hour report. The Unit Manager or designee will compare the written order to the EMR entry daily to ensure it includes a task to document the percentage consumed. How to monitor to make sure the solutions are sustained: The findings of this audit will be reviewed and discussed at the monthly QA meeting. Any concerns identified will be corrected. Monthly reports will be submitted to the QAPI committee on a quarterly basis for four quarters with additional follow up, if any, at the recommendation of the QAPI committee.	

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 ______	R 03/09/2023

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
{F 684}	Continued From page 4 On 03/07/23 at approximately 4:00 PM, the DON was again asked for clarification and asked if the amount of supplement consumed by Resident #105 should be documented. The DON stated that is what 'we' usually do and stated, 'we' usually do track percentages. The DON stated that when the order was put in, they (staff) entered it wrong and should have made it where the amount consumed would have been directly under the check off for the Ensure and that way, it would have been documented as offered/administered in one spot and then under it, the amount the resident actually accepted could have been entered in. No further information and/or documentation was presented prior to the exit conference on 03/07/23/ at 4:45 PM.	{F 684}		