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 _____	01/12/2023

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 An unannounced Emergency Preparedness survey was conducted 1/10/2023 through 1/12/2023. The facility was in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/10/2023 through 1/12/2023. No complaints were investigated. Significant corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 30 certified bed facility was 29 at the time of the survey. The survey sample consisted of 11 current Resident reviews and two closed record reviews.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		2/24/23

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

Electronically Signed | 02/13/2023

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 _____	01/12/2023

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 656	Continued From page 1 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to develop a comprehensive care plan for one of thirteen residents. Resident #15 did not have a care plan to address the use of a cast shoe. Findings were:	F 656	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	

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 _____	01/12/2023

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 656	Continued From page 2 Resident #15 was admitted to the facility with the following diagnoses including but not limited to: Arthritis, heart disease, vascular dementia, and hard of hearing. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/24/2022. She was assessed as cognitively intact for daily decision making, with a summary score of 15 out of 15. On 01/11/2023, Resident #15 was sitting in her wheelchair. A splint/fracture shoe was observed on her right foot. The clinical record of Resident #15 was reviewed on 01/11/2023 at approximately 2:00 p.m. No physician orders were observed for the use of a splint/fracture shoe. The care plan of Resident #15 was reviewed. There were no interventions on her care plan regarding the need for the device or the use of the device. During an end of the day meeting on 01/11/2023 at approximately 5:00 p.m., the DON was asked about the splint/fracture shoe. She stated, "It is a cast shoe...She self propels in her wheelchair with her right foot.." On 01/12/2023 the DON was asked if the use of a cast shoe should be part of Resident #15's care plan. She stated, "Yes." No further information was obtained prior to the exit conference on 01/12/2023.	F 656	regulatory requirements. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The comprehensive care plan for Resident #15 was updated to reflect a care plan intervention for a splint/fracture shoe. How the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of all residents with splint/fracture shoes was completed and updates were made to care plans as appropriate. Physical observations of residents were completed to review for any assistive devices in use ensuring physician orders in place and care plans updated. Systemic changes made to ensure that the deficient practice will not recur: Nurses were educated on the need to update care plans to reflect the use of splint/fracture shoes. A weekly care plan audit will be performed by Unit Manager or designee. Weekly observations of all residents with assistive devices will be made by Unit Manager or designee. The MD/NP will be notified of any new identified assistive devices for a physician order and care plan will be updated accordingly. How to monitor to make sure the solutions are sustained: The findings of the care plan audits will be reviewed and discussed at the monthly QA meeting. Any	

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 _____	01/12/2023

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 656	Continued From page 3	F 656	concerns identified will be corrected.	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to review and revise a comprehensive care plan for two of thirteen residents. Resident #23's care plan was not revised to include the	F 657	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The comprehensive care plan for Residents #23 and #15 were updated to	2/24/23

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 _____	01/12/2023

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 657	Continued From page 4 development and subsequent treatment for bilateral pressure ulcers. Resident #15 did not have a care plan to address wound care. Findings were: 1. Resident #23 was admitted to the facility with the following diagnoses, including but not limited to: Dementia with agitation, depressive disorder, anxiety, and psoriasis. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/01/2022. Resident #23 was assessed as having difficulty with both long and short term memory, as well as having difficulty with daily decision making skills. On 01/11/2022 at approximately 4:30 p.m., the hospice note section of the clinical record was reviewed. An IDG (interdisciplinary group) Comprehensive Assessment dated 01/05/2023 was observed. Under the section "Client Orders (since last IDG meeting)", was a new order, "CLEANSE STAGE II PRESSURE ULCER TO LEFT AND RIGHT HIP, APPLY BETADINE, ALLOW TO DRY, APPLY HYDROGEL, AND LEAVE OPEN TO AIR DAILY, WEEKLY BY HOSPICE STAFF." Resident #23's medical record was reviewed. A physician order, written 01/05/2023, contained the following: "Apply betadine to R (right) and L (left) greater trochanters BID (twice a day), allow to dry and leave open to air until healed." The progress note section was reviewed. A note dated 01/04/2023 contained the following: "Resident noted to have small, scabbed area on right hip approximately the size of a dime. Passed	F 657	reflect wound areas. How the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of all residents with wound areas was completed and care plans updated as appropriate. Systemic changes made to ensure that the deficient practice will not recur: Nurses were educated on the need to update care plans to reflect wound areas. An audit of the weekly skin assessments will be performed by Unit Manager or designee to ensure physician orders and care plans are updated for newly identified concerns. How to monitor to make sure the solutions are sustained: The findings of the care plan audit and weekly skin assessments will be reviewed and discussed at the monthly QA meeting. Any concerns identified will be corrected.	

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 _____	01/12/2023

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 657	Continued From page 5	F 657		

on to RN (registered nurse) Supervisor to assess and TX (treat)..."

The care plan was reviewed. A focus area noted, "...at risk for pressure ulcers related to decreased mobility and incontinence...", and included, but was not limited to, the following interventions: "Assist with meals as needed. She must be fed at times; pressure reducing cushion to chair...; pressure reduction mattress to bed; weekly skin assessment by a licensed nurse." There were no entries, changes, or updates related to the pressure wound to Resident #23's right or left greater trochanter.

An end of the day meeting was held with the DON (director of nursing) and the administrator on 01/11/2023 at approximately 5:00 p.m. The DON was asked if a care plan should be have been updated to include the wound areas identified by the hospice nurse and addressed in the facility progress notes on 01/04/2022. She stated, "Yes."

The facility policy regarding pressure ulcers was requested and presented. Per the DON the policy "Pressure Ulcer and Skin Care" was used by the nursing facility as well as the assisted living facility. Per the policy, "Residents with pressure ulcers should be documented weekly using (name of form)...
The DON is responsible for weekly verifying that the appropriate treatment is administered as ordered and that documentation and evaluation reflect the current status of each pressure ulcer. The interdisciplinary care plan for the resident must identify current resident problems, goals, and actions directed towards the prevention and/or resolution of pressure ulcers...When a pressure ulcer is reported or identified the charge

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 _____	01/12/2023

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 657	Continued From page 6	F 657		

nurse must visually assess the affected area on the resident and complete the initial assessment of each pressure ulcer..."

No further information was obtained prior to the exit conference.

2. Resident #15 was admitted to the facility with the following diagnoses including but not limited to: Arthritis, heart disease, vascular dementia, and hard of hearing. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/24/2022. Resident #15 was assessed as cognitively intact for daily decison making, with a summary score of 15 out of 15.

Resident #15's clinical record was reviewed on 01/11/2023 at approximately 2:00 p.m. The following orders were observed: "Apply corn pad to opened wound between 3rd and 4th digits, change every 3 days; skin prep to left outer ankle scabbed area BID until healed."

The care plan was reviewed. The following was observed: "Category: Pressure Ulcer...experiences incontinence and is at risk for skin breakdown/pressure injury...Goal: will not have any new pressure injury/skin breakdown over the next review." Interventions included but were not limited to: "Report any signs of skin breakdown...weekly skin assessments by a licensed nurse."

The weekly skin observations for Resident #15 were reviewed, neither of the above areas were identified on the weekly skin observation sheets. The DON was interviewed on 01/12/2023 at approximately 11:30 a.m. and asked about the

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 _____	01/12/2023

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 657	Continued From page 7 observation sheets and what should be on them. She stated, "Both the areas between her toes and the area on her ankle should be addressed on the observation sheets until they are healed...they are supposed to be done weekly." When asked if the care plan should have been reviewed and revised to include these wound areas, the DON stated, "Yes." The above information was discussed during a meeting with the DON and the administrator at approximately 12:30 p.m., the above information was discussed. No further information was obtained prior to the exit conference on 01/12/2023.	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is	F 661		2/24/23

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 _____	01/12/2023

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 661	Continued From page 8 developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed for one of 13 residents (Resident # 4) in the survey sample to complete a Discharge Minimum Data Set. A Discharge Minimum Data Set (MDS) was not completed upon the resident #4's discharge from the facility. The findings were: Resident # 4 in the survey sample was admitted with diagnoses that included peripheral vascular disease, diabetes mellitus, hypothyroidism, and lumbago with sciatica. According to the most recent MDS, a Quarterly review with an Assessment Reference Date of 8/11/2022, the resident was assessed under Section C (Cognitive Patterns) as being severely cognitively impaired for daily decision making,with a Summary Score of 07 out of 15. On 9/17/2022, Resident # 4 was discharged to the facility's Assisted Living Facility. A review of the resident's Electronic Health Record found there was no Discharge MDS. At 9:10 a.m. on 1/12/2023, the Director of Nursing (DON), who identified herself as the MDS	F 661	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The discharge MDS assessment was completed for Resident #4. How the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of discharged residents was completed. Systemic changes made to ensure that the deficient practice will not recur: A monthly audit of all discharged residents will be completed by the DON or designee. How to monitor to make sure the solutions are sustained: The findings of the discharge audit will be reviewed and discussed at the monthly QA meeting. Any concerns identified will be corrected.	

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 _____	01/12/2023

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 661	Continued From page 9 Coordinator, was interviewed regarding the lack of a Discharge MDS for Resident # 4. After checking her files, the DON confirmed the Discharge MDS was not done, saying, "I just missed it." The finding was discussed during a meeting at 1:00 p.m. on 1/12/2023, prior to the Exit Conference, that included the Administrator, DON, Assistant Director of Nursing, and the survey team. No further information was provided.	F 661		
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 observation, staff interview, and clinical record review, the facility staff failed to follow physicians orders for one of 13 in the survey sample (Resident # 29) and also failed to obtain a physician order for the use of a cast shoe for Resident # 15. facility staff failed to obtain and/or follow physician orders for medical devices for 2 of 13 residents in the survey sample (Resident #29 and Resident #15).	F 684	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #29's TED hose were applied when observation was made known. LPN #1 was counseled and a treatment pass observation was completed. How the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of all	2/24/23

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 _____	01/12/2023

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 10 Findings include: 1. The facility staff failed to follow physician orders for the application of medical devices (TED hose) for Resident # 29. Resident # 29 was admitted to the facility 11/7/22 with diagnoses to include, but were not limited to: dementia with behaviors, congestive heart failure, GERD, and hypothyroidism. The most recent MDS(minimum data set) was the admission assessment dated 11/18/22, which coded Resident # 29 as having long and short term memory problems, as well as severely impaired in daily decision making skills. On 1/11/23 at approximately 9:30 a.m., Resident # 29 was observed in his room, sitting in a wheelchair, wearing regular blue socks with shoes. Resident # 29's clinical record was reviewed on 1/11/23, at approximately 9:50 a.m. A current physician order with the start date 11/7/22 directed "TED hose in AM; off in PM." The MAR (medication administration record) was reviewed and revealed that the TED hose were documented as having been applied on the 7-3 shift of 1/11/23. On 1/11/23 at approximately 10:10 a.m., LPN (licensed practical nurse) #1 accompanied me to Resident # 29's room. She was asked if the resident had on TED hose. LPN # 1 obtained permission from the resident to look at his socks. She pulled up his pants' leg and stated "No, he does not." LPN # 1 went on to say that the 11-7 shift must have forgotten to put them on. LPN #	F 684	residents with physician orders for TED hose was completed to ensure appropriate application. Physical observations of residents were completed to review for any assistive devices in use ensuring physician orders in place and care plans updated. Systemic changes made to ensure that the deficient practice will not recur: Nurses were educated on ensuring TED hose are applied as ordered. A daily audit of all residents with TED hose orders will be performed for 8 weeks, then twice weekly for 4 weeks, then once weekly as part of an assistive device audit by the Unit Manager or designee. How to monitor to make sure the solutions are sustained: The findings of the TED hose use / assistive device audits 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 4 quarters with additional follow up, if any, at the recommendation of the QAPI committee. 2. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: A physician order for Resident #15 was obtained to reflect use of the splint/fracture shoe. How the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of all	

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 _____	01/12/2023

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 11 1 was then asked about the current time, after 10 a.m., and advised her initials were on MAR as having applied them on 7-3 shift today. LPN # 1 did not answer. On 1/11/22 at approximately 5:00 p.m. the administrator and DON (director of nursing) were made aware of the above findings. No further information was provided prior to the exit conference. 2. The facility staff failed to obtain a physician order for the use of a medical device (splint/fracture shoe) for Resident # 15. Resident #15 was admitted to the facility with the following diagnoses including but not limited to: Arthritis, heart disease, vascular dementia, and hard of hearing. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/24/2022. She was assessed as cognitively intact for daily decision making, with a summary score of 15 out of 15. On 01/11/2023, Resident #15 was sitting in her wheelchair. A splint/fracture shoe was observed on her right foot. The clinical record was reviewed on 01/11/2023 at approximately 2:00 p.m. There no orders were observed for the use of a splint/fracture shoe. The care plan was reviewed. There were no interventions on the care plan regarding the need for the device or the use of the device. During an end of the day meeting on 01/11/2023 at approximately 5:00 p.m., the above findings were presented to the DON. When asked about	F 684	residents with physician orders for splint/fracture shoes was completed. Weekly observations of all residents with assistive devices will be made by Unit Manager or designee. The MD/NP will be notified of any new identified assistive devices for a physician order and care plan will be updated accordingly. Systemic changes made to ensure that the deficient practice will not recur: Nurses were educated on the need for physician orders related to the use of a splint/fracture shoe. Weekly observations of all residents with assistive devices will be made by Unit Manager or designee. The MD/NP will be notified of any new identified assistive devices for a physician order and care plan will be updated accordingly. How to monitor to make sure the solutions are sustained: The findings of the weekly assistive device 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 4 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 _____	01/12/2023

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 12 the splint/fracture shoe, the DON stated, "It is a cast shoe...She [Resident #15] self propels in her wheelchair with her right foot...we dropped the seat of her wheelchair to help her but she still presses down on her toes and it hurts her...we started using the cast shoe to protect her foot." On 01/12/2023 the DON was asked if there should be an order for the cast shoe used by Resident #15. She stated, "We had an order for it that ended, but she was still using it. I spoke with the nurse practitioner about it today and it's okay for her to continue to use it...I am going to update the order." No further information was obtained prior to the exit conference on 01/12/2023.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview, and facility document review, the	F 686	How the corrective action will be accomplished for those residents found to	2/24/23

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 _____	01/12/2023

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 686	Continued From page 13 facility staff failed to provide treatment and services for the prevention of an unstageable pressure ulcers for one of 13 residents, Resident #23. This was identified as harm. The facility also failed to accurately complete weekly skin observations for one of thirteen residents, Resident #15. Findings were: 1. Resident #23 was admitted to the facility with the following diagnoses, including but not limited to: Dementia with agitation, depressive disorder, anxiety, and psoriasis. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/01/2022. Resident #23 was assessed as having difficulty with both long and short term memory, as well as having difficulty with daily decision making skills. On 01/11/2022 at approximately 4:30 p.m., the hospice note section of the clinical record was reviewed. An IDG (interdisciplinary group) Comprehensive Assessment dated 01/05/2023 was observed. Under the section "Client Orders (since last IDG meeting)", was a new order, "CLEANSE STAGE II PRESSURE ULCER TO LEFT AND RIGHT HIP, APPLY BETADINE, ALLOW TO DRY, APPLY HYDROGEL, AND LEAVE OPEN TO AIR DAILY, WEEKLY BY HOSPICE STAFF." There were no measurements or description of the wound within the documentation. Resident #23's medical record was reviewed. The physician orders included an order written 01/05/2023, which contained the following: "Apply betadine to R (right) and L (left) greater	F 686	have been affected by the deficient practice: Skin assessments were completed for Resident #23 and Resident #15. Findings were addressed with NP and hospice, and treatment orders were changed. How the facility will identify other residents having the potential to be affected by the same deficient practice: Skin assessments for all residents were completed by nurse. Findings that required treatment or preventative treatment were discussed with MD/NP, RP and hospice if appropriate. Orders were initiated or changed as appropriate. Systemic changes made to ensure that the deficient practice will not recur: Nurses were educated on proper completion of weekly skin assessments and the completion of CNA skin checks at each shower, with communication of new findings to Unit Manager or DON. The aides will complete skin checks as part of the bathing / shower routine for each resident. The nurse will perform weekly skin assessments. Assessment documentation will include an initial documentation of wound assessment, documentation of wound assessments, and weekly skin/wound reports. New findings will be reported to the Unit Manager or DON. Hospice and Unit Manager or DON will communicate after each visit weekly for four weeks to discuss findings. Any new findings will be communicated to the MD/NP and/or hospice for assessment and interventions	

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 _____	01/12/2023

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 686	Continued From page 14 trochanters BID (twice a day), allow to dry and leave open to air until healed." Weekly skin observations were observed in the clinical record. An observation was completed on 12/18/2022. Additional observations were not documented until 01/07/2023 (20 days later). Neither documented any areas on either of Resident #23's greater trochanters. The progress note section was reviewed. A note dated 01/04/2023 contained the following: "Resident noted to have small, scabbed area on right hip approximately the size of a dime. Passed on to RN (registered nurse) Supervisor to assess and TX (treat)..." The care plan was reviewed. A focus area noted, "...at risk for pressure ulcers related to decreased mobility and incontinence...", included but was not limited to the following interventions: "Assist with meals as needed. She must be fed at times; pressure reducing cushion to chair...; pressure reduction mattress to bed; weekly skin assessment by a licensed nurse." There were no entries, changes, or updates related to the pressure area on either of Resident #23's right or left greater trochanter. Review of the clinical record also included Resident #23's weights. From 06/09/2022 until 01/06/2023, Resident #23 lost a total of 23.55% of her body weight (107 lbs to 81.8) pounds from 06/09/2022 until 01/06/2023. No supplements or interventions had been implemented for weight maintenance or to promote wound healing. An end of the day meeting was held with the DON (director of nursing) and the administrator on	F 686	as appropriate. The care plan will be updated as needed. An audit of the weekly skin assessments will be performed by the Unit Manager or desginee twice weekly to ensure skin assessments are complete and all new findings are addressed. Status of findings will be reviewed with MD/NP and hospice weekly. How to monitor to make sure the solutions are sustained: The findings of the weekly skin audits will be reviewed and discussed at the monthly QA meeting. Any concerns identified will be corrected.	

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 _____	01/12/2023

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 686	Continued From page 15	F 686		

01/11/2023 at approximately 5:00 p.m. When asked about the documentation in the hospice note, the DON stated that the areas were scratches and not pressure areas, but added that she had not observed them. Concerns were voiced regarding Resident #23's significant weight loss and the development of pressure ulcers as identified by the hospice nurse.

On 01/12/2023 at approximately 10:00 a.m., the areas on Resident #23's greater trochanters were observed by two members of the survey team. The DON and LPN (licensed practical nurse) #2, rolled Resident #23 to her left side exposing a pressure ulcer on to the right trochanter (hip). A round, open wound, covered in dark brown/black eschar (dead tissue) was measured by the DON per the survey team's request. The area of eschar measured 1.7 cm X 1.4 cm, the periwound was red and puffy. LPN #2 pressed on the red area, then stated that the area was not warm to touch, but did not blanch (lighten in color) when she applied pressure. Resident #23 voiced discomfort when LPN #2 pressed on the area. The entire area including the periwound measured as 3.0 cm X 3.5 cm. The area was directly over the right greater trochanter (hip). The DON stated, "These started as scratches." There were elongated scratch marks near the pressure wound but not directly around it. When asked if she thought the scratches caused the areas or the areas caused the scratching, the DON did not answer.

Resident #23 was turned to her right side and the left trochanter area was observed and measured by the DON as 0.8 cm X 0.4 cm. The area around the wound was not red or tender, when palpated by LPN #2. This area was also directly over the

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 _____	01/12/2023

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 686	Continued From page 16	F 686		

greater trochanter and was covered by light brown eschar (dead tissue). Elongated scratches were observed near the wound area but not directly over it. The DON stated, "I haven't looked at these areas since the betadine was started...the nurse practitioner told us not to use the hydrogel that hospice suggested, just the betadine." When asked if the nurse practitioner or the physician had observed the areas, the DON stated, "No." When asked if the nurse practitioner was available, the DON replied, "She [nurse practioner] just took these patients over last week and she is off until the twenty-third.." LPN #2 stated, "I saw the areas last week, they didn't look like that." When asked if there was a wound nurse in the facility, the DON stated, "No." When asked who completed the skin observations for the residents, the DON stated, "The charge nurse is supposed to do them every week and whenever there is a change."

The hospice RN was contacted via telephone on 01/12/2023. When questioned, the hospice RN stated that the notes in the clinical record were summaries of her monthly visits. The hospice RN stated she would send the weekly visit notes to the facility for review. The hospice RN was asked if she did a complete body assessment each time she visited Resident #23. The hospice RN stated, "No, I only do that if they are in the bed...if they are in the dining room, eating, or in activities, I don't do that....I will look at their arms and their legs but that's it."

The weekly hospice visit note dated 01/04/2023 was received and contained the following: "RT-GREATER TROCHANTER, PU (pressure ulcer) STAGE II...LENGTHxWIDTHxDEPTH 1.4 X 0.8 X 0...GRANULATION TISSUE-NONE;

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 _____	01/12/2023

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 686	Continued From page 17	F 686		

EDGES-NOT ATTACHED;
SHAPE-ROUND...EPITHELIAZATION 100%;
TOTAL NECROTIC TISSUE SLOUGH 0-25%;
TOTAL NECROTIC TISSUE ESCHAR 0-25%."
LT GREATER TROCHANTER PU STAGE II...LENGTHxWIDTHxDEPTH 0.5 X 0.3 X 0...GRANULATION TISSUE-<75 & >25%;
EDGES-DISTINCT;
SHAPE-ROUND...EPITHELIAZATION 25-<50%;
TOTAL NECROTIC TISSUE SLOUGH 0-25%;
TOTAL NECROTIC TISSUE ESCHAR 0-25%."
The note also included, "STAFF REPORT PATIENT HAS NEW AREAS TO BOTH HIPS...LAID DOWN BY FACILITY STAFF...AREAS TO BILATERAL HIPS WERE ASSESSED...NEW ORDERS...CLEANSE STAGE II PRESSURE ULCER TO LEFT AND RIGHT HIP, APPLY BETADINE, ALLOW TO DRY, APPLY HYDROGEL AND LEAVE OPEN TO AIR DAILY, WEEKLY BY HOSPICE STAFF..."

The facility policy regarding pressure ulcers was requested and presented. Per the DON the policy "Pressure Ulcer and Skin Care" was used by the nursing facility as well as the assisted living facility. Per the policy, "Residents with pressure ulcers should be documented weekly using (name of form)...
The DON is responsible for weekly verifying that the appropriate treatment is administered as ordered and that documentation and evaluation reflect the current status of each pressure ulcer.
The interdisciplinary care plan for the resident must identify current resident problems, goals, and actions directed towards the prevention and/or resolution of pressure ulcers...When a pressure ulcer is reported or identified the charge nurse must visually assess the affected area on the resident and complete the initial assessment

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 _____	01/12/2023

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 686	Continued From page 18	F 686		

of each pressure ulcer..."

The above conversation with the hospice nurse was discussed with the DON. She stated, "I will talk to her, she is supposed to assess the residents every time she sees them." The DON was asked to present any additional information she had regarding Resident #23's bilateral pressure ulcers.

During a meeting with the DON and the administrator at approximately 12:30 p.m., the above findings were was discussed. Concerns were voiced that Resident #23's pressure ulcers had been allowed to deteriorate to an unstageable (unidentified wound severity) status, without any change in intervention/treatment or the needed assessments. The facility staff were informed that the survey team was recommending this at a harm level.

No further information was obtained prior to the exit conference.

2. Resident #15 was admitted to the facility with the following diagnoses including but not limited to: Arthritis, heart disease, vascular dementia, and hard of hearing. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/24/2022. Resident #15 was assessed as cognitively intact for daily decision making, with a summary score of 15 out of 15.

Resident #15's clinical record was reviewed on 01/11/2023 at approximately 2:00 p.m. The following orders were observed: "Apply corn pad

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 _____	01/12/2023

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 686	Continued From page 19	F 686		

to opened wound between 3rd and 4th digits, change every 3 days; skin prep to left outer ankle scabbed area BID until healed."

Resident #15's care plan was reviewed. The following was observed: "Category: Pressure Ulcer...experiences incontinence and is at risk for skin breakdown/pressure injury...Goal: will not have any new pressure injury/skin breakdown over the next review." Interventions included but were not limited to: "Report any signs of skin breakdown...weekly skin assessments by a licensed nurse."

The weekly skin observations for Resident #15 were reviewed, neither of the wounds identified above were documented on the weekly skin observation sheets. The DON was interviewed on 01/12/2023 at approximately 11:30 a.m. and asked about the observation sheets and what should be on them. The DON stated, "Both the areas between her toes and the area on her ankle should be addressed on the observation sheets until they are healed...they are supposed to be done weekly." When asked if they should be included on the care plan, the DON stated, "Yes."

At approximately 11:40 a.m., the areas between Resident #15's toes and the area on the outside of her left ankle were observed with the DON. Salonpas pain patch was observed stretching across the top of her right foot and corn pads were observed between her toes as ordered. The DON stated, "These areas between her toes are where they got red and moist." When asked if the areas between her toes was related to the Salonpas pushing her toes together, the DON stated, "No." The area on the left outer ankle was observed as a round area covered in eschar

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 _____	01/12/2023

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 686	Continued From page 20 (necrotic/dead tissue), approximately the size of a dime. When asked if the area to the ankle was pressure related, the DON stated, "No, it started out as a scratch." She was asked if the physician or nurse practitioner had looked at the areas. She stated, "No." The above findings were discussed during a meeting with the DON and the administrator at approximately 12:30 p.m. Concerns were voiced that weekly skin observations had been documented for Resident #15, but none of her current wounds to her right ankle and foot were included or identified. No further information was obtained prior to the exit conference on 01/12/2023.	F 686		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		2/24/23

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 _____	01/12/2023

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 692	Continued From page 21 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to implement interventions for a significant weight loss for one of 13 residents, Resident #23. During a six month time span from 06/09/2022 until 12/07/2022, Resident #23 lost 21.50% (23 pounds). Resident #23 was not assessed by the registered dietician at the facility, nor were any interventions put in place to address her significant weight loss. This was identified as harm by the survey team. Findings were: Resident #23 was admitted to the facility with the following diagnoses, including but not limited to: Dementia with agitation, depressive disorder, anxiety, and psoriasis. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/01/2022. Resident #23 was assessed as having difficulty with both long and short term memory, as well as having difficulty with daily decision making skills. On 01/11/2023, at approximately 9:00 a.m., Resident #23 was observed sitting in the dining room. CNA (certified nursing assistant) #1 was at her side. Her divided plate in front of her was empty, she was drinking orange juice from a cup with a lid and a straw. When asked what Resident #23 had eaten, CNA#1 stated, "100 percent, eggs, toast, bacon." When asked what assistance she needed, CNA#1 stated, "I remind	F 692	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The weights for Resident #23 were reviewed and findings discussed with NP, hospice and RD. Supplements were initiated. How the facility will identify other residents having the potential to be affected by the same deficient practice: A weight audit of all residents was completed. Those with significant weight loss were discussed with MD/NP and RD and interventions implemented as appropriate. Those residents on hospice were discussed with MD/NP, hospice and RP. Systemic changes made to ensure that the deficient practice will not recur: All weights will be monitored monthly by the Unit Manager or designee as ordered by MD/NP. Residents with weight loss will be discussed with MD/NP and RD for further nutritional intervention. The Director of Nursing and Unit Manager discussed the hospice plan of care with hospice, MD/NP and RP. Weights and/or mid-arm circumferences will be monitored by hospice per hospice plan of care. All residents will be monitored for decline in nutritional status and/or decreased meal / supplement intake. Hospice and Unit Manager or DON will communicate after	

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 _____	01/12/2023

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 692	Continued From page 22 her to eat and help her if she needs it....she does pretty good." On 01/11/2023, at approximately 12:30 p.m., Resident #23 was observed in the dining room, while eating her lunch. Again, Resident #23 consumed 100% of her meal, with assistance. Resident #23's clinical record was reviewed on 01/11/2023 at approximately 1:30 p.m. The physician orders were reviewed. Resident #23 was ordered a regular diet. No dietary supplements were ordered. Her weights from June 2022 through January 2023 were as follow: 06/09/2022 107 lbs 07/14/2022 106.4 lbs 09/01/2022 92.8 lbs 10/07/2022 91.8 lbs 11/09/2022 91.2 lbs 12/07/2022 84 lbs 01/06/2023 81.8 lbs On 01/11/2022 at approximately 4:30 p.m., the hospice note section of the clinical record was reviewed. An IDG (interdisciplinary group) Comprehensive Assessment dated 01/05/2023. Documentation included: "LUMAC (Left upper mid arm circumference) is down 2 cm this recert period. No weights are available but patient's clothes are baggy. She is thin and frail. Facility staff report she is eating 0.5-0.75 cups per meal...She is eating 25% of offered meals. She will often forget to eat and periodically require to be fed partial meals. She is requiring caregivers to place only one utensil on the table as needed, which she often uses her hands..." The note also included the identification of Stage II pressure ulcers on her bilateral greater trochanters."	F 692	each visit weekly for four weeks to discuss findings. Changes will be addressed per hospice plan of care, offering nutritional supplements if appropriate and as tolerated by resident and in agreement with MD/NP and RP. How to monitor to make sure the solutions are sustained: The findings of the weight audits and notifications of hospice residents' nutritional decline will be discussed at the monthly QA meeting. Any concerns identified will be corrected.	

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 _____	01/12/2023

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 692	Continued From page 23	F 692		

Resident #23's care plan was reviewed. A focus area documented "...at risk for pressure ulcers related to decreased mobility and incontinence...", and included but was not limited to the following interventions: "Assist with meals as needed. She must be fed at times; document nutritional intake; Offer and encourage fluids often throughout the day." Another focus area documented "...dependent with ADL's [activities of daily living] included the following interventions: "Set up meal trays and give assistance with all meals as needed. She will attempt to feed self at times."

The Registered Dietician (RD) notes were reviewed. The last RD note was written 11/02/2022 and contained the following: "No weights due to hospice enrollment. She is nonambulatory and is transported via wheelchair, she is alert and orient to self. Her diet order is Regular. Resident tested positive for COVID in August...will continue with her nutrition plan of care as ordered..."

An end of the day meeting was held with the DON (director of nursing) and the administrator on 01/11/2023, at approximately 5:00 p.m. Concerns were voiced regarding Resident #23's significant weight loss and the development of pressure ulcers, which were identified by the hospice nurse on 01/04/2023.

On 01/12/2023 at approximately 8:30 a.m., Resident #23 was observed in the dining room eating breakfast. CNA (Certified nursing assistant) #1 was at her side. He stated that Resident #23 had eaten 100% of her breakfast.

The breakfast observation was discussed with

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 _____	01/12/2023

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 692	Continued From page 24	F 692		

the DON at approximately 8:45 a.m. Asked if there was a reason why residents receiving hospice were not offered supplements or fortification of their food, the DON stated, "I understand what you are saying. I spoke with the hospice nurse this morning. She said hospice doesn't pay for supplements. I told her that didn't matter, we could take care of that here. I am going to contact [hospice RN Name redacted] to get an order for some Ensure Clear...she drinks better than she eats some days." When asked if the facility RD was involved at all, as her notes indicated "no weights" were available due to Resident #23 being enrolled in hospice, the DON stated, "I get their weights for the MDS, the RD has access to those. I don't know what happened."

The hospice RN was contacted via telephone on 01/13/2023. When questioned, the hospice RN stated that the notes in the clinical record were summaries of her monthly visits. Asked about Resident #23's weight loss and whether or not an RD from hospice had seen her, the hospice RN stated, "We don't have an RD." Asked if she had looked at Resident #23's weights, the hospice RN stated, "No, I don't have access to those. We usually expect them to lose weight when they are in hospice." Concerns were voiced that although Resident #23 is in hospice, review of her intake as documented by the facility from November to the present showed that she was eating 51-75% and 76-100% at most meals. Of the last 75 meals documented, only 14 documented that Resident #23 had eaten less that 50%. The hospice RN stated, "I document what they tell me. I don't really look at their intake sheets...we don't do supplements."

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 _____	01/12/2023

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 692	Continued From page 25 During a meeting on 1/13/23 with the DON and the administrator, at approximately 12:30 p.m., the above findings were discussed. Concerns were voiced that Resident #23's had suffered a significant weight loss without intervention from the facility. Although Resident #23 required assistance, observation by the survey team and documentation in the facility clinical record indicated that she was eating. The facility RD had not recommended any interventions nor had she identified a significant weight loss, although the weight loss was documented in the medical record. The facility staff was informed that the survey team was recommending this deficient practice at a harm level. No further information was obtained prior to the exit conference.	F 692		