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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, staff interview, and facility document review, the facility staff failed to properly dispose of trash in one of one facility dumpster.The findings include:On 3/17/26 at 11:09 a.m., the Director of Maintenance and the Director of Dining Services accompanied the surveyor outside the building for observation of the dumpster. The dumpster did not have a cover over it. The Director of Dining Services attempted to close the two piece lid to the dumpster. The two pieces did not cover the entire top to the dumpster; multiple areas remained open to air even after the lid pieces were pulled over the top. The Director of Maintenance stated the dumpster is emptied every day and had not been closed since it had been emptied earlier in the morning. He stated the dish washing staff is responsible for making sure the lid is closed after the dumpster is emptied each morning. He agreed that the dumpster was not completely covered with the current lid and stated he would call the dumpster company to order a new one. He stated that the dumpster should be covered at all times to avoid attracting rodents and other pests and creating an unsanitary environment.On 3/18/26 at 5:09 p.m., the Administrator and the Director of Nursing were informed of these concerns.A review of the facility policy, Food Services Infection Control, revealed, in part: The following activities of food service personnel may involve or have an effect on the risk of infection for residents and personnel. Infection prevention and control measures are.Using garbage containers that are leakproof, pest proof, and easily cleaned. Lids should fit tightly.Using appropriate control measures to eliminate insects and rodents.No additional 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

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interview and facility document review, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for five of 19 residents in the survey sample, Residents #9, #6, #18, #17 and #8. The findings include:1. For Resident #9 (R9), the facility staff failed to develop the comprehensive care plan to address nutritional needs and weight loss. R9 was admitted to the facility with diagnoses that included but were not limited to protein-calorie malnutrition (1), dementia (2) and bariatric surgery status (3). On the most recent minimum data set (MDS), a quarterly assessment with an assessment of reference date (ARD) of 1/28/2026, the resident was assessed as being severely impaired for making daily decisions and not having a weight loss. Review of the comprehensive care plan failed to evidence a focus/goal or interventions regarding nutritional needs or weight loss. Review of R9's weights documented the following weight changes. On 02/14/2026, the resident weighed 122.2 lbs. On 03/14/2026, the resident weighed 117.6 lbs which is a -3.76% loss in one month. On 12/02/2025, the resident weighed 137 lbs. On 03/14/2026, the resident weighed 117.6 lbs which is a -14.16% loss in three months. On 10/03/2025, the resident weighed 137.4 lbs. On 03/14/2026, the resident weighed 117.6 lbs which is a -14.41% loss in six months. The physician orders for R9 documented in part, - weigh weekly x 4 weeks one time a day every Tue (Tuesday). Start Date: 02/10/2026. D/C (discontinue) Date: 02/06/2026. - weigh weekly x 4 weeks one time a day every Sat (Saturday). Start Date: 02/07/2026. D/C Date: 03/14/2026. - weigh weekly x 4 weeks one time a day every Sat. Start Date: 02/07/2026. D/C Date: 03/14/2026. - Weigh weekly one time a day every Sat for weight loss. Start Date: 03/21/2026. - House Supplement every day shift for weight loss. Start Date: 02/07/2026. D/C Date:02/23/2026. - House supplement one time a day for weight loss. Start Date: 02/24/2026. - Drawn CMP (comprehensive metabolic panel) and TSH (thyroid stimulating hormone) R63.4, one time only for weight loss. Start Date: 03/03/2026. - Dexamethasone Tablet 0.5 MG Give 1 tablet by mouth one time a day for to assist weight loss. Start Date: 03/05/2026. The progress notes for R9 documented in part, (continued on next page)

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 2/3/2026 14:22 (2:22 PM) Note Text: WEIGHT WARNING: Value: 123.0, Vital Date: 2026-02-03 09:14:00.0. MDS: -5.0% change over 30 day(s) [8.2% , 11.0], -3.0% change from last weight [8.2% , 11.0], -7.5% change [10.2% , 14.0]. Recommned [sic] a reweigh for to verify this weight exception. Prior to this month she had been gaining. Her Jan weight was up +13.2% or +16 Lbs compared to her July weights of 121.4#. Her Feb weight is very close to her initial weights in July. Is she coming back down to a more usual baseline weight? Her PO (by mouth) intakes have been recorded mostly as 51-75%. Her diet is Regular. If her NP [Nurse Practitioner] is interested in adding an oral supplement PO QD (daily), I can support that. Her BMI (body mass index) is 21.8, normal. The risk of a supplement is decreased PO related to reduced hunger. Consider a PM or HS (bedtime) timeframe. Will monitor prn (as needed). - 2/6/2026 14:02 (2:02 PM) Note Text: NP [Name of NP] in to see resident ordered magic cup 1 x a day, weight weekly on Saturday, and decline Omnicare consultation to GDR (gradual dose reduction) duloxetine, RP [Name of RP] updated on new orders. - 2/24/2026 12:59 (12:59 PM) Note Text: WEIGHT WARNING: Value: 122.1, Vital Date: 2026-02-21 09:32:34.0. MDS: -10.0% change over 180 day(s) [12.2% , 17.0] since 8/25/2025, 139# -7.5% change [10.9% , 14.9] 12/2/2025, 137#. Res's 2/21 weight triggered on the weight exception report with a 12.2% loss compared to her 8/25 weight of 139#. Per IDT (interdisciplinary team), her NP is aware. NON (new orders noted) 2/24 for a house supplement QAM. She has weekly weights ordered 2/7 to 2/28. Will monitor. - 3/2/2026 17:15 (5:15 PM) Note Text: Update RP on weight loss and new orders for blood work pertaining to weight loss, xray ordered for left for [sic] redness and to hold profore until xray have been done. Reach to dietitian for recommendations. - 3/4/2026 20:22 (8:22 PM) Note Text: Updated RP on new order after blood work for TSH and CMP came back for [Name of physician] start dexamethasone 0.5mg (4) daily for weight loss, agree with medication change to help with weight loss. will provide schedule when coming to facility to meet with RP when seeing residents. - 3/5/2026 17:18 (5:18 PM) Note Text: WEIGHT WARNING: Value: 116, Vital Date: 2026-03-04. MDS: -5.0% change over 30 day(s) [Comparison Weight 2/3/2026, 123 Lbs, -5.7% , -7 Lbs] MDS: -10.0% change over 180 day(s) [Comparison Weight 9/4/2025, 139 Lbs, -16.5% , -23 Lbs] -7.5% change [Comparison Weight 1/2/2026, 134.0 Lbs, -13.4% , -18.0 Lbs] Res's March weight continues to trigger on the weight exception report with a significant loss compared to her Feb, Sept and Jan weights. Per IDT, her NP is aware. We added a House supplement on 2/24. Her diet order is Regular. Her ADLs (activities of daily living) show more variability in her PO intakes over the past 14 days. She has variable support at meals based on her needs of the day. She accepts her ONS (oral nutritional supplement) 50-100% most times. 25% recorded rarely. She is receiving treatment to a DTI (deep tissue injury) to her left heal [sic]. She has a new order 3/4 for: Dexamethasone Tablet 0.5 MG. Give 1 tablet by mouth one time a day for to assist weight loss. Will ask her IDT if they want to increase her ONS to BID (twice a day). On 3/18/2026 an interview was conducted with licensed practical nurse (LPN) #1 who stated that the purpose of the care plan was to have a pathway to keep the residents healthy and safe. She stated that she did not develop the care plan, and she thought that the director of nursing and assistant director of nursing developed the care plan with the family and physician input. (continued on next page)

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/18/2026 at 4:09 PM, an interview was conducted with the regional health coordinator who stated that the care plan purpose was to lay out the plan of how they care for the residents and to give staff guidelines on how to care for the resident based on the MDS assessment. She stated that the MDS coordinator developed the care plan based on the MDS assessment and it also involved the social worker, activities and families. She stated that when there was a change or new orders the nurse or whoever took the order should update the care plan and she would expect weight loss to be addressed on the care plan and to be updated by nursing. The facility policy NS-16p Comprehensive Person-Centered Care Planning revised June 2025 documented in part, .The community will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychological needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) process . Each resident's comprehensive care plan will describe the following: Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychological well-being . The comprehensive care plan will: Incorporate identified problem areas; Incorporate risk factors associated with identified problems . On 3/18/2026 at 5:04 PM, the executive director, the director of nursing and the health services administrator were made aware of the findings. No further information was provided prior to exit. Reference: (1) The word malnutrition is based in Latin, meaning bad (mal) nourishment (nutrition). Malnutrition may be found in one of two forms: undernutrition or overnutrition. Undernutrition may result when an individual isn't able to meet their calorie or protein needs over a period of time. It may also occur if the body can't absorb or use specific nutrients. Individuals who are undernourished often lose weight without trying, because their body is breaking down fat or muscle for fuel. Overnutrition is the result of eating more calories than needed. The extra calories are stored as body fat and can lead to obesity. These individuals can become malnourished if they aren't getting the nutrients they need . This information was obtained from the website: How an RDN Can Help with Malnutrition (2) Dementia is a loss of mental functions that is severe enough to affect your daily life and activities. These functions include: Memory, Language skills, Visual perception (your ability to make sense of what you see), Problem solving, Trouble with everyday tasks, The ability to focus and pay attention. It is normal to become a bit more forgetful as you age. But dementia is not a normal part of aging. It is a serious disorder that interferes with your daily life . This information was obtained from the website: Dementia | MedlinePlus (3) Weight loss surgery helps people with extreme obesity to lose weight. It may be an option if you cannot lose weight through diet and exercise or have serious health problems caused by obesity. There are different types of weight loss surgery. They often limit the amount of food you can take in. Some types of surgery also affect how you digest food and absorb nutrients. All types have risks and complications, such as infections, hernias, and blood clots. Many people who have the surgery lose weight quickly, but regain some weight later on. If you follow diet and exercise recommendations, you can keep most of the weight off. You will also need medical follow-up for the rest of your life . This information was obtained from the website: Bariatric Surgery | Weight Loss Surgery | Gastric Bypass | MedlinePlus (continued on next page)

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(4) Dexamethasone, a corticosteroid, is similar to a natural hormone produced by your adrenal glands. It often is used to replace this chemical when your body does not make enough of it. It relieves inflammation (swelling, heat, redness, and pain) and is used to treat certain forms of arthritis; skin, blood, kidney, eye, thyroid, and intestinal disorders (e.g., colitis); severe allergies; and asthma. Dexamethasone is also used to treat certain types of cancer . This information was obtained from the website: Dexamethasone: MedlinePlus Drug Information 2. For Resident #6 (R6), the facility staff failed to apply a left-hand palm pillow, per the resident's comprehensive care plan. R6's comprehensive care plan dated 12/11/25 documented, Apply palm pillow as ordered. Further review of R6's clinical record revealed a physician's order dated 12/11/25 for a left-hand palm pillow to be applied at 7:00 a.m. and removed at 7:00 p.m. for a contracture. On 3/17/26 at 12:06 p.m., and 3/18/26 at 7:41 a.m., R6 was observed clinching their left fist with no palm pillow in place. On 3/18/26 at 2:28 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #1. LPN #1 stated the care plan is a pathway to keeping residents healthier, and to making sure negative things do not happen to residents. LPN #1 stated the nurse has the major responsibility for implementing the care plan, and added CNAs (certified nursing assistants), the Director of Nursing and Assistant Director of Nursing are also responsible for making sure each resident's care plan is followed. On 3/18/26 at 2:39 p.m., another interview was conducted with LPN #1. LPN #1 stated she believed R6's palm pillow was for the resident's contracture and the certified nursing assistants applied the resident's palm pillow. On 3/19/26 at 9:07 a.m., the Executive Director and the Director of Nursing were made aware of the above findings. No further information was presented prior to exit. 3. For Resident #18 (R18), the facility staff did not implement the Life Enrichment care plan. During the course of the survey, the following observations were made:On 3/17/26 at 11:40 a.m., R18 was seated in a wheelchair in the middle of the hallway. He was leaning forward in his wheelchair grasping at his right ankle. Two staff members passed the resident and neither acknowledged nor attempted to assist the resident. On 3/17/26 at 11:41 a.m., a staff member approached R18 and repositioned his wheelchair so it was facing the widest open part of the hallway. On 3/17/26 at 11:47 a.m., R18 self-propelled the wheelchair to the door of the biohazard room. He repeatedly reached for the wheels on his wheelchair and reached out to touch the door. Two staff members, including the Director of Nursing, walked by the resident. Each staff member spoke to the resident, but neither one attempted to reposition the wheelchair. On 3/17/26 at 2:02 p.m., R18 was sitting in his wheelchair in the small alcove between the dining (continued on next page)

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room doors and the wall separating the alcove from the hallway. He attempted to move the wheelchair into the hallway but was not successful. On 3/17/26 at 2:07 p.m., a staff member pushed R18 in his wheelchair from the alcove to the middle of the long hallway. The staff member left the resident's wheelchair in the middle of the hallway. On 3/17/26 at 2:10 p.m. R18 was in his wheelchair in the living room. He was not engaged in any activity or paying attention to the television. On 3/17/26 at 3:19 p.m., R18 was still in his wheelchair in the living room. His head was bent forward and the resident's eyes were closed. On 3/18/26 at 8:57 a.m., R18 was in his wheelchair and self-propelled down the hallway towards the living room. On 3/18/26 at 9:08 a.m., R18 was in his wheelchair in the living room. He touched some of the knobs and locks on an activity board but did not stay engaged in that activity more than a couple of minutes. When he finished with the activity board, he propelled himself around the living room in his wheelchair, sometimes coming into contact with other residents and/or their chairs. On 3/16/26 at 9:40 a.m., R18 was in his wheelchair in the living room with his back to the television. The television projected a cartoon movie. On 3/18/26 at 10:01 a.m., two staff members were observed in the living room. Neither of these staff members engaged R18 in any sort of activity. R18's daughter was seated in the living room near R18's wheelchair. On 3/18/26 at 10:23 a.m., R18's daughter left the living room. R18 immediately moved his wheelchair to an area between two other residents in the living room. 03/18/2026 10:23 a.m., Daughter has left. Activities aide still in room. Resident has wheeled his wheelchair up to the area between 2 other residents in the room. Resident is not engaged in any activity. On 3/18/26 at 10:26 a.m., R18 was in his wheelchair in the hallway outside the living room. He attempted to propel the wheelchair forward, but the wheelchair continued to move backwards. On 3/18/26 at 10:28 a.m., 10:36 a.m., and 10:53 a.m., R18 sat in his wheelchair outside the living room attempting to move the wheelchair forward with gradual success. [Of note, the activities calendar for the facility advertised a Hymns and Devotions activity on 3/18/26 at 10:30 a.m.] On 3/18/26 at 10:58 a.m., R18 self-propelled his wheelchair in a circle around the nurses' station, beginning and ending at entrance to the nurses' station most distant from the living room. On R18's annual MDS assessment with an ARD of 5/20/25, the following activities were coded as being of high importance to the resident: going outside when the weather is good; having books, newspapers, and magazines to read; listening to music; doing things with groups; and participating in (continued on next page)

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	religious services. A review of R18's Life Enrichment progress notes revealed the following note dated 2/24/26: Quarterly Note: [R18] is being followed by [name of local hospice provider]. Occasionally [R18] will partake (sic) in programs. [R18] will participate in music entertainment, small groups, and outdoor visits.[R18] will participate in programs of his desire until his next review. A review of R18's activities participation calendars for February and March 2026 revealed no activity participation on any days except Mondays and Fridays. On each Monday and Friday of both months, the calendars revealed evidence that the staff attempted one-on-one activities with the residents. There were no activities documented for any other days in either month. A review of R18's comprehensive care plan dated 6/20/25 revealed, in part: Life Enrichment.Invite/encourage the resident's family members to attend activities with resident in order to support participation.Staff will invite and escort [R18] outside when weather permits.The resident needs assistance/escort to activity functions. On 3/28/26 at 2:28 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated the care plan is a pathway to keeping residents healthier, and to making sure negative things do not happen to residents. She explained that the care plan helps keep residents safe from harm. She stated that nurses, the Director of Nursing and CNAs (certified nursing assistants) all play a part in implementing a care plan. On 3/18/26 at 3:12 p.m., the Life Enrichment Director was interviewed. She stated that a large percentage of residents in the facility have cognitive impairment, and residents who do not have cognitive impairment prefer to do activities with a group that is bigger and more fun. She explained that the nursing facility connects to the adjacent assisted living memory care facility where more of the residents are mobile and more easily participate in group activities. She explained this is the reason that most group activities to which nursing facility residents are invited actually take place in the adjacent assisted living activity room. She stated that the activity room in the assisted living facility is better designed. She stated that activities for the advanced dementia residents in the nursing facility happen in a common room where more tactile small group programs take place. She stated in order to determine which activities would be best suited for each individual resident, she interviews the residents and their families. She stated sometimes, the families are not as helpful because they remember how their loved ones used to be, not how the residents are in reality in the present time. She stated she takes the information she gathers from these interviews and creates a program for each resident. She stated R18's dementia care program is comprised of something she had done in the past when she made a kit for him. She explained he likes to go to music entertainment occasionally and to roll up and down the hall. She stated the staff sometimes takes him outside when staff is available to do so. She added: He is more of a one-on-one person. She stated she was not aware of and did not know why R18 was not invited to attend that morning's Hymns and Devotions activity. However, she explained that R18 would not have enjoyed the devotional part of that activity. She stated she was not aware of R18's assessed preference for religious activities on the most recent annual MDS. On 3/18/26 at 5:09 p.m., the Administrator and the Director of Nursing were informed of these concerns. No additional information was provided prior to exit. (continued on next page)

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. For Resident #17 (R17), the facility did not develop a care plan for the resident's cognitive impairment. R17 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date of 2/3/26, R17 was coded as having severe problems with both long term and short term memory. A review of R17's progress notes revealed the following: 11/10/25 19:37 (7:37 p.m.) Resident very resistant to care, taking meds, hypervigilant, attempting to stand/walk without assistance. Staff ambulating resident to assist with this behavior with no relief noted. He was hitting, pinching, trying to squeeze, twist staff arms, wrist, etc. 11/11/25 12:15 (p.m.) Change in Condition.Behavioral Status Evaluation: Physical Aggression, Verbal Aggression, Danger to self or others. 11/19/25 07:54 (7:54 a.m.) Resident refused to take his 6 am medications. Tried for how many times but still not cooperative and trying to hurt the nurse. 12/8/25 23:29 (11:29 p.m.) The staff was sitting with the resident one on one and the writer witnessed him twisting her finger then also grabbing her by the hair. The resident refused to let the staff's hair go when asked three times. 3/16/26 23:30 (11:30 p.m. Staff was attempting to assist the resident from the dining room and he became agitated. The resident hit at the staff and his left arm hit the dining room table. Further review of R17's clinical record failed to reveal assessment of the root causes of R18's behaviors, triggers, or other factors related to his dementia diagnosis. A review of R17's comprehensive care plan dated 2/14/26 revealed in part: Focus: Impaired Cognitive Function. No interventions or additional information were provided. On 3/28/26 at 2:28 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated the care plan is a pathway to keeping residents healthier, and to making sure negative things do not happen to residents. She explained that the care plan helps keep residents safe from harm. She stated she had never developed a care plan, and that she thought the physician, family, Director of Nursing, and Assistant Director of Nursing all play a role in developing a resident's care plan. On 3/18/26 at 4:09 p.m., the MDS Coordinator was interviewed. She stated the care plan lays out the path that the facility will take in caring for the residents. She stated that all disciplines participate in formulating a care plan, but she is responsible for entering the information on the care plan. She stated she reviews the MDS, providers' orders, resident and family interviews, and staff interviews to develop care plans. She stated that a resident's cognitive impairment should be included in the care plan. On 3/18/26 at 5:09 p.m., the Administrator and the Director of Nursing were informed of these concerns. No additional information was provided prior to exit. (continued on next page)

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. For Resident #8 (R8), the facility staff did not develop a care plan for the use of an anticoagulant medication. A review of R8's provider's orders revealed the following order dated 2/12/26: Eliquis (1) Tablet 5 mg (milligrams) Give 1 tablet by mouth two times a day. A review of R8's comprehensive care plan failed to reveal any information related to the anticoagulant. On 3/18/26 at 4:09 p.m., the MDS Coordinator was interviewed. She stated the care plan lays out the path that the facility will take in caring for the residents. She stated that all disciplines participate in formulating a care plan, but she is responsible for entering the information on the care plan. She stated she reviews the MDS, providers' orders, resident and family interviews, and staff interviews to develop care plans. She stated that an anticoagulant should be included in the care plan. On 3/18/26 at 5:09 p.m., the Administrator and the Director of Nursing were informed of these concerns. No additional information was provided prior to exit. Reference(1) Apixaban (Eliquis) is used to help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease. Apixaban is also used to prevent deep vein thrombosis (DVT; a blood clot, usually in the leg) and pulmonary embolism (PE; a blood clot in the lung) in people who are having hip replacement or knee replacement surgery. Apixaban is also used to treat DVT and PE and may be continued to prevent DVT and PE from happening again after the initial treatment is completed. Apixaban is in a class of medications called factor Xa inhibitors. It works by blocking the action of a certain natural substance that helps blood clots to form. This information was taken from the website https://medlineplus.gov/druginfo/meds/a613032.html.

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observations, staff interview, and facility document review, the facility staff failed to provide person-centered activities based on the comprehensive assessment and resident preferences for one of 19 residents in the survey sample, Resident #18.The findings include:For Resident #18 (R18) the facility staff failed to provide meaningful, person centered activities based on his preferences and holistic needs in February and March 2026.During the course of the survey, the following observations were made:On 3/17/26 at 11:40 a.m., R18 was seated in a wheelchair in the middle of the hallway. He was leaning forward in his wheelchair grasping at his right ankle. Two staff members passed the resident and neither acknowledged nor attempted to assist the resident.On 3/17/26 at 11:41 a.m., a staff member approached R18 and repositioned his wheelchair so it was facing the widest open part of the hallway.On 3/17/26 at 11:47 a.m., R18 self-propelled the wheelchair to the door of the biohazard room. He repeatedly reached for the wheels on his wheelchair and reached out to touch the door. Two staff members, including the Director of Nursing, walked by the resident. Each staff member spoke to the resident, but neither one attempted to reposition the wheelchair.On 3/17/26 at 2:02 p.m., R18 was sitting in his wheelchair in the small alcove between the dining room doors and the wall separating the alcove from the hallway. He attempted to move the wheelchair into the hallway but was not successful.On 3/17/26 at 2:07 p.m., a staff member pushed R18 in his wheelchair from the alcove to the middle of the long hallway. The staff member left the resident's wheelchair in the middle of the hallway.On 3/17/26 at 2:10 p.m. R18 was in his wheelchair in the living room. He was not engaged in any activity or paying attention to the television.On 3/17/26 at 3:19 p.m., R18 was still in his wheelchair in the living room. His head was bent forward and the resident's eyes were closed.On 3/18/26 at 8:57 a.m., R18 was in his wheelchair and self-propelled down the hallway towards the living room.On 3/18/26 at 9:08 a.m., R18 was in his wheelchair in the living room. He touched some of the knobs and locks on an activity board but did not stay engaged in that activity more than a couple of minutes. When he finished with the activity board, he propelled himself around the living room in his wheelchair, sometimes coming into contact with other residents and/or their chairs.On 3/16/26 at 9:40 a.m., R18 was in his wheelchair in the living room with his back to the television. The television projected a cartoon movie.On 3/18/26 at 10:01 a.m., two staff members were observed in the living room. Neither of these staff members engaged R18 in any sort of activity. R18's daughter was seated in the living room near R18's wheelchair.On 3/18/26 at 10:23 a.m., R18's daughter left the living room. R18 immediately moved his wheelchair to an area between two other residents in the living room.03/18/2026 10:23 AM Daughter has left. Activities aide still in room. Resident has wheeled his wheelchair up to the area between 2 other residents in the room. Resident is not engaged in any activity.On 3/18/26 at 10:26 a.m., R18 was in his wheelchair in the hallway outside the living room. He attempted to propel the wheelchair forward, but the wheelchair continued to move backwards.On 3/18/26 at 10:28 a.m., 10:36 a.m., and 10:53 a.m., R18 sat in his wheelchair outside the living room attempting to move the wheelchair forward with gradual success.[Of note, the activities calendar for the facility advertised a Hymns and Devotions activity on 3/18/26 at 10:30 a.m.]On 3/18/26 at 10:58 a.m., R18 self-propelled his wheelchair in a circle around the nurses' station, beginning and ending at entrance to the nurses' station most distant from the living room.On R18's annual MDS assessment with an ARD of 5/20/25, the following activities were coded as being of high importance to the resident: going outside when the weather is good; having books, newspapers, and magazines to read; listening to music; doing things with groups; and participating in religious services. A review of R18's Life Enrichment progress notes revealed the following note dated 2/24/26: Quarterly Note: [R18] is being followed by [name of local hospice provider]. Occasionally [R18] will partake (sic) in programs. [R18] will participate in music entertainment, small groups, and outdoor visits.[R18] will participate in programs of his desire until his next review.A review of R18's activities participation calendars for February and March 2026 (continued on next page)

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed no activity participation on any days except Mondays and Fridays. On each Monday and Friday of both months, the calendars revealed evidence that the staff attempted one-on-one activities with the residents. There were no activities documented for any other days in either month.A review of R18's comprehensive care plan dated 6/20/25 revealed, in part: Life Enrichment.Invite/encourage the resident's family members to attend activities with resident in order to support participation.Staff will invite and escort [R18] outside when weather permits.The resident needs assistance/escort to activity functions.On 3/18/26 at 3:12 p.m., the Life Enrichment Director was interviewed. She stated that a large percentage of residents in the facility have cognitive impairment, and residents who do not have cognitive impairment prefer to do activities with a group that is bigger and more fun. She explained that the nursing facility connects to the adjacent assisted living memory care facility where more of the residents are mobile and more easily participate in group activities. She explained this is the reason that most group activities to which nursing facility residents are invited actually take place in the adjacent assisted living activity room. She stated that the activity room in the assisted living facility is better designed. She stated that activities for the advanced dementia residents in the nursing facility happen in a common room where more tactile small group programs take place. She stated in order to determine which activities would be best suited for each individual resident, she interviews the residents and their families. She stated sometimes, the families are not as helpful because they remember how their loved ones used to be, not how the residents are in reality in the present time. She stated she takes the information she gathers from these interviews and creates a program for each resident. She stated R18's dementia care program is comprised of something she had done in the past when she made a kit for him. She explained he likes to go to music entertainment occasionally and to roll up and down the hall. She stated the staff sometimes takes him outside when staff is available to do so. She added: He is more of a one on one person. She stated she was not aware of and did not know why R18 was not invited to attend that morning's Hymns and Devotions activity. However, she explained that R18 would not have enjoyed the devotional part of that activity. She stated she was not aware of R18's assessed preference for religious activities on the most recent annual MDS. She did not provide any evidence of a dementia related program of engagement or activities for R18.On 3/18/26 at 5:09 p.m., the Administrator and the Director of Nursing were informed of these concerns. Policies related to providing person centered activities according to the needs and preferences of residents were requested.No additional information was provided prior to exit.

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide care and services to promote the highest level of wellbeing for residents with dementia for two 19 in the survey sample, Residents #18 and #17.The findings include:1. For Resident #18 (R18), the facility staff failed to provide person-centered care focusing on the resident's dementia diagnosis and related behavioral symptoms.R18 was admitted to the facility on [DATE] with diagnoses including dementia and hallucinations. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/20/25, R18 was coded as having severe problems with both short and long term memory. During the course of the survey, the following observations were made:On 3/17/26 at 11:40 a.m., R18 was seated in a wheelchair in the middle of the hallway. He was leaning forward in his wheelchair grasping at his right ankle. Two staff members passed the resident and neither acknowledged nor attempted to assist the resident.On 3/17/26 at 11:41 a.m., a staff member approached R18 and repositioned his wheelchair so it was facing the widest open part of the hallway.On 3/17/26 at 11:47 a.m., R18 self-propelled the wheelchair to the door of the biohazard room. He repeatedly reached for the wheels on his wheelchair and reached out to touch the door. Two staff members, including the Director of Nursing, walked by the resident. Each staff member spoke to the resident, but neither one attempted to reposition the wheelchair.On 3/17/26 at 2:02 p.m., R18 was sitting in his wheelchair in the small alcove between the dining room doors and the wall separating the alcove from the hallway. He attempted to move the wheelchair into the hallway but was not successful.On 3/17/26 at 2:07 p.m., a staff member pushed R18 in his wheelchair from the alcove to the middle of the long hallway. The staff member left the resident's wheelchair in the middle of the hallway.On 3/17/26 at 2:10 p.m. R18 was in his wheelchair in the living room. He was not engaged in any activity or paying attention to the television.On 3/17/26 at 3:19 p.m., R18 was still in his wheelchair in the living room. His head was bent forward and the resident's eyes were closed.On 3/18/26 at 8:57 a.m., R18 was in his wheelchair and self-propelled down the hallway towards the living room.On 3/18/26 at 9:08 a.m., R18 was in his wheelchair in the living room. He touched some of the knobs and locks on an activity board but did not stay engaged in that activity more than a couple of minutes. When he finished with the activity board, he propelled himself around the living room in his wheelchair, sometimes coming into contact with other residents and/or their chairs.On 3/16/26 at 9:40 a.m., R18 was in his wheelchair in the living room with his back to the television. The television projected a cartoon movie.On 3/18/26 at 10:01 a.m., two staff members were observed in the living room. Neither of these staff members engaged R18 in any sort of activity. R18's daughter was seated in the living room near R18's wheelchair.On 3/18/26 at 10:23 a.m., R18's daughter left the living room. R18 immediately moved his wheelchair to an area between two other residents in the living room.03/18/2026 10:23 AM Daughter has left. Activities aide still in room. Resident has wheeled his wheelchair up to the area between 2 other residents in the room. Resident is not engaged in any activity.On 3/18/26 at 10:26 a.m., R18 was in his wheelchair in the hallway outside the living room. He attempted to propel the wheelchair forward, but the wheelchair continued to move backwards.On 3/18/26 at 10:28 a.m., 10:36 a.m., and 10:53 a.m., R18 sat in his wheelchair outside the living room attempting to move the wheelchair forward with gradual success.[Of note, the activities calendar for the facility advertised a Hymns and Devotions activity on 3/18/26 at 10:30 a.m.]On 3/18/26 at 10:58 a.m., R18 self-propelled his wheelchair in a circle around the nurses' station, beginning and ending at entrance to the nurses' station most distant from the living room.A review of R18's progress notes revealed the following notes: 2/4/2026 23:43 (11:43 p.m.) The resident was combative, no crying tonight, yelling 'help.' Going in and out other residents rooms threatening to hit the residents. The staff and nurse assisting the resident out of the room. (continued on next page)

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/6/26 23:57 (11:57 p.m.) Bruises noted on the residents' hands and arms. No open areas. The resident hitting the walls, doors and windows. Yelling and pushing other residents wc (wheelchair) without the resident's permission. Non-compliant when attempting to redirect. He got into a pushing the table match with his roommate/tablemate @ (at) dinner time. 2/20/26 23:26 (11:26 p.m.) The resident awakened at 6 p.m. and ate 100% of his meal. He became agitated and attempted outside x1 then began banging on the doors and wall. 3/5/26 15:56 (3:56 p.m.) Resident was combative with CNA (certified nursing assistant) staff this morning when assistance was offered/provided for dressing and getting out of bed. Resident was asleep during mealtimes and refused to wake up.Resident was again combative with CNA staff this afternoon during brief change.Further review of R18's clinical record failed to reveal assessment of the root causes of R18's behaviors, triggers, or other factors related to his dementia diagnosis.A review of R18's comprehensive care plan dated 6/9/25 revealed, in part: Impaired Cognition/Memory [R18]'s memory and cognitive functioning are severely impaired secondary to dementia.Before care begins make efforts to explain in simple terms what is about to be done for him as he needs care and assistance.During visits with [R18], invite him to share his thoughts, making the effort to follow his train of thought. Make effort to ask him about his residence and note his response.Provide encouragement and reassurance of his safety and security by stating what an honor it is to have him as a part of this community.Wandering [R18] is at risk for injury r/t (related to) cognitive impairment and wandering behavior. He has a hx (history) of attempting to wander to doors that lead to outside.Assess for emotional or psychological distress.Assess him for needs, such as hunger, thirst, pain, discomfort, or elimination.Provide rest periods.Provide safe and secure surroundings. The review of the care plan revealed no interventions related to de-escalating outbursts or engaging him in meaningful activities.On 3/18/26 at 3:12 p.m., the Life Enrichment Director was interviewed. She stated that a large percentage of residents in the facility have cognitive impairment, and residents who do not have cognitive impairment prefer to do activities with a group that is bigger and more fun. She explained that the nursing facility connects to the adjacent assisted living memory care facility where more of the residents are mobile and more easily participate in group activities. She explained this is the reason that most group activities to which nursing facility residents are invited actually take place in the adjacent assisted living activity room. She stated that the activity room in the assisted living facility is better designed. She stated that activities for the advanced dementia residents in the nursing facility happen in a common room where more tactile small group programs take place. She stated in order to determine which activities would be best suited for each individual resident, she interviews the residents and their families. She stated sometimes, the families are not as helpful because they remember how their loved ones used to be, not how the residents are in reality in the present time. She stated she takes the information she gathers from these interviews and creates a program for each resident. She stated R18's dementia care program is comprised of something she had done in the past when she made a kit for him. She explained he likes to go to music entertainment occasionally and to roll up and down the hall. She stated the staff sometimes takes him outside when staff is available to do so. She added: He is more of a one on one person. She stated she was not aware of and did not know why R18 was not invited to attend that morning's Hymns and Devotions activity. However, she explained that R18 would not have enjoyed the devotional part of that activity. She did not provide any evidence of a dementia related program of engagement or activities for R18.On 3/18/26 at 3:55 p.m., the Social Worker was interviewed. In describing the facility's process for meeting psychosocial needs for residents with dementia, she stated: It is person-centered. I see them and interact with them and make eye contact with them. She explained that it is important for her to gain insight into who residents have been prior to their cognitive decline. She used R18 as an example of someone she knows well, and whose history she knows well. She stated when R18 has a difficult day, we try to reassure him that everything is okay. The Social Worker did not provide any evidence of a process of assessing for and providing for the psychosocial needs of residents with dementia.On 3/18/26 at 4:16 p.m., the Health (continued on next page)

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Services Administrator was interviewed. She stated the facility's process for providing specialized, individualized dementia care centers around the care plan. She stated the resident's care plan should identify symptom management concerns and interventions. She stated the resident's care plan should have interventions for alleviating behaviors and approaches for dealing with adverse events such as agitation, anger, and physical violence. She stated the facility should do everything they can to identify a resident's triggers, and these triggers should be included on the care plan.On 3/18/26 at 4:16 p.m., the Director of Nursing was interviewed. She explained that the facility's process for providing individualized dementia care for residents is centered on each resident's individual needs. She explained: We know our residents so well. She stated the facility staff gets to know each resident well, and there are constant in services and staff huddles to continually educate staff on how to care for residents. She did not verbalize a process for assessing a resident's needs or behavioral triggers, or for developing interventions based on those assessments. She stated a care plan for a resident with dementia should center around communication, adding: Communication is key. She stated the Life Enrichment staff and Social Worker should be updating the resident's care plan for communication concerns.On 3/18/26 at 4:27 p.m., the Administrator was interviewed. She stated all staff receive education on caring for residents with dementia, especially given the high percentage of facility residents who have dementia. She stated dementia training includes all staff across all departments, including housekeeping and dietary. She stated resident needs are assessed prior to a resident's admission to the facility. Family is interviewed in an effort to determine the best way to support a resident. She explained that when a resident moves into the facility, staff are educated as much as possible on the resident's history, preferences and triggers. She stated the Life Enrichment Staff drives much of a resident's day to life in the facility and are constantly engaging the residents in activities tailored to meet their individual needs. She stated the facility also uses many volunteers to provide one on one experiences for residents when appropriate, as well as formalized opportunities for small group socialization. She stated the Life Enrichment Staff and Social Worker capture what dementia care is being provided for residents day to day. She also stated care plans will demonstrate how life is for these people and how well we are achieving these goals.On 3/18/26 at 5:09 p.m., the Administrator and the Director of Nursing were informed of these concerns. Policies related to meeting the needs of residents with dementia were requested.No additional information was provided prior to exit.2. For Resident #17 (R17) the facility staff failed to provide evidence of holistic, person-centered care focusing on the resident's dementia diagnosis and related behavioral symptoms.R17 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbance. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date of 2/3/26, R17 was coded as having severe problems with both long term and short term memory.A review of R17's progress notes revealed the following: 11/10/25 19:37 (7:37 p.m.) Resident very resistant to care, taking meds, hypervigilant, attempting to stand/walk without assistance. Staff ambulating resident to assist with this behavior with no relief noted. He was hitting, pinching, trying to squeeze, twist staff arms, wrist, etc. 11/11/25 12:15 (p.m.) Change in Condition.Behavioral Status Evaluation: Physical Aggression, Verbal Aggression, Danger to self or others. 11/19/25 07:54 (7:54 a.m.) Resident refused to take his 6 am medications. Tried for how many times but still not cooperative and trying to hurt the nurse. 12/8/25 23:29 (11:29 p.m.) The staff was sitting with the resident one on one and the writer witnessed him twisting her finger then also grabbing her by the hair. The resident refused to let the staff's hair go when asked three times. 3/16/26 23:30 (11:30 p.m. Staff was attempting to assist the resident from the dining room and he became agitated. The resident hit at the staff and his left arm hit the dining room table.Further review of R17's clinical record failed to reveal assessment of the root causes of R18's behaviors, triggers, or other factors related to his dementia diagnosis.A review of R17's comprehensive care plan dated 2/14/26 revealed in part: Focus: Impaired Cognitive Function. No interventions or additional information were provided.On 3/18/26 at 3:12 p.m., the Life Enrichment Director was interviewed. (continued on next page)

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She stated that a large percentage of residents in the facility have cognitive impairment, and residents who do not have cognitive impairment prefer to do activities with a group that is bigger and more fun. She explained that the nursing facility connects to the adjacent assisted living memory care facility where more of the residents are mobile and more easily participate in group activities. She explained this is the reason that most group activities to which nursing facility residents are invited actually take place in the adjacent assisted living activity room. She stated that the activity room in the assisted living facility is better designed. She stated that activities for the advanced dementia residents in the nursing facility happen in a common room where more tactile small group programs take place. She stated in order to determine which activities would be best suited for each individual resident, she interviews the residents and their families. She stated sometimes, the families are not as helpful because they remember how their loved ones used to be, not how the residents are in reality in the present time. She stated she takes the information she gathers from these interviews and creates a program for each resident. On 3/18/26 at 3:55 p.m., the Social Worker was interviewed. In describing the facility's process for meeting psychosocial needs for residents with dementia, she stated: It is person-centered. I see them and interact with them and make eye contact with them. She explained that it is important for her to gain insight into who residents have been prior to their cognitive decline. The Social Worker did not provide any evidence of a process of assessing for and providing for the psychosocial needs of residents with dementia.On 3/18/26 at 4:16 p.m., the Health Services Administrator was interviewed. She stated the facility's process for providing specialized, individualized dementia care centers around the care plan. She stated the resident's care plan should identify symptom management concerns and interventions. She stated the resident's care plan should have interventions for alleviating behaviors and approaches for dealing with adverse events such as agitation, anger, and physical violence. She stated the facility should do everything they can to identify a resident's triggers, and these triggers should be included on the care plan.On 3/18/26 at 4:16 p.m., the Director of Nursing was interviewed. She explained that the facility's process for providing individualized dementia care for residents is centered on each resident's individual needs. She explained: We know our residents so well. She stated the facility staff gets to know each resident well, and there are constant in services and staff huddles to continually educate staff on how to care for residents. She did not verbalize a process for assessing a resident's needs or behavioral triggers, or for developing interventions based on those assessments. She stated a care plan for a resident with dementia should center around communication, adding: Communication is key. She stated the Life Enrichment staff and Social Worker should be updating the resident's care plan for communication concerns.On 3/18/26 at 4:27 p.m., the Administrator was interviewed. She stated all staff receive education on caring for residents with dementia, especially given the high percentage of facility residents who have dementia. She stated dementia training includes all staff across all departments, including housekeeping and dietary. She stated resident needs are assessed prior to a resident's admission to the facility. Family is interviewed in an effort to determine the best way to support a resident. She explained that when a resident moves into the facility, staff are educated as much as possible on the resident's history, preferences and triggers. She stated the Life Enrichment Staff drives much of a resident's day to life in the facility and are constantly engaging the residents in activities tailored to meet their individual needs. She stated the facility also uses many volunteers to provide one on one experiences for residents when appropriate, as well as formalized opportunities for small group socialization. She stated the Life Enrichment Staff and Social Worker capture what dementia care is being provided for residents day to day. She also stated care plans will demonstrate how life is for these people and how well we are achieving these goals.On 3/18/26 at 5:09 p.m., the Administrator and the Director of Nursing were informed of these concerns. Policies related to meeting the needs of residents with dementia were requested.No additional information was provided prior to exit.

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 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 observation, staff interview, and facility document review, the facility staff failed to prepare, store, and serve food in a sanitary manner in one of one facility kitchen, and in one of one satellite kitchen.The findings include:On 3/17/26, the facility staff failed to cover raw food in a refrigerator, to label food that had been opened in the refrigerator and freezer, to maintain the dishwasher drain so that it washed dishes in a sanitary manner, to maintain the kitchen floor and appliance knobs in a sanitary manner, and to serve food in a sanitary manner.On 3/17/26 at 10:29 a.m., observation was made of the main facility kitchen. The walk in refrigerator contained a sheet pan with two raw slabs of meat; both slabs were uncovered. The Dining Services Director, who accompanied the surveyor, stated the meat did not need to be covered because the meat was going to be cooked later that morning in preparation for the evening meal. This refrigerator also contained a 5 pound roll of ground beef that was open but without a date. The walk in freezer contained four different open bags of spinach and other vegetables; none of these bags had an open date. The Director of Dining Services stated the roll of open ground beef should have a date, but the frozen vegetables did not need a date because frozen foods did not require an open date. The observation continued in the food preparation area. The floors in the food prep area, including under and around appliances, had areas that were alternately slick and sticky, and contained a large amount of dark food particles. The stove and large soup kettle knobs were sticky and contained food particles on them. On 3/17/26 at 5:05 p.m., OSM (other staff member) #1, a dietary aide, was observed in the nursing center satellite kitchen preparing plates for resident meals. OSM #1 was wearing gloves. She touched multiple drawer handles, serving utensils, appliance handles, the countertop, and steam table surface. Without changing gloves, she cut two sandwiches into quarters and touched all pieces of the sandwiches with the contaminated gloves as she put the sandwiches on the plate. Without changing gloves, she also sliced a sweet potato in half and touched the halves with contaminated gloves. On 3/18/26 at 2:49 p.m., the Director of Dining Services was interviewed. She stated OSM #1 should have removed her gloves and washed her hands between touching the potentially contaminated surfaces and the food. She stated that this prevents the risk of contamination of food, the spread of bacteria, and cross contamination of food from various sources.On 3/18/26 at 5:09 p.m., the Administrator and the Director of Nursing were informed of these concerns.A review of the facility policy, Food Services Infection Control, revealed, in part: Food is purchased, prepared, stored, transported, and served in ways that minimize contamination by microorganisms and dangerous chemicals.Storage of leftovers shall be dated and held for use no longer than 72 hours after being stored.The following activities of food service personnel may involve or have an effect on the risk of infection for residents and personnel. Infection prevention and control measures are.Preparing food with as little handling as possible.Distributing food to residents with a minimum of handling by personnel.Protection of food from airborne contamination by covering food when unattended.No additional information was provided prior to exit.

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, staff interview, and clinical record review, the facility staff failed to maintain dignity for one of 19 residents in the survey sample, Resident #8. The findings include:For Resident #8 (R8), the facility staff failed to maintain the resident's urinary catheter bag in a dignified manner. A review of R8's clinical record revealed a physician's order dated 2/13/26 for a urinary catheter. On 3/18/26 at 8:38 a.m., R8 was observed in a wheelchair in the hall and the resident's urinary catheter bag was visible with urine in the bag. On 3/18/26 at 10:53 a.m., R8 was observed in a chair in the day room and the resident's urinary catheter bag was visible with urine in the bag. On 3/18/26 at 2:39 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 stated a urinary catheter bag should not be visible for everyone to see, for privacy reasons. On 3/18/26 at 5:25 p.m., the Executive Director and the Director of Nursing were made aware of the above findings. The facility did not provide a policy regarding urinary catheters. No further information was presented prior to exit.

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on staff interview, clinical record review, and facility document review, the facility staff failed to meet education and consent requirements for the administration of an antipsychotic medication for one of 19 residents, Resident #17.The findings include: For Resident #17 (R17), the facility staff failed to provide evidence of education to the resident or RR (resident representative) of the risks and benefits, alternatives for treatment, and informed consent for the initiation of dosage of Seroquel (1) on 12/5/25.A review of R17's clinical record revealed the following order written 12/5/25: Seroquel Oral Tablet 25 mg (milligrams Give 1 tablet by mouth in the evening related to unspecified dementia with other behavioral disturbance.A review of R17's MARs (medication administration records) for December 2025, January 2026, February 2026, and March 2026 revealed that the resident had been receiving the medication as ordered.Further review of R17's clinical record failed to reveal evidence that the resident or his RR had been educated on the risks and benefits of the Seroquel, alternatives to treatment with Seroquel, or had provided informed consent prior to the administration of Seroquel.On 3/18/26 at 2:28 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated that when a new order is given for an antipsychotic medication, the nursing staff is responsible for monitoring the resident's mood and behaviors for any drastic changes. She stated she has not educated the family or obtained consent for the initiation of an antipsychotic.On 3/18/26 at 4:16 p.m., the Director of Nursing was interviewed. She stated she was aware that R17 was started on Seroquel on 12/5/25. She provided evidence that R17's RR was educated on the risks and benefits of Seroquel and that the RR had given consent for the use of Seroquel, but the form was dated 2/11/26.On 3/18/26 at 5:09 p.m., the Administrator and the Director of Nursing were informed of these concerns.A review of the facility policy, Psychopharmacological Medication, revealed no information related to resident/RR education on the risks and benefits, alternatives to therapy, and informed consent prior to the initiation of antipsychotic therapy.No additional information was provided prior to exit.(1) Seroquel - 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. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a698019.html.

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, staff interview, and clinical record review, the facility staff failed to maintain an accurate MDS (minimum data set) assessment for one of 19 residents in the survey sample, Resident #5. The findings include:For Resident #5 (R5), the facility staff failed to accurately code the resident's quarterly MDS assessment with an assessment reference date of 2/17/26 regarding section P. Restraints and Alarms. A review of R5's quarterly MDS assessment with an assessment reference date of 2/17/26 revealed the resident was coded as having a restraint. On 3/17/26 at 2:06 p.m., and 3/18/26 at 7:40 a.m., R5 was observed and did not have a restraint. On 3/18/26 at 12:09 p.m., an interview was conducted with the Health Services Administrator. The Health Services Administrator stated the physical restraint coded on R5's MDS assessment was an entry error. On 3/18/26 at 5:25 p.m., the Executive Director and the Director of Nursing were made aware of the above findings. The Centers for Medicare and Medicaid Services Resident Assessment Instrument manual documented, SECTION P: RESTRAINTS AND ALARMS: Intent: The intent of this section is to record the frequency that the resident was restrained by any of the listed devices or an alarm was used, at any time during the day or night, during the 7-day look-back period. No further information was presented prior to exit.

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to review and revise the comprehensive care plan for two of 19 residents in the survey sample, Residents #2 and #4. The findings include:1. For Resident #2 (R2), the facility staff failed to review and revise the resident's comprehensive care plan for falls. A review of R2's clinical record revealed the resident fell and did not sustain an injury on 12/21/25. A review of R2's comprehensive care plan dated (initiated on 5/29/25) failed to reveal that the care plan was reviewed and revised regarding the 12/21/25 fall. On 3/18/26 at 2:28 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 stated the care plan is a pathway to keeping residents healthier, and to making sure negative things do not happen to residents. LPN #1 stated the care plan should be reviewed and revised after a fall. On 3/18/26 at 5:25 p.m., the Executive Director and the Director of Nursing were made aware of the above findings. The facility policy titled, Comprehensive Person-Centered Care Planning documented, 15. The Care Planning/Interdisciplinary Team are responsible for the review and updating of the care plans: When there has been a significant change in the resident's condition. No further information was presented prior to exit. 2. For Resident #4 (R4), the facility staff failed to revise the resident's comprehensive care plan for the use of oxygen. On the following dates and times, R4 was observed lying in bed with her eyes closed. At each observation she was receiving oxygen via a nasal device from a concentrator; the concentrator setting was just below two liters per minute: 3/17/26 at 11:52 a.m., 12:01 p.m., and 3:26 p.m.; 3/18/26 at 8:47 a.m. A review of R4's provider's orders revealed the following order dated 2/25/26: Oxygen at 3.5 L (liters per minute) via NC (nasal cannula). A review of R4's comprehensive care plan dated 6/23/25 failed to reveal any evidence related to oxygen administration. On 3/18/26 at 2:28 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated that floor nurses do not update care plans or make changes on them. On 3/18/26 at 4:09 p.m., the MDS Coordinator was interviewed. She stated the care plan lays out the path that the facility will take in caring for the residents. She stated that care plans should be updated by the nurse who takes an order for something that should be included in the care plan. She stated that a resident's care plan should be updated to include the administration of oxygen. (continued on next page)

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/26 at 5:09 p.m., the Administrator and the Director of Nursing were informed of these concerns. No additional information was provided prior to exit.

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of practice for one of 19 residents in the survey sample, Resident #17.The findings include:For Resident #17 (R17), the facility failed to have a licensed nurse administer medications to the resident on 1/7/26.A review of a facility synopsis of events dated 1/13/26 revealed, in part: Nurse delegated medication administration task outside scope of practice to aide.This is both initial and final investigation report.Nurse directed CNA (certified nursing assistant) to administer three medications to nursing home resident and CNA complied. Resident did not have any adverse effects from the incident. Both staff were suspended pending investigation and reported to the Board of nursing.On 1/7/26, [LPN (licensed practical nurse) #3] was overheard by the RN (registered nurse) supervisor telling a CNA to administer medications to [R17] and was witnessed handing a medication cup with medications to the CNA. [LPN #3].Due to the serious nature of incident, [LPN #3]'s employment was terminated effective immediately.[CNA #1] administered medications to a resident after being asked to do so by her charge nurse.[CNA #1] was educated on her scope of practice as a CNA and she can refuse direction from the Charge Nurse or Supervisor if the task is outside her scope of practice if she has not received training to complete the task.A review of a statement by CNA #1 dated 1/8/26 revealed, in part: On 1/7/26 at approximately 1pm I went up to the nurse to let her know that I was able to get [R17] up in his chair to eat his food. She then asked me if I would try to get him to take his medication and I said yes. She then handed me the cup of medicine and a cup of water. She told it was his vitamins and some other kind of medication. I then walked to his room and gave him his medication. After he took the medication I went to the nurse and told her that he took it and then threw the cup away. A review of a statement by LPN #3 dated 1/8/26 revealed, in part: I [LPN #3] asked [CNA #1] to give a resident some medication: Metoprolol (1), a Multivitamin, and Buspar (2). She agreed and did as I had asked. I knew it was wrong and it was my fault. I should never have asked her to do this. It was out of her scope of practice. I was busy administering other residents' medication. I was unable to administer [R17's medications] earlier due to refusal secondary to sleeping. Resident spit them out.threw his shoe at staff stating no. So when he sat up in his room to eat his lunch, I asked [CNA #1] if she would give meds. This is all on me and [CNA #1] should not get in trouble. I should not have asked her to give a medication.I know it was wrong and will never do this again no matter how overwhelmed I may be feeling.A review of R17's clinical record failed to reveal any information related to the unlicensed personnel administering medications to the resident. The facility staff provided credible evidence that R17 was assessed by the provider just hours after the medication was administered, and that he suffered no adverse effects. The medications were ordered by the provider and were administered per the orders.On 3/18/26 at 2:21 p.m., CNA #1 was interviewed. She stated that during the lunch meal on 1/7/26, LPN #3 had been experiencing difficulties administering medications to R17. She stated LPN #3 asked her if she would try to administer the medications to the residents. She stated she took the medications to R17 and offered them to him. R17 took the medications. She explained that in her mind at that particular moment, she was doing what her charge nurse needed for her to do. She stated that in retrospect, she understood it was wrong. She added: I have not done it since, and I will never, ever do it again. Further review of facility disciplinary records revealed evidence that CNA #1 was suspended for three days, then allowed to return to work after receiving education about practicing within her scope.On 3/18/26 at 4:16 p.m., the Director of Nursing was interviewed. She stated LPN #3's employment was terminated as a result of her actions on 1/6/26. She confirmed that CNA #1 was suspended for several days, then allowed to return to work. She also confirmed that the actions of both LPN #3's and CNA #1's actions were not within professional standards of practice. She stated there have been no similar incidents since this one in January 2026. On 3/18/26 at 5:09 p.m., the Administrator and the Director of Nursing were informed of these concerns.No additional information (continued on next page)

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was provided prior to exit.References(1) Metoprolol is used alone or in combination with other medications to treat high blood pressure. It also is used to treat chronic (long-term) angina (chest pain). Metoprolol is also used to improve survival after a heart attack. Metoprolol also is used in combination with other medications to treat heart failure. Metoprolol is in a class of medications called beta blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure. This information is taken from the website https://medlineplus.gov/druginfo/meds/a682864.html.(2) Buspirone is used to treat anxiety disorders or in the short-term treatment of symptoms of anxiety. Buspirone is in a class of medications called anxiolytics. It works by changing the amounts of certain natural substances in the brain. This information was obtained from the website https://medlineplus.gov/druginfo/meds/a688005.html.

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, staff interview, and clinical record review, the facility staff failed to provide appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for one of 19 residents in the survey sample, Resident #6 (R6). The findings include:For Resident #6 (R6), the facility staff failed to apply a physician ordered left-hand palm pillow. A review of R6's clinical record revealed a physician's order dated 12/11/25 for a left-hand palm pillow to be applied at 7:00 a.m. and removed at 7:00 p.m. for a contracture. On 3/17/26 at 12:06 p.m., and 3/18/26 at 7:41 a.m., R6 was observed clinching their left fist with no palm pillow in place. On 3/18/26 at 2:39 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 stated she believed R6's palm pillow was for the resident's contracture and the certified nursing assistants applied the resident's palm pillow. On 3/18/26 at 5:25 p.m., the Executive Director and the Director of Nursing were made aware of the above findings. The facility did not provide a policy regarding palm pillows. No further information was presented prior to exit.

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement interventions to prevent accidents for one of 19 residents in the survey sample, Resident #2. The findings include:For Resident #2 (R2), the facility staff failed to address/implement an intervention to prevent falls after the resident fell on [DATE]. A review of R2's clinical record revealed the resident fell and did not sustain an injury on 12/21/25. A review of R2's comprehensive care plan (initiated on 5/29/25) and nurse's notes for December 2025 failed to reveal the facility staff addressed and/or implemented an intervention to prevent future falls. R2 fell again on 1/1/26 and did not sustain an injury. On 3/18/26 at 2:39 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 stated an intervention should be implemented after a resident falls, for the resident's safety and well-being. On 3/18/26 at 5:25 p.m., the Executive Director and the Director of Nursing were made aware of the above findings. The facility policy regarding a post fall evaluation and intervention documented, The nursing staff will evaluate falls by assessing causation and potential contributing factors and implementing appropriate interventions to prevent reoccurrence as part of quality assurance of the community. No further information was presented prior to exit.

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, staff interview, and facility document review, the facility staff failed to provide respiratory care and services to two of 19 residents in the survey sample, Residents #4 and #2.The findings include:1. For Resident #4 (R4), the facility staff failed to administer oxygen at the rate ordered by the provider. On the following dates and times, R4 was observed lying in bed with her eyes closed. At each observation she was receiving oxygen via a nasal device from a concentrator; the concentrator setting was just below two liters per minute: 3/17/26 at 11:52 a.m., 12:01 p.m., and 3:26 p.m.; 3/18/26 at 8:47 a.m. A review of R4's provider's orders revealed the following order dated 2/25/26: Oxygen at 3.5 L (liters per minute) via NC (nasal cannula). A review of R4's comprehensive care plan dated 6/23/25 failed to reveal any evidence related to oxygen administration. On 3/18/26 at 2:28 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated that each resident who needs oxygen should have a provider's order specifying the rate at which the oxygen should be administered. She stated the top of the bubble on the concentrator should just touch the bottom of the line of the ordered rate. On 3/18/26 at 5:09 p.m., the Administrator and the Director of Nursing were informed of these concerns. A review of the facility policy, Oxygen Therapy, revealed, in part: The facility shall have a valid physician or other prescriber's order that includes.the flow rate. No additional information was provided prior to exit. 2. For Resident #2 (R2), the facility staff failed to store oxygen tubing/nasal cannula in a sanitary manner. A review of R2's clinical record revealed a physician's order dated 3/2/26 for oxygen at two liters per minute as needed. On 3/18/26 at 7:35 a.m., and 12:38 p.m., R2 was observed lying in bed. The resident's oxygen tubing and nasal cannula were hung over the oxygen concentrator and resting against the back of the concentrator with no covering. On 3/18/26 at 2:39 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 stated oxygen tubing should not be left out, and she would change the tubing or put it in a bag. On 3/18/26 at 5:25 p.m., the Executive Director and the Director of Nursing were made aware of the above findings. The facility policy regarding oxygen failed to document information about storage of oxygen tubing. No further information was presented prior to exit.

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to implement bed rail requirements for one of 19 residents in the survey sample, Resident #26. The findings include:For Resident #26 (R26), the facility staff failed to review the risks and benefits for a bed rail in use. A review of R26's clinical record revealed a physician's order dated 6/2/25 for a grab bar (bed rail) on the right side of the bed for assistance with reducing pain, transfers, and repositioning in bed. Further review of R26's clinical record failed to reveal the resident (or resident representative) were made aware of the risks and benefits regarding bed rails. On 3/17/26 at 2:10 p.m., and 3/18/26 at 7:41 a.m., R26 was observed lying in bed with a grab bar on the right side of the bed in an upright position. On 3/18/26 at 2:39 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 stated residents should be made aware of the risks and benefits of bed rails. On 3/18/26 at 5:25 p.m., the Executive Director and the Director of Nursing were made aware of the above findings. The facility policy titled, Side Rail Assessment documented, If the resident's assessment identifies him or her as appropriate for the use of side rail(s), the following procedures will be followed: Educate the resident/resident representative on the risks and obtain consent for use. No further information was presented prior to exit.

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	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Peace Inc	751 Hillsdale Drive Charlottesville, VA 22901

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to follow infection control practices during medication administration for one of eight residents observed during medication administration, Resident #7.The findings include:For Resident #7 (R7), the facility staff failed to follow infection control practices for disinfecting the glucometer.On 3/17/2026 at 4:20 PM, an observation was made of licensed practical nurse (LPN) #2 administering medications. LPN #2 was observed removing a glucometer from the medication cart and checking R7's blood glucose. After completion of the procedure LPN #2 was observed cleaning the glucometer with an alcohol swab.On 3/17/2026 at approximately 4:25 PM, an interview was conducted with LPN #2 who stated that R7 was the only resident who required glucometer checks and the machine was dedicated to only R7. She stated that the glucometer was cleaned after every use with an alcohol swab and allowed to air dry. On 3/18/2026 at approximately 2:27 PM, an interview was conducted with LPN #1 who stated that she knew the glucometer was wiped down after each use but was not sure what was used to wipe it down. She stated that R7 did not require glucometer checks on her shift, so she never had to clean it before.On 3/18/2026 at approximately 4:16 PM, an interview was conducted with the director of nursing who stated that there were two types of wipes that could be used to clean the machine, the Sani-wipes or the Clorox wipes. She stated that the glucometer was wiped down with either of those and air dried and alcohol should not be used. The facility provided manufacture instructions for use documented in part, . 4. To disinfect your meter, clean the meter with one of the validated disinfecting wipes listed below. Other EPA (environmental protection agency) registered wipes may be used for disinfecting the EvenCare G2 system, however these other wipes have not been validated and could affect the performance of your meter. - Dispatch Hospital Cleaner Disinfectant Towels with Bleach (EPA Registration Number: 56392-8), -Clorox Healthcare Bleach Germicidal and Disinfectant Wipes (EPA Registration Number: 67619-12), -Medline Micro-Kill Bleach Germicidal Bleach Wipes (EPA Registration Number: 37549-1).On 3/18/2026 at 5:04 PM, the executive director, the director of nursing and the health services administrator were made aware of the findings.No further information was provided prior to exit.