STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E256	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Our Lady of Perpetual Help	4560 Princess Anne Road Virginia Beach, VA 23462

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 and staff interview, the facility's staff failed to maintain dignity during mealtime for 1 of 15 residents (Resident #13), in the survey sample. The findings included: Resident #13 was originally admitted to the facility 2/14/20 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Alzheimer's Disease. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 04/02/25 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired for daily decision making. In sectionGG(Functional Abilities) the resident was coded as dependent with eating, oral hygiene, toileting hygiene, personal hygiene and shower/bathe self. On 06/10/25 at approximately 1:33 pm., Certified Nursing Assistant (CNA) #1 was observed standing while feeding Resident #13 during lunch. On 06/10/25 at 3:43 pm., a brief interview was conducted with CNA #1 concerning Resident #13. CNA #1 said that she couldn't remember if she should have sat down or continued to stand while feeding the resident. CNA #1 also said that she realizes that she should have been sitting down while feeding the resident. On 6/12/25 at approximately 3:10 p.m., the above findings were shared with the Administrator, Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the DON said it's not appropriate to feed a resident while standing.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews, and staff interviews, the facility staff failed to post the most recent survey results in a place readily accessible to resi-dents, family members, and legal representatives of residents. The findings included: Resident Council interview was done on 6/11/25 at 11:00 AM. Inquired whether residents know where the results of the most recent State survey is located. Resi-dents were unaware of where to find the report to review. An interview was conducted on 6/11/25 at 11:50 AM with the Social Worker. The Social Worker stated that she does not know where the results of the most recent survey results are located in the facility. The Social Worker also stated that she has not educated the residents on the location of the facilities survey results during the monthly resident council meetings. During an observation tour on 6/11/25 at 12:00 PM a sign was observed in the fa-cility lobby that read: Our most recent survey results are inside the labeled book-case drawer located next to the living room fireplace and card room area. Concurrent observation with the Administrator on 6/11/25 at 12:05 PM regarding the location of the results of the State Agency's last survey. The survey results are in a brown cabinet located next to the living room fireplace. The sign above the cabinet stated the survey results are below in labeled drawer. Also the sign was [NAME]-round by books and was not easily visible to residents, family members, and visi-tors. The Administrator was not able to say how many residents utilize the space to easily view the sign that tells them where the results are. On 6/12/25 at approximately 3:25 p.m., a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, Director of Din-ing Services, Director of Maintenance, and Social Worker. An opportunity was of-fered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review, and review of facility documents, the facility's staff failed to ensure professional standards of quality for were followed for 1 of 15 residents (Resident #5), in the survey sample. The findings included: The facility staff failed to check Resident #5s Blood Pressure (bp) prior to administering a prescribed dose of Furosemide 20 mg on 6/11/25 at 4:35 pm. Resident #5 was originally admitted to the facility 12/27/24 and readmitted [DATE] after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Acute or Chronic Diastolic Congestive Heart Failure. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 03/26/25 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 5 out of a possible 15. This indicated Resident #5 cognitive abilities for daily decision making were severely impaired. The Care Plan dated 3/25/25 read that Resident #5 was at risk related to decreased cardiac output related to myocardial contractility. The Goal for Resident #5 is that the resident will maintain vital signs within normal limits. The interventions for the resident are to monitor blood pressure and to monitor urinary output, noting decreasing output and concentrated urine. The June 2025 Physician's Order Summary (POS) read Ferosemide 20 mg tablet, give 1 tablet by mouth two times a day. Hold for SBP (systolic blood pressure) less than 100. Order date 2/04/25. The Medication Administration Record (MAR) for June 2025 read: Furosemide 20 mg tablet, give 1 tablet by mouth two times a day. Hold for SBP less than 100-Start Date 05/01/2025. Administer at 10:00 am., and 5:00 pm. A review of the June 2025 MAR revealed Resident #5 received all doses of Furosemide 20 mg. On 6/11/25 at approximately 4:35 pm., a medication observation was made with Licensed Practical Nurse (LPN) #2. LPN #2 was observed administering Furosemide 20 mg, 1 tab po crushed. The order read: Furosemide 20 mg, 1 tab po crushed, check blood pressure twice daily, check Systolic Blood Pressure (SBP), hold if SBP is less than 100. Shortly thereafter, LPN #2 was asked to give the resident's BP reading, but said it hadn't been checked. LPN #2 checked the order and said the resident's blood pressure should have been checked prior to administration of her Furosemide. A review of the vital signs record reveal Resident #5s Blood Pressure (BP) was not checked on 6/11/25 at or around the schedule 5:00 pm., dosage. On 06/12/25 at approximately 11:04 am., a brief interview was conducted with The Assistant Director of Nursing (ADON). The ADON said the order should have been check before administration of the medication (Furosemide). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Furosemide (Lasix)-Furosemide is a diuretic, also called a water pill, that is commonly used to reduce edema (fluid retention) caused by the following conditions. Congestive heart failure, which is a condition where the heart is not pumping as well as it should Liver disease, such as cirrhosis, which can lead to a buildup of fluid in the abdomen (ascites) kidney disease, including protein in the urine (nephrotic syndrome) Furosemide may also be used to treat high blood pressure (hypertension). Furosemide may also be used for other conditions as determined by your healthcare provider. Furosemide works by increasing how much you pee. It does this by helping the kidneys remove electrolytes, such as sodium (salt), and water from the body. The most common side effects of furosemide are Low blood pressure, Electrolyte changes, increased blood sugar and an increase in how much you pee. Keep your appointments to have your blood checked. https://www.webmd.com/drugs/2/drug-5512-8043/furosemide-oral/furosemide-oral/details On 6/12/25 at approximately 3:10 p.m., the above findings were shared with the Administrator, Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the DON said that it could be a medication error and that the doctor was notified.