STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495366	A. BUILDING _____ B. WING _____	C 01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PRINCE WOODS, INC	100 ANNA GOODE WAY SUFFOLK, VA 23434

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 1/26/2016 through 1/28/2016. Corrections are required for compliance with the following Federal Long Term Care Requirements 42 CFR Part 483. The Life Safety report will follow. The census in this 40 certified bed facility was 30 at the time of the survey. The survey sample consisted of ten current resident reviews, Residents #1 through #10. Closed record review was Resident #11.	F 000		
F 371 SS=F	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.35(i) The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility staff failed to prepare foods under sanitary conditions. The findings include: An initial kitchen inspection was conducted on 01/27/16 at approximately 9:00 a.m., with Dietary	F 371		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/19/2016

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Department #3.

An interview was conducted on 01/27/16 at approximately 11:30 a.m., with Dietary Department #1 who was preparing a bread slurry (bread prepared for physician ordered pureed diets). Dietary Department #1 was asked how she knew what consistency (thickness) was required, she explained her process and stated: "It's supposed to be baby food consistency and pointed to a sign on the wall which stated: "Pureed Food is to be baby food consistency."

An interview was conducted on 01/27/16 at approximately 11:38 a.m., with the Dietary Manager. When asked what consistency the pureed food was to be she stated: "It's to be pudding consistency." When the Dietary Manager was informed that there was a posting in the preparation area stating the consistency was to be baby food consistency she left her enclosed office which was next to the kitchen, went into the area where the noon meal was being prepared and removed the sign from the wall above the machine which contained the bread waiting to be prepared by the cook for the pureed diets. She did not have her hair contained by either a hair net or a hat. When this was brought to the Dietary Manager's attention she stated: "It is the policy of the facility that anyone in the kitchen or when food is being plated and served needs to contain their hair. I know I should have my hair contained when I went into the kitchen preparation area but I was so focused on the information that you had shared with me about the sign I guess I forgot." All other individuals who were in the kitchen preparation area wore hair nets to contain their hair. The kitchen policy was obtained and reviewed which

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F 371	Continued From page 2 stated hair was to be contained when in the kitchen/food preparation areas. Administration which consisted of the Administrator and the DON (director of nursing) were informed of the findings at a briefing conducted on 01/28/16 at approximately 3:30 p.m. No additional information was submitted for review.	F 371		
F 425 SS=D	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.60(a),(b) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and	F 425		

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staff interview it was determined for Resident #8, one of ten residents in the survey sample, that facility staff failed to assure her eye drops were available for administration.

During the 1/27/16 evening medication pass and pour observation Resident's #8's Patanol 0.1% eye drops (to treat glaucoma) was not available for administration.

The findings included:

Resident #8 was admitted to the facility on 7/29/2015. Review of the resident's 11/09/15 quarterly Minimum Data Set (MDS) evidenced the resident was rarely understood but usually understands others. The brief interview for mental status could not be completed. The resident was noted with long and short term memory loss and was severely impaired in her ability to make daily decisions. For activities of daily living the resident required the limited or extensive assistance of one staff person.

Diagnoses included anxiety, depression, pulmonary disease and glaucoma (increased pressure behind the eye).

Review of the physician's orders evidenced an order for Patanol 0.1% (1 gtt) one drop in both eyes twice a day for glaucoma.

During the 1/27/16 6 pm medication pass and pour observation Licensed Practical Nurse (LPN) #1 attempted to administer Resident #8's Patanol eye drops. LPN #1 stated to the surveyor that the drops were not in the medication cart. LPN #1 checked the computer and stated to the surveyor

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that the drops had been ordered but information back from the pharmacy evidenced that the prescription could not be refilled until 2/2/16. LPN #1 stated she would call the resident's physician and get an order to "hold" the eye drops until available from the pharmacy. LPN #1 was unable to state why the drops had run out almost a week prior to the refill date.

The following morning (9:30 am - 1/28/16) the clinical record was reviewed and revealed a telephone order to hold the eye drops until available from the pharmacy. The clinical record also evidenced a similar order dated 1/8/16 to also hold the Patanol drops until available from the pharmacy.

RN #1 was available at the nursing desk and during interview stated that the eye drops had been delivered and were now in the medication cart. RN #1 and the surveyor proceeded to the medication cart. The Patanol drop were in the drawer. RN #1 stated that the drops had apparently been delivered last night around 10 p.m.

Further review of the clinical record did not evidence that the drops had been administered the prior evening when delivered. The Patanol drops were dated as opened on 1/28/16.

The Director of Nurses was interviewed on 1/28/16 at 10 am. The DON stated that LPN #1 had come to her the evening before (after the medication pass) and let her know the Patanol drops were unavailable and the DON called the pharmacy and ordered the drops delivered "stat" or as soon as possible. The DON continued that she is the only one who can order the extra or

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"stat" delivery.

During the interview the DON stated that because the resident receives the drops in both eyes twice a day one vial is not sufficient to last for 30 days. The DON was aware of the problem but thought the mix up had been resolved with the pharmacy to deliver twice a month.

At 11:04 am the DON reported back to the survey team she had spoken with the pharmacy representative and the pharmacy computer had the information that the eye drops were to be delivered twice a month or every two weeks. The pharmacy representative had calculated that the vial that was being delivered to the facility would not support the resident receiving four drops a day (each eye twice a day) for a month.

The DON stated she thought this had been settled with the pharmacy after the resident was without drops on 1/8/16 but it had not been. The pharmacy will now deliver two vials at a time to assure Resident #8 has the needed quantity.