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 _____	02/03/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/01/22 through 02/03/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaint were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/01/22 through 02/03/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 40 certified bed facility was 22 at the time of the survey. The survey sample consisted of 15 current Resident reviews and 4 closed record review.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and clinical record review the facility staff failed to provide the accommodation needed for 1 of 19 residents (Resident #2) in the survey sample.	F 558	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Lake Prince Woods of the truth of the facts alleged in this statement of deficiency and plan of	2/16/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/16/2022

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.

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F 558	Continued From page 1 The findings included: The facility staff to ensure Resident #2's call bell remained within reach. Resident #2 was admitted to the nursing facility on 08/29/16. Diagnosis for Resident #2 included but not limited Anxiety disorder and muscle weakness. The current Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/19/21 coded Resident #2 Brief Interview for Mental Status (BIMS) scored a 99 indicating short and long term memory problems and with severe cognitive impairment - never/rarely made decisions. The MDS coded Resident #2 total dependence of two with transfer, toilet use, personal hygiene and bathing, total dependence of one with dressing and extensive assistance of one with eating with Activities of Daily Living (ADL) care. Resident #2's comprehensive care plan documented Resident #2 at risk for falls related to impaired mobility, dementia, bipolar and occasion pain from arthritis. The goal set for the resident by the staff will have interventions in place to minimize the risk of a serious injury. Some of the approaches to manage goal is to keep the call light within reach and to encourage the resident to use call bell or call out for assistance. On 02/02/22 at approximately 10:00 a.m., Resident was observed sitting up in the wheel chair with the call bell back behind the resident's bed. On the same day at approximately 3:09 p.m., Resident #2 was observed lying in bed; call bell remain in the same place (back behind the resident bed). License Practical Nurse (LPN) #1 went into Resident #2's room along with this	F 558	correction.¿ In fact, this plan of correction is submitted exclusively to comply with state and federal law, and because the facility has been threatened with termination from the Medicare and Medicaid programs if it fails to do so.¿ The facility contends that it was in substantial compliance with all requirements on the survey date, and denies that any deficiency exists or existed or that any such plan is necessary.¿ Neither the submission of such plan, nor anything contained in the plan, should be construed as an admission of any deficiency, or of any allegation contained in this survey report.¿ The facility has not waived any of its rights to contest any of these allegations or any other allegation or action.¿ This plan of correction serves as the allegation of substantial compliance. Prefix Tag: F558 CFR(s): 483.10(e)(3) It is the intent of this facility for residents to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. 1) How corrective action will be accomplished for those residents found to have been affected by the deficient	

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F 558	Continued From page 2 surveyor. The LPN removed Resident #2's call light from back behind the resident's bed and attached it to the resident's covering. When asked, "What is the purpose for keeping Resident #2's call light within her reach, The LPN stated, "The call bell should be within reach so the resident can call for assistance." She said Resident #2 cannot use the call be all the time but at times she will put the call light when she needs help. An interview was conducted with the Director of Nursing on 02/03/22 at approximately 12:50 p.m. The DON said the resident's call bell should be within reach at all times. She said the call light should be attached/clipped to their shirt or blanket and for best practice to inform the staff of their needs and to help prevent falls. A pre-exit conference was conducted with the Administrator and Director of Nursing on 02/03/22 at approximately 3:30 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit. The facility titled: Call Light board of approval date of 10/25/02. Policy statement: The purpose of this procedure is to respond to the resident's requests and needs. Key Procedural Points read in part: 5. When the resident is in bed or confined to a chair, be sure the call light is within reach of the resident.	F 558	practice The Director of Nursing, upon being informed of the call bell placement, by the surveyor, on February 3, 2022, immediately directed the Unit Manager to place the call bell , for this resident #2 within reach and clip the call bell cord so that is would stay securely within reach. The Director of Nursing then went to the resident room and visually observed the placement of the call bell. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice All other residents have the potential to have their call bell out of reach. The Administrator assigned the Care Transition Coordinator to go to each residents room and visually observe the placement of the call bell and assure resident were able to access their call bell and clips were on each call bell cord and they were secured. The Care Transition Coordinator went to each room and all other call bells were within reach, had clips and were accessible to residents. 3) What measures will be put into place or systemic changes made to ensure that	

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F 558	Continued From page 3	F 558	the deficient practice will not recur On February 3, 2022 7:00 a.m. □ 3:00 p.m., staff who were on shift when the call bell was not within reach were immediately inserviced, and the oncoming staff were inserviced as they arrived, by the Unit Manager on the placement of call bells and the need to relocate the call bells, as residents move from their beds to stationary chair or wheel chair, all staff were in-serviced by February 7, 2022, to include staff from other disciplines who have opportunity to enter a resident room to perform services with the resident or with in the room. Staff receive training upon hire and annually using the Knowledge, Skills, Competency Verification Checklist and through observation. The Staff Development Nurse will monitor the orientation and annual compliance for direct care staff. The Director of Nursing will provide oversight for regular monitoring of the call bell location in relationship to resident. For 1 year the Director of Nursing will provide oversight to the monitoring of call bell location in relation to residents location, 1 time per shift, for 6 months the call bell placement will be monitored 1 time a week for 6 months. 4) How the facility plans to monitor its performance to make sure that solutions	

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F 558	Continued From page 4	F 558	are sustained; and include dates when corrective action will be completed. These corrective measures will be monitored by the Director of Nursing with oversight by the Administrator through the QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Administrator will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the corrective measures as needed. The Committee is authorized to charter Performance Improvement Projects when most appropriate. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by:	F 881		2/16/22

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F 881	Continued From page 5 Based on information gleamed during the antibiotic stewardship task, observation, staff interview, and clinical record review the facility staff failed to ensure a Resident who is prescribed an antibiotic has appropriate indication for use and receives the antibiotic timely for 1 of 19 residents (Resident #21), in the survey sample. The findings included: Resident #21 was originally admitted to the facility 1/24/20 and had not been discharged from the facility. The current diagnoses included; dementia and obstructive uropathy. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/11/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 10 out of a possible 15. This indicated Resident #21's cognitive abilities for daily decision making were moderately impaired. In section "G" (Physical functioning) the resident was coded as requiring supervision after set-up with bed mobility, transfers, and locomotion, limited assistance of one person personal hygiene, dressing, and toileting and physical help of one person in part of his bathing activity. In section "H" (Bladder and Bowel) the resident was coded for use of an indwelling catheter. The physician order summary included and order dated 9/1/21 which read; Urinary Catheter 16 french 30 cc balloon three times each day. The current care plan included a problem dated 1/24/20 read; (name of the resident) has a history of urinary tract infection with an indwelling urinary	F 881	Prefix Tag:881 CFR(s): 483.80 (a)(3) It is the intent of this facility to ensure residents prescribed an antibiotics has appropriate indication for use and receives the antibiotic timely. 1) How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #21infection resolved after completion of antibiotic no further infections to date. Resident monitored, ongoing, for signs and symptoms of UTI□s. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice The Director of Nursing on February 4, 2022 reviewed all charts to see if any residents were receiving antibiotics, no residents at this time. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Education provided to all nurses by the Director of Nursing on proper diagnosis	

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F 881	Continued From page 6 catheter and remains at risk for recurrent urinary tract infections. The goal read; (name of the resident) will have interventions in place to minimize the risk of urinary tract infections through next review, 5/5/21. The interventions included; Keep fluids next to the resident at all times. Provide cues/assist the resident to drink fluids with medications and between meals. Monitor the resident for burning/painful urination. Record Intake and Output. Monitor for bladder distention. On 2/2/22, the resident was observed in the activity area, an indwelling catheter bag was attached to his chair and bright yellow urine was observed in the catheter tubing. Resident #21 was identified as one of the residents requiring use of an antibiotic on the antibiotic stewardship report for December 2021. The Director of Nursing stated documentation revealed the resident presented with a new onset of confusion, acute meatus tenderness, purulent drainage and hematuria, therefore an assessment by the Nurse Practitioner (NP) was requested. Review of the clinical record revealed; a progress note dated 11/29/21 at 20:56 which read; Resident alert and oriented times three. Skin warm and dry to touch. Denies pain or discomfort. Indwelling catheter patent and draining yellow urine with bloody sediment. Resident had paper towels stuffed in his brief with yellowish color stain. He also had thrown a stained paper towel on the floor. Educated resident on use of trash can, not putting paper towels in brief and notifying staff of need to change brief. Resident noted to have redness noted to scrotum and groin. Peri	F 881	for antibiotic use and the use of the stat box or back up pharmacy to initiate orders timely beginning February 3, 2022. The provider and Medical Director were educated by the Director of Nursing on proper diagnosis for antibiotic use on February 4, 2022. The staff development nurse using the Knowledge Skills Competency Verification Checklist, will review with all new hire nurses and annually the need to assure orders and documentation for antibiotics are appropriate and new orders are initiated timely using the stat box or back up pharmacy. February 7, 2022 staff to complete 2 times a shift for 6 months, then for 6 months 1 time a shift. using the Antibiotic Order Monitoring form, which monitors diagnosis and timeliness of administration of first dose This will be monitored by the Director of Nursing and Staff Development Nurse. 4) How the facility plans to monitor its performance to make sure that solutions are sustained; and include dates when corrective action will be completed. These corrective measures will be monitored by the Director of Nursing with oversight by the Administrator through the	

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F 881	Continued From page 7 care provided and Nystatin cream applied. Resident resting comfortably in bed with call bell in reach. On 11/30/21 the NP visited Resident #21 secondary to the above observations indicating a possible urinary tract infection. The NP ordered a Urine, Culture & Sensitivity to be collected One Time Daily for One Day (Starting 11/30/2021 Ending 11/30/2021 Anytime) Another progress note dated 12/1/21 at 6:17 read; Per Provider orders removed 16 French (Fr) catheter with 20 cubic centimeter (cm) balloon without issues. Inserted 16 Fr catheter with 30 cc balloon without issues with yellow color urine return. Used Lidocaine 2% Jelly Urojet for comfort. Resident tolerated the procedure without difficulty. There is some jelly bloody like substance leaking around the catheter, which is from the jelly which was injected into the penis prior to insertion of catheter. Will report to oncoming shift to continue to monitor. A note dated 12/2/21 read; Seen by NP order for new Foley to be placed. Order for Lidocaine with applicator to be applied before insertion, and a lab order to obtain a Urinalysis/Culture and Sensitivity (UA/CS) to be sent after placement of the new Foley catheter. A progress note dated 12/7/21 at 11:09 read; Resident seen by NP for results of the UA/CS. An order was obtained to start Macrobid on 12/08/21. Macrobid is an antibiotic used to treat bladder infections (acute cystitis). It works by stopping the growth of bacteria. This antibiotic treats only bacterial infections.	F 881	QAPI process to ensure the plan of correction is effective and that the deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing will report on the corrective measures to the QAPI Committee which will evaluate for effectiveness for a minimum of 12 months. The Committee will make further recommendations to adjust the corrective measures as needed. The Committee is authorized to charter Performance Improvement Projects when most appropriate. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	

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F 881	Continued From page 8 On 2/2/22 at 12:30 p.m., review of the laboratory report revealed the urine specimen was received by the laboratory on 12/1/21, the results were received from the laboratory by the nursing facility 12/6/21 which revealed the urine specimen contained 100,000 colonies of klebsiella oxytoca and was susceptible to the antibiotic Macrobid. The results were reported to the Practitioner on 12/7/21. The NP ordered Macrobid 100 milligrams by mouth every 12 hours for 7 days for urinary retention. The laboratory report revealed the resident had a urinary tract infection and the bacterias were susceptible to an antibiotic not to administer an antibiotic for urinary retention. The antibiotic Macrobid was first administered to Resident #21 on 12/8/21, therefore from the observation of Resident #21's onset of confusion, acute meatus tenderness, purulent drainage and hematuria it took eight since the changes were An interview was conducted with the Director of Nursing/Infection Preventionist on 2/3/22 at approximately 1:30 p.m. The Director of Nursing stated the delay in processing the specimen is related to the backup in the lab secondary to COVID-19 test; that information was confirmed by lab technician at the local laboratory. The DON further stated there was no reason for the delay in initiating the antibiotic for the medication was available in their in house supply. The Director of Nursing further stated when the nurse obtained the order a starting dose should have been administered and all other doses scheduled thereafter.	F 881		

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F 881	Continued From page 9 On 2/3/22 at approximately 3:15 p.m., the above findings were shared with the Administrator and Director of Nursing. An opportunity was offered to the facility's staff to present additional information but no additional information was provided and no concerns were voiced.	F 881		