STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ B. WING VA0375 02/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 ANNA GOODE WAY LAKE PRINCE WOODS, INC. SUFFOLK, VA 23434 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 000 Initial Comments F 000 An unannounced biennial State Licensure Inspection was conducted 02/01/22 through 02/03/22. The facility was in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. No complaints were investigated during the survey. The census in this 40 licensed 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 001 Non Compliance F 001 2/16/22 The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-220 (A, C). Nursing Services. Preparation and execution of this plan of Cross reference to F-558 & F-881. 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 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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

report... The facility has not waived any of

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State of Virginia STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION VA0375 NAME OF PROVIDER OR SUPPLIER LAKE PRINCE WOODS, INC SUMMARY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X4) ID PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 ANNA GOODE WAY SUFFOLK, VA 23434							03/31/2022 APPROVED
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	F 001	Continued From pa	ge 1	F 001	allegations or any other allegation action.; This plan of correction set the allegation of substantial comp Prefix Tag: F558 CFR(s): 483.10(all tis the intent of this facility for responded and receive services in the with reasonable accommodation or resident needs and preferences ewhen to do so would endanger the or safety of the resident or other residents.	erves as liance. e)(3) sidents to facility of enealth esidents. found to nt upon cement, 022, nager to at #2 cord so reach. It to the	

2) How the facility will identify other residents having the potential to be

PRINTED: 03/31/2022 FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING VA0375 02/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 ANNA GOODE WAY LAKE PRINCE WOODS, INC SUFFOLK, VA 23434 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) F 001 | Continued From page 2 F 001 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 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

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:
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02/03/2022

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

100 ANNA GOODE WAY

LAKE PRINCE WOODS, INC 100 ANNA GOODE WAY SUFFOLK, VA 23434				
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F 001	Continued From page 3	F 001	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 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	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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F 001	Continued From pa	ige 4	F 001	appropriate. The Administrator is responsible to see that recommer are acted upon in a timely manner. Prefix Tag:881 CFR(s): 483.80 (a) It is the intent of this facility to ens residents prescribed an antibiotics appropriate indication for use and the antibiotic timely. 1) How corrective action will be accomplished for those residents have been affected by the deficier practice. Resident #21infection after completion of antibiotic no furinfections to date. Resident monitoring on the sidents having the potential to be affected by the same deficient practice. The Director of Nursing on February 2022 reviewed all charts to see if residents were receiving antibiotic residents at this time.	found to nt resolved orther ored, of	
				3) What measures will be put into systemic changes made to ensure		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE COMPI	
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F 001	Continued From pa	ge 5	F 001	deficient practice will not recur provided to all nurses by the Direct Nursing on proper diagnosis for a use and the use of the stat box oup pharmacy to initiate orders time beginning February 3, 2022. The provider and Medical Director we educated by the Director of Nursi proper diagnosis for antibiotic use February 4, 2022. The staff devenurse using the Knowledge Skills Competency Verification Checkli review with all new hire nurses a annually the need to assure ordedocumentation for antibiotics are appropriate and new orders are in timely using the stat box or back pharmacy. February 7, 2022 state complete 2 times a shift for 6 monthen for 6 months 1 time a shift. The Antibiotic Order Monitoring for which monitors diagnosis and time of administration of first dose. The monitored by the Director of Nurse Staff Development Nurse.	ctor of intibiotic or back ely	
				are sustained; and include dates corrective action will be complete		

These corrective measures will be

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AND PLAN OF CORRECTION (2)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY LETED
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F 001	Continued From pa	ge 6	F 001	monitored by the Director of Nuroversight by the Administrator the QAPI process to ensure the plan correction is effective and that the deficiency cited remains correction compliance with the regulator requirements. The Director of Noreport on the corrective measure QAPI Committee which will eval effectiveness for a minimum of The Committee will make further recommendations to adjust the recommendations to adjust the recommendations to adjust the recommendations to charter Performant Improvement Projects when more appropriate. The Administrator is responsible to see that recommendate acted upon in a timely mannary control of Norection in the Norection of Norection of Norection in the Norection of Norection in the Norection of Norec	arough the n of ne ed and/or y dursing will es to the uate for 12 months. It corrective nmittee is ce st s endations	