TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       DATE         F 000       Initial Comments       F 000       F 000       An unannounced Biennial licensure survey was conduced on 8/27/19 though 8/29/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety survey/report will follow.       F 000       F 000       Initial Comments       F 000         The census in this 40 certified bed facility was 26 at the time of the survey. The survey sample consisted of 15 current Resident reviews and 3 closed record reviews .       The facility was not in compliance with the following Virginia Rules and Regulations for Licensure of NUrsing Facilities.       To VAC 5-371-300 (H): Cross reference to F 758.       Image: Cross reference to F 758.       Image: Cross reference to F 758.	AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 08/29/2019	
ARE PRINCE WOODS, INC         Building of the processing of the proces of the processing of the processing of the processing			VA0375				
FOOD     SUFFOLK, VA 23434       (M) ID PREFIX TAG     SUMANY STREEN OF DEFICIENCIES (RESULATORY OR LSC IDENTIFING INFORMATION)     ID PROVIDERS PLAN OF CORRECTOR STOLLD BE CROSS-REFERENCE WOODS, INC.     (09) (CROSS-REFERENCE WOODS WOULD BE CROSS-REFERENCE WOODS WOULD BE CROSS-REFERENCE WOODS WOULD BE CROSS-REFERENCE WOODS, INC.     (09) (CROSS-REFERENCE WOODS WOULD BE CROSS-REFERENCE WOODS, INC.     (09) (CROSS-REFERENCE WOODS WOULD BE CROSS-REFERENCE WOODS WOULD BE CROSS-REFERENCE WOODS, INC.     (09) (CROSS-REFERENCE WOODS WOULD BE CROSS-REFERENCE WOODS, INC.     (09) (CROSS-REFERENCE WOODS, INC.     (09) (CROSS-REFERENCE WOODS, INC.     (09) (CROSS-REFERENCE WOODS, INC.     (09) (CROSS-REFERENCE WOODS, INC.     (00) (CROSS-REFERENCE WOODS, INC. <t< th=""><th>AME OF PF</th><th>ROVIDER OR SUPPLIER</th><th>STREET</th><th>ADDRESS, CITY, ST</th><th>ATE, ZIP CODE</th><th></th></t<>	AME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
Preprint TAG         (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX TAG         (EACH CORRECT ACTION SHOULD BE CROSS-REFERENCE) to THE APPROPRIATE         Control           F 000         Initial Comments         F 000         F 001         F 001 <td< th=""><th>AKE PRII</th><th>NCE WOODS, INC</th><th></th><th></th><th></th><th></th></td<>	AKE PRII	NCE WOODS, INC					
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conduced on 8/27/19 though 8/22/19.         Corrections are required for compliance with 42         CFR Part 483 Federal Long Term Care         requirements. The Life Safety survey/report will         follow.         The census in this 40 certified bed facility was 26         at the time of the survey. The survey sample         consisted of 15 current Resident reviews and 3         closed record reviews.         The facility was not in compliance with the         following Virginia Rules and Regulations for         Licensure of NUrsing Facilities.         12 VAC 5-371-300 (H): Cross reference to F         758.         F 001         Non Compliance         This RULE: is not met as evidenced by:         Policies and Procedures.         12 VAC 5-371-300 (H)         Based on staff interview and clinical record         review, the facility staff failed to ensure that a 1 of         15 residents in the survey sample was free from administration of an unnecessary psychotropic medication (Resident #16).         The findings included:	F 000	Initial Comments		F 000			
F 001Non ComplianceF 0018/30/19The facility was out of compliance with the following state licensure requirements:F 0018/30/19This RULE: is not met as evidenced by: Policies and Procedures.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 correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law, and because the facility staff failed to ensure that a 1 of 15 residents in the survey sample was free from administration of an unnecessary psychotropic medication (Resident #16).F 0018/30/19The findings included:The findings included:F 0018/30/198/30/19		conduced on 8/27/19 Corrections are required CFR Part 483 Federa requirements. The L follow. The census in this 40 at the time of the sum consisted of 15 curre closed record review. The facility was not in following Virginia Rul Licensure of NUrsing 12 VAC 5-371-300 (19)	though 8/29/19. red for compliance with 42 al Long Term Care ife Safety survey/report will certified bed facility was 26 wey. The survey sample nt Resident reviews and 3 s. n compliance with the es and Regulations for Facilities.				
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		Based on staff intervirreview, the facility sta 15 residents in the su administration of an u medication (Residen The findings included	ew and clinical record aff failed to ensure that a 1 of urvey sample was free from unnecessary psychotropic It #16).		Woods of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correctior 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. Th facility contends that it was in substantia compliance with all requirements on the	n	
		The facility staff failed	a to ensure Resident #16		survey date, and denies that any		

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If continuation sheet 1 of 4

State of Virginia STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	SURVEY PLETED
	VA0375		B. WING	08	/29/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
LAKE PRI	NCE WOODS, INC		A GOODE WAY	,		
			K, VA 23434			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
F 001	Continued From pag	e 1	F 001			
	was free from admini unnecessarily. The p resident to receive At not provide a stop da Resident #16 was re 7/25/19 with the follo limited to anemia, ca clot, cirrhosis, anxiety infection. On the adr Data Set) with an AR Date) of 8/1/19 code BIMS (Brief Interview 14 out of a possible s was also coded as re of 1 staff member for and bathing. During the clinical rea the surveyor, it was r ordered Ativan 2 mg/ ml as needed every for ordered was written of stop date provided for for 14 days and then physician to assess i continued need of thi needed to be discont The surveyor notified Nursing) of the above 8/29/19 at 11:13 am. order for the Ativan w resident was admitte the thinking of not ha Ativan was "OK beca	istration of Ativan ohysician ordered the tivan prn (as needed) and did ate of 14 days. admitted to the facility on wing diagnosis of, but not ncer, atrial fibrillation, blood y disorder and urinary tract mission, MDS (Minimum RD (Assessment Reference d the resident as having a v for Mental Status) score of score of 15. Resident #16 equiring extensive assistance to dressing, personal hygiene cord review on 8/29/19 by noted that the physician /ml (milligram/milliliter) 0.25 four hours for anxiety. This on 7/29/19. There was not a or the medication to be given be re-evaluated by the f the resident would need is medication or if this tinued. A the DON (Director of e documented findings on The DON stated that the was received when the d to hospice services and wing a stop date for the ause the resident was in		<ul> <li>deficiency exists or existed or f such plan is necessary. Neither submission of such plan, nor a contained in the plan, should b as an admission of any deficient any allegation contained in this report. The facility has not wait its rights to contest any of thes allegations or any other allegat action. This plan of correction the allegation of substantial correction the allegation of substantial correstion the intent of this facility to a residents remain free from adm of an unnecessary psychotropic medication and to ensure that orders for PRN psychotropic m are renewed every 14 days.</li> <li>1) How corrective action will be accomplished for those resider have been affected by the define practice The Director of Nursing, receiv from the hospice physician, on 2019 to discontinue Resident # psychotropic medication for no Director of Nursing met with representatives from hospice of 30, 2019, to review the citation approved not having this type of unless a resident is actively us medication.</li> <li>2) How the facility will identify of residents having the potential that affected by the same deficient</li> </ul>	er the nything be construed ncy, or of s survey ived any of e tion or serves as mpliance. (1)-(5) ensure that ninistration ic medications e nts found to cient red an order August 29, #16 PRN onuse. The on August and of order ing the	
		n was provided to the exit conference on 8/29/19.		The Director of Nursing, on Au 2019, reviewed PRN psychotro	gust 29,	

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State of Virginia STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		VA0375	B. WING		08//	29/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
LAKE PR	INCE WOODS, INC					
	STIMWADA S		LK, VA 23434	PROVIDER'S PLAN OF CORF	PECTION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
F 001	Continued From pag	je 2	F 001			
F 001 Continued From page 2			<ul> <li>medication orders for all resider the Medication Administration R assure compliance. No discrepa were identified.</li> <li>3) What measures will be put in systemic changes made to ensu deficient practice will not recur The Director of Nursing met with representatives, on August 30, 2 discussed the regulation pertain PRN psychotropic use All of the who work in health care were educated on August 29, 24 regulation/requirement to renew psychotropic medication every Nurses upon hire will receive tra the regulation requiring PRN ps renewal with a new order every medication has not been given, should be discontinued. A mo tool was developed to monitor of with the 14 day stop date (attac provide information on non-use PRN psychotropic for orders no renewed. The Director of Nursi oversee monitoring daily for 1 m weekly for 3 months, then bi-we months and monthly for 4 month</li> </ul>	to place or ure that the h hospice 2019 and hing to the nurses 019 on the V PRN 14 days. aining on ychotropic 14 days. If order nitoring compliance hed) and to of the t to be ng will honth, then tekly for 4		
				4) How the facility plans to moniperformance to make sure that are sustained; and include date corrective action will be completed	solutions s when	
				These corrective measures will monitored by the Director of Nu oversight by the Administrator th	rsing with	

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State of Virginia STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		VA0375	B. WING		08	/29/2019	
	PROVIDER OR SUPPLIER	100 AN	ADDRESS, CITY, ST. NA GOODE WAY LK, VA 23434		·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
F 001	Continued From pag	e 3	F 001	QAPI process to ensure the p correction is effective and that deficiency cited remains corre in compliance with the regular requirements. The Director of report on the corrective meas QAPI Committee which will e effectiveness for a minimum of The Committee will make furt recommendations to adjust the measures as needed. The C authorized to charter Perform Improvement Projects when a appropriate. The Administrator responsible tosee that recom are acted upon in a timely mathematical descent states and the states of the states of the states are acted upon in a timely mathematical states of the states	at the ected and/or itory of Nursing will sures to the evaluate for of 12 months. ther he corrective committee is hance most or is imendations		

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