State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0375	A. BUILDING: _____ B. WING _____	08/29/2019

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) COMPLETE DATE
F 000	Initial Comments 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. 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 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: 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: The facility staff failed to ensure Resident #16	F 001	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 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	8/30/19

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

Electronically Signed | 10/08/19

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F 001	Continued From page 1 was free from administration of Ativan unnecessarily. The physician ordered the resident to receive Ativan prn (as needed) and did not provide a stop date of 14 days. Resident #16 was readmitted to the facility on 7/25/19 with the following diagnosis of, but not limited to anemia, cancer, atrial fibrillation, blood clot, cirrhosis, anxiety disorder and urinary tract infection. On the admission, MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/1/19 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #16 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and bathing. During the clinical record review on 8/29/19 by the surveyor, it was noted that the physician ordered Ativan 2 mg/ml (milligram/milliliter) 0.25 ml as needed every four hours for anxiety. This ordered was written on 7/29/19. There was not a stop date provided for the medication to be given for 14 days and then be re-evaluated by the physician to assess if the resident would need continued need of this medication or if this needed to be discontinued. The surveyor notified the DON (Director of Nursing) of the above documented findings on 8/29/19 at 11:13 am. The DON stated that the order for the Ativan was received when the resident was admitted to hospice services and the thinking of not having a stop date for the Ativan was "OK because the resident was in Hospice." No further information was provided to the surveyor prior to the exit conference on 8/29/19.	F 001	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: F758 483.45(c)(3)-(1)-(5) It is the intent of this facility to ensure that residents remain free from administration of an unnecessary psychotropic medication and to ensure that medication orders for PRN psychotropic medications are renewed every 14 days. 1) How corrective action will be accomplished for those residents found to have been affected by the deficient practice The Director of Nursing, received an order from the hospice physician, on August 29, 2019 to discontinue Resident #16 PRN psychotropic medication for nonuse. The Director of Nursing met with representatives from hospice on August 30, 2019, to review the citation and approved not having this type of order unless a resident is actively using the medication. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice The Director of Nursing, on August 29, 2019, reviewed PRN psychotropic	

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F 001	Continued From page 2	F 001	medication orders for all residents using the Medication Administration Records to assure compliance. No discrepancies were identified. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The Director of Nursing met with hospice representatives, on August 30, 2019 and discussed the regulation pertaining to the PRN psychotropic use All of the nurses who work in health care were educated on August 29, 2019 on the regulation/requirement to renew PRN psychotropic medication every 14 days. Nurses upon hire will receive training on the regulation requiring PRN psychotropic renewal with a new order every 14 days. If medication has not been given, order should be discontinued. . A monitoring tool was developed to monitor compliance with the 14 day stop date (attached) and to provide information on non-use of the PRN psychotropic for orders not to be renewed. The Director of Nursing will oversee monitoring daily for 1 month, then weekly for 3 months, then bi-weekly for 4 months and monthly for 4 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	

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F 001	Continued From page 3	F 001	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 tosee that recommendations are acted upon in a timely manner.	