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Lake Prince Woods
100 Anna Goode Way
Suffolk, VA 23434
(757) 923-5500

Current Inspector: Darunda Flint (757) 807-9731

Inspection Date: Oct. 5, 2021

Complaint Related: No

Areas Reviewed:

22VAC40-73 ADMINISTRATION AND ADMINISTRATIVE SERVICES
22VAC40-73 PERSONNEL
22VAC40-73 STAFFING AND SUPERVISION
22VAC40-73 ADMISSION, RETENTION, AND DISCHARGE OF RESIDENTS
22VAC40-73 RESIDENT CARE AND RELATED SERVICES
22VAC40-73 RESIDENT ACCOMODATIONS AND RELATED PROVISIONS
22VAC40-73 BUILDING AND GROUNDS
22VAC40-73 EMERGENCY PREPAREDNESS
22VAC40-73 ADDITIONAL REQUIREMENTS FOR FACILITIES THAT CARE FOR ADULTS WITH SERIOUS COGNITIVE IMPAIRMENTS

Article 1
Subjectivity

Comments:

A renewal inspection was initiated on 10/5/2021 and concluded on 10/20/2021. The Administrator was contacted by telephone to initiate the inspection. The Administrator/AL Director reported that the current census was 28. The inspector emailed the Administrator/AL Director a list of items required to complete the remote documentation review portion of the inspection. The inspector reviewed 3 resident records, 3 staff records, staff schedule, activity calendar, fire and emergency drills, and menus submitted by the facility to ensure documentation was complete. Two inspectors conducted the on-site portion of the inspection on 10/19/2021. An exit interview was conducted with the Administrator/AL Director on the date of inspection, where findings were reviewed and an opportunity was given for questions, as well as for providing any information or documentation which was not available during the inspection.

Information gathered during the inspection determined non-compliance(s) with applicable standards or law, and violations were documented on the violation notice issued to the facility.

Violations:

Standard #:	22VAC40-73-450-C
Description:	Based on documentation review, the facility failed to ensure the Individualized Service Plan (ISP) included a description of the resident?s identified needs based on the Uniform Assessment Instrument (UAI). Evidence: 1. Resident #1?s UAI dated 07-06-2021 documented the need of supervision with dressing; however, the current ISP states Resident #1 needs physical assistance with dressing on 07-06-2021. Resident #1?s UAI also documented the need of assistance with laundry; however, the current ISP does not include documentation of the need of assistance with laundry. Resident #1?s UAI and ISP also does not document Resident #1 as a high fall risk; however, the most recent fall risk rating completed on 09-02-2021 documents Resident #1 as a high fall risk. Resident #1?s UAI does not document the code status of Resident #1; however, the current ISP documents Resident #1 as a Full Code as of 02-01-2021. Additionally, Resident #1?s UAI does not document the use of psychoactive medications; however, the current ISP identified a need of mental health services/psychoactive medications on 09-22-2021. Lastly, Resident #1?s UAI does not document the diet of Resident #1; however, the current ISP documents the nutrition needs to include no added salt dietary restrictions on 02-01-2021. The dietary clinical note dated 08-18-2021 further states the need of a no added salt diet. 2. Resident #2?s UAI dated 07-14-2021 documented the need for supervision with toileting; however on the current ISP, a need for mechanical and physical assistance with toileting was identified on 04-15-2021. Resident #2?s UAI does not document Resident #2 as a high fall risk; however, the current ISP identified that Resident #2 is at risk for falls due to unsteady gait, history of falls and cannot remember to ask for assistance on 11-10-2020. Additionally on 09-02-2021, the most recent fall risk rating documents Resident #2 as a high fall risk.

	3. Resident #3?s UAI dated 06-20-2021 documented there is not a need for dressing; however on the current ISP a mechanical need of utilizing a shoe horn was documented on 06-25-2021. Resident #3?s UAI also does not document the code status of Resident #3; however, the current ISP documents Resident #3 as a Full Code as of 06-25-2021.
Plan of Correction:	The Clinical Coordinator and AL Director updated residents #1, #2 & #3?s UAI?s & ISP?s to reflect accurate and correct information is on each resident?s ISP based off of information from the UAI. Each UAI & ISP that are completed by the Clinical Coordinator or any UAI certified personnel will be reviewed and verified for accuracy by the AL Director prior to filing in the resident?s chart.

Standard #:	22VAC40-73-620-A
Description:	Based on documentation review and interview, the facility failed to ensure oversight at least every six months of special diets by a dietitian or nutritionist for each resident who has such a diet. Evidence: 1. During documentation review, Resident #4 has an order for a No Added Salt diet dated 08-01-2021. 2. During interview, Staff #4 could not provide documentation that Resident #4 has been seen by a dietitian or nutritionist for oversight of special diet.
Plan of Correction:	All records were audited and reviewed with the dietitian and all residents with special diets have been seen. The dietitian will leave a list of all residents on special diets after each review with the AL Director. The AL Director will ensure all residents with special diets have been seen.

Standard #:	22VAC40-73-640-A
Description:	Based on documentation review and interview, the facility failed to implement their written plan for medication management which includes methods to ensure that each resident's prescription medications and any over-the- counter drugs and supplements ordered for the resident are filled and refilled in a timely manner to avoid missed dosages. Evidence: 1. During review of the MAR for Resident #1, Fentanyl 25 mcg transdermal patch to be applied every three days was not administered to Resident #1 as the medication was not available on 09-04-2021. 2. During review of the MAR for Resident #2, Memantine 10 mg tablet to be administered one time daily was not administered to Resident #2 as the medication was not available on 10-05-2021. Additionally, during review of the MAR for Resident #2, Donepezil 5 mg tablet to be administered one time daily was not administered to Resident #2 as the medication was not available on 09-22-2021, 09-24-2021, 09-25-2021, 09-26-2021, and 09-27-2021. 3. During review of the MAR for Resident #3, Sodium Chloride 1 gram tablet to be administered three times daily was not administered to Resident #3 as the medication was not available from 09-11-2021 to 09-15-2021.
Plan of Correction:	The Clinical Coordinator & AL Director have in-serviced all staff and the Pharmacy on the written medication management plan. All staff were reeducated on reordering and refilling medications in a timely manner. A review was done with the Pharmacy on the plan for use of the backup pharmacy when medications are not available at their location, in order to receive all medications timely. Medication reorder dates have been set for Mondays & Thursdays on 11pm -7am shifts. When the medications are reordered a copy is left for the Clinical Coordinator to review. Compliance will be reported to the AL Director monthly.

Standard #:	22VAC40-73-650-E
Description:	Based on observation, the facility failed to ensure the resident's record contained the physician's or other prescriber's signed written order or a dated notation of the physician's or other prescriber's oral order. Evidence: 1. During an inspection of the facility on 10-19-2021 with Staff #4, the Licensing Inspector observed two bottles of TUMs in Resident #5?s bathroom. Staff #4 removed the items from apartment and stated these items may have been brought in with or from family members. 2. During an inspection of the facility on 10-19-2021 with Staff #4, the Licensing Inspector observed a container of roll-on Aspercreme on Resident?s #6 walker. 3. During interview on 10-20-2021, Staff #4 confirmed Resident #5 and Resident #6 did not have a physician?s order for the medications observed.
Plan of Correction:	All resident?s rooms have been checked for any medications without physician?s orders and obtained any orders as needed. A schedule has been set up for review weekly of all rooms. The Clinical Coordinator will monitor weekly and make the AL Director aware of any non-compliance.

Standard #:	22VAC40-73-960-B
Description:	Based on observation, the facility failed to ensure a fire and emergency evacuation drawing include areas of refuge and assembly areas. Evidence:

	1. During an inspection of the facility on 10-19-2021, adjacent to the posted activity calendar, a fire evacuation plan of the first floor was present. In the legend, the area of refuge and assembly area were noted; however, the actual placement of these two areas were not on the map of the fire evacuation plan posted. 2. During interview on 10-20-2021, Staff #4 acknowledged the posted fire and emergency evacuation drawings did not include the area of refuge or assembly area.
Plan of Correction:	All fire and evacuation drawings have been updated to reflect areas of refuge and areas of assembly throughout the facility by our Director of Plant Operations.

Disclaimer:
This information is provided by the Virginia Department of Social Services, which neither endorses any facility nor guarantees that the information is complete. It should not be used as the sole source in evaluating and/or selecting a facility.