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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 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. 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 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. (continued on next page)

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.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 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 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 care provided and Nystatin cream applied. Resident resting comfortably in bed with call bell in reach. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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.