

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Princess Anne Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1948 Landstown Centre Way Virginia Beach, VA 23456	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42183</p> <p>Based on staff interview and facility document review, it was determined the facility staff failed to notify the physician of a change in condition for three of six residents in the survey sample, Resident #1, Resident #4 and Resident #6.</p> <p>The findings include:</p> <p>1.The facility failed to notify the physician of Resident #1's missed medication administration.</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: hemiplegia, diabetes mellitus (DM), Cerebrovascular accident (CVA) and chronic kidney disease (CKD).</p> <p>The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 1/31/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring moderate assistance for bathing and supervision for bed mobility, transfer, dressing, hygiene and eating; independent for locomotion.</p> <p>A review of the comprehensive care plan dated 1/26/24 revealed, FOCUS: ANTIPLATELETS: the resident is at risk for bleeding, hemorrhage, excessive bruising, and complications due to antiplatelet use secondary to history of CVA. INTERVENTIONS: Administer medications as ordered.</p> <p>A review of the physician orders dated 1/25/24, revealed Clopidogrel Bisulfate Oral Tablet 75 MG (milligram). Give 1 tablet by mouth in the morning for Prevent DVT (deep vein thrombosis). Aspirin Low Dose Oral Tablet Chewable 81 MG. Give 1 tablet by mouth in the morning for prevent DVT. Carvedilol Oral Tablet 6.25 MG (Carvedilol) Give 1 tablet by mouth two times a day for HTN Hold SBP&lt;115 HR&lt;60. Chlorthalidone Oral Tablet 25 MG Give 1 tablet by mouth in the morning for HTN, Duloxetine HCl Oral Capsule Delayed Release Particles 20 MG Give 1 capsule by mouth in the morning for MDD, Gabapentin (EPCS) Capsule 400 MG Give 1 capsule by mouth every 8 hours for neuropathic pain, Lidocaine Patch 4 % Apply to low back topically one time a day for pain 12 hrs. on/off, Metformin HCl Oral Tablet 1000 MG Give 1 tablet by mouth two times a day for DM2, Nifedipine ER Oral Tablet Extended Release 24 Hour 90 MG Give 1 tablet by mouth in the morning for HTN Hold SBP&lt;120 HR&lt;60 and Spironolactone Oral Tablet 25 MG (Spironolactone) Give 2 tablet by mouth in the morning for HTN.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the April 2024 MAR (medication administration record) revealed Clopidogrel Bisulfate Oral Tablet 75 MG (milligram), Aspirin Low Dose Oral Tablet Chewable 81 MG, Carvedilol Oral Tablet 6.25 MG, Chlorthalidone Oral Tablet 25 MG, Duloxetine HCl Oral 20 MG, Gabapentin (EPCS) Capsule 400 MG, Lidocaine Patch 4 %, Metformin HCl Oral Tablet 1000 MG, Nifedipine ER Oral Tablet Extended Release 24 Hour 90 MG and Spironolactone Oral Tablet 25 MG was administered at 1:14 PM on 4/4/24. Scheduled administration time was 8:00 AM or 9:00AM.</p> <p>There was no documentation of Physician notification of medications not administered as ordered.</p> <p>An interview was conducted on 5/23/24 at 1:00 PM with ASM (administrative staff person) #2, the assistant director of nursing. When asked if the Physician should be notified if medications are not given as ordered, ASM #2 stated, Yes, they should be notified. When asked if this would be documented, ASM #2 stated, Yes, it should be documented in the progress notes.</p> <p>An interview was conducted on 5/23/24 at 1:20 PM with ASM #4, the physician. When asked if he is getting notified of medications not given as ordered, ASM #4 stated, No, I am not getting called if patients are not getting their medications. Did not know about the drug shortage list, I have not been getting any calls regarding needing to order an alternative medication.</p> <p>On 5/23/24 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of operations were made aware of the findings.</p> <p>According to the facility's Medication Error policy which revealed, The provider will be notified of the medication error.</p> <p>No further information was provided prior to exit.</p> <p>2. The facility failed to notify the physician of Resident #4's missed medication administration due to drug shortage.</p> <p>Resident #4 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: diabetes mellitus (DM), chronic respiratory failure and chronic kidney disease (CKD).</p> <p>The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 4/14/24, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring max assistance for bathing and supervision for bed mobility, transfer, dressing, hygiene and independent for eating.</p> <p>A review of the comprehensive care plan dated 4/14/26/24 revealed, FOCUS: The resident is at risk for complications and blood glucose fluctuations related to diagnosis of diabetes mellitus. INTERVENTIONS: Administer medications as ordered. Observe for signs and symptoms of hyper/hypoglycemia and notify md as indicated.</p> <p>A review of the physician orders dated 4/11/24 revealed, Mounjaro Subcutaneous Solution Pen-injector 5 MG/0.5ML Inject 5 mg subcutaneously one time a day every Sat for DM.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the April MAR (medication administration record) revealed, 4/13/24 Mounjaro 5 mg administered, no administration documented on 4/20/24 or 4/27/24.</p> <p>There was no documentation of Physician notification of medications not administered as ordered.</p> <p>An interview was conducted on 5/23/24 at 1:00 PM with ASM (administrative staff person) #2, the assistant director of nursing. When asked if the Physician should be notified if medications are not given as ordered, ASM #2 stated, Yes, they should be notified. When asked if this would be documented, ASM #2 stated, Yes, it should be documented in the progress notes.</p> <p>An interview was conducted on 5/23/24 at 1:20 PM with ASM #4, the physician. When asked if he is getting notified of medications not given as ordered, ASM #4 stated, No, I am not getting called if patients are not getting their medications. Did not know about the drug shortage list, I have not been getting any calls regarding needing to order an alternative medication.</p> <p>On 5/23/24 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of operations were made aware of the findings.</p> <p>According to the facility's Medication Error policy which revealed, The provider will be notified of the medication error.</p> <p>No further information was provided prior to exit.</p> <p>3. The facility failed to notify the physician of Resident #6's missed antibiotic administration.</p> <p>Resident #6 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: diabetes mellitus (DM) and osteoarthritis.</p> <p>The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 5/5/24, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring max assistance for hygiene, dressing, bathing and partial assist for bed mobility, transfer; independent for eating.</p> <p>A review of the comprehensive care plan dated 5/2/24 revealed, FOCUS: The resident is at risk for complications and blood glucose fluctuations related to diagnosis of diabetes mellitus. The resident has a PICC Line venous access to the left arm. INTERVENTIONS: Administer medications as ordered. Observe for signs and symptoms of hyper/hypoglycemia and notify md as indicated. Dressing change per order. Flush PICC as ordered.</p> <p>A review of the physician orders dated 5/2/24 revealed, Cefazolin Sodium Injection Solution Reconstituted 2 GM (grams). Use 2 gram intravenously three times a day for sepsis for 21 Days.</p> <p>A review of the May MAR (medication administration record) revealed, 4/13/24 Cefazolin Sodium Injection Solution 2 GM, no administration documented on 5/12/24 2:00 PM, 5/19/24 6:00 AM and 5/21/24 2:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There was no documentation of Physician notification of medications not administered as ordered.</p> <p>An interview was conducted on 5/23/24 at 1:00 PM with ASM (administrative staff person) #2, the assistant director of nursing. When asked if the Physician should be notified if medications are not given as ordered, ASM #2 stated, Yes, they should be notified. When asked if this would be documented, ASM #2 stated, Yes, it should be documented in the progress notes.</p> <p>An interview was conducted on 5/23/24 at 1:20 PM with ASM #4, the physician. When asked if he is getting notified of medications not given as ordered, ASM #4 stated, No, I am not getting called if patients are not getting their medications. Did not know about the drug shortage list, I have not been getting any calls regarding needing to order an alternative medication.</p> <p>On 5/23/24 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of operations were made aware of the findings.</p> <p>According to the facility's Medication Error policy which revealed, The provider will be notified of the medication error.</p> <p>No further information was provided prior to exit.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42183</p> <p>Based on observations, resident/staff interviews, facility document review and clinical record review, it was determined the facility staff failed to develop/implement the care plan for two of six residents in the survey sample, Residents #1 and #2.</p> <p>The findings include:</p> <p>1.The facility staff failed to implement the comprehensive care plan for administer medications as ordered for Resident #1.</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: hemiplegia, diabetes mellitus (DM), Cerebrovascular accident (CVA) and chronic kidney disease (CKD).</p> <p>The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 1/31/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring moderate assistance for bathing and supervision for bed mobility, transfer, dressing, hygiene and eating; independent for locomotion.</p> <p>A review of the comprehensive care plan dated 1/26/24 revealed, FOCUS: ANTIPLATELETS: the resident is at risk for bleeding, hemorrhage, excessive bruising, and complications due to antiplatelet use secondary to history of CVA. INTERVENTIONS: Administer medications as ordered.</p> <p>A review of the physician orders dated 1/25/24, revealed Clopidogrel Bisulfate Oral Tablet 75 MG (milligram). Give 1 tablet by mouth in the morning for Prevent DVT (deep vein thrombosis). Aspirin Low Dose Oral Tablet Chewable 81 MG. Give 1 tablet by mouth in the morning for prevent DVT. Carvedilol Oral Tablet 6.25 MG (Carvedilol) Give 1 tablet by mouth two times a day for HTN Hold SBP&lt;115 HR&lt;60. Chlorthalidone Oral Tablet 25 MG Give 1 tablet by mouth in the morning for HTN, Duloxetine HCl Oral Capsule Delayed Release Particles 20 MG Give 1 capsule by mouth in the morning for MDD, Gabapentin (EPCS) Capsule 400 MG Give 1 capsule by mouth every 8 hours for neuropathic pain, Lidocaine Patch 4 % Apply to low back topically one time a day for pain 12 hrs. on/off, Metformin HCl Oral Tablet 1000 MG Give 1 tablet by mouth two times a day for DM2, Nifedipine ER Oral Tablet Extended Release 24 Hour 90 MG Give 1 tablet by mouth in the morning for HTN Hold SBP&lt;120 HR&lt;60 and Spironolactone Oral Tablet 25 MG (Spironolactone) Give 2 tablet by mouth in the morning for HTN.</p> <p>A review of the April 2024 MAR (medication administration record) revealed Clopidogrel Bisulfate Oral Tablet 75 MG (milligram), Aspirin Low Dose Oral Tablet Chewable 81 MG, Carvedilol Oral Tablet 6.25 MG, Chlorthalidone Oral Tablet 25 MG, Duloxetine HCl Oral 20 MG, Gabapentin (EPCS) Capsule 400 MG, Lidocaine Patch 4 %, Metformin HCl Oral Tablet 1000 MG, Nifedipine ER Oral Tablet Extended Release 24 Hour 90 MG and Spironolactone Oral Tablet 25 MG was administered at 1:14 PM on 4/4/24. Scheduled administration time was 8:00 AM or 9:00AM.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 5/23/24 at 8:05 AM with LPN (licensed practical nurse) #4. When asked if the care plan had been implemented if medications were not administered as ordered, LPN #4 stated, No, not at all.</p> <p>On 5/23/24 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of operations were made aware of the findings.</p> <p>According to the facility's Care Planning policy which revealed, A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health related services to attain or maintain the highest practical physical, mental and psychosocial well-being of the patient.</p> <p>No further information was provided prior to exit.</p> <p>2.The facility staff failed to implement the comprehensive care plan for incontinence care for Resident #2.</p> <p>Resident #2 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: dementia, COVID and fracture right femur. hospitalized [DATE]-[DATE].</p> <p>The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 12/28/23, coded the resident as scoring a 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring max assistance for bathing, bed mobility, transfer, dressing, hygiene and partial assistance for eating.</p> <p>A review of the comprehensive care plan dated 12/5/23 revealed, FOCUS: The resident is incontinent of bladder and/or bowels. INTERVENTIONS: provide toileting hygiene with brief changes.</p> <p>A review of the December 2023 and January 2024 ADL (activities of daily living) document which reveals the following shifts and dates of missing documentation:</p> <p>Day Shift: 12/13, 12/23, 12/24, 1/1 and January 4th.</p> <p>Evening Shift: 12/11, 12/24, 12/25, 12/31, January 4th and 1/5.</p> <p>Night Shift: 12/5 and 1/1.</p> <p>An interview was conducted on 5/22/24 at 1:20 PM with CNA (certified nursing assistant) #1. When asked the frequency of incontinence care, CNA #1 stated, We try to do it every 2 hours but it depends on staffing. When asked where they would evidence that incontinence care had been provided, CNA #1 stated, It would be in PCC (point click care) on the ADL form. When asked if there was not evidence of incontinence care, was the care plan implemented, CNA #1 stated, No, it was not.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 5/22/24 at 3:40 PM with CNA #6. When asked the frequency of incontinence care, CNA #6 stated, We are to do it every two hours. When asked if it is done every two hours, CNA #6 stated, Not always due to staffing on evenings. When asked where the evidence of incontinence care being provided would be, CNA #6 stated, On the ADL document in PCC. When asked if the care plan was implemented if there was not evidence of incontinence care, CNA #6 stated, It was not implemented.</p> <p>On 5/23/24 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of operations were made aware of the findings.</p> <p>According to the facility's Care Planning policy which revealed, A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health related services to attain or maintain the highest practical physical, mental and psychosocial well-being of the patient.</p> <p>No further information was provided prior to exit.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183</b></p> <p>Based on resident and staff interview, clinical record review and facility document review, it was determined the facility staff failed to meet professional standards for one of 6 residents, Resident #1.</p> <p>The findings include:</p> <p>The facility staff failed to meet professional standards by administering medications as ordered with a licensed clinical nurse: RN or LPN (registered nurse or licensed practical nurse) providing the medications to Resident #1.</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: hemiplegia, diabetes mellitus (DM), Cerebrovascular accident (CVA) and chronic kidney disease (CKD).</p> <p>The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 1/31/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring moderate assistance for bathing and supervision for bed mobility, transfer, dressing, hygiene and eating; independent for locomotion.</p> <p>A review of the comprehensive care plan dated 1/26/24 revealed, FOCUS: ANTIPLATELETS: the resident is at risk for bleeding, hemorrhage, excessive bruising, and complications due to antiplatelet use secondary to history of CVA. INTERVENTIONS: Administer medications as ordered.</p> <p>A review of the physician orders dated 1/25/24, revealed Clopidogrel Bisulfate Oral Tablet 75 MG (milligram). Give 1 tablet by mouth in the morning for Prevent DVT (deep vein thrombosis). Aspirin Low Dose Oral Tablet Chewable 81 MG. Give 1 tablet by mouth in the morning for prevent DVT. Carvedilol Oral Tablet 6.25 MG (Carvedilol) Give 1 tablet by mouth two times a day for HTN Hold SBP&lt;115 HR&lt;60. Chlorthalidone Oral Tablet 25 MG Give 1 tablet by mouth in the morning for HTN, Duloxetine HCl Oral Capsule Delayed Release Particles 20 MG Give 1 capsule by mouth in the morning for MDD, Gabapentin (EPCS) Capsule 400 MG Give 1 capsule by mouth every 8 hours for neuropathic pain, Lidocaine Patch 4 % Apply to low back topically one time a day for pain 12 hrs. on/off, Metformin HCl Oral Tablet 1000 MG Give 1 tablet by mouth two times a day for DM2, Nifedipine ER Oral Tablet Extended Release 24 Hour 90 MG Give 1 tablet by mouth in the morning for HTN Hold SBP&lt;120 HR&lt;60 and Spironolactone Oral Tablet 25 MG (Spironolactone) Give 2 tablet by mouth in the morning for HTN.</p> <p>A review of the April 2024 MAR (medication administration record) revealed Clopidogrel Bisulfate Oral Tablet 75 MG (milligram), Aspirin Low Dose Oral Tablet Chewable 81 MG, Carvedilol Oral Tablet 6.25 MG, Chlorthalidone Oral Tablet 25 MG, Duloxetine HCl Oral 20 MG, Gabapentin (EPCS) Capsule 400 MG, Lidocaine Patch 4 %, Metformin HCl Oral Tablet 1000 MG, Nifedipine ER Oral Tablet Extended Release 24 Hour 90 MG and Spironolactone Oral Tablet 25 MG was administered at 1:14 PM on 4/4/24. Scheduled administration time was 8:00 AM or 9:00AM.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted during entrance conference on 5/22/24 at 11:15 AM with ASM (administrative staff member) #1, the administrator. When asked about administering medications to residents, ASM #1 stated, Yes, I have only done that once with Resident #1. Our DON (director of nursing) at the time, she basically she could not stand for periods of time, she was on the cart in the hallway. I took the meds from her hand and delivered it to the resident. The DON was watching me give it to Resident #1. The DON popped the medications into the cup and signed them off and told me what medications were being given. I made sure that the resident took the medications with water.</p> <p>An interview was conducted on 5/22/24 at 12:15 PM with Resident #1, when asked about the administrator giving her medications, Resident #1 stated, It was only the one time. The medications were late because they were short staffed. It was on a Sunday. I did not get my morning medications till early afternoon. The DON was in the hall and the administrator walked about the 10-12 feet to give me my medicines.</p> <p>On 5/23/24 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of operations were made aware of the findings.</p> <p>According to the facility's Administration Procedure for Medications policy which revealed, Medications will be administered a safe and effective manner. At a minimum, review the 5 rights at each of the following steps of medication administration.</p> <p>No further information was provided prior to exit.</p>		

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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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42183</p> <p>Based on observations, staff interviews, facility document review and clinical record review, it was determined the facility staff failed to provide evidence of ADL (activities of daily living) care for two of six residents in the survey sample, Resident #2 and Resident #3.</p> <p>The findings include:</p> <p>1.The facility staff failed to provide evidence of ADL specifically incontinence care for Resident #2.</p> <p>Resident #2 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: dementia, COVID and fracture right femur. hospitalized [DATE]-[DATE].</p> <p>The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 12/28/23, coded the resident as scoring a 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring max assistance for bathing, bed mobility, transfer, dressing, hygiene and partial assistance for eating.</p> <p>A review of the comprehensive care plan dated 12/5/23 revealed, FOCUS: The resident is incontinent of bladder and/or bowels. INTERVENTIONS: provide toileting hygiene with brief changes.</p> <p>A review of the December 2023 and January 2024 ADL (activities of daily living) document which reveals the following shifts and dates of missing documentation:</p> <p>Day Shift: 12/13, 12/23, 12/24, 1/1 and January 4th.</p> <p>Evening Shift: 12/11, 12/24, 12/25, 12/31, January 4th and 1/5.</p> <p>Night Shift: 12/5 and 1/1.</p> <p>An interview was conducted on 5/22/24 at 1:20 PM with CNA (certified nursing assistant) #1. When asked the frequency of incontinence care, CNA #1 stated, we try to do it every 2 hours but it depends on staffing. When asked where they would evidence that incontinence care had been provided, CNA #1 stated, it would be in PCC (point click care) on the ADL form.</p> <p>An interview was conducted on 5/22/24 at 3:40 PM with CNA #6. When asked the frequency of incontinence care, CNA #6 stated, We are to do it every two hours. When asked if it is done every two hours, CNA #6 stated, Not always due to staffing on evenings. When asked where the evidence of incontinence care being provided would be, CNA #6 stated, On the ADL document in PCC.</p> <p>On 5/23/24 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of operations were made aware of the findings.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>According to the facility's Urinary Elimination policy which revealed, Persons who are incontinent need frequent care. Record the person's voiding.</p> <p>No further information was provided prior to exit.</p> <p>2.The facility staff failed to provide evidence of ADL specifically incontinence care for Resident #3.</p> <p>Resident #3 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: diabetes mellitus (DM), chronic obstructive pulmonary disease (COPD), encephalopathy and asthma.</p> <p>The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 5/4/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as being dependent for bathing, bed mobility, transfer, dressing, hygiene and independent for eating.</p> <p>A review of the comprehensive care plan dated 3/18/24 revealed, FOCUS: The resident is occasionally incontinent of bladder and bowel due to stress incontinence, reduced mobility, weakness. INTERVENTIONS: 1 person assist with toileting, prompt to toilet upon rising, before and after meals and before bedtime, provide toileting hygiene as needed for incontinent episodes.</p> <p>A review of the April and May 2024 ADL (activities of daily living) document which reveals the following shifts and dates of missing documentation:</p> <p>Day Shift: 4/10, 4/12, 5/4, 5/10, 5/12, 5/13, 5/14 and 5/16.</p> <p>Evening Shift: 4/12, 5/4, 5/11, 5/12, 5/13, 5/15 and 5/17.</p> <p>Night Shift: 4/10, 5/2, 5/3, 5/11, 5/19, and 5/20.</p> <p>An interview was conducted on 5/22/24 at 1:20 PM with CNA (certified nursing assistant) #1. When asked the frequency of incontinence care, CNA #1 stated, We try to do it every 2 hours but it depends on staffing. When asked where they would evidence that incontinence care had been provided, CNA #1 stated, It would be in PCC (point click care) on the ADL form.</p> <p>An interview was conducted on 5/22/24 at 3:40 PM with CNA #6. When asked the frequency of incontinence care, CNA #6 stated, We are to do it every two hours. When asked if it is done every two hours, CNA #6 stated, Not always due to staffing on evenings. When asked where the evidence of incontinence care being provided would be, CNA #6 stated, On the ADL document in PCC.</p> <p>On 5/23/24 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of operations were made aware of the findings.</p> <p>According to the facility's Urinary Elimination policy which revealed, Persons who are incontinent need frequent care. Record the person's voiding.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>No further information was provided prior to exit.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42183</p> <p>Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide the care and services to prevent pressure wounds for one of six residents in the survey sample, Resident #6.</p> <p>The findings include:</p> <p>The facility evidences the provision of pressure wound care for Resident #6.</p> <p>Resident #6 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: diabetes mellitus (DM) and osteoarthritis.</p> <p>The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 5/5/24, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring max assistance for hygiene, dressing, bathing and partial assist for bed mobility, transfer; independent for eating.</p> <p>A review of the comprehensive care plan dated 5/2/24 revealed, FOCUS: The resident is at risk for complications and blood glucose fluctuations related to diagnosis of diabetes mellitus. The resident has a PICC Line venous access to the left arm. INTERVENTIONS: Administer medications as ordered. Observe for signs and symptoms of hyper/hypoglycemia and notify md as indicated. Dressing change per order. Flush PICC as ordered.</p> <p>A review of the physician orders dated 5/3/24 revealed, WOUND CARE - RIGHT PUBIC AREA - ABSCESS - ADM/W: Cleanse with Wound Cleanser, pat dry, apply BACITRACIN OINTMENT, cover with dressing. Change daily and PRN for saturation or accidental removal. Monitor for s/s of infection and report to physician. sign and date dressings. Everyday shift for WOUND CARE.</p> <p>A review of the May 2024 TAR (treatment administration record) revealed, WOUND CARE - RIGHT PUBIC AREA -ABSCESS missing documentation of treatments provided on 5/5 and 5/6.</p> <p>An interview was conducted on 5/23/24 at 8:05 AM with LPN (licensed practical nurse) #4. When asked where pressure wound care would be evidenced as being completed, LPN #4 stated, It would be on the TAR. When asked if those areas had no documentation, was there evidence that the treatment had been provided, LPN #4 stated, No, there is no evidence.</p> <p>On 5/23/24 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of operations were made aware of the findings.</p> <p>According to the facility's Wound/Skin Impairments policy which revealed, Any wounds and/or skin impairments will be routinely assessed and treated as ordered. Provide treatments as ordered.</p> <p>(continued on next page)</p>		

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F 0686  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	No further information was provided prior to exit.

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42183</p> <p>Based on resident and staff interview, resident observation, facility document review and clinical record review, it was determined that the facility staff failed to provide sufficient staffing to meet resident needs for three of six residents, Resident #1, #4 and #5.</p> <p>The findings include:</p> <p>During the course of the standard, licensure and complaint Medicare survey conducted 5/22/24-5/23/24, a request was made for the as worked staffing schedule from 4/1/24-5/23/24. When asked during the entrance conference if there were any staffing waivers, ASM (administrative staff member) #1, the administrator, stated, No, there are no waivers.</p> <p>A review of the as worked staffing sheets revealed:</p> <p>Unit 100: Saturday 4/27/24 Evening shift- no nurse.</p> <p>Unit 200: Sunday: 4/14/24 Day shift- no nurse, Evening-only 1 CNA,</p> <p>Unit 300: Friday 4/19/24 Evening shift- no nurse, Saturday 5/11/24 Night shift-no nurse,</p> <p>Unit 400: Sunday 4/28/24 Evening shift- no nurse, Sunday 5/12/24 Evening shift-no nurse, Tuesday 5/14/24 Evening shift-no nurse, 5/18/24 Night shift-no nurse.</p> <p>1.The facility staff failed to provide sufficient staffing to meet resident needs. Resident #1 was located on Unit 200.</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: hemiplegia, diabetes mellitus (DM), Cerebrovascular accident (CVA) and chronic kidney disease (CKD).</p> <p>The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 1/31/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring moderate assistance for bathing and supervision for bed mobility, transfer, dressing, hygiene and eating; independent for locomotion.</p> <p>A review of the comprehensive care plan dated 1/26/24 revealed, FOCUS: ANTIPLATELETS: the resident is at risk for bleeding, hemorrhage, excessive bruising, and complications due to antiplatelet use secondary to history of CVA. INTERVENTIONS: Administer medications as ordered.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the physician orders dated 1/25/24, revealed Clopidogrel Bisulfate Oral Tablet 75 MG (milligram). Give 1 tablet by mouth in the morning for Prevent DVT (deep vein thrombosis). Aspirin Low Dose Oral Tablet Chewable 81 MG. Give 1 tablet by mouth in the morning for prevent DVT. Carvedilol Oral Tablet 6.25 MG (Carvedilol) Give 1 tablet by mouth two times a day for HTN Hold SBP&lt;115 HR&lt;60. Chlorthalidone Oral Tablet 25 MG Give 1 tablet by mouth in the morning for HTN, Duloxetine HCl Oral Capsule Delayed Release Particles 20 MG Give 1 capsule by mouth in the morning for MDD, Gabapentin (EPCS) Capsule 400 MG Give 1 capsule by mouth every 8 hours for neuropathic pain, Lidocaine Patch 4 % Apply to low back topically one time a day for pain 12 hrs. on/off, Metformin HCl Oral Tablet 1000 MG Give 1 tablet by mouth two times a day for DM2, Nifedipine ER Oral Tablet Extended Release 24 Hour 90 MG Give 1 tablet by mouth in the morning for HTN Hold SBP&lt;120 HR&lt;60 and Spironolactone Oral Tablet 25 MG (Spironolactone) Give 2 tablet by mouth in the morning for HTN.</p> <p>A review of the April 14, 2024 MAR (medication administration record) revealed Clopidogrel Bisulfate Oral Tablet 75 MG (milligram), Aspirin Low Dose Oral Tablet Chewable 81 MG, Carvedilol Oral Tablet 6.25 MG, Chlorthalidone Oral Tablet 25 MG, Duloxetine HCl Oral 20 MG, Gabapentin (EPCS) Capsule 400 MG, Lidocaine Patch 4 %, Metformin HCl Oral Tablet 1000 MG, Nifedipine ER Oral Tablet Extended Release 24 Hour 90 MG and Spironolactone Oral Tablet 25 MG was administered at 1:14 PM on 4/14/24. Scheduled administration time was 8:00 AM or 9:00AM.</p> <p>An interview was conducted on 5/22/24 at 12:00 PM with ASM (administrative staff member) #1, the administrator. When asked about staffing, ASM #1 stated, We are challenged with staffing even before I got here. It seemed like it started summer 2023. Staffing based on census and each unit has 30 beds. Units 200-300 are skilled; Units 100-400 are long term care: This is the normal staffing pattern: 100 &amp; 400: day: 2 nurses / 2 CNAs eve: 2 nurses / 2 CNAs nights 1 nurse/2 CNAs. 200 &amp; 300: days: 2 nurses/ 3 CNAs eve: 2 nurses/3 CNAs nights 1 nurse/2 CNAs. Our call outs are the most on evening shift and late call outs. Supposed to call out on the on-call phone, some call the facility or text coworker. There is an issue leaving early without coverage and not handing off to another nurse. Usually, we get a call that the nurse had left the med cart locked/and med keys in narc book. Our ADON has been in the position for 2 days. Our DON at the time, had been on leave so there was not back up.</p> <p>An interview was conducted on 5/22/24 at 1:20 PM with Resident #1. When asked about staffing, Resident #1 stated, Yes, there are staffing issues. Sometimes there is only one nurse, other times no nurse at all on this unit and the nurse from the other unit has to cover both units. Impossible to get medications on time if at all.</p> <p>On 5/23/24 at approximately 6:30 AM entered the facility to observe night shift staffing. As rounds were made on each unit became aware that the nurse on Unit 3 had left early at approximately 6:15-6:30 AM. Approximately at 7:15 AM was made aware that the night nurse on unit 100 had left at 6:00 AM.</p> <p>An interview was conducted on 5/23/23 at 6:40 AM with CNA (certified nursing assistant) #5 and #6 on Unit 300. When asked about the night nurse leaving early, CNA #5 and #6 stated, It happens frequently. The residents do not get their medications and care they need. Usually, the nurse puts the narcotics keys in the narcotics book. Surveyor looked in the narcotic books on both medication carts and found no keys. CNA #6 stated, Maybe she gave them to the nurse on the other unit. When asked what happens if there is a resident issue or residents have complaints of pain, CNA #6 stated, She may have given them to the nurse on Unit 200.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on 5/23/24 at 6:45 AM with LPN (licensed practical nurse) #1, the night nurse on Unit 200. When asked if the LPN on Unit 300 had reported off to her and counted narcotics, LPN #1 stated, No, she did not. She just gave me the keys. When asked her responsibilities for the residents on Unit 300, LPN #1 stated, There is no responsibility for them. When asked if a resident needed medication, fell or had a medical issue, what would the process be, LPN #1 stated, I guess the CNA would come and get me.</p> <p>An interview was conducted on 5/23/24 at 7:05 AM with LPN #4. When asked about staffing, LPN #4 stated, I came into work another unit on evening shift, the second nurse did not show up and the night nurse did not show up, so they pulled a nurse from another unit, which I understand left that unit without a nurse. A review of the 5/18/24 as worked staffing sheets evidenced no nurse working on Unit 300 for night shift.</p> <p>On 5/23/24 at 7:15 AM, narcotic count for both medication carts on Unit 300 by the two-day shift nurses, LPN #2 and LPN #3. The narcotic count was correct for both medication carts.</p> <p>An interview was conducted on 5/23/24 at 12:30 PM with OSM (other staff member) #2, the scheduler. When asked about the staffing process, OSM #2 stated, The corporation contracted with oculus. We are trying to get staff in hired and contracted. We're already short with only 20 employed LPN's. I send out the needs list for open shifts. Last night, no one called to inform me they were leaving early. I took the on-call phone when the DON left about the 3rd week of April.</p> <p>On 5/23/24 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of operations were made aware of the findings.</p> <p>According to the facility's Facility Assessment which revealed, Based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time.</p> <p>No further information was provided prior to exit.</p> <p>2. The facility staff failed to provide sufficient staffing to meet resident needs, Resident #4 was a resident on Unit 200.</p> <p>Resident #4 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: diabetes mellitus (DM), chronic respiratory failure and chronic kidney disease (CKD).</p> <p>The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 4/14/24, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring max assistance for bathing and supervision for bed mobility, transfer, dressing, hygiene and independent for eating.</p> <p>A review of the comprehensive care plan dated 4/14/26/24 revealed, FOCUS: The resident is at risk for complications and blood glucose fluctuations related to diagnosis of diabetes mellitus. INTERVENTIONS: Administer medications as ordered. Observe for signs and symptoms of hyper/hypoglycemia and notify md as indicated.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the physician orders dated 4/11/24 revealed, Insulin Aspart for PUMP: 1 click =2 units: 5 clicks with breakfast lunch and dinner; If BS is 150-180 give additional click, 180-210 give another additional click, give 1</p> <p>click with snacks as needed before meals and at bedtime. Protonix Tablet Delayed Release 40 MG, Give 1 tablet by mouth one time a day for GERD. Acetaminophen Extra Strength Oral Tablet 500 MG, Give 2 tablet by mouth three times a day for Pain. Cleanse left shin with WC, apply oil emulsion, wrap with kerlix and ace bandage everyday shift for wound care.</p> <p>A review of the April MAR revealed, 4/14/24: 7:30 AM and 12 PM blood sugar and Insulin not given, Medications listed as 5 (hold/see progress note) are as follows: Baclofen Oral Tablet 10 MG at 9 AM, Acetaminophen Extra Strength Oral Tablet 500 MG at 9 AM and 1 PM. Day Shift: cleanse left shin with WC, apply oil emulsion, wrap with kerlix and ace bandage every day shift for wound care not done.</p> <p>A review of the progress note dated 4/14/24 at 2:50 PM revealed, Hyperglycemia. The nurse consulted Third Eye Health for hyperglycemia. Glucose level was 341. Vital Signs: HR: 88 (bpm), BP Sys: 138//Dia: 87, RR: 16, SpO2: 95 (%). Orders: Check finger stick QAC &amp; HS. Inject Humalog per sliding scale: 0-200= 0 units</p> <p>201 - 250 = 2 units,251 - 300 = 4 units,301 - 350 = 6 units,351 -400= 8 units, Notify provider for blood sugar &lt;70 or &gt;400. Notify a clinician of any change in condition.</p> <p>No further progress note found on 4/14/24 although Resident #4 was transferred out of the facility.</p> <p>An interview was conducted on 5/22/24 at 12:00 PM with ASM (administrative staff member) #1, the administrator. When asked about staffing, ASM #1 stated, We are challenged with staffing even before I got here. It seemed like it started summer 2023. Staffing based on census and each unit has 30 beds. Units 200-300 are skilled; Units 100-400 are long term care: This is the normal staffing pattern: 100 &amp; 400: day: 2 nurses / 2 CNAs eve: 2 nurses / 2 CNAs nights 1 nurse/2 CNAs. 200 &amp; 300: days: 2 nurses/ 3 CNAs eve: 2 nurses/3 CNAs nights 1 nurse/2 CNAs. Our call outs are the most on evening shift and late call outs. Supposed to call out on the on-call phone, some call the facility or text coworker. There is an issue leaving early without coverage and not handing off to another nurse. Usually, we get a call that the nurse had left the med cart locked/and med keys in narc book. Our ADON has been in the position for 2 days. Our DON at the time, had been on leave so there was not back up.</p> <p>On 5/23/24 at approximately 6:30 AM entered the facility to observe night shift staffing. As rounds were made on each unit became aware that the nurse on Unit 3 had left early at approximately 6:15-6:30 AM. Approximately at 7:15 AM was made aware that the night nurse on unit 100 had left at 6:00 AM.</p> <p>An interview was conducted on 5/23/23 at 6:40 AM with CNA (certified nursing assistant) #5 and #6 on Unit 300. When asked about the night nurse leaving early, CNA #5 and #6 stated, It happens frequently. The residents do not get their medications and care they need. Usually, the nurse puts the narcotics keys in the narcotics book. Surveyor looked in the narcotic books on both medication carts and found no keys. CNA #6 stated, Maybe she gave them to the nurse on the other unit. When asked what happens if there is a resident issue or residents have complaints of pain, CNA #6 stated, She may have given them to the nurse on Unit 200.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on 5/23/24 at 6:45 AM with LPN (licensed practical nurse) #1, the night nurse on Unit 200. When asked if the LPN on Unit 300 had reported off to her and counted narcotics, LPN #1 stated, No, she did not. She just gave me the keys. When asked her responsibilities for the residents on Unit 300, LPN #1 stated, there is no responsibility for them. When asked if a resident needed medication, fell or had a medical issue, what would the process be, LPN #1 stated, I guess the CNA would come and get me.</p> <p>An interview was conducted on 5/23/24 at 7:05 AM with LPN #4. When asked about staffing, LPN #4 stated, I came into work another unit on evening shift, the second nurse did not show up and the night nurse did not show up, so they pulled a nurse from another unit, which I understand left that unit without a nurse. A review of the 5/18/24 as worked staffing sheets evidenced no nurse working on Unit 300 for night shift.</p> <p>On 5/23/24 at 7:15 AM, narcotic count for both medication carts on Unit 300 by the two-day shift nurses, LPN #2 and LPN #3. The narcotic count was correct for both medication carts.</p> <p>An interview was conducted on 5/23/24 at 12:30 PM with OSM (other staff member) #2, the scheduler. When asked about the staffing process, OSM #2 stated, The corporation contracted with oculus. We are trying to get staff in hired and contracted. We're already short with only 20 employed LPN's. I send out the needs list for open shifts. Last night, no one called to inform me they were leaving early. I took the on-call phone when the DON left about the 3rd week of April.</p> <p>On 5/23/24 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of operations 34m were made aware of the findings.</p> <p>According to the facility's Facility Assessment which revealed, Based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time.</p> <p>No further information was provided prior to exit.</p> <p>3. The facility staff failed to provide sufficient staffing to meet resident needs, Resident #5 was a resident on Unit 300.</p> <p>Resident #5 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: diabetes mellitus (DM) and spinal stenosis.</p> <p>The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 4/23/24, coded the resident as scoring a 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring moderate assistance for hygiene, dressing, bathing, bed mobility and transfer; independent for eating.</p> <p>A review of the comprehensive care plan dated 4/18/24 revealed, FOCUS: The resident is at risk for complications.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/23/2024
NAME OF PROVIDER OR SUPPLIER  Princess Anne Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1948 Landstown Centre Way Virginia Beach, VA 23456	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>secondary to chronic kidney disease, hyperlipidemia and hypertension. INTEVENTIONS: Administer medications as ordered.</p> <p>A review of the physician orders dated 4/18/24 revealed, Levothyroxine Sodium Oral Tablet 112 MCG, Give 1 tablet orally one time a day for hypothyroidism. Omeprazole Oral Capsule Delayed Release 20 MG, Give 1 capsule by mouth two times a day for GERD.</p> <p>A review of the April and May 2024 MAR (medication administration record) revealed, no administration of Levothyroxine 112 micrograms and Omeprazole 20 milligram at 6:00 AM on 4/29/24 and 5/19/24.</p> <p>An interview was conducted on 5/22/24 at 12:00 PM with ASM (administrative staff member) #1, the administrator. When asked about staffing, ASM #1 stated, We are challenged with staffing even before I got here. It seemed like it started summer 2023. Staffing based on census and each unit has 30 beds. Units 200-300 are skilled; Units 100-400 are long term care: This is the normal staffing pattern: 100 &amp; 400: day: 2 nurses / 2 CNAs eve: 2 nurses / 2 CNAs nights 1 nurse/2 CNAs. 200 &amp; 300: days: 2 nurses/ 3 CNAs eve: 2 nurses/3 CNAs nights 1 nurse/2 CNAs. Our call outs are the most on evening shift and late call outs. Supposed to call out on the on-call phone, some call the facility or text coworker. There is an issue leaving early without coverage and not handing off to another nurse. Usually, we get a call that the nurse had left the med cart locked/and med keys in narc book. Our ADON has been in the position for 2 days. Our DON at the time, had been on leave so there was not back up.</p> <p>On 5/23/24 at approximately 6:30 AM entered the facility to observe night shift staffing. As rounds were made on each unit became aware that the nurse on Unit 3 had left early at approximately 6:15-6:30 AM. Approximately at 7:15 AM was made aware that the night nurse on unit 100 had left at 6:00 AM.</p> <p>An interview was conducted on 5/23/23 at 6:40 AM with CNA (certified nursing assistant) #5 and #6 on Unit 300. When asked about the night nurse leaving early, CNA #5 and #6 stated, It happens frequently. The residents do not get their medications and care they need. Usually, the nurse puts the narcotics keys in the narcotics book. Surveyor looked in the narcotic books on both medication carts and found no keys. CNA #6 stated, Maybe she gave them to the nurse on the other unit. When asked what happens if there is a resident issue or residents have complaints of pain, CNA #6 stated, She may have given them to the nurse on Unit 200.</p> <p>An interview was conducted on 5/23/24 at 6:45 AM with LPN (licensed practical nurse) #1, the night nurse on Unit 200. When asked if the LPN on Unit 300 had reported off to her and counted narcotics, LPN #1 stated, No, she did not. She just gave me the keys. When asked her responsibilities for the residents on Unit 300, LPN #1 stated, there is no responsibility for them. When asked if a resident needed medication, fell or had a medical issue, what would the process be, LPN #1 stated, I guess the CNA would come and get me.</p> <p>On 5/23/24 at 7:15 AM, narcotic count for both medication carts on Unit 300 by the two-day shift nurses, LPN #2 and LPN #3. The narcotic count was correct for both medication carts.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on 5/23/24 at 12:30 PM with OSM (other staff member) #2, the scheduler. When asked about the staffing process, OSM #2 stated, The corporation contracted with oculus. We are trying to get staff in hired and contracted. We're already short with only 20 employed LPN's. I send out the needs list for open shifts. Last night, no one called to inform me they were leaving early. I took the on-call phone when the DON left about the 3rd week of April.</p> <p>On 5/23/24 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of operations34m were made aware of the findings.</p> <p>According to the facility's Facility Assessment which revealed, Based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time.</p> <p>No further information was provided prior to exit.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183</b></p> <p>Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to administer medication in a safe manner to prevent significant medication errors for four of six residents in the survey sample, Resident #1, Resident #4, Resident #5 and Resident #6.</p> <p>The findings include:</p> <p>1. The facility staff failed to administer medication in a safe manner to prevent significant medication errors on 4/14/24 for</p> <p>Resident #1.</p> <p>Resident #1 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: hemiplegia, diabetes mellitus (DM), Cerebrovascular accident (CVA) and chronic kidney disease (CKD).</p> <p>The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 1/31/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring moderate assistance for bathing and supervision for bed mobility, transfer, dressing, hygiene and eating; independent for locomotion.</p> <p>A review of the comprehensive care plan dated 1/26/24 revealed, FOCUS: ANTIPLATELETS: the resident is at risk for bleeding, hemorrhage, excessive bruising, and complications due to antiplatelet use secondary to history of CVA. INTERVENTIONS: Administer medications as ordered.</p> <p>A review of the physician orders dated 1/25/24, revealed Clopidogrel Bisulfate Oral Tablet 75 MG (milligram). Give 1 tablet by mouth in the morning for Prevent DVT (deep vein thrombosis). Aspirin Low Dose Oral Tablet Chewable 81 MG. Give 1 tablet by mouth in the morning for prevent DVT. Carvedilol Oral Tablet 6.25 MG (Carvedilol) Give 1 tablet by mouth two times a day for HTN Hold SBP&lt;115 HR&lt;60. Chlorthalidone Oral Tablet 25 MG Give 1 tablet by mouth in the morning for HTN, Duloxetine HCl Oral Capsule Delayed Release Particles 20 MG Give 1 capsule by mouth in the morning for MDD, Gabapentin (EPCS) Capsule 400 MG Give 1 capsule by mouth every 8 hours for neuropathic pain, Lidocaine Patch 4 % Apply to low back topically one time a day for pain 12 hrs. on/off, Metformin HCl Oral Tablet 1000 MG Give 1 tablet by mouth two times a day for DM2, Nifedipine ER Oral Tablet Extended Release 24 Hour 90 MG Give 1 tablet by mouth in the morning for HTN Hold SBP&lt;120 HR&lt;60 and Spironolactone Oral Tablet 25 MG (Spironolactone) Give 2 tablet by mouth in the morning for HTN.</p> <p>A review of the April 14, 2024 MAR (medication administration record) revealed Clopidogrel Bisulfate Oral Tablet 75 MG (milligram), Aspirin Low Dose Oral Tablet Chewable 81 MG, Carvedilol Oral Tablet 6.25 MG, Chlorthalidone Oral Tablet 25 MG, Duloxetine HCl Oral 20 MG, Gabapentin (EPCS) Capsule 400 MG, Lidocaine Patch 4 %, Metformin HCl Oral Tablet 1000 MG, Nifedipine ER Oral Tablet Extended Release 24 Hour 90 MG and Spironolactone Oral Tablet 25 MG was administered at 1:14 PM on 4/14/24. Scheduled administration time was 8:00 AM or 9:00AM.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There was no documentation of Physician notification of medications not administered as ordered.</p> <p>An interview was conducted on 5/23/24 at 1:00 PM with ASM (administrative staff person) #2, the assistant director of nursing. When asked if the Physician should be notified if medications are not given as ordered, ASM #2 stated, Yes, they should be notified. When asked if this would be documented, ASM #2 stated, Yes, it should be documented in the progress notes. When asked if this is a significant medication error, ASM #2 stated, Yes.</p> <p>An interview was conducted on 5/23/24 at 1:20 PM with ASM #4, the physician. When asked if he is getting notified of medications not given as ordered, ASM #4 stated, No, I am not getting called if patients are not getting their medications. Did not know about the drug shortage list, I have not been getting any calls regarding needing to order an alternative medication.</p> <p>On 5/23/24 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of operations were made aware of the findings.</p> <p>According to the facility's Medication Error policy which revealed, The provider will be notified of the medication error. Any follow-up orders of the provider will be followed.</p> <p>No further information was provided prior to exit.</p> <p>2. Resident #4 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: diabetes mellitus (DM), chronic respiratory failure and chronic kidney disease (CKD).</p> <p>The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 4/14/24, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring max assistance for bathing and supervision for bed mobility, transfer, dressing, hygiene and independent for eating.</p> <p>A review of the comprehensive care plan dated 4/14/26/24 revealed, FOCUS: The resident is at risk for complications and blood glucose fluctuations related to diagnosis of diabetes mellitus. INTERVENTIONS: Administer medications as ordered. Observe for signs and symptoms of hyper/hypoglycemia and notify md as indicated.</p> <p>A review of the physician orders dated 4/11/24 revealed, Mounjaro Subcutaneous Solution Pen-injector 5 MG/0.5ML Inject 5 mg subcutaneously one time a day every Sat for DM.</p> <p>A review of the April MAR (medication administration record) revealed, 4/13/24 Mounjaro 5 mg administered, no administration documented on 4/20/24 or 4/27/24.</p> <p>There was no documentation of Physician notification of medications not administered as ordered.</p> <p>A review of the facility Drug Shortage Report dated 5/16/24 revealed Medication Name: Mounjaro injection. Alternatives: Ozempic injection.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on 5/23/24 at 1:00 PM with ASM (administrative staff person) #2, the assistant director of nursing. When asked if the Physician should be notified if medications are not given as ordered, ASM #2 stated, Yes, they should be notified. When asked if this would be documented, ASM #2 stated, Yes, it should be documented in the progress notes. When asked if this is a significant medication error, ASM #2 stated, Yes.</p> <p>An interview was conducted on 5/23/24 at 1:20 PM with ASM #4, the physician. When asked if he is getting notified of medications not given as ordered, ASM #4 stated, No, I am not getting called if patients are not getting their medications. Did not know about the drug shortage list, I have not been getting any calls regarding needing to order an alternative medication.</p> <p>On 5/23/24 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of operations were made aware of the findings.</p> <p>According to the facility's Medication Error policy which revealed, The provider will be notified of the medication error. Any follow-up orders of the provider will be followed.</p> <p>No further information was provided prior to exit.</p> <p>3. Resident #5 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: diabetes mellitus (DM) and spinal stenosis.</p> <p>The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 4/23/24, coded the resident as scoring a 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring moderate assistance for hygiene, dressing, bathing, bed mobility and transfer; independent for eating.</p> <p>A review of the comprehensive care plan dated 4/18/24 revealed, FOCUS: The resident is at risk for complications secondary to chronic kidney disease, hyperlipidemia and hypertension. INTERVENTIONS: Administer medications as ordered.</p> <p>A review of the physician orders dated 4/18/24 revealed, Levothyroxine Sodium Oral Tablet 112 MCG, Give 1 tablet orally one time a day for hypothyroidism. Omeprazole Oral Capsule Delayed Release 20 MG, Give 1 capsule by mouth two times a day for GERD.</p> <p>A review of the April and May 2024 MAR (medication administration record) revealed, no administration of Levothyroxine 112 micrograms and Omeprazole 20 milligram at 6:00 AM on 4/29/24 and 5/19/24.</p> <p>An interview was conducted on 5/23/24 at 1:00 PM with ASM (administrative staff person) #2, the assistant director of nursing. When asked if the Physician should be notified if medications are not given as ordered, ASM #2 stated, Yes, they should be notified. When asked if this would be documented, ASM #2 stated, Yes, it should be documented in the progress notes. When asked if this is a significant medication error, ASM #2 stated, Yes.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on 5/23/24 at 1:20 PM with ASM #4, the physician. When asked if he is getting notified of medications not given as ordered, ASM #4 stated, No, I am not getting called if patients are not getting their medications. Did not know about the drug shortage list, I have not been getting any calls regarding needing to order an alternative medication.</p> <p>On 5/23/24 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of operations 34m were made aware of the findings.</p> <p>According to the facility's Medication Error policy which revealed, The provider will be notified of the medication error. Any follow-up orders of the provider will be followed.</p> <p>No further information was provided prior to exit.</p> <p>4. Resident #6 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: diabetes mellitus (DM) and osteoarthritis.</p> <p>The most recent MDS (minimum data set) assessment, a 5-day assessment, with an ARD (assessment reference date) of 5/5/24, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring max assistance for hygiene, dressing, bathing and partial assist for bed mobility, transfer; independent for eating.</p> <p>A review of the comprehensive care plan dated 5/2/24 revealed, FOCUS: The resident is at risk for complications and blood glucose fluctuations related to diagnosis of diabetes mellitus. The resident has a PICC Line venous access to the left arm. INTERVENTIONS: Administer medications as ordered. Observe for signs and symptoms of hyper/hypoglycemia and notify md as indicated. Dressing change per order. Flush PICC as ordered.</p> <p>A review of the physician orders dated 5/2/24 revealed, Cefazolin Sodium Injection Solution Reconstituted 2 GM (grams). Use 2 gram intravenously three times a day for sepsis for 21 Days.</p> <p>A review of the May MAR (medication administration record) revealed, 4/13/24 Cefazolin Sodium Injection Solution 2 GM, no administration documented on 5/12/24 2:00 PM, 5/19/24 6:00 AM and 5/21/24 2:00 PM.</p> <p>There was no documentation of Physician notification of medications not administered as ordered.</p> <p>An interview was conducted on 5/23/24 at 1:00 PM with ASM (administrative staff person) #2, the assistant director of nursing. When asked if the Physician should be notified if medications are not given as ordered, ASM #2 stated, Yes, they should be notified. When asked if this would be documented, ASM #2 stated, Yes, it should be documented in the progress notes. When asked if this is a significant medication error, ASM #2 stated, Yes.</p> <p>An interview was conducted on 5/23/24 at 1:20 PM with ASM #4, the physician. When asked if he is getting notified of medications not given as ordered, ASM #4 stated, No, I am not getting called if patients are not getting their medications. Did not know about the drug shortage list, I have not been getting any calls regarding needing to order an alternative medication.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/23/24 at 4:00 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, ASM #3, the regional director of clinical services and ASM #5, the vice president of operations were made aware of the findings.</p> <p>According to the facility's Medication Error policy which revealed, The provider will be notified of the medication error. Any follow-up orders of the provider will be followed.</p> <p>No further information was provided prior to exit.</p>		