SUNRISE ASSISTED LIVING – SUNRISE AT COUNTRYSIDE – FREEDOM OF INFORMATION ACT RESPONSES

Sunrise of Countryside
45800 Jona Drive
Potomac Falls, VA 20165
Phone: 703-430-0681

Facility Characteristics:

- Providing 24 nursing care in an assisted living setting
- Facility is part of the Sunrise chain, managed by Sunrise Senior Living Inc and Sunrise Senior Living Management Inc.
- Private insurance is generally not accepted unless it is long term care insurance
- Facility is across from Dulles Town Center and boasts a landscaped grounds and on-site beautician, with communal dining hall. All means prepared for residents who require such assistance
- Admission contract required. Some facilities require patients to sign mandatory arbitration provisions (waiving your right to a jury trial) as a condition of admission
- Hospice care and therapy services offered.
- Private rooms range from $5,000 to 8,000 per month depending on level of services provided

A note by Attorney Jeffrey J. Downey:
Thank you for visiting my website. Anyone who is considering the admission of a loved one into an assisted living facility should undertake a review of surveys or other data that will provide a snapshot of some of the issues or problems that the facility is experiencing. Keep in mind that this information can be limited and may not reflect the actual condition of the facility when your loved one is admitted. Anyone who is considering admission into such a facility should undertake their own investigation, including a personal visit and discussion with the staff and residents, if permitted.

Most assisted living facilities in Virginia are required to follow regulations, which have been enacted to protect the residents and assure that their rights are protected. Under Virginia's "Standards for Licensed Assisted Living Facilities" a facility is required to provide a program of care that meets the resident's "physical, mental and psychosocial needs" and "the objectives of the service plan." 22 VAC 40-72-40, *Program of Care*. A facility is required to provide "staff adequate in knowledge, skills and abilities and sufficient in numbers to provide services to attain and maintain the physical, mental and psychosocial well-being of each resident as determined by resident assessments and

individualized service plans." Under Virginia regulations, facilities are prohibited from admitting patients "whose physical or mental health care needs cannot be met in the specific assisted living facility. . ." 22 VAC 40-72-340(G)(12).

Many assisted living facilities have aggressive marketing tactics that seek to admit patients who may not be suitable for an assisted living setting. An assisted living facility is not a nursing home and they are generally not staffed to provide the level of skilled nursing care that a nursing home would provide. This may lead to the neglect of a resident's needs, especially if that resident is at high risk for pressure wounds, skin break-down, falls, malnutrition or dehydration, or suffers from other complex medical issues.

Searching the internet for information on assisted living facilities can be challenging, as there are multiple sources of potential information. The below information was obtained through a Freedom of Information act request and may provide some useful information on the facilities identified herein. Feel free to contact the Law Office of Jeffrey J. Downey for additional information on this or other facilities.

SUNRISE ASSISTED LIVING – SUNRISE AT COUNTRYSIDE – FREEDOM OF INFORMATION ACT RESPONSES

Disclaimer: The following information comes from a Freedom of Information Act (FOIA) issued to the Virginia Department of Social Services, the agency that licenses assisted living facilities in Virginia. The online compliance history includes only information after July 1, 2003. Not all surveys have been copied to this website. In addition, the online compliance history includes information regarding adverse actions that may be the subject of a pending appeal or plans of correction. An adverse action is not final until a provider has exhausted or waived all due process rights. For compliance history prior to July l, 2003, or information regarding the status of pending adverse actions, the reader should contact the Licensing Inspector listed in the facility's information. Not all the information contained herein is necessarily current and errors may have occurred in the conversion of this document from PDF to a searchable word document. Anyone considering admission to an assisted living facility should review the most recent survey results and visit the facility to make their own observations about the quality of care

Social Service Inspection Reports:

Current Inspector: Marshall G Massenberg (703) 431-4247

Inspection Date: Dec. 3, 2015

Complaint Related: No

Areas Reviewed:

22VAC40-72 GENERAL PROVISIONS
22VAC40-72 ADMINISTRATION AND ADMINISTRATIVE SERVICES.
22VAC40-72 PERSONNEL.
22VAc40-72 STAFFING AND SUPERVISION.
22VAC40-72 ADMISSION, RETENTION AND DISCHARGE OF RESIDENTS
22VAc40-72 RESIDENT CARE AND RELATED SERVICES
22VAC40-72 RESIDENT ACCOMMODATIONS AND RELATED PROVISIONS.
22VAC40-72 BUILDINGS AND GROUNDS.
22VAC40-72 EMERGENCY PREPAREDNESS.
22VAC40-72 ADDITIONAL REQUIREMENTS FOR FACILITIES THAT CARE FOR ADULTS WITH SERIOUS COGNITIVE IMPAIRMENTS WHO CANNOT RECOGNIZE DANGER OR PROTECT THEIR OWN SAFETY AND WELFARE.
Articlel .
Subjectivity.
63.2 General Provisions.
63.2 Protection of adults and reporting.
63.2 Licensure and Registration Procedures

63.2 Facilities and Programs..
22VAC40-90 Background Checks for Assisted Living Facilities
22VAC40-90 The Sworn Statement or Affirmation
22VAC40-90 The Criminal History Record Report
22VAC40-80 THE LICENSE.

Technical Assistance:

Please review the updated Technical Assistance document available on the public website. Updated information has been included regarding the infection control plan. The facility must include a step-by-step blood glucose monitoring procedure document in either their infection control or medication management plan (or both if the facility so chooses) that is consistent with current practice recommendations. The document must be readily accessible by all staff responsible for performing this procedure and updated as needed. Additional information has also been provided concerning incident reports, as any injury to a resident that requires emergency treatment and/or admission to a hospital needs to be reported. This does not include minor injuries that require only first aid

Resident #8 was not re-ordered until the resident had only a two day supply of the medication. The resident did not receive the medication during the observed administration of medication, as the medication had not yet arrived at the facility.

<u>Action to be Taken</u>: The facility was in process of waiting for physician to re-write script as his original had wrong date for resident #8. The medication was received via pharmacy delivery the following day by the wellness nurse. All Med Care managers were re-educated by the Resident Care Director on the process of re-ordering medication when supply is down to 5 days availability. Med Care Managers continue to monitor on a daily basis. These will be monitored/reviewed on a monthly basis by Wellness Nurse/Resident Care Director.

Standard #: 22VAC40-72-670-C

Description: Based on observation and record review, the facility failed to administer medication in accordance with the physician's or other prescriber's instructions and consistent with the standards of practice outlined in the current registered medication aide curriculum approved by the Virginia Board of Nursing. Evidence: Medication administration was observed for Resident #10 and the resident did not receive Namenda XR 28mg, ordered 11/30/15. No order was present in the record for the discontinuation of the medication.

<u>Action to be Taken</u>: Facility assured that medication for resident #10 (elevated dosage). Resident Care Director verified order. Subsequently resident had physician’s order for maintenance dose of medication after

completing elevated dosage. (starter pack). All Med Care Managers were trained on recognition of receiving orders after physician visits. Resident Care Coordinator and or Wellness Nurse will review all documentation from physician appointments that resident presents.

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Sunrise at Countryside
45800 Jona Drive
Sterling, VA 20165
(703) 430-068 lt..

Current Inspector: Marshall G Massenberg (703) 431-4247

Inspection Date: Oct. 27, 2015

Complaint Related: No

Areas Reviewed:

22VAC40-72 RESIDENT CARE AND RELATED SERVICES

Comments:

An unannounced focused monitoring inspection, to follow-up on a high-risk violation cited on 8/31/15, was conducted on 10/27/15 from 9:20am until 12:20pm. Resident rooms and seven resident records were observed. Violations discussed and an exit meeting was held. Areas of non-compliance are identified on the violation notice. Please complete the 'plan of correction' and 'date to be corrected' for each violation cited on the violation notice and return to the licensing office within 10 calendar days. Please specify how the deficient practice will be or has been corrected. Just writing the word 'corrected' is not acceptable. The 'plan of correction' must contain: 1) Steps to correct the non-compliance with the standards, 2) Measures to prevent the non-compliance from occurring again, and 3) Person responsible for implementing each step and/or monitoring any preventative measures. Thank you for your cooperation and if you have any questions, please call 703-431-4247C•, or contact me via e-mail at M.Massenberg@dss.virginia.gov.

Violations:

Standard #: 22VAC40-72-650-B

Description: Based on observation and record review, the facility failed to limit medication storage to residents permitted to keep his own medication in a secure place in his room if the uniform assessment instrument (UAI) has indicated that the resident is capable of self-administering medication. The medication and any dietary supplements shall be stored so that they are not accessible to other residents. Evidence: Preservision and Tylenol were found unlocked and unattended in the shared room of Resident #1 and Resident #2. The UAI for Resident #1, dated 6/3/1 5, states that the resident is able to administer his medication without assistance. The UAI for Resident #2, dated 5/29/15, states that the resident needs staff assistance in order to administer medication. Nasal Spray was found unlocked in the room of Resident #3. The UAI for Resident #3, dated 4/25/15, states that the resident needs staff assistance for medication administration. The

individualized service plan (ISP) for Resident #3, dated 4/25/15, states that the resident is unable to self-administer medication. Vitamin A&D ointment was found unlocked in the room of Resident #4. The UAI for Resident #4, dated 4/25/15, states that the resident needs staff assistance for medication administration. Advil, Vitamin D, Tylenol, Lovastatin and Omeprazole were found unlocked in the room of Resident #5. The UAI for Resident #5, dated 9/22/15, states that the resident needs staff assistance for medication administration. The ISP for Resident #5, updated 9/23/15, states that the resident is unable to self-administer medication. Chloraseptic spray, Nasacort and vaporizing ointment were found unlocked in the room of Resident #6. The UAI for Resident #6, dated 10/7/15, states that the resident needs staff assistance for medication administration. The ISP for Resident #6, updated 10/16/15, states that the resident is unable to self-administer medication. Vitamin A&D ointment was found unlocked in the room of Resident #7. The UAI for Resident #7, dated 7/15/15, states that the resident needs assistance with medication administration. The ISP for Resident #7, updated 7/21/15, states that the resident is unable to self-administer medication.

Action to be Taken: Resident #1 's Preservision and Tylenol was removed by Assisted Living Coordinator/Resident Care Coordinator, out of the resident's room and made inaccessible to resident #2, until an appropriate method of storing the resident's medications was established. Locked/secured box was provided at that time. The Nasal Spray was removed out of resident #3's room and stored appropriately in the medication cart by Assisted Living Coordinator/Resident Care Coordinator. Vitamin A&D ointment was removed out of resident #4's room and stored appropriately in the medication cart by Assisted Living Coordinator/Resident Care Coordinator. Advil, Vitamin D, Tylenol, Lovastatin and Omeprazole was removed out of resident #5's room and stored appropriately in the medication cart by Assisted Living Coordinator/Resident Care Coordinator. Chloraseptic spray, Nasacort and vaporizing ointment was removed out of resident #6?s room and stored appropriately in the medication cart by Assisted Living Coordinator/Resident Care Coordinator. Vitamin A&D ointment was removed out of resident #7's room and stored appropriately in the medication cart by Assisted Living Coordinator/Resident Care Coordinator. Audits of resident rooms were conducted to ensure no other residents had medication inappropriately stored. Any resident that has been identified by assessment (UAI) and documented on the ISP as being able to self administer medication has been provided with a locked box/drawer within the Resident's apartment. All Direct Care staff members, Medication Aides and Housekeeping team were provided training/in service on recognizing/identifying exposed medications or dietary supplements and the process of immediately removing and reporting

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those found within Resident's apartments so the RCD can determine an appropriate storage method. The RCD and Wellness Nurses conduct monthly wellness visits where residents who self-administer are assessed for the continued ability to self-administer medications. This also provides the RCD and Wellness Nurses and opportunity to identify any medications in resident rooms that should be stored in medication carts. The results of room checks by staff and outcomes of monthly wellness visits for unsecured medications will be reviewed by the RCD, who will report findings and patterns to the ED during the monthly Quality Assurance and Performance Improvement meeting. Plans to address any areas needing improvement will be developed as needed.

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Sunrise at Countryside

45800
Sterling, VA 20165
(703) 430-068 le
Current Inspector: Marshall G Massenberg (703) 431-4247

Inspection Date: Aug. 31, 2015

Complaint Related: No

Areas Reviewed:

22VAC40-72 RESIDENT CARE AND RELATED SERVICES

Comments:

An unannounced focused monitoring inspection took place on 8/3 1/1 5 from 10:05am until noon to follow-up on a high risk violation cited on 7/6/15. Resident rooms were observed and three resident records were reviewed. Violations discussed with the Administrator and an exit meeting was held. Areas of non-compliance are identified on the violation notice. Please complete the 'plan of correction' and 'date to be corrected' for each violation cited on the violation notice and return to the licensing office within 10 calendar days. Please specify how the deficient practice will be or has been corrected. Just writing the word 'corrected' is not acceptable. The 'plan of correction' must contain: l) Steps to correct the non-compliance with the standards, 2) Measures to prevent the noncompliance from occurring again, and 3) Person responsible for implementing each step and/or monitoring any preventative measures. Thank you for your cooperation and if you have any questions, please call 703-431-4247 or contact me via e-mail at M.Massenberg@dss.virginia.gov.

Violations:

Standard #: 22VAC40-72-650-B

Description: Based on observation and record review, the facility failed to limit medication storage to residents permitted to keep his own medication in a secure place in his room if the UAI has indicated that the resident is capable of self-administering medication. The medication and any dietary supplements shall be stored so that they are not accessible to other residents. Evidence: Benadryl anti-itch gel and Equate One Daily Men's Health tablets were found on the counter of Resident #1. The UAI for Resident #1, completed 6/24/15, states that the resident needs his medication administered/monitored by professional nursing staff.

Action to be Taken: Medications/Dietary supplements were immediately removed from Resident apartment by Assisted Living Coordinator. Any medications

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that have been identified by UAI as the resident is capable of doing self administration will be secured within a locked box/drawer within the Resident's apartment. This will be monitored and reviewed monthly by wellness nurse and Resident Care Coordinator.

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(703) 430-0681

Current Inspector: Marshall G Massenberg (703) 43 1-4247

Inspection Date: July 6, 2015

Complaint Related: No

Areas Reviewed:
22vAc40-72 RESIDENT CARE AND RELATED SERVICES

Comments:
An unannounced focused monitoring inspection to follow-up on high risk violations cited on 5/5/15 was conducted on 7/6/15 from 8:00 am until I I am. Medication administration was observed and five resident records were reviewed. Violations were discussed with the assisted living coordinator and an exit meeting was held. Areas of noncompliance are identified on the violation notice. Please complete the 'plan of correction' and 'date to be corrected' for each violation cited on the violation notice and return to the licensing office within 10 calendar days. Please specify how the deficient practice will be or has been corrected. Just writing the word 'corrected' is not acceptable. The 'plan of correction' must contain: l) Steps to correct the non-compliance with the standards, 2) Measures to prevent the non-compliance from occurring again, and 3) Person responsible for implementing each step and/or monitoring any preventative measures. Thank you for your cooperation and if you have any questions, please call 703-431-4247 or contact me via e-mail at M.Massenberg@dss.virginia.gov.

Violations:
Standard #. 22VAC40-72-560-G

Description: Based on observation, the facility failed to ensure all records that contain the information required by these standards for residents are kept in a locked area. Evidence: During the inspection, the door for the wellness office was observed to be left open and unattended. Resident records are kept in the wellness office and they were unlocked and unattended.

Action to be Taken: The Wellness Nurse immediately secured all resident information by locking office door to records. This area was reviewed and reeducated with the Wellness Nurses and Med-Aides of importance of securing resident information and HIPPA. This area will be monitored on a daily basis by the wellness nurse and reviewed monthly.

Standard #: 22VAC40-72-650-A-1

Description: Based on observation, the facility failed to store medication and dietary supplements in a locked medicine cabinet, container or compartment. Evidence: During the inspection, the door to the wellness office was observed to be open with no staff member present. Several medications were on a desk in the office. The medication was not being supervised by a staff member nor was the medication kept in a locked storage area.

Action to be Taken: The wellness Nurse immediately placed all medications in a locked cabinet in the wellness office. The wellness office door was also closed and locked. The Wellness office door is kept secured and locked at all times. All medications that are in office are secured in a locked cabinet at all times. This area was reviewed and re-educated with Wellness Nurses and Med-Aides of the importance of securing office door and securing any medications within office. This will be monitored daily on rounds and reviewed during monthly quality meetings and develop a improvement plan as needed.

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Current Inspector: Marshall G Massenberg (703) 431-4247

Inspection Date: May 5, 2015

Complaint Related: No

Areas Reviewed:
22VAc40-72 RESIDENT CARE AND RELATED SERVICES

Comments:

An unannounced focused monitoring visit was conducted from 8:45 am to 1 :30pm on May 5, 2015. Medication administration was observed, the medication cart was inspected and PRN medications were checked for availability. Five resident records were reviewed. Violations were discussed with the administrator and an exit meeting was held. Areas of non-compliance are identified on the violation notice. Please complete the 'plan of correction' and 'date to be corrected' for each violation cited on the violation notice and return to the licensing office within 10 calendar days. Please specify how the deficient practice will be or has been corrected. Just writing the word 'corrected' is not acceptable. The 'plan of correction' must contain: l) Steps to correct the non-compliance with the standards, 2) Measures to prevent the non-compliance from occurring again, and 3) Person responsible for implementing each step and/or monitoring any preventative measures. Thank you for your cooperation and if you have any questions, please call 703-431-4247€'-1 or contact me via email at M.Massenberg@dss.virginia.gov.

Violations:

Standard #: 22VAC40-72-630-A

Description: Based on observation, the facility failed to follow the plan for medication management. Evidence: The Donepezil for Resident #3 was being prepared for administration, although the medication was to be discarded after 3/31/15.

Action to be Taken: During the inspection, the Donepezil was removed from the medication cart by one of the nurses at the community. The medication cart was audited to ensure all expired meds are removed on a weekly basis by the HCC, Wellness Nurse or designee. This will be done for the next eight weeks and then monthly thereafter.

Standard#:22VAC40-72-640-A

Description: Based on record review, the facility failed to ensure that a valid order from a physician or other prescriber was present for all medications

being administered. Evidence: Famotidine was administered to Resident #3 on May 5, 2015, although the record for the resident contained an order to discontinue the medication in April 2015. The record did not contain an order from the physician, to have the resident begin taking the medication again.

Action to be Taken: The medication was ordered by the wellness nurse during the survey and added to the medication administration record once received. The resident did not suffer any adverse side effects from not having the medication available. The resident suffered no adverse side effects due. New process for discontinued meds put in place. The order will be faxed to the pharmacy and fax receipt will be attached to the order and placed in a binder. Nurse and/or designee will discontinue the order and the medication will be removed from the medication cart. The medication cart was audited to ensure all medications have orders. This will occur on a weekly basis by the HCC, Wellness Nurse or designee for the next eight weeks and then weekly thereafter.

Standard #: 22VAC40-72-670-B

Description: Based on observation the facility failed to have medications administered not earlier than one hour before and not later than one hour after the facility's standard dosing schedules. Evidence: Medications for Resident #4 and Resident #5 were administered more than an hour after the medication was to be given, as documented on the medication administration record (MAR).

Action to be Taken: Coached medication aide on proper medication administration policy the day of survey. Community to evaluate medication times to ensure delivery occurs within physician orders. This includes working with the pharmacy and physicians to ensure medications on 3rd floor are prescribed for 7am, medication on 2nd floor prescribed for 8am and medication on 1st floor prescribed for 9am. All medication care managers to be re-educated on proper medication administration and documentation procedures.

Standard #: 22VAC40-72-670-C

Description: Based on staff interview and record review, the facility failed to administer all medications in accordance with the physician's or other prescriber's instructions. Evidence: Olanzapine was being

administered in the morning for Resident #4, but the physician's order for the medication indicated that it was to be given to the resident in the evening.

Action to be Taken: Communication sent to physician on 5/5/15 regarding the correct time to dispense the medication for resident #4. The MAR was updated to reflect updated physician orders. The resident suffered no adverse side effects. The HCC, Wellness Nurse or designee will review the POS during changeover to ensure the medication delivery is not changed from the doctor’s orders.

Standard #: 22VAC40-72-670-H

Description: Based on record review and staff interview, the facility failed to document on a medication administration record (MAR) all medications administered to residents. Evidence: The daytime medication for Resident #2 was not documented as given for May 4, 2015. Staff was asked about the resident and it was reported that the resident did receive the medication, but the MAR was not updated after the medication was administered.

Action to be Taken: Coaching and documentation occurred with medication care manager during the survey on proper documentation procedure and administration of medications. All medication care managers to be reeducated on proper medication administration and documentation procedures. Medication care managers will audit at the end of their shifts to make sure they did not miss initialing or signing. This will be audited by the HCC, Wellness Nurse or designee for the next eight weeks and then monthly thereafter.

Standard #: 22VAC40-72-670-K

Description: Based on observation and staff interview, the facility failed to ensure medications ordered for PRN administration are available, properly labeled and stored at the facility. Evidence: All PRN medications for Resident #4 were not available at the facility. The medication cart was checked for the resident's medication and staff reported that the Loperamide and Acetaminophen for the resident were not at the facility.

Action to be Taken: Resident #4?s PRN medications were ordered by the wellness nurse. The resident did not suffer any adverse side effects. The medication cart was audited to ensure all medications are available on a weekly basis by the HCC, Wellness Nurse or designee for the next eight weeks and then monthly thereafter.

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Sunrise at Countryside
45800 Jona Drive
Sterling, VA
20165 (703) 430-
068 lt.

Current Inspector: Marshall G Massenberg (703) 431-4247

Inspection Date: March 10, 2015

Complaint Related: No

Areas Reviewed:

22VAC40-72 STAFFING AND SUPERVISION.
22VAC40-72 RESIDENT CARE AND RELATED SERVICES
22VAC40-72 RESIDENT ACCOMMODATIONS AND RELATED PROVISIONS.

Comments:

An unannounced focused monitoring visit was conducted from 8:30 am to 12:00pm on 3/10/15 to ensure correction of violations cited during the 1/15/15 renewal study. The sample size consisted of four resident records. Resident records and other documentation reviewed, including resident medication administration records. Medication cart inspected. Violation notice issued, risk ratings reviewed and exit interview held. Areas of non-compliance are identified on the violation notice. Please complete the "plan of correction" and "date to be corrected" for each violation cited on the violation notice and return to the licensing office within 10 calendar days. Please specify how the deficient practice will be or has been corrected. Just writing the word "corrected" is not acceptable. The "plan of correction" must contain: l) Steps to correct the non-compliance with the standards, 2) Measures to prevent the non-compliance from occurring again, and 3) Person responsible for implementing each step and/or monitoring any preventative measures. Thank you for your cooperation and if you have any questions, please call 703-431 4247. or contact me via email at M.Massenberg@dss.virginia.gov.

Violations:

Standard #: 22VAC40-72-440-C

Description: Facility failed to ensure that the individualized service plan shall reflect the resident's assessed needs. Evidence: 2/4 resident ISPs did not reflect the resident's assessed needs. Resident #2's most recent ISP dated 9/22/14 does not include resident self-administering a medication. Resident #3's most recent ISP dated 10/28/14 indicates that the resident requires assistance with bathing and mobility. ISP indicates that assistance is provided by a personal duty aide it does not detail the assistance that is required.

Action to be Taken:

The Senior Healthcare Coordinator and the Assisted Living Coordinator immediately reviewed resident #2's ISP and updated the ISP to reflect that the resident self-administers medications. The Senior Healthcare Coordinator and the Assisted Living Coordinator immediately reviewed resident #3 t s ISP and updated the ISP to reflect the resident's actual needs and care provided by the Private Duty Aide and those by the designated Care Manager of Sunrise Senior Living at Countryside. Resident changes will be discussed bi-weekly by the ALC, Nurse of Nurse designee and Administrator during at-risk meetings. Wellness nurse will be trained by Sr. HCC RN on documenting changes of resident needs on the ISP. The Healthcare Coordinator or designee will review a random sampling of ISP's monthly for 3 months and quarterly for 2 quarters to audit the information documented on the ISP, to ensure the ISP reflects the resident's assessed needs and care being provided. Any ISPs found out of compliance will be corrected immediately and the process for updating ISP will be reviewed and improved.

Standard #: 22VAC40-72-670-C

Description: Facility failed to ensure that all medications shall be administered in accordance with the physician's or other prescriber's instructions. Evidence: 1/4 residents did not have ordered medication available. Resident #2 has a physician's order for Mirapex to be taken one time a day. This medication was not available on 3/3/15,3/4/15 or 3/5/15. Progress notes indicate that the family was not contacted until after the medication supply was depleted.

Action to be Taken: The Wellness Nurse inspected the medication cart and the supply of medications on hand for resident #2. The family was notified of the missing medication supplied by the family; the medication was ordered by the family, received and administered to the resident. Resident physician was notified, no adverse reactions were noted. The Senior Healthcare Coordinator (RN) has scheduled an in-service for medication technicians and nurses on 3/19/2015 to discuss and review he process of ordering medications before running out and the immediate and daily notification to the nurse or designee of medication supply depleting. The medication technicians will review the agreement and notice regarding purchase of medications from alternate pharmacy and order medication from contracted/back-up pharmacy. The medication technician or nurse will order medications from the contracted pharmacy to allow medications to be administered in a timely fashion. A full medication cart audit was completed on 3/19/2015 by Sr. HCC RN and Wellness Nurse and addressed any discrepancies or ordering medications, discontinuing medications or refilling medications. The Healthcare Coordinator (RN) or designee will review the results of the medication cart audits on a monthly basis to determine if improvement in the

medication cart audit process and medication re-ordering process has been made and is consistent. If errors are identified improvements will be implemented.

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Search for an Assisted Living Facility

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Sunrise at Countryside
45800 Jona Drive
Sterling, VA
20165 (703) 430-
068 lt.

Current Inspector: Marshall G Massenberg (703) 43 1-4247

Inspection Date: Jan. 15, 2015

Complaint Related: No

Areas Reviewed:

22VAC40-72 GENERAL PROVISIONS
22VAc40-72 ADMINISTRATION AND ADMINISTRATIVE SERVICES.
22VAC40-72 PERSONNEL.
22VAC40-72 STAFFING AND SUPERVISION.
22VAC40-72 ADMISSION, RETENTION AND DISCHARGE OF RESIDENTS
22VAC40-72 RESIDENT CARE AND RELATED SERVICES
22VAC40-72 RESIDENT ACCOMMODATIONS AND RELATED PROVISIONS.
22VAC40-72 BUILDINGS AND GROUNDS.
22VAC40-72 EMERGENCY PREPAREDNESS.
22VAc40-72 ADDITIONAL REQUIREMENTS FOR FACILITIES THAT CARE FOR ADULTS WITH SERIOUS COGNITIVE IMPAIRMENTS WHO CANNOT RECOGNIZE DANGER OR PROTECT THEIR OWN SAFETY AND WELFARE.
Article I .
Subjectivity.
13.3 The Board of Nursing shall accept as evidence
32.1 Report by person other than physician
63.2 General Provisions.
63.2 Protection of adults and reporting.
63.2 Licensure and Registration Procedures
63.2 Facilities and Programs..
22VAC40-90 Background Checks for Assisted Living Facilities
22VAC40-90 The Sworn Statement or Affirmation
22VAC40-90 The Criminal History Record Report
22VAC40-80 THE LICENSE.
22VAC40-80 THE LICENSING PROCESS. 22VAC40-
80 SANCTIONS.

Technical Assistance:

A completed Renewal Application must be submitted and deemed complete prior to the expiration of the current license. The facility should receive an application in the mail,

however if an application has not been received one can be obtained from our web site or by calling the main office at 703-934-1505.

Comments:

An unannounced renewal study was conducted from 8:45am - 2:00pm on 1/15/15. At the time of entrance 98 residents were in care. The sample size consisted of eight resident records, three staff records and four individual interviews. Resident and staff records and other documentation reviewed. Residents were observed eating breakfast and lunch and engaging in activities. Medication administration was observed. Violation notice issued, risk ratings reviewed and exit interview held. Areas of non-compliance are identified on the violation notice. Please complete the "plan of correction" and "date to be corrected" for each violation cited on the violation notice and return to the licensing office within 10 calendar days. Please specify how the deficient practice will be or has been corrected. Just writing the word "corrected" is not acceptable. The plan of correction must contain: l) steps to correct the non-compliance with the standard(s), 2) measures to prevent the noncompliance from occurring again; and 3) person(s) responsible for implementing each step and/or monitoring any preventative measure(s). Thank you for your cooperation and if you have any questions please call 703-479-4708Vi or contact me via e-mail at lynette.storr@dss.virginia.gov.

Violations:

Standard #: 22VAC40-72-320-A

Description: Facility failed to ensure that the assisted living facility shall have staff adequate in knowledge, skills, and abilities to provide services to attain and maintain the physical, mental and psychosocial well being of each resident as determined by resident assessments and individualized service plans, and to assure compliance with this chapter. Evidence: A door alarm located next to room 1 14 which opens to a stairwell that leads to an outside door was activated by Licensing Inspector. Staff took several minutes to respond and when the staff responded, the alarm was turned off however no search of the stairwell was conducted to ensure resident safety.

Action to be Taken: The Executive Director, the Maintenance Coordinator and the 22VAC40-72- Assisted Living Coordinator inspected the door alarm located next to (4)-320-A room 1 14 and verified alarm was fully operational and that team members were receiving the alerts. Prior to the State Inspectors arrival, staff was informed of the system being tested. They assumed state inspector was including in the testing of the alarm and did not respond. A work log dated 1/15/2015 was provided by Stanley and Simplex Grinnell Systems indicating alarms were being reprogrammed. According to the Maintenance Director staff was aware and monitoring the exit door and 2nd floor stairwell. (Attachment A) The Executive Director immediately instructed Staff on duty of the expectation to respond to false alarms timely for the safety of residents who may be at risk. The Maintenance Coordinator will train staff on 1/29/2015 regarding emergency preparedness and responding to alarms, upon hire and annually. The Executive Director, the Assisted Living Coordinator and the Maintenance Coordinator will pull random alarms and document ongoing timing response times, discuss in daily stand up meetings or risk meetings to

monitor its corrective action and identify areas to prevent violations from reoccurring.

Standard #: 22VAC40-72-440-C

Description: Facility failed to ensure that the individualized service plan shall reflect the resident's assessed needs. Evidence: 1/6 resident ISPs did not reflect the resident's assessed needs. Resident #5's ISP most recent ISP dated 10/10/14 does not specifically address prevention and intervention for her anxiety.

Action to be Taken: The Healthcare Coordinator and Assisted Living Coordinator immediately (1/15/2015) reviewed resident #5's ISP and added interventions specifically to address prevention and intervention of resident #5's anxiety. Revised: The Assisted Living Coordinator, the Healthcare Coordinator or Wellness Nurse will attend daily stand-up meetings, weekly department meetings and/or risk meetings to review changes in resident needs, address interventions and preventions and update ISP when indicated to ensure compliance with this chapter and prevent violations from recurring.

Standard #: 22VAC40-72-440-E

Description: Facility failed to ensure that the individualized service plan shall be signed and dated by the licensee/administrator or his designee, i.e., the person who has developed the plan, and by the resident or his legal representative. Evidence: 1/6 resident ISPs were not signed by the resident or his legal representative. Resident #4's ISP dated 1/2/15 is not signed by the resident or legal representative.

Action to be Taken: The Executive Director immediately reviewed the ISP for Resident #4 dated 1/2/2015. A notation was made by Assisted Living Coordinator on 1/2/2015 indicating resident's POA will attend ISP meeting on 1/16/15 via conference call and would sign and date the ISP on 1/25/2015. The Assisted Living Coordinator mailed the ISP prior to the 1/16/2015 conference call. Due to her being physically unable to sign the ISP during the conference. As instructed by State Inspector, Resident signed ISP on 1/20/2015. The Assisted Living Coordinator makes note of efforts to obtain signature during the ISP from POA or obtain signature of Resident. The Assisted Living Coordinator continues to obtain signatures from resident's that are able to sign on their own behalf at the time of the ISP and immediately incorporate ISP in chart. The Executive Director will review ISP and verify signatures during the month of Service Health and Assessment Update and ISP meetings. The outcome of the audits will be discussed during daily stand-up meetings to determine effectiveness to ensure compliance to prevent violation from recurring.

Standard #: 22VAC40-72-620-B

Description: Facility failed to ensure that menus for meals and snacks for the current week shall be dated and posted in an area conspicuous to residents.
Evidence: Upon inspector's arrival there was not a menu

posted. During breakfast a daily menu was posted but a dated weekly menu was not posted.

Action to be Taken: The Food Service Coordinator immediately posted the dated weekly menu in the Menu board directly outside of the dining room entrance. The Food Service Coordinator post the dated menu every week for the upcoming week on Sundays. The Executive Director ensures compliance by verifying the weekly menu is dated and posted during weekly facility rounds. To prevent this violation from reoccurring the Executive Director monitors compliance and assigns department coordinators to verify that the weekly menu is dated and posted in the event of her absents from the community.

Standard #: 22VAC40-72-670-c

Description: Facility failed to ensure that all medications shall be administered in accordance with the physician's or other prescriber's instructions. Evidence: 2/4 residents did not have ordered medication available. Resident #2 is prescribed Klor - Con 10mcq at 9am. This medication was not available. Resident #4 is prescribed Lialda I .2gm at 9am. This medication was not available.

Action to be Taken: The Healthcare Coordinator (Registered Nurse) immediately inspected medication cart and supply of medications on hand for resident #2 and resident #4. Resident #2's Klor-Con 10mcq was available on the cart but misfiled. The Healthcare Coordinator reviewed Medication Administration Record and medication was administered within the 2 hour time frame. The Healthcare Coordinator Resident #4's located Lialda I .2gm on the medication cart in a Kaiser provided bottle. Medication was not administered. Nurse notified physician notified of medication error. The Healthcare Coordinator provided an in-service to address prevention of medication errors to the medication technicians and nurses on 1/23/2015. The Wellness nurse or nurse designee audits all medication carts for medication availability by 1/31/2015 then monthly x 3 months. The Healthcare Coordinator completes full audit of medication carts quarterly and discuss at risk meetings to determine if plan is working and to prevent violation from recurring.

Standard #. 22VAC40-72-730-D

Description: Facility failed to ensure that they shall have sufficient bed and bath linens in good repair so that residents always have clean sheets. Evidence: Licensing Inspector observed a stained fitted sheet on a resident's bed in Room 114.

Action to be Taken: The Care Manager immediately removed soiled sheet from the bed, remade bed with clean linens of resident in Room#1 14. The Assisted Living Coordinator makes daily and weekly rounds to assess cleanliness of resident rooms and needs of the resident's relating to

Activities of Daily Living to ensure individual needs are being met. The results of the rounds will be discussed in daily stand-up and

weekly department meeting to ensure plan is working. The Assisted Living Coordinator ensures compliance with this chapter by documenting those changes on ISP. The Assisted Living Coordinator monitors compliance by meeting regularly with the Lead Care Managers and reviewing documentation relating to any resident changes.

Disclaimer:
A compliance history is in no way a ratingfor a facility.

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FOIA Responses – Sunrise Assisted Living at Countryside

Sunrise at Countryside
45800 Jona Drive
Sterling, VA
20165 (703) 430-
068 lt..

Current Inspector: Marshall G Massenberg (703) 431-4247

Inspection Date: July 28, 2014

Complaint Related: No

Areas Reviewed:

22\./Ac40-72 RESIDENT CARE AND RELATED SERVICES 22VAC40-72 BUILDINGS AND GROUNDS.

Technical Assistance:

It is recommended that all staff be retrained on their role as a mandated reporter for resident abuse and neglect. It was noted that the outside door to the assisted living unit no longer has a key pad entry required during daytime hours.

Comments:

Licensing Inspector conducted an unannounced inspection in response to a facility report received by the licensing office on 7/24/2014. One resident and two staff interviews were conducted relating to resident care and related services. One resident record and other documentation were reviewed. Although there is a violation, the facility took immediate action to resolve this violation prior to the inspection. An exit meeting was held during the inspection with a final exit by telephone on 7/31/2014 when the risk rating was reviewed. The documents are being emailing 7/31/2014 to the assisted living coordinator for signature and completion. The area of non-compliance is identified on the violation notice. Please complete the "plan of correction" and "date to be corrected" for each violation cited on the violation notice and return to the licensing office within 10 calendar days. Please specify how the deficient practice will be or has been corrected. Just writing the word "corrected" is not acceptable. The plan of correction must contain: l) steps to correct the non-compliance with the standard(s), 2) measures to prevent the noncompliance from occurring again; and 3) person(s) responsible for implementing each step and/or monitoring any preventative measure(s). Time spent at the facility: 7/28/2014: 10:00 a. m. - 12:30 p. m.

Violations:

Standard #. 22VAC40-72-550-C

Description: Based on interviews and a review of the resident's record and other documentation, the facility failed to ensure a resident's rights.
Evidence: Resident #1 states that during the third shift (1 1 :00 p. m. -
7:00 a. m.) on 7/23/14 the direct care staff who assists with her care

://www.dss.virginia.gov/printer/facility/search/alf.cgi?rm=Inspection;Inspection=2021...

removed her emergency call bell pendant and placed it out of reach on the night stand near the lamp. States the staff person told her she does not need help and gestured (demonstrated during the interview) to the resident that she thought the resident was crazy. Says she was finally able to "wiggle" her way over and reach the call bell pendant. Staff #3 states that Resident #1 is alert and oriented and that the information given by the resident is consistent with information provided by the resident during an interview conducted by staff on 7/24/14. Says the resident stated during the 7/24/14 interview that she was able to reach the call bell pendant just before her eye drops were administered and that the pendant call log indicates that the resident paged at 5:33 a. m. on 7/24/14; states the resident did not share any information with third shift staff. Staff #3 confirmed that the staff person in question is Staff #2 who was assigned to this resident overnight on 7/23/14; that when Staff #2 was interviewed on 7/24/14, she denied removing the pendant but stated she had told Resident #1 if she does not need to "go much", not to page her. Staff #1 who was assigned to the resident on the day shift (7:00 a. m. - 3:00 p. m.) on 7/24/14 states that when Resident was checked on during her rounds at shift change on 7/24/14, the resident's sleepwear and bedding were wet and her briefs were "heavy". States this is not the normal condition the resident is found. Says the resident was tearful when she told Staff #1 about what had occurred and stated this had happened before. Resident #1 's assessment in 4/2014 and updated in 5/2014, as well as, her Individualized Service Plan (ISP) dated 4/8/14 filed in her record confirms the resident is "up during the night to use the bathroom". The ISP states the resident needs physical assistance of one person for transferring and toileting needs, uses walker and, sometimes, needs assistance propelling her wheelchair to the bathroom. A call bell cord on the wall was observed at the headboard of Resident #1 's bed but the resident states she does not use it since she has a call bell pendant.

Action to be Taken: The direct care staff member assigned to care for Resident #1 on the 1 1 :00pm-7:00am shift was immediately placed on administrative leave and an investigation was initiated by the Executive Director/Designee. (7/24/14) At the conclusion of the internal investigation, the employment of the direct care staff member assigned to care for Resident #1 on the 1 1 00pm-7:00am shift on 7/23/14 was terminated. (7/25/14) All Direct care staff members were re-educated on resident rights, the community pull cord system including responsibilities and response times, and service and courtesy in the provision of resident care by the Assisted Living Coordinator and Healthcare Coordinator. (7/30/14) Staff members will be re-educated on Mandated Reporting/Abuse and Neglect and training topics from training on 7/30/14 will be reinforced. (8/7/14) The Executive Director or Designee will review and provide training on Mandated Reporting/Abuse and Neglect ongoing as required by State regulation. (8/7/14 and Ongoing) The Executive Director or designee is responsible for ensuring the status of this Plan of

Correction is reviewed and discussed at Quality Assurance/lmprovement Meetings and action initiated as/if required. (7/30/14 and Ongoing)

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FOIA – SUNRISE AT COUNTRYSIDE

Sunrise at Countryside
45800 Jona Drive
Sterling, VA

20165 (703) 430-
068 lt..

Current Inspector: Marshall G Massenberg (703) 43 1-4247

Inspection Date: April 28, 2014 , April 29, 2014 and May 7, 2014

Complaint Related: Yes

Areas Reviewed:

22VAC40-72 ADMINISTRATION AND ADMINISTRATIVE SERVICES.
22VAC40-72 PERSONNEL.
22VAC40-72 ADMISSION, RETENTION AND DISCHARGE OF RESIDENTS
22VAc40-72 RESIDENT CARE AND RELATED SERVICES

Comments:

Licensing Inspector conducted an unannounced complaint investigation in response to a complaint received by the licensing office on 4/21/14. Observed residents. Eight staff member interviews were conducted relating to administration and administrative services, personnel, admission, retention and discharge of residents, resident care and related services. Two resident records and other documentation were reviewed. The areas of noncompliance are identified on the violation notice. The complaint is found valid in the area of personal care services and general supervision and care. Exit meeting held and the risk ratings were reviewed by telephone with the administrator on 6/13/14 prior to emailing the documents to the administrator for completion and signature. Please complete the
'plan of correction" and "date to be corrected" for the violations cited on the violation notice and return to the licensing office within 10 calendar days from receipt of the inspection documents. Please specify how the deficient practice will be or has been corrected. Just writing the word "corrected" is not acceptable. The plans of correction must contain: l) steps to correct the non-compliance with the standard(s), 2) measures to prevent the non-compliance from occurring again; and 3) person(s) responsible for implementing each step and/or monitoring any preventative measure(s). Time on-site:
4/28/14 - 10:00 a. m. - 1:30 p. 4/29/14 - 10:35 a. m. - 3:15 p. 5/7/14 - 2:55 - 4:15

Violations:

Standard 22VAC40-72-100-A
Complaint related: Yes
Description: Based on the review of resident records, the facility failed to report a major incident to the licensing office by the next working day. Evidence: On 4/29/14, the record of Resident #1 includes signed Physician's Interim/Telephone Orders dated 10/2/13 which states,

"Hospice will perform wound care . . . to Stage 2 pressure ulcer . . . ."There is also a notation in the Hospice notes dated 10/14/13 for this resident about the Stage 2 wound. The licensing office received no report of this incident.

Action to be Taken: Executive Director provided comprehensive refresher training to the Health Care Coordinator (HCC) and ALC on State-reportable incidents and the proper reporting process. (4/29/14) The HCC is conducting training with clinical staff on State-reportable incidents and the proper reporting process. (7/1/14) Incident reports are discussed every morning in stand-up to assure that all appropriate follow-up and reporting has been done. (Ongoing) The ED or designee is responsible for ensuring implementation and ongoing compliance with all components of this Plan of Correction and addressing and resolving any variance that may occur. (Ongoing) The ED or designee is responsible for ensuring the status of this Plan of Correction is reviewed and discussed at Quality Assurance/lmprovement Meetings and action initiated as/if required. (Ongoing)

Standard #: 22VAC40-72-100-C

Complaint related: Yes

Description: Based on the review of resident records, one written report of a reportable incident was not submitted to the licensing office within seven days. Evidence: The licensing office has not received a written report of the Stage 2 pressure ulcer of Resident #1 which was included in the signed Physician's Interim/Telephone Orders dated 10/2/13 and the Hospice notes dated 10/14/13.

Action to be Taken: Executive Director provided comprehensive refresher training to the Health Care Coordinator (HCC) and ALC on State-reportable incidents and the proper reporting process. (4/20/14) The HCC is conducting training with clinical staff on State-reportable incidents and the proper reporting process. (7/1/2014) Incident reports are discussed every morning in stand-up (a daily leadership meeting) to assure that all appropriate follow-up and reporting has been done. (Ongoing) The ED or designee is responsible for ensuring implementation and ongoing compliance with all components of this Plan of Correction and addressing and resolving any variance that may occur. (Ongoing) The ED or designee is responsible for ensuring the status of this Plan of Correction is reviewed and discussed at Quality Assurance/lmprovement Meetings and action initiated as/if required. (Ongoing)

Standard #: 22VAC40-72-450-D

Complaint related: Yes

Description: Based on staff interviews and the review of the resident record, the facility failed to provide adequate supervision of one resident

during transfer causing the resident to fall and obtain an injury. Evidence: l . Staff #3 states: On the morning of 12/2/13, Resident #1 was being

assisted with getting ready for breakfast. He states that transferring the resident from the bed to the wheelchair was done in the usual way, sitting the resident on the side of the bed and then pulling the wheelchair up and sitting her in it. However on 12/2/13, the wheelchair was locked and Staff #3 states he had to turn completely around to unlock the wheelchair and in a "matter of seconds", Resident #1 fell forward onto the floor obtaining facial injuries and was sent to the hospital; states the resident's health/condition had been declining since midyear and the resident, at times, would fall back onto the bed or "wobble back and forth"; states the wheelchair was not that far away but this one time the wheels were locked and it could not, readily, be pulled around to the side of the bed. 2. According to staff interviews, Resident 's body was rigid/stiff. Staff #2 states that when Resident #1 was in a sitting position, she would lean forward. Staff #4 states that if the resident was placed in a sitting position on the side of the bed during transfer, the resident would have a chance of sliding off the bed or fall back onto the bed. Staff #6 states that Resident #1 was not able to sit on the side of the bed without help. She demonstrated how she would move the wheelchair close to the bed to transfer the resident. Staff #7 states that before sitting Resident #1 up on the side of the bed, the wheelchair had to be right by the bed. Staff #8 states the wheelchair had to be very close to the bed before sitting the resident on the side of the bed, demonstrating how she did it, always having an arm around the resident's back to keep her from falling back, lifting and placing the resident into the wheelchair. 3. Hospice notes dated 4/22/13 in the record of Resident #1 states the resident "leans far forward when sitting in chair" and that the "patient is increased fall risk due to leaning forward." The resident's Individualized Service Plan (ISP) dated 10/15/13 states she is a I-person assist for all Activities of Daily Living (includes transfers) and the resident's fall history states that she "rarely falls". 4. Nurses' notes from 12/2/13 supports how Staff #3 states the fall occurred: That Staff #3 got the wheelchair from beside the resident's dresser, found the brakes were locked and while unlocking the brakes, the resident "moved back and forth and fell forward onto the floor."

Action to be Taken: Staff #3 was immediately provided comprehensive refresher training by Executive Director (ED) and Assisted Living Coordinator (ALC) on the importance of proper and safe transferring techniques. (12/2/13) An in-service by Legacy Therapy (Director of Therapy or designee) Services was held for care staff on proper transferring techniques and procedures. (12/3/13) Monthly training is being conducted by in-house therapy services (Director of Therapy or designee) on proper resident transferring techniques. (Ongoing) Resident-specific training on

proper transferring is being conducted with new admissions and existing residents as dictated by the residents assessed needs. (Ongoing) The ED or designee is responsible for ensuring implementation and ongoing compliance

with all components of this Plan of Correction and addressing and resolving any variance that may occur. (Ongoing) The ED or designee is responsible for ensuring the status of this Plan of Correction is reviewed and discussed at Quality Assurance/improvement Meetings and action initiated as/if required. (Ongoing)

FOIA RESONSES – SUNRISE OF COUNTRYSIDE

<u>Sunrise at Countryside</u>
45800 Jona Drive
Sterling, VA 20165
(703) 430-068 le
Current Inspector: Marshall G Massenberg (703) 431-4247 [I]S

Inspection Date: Dec. 3, 2013

Complaint Related: No

Areas Reviewed:

22VAC40-72 GENERAL PROVISIONS
22VAc40-72 ADMINISTRATION AND ADMINISTRATIVE SERVICES.
22VAC40-72 PERSONNEL.
22VAC40-72 STAFFING AND SUPERVISION.
22VAC40-72 ADMISSION, RETENTION AND DISCHARGE OF RESIDENTS
22VAC40-72 RESIDENT CARE AND RELATED SERVICES
22VAC40-72 RESIDENT ACCOMMODATIONS AND RELATED PROVISIONS.
22VAC40-72 BUILDINGS AND GROUNDS.
22vAC40-72 EMERGENCY PREPAREDNESS.
22VAC40-72 ADDITIONAL REQUIREMENTS FOR FACILITIES THAT CARE FOR
ADULTS WITH SERIOUS COGNITIVE IMPAIRMENTS WHO CANNOT RECOGNIZE DANGER OR PROTECT THEIR OWN SAFETY AND WELFARE.
Article 1.
Subjectivity.
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32.1 Report by person other than physician
63.2 General Provisions.
63.2 Protection of adults and reporting.
63.2 Licensure and Registration Procedures
63.2 Facilities and Programs..
22VAC40-90 Background Checks for Assisted Living Facilities
22VAC40-90 The Sworn Statement or
Affirmation 22VAC40-90 The Criminal History
Record Report 22VAC40-80 THE LICENSE.
22VAC40-80 THE LICENSING PROCESS.

Technical Assistance:

We discussed the following: l . Please ensure you are following your Medication Management Plan regarding the storage of a resident's medicine that you do not have a physician's order on file. 2. It is recommended that the Health Care Coordinator and the Wellness Nurse attend the Phase Il training conducted by this office. The email for the

person to sign up with was shared with you. 3. A reminder: If a resident has selfadministered medications, as well as, those administered by staff, the specific self-

administered medications need to be included in the UAI (refer to the technical assistance for Standard #670.C). 4. Please submit your renewal application as soon as possible due to the time it takes to process.

Comments:

An unannounced mandated monitoring inspection to renew license was conducted on 12/3/13 using the team approach. There are 106 residents. Walked physical plant. Reviewed ten resident records, three staff records and other documentation. Conducted four resident interviews and two family member interviews. Observed the morning medication pass, breakfast, lunch and activities. Compared the Medication Administration Record (MAR) and the physician orders. Inspected the medication cabinets. The previous violations were reviewed and one was found not to be corrected. Those and other areas of non-compliance are identified on the violation notice. An exit meeting was conducted. A follow-up exit meeting by telephone was done with the administrator on 12/4/13 and the risk ratings were reviewed. The inspection documents are being emailed 12/4/13 to the administrator for completion. Please complete the "plan of correction" and "date to be corrected" for each violation cited on the violation notice and return to the licensing office within 10 calendar days. Please specify how the deficient practice will be or has been corrected. Just writing the word "corrected" is not acceptable. The plan of correction must contain: 1) steps to correct the non-compliance with the standard(s), 2) measures to prevent the non-compliance from occurring again; and 3) person(s) responsible for implementing each step and/or monitoring any preventative measure(s). Hours on-site:
8:40 a. m. - 2:30 p . m.

Violations:

Standard #: 22VAC40-72-430-A

Description: Based on the review of resident records, the facility failed to adequately complete the UAI of one out of ten residents. Evidence: The UAI dated 10/11/13 for Resident #6 states the resident is continent. The Individualized Service Plan (ISP) of the resident dated 10/1 1/13 addresses the assistance needed with bathing and toileting because of urine smell and occasional incontinence of the bladder.

Action to be Taken: The UAI was corrected for Resident #6 during the inspection on 12/3/13 by the Assisted Living Coordinator (ALC) and Health Care Coordinator (HCC). The ALC and HCC reviewed resident #6?s (UAI) and (ISP). Both documents were updated to reflect the actual needs and services of the resident. The ALC and/or designee will conduct a review of all resident UAI?s and ISP?s to ensure that the information documented reflects the services being provided and that the resident’s needs are being met. (1/1/14) The ISPs are audited by the Executive Director (ED) or designee and the HCC to ensure UAI?

s and ISP?s for each resident appropriately reflect the current care need of each resident. (Ongoing)

Standard #: 22VAc40-72-440-c

Description: Based on the review of resident records, the facility failed to include the resident's assessed needs in the Individualized Service Plan (ISP) of one out often residents. Evidence: The Uniform Assessment

Instruments (UAI) dated 1 1/18/13 states that Resident #1 needs mechanical and human help in bathing, dressing, toileting and transferring; The ISP dated 1 1/18/13 does not address the mechanical help in any of these areas. The UAI assesses the resident as needing help in housekeeping and money management but the ISP does not address these needs.

Action to be Taken: The ISP was corrected during the inspection on 12/3/13 by the ALC and HCC. The ALC and HCC reviewed Resident #1 (please note the citation was for Resident #1) (UAI) and (ISP). Both documents were updated to reflect the actual needs and services of the resident. The ALC and/or designee will conduct a review of all resident UAI?s and ISP?s to ensure that the information documented reflects the services being provided and that the residents needs are being met. (1/1/13) The ISP?s are audited by the ED or designee and the HCC to ensure UAI?s and ISP?s for each resident appropriately reflect the current care need of each resident (Ongoing)

Standard #: 22VAC40-72-480-A

Description: (480.A.2) Based on document review, the facility failed to have the health care oversight completed every three months for residents meeting the assisted living level of care. Evidence: The facility's last health care oversight on file is dated 6/30/13.

Action to be Taken: The health care oversight was completed during the inspection on 12/3/13. The ED in-serviced the new HCC on healthcare oversight procedures and expectations of completion quarterly by the HCC or designee. ED to audit Healthcare oversight quarterly. (Ongoing)

Standard #: 22VAC40-72-640-A

Description: Based on the observation of medications being administered, the comparing of the Medication Administration Record (MAR) and physicians' orders, the facility failed to follow the physician's order for one out of five residents. Evidence: The morning medication pass of five residents was observed. Staff #2 administered Polythylene Glycol (Miralax) to Resident #2 in a 3-ounce cup. Staff #2 offered Resident #2 more water to finish what was left in the bottom of the cup. The December 2013 MAR and the physician's order dated 9/23/13 both state to "mix 17GM (1 capful) in 8 ounces of water or juice. .. ."

Action to be Taken: HCC ordered 80z cups to be used during medication passes (12/4/13) The HCC and/or designee will review the medication carts and MARs to ensure that all medication that is routine and/or PRN is being given per the Physician's order.. The HCC and/or designee will conduct refresher training to all team members that are administering medication to ensure proper distribution and documentation for all residents. (1/1/14) Medication Pass observations and medication cart audits will be conducted by the HCC or designee quarterly there '/www.dss.virginia. gov/printer/facility/search/alf. cgi

should be reference her following orders as prescribed. [sic] (Ongoing)

Standard #: 22VAC40-72-670-H

Description: Based on observation of the morning medication pass, staff interview and a review of the December 2013 Medication Administration Records (MAR) of five residents, the facility failed to properly document the MAR of two residents.. Evidence: On the MAR of Resident #1, the third shift staff (l I p. m. - 7:00 a. m.) had already initialed on today's date (12/3/13) as having completed: propping up heels while in bed, slippers and socks on, turn every shift from side to side when in bed, and Vitamin A&D Ointment applied to left heel.

Resident #2: l) The MAR indicates (initialed) that on 12/1/13 the PRN Oxycodone with Tylenol 5-325mg (Percocet) was administered. The back of the MAR has no entry about this medication, i. e., the reason this medication was administered and whether or not it was effective. 2) Licensing Inspector observed Staff #2 administer Polythylene Glycol 17GM (Miralax) with all other morning medications to the resident. When initialling that the morning medications had been administered, Staff #2 did not initial as having administered the Miralax. Also, the Miralax had not been initialed as having been administered on 12/1/13, or 12/2/13. When asked, Staff #2 stated that since there is no hour included as to when the Miralax was to be administered, she had not initialed. Staff proceeded to write in 0900 under 'hour' and initialed both, 12/2/13 and 12/3/13. 3) Staff #2 initialed the MAR as having administered Vitamin B

Complex and Vitamin D3 during the morning medication pass even though the two supplements were not administered by Staff #2. The MAR includes "self administer" for both. These two supplements also were initialed as having been administered by staff on 12/1/13 and 12/2/13. When Staff #2 was asked why she initialed as having administered these supplements, she stated it is because Sunrise orders these supplements for the resident. Staff #2 then proceeded to circle today's initials, as well as, her initials on 12/2/13 indicating an error or omission and writing on the back that the resident self administers.

Action to be Taken: HCC Conducted immediate in-service with Med Aids to ensure clear understanding of documentation of AM/ PM orders on TAR. (12/4/13) An in-service will be completed by the HCC with staff administering medications on the proper documentation of routine and PRN meds. (1/1/14) Medication Pass observations and documentation review will be conducted by the HCC or designee quarterly and PRN. (Ongoing)

Standard #: 22VAC40-72-670-K

Description: Based on the inspection of one medication cabinet and review of the Medication Administration Records (MAR), the facility failed to ensure PRN (as needed) medications are available for two out of two residents. Evidence: The following PRN medications were found not

available for administering during the medication cabinet inspection conducted at I I :00 a. m.: Resident #12: Clonidine HCL 0. Img. Resident #13: Tramadol with Tylenol 37.5mg/325mg, Ondansetron HCL 4mg (Zofran), and Cepacol Sore Throat Lozenge (expired 7/2013).

Action to be Taken: Physician and Pharmacy were contacted by the HCC and wellness nurse to address the PRN medication issues that were noted by the Ll. HCC Contacted Physician to D/C PRN orders. Orders were received and faxed to pharmacy 12/3/13. An in-service will be completed by the HCC with staff administering medications on the proper ordering procedures to ensure PRN medications are available. (1/1/14) Medication cart audits will be conducted by the HCC or designee quarterly to ensure PRN medications are being ordered properly (Ongoing)

Standard#:22VAC40-72-690-2

Description: Based on physical plant inspection, the facility failed to post a "No Smoking-Oxygen in Use" sign for Resident #6, a resident who was observed with oxygen in her room.

Action to be Taken: Corrected during inspection on 12/3/13 a ?No Smoking Oxygen-In Use? sign was put on Resident #6?s door. ED in-serviced the HCC and Wellness Nurse (WN) on oxygen use in the facility policies and procedures. (12/3/13) ED and/or designee to audit proper use of ? oxygen in use? signage quarterly. (Ongoing)

Standard#:22VAC40-72-850-A

Description: Based on the physical plant inspection, the facility failed to maintain the building in good repair. Evidence: The paint is buckling and chipping from the wall left of the toilet in the bathroom of Resident

Action to be Taken: The paint on the wall left of the toilet of Resident #1 1 was corrected during inspection on 12/313. Maintenance Coordinator (MC) and/or designee to correct reported physical plant issues within 24hours of receipt of issue. Maintenance Log to be kept by concierge and reviewed daily by MC. ED to audit response times monthly (Ongoing)

Standard #: 22VAC40-72-900-B

Description: Based on the building inspection, the facility failed to have liquid soap for hand washing. Evidence: At I I :30 a. m., the Licensing Inspector found the liquid soap container empty in the common bathroom on the first floor of the assisted living unit near the copier room.

Action to be Taken: Liquid soap was refilled in the common bathroom on the first floor and corrected during inspection on 12/3/13. Housekeeping staff to be in-serviced on housekeeping procedures and expectations conducted by the MC. (1/1/14) MC and/or designee to correct reported physical plant issues within 24 hours of receipt of issue. Maintenance Log to be kept by concierge and reviewed daily by MC. ED to audit response times monthly. (Ongoing)

Disclaimer: The following information comes from a Freedom of Information Act (FOIA) issued to the Virginia Department of Social Services, the agency that licenses assisted living facilities in Virginia. The online compliance history includes only information after July 1, 2003. In addition, the online compliance history includes information regarding adverse actions that may be the subject of a pending appeal. An adverse action is not final until a provider has exhausted or waived all due process rights. For compliance history prior to July l, 2003, or information regarding the status of pending adverse actions, the reader should contact the Licensing Inspector listed in the facility's information. Not all the information contained herein is necessarily current and anyone considering admission to an assisted living facility should review the most recent survey results and visit the facility to make their own observations about the quality of care