Search for an Assisted Living Facility

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Sunrise at Countryside
45800 Jona Drive
Potomac falls, VA 20165
(703) 430-0681

Current Inspector: Amanda Velasco (703) 397-4587

Inspection Date: Aug. 3, 2021 and Aug. 5, 2021

Complaint Related: No

Areas Reviewed:

22VAC40-73 GENERAL PROVISIONS
22VAC40-73 ADMINISTRATION AND ADMINISTRATIVE SERVICES
22VAC40-73 PERSONNEL
22VAC40-73 STAFFING AND SUPERVISION
22VAC40-73 ADMISSION, RETENTION, AND DISCHARGE OF RESIDENTS
22VAC40-73 RESIDENT CARE AND RELATED SERVICES
22VAC40-73 RESIDENT ACCOMODATIONS AND RELATED PROVISIONS
22VAC40-73 BUILDING AND GROUNDS
22VAC40-73 EMERGENCY PREPAREDNESS
32.1 Reported by persons other than physicians
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.

Comments:

A renewal inspection was initiated on 8/3/2021 and concluded on 8/5/2021. The administrator was contacted by telephone to initiate the inspection. The administrator reported that the current census was 24. The inspector emailed the administrator a list of items required to complete the remote documentation review portion of the inspection. The inspector reviewed three resident records, three staff records, annual health and fire inspections, dietary and healthcare oversight reports, staff work schedule, monthly activities and menus submitted by the facility to ensure documentation was complete. Criminal Background Checks of all staff hired since the previous inspection conducted on 5/21/2021 were reviewed. The inspector conducted the on-site portion of the inspection on 8/4/2021. An exit interview was conducted with the administrator and resident care coordinator on 8/5/2021 where findings were reviewed and an opportunity was given for questions, as well as for providing any information or documentation which was not available during the inspection.

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

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 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).

Thank you for your cooperation and if you have any questions please call 703-479-5247 or contact me via e-mail at jamie.eddy@dss.virginia.gov.

Violations:

Standard #: 22VAC40-73-680-D

Description: Based upon a review of records and interview, the facility failed to ensure that medications shall be administered in accordance with the physician?s or other prescriber?s instructions and consistent with the standards of practice outlined in the current registered mediation aide curriculum approved by the Virginia Board of Nursing.

Evidence: Resident #1 has a physician?s order to receive 5mg of Oxycodone twice a day. On 7/18/2021 the Medication Administration Record (MAR) indicated that Resident #1 was administered the regularly scheduled dosage of Oxycodone at approximately 21:00 (9 pm), however, this dosage is not recorded on the Controlled Medication Utilization Record as being administered. According to the Controlled Medication Utilization Record, after the administration of the 9 am dosage of Oxycodone on 7/18/2021 at approximately 8 am, there were 13 pills remaining. The next date listed on the Controlled Medication Utilization Report is 7/19/2021 at 9:00am, indicating that one tablet of Oxycodone was administered at approximately 9 am and there were 12 remaining pills.

The MAR for 8/2/2021 indicates that Resident #1 was administered at approximately 9 am, the prescribed order of 5mg of Oxycodone, however, this dosage is not recorded on the Controlled Medication Utilization Record as being administered. The Controlled Medication Utilization Record indicates that Resident #1 was administered the dosage of Oxycodone on 8/1/2021 at approximately 21:00 (9pm) leaving 40 pills remaining. The next date listed on the Controlled Medication Utilization Record is 8/2/2021 at approximately 21:00, indicating that one tablet of Oxycodone was administered and there were 39 pills remaining.

Resident #3 has a physician?s order to receive 0.5 mg of Clonazapam every 24 hours. According to the MAR, Resident #3 was administered the medication twice on 7/5/2021 at approximately 12:31 am and 10:35 pm.

Plan of Correction: Resident #1 experienced no negative outcomes as a result of missing one dose of a prescribed order of Oxycodone 5mg twice a day not being administered on 7/18/2021 and 8/2/2021 as prescribed. Resident #3 experienced no negative outcomes as a result of receiving Clonazepam 0.5mg twice on 7/5/2021 when the order states Clonazepam 0.5mg once every 24 hours as needed. The Resident Care Director (RCD) conducted an audit on the Controlled Medication Utilization Records against the Electronic Medication Administration Records (EMARS) to ensure medication administration was correctly documented. The RCD and Wellness Nurse conducted medication pass observations to confirm medications are administered in accordance with physician orders. No additional concerns were identified. Medication Care Managers (MCMs) were re-educated by the RCD regarding the process for correct documentation regarding controlled substance. Education modules pertaining to PRN (as needed) medication management, medication administration, avoiding common errors, medication pass process, and

documenting in the EMAR were assigned to all MCMs and will be mandatory to complete by 8/31/2021. The RCD or Wellness Nurse conducts weekly medication pass observations for 1 month and then monthly for 2 months to confirm that medications are being administered in accordance with physician orders. The RCD or Wellness Nurse audits Controlled Medication Utilization Records against the EMAR weekly for 1 month and then monthly for 2 months to confirm medications are being documented in accordance with physician's orders. The RCD or wellness designee will present the results of the audits to the Qualify Assurance and Performance Improvement (QAPI) Committee monthly for three months. During and at the end of the 3 months, the QAPI Committee will evaluate the results of the resident record audits and determine if additional focus or action is warranted. The Executive Director or designated coordinator is responsible for implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.

Search for an Assisted Living Facility

Sunrise at Countryside
45800 Jona Drive
Potomac falls, VA 20165
(703) 430-0681

Current Inspector: Amanda Velasco (703) 397-4587

Inspection Date: Sept. 23, 2024

Complaint Related: No

Areas Reviewed:

22VAC40-73 GENERAL PROVISIONS
22VAC40-73 ADMINISTRATION AND ADMINISTRATIVE SERVICES
22VAC40-73 PERSONNEL
22VAC40-73 STAFFING AND SUPERVISION
22VAC40-73 ADMISSION, RETENTION AND DISCHARGE OF RESIDENTS
22VAC40-73 RESIDENT CARE AND RELATED SERVICES
22VAC40-73 BUILDINGS AND GROUND
22VAC40-73 EMERGENCY PREPAREDNESS
ARTICLE 1 ? SUBJECTIVITY
63.2- (1) GENERAL PROVISIONS

Technical Assistance:

Private Duty Companion Files, Aggressive Resident Training

Comments:

Type of inspection: Monitoring

A self-reported incident was received by VDSS Division of Licensing on 09/03/2024 regarding allegations in the area of resident care and related services.

Date of inspection and time the licensing inspector was on-site at the facility for each day of the inspection:
09/23/2024 10:30 AM to 2:40 PM

The Acknowledgement of Inspection form was signed and left at the facility for each date of the inspection.

Number of residents present at the facility at the beginning of the inspection: 66

The licensing inspector completed a tour of the physical plant that included the building and grounds of the facility.

Number of resident records reviewed: 2
Number of staff records reviewed: 1 (Volunteer)
Number of interviews conducted with residents: 3
Number of interviews conducted with staff: 3

Observations by licensing inspector: Activities (Bingo)

Additional Comments/Discussion: This inspection was conducted in partnership with Loudoun County Adult Protective Services.

An exit meeting will be conducted to review the inspection findings.

The evidence gathered during the investigation supported the self-report of non-compliance with standard(s) or law, and violation(s) were issued. Any violation(s) not related to the self-reported incident but identified during the course of the investigation can also be found on the violation notice. The licensee has the opportunity to submit a plan of correction to indicate how the cited violation(s) will be addressed in order to return the facility to compliance and maintain future compliance with applicable standard(s) or law.

If the licensee wishes to provide a plan of correction: (i) type the plan on a separate Word document, (ii) identify the standard violation number being addressed, (iii) include the date the violation will be corrected, (IV) do not include any names or confidential information, and (V) return to the licensing inspector by email within five (5) business days of the exit interview.

Compliance with all applicable regulations and law shall be maintained and any areas of noncompliance must be corrected.

Within 15 calendar days of your receipt of the inspection findings (inspection summary, violation notice, and supplemental information), you may request a review and discussion of these findings with the inspector's immediate supervisor. To make a request for review and discussion, you must contact the licensing supervisor at the regional licensing office that serves your geographical area.

Regardless of whether a supervisory review has been requested, the results of the inspection will be posted to the DSS public website within 5 business days of your receipt of the Inspection Summary and/ or Violation Notice.

The department's inspection findings are subject to public disclosure.

Please Note: A copy of the findings of the most recent inspection are required to be posted on the premises of the facility.

For more information about the VDSS Licensing Programs, please visit: www.dss.virginia.gov

Should you have any questions, please contact Amanda Velasco, Licensing Inspector at (703) 397-4587 or by email at Amanda.Velasco@dss.virginia.gov.

Violations:

Standard #: 22VAC40-73-220-A

Description: Based on resident record review and staff interview, the facility failed to ensure that the files for private duty personnel from licensed home care organizations contained proper documentation.

Evidence:
1. In an incident report submitted to the LI on 09/03/2024, Staff 1 stated ? [Resident 1] was put on 1:1 care until she completes her antibiotics.?

2. In an interview with LI on 09/23/2024, Staff 1 confirmed a private duty aide hired through an outside agency was assigned to Resident 1 during waking hours.

3. Staff 1 stated that they did not have the paperwork for the private duty aide including a criminal background report, tuberculosis screening (TB), and training/orientation specific to the facilities? policies and procedures for the private duty aides assigned to Resident 1 prior to the beginning of service; however, they would reach out to the home health agency to obtain the required information.

Plan of Correction: Resident 1 is no longer at the facility there the private duty aid information is no longer needed.

Moving forward, any resident that hires a private duty aid, the aid will be required to provide a background check report and TB screening.

The resident care coordinator is responsible for documentation training/orientation to the third-party aids and ensuring proper documentation is in place prior to the aid starting.

Standard #: 22VAC40-73-240-G

Description: Based on resident interview, resident record review, and staff interview, the facility failed to ensure all volunteers were under the supervision of a designated staff person when residents are present.

Evidence:

1. Staff 4?s volunteer application states that they applied to work at the facility on 08/02/2024.

2. In an interview with the LI on 09/23/2024, Staff 2 stated that Staff 4 assists with Bingo on Monday afternoons. Staff 2 stated that on 09/02/2024, they were at the front desk in the hallway outside of the room and heard yelling. Staff 2 confirmed that sometimes they get loud during activities, so they were not worried at first. When it continued, Staff 2 stated that they rushed to the room and began to assist Staff 4 and call for help.

3. In an interview with the LI on 09/23/2024, Resident 4 stated that staff came in right behind Resident 1 and Resident 1?s son when the yelling started.

4. In an interview with the LI on 09/23/2024, Staff 1 confirmed that there was not a staff member present in the activity room; however, there was a volunteer leading activity.

5. In an interview with the LI on 09/23/2024, Staff 1 confirmed that there was not a staff member supervising the activity or the volunteer.

Plan of Correction: All volunteers are supervised by a designated staff person. The designated staff person is knowledgeable of the responsibilities of the volunteer.

The activities coordinator is responsible for ensuring the volunteers are supervised at all times.

This practice started on 09/24/2024

Standard #: 22VAC40-73-270-1

Description: Based on resident record review and staff interview, the facility failed to ensure that direct care staff were trained in methods of dealing with aggressive residents

that included information, demonstration, and practical experience in self-protection and in the prevention and de- escalation of aggressive behavior.

Evidence:
1. Resident 1?s record contains a UAI dated 09/09/2024. Resident 1?s UAI states that the behavior pattern of Resident 1 is ?Abusive/ Aggressive/ Disruptive- Less than weekly.? The section titled ?Types of Behavior? includes a typed note that states ?verbally aggressive towards staff and residents.?

2. Resident 1?s progress notes were reviewed for the months of June 2024 through September 2024. There were 7 instances of verbally or physically aggressive behavior, and 13 instances of refusal of care to include refusal to take medications, change wet sheets, and refusals to shower.
1. Episodes of aggressive, aggressive, or abusive behavior were documented on 07/22/2024, 08/03/2024, 08/06/2024, 08/30/2024, 09/02/2024, 09/09/2024, 09/10/2024.
2. Episodes of refusal of care were documented on 07/13/2024, 07/13/2024, 07/18/2024, 07/18/2024, 07/22/2024, 07/30/2024, 08/03/2024, 08/06/2024, 08/07/2024, 09/03/2024, 09/09/2024, 09/10/2024, 09/16/2024.

3. In an interview with the LI on 09/23/2024, Resident 3 said that they were present during the incident on 09/02/2024. Resident 3 stated that they felt the staff were not prepared.

4. Staff 1 provided the ?The Training Requirements for Virginia? and the ?Annual Training Assignments? for the staff members that included the title, duration, and which staff are required to attend.

5. The ?Training Requirements for Virginia? did not include training for Aggressive Residents, or training that included practical experience self-protection and, in the prevention, and de- escalation of aggressive behavior.

6. The ?Annual Training Assignments? contained one 30-minute training titled ? All Behavior is Communication? scheduled for direct care staff in April; however Staff 1 could not confirm what was included in that training.

7. Staff 1 confirmed there was no additional training for staff regarding aggressive residents.

Plan of Correction: All staff members will be trained on dealing with aggressive residents that include information, demonstration, and practical experience in self-protection, prevention, and de-escalation of aggressive behaviors.

This training will be completed by 12/30/2024.

The executive director and resident care director is responsible for ensuring this training is completed upon new behaviors and at minimum annually.

Standard #: 22VAC40-73-930-D

Description: Based on resident record review and staff interview, the facility failed to ensure that the Individualized Service Plan (ISP) specified a minimal frequency of daily rounds to be made by direct care staff to monitor for emergencies or other unanticipated resident needs.

Evidence:

1. Resident 1?s ISP, reviewed by the facility on 09/17/2024, contained a focus that stated, ?Inability to use signaling device with need for night safety checks.? The interventions included the following:
a. ?I am unable to use my signaling device due to cognition and require safety needs to be met and anticipated.:
b. ?I require night safety check due to inability to use signaling device.?

2. Resident 1?s ISP did not specify the minimal frequency of daily rounds to be made by direct care staff to monitor for emergencies or other unanticipated resident needs.

3. Staff 1 confirmed that Resident 1?s ISP did not specify the minimal frequency of daily rounds.

Plan of Correction: Resident #1?s ISP will be updated and clarify the frequency of daily rounds such as 8am and 12pm by 11/30/2024.

All resident ISPs will be updated to clarify specific times as their care plans come up for renewal.

The resident care coordinator and executive director are responsible for ensuring all care plans are updated appropriately.

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Sunrise at Countryside
45800 Jona Drive
Potomac falls, VA 20165
(703) 430-0681

Current Inspector: Amanda Velasco (703) 397-4587

Inspection Date: Aug. 15, 2024 and Aug. 16, 2024

Complaint Related: No

Areas Reviewed:

22VAC40-73 GENERAL PROVISIONS
22VAC40-73 ADMINISTRATION AND ADMINISTRATIVE SERVICES
22VAC40-73 PERSONNEL
22VAC40-73 STAFFING AND SUPERVISION
22VAC40-73 ADMISSION, RETENTION AND DISCHARGE OF RESIDENTS
22VAC40-73 RESIDENT CARE AND RELATED SERVICES
22VAC40-73 RESIDENT ACCOMMODATIONS AND RELATED PROVISIONS
22VAC40-73 BUILDINGS AND GROUND
22VAC40-73 EMERGENCY PREPAREDNESS
63.2- (1) GENERAL PROVISIONS
22VAC40-90 BACKGROUND CHECKS FOR ASSISTED LIVING FACILITIES
22VAC40-90 THE SWORN STATEMENT OR AFFIRMATION

Technical Assistance:

N/A

Comments:

Type of inspection: Renewal

Date of inspection and time the licensing inspector was on-site at the facility for each day of the inspection:
08/15/2024 8:55 AM to 2:45 PM
08/16/2024 9:05 AM to 1:45 PM

The Acknowledgement of Inspection form was signed and left at the facility for each date of the inspection.

Number of residents present at the facility at the beginning of the inspection: 64

The licensing inspector completed a tour of the physical plant that included the building and grounds of the facility.

Number of resident records reviewed: 6
Number of staff records reviewed: 3
Number of interviews conducted with residents: 3
Number of interviews conducted with staff: 3

Observations by licensing inspector: meals, activities, medication pass.

Additional Comments/Discussion: Upcoming renovation currently in the process of approval.

An exit meeting will be conducted to review the inspection findings.

The evidence gathered during the inspection determined non-compliance with applicable standard(s) or law, and violation(s) were documented on the violation notice issued to the facility. The licensee has the opportunity to submit a plan of correction to indicate how the cited violation(s) will be addressed in order to return the facility to compliance and maintain future compliance with applicable standard(s) or law.

If the licensee wishes to provide a plan of correction: (i) type the plan on a separate Word document, (ii) identify the standard violation number being addressed, (iii) include the date the violation will be corrected, (IV) do not include any names or confidential information, and (V) return to the licensing inspector by email within five (5) business days of the exit interview.

Compliance with all applicable regulations and law shall be maintained and any areas of noncompliance must be corrected.

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Regardless of whether a supervisory review has been requested, the results of the inspection will be posted to the DSS public website within 5 business days of your receipt of the Inspection Summary and/ or Violation Notice.

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Please Note: A copy of the findings of the most recent inspection are required to be posted on the premises of the facility.
For more information about the VDSS Licensing Programs, please visit: www.dss.virginia.gov

Should you have any questions, please contact Amanda Velasco, Licensing Inspector at (703) 397-4587 or by email at Amanda.Velasco@dss.virginia.gov

Violations:

Standard #: 22VAC40-73-100-A

Description: Based on facility document review and staff interview, the facility failed to ensure an annual review of the infection prevention policies and procedures with a licensed health care professional.

Evidence:
1. The facility participated in an on site ALF Infection Prevention and Control Assessment on 06/27/2023 documented by a letter from the Virginia Department of Social Services sent to the facility on 07/05/2024.

2. The letter states ?A follow-up assessment with your facility will be scheduled in six months (December 2023).?

3. Staff 2 confirmed a review of the infection control policy had not been

completed and no documentation of the follow-up assessment was able to be located or confirmed.

Plan of Correction: An annual review of infection control policies was completed on 09/11/24 by the resident care director and administrator.
The administrator is responsible for ensuring the infection control policies are reviewed on an annual basis.
This was completed on 09/11/24.

Standard #: 22VAC40-73-50-B

Description: 1. The following resident records did not contain an acknowledgement of the disclosure form:
a. Resident 2 admitted 03/15/2024.
b. Resident 3 admitted 01/02/2024.
c. Resident 5 admitted 08/22/2024.
d. Resident 6 admitted 06/06/2012.

2. Staff 2 confirmed the disclosure forms were not in the resident?s record.

Plan of Correction: The disclosures for resident 2, 3, 5 and 6 have been reviewed and signed by each resident as of 10/1/24.
Any new residents will sign the disclosure within 72hrs of physical move in.
The administrator is responsible for ensuring the disclosure is signed by the resident and filed appropriately.
This was completed on 10/1/24 and will be ongoing.

Standard #: 22VAC40-73-410-A

Description: Based on resident record review and staff interview, the facility failed to ensure that an orientation for new residents and legal representatives was provided upon admission and documentation of the orientation was signed by the resident and kept in the resident?s record.

Evidence:
1. Resident 4?s, admitted 11/06/2019, record contained a ?Orientation of New Resident to the Community? form signed by a Sunrise Representative and Resident 4?s legal representative on 11/06/2019.

2. Resident 2?s, admitted 03/15/2024, record contained a ?Orientation of New Resident to the Community? form signed by a Sunrise Representative and Resident 2?s legal representative on 03/29/2024.

3. Staff 2 confirmed that the orientation forms were not signed by the resident.

4. The following resident records did not contain an orientation form:

a. Resident 3 admitted 01/02/2024.
b. Resident 5 admitted 08/22/2024.
c. Resident 6 admitted 06/06/2012.

5. Staff 2 confirmed that the resident records did not contain an orientation form.

Plan of Correction: The new resident orientation was reviewed and signed for residents 4, 2, 3, 5, and 6 on 10/1/24.
The new resident orientation will be reviewed and signed by the resident within 72hrs of physical move in.
The resident care director is responsible for ensuring this document is signed and

filed appropriately.
This was completed on 10/1/24 and will be ongoing.

Standard #: 22VAC40-73-490-D

Description: Based on facility document review and staff interview, the facility failed to ensure that the licensed health care professional who provided the health care oversight certified that the requirements were met, including the dates of the health care oversight and identifying the residents for whom oversight was provided.

Evidence:
1. On 08/15/2024, Staff 2 provided the health care oversight from the state binder dated 01/23 through 06/23. Staff 2 confirmed that a more recent healthcare oversight could not be located.

2. On 08/162024, Staff 2 provided a copy of the ?Record of On-site Health Care Oversight? completed by Staff 3 that was undated.

3. The ?Record of On-site Health Care Oversight? form did not contain the name of the facility, or the beginning and completion dates.

4. The ?Record of On-site Health Care Oversight? did not contain a list of the residents reviewed.

5. The section of the form labeled ?recommendations for change/comments as needed? had N/A written in box number one (1) with a line through boxes two (2) through eight (8).

6. The section of the form for ?evaluate need for staff training? was blank in the boxes for the date the oversight was provided and the signature of the licensed health care professional.

7. The boxes on the form for ?evaluate the ability of residents who self-administer medications to safely do so? and ?observe infection control measures and consistency with the infection control program of the facility? states ?monthly? under the dates oversight provided.

Plan of Correction: The healthcare oversight document was reviewed with the resident care director and administrator on 9/30/24.
The document will be utilized on an ongoing basis and all tasks will be completed per the document?s timeline.
The administrator is responsible for ensuring this documented is completed on a semi-annual basis.
The document was reviewed on 9/30/24 and will consist of weekly meetings

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Standard #: 22VAC40-73-550-G

Description: Based on resident record review and staff interview, the facility failed to ensure that the rights and responsibilities of residents in assisted living facilities was reviewed annually, and the evidence of this review was filed in the resident?s record.

Evidence:
1. The following resident records did not contain an annual review of the resident rights:
a. Resident 4 admitted 11/06/2019.

b. Resident 6 admitted 06/06/2012.

2. Staff 2 confirmed a review of the resident rights had not been completed annually for these residents.

Plan of Correction: Resident rights were reviewed and signed for resident 4 and 6.
Resident rights will be reviewed at each care plan meeting.
The resident care director is responsible for ensuring this document is signed and filed appropriately.
This was completed on 10/1/24 and will be ongoing.

Standard #: 22VAC40-73-560-E

Description: Based on direct observation, the facility failed to ensure that resident records were stored in a locked area.

Evidence:
1. On the first floor of the facility, an unlabeled medication closets across from the electric room was unlocked.

2. The medication closet contained three empty Metamucil boxes with resident room numbers listed, two empty pill packs that had prescription labels, and a stack of resident face sheets, order summary reports, and photo ID scans.

3. On the bulletin board behind the computer was multiple post-it notes that contained communication between staff from residents and legal representatives.

4. Photo evidence obtained.

Plan of Correction: The first-floor medication room was secured upon finding.
Retraining was completed with the med-techs to ensure all resident information is secured under lock and key.
The med-techs and resident care director are responsible for ensuring all resident information is secured.
This was completed on 08/15/24.

Standard #: 22VAC40-73-620-B

Description: Based on facility document review and staff interview, the facility failed to ensure that the oversight of special diets included certification that the requirements of this subsection were met.

Evidence:
1. The facility?s special diet oversight was completed on 07/19/2024.

2. The special diet oversight did not contain a certification statement from the dietician confirming that the requirements of this subsection were met.

3. Staff 2 confirmed that the special diet oversight did not contain a statement certifying that the requirements were met.

Plan of Correction: The special diet oversight now contains a certification statement from the dietician confirming that the requirements of this subsection were met. The next dietician review has been scheduled for October 2024 and at that time the documentation will be signed.
The dietary services coordinator is responsible for ensuring this document is signed upon every inspection.
This will be completed by 10/31/2024.

Standard #: 22VAC40-73-660-A-1

Description: Based on direct observation, the facility failed to ensure that medication was stored in a locked area.

Evidence:
1. In the lobby area, a medication cart labeled ?med cart? was unattended with a computer, two water pitchers, a coffee mug, and a box of medication sitting on the top.

2. The medication box was labeled for Resident 9 and contained the generic version of Maxitrol eye drops.

3. The LI requested that the front desk remove the eye drops. The front desk called Staff 7.

4. Staff 7 removed the eye drops from the counter and placed them in the locked cart.

5. Photo evidence obtained.

Plan of Correction: The Maxitrol eye drops were placed inside the med cart upon finding.
Retraining was completed with staff 7 regarding all medication needing to be locked up.
The med-techs and resident care director are responsible for ensuring all medications are stored in a locked area.
This was completed on 08/15/24.

Standard #: 22VAC40-73-700-1

Description: Based on resident record review, the facility failed to ensure that when oxygen therapy is provided, the physician orders include the oxygen source, delivery device, and the flow rate.

Evidence:
1. Resident 2?s order summary report, dated 05/14/2024, contains an order that states: ?Oxygen 2-4 L/min PRN via nasal cannula due low oxygen sat.?

2. The oxygen order does not contain the source or the flow rate that indicates a what low oxygen saturation is for Resident 2.

Plan of Correction: Resident 2?s oxygen order has been updated to include the source of the oxygen.
All resident oxygen orders were reviewed and updated as needed on 10/10/24.
The resident care director is responsible for ensuring any oxygen orders contain the flow rate and source of oxygen.
This will be completed by 10/10/24.

Standard #: 22VAC40-73-830-E

Description: Based on facility document review and staff interview, the facility failed to ensure that a written response was provided to the council prior to the next meeting.

Evidence:
1. The facility provided a copy of the Resident Council Meeting Notes.

2. The Resident Council Meeting notes did not include updates to previous meeting requests.

3. Staff 6 stated the residents refuse the meeting notes to be read due to a previous mix-up where meeting notes were read twice.

4. Staff 2 and 6 confirmed that a written response had not been provided to residents prior to the next council meeting.

Plan of Correction: Resident council notes are responded to within 5 days of the council meeting by the administrator. The notes and responses are on the same form and displayed on the resident communication board for review. This began on 8/27/24.
The administrator is responsible for ensuring responses to the resident council are received by the residents within 5 days.
This was completed on 08/27/24 and is ongoing.

Standard #: 22VAC40-73-860-I

Description: Based on direct observation, the facility failed to ensure that cleaning supplies and hazardous materials were stored in a locked area.

Evidence:
1. On the first floor of the facility, an unlabeled medication closet across from the electric room was unlocked.

2. The closet contained germicidal disposable wipes, three covid-19 tests, and two bottles of spray cleaners including a protein spot digester and a disinfectant.

3. Photo evidence obtained.

Plan of Correction: Not available online. Contact Inspector for more information.

Standard #: 22VAC40-73-870-A

Description: Based on direct observation, the facility failed to ensure that the interior and exterior of all buildings was maintained in good repair and kept clean and free of rubbish.

Evidence:

1. In a hallway on the first floor across from the unlabeled medication closet and electrical closet, a large patch of wallpaper was missing from the center of the wall to the ceiling in the shape of a rectangle.

2. There were two square cuts in the drywall, as well as a rectangular hole in the wall that allowed for the inside insultation to be viewed.

3. In the hallway, the paint was scratched and chipped, with pieces falling on the carpet from the base boards.

4. Photo evidence obtained.

Plan of Correction: The hallway on first floor was repaired and painted on August 27, 2024.
The maintenance coordinator is responsible for ensuring the facility is maintained and in good repair.
This was completed on 08/27/24.

Standard #: 22VAC40-73-940-A

Description: Based on facility document review and staff interview, the facility failed to ensure that an annual fire inspection was completed.

Evidence:
1. The facility?s Fire Marshal permit expired on 06/30/2024.

2. The date of the facility?s last inspection was 07/17/2023.

3. Staff 2 provided confirmation that inspection was paid for on 08/07/2024; however, the inspection had not been scheduled.

Plan of Correction: The Fire Marshall completed an annual survey and permit was issued on 8/27/24. The administrator and maintenance coordinator are responsible for ensuring the annual survey is conducted prior to the expiration date of the current survey. This was completed on 08/27/24.

Standard #: 22VAC40-73-950-E

Description: Based on facility document review and staff interview, the facility failed to implement a semi-annual review on the emergency preparedness and response plan for all residents, staff, and volunteers.

Evidence:

1. Staff 2 provided the most recent reviews that were completed on 06/06/2023 and 12/07/2022, as well as a training participation log for the semi-annual review of resident emergencies, practice exercises, and the safety data sheets dated on 03/23/2023.

2. Staff 2 confirmed the semi-annual review of the emergency preparedness plan had not been completed.

Plan of Correction: The emergency preparedness and response plan will be reviewed by 10/31/24 by all team members and acknowledged.
The administrator is responsible for ensuring this document is completed on a semi-annual basis.
This will be completed by 10/31/24.

Search for an Assisted Living Facility

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Sunrise at Countryside
45800 Jona Drive
Potomac falls, VA 20165
(703) 430-0681

Current Inspector: Amanda Velasco (703) 397-4587

Inspection Date: Aug. 10, 2022

Complaint Related: No

Areas Reviewed:

22VAC40-73 GENERAL PROVISIONS
22VAC40-73 ADMINISTRATION AND ADMINISTRATIVE SERVICES
22VAC40-73 PERSONNEL
22VAC40-73 STAFFING AND SUPERVISION
22VAC40-73 ADMISSION, RETENTION AND DISCHARGE OF RESIDENTS
22VAC40-73 RESIDENT CARE AND RELATED SERVICES
22VAC40-73 RESIDENT ACCOMMODATIONS AND RELATED PROVISIONS
22VAC40-73 BUILDINGS AND GROUND
22VAC40-73 EMERGENCY PREPAREDNESS
ARTICLE 1 ? SUBJECTIVITY
32.1 REPORTED BY PERSONS OTHER THAN PHYSICIANS
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

Comments:

Type of inspection: Renewal
Date(s) of inspection and time the licensing inspector was on-site at the facility for each day of the inspection: LI entered the facility on 8/10/2022 at 8:40am and exited the facility on 8/10/2022 at 2:15pm.
The Acknowledgement of Inspection form was signed and left at the facility for each date of the inspection.
Number of residents present at the facility at the beginning of the inspection: 48
The licensing inspector completed a tour of the physical plant that included the building and grounds of the facility.
Number of resident records reviewed: 8
Number of staff records reviewed: 4
Number of interviews conducted with residents: 1
Number of interviews conducted with staff: 1
Observations by licensing inspector: LI observed medication administration. LI observed residents eating lunch and engaging in activities.
Additional Comments/Discussion:

An exit meeting will be conducted to review the inspection findings.

The evidence gathered during the inspection determined non-compliance with applicable standard(s) or law, and violation(s) were documented on the violation notice issued to the facility. The licensee has the opportunity to submit a plan of correction to indicate how the cited violation(s) will be addressed in order to return the facility to compliance and maintain future compliance with applicable standard(s) or law.

If the licensee wishes to provide a plan of correction: (i) type the plan on a separate Word document, (ii) identify the standard violation number being addressed, (iii) include the date the violation will be corrected, (IV) do not include any names or confidential information, and (V) return to the licensing inspector by email within five (5) business days of the exit interview.

Compliance with all applicable regulations and law shall be maintained and any areas of noncompliance must be corrected.

Within 15 calendar days of your receipt of the inspection findings (inspection summary, violation notice, and supplemental information), you may request a review and discussion of these findings with the inspector's immediate supervisor. To make a request for review and discussion, you must contact the licensing supervisor at the regional licensing office that serves your geographical area.

Regardless of whether a supervisory review has been requested, the results of the inspection will be posted to the DSS public website within 5 business days of your receipt of the Inspection Summary and/ or Violation Notice.

The department's inspection findings are subject to public disclosure.

Please Note: A copy of the findings of the most recent inspection are required to be posted on the premises of the facility.

For more information about the VDSS Licensing Programs, please visit: www.dss.virginia.gov

Should you have any questions, please contact Jamie Eddy, Licensing Inspector at (703) 479-5247 or by email at jamie.eddy@dss.virginia.gov

Violations:

Standard #: 22VAC40-73-960-B

Description: Based upon observation of the building, the facility failed to ensure that a fire and emergency evacuation drawing shall be posted in a conspicuous place on each floor of each building used by residents. The drawing shall show primary and secondary escape routes, areas of refuge, assembly areas, telephones, fire alarms boxes, and fire extinguishers, as appropriate.

Evidence: LI walked the entire hallways of each floor of the building and only observed the fire and emergency evacuation drawing posted on the first floor near next to the main exit of building located at 45780 Jona Drive, Potomac Falls, VA. LI walked the first floor and second floor of the building located at 457800 Jona Drive, Potomac Falls, VA and observed that there was no fire and emergency evacuation drawing on the first floor.

Plan of Correction: The violation of a missing fire and emergency evacuation drawing on each floor was corrected on the day of the inspection. The community will revisit emergency preparedness plan and ensure that we are in compliance with all sections regarding preparation and response in the event of an emergency. The fire and emergency evacuation drawings have been posted in a conspicuous place on each floor of

each building used by residents. The drawings show primary and secondary escape routes, areas of refuge, assembly areas, telephones, fire alarm boxes, and fire extinguishers. The Executive Director (ED) or Maintenance Coordinator will continue to examine and confirm that fire and emergency evacuation drawings remain intact on the wall on each floor of each building used by residents. This audit will take place monthly. The ED or designee will present the results of the audits to the Quality Assurance and Performance Improvement (QAPI) committee each month. The ED or Maintenance Coordinator is responsible for implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.