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Tall Oaks Assisted Living
12052 N. Shore Drive
Reston, VA 20190
(703) 834-9800

Current Inspector: Jacquelyn Kabiri (703) 397-3017

Inspection Date: Dec. 18, 2020

Complaint Related: Yes

Areas Reviewed:

22VAC40-73 PERSONNEL
22VAC40-73 STAFFING AND SUPERVISION
22VAC40-73 RESIDENT CARE AND RELATED SERVICES
22VAC40-73 ADDITIONAL REQUIREMENTS FOR FACILITIES THAT CARE FOR ADULTS WITH SERIOUS COGNITIVE IMPAIRMENTS

Article 1
Subjectivity

Comments:

This inspection was conducted by licensing staff using an alternate remote protocol, necessary due to a state of emergency health pandemic declared by the Governor of Virginia.

A complaint inspection was initiated on 12/18/20 and concluded on 2/12/21. A complaint was received by the department regarding allegations in the areas of: Personnel, Staffing and Supervision, Resident Care and Related Services, and Requirements for Facilities that Care for Adults with Serious Cognitive Impairments. The administrator was contacted by telephone to conduct the investigation. The licensing inspector emailed the administrator a list of documentation required to complete the investigation.

The evidence gathered during the investigation supported the allegations of non-compliance with standards or law, and violations were issued. Any violations not related to the complaint but identified during the course of the investigation can be found 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 contact me via e-mail at m.massenberg@dss.virginia.gov.

Violations:

Standard #:	22VAC40-73-1090-A
Complaint related:	Yes
Description:	Based on record review, the facility failed to ensure that each resident is assessed by an independent clinical psychologist licensed to practice in the Commonwealth or by an independent physician as having a serious cognitive impairment due to a primary psychiatric diagnosis of dementia with an inability to recognize danger or protect his own safety and welfare, prior to his/her admission to the safe, secure environment. Evidence: Resident #1?s record was observed during the inspection. The resident record includes documentation about Resident #1's placement in the memory care unit on 6/29/20. The resident?s record contained a Physician Assessment of Serious Cognitive Impairment for Admission to Memory Care. The form includes an area to document the resident?s serious cognitive impairment status as well as the resident?s ability to recognize danger and protect his/her safety and welfare, but the areas were left blank. The form documented Resident #1?s name and says ?see attached.? The attachment included an initial evaluation conducted by a geriatric psychiatrist, dated 6/22/20. The evaluation lists Resident #1 as having a diagnosis of dementia and that the resident presents as moderately impaired. The evaluation does not state that Resident #1 has a serious cognitive impairment due to a primary psychiatric diagnosis of dementia with an inability to recognize danger or protect his own safety and welfare. Additional documentation from the psychiatrist was included, but the visits were conducted after the resident had been placed in the memory care unit.
Plan of Correction:	All documents will be reviewed by the ED, DON, or designee before the resident is placed in the secured neighborhood to ensure proper forms are accurately completed by the MD.

	Upon further review, the Assistant Executive Director and Director of Nursing were able to locate the appropriate form from the discharge file that was previously in storage on site. The Serious Cognitive Impairment form listed was received from the primary care physician on 6-29-20 at 5:46pm, which was prior to the resident?s placement in the secured neighborhood.
Standard #:	22VAC40-73-680-D
Complaint related:	Yes
Description:	Based on record review, the facility failed to ensure that medications are administered in accordance with the physician?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: Resident #1?s August and September medication administration records (MARs) were observed during the inspection. Resident #1?s Memantine was discontinued on 8/9/20. The MAR stated that Memantine was administered to Resident #1 on 8/10/20. Resident #1?s record contained a PRN order for Ativan 0.5mg, dated 8/17/20, that called for the resident to receive the medication every 8 hours as needed. The MAR states that the medication was given when less than eight hours elapsed between administrations on: 8/26/20 (9:17 AM and 4:38 PM), 8/27/20 (9:29 AM and 1:08 PM), 8/28/20 (12:36 PM and 7:15 PM), and 8/31/20 (11:20 AM and 1:27 PM). Resident #1?s record contained an order for Ativan 0.5mg, dated 8/24/20, that called for the resident to receive the medication two times per day. The MAR states that the scheduled medication did not begin until 9/1/20.
Plan of Correction:	All readmission medications will be checked by the Charge Nurse on duty at the community and a call to pharmacy to reconcile and update the profile each time for accuracy will be completed at the time of readmission. Director of Nursing to address, train, and provide in-service sessions for the RMA?s and LPN?s on the process of accessing the EMR portal to address updates on any changes to resident medications, treatment orders, or profile information. The contracted pharmacy partner associated with this community will provide on-site training on the EMR portal and provide access to the community employees that have access to this platform. Resident #1 was discharged from Reston Hospital Center at 11:27pm back to the community. Upon readmission the updated orders from the discharging physician were faxed to the pharmacy as well as the resident?s primary care physician. Pharmacy administrative employees updated the profile that included a medication that was discontinued after the medication was administered as previously ordered at 9am. The profile was updated at 10am. Director of Nursing provided mandated in-service training sessions to the RMA?s and LPN?s to ensure appropriate corrective actions taken with the focus being on medication administration as prescribed by the attending physicians. The community will continue training and medication administration observation will be conducted by the Director of Nursing, Nursing Department Coordinator, Assistant Executive Director, and Executive Director on a monthly basis. RMA involved in early administration of PRN meds will be trained specially every month for the next 6 months. Director of Nursing has contacted all attending physicians to ensure that they all have a direct line to the contracted pharmacy partner when calling in any medications that need a hard prescription on record. A copy of this will also be provided to the community for the resident?s medical record. The medication listed, Ativan, is a controlled substance and cannot be filled without a prescription. The phone order was called into the pharmacy; however, the pharmacy would not fill the order until the prescribing physician had signed the order. To prevent future delay in dispensing narcotics, all physicians will call prescriptions directly to the pharmacy.
Standard #:	22VAC40-73-680-K
Complaint related:	Yes
Description:	Based on record review, the facility failed to obtain a detailed medication order from the resident?s physician, for medication aides to administer PRN Medication. The order shall include symptoms that indicate the use of the medication, exact dosage, the exact time frames the medication is to be given in a 24-hour period, and directions as to what to do if symptoms persist. Evidence: Resident #1?s record contained a PRN order for Ativan 0.5mg, dated 8/17/20. The order did not include the symptoms that indicate the use of the medication or directions as to what to do if symptoms persist. The MAR states that Resident #1?s PRN Ativan was first administered by a medication aide on 8/19/20.
Plan of Correction:	All nursing staff responsible for distribution of medications will be in serviced to ensure that all medication order received have a diagnosis. Follow up with MD within 24 hours of administering PRN medication must be included in the order. Director of Nursing and Nursing Department Coordinator will ensure orders for PRN medications shall include symptoms that indicate the use of the medication, exact dose, the exact time frames the medication is to be given in a 24-hour period, and directions as to what to do if symptoms persist. Director of Nursing will continue to provide in-service trainings for RMA?s to ensure they are looking at the above-named items and document accordingly.