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Journeys Crossing

102 N. Stuart Avenue
Elkton, VA 22827
(540) 298-0054

Current Inspector: Jill James (540) 418-2631

Inspection Date: April 16, 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 ACCOMMODATIONS AND RELATED PROVISIONS
22VAC40-73 EMERGENCY PREPAREDNESS
22VAC40-73 ADDITIONAL REQUIREMENTS FOR FACILITIES THAT CARE FOR ADULTS WITH SERIOUS COGNITIVE IMPAIRMENTS

Article 1

Subjectivity

32.1 Reported by persons other than physicians

63.2 General Provisions.

63.2 Protection of adults and reporting.

22VAC40-90 Background Checks for Assisted Living Facilities

22VAC40-90 The Sworn Statement or Affirmation

22VAC40-90 The Criminal History Record Report

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 renewal inspection was initiated on 04/16/21 and concluded on 05/10/21. The administrator was contacted to initiate the inspection. The administrator reported that the current census was 31. The inspector emailed the administrator a list of items required to complete the inspection. The inspector reviewed three resident records, three staff records, staff schedule, criminal history reports, and the medication management plan submitted by the facility to ensure documentation was complete.

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

Upon receipt of this violation notice, a plan of correction is requested for each violation. The plan of correction should include:

1) Steps to correct non-compliance; 2) Measures to prevent reoccurrence of noncompliance; 3) Person(s) responsible for implementing each step and/or monitoring and preventative measure(s); 4) Date by which the non-compliance will be corrected.

Violations:

Standard #:	22VAC40-73-460-B
Description:	Based upon review of resident's record, and an interview, the facility failed to provide resident centered care by ensuring prompt response by staff to resident needs as reasonable to the circumstances as required by 22 VAC 40-73-460-B-3. FINDINGS: 1) Resident A has the following order effective 11/23/20: Acetaminophen 500mg-Take one tablet by mouth every 4 hours as needed for pain or fever. Resident A also has an order written effective 02/05/21 to administer Acetaminophen 500 mg first for pain if able, before Oxycodone. 2) Resident A has the following order effective 01/27/21: Oxycodone Concentrate 20mg/ml-Take 0.25ml (5mg) by mouth every 1 hour as needed for pain. 3) The Medication Administration Record (MAR) indicates Oxycodone was administered on 04/27/21 at 5:49pm "resident yelling uncontrollable for 3 1/2 hours signs and symptoms of pain." a. Results following the administration of medication are documented as "resident in bed with eyes closed."

- 4) There is no documentation Acetaminophen was administered prior to the administration of Oxycodone.
- 5) There is no documentation of Oxycodone being administered prior to 5:49pm.
- 6) The physician's order sheet requested by the licensing inspector and submitted by the administrator on 05/07/21 has an informational order "resident is being followed by hospice. Please call with any change in condition."
- 7) The licensing inspector interviewed the administrator via phone on 05/06/21 who stated "hospice was not notified."
- 8) Based on the licensing inspector's interview with the administrator, the administrator also indicated she had interviewed the staff regarding the incident and the employee stated she had no reason for not administering the medication or calling hospice.

Plan of Correction: Facility administrator to educate all medication aides on [PRN](#) administration, signs and symptoms of pain, and documentation of interventions attempted prior to medication administration. Facility administrator to check any order variances and follow up for correctness.

Standard #: 22VAC40-73-680-D

Description: Based upon review of residents' records, the facility failed to ensure medications are administered in accordance with the physician's or other prescriber's instructions and consistent with the standards of practice outlines in the current registered medication aide curriculum approved by the Virginia Board of Nursing.

FINDINGS:

1) Resident A has the following orders:

Effective 11/23/20: Acetaminophen 500mg-Take one tablet by mouth every 4 hours as needed for pain or fever.

Effective 02/05/21 administer Acetaminophen 500 mg first for pain if able, before Oxycodone.

Effective 01/27/21: Oxycodone Concentrate 20mg/ml-Take 0.25ml (5mg) by mouth every 1 hour as needed for pain.

2) The Medication Administration Record ([MAR](#)) indicates Oxycodone was administered to resident A on 04/27/21 at 5:49pm "resident yelling uncontrollable for 3 1/2 hours signs and symptoms of pain."

a. Results following administration of medication are documented as "resident in bed with eyes closed."

3) There is no documentation Acetaminophen was administered prior to the administration of Oxycodone.

4) There is no documentation of Oxycodone being administered prior to 5:49pm.

5) The physician's order sheet requested by the licensing inspector and submitted by the administrator on 05/07/21 has an informational order "resident is being followed by hospice. Please call with any change in condition."

6) The licensing inspector interviewed the administrator via phone on 05/06/21 who stated "hospice was not notified."

Plan of Correction: Facility administrator to educate all medication aides on proper hospice medication procedures and follow up if symptoms persist after medication administration.

Standard #: 22VAC40-73-680-I

Description: Based upon review of residents' records, the facility failed to ensure that the Medication Administration Record ([MAR](#)) includes the effectiveness of "as needed" [PRN](#) medications as required by 22 VAC 40-73-680-I-13-c.

FINDINGS:

1) Resident B has the following order effective 04/09/21: Senna Laxative 8.6mg-Take 1 tablet by mouth every day as needed for constipation.

a. Documentation in the [MAR](#) indicates medication was administered on 04/09/21 at 11:40pm due to "resident complaining of belly pain, constipation." Results documented "resident resting in bed with eyes closed"

b. There is no documentation of follow-up for effectiveness of medication's specific use.

Plan of Correction: Facility administrator to educate all medication aides on complete documentation to medication administration and follow up. Facility administrator to check any order variances and follow up for correctness.

Standard #: 22VAC40-90-40-B

Description: Based upon review of staff records, the facility failed to ensure criminal history reports were obtained on or prior to the 30th day of employment for each employee.

FINDINGS:

1) The criminal history report for staff A (hired on 11/11/20) is dated 12/29/20.

2) The criminal history report for staff B (hired on 12/19/20) is dated 07/23/20.

Plan of Correction: Region administrator to double check? facility administrator on completing criminal history checks within the proper time frame quarterly and as needed.

Disclaimer:

This information is provided by the Virginia Department of Social Services, which neither endorses any facility nor guarantees that the information is complete. It should not be used as the sole source in evaluating and/or selecting a facility.