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### Timberview Crossing

351 New Market Road  
Timberville, VA 22853  
(540) 896-9858

**Current Inspector:** Jill James (540) 418-2631

**Inspection Date:** April 26, 2021

**Complaint Related:** Yes

#### Areas Reviewed:

22VAC40-73 ADMINISTRATION AND ADMINISTRATIVE SERVICES  
22VAC40-73 PERSONNEL  
22VAC40-73 RESIDENT CARE AND RELATED SERVICES

#### 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 04/26/21 and concluded on 05/28/21. A complaint was received by the department regarding allegations in the areas of administration, resident care and staff. The administrator was contacted 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.

#### Violations:

Standard #: 22VAC40-73-70-A

Complaint related: No

Description: Based on a review of documentation, the facility failed to report to the regional licensing office, within 24 hours, any major incident that affected or that threatens the life, health, safety, or welfare of any resident.

##### EVIDENCE:

1. Facility form, "Resident Incident/Accident Report" prepared on 12/29/2020, indicated that resident D reported an unwitnessed fall. Documentation shows the resident was "very confused, shaky", "appears to be very confused. Apparent R droop on face." Resident D was transported to the hospital at 9:00am on 12/29/2020. This incident had not been reported to the regional licensing office.
2. Facility form, "Resident Incident/Accident Report" prepared on 02/14/2021, indicated resident H had an unwitnessed fall and was found on the floor with a skin tear on left ankle. Resident was sent to the hospital on 02/14/2021 at 7:30am. This incident had not been reported to the regional licensing office.
3. "After Visit Summary" indicated resident E was seen in the emergency room and diagnosed "contusion of right chest wall" on 04/21/2021. This incident had not been reported to the regional licensing office.
4. Facility form, "Resident Incident/Accident Report" prepared on 04/23/2021, indicated that resident B was found lying on his right side on the floor, complained of pain in both hips, on the right side of his forehead and was sent to the hospital at 10:15am. This incident was not reported to the regional licensing office.

Plan of Correction: New administrator will be hired. Facility will report incidents that result in an emergency room evaluation according to policy and regulations.

Standard #: 22VAC40-73-250-D

Complaint related: Yes

Description: Based on a review of documentation, the facility failed to ensure that the submitted results of a risk assessment documented the absence of tuberculosis in a communicable form as evidenced by the completion of the current screening form published by the Virginia Department of Health or a form consistent with it.

##### EVIDENCE:

1. The Tuberculosis Screening form for staff B, signed on 03/01/2021, was incomplete as it did not specify who evaluated the staff; nor did the Health Care Professional document whether a Tuberculin Skin Test (PPD) was not indicated at the

time due to the absence of symptoms; whether a Tuberculin Skin Test (PPD) was administered; whether the staff has a history of positive tuberculin skin tests due to latent TB infections; or whether the staff had a chest x-ray.

**Plan of Correction:** New administrator will be hired. Facility will assure that TB screenings are complete per regulations.

Standard #: 22VAC40-73-470-F

Complaint related: No

Description: Based on a review of documentation, the facility failed to ensure that when a resident suffers serious accident, injury, illness or medical condition, or there is reason to suspect that such has occurred, medical attention from a licensed health care professional shall be secured immediately.

EVIDENCE:

1. Facility form, "Resident Incident/Accident Report" prepared on 05/18/2021, indicated that resident G "fell backwards and hit her head on door before hitting floor". There was no documentation to show that medical attention from a licensed health care professional was secured.
2. Facility form, "Resident Incident/Accident Report" prepared on 03/13/2021, indicated that after hearing a loud bang, resident G was found "face down on the floor, with her head laying against bed leg. flipped recliner". There was no documentation to show that medical attention from a licensed health care professional was secured.
3. Facility form, "Resident Incident/Accident Report" prepared on 04/30/2021, indicated "Pt (resident C) rang @ 2:30 a.m. When staff open door- PT on floor, Pt stated fell over face first to floor " carpet burn abrasion to forehead- Pt " stated he leaned over to far ?? There was no documentation to show that medical attention from a licensed health care professional was secured.

**Plan of Correction:** New administrator will be hired. Facility will assure that when PCP is notified of an incident, that documentation is in the resident's chart regardless if the PCP decided to treat or evaluate or not.

**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.*