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Bellaire at Stone Port

1684 Port Hills Drive
Harrisonburg, VA 22801
(540) 246-0888

Current Inspector: Angela N Via (540) 682-1739

Inspection Date: July 23, 2021 , July 26, 2021 , July 27, 2021 , July 28, 2021 and July 29, 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 BUILDING AND GROUNDS
22VAC40-73 EMERGENCY PREPAREDNESS
22VAC40-73 ADDITIONAL REQUIREMENTS FOR FACILITIES THAT CARE FOR ADULTS WITH SERIOUS COGNITIVE IMPAIRMENTS

Article 1

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.

22VAC40-80 THE LICENSING PROCESS.

Technical Assistance:

Recommendations discussed with the director of health and wellness:

1. Attach the list of medications in the stat box directly onto the outside rather than keeping it in a separate area.
2. Director of health and wellness and executive director attend the individualized service plan and uniform assessment instrument training again since it has been a while since they were completed.
3. Do not bunch the ambulation activities of daily living all together - each needs to be addressed separately.
4. Even though hospice services were listed on the [ISP](#) ensure the information is very specific to each service provided.
5. Having all medication aides document the insulin information the same way. All information was documented; however, one medication aide was documenting the information differently than the others.

Comments:

A renewal inspection was initiated on 7/23/2021 and concluded on 7/29/2021. The administrator was contacted by telephone to initiate the inspection. The administrator reported that the current census was 66. The inspector emailed the administrator a list of items required to complete the remote documentation review portion of the inspection. The inspector reviewed four resident records, four staff records, one additional resident and one additional staff record, two contract staff records, activities calendar, menu, fire drills, staff schedules, health care oversight, dietary reviews, medication administration records, physicians' orders, as well as other information submitted by the facility to ensure documentation was complete. The inspector conducted the on-site portion of the inspection on 7/28/2021. An exit interview was conducted with the director of health and wellness on the date of inspection and on 7/29/2021, 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 issued to the facility.

Violations:

Standard #: 22VAC40-73-450-C

Description: Based upon documentation and an interview, the facility failed to ensure all assessed needs were listed on two of the four individualized service plans ([ISPs](#)) reviewed.

EVIDENCE:

1. Resident 1 had physician's orders (signed 5/21/2021) for physical and occupational therapies. The [ISP](#) (completed 7/20/2021) for resident 1 did not include this service.
2. The [UAI](#) completed 7/13/2021, indicated resident 1 required mechanical assistance with toileting, supervision with eating and was disoriented to time and place; however, these needs were not listed on the [ISP](#) completed 7/20/2021.
3. Resident 2 had a signed physician's order on file dated 5/28/2021 for physical therapy. The order was discontinued on 7/22/2021; however, the [ISP](#) (completed 7/21/2021) did not include this service.
4. The [UAI](#) (completed 6/2/2021) for resident 2 indicated mechanical assistance with bathing, supervision with toileting, supervision and mechanical assistance with transferring.
5. On 7/28/2021, the LI interviewed the DHW who stated these needs and services were not listed on these [ISPs](#).

Plan of Correction: Assessed needs and services will be included in the [ISP](#) to include physical and occupational therapy. The services will not be removed from the [ISP](#) until the order has been discontinued. Weekly meetings are held with the rehab providers, and each week the DHW and director of memory care (DMC) meet with the ED for continuous quality improvement (CQI). The list of residents receiving therapy will be reviewed to confirm that this service has been added to the [ISP](#). The ED will review updated [ISPs](#) weekly to check for accuracy. The ED or designee will ensure that the assessed needs on the [UAI](#) are indicated on the [ISP](#) as part of the [ISP](#) process. Current [UAIs](#) and [ISPs](#) will be audited to ensure that assessed needs are accurate and are reflected on the [ISP](#).

Standard #: 22VAC40-73-640-A

Description: Based upon documentation and interviews, the facility failed to implement the current medication management plan for one of four residents' records reviewed.

EVIDENCE:

1. A medication self-administration assessment form for resident 4 was completed on 10/21/2016 which stated, "Timolol 0.5% eye gtt's two drops instill 2 qHS to each eye daily." A second assessment was completed on 1/18/2017 which stated, "Timolol 0.5% eye gtt's, two drops into each eye @ 9am - Dx. Glaucoma."
2. The uniform assessment instrument ([UAI](#)) completed on 4/4/2018 assessed Resident 4 as capable of self-administering eye drops. A note at the bottom of the second page stated, "Resident checks and records and reports her own blood sugar. Admins her own insulin and administers her own eye drops."
3. The initial order for Timolol for resident 4 was dated/signed 3/22/2016 and the most current order was dated/signed 7/29/2021.
4. The July medication administration record ([MAR](#)) indicated the Timolol eye drops for resident 4 were self-administered.
5. The [UAI](#) (completed 4/4/2019, 5/7/2020 and 5/27/2021) assessed resident 4 as needing assistance for medication administration.
6. On 7/28/2021, the licensing inspector (LI) interviewed staff 3 who stated resident 4 self-administered Timolol.
7. On 7/28/2021, the LI interviewed resident 4 who stated she does not have eye drops and does not use eye drops.
8. The pharmacy reported Timolol for resident 4 was last ordered on 7/11/2019.
9. The facility's medication management plan stated on page 2, #4, "Weekly review of the EMAR dashboard by the director of health and wellness (DHW) or designee shall be performed to ensure accurate and complete documentation." On page 3, #7, "Residents shall be assisted with their medications in such a way as to promote the highest level of their ability, according to the [UAI](#) and [ISP](#) evaluations." Page 8, #18, "A resident in assisted living may self-administer medications if:
i. The [UAI](#) and physician History and Physical has indicated that the resident is capable of self-administering medications.
ii. A physician's order has been obtained indicating the resident may self-administer the medication.
iii. Assessment for medication self-management completed by DHW or designee indicates resident is capable of self-administering medications. Assessment is completed by DHW or designee upon admission and quarterly.
iv. Nurses/RMAs report any concerns regarding resident's ability to self-administer medications to ED, DHW or designee."
10. There were no assessments on file to determine if resident 4 was still capable of self-administering Timolol.
11. The individualized service plan ([ISP](#)) signed and dated as completed on 7/2/2021, listed the need of medication administration as, "Med Admin/monitored by staff. Administer medications as ordered within the timeframes specified. Document on [MAR](#). If treatments are ordered, document on TAR. Services to be provided by Nurse/Med Tech."

Plan of Correction: All residents who wish to self-administer medications must successfully complete an Assessment for Medication Self Management. Once the resident has satisfactorily passed the evaluation, the DHW or designee will ensure there is a physician's order in place that indicates the resident is able to store and self-administer their medications. A re-evaluation of the resident's ability to safely store and self-administer their medications will be conducted during each service plan review by the DHW or designee. The executive director (ED) will check each month to see that the scheduled reviews have been done. The DHW, designee, or the ED will be authorized to implement medication management to any resident they determine to be at risk for mismanaging their medication. At any time a resident who desires to self-manage their

medications is not able to pass the evaluation, or should a physician's order indicate that a resident is able to self-manage their medications and the community disagrees due to the resident's inability to pass the evaluation, the DHW or designee, in collaboration with the ED, will make the determination as to the resident's ability to have possession of their medications. If the resident can no longer self-manage their medications, the resident's [UAI](#) and [ISP](#) will be updated to reflect they are on the community's medication management plan. For residents who self-administer medications, the DHW or designee will ensure, each month, that the resident continues to have the prescribed medications in their possession in a safe and secure location, and that there are no concerns noted. The monitoring of medication supply will be documented in the resident's electronic health record (EHR).

Standard #: 22VAC40-73-680-D

Description: Based upon documentation, observations and interviews, the facility failed to ensure one medication for one of four residents was administered according to the physician's order.

EVIDENCE:

1. Resident 4 had signed physician's orders on 3/22/2016 (on the initial physical), 4/29/2021 and the most current order dated 7/29/2021, for Timolol eye drops, two drops into both eyes daily for glaucoma.
2. The July [MAR](#) indicated the Timolol eye drops were self-administered.
3. The [UAI](#) (completed 4/4/2019, 5/7/2020, 5/27/2021) assessed resident 4 as needing assistance of a lay person for medication administration.
4. On 7/28/2021, The LI interviewed resident 4 who stated she does not have eye drops and does not use eye drops.
5. The pharmacy reported Timolol for resident 4 was last ordered on 7/11/19.
6. A medication cart audit was conducted on 7/28/2021 for the medications for resident 4 and the Timolol eye drops were not in the medication cart.
7. On 7/28/2021, LI interviewed the registered medication aide (RMA) on duty, staff 3, who stated resident 4 self-administered Timolol.

[Plan of Correction:](#) DHW or designee will ensure that medications are administered according to physician's order. For residents who self-administer medications, the order shall state that the resident may self-administer the medication and the Assessment of Medication Self-Management shall be completed. A monthly audit will be conducted by the RMA/nurse to assure that the resident still has the medication available, and to confirm with the resident that the resident is still taking the medications. The confirmation will be documented in the electronic [MAR](#) (E-MAR). The DHW or designee shall monitor this process monthly using the E-MAR system.

Standard #: 22VAC40-73-930-D

Description: Based upon documentation and an interview, the facility failed to ensure the residents' inability to use the emergency call system was indicated on two of the four residents' [ISPs](#) reviewed.

EVIDENCE:

1. The list of residents residing in the secured unit submitted by the administrator included residents 1 and 3.
2. The [ISP](#) (completed 7/20/2021) for resident 1 and 6/30/2021 for resident 3, did not include their inability to use the emergency call system.
3. On 7/28/2021, the LI interviewed the DHW who stated residents 1 and 3 were unable to use the emergency call system and that this inability was not listed on their [ISPs](#).

[Plan of Correction:](#) For each resident with an inability to use the signaling device, the ED or designee shall ensure that the inability is included in the resident's [ISP](#). This information will be reviewed as part of the [ISP](#) process. The plan shall also specify a minimal frequency of daily rounds (safety checks) to be made by direct care staff to monitor for emergencies or other unanticipated resident needs. Direct care staff will notify supervisor whenever a change in inability is noted. The electronic system used to develop [ISPs](#) has been updated to support the addition of services related to inability to use signaling device.

Standard #: 22VAC40-73-970-A

Description: Based upon documentation and an interview, the facility failed to ensure fire drills were conducted on each shift for each quarter.

EVIDENCE:

1. The fire drill log indicated fire drills were held on second shift (2:00 pm to 10:00 pm) in February (2/26/2021 at 3:22 pm), April (4/29/2021 at 2:46 pm) and May (5/27/2021 at 2:44 pm).
2. On 7/27/2021, the LI interviewed the DHW who stated the dates and times of the fire drills were accurate.

[Plan of Correction:](#) The ED will review records of fire drills to ensure the drill was conducted at the correct time. If the drill is conducted late and rolls into the next shift, another drill will be scheduled during the correct shift. A new schedule has been created to assist with this process. The ED will update the spreadsheet after the completion of each fire drill.

Standard #: 22VAC40-90-40-B

Description: Based upon documentation and an interview, the facility failed to ensure a criminal record check ([CRC](#)) was completed within 30 days of hire for one of 30 staff records reviewed.

EVIDENCE:

1. Staff 5 (hired 3/12/2021) had a [CRC](#) on file dated as completed on 4/29/2021.
2. On 7/27/2021, the LI interviewed the DHW who stated the date of hire and [CRC](#) completion dates were accurate and the [CRC](#) was not completed within 30 days of hire.

[Plan of Correction](#): The ED will ensure that criminal record checks are completed within 30 days of hire for all staff. If a staff member is terminated and then re-hired, a new criminal record check will be conducted. This protocol has been reviewed with the team that assists with the hiring process. The business office manager will oversee this process and utilize a tracking tool to ensure that this is done in a timely manner, and to remove the staff member from the schedule if the background check has not been received within 30 days. The background check is requested prior to the staff member's start date.

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.

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