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Tribute at One Loudoun

20335 Savin Hill Drive
Ashburn, VA 20147
(571) 252-8292

Current Inspector: Amanda Velasco (703) 397-4587

Inspection Date: Nov. 20, 2020 and Dec. 2, 2020

Complaint Related: No

Areas Reviewed:

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 focused monitoring inspection was initiated on 11/20/2020 and concluded on 12/02/2020. A self-reported incident was received by the department regarding allegations in the areas of resident care. The administrator was contacted by email to conduct the investigation. The licensing inspector emailed the administrator a list of documentation required to complete the investigation. The exit interview was held on 12/02/2020 by telephone.

Two resident records and one staff record was reviewed. The administrator and resident services director were interviewed. Copies of written statement by the staff member involved was collected. The evidence gathered during the investigation supported the self-report of non-compliance with standards or law, and violations were issued.

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-B |
| Description: | Based upon staff member's written statement and interview with administration, the facility failed to ensure that medications shall remain in the pharmacy issued container with the prescription label or direction label attached, until administered to resident. Evidence: According to the written statement of 11/20/2020, provided by Staff #1, as she was preparing to administer medications to Resident #1, "On my way going, I saw that it still remain 9 minutes to enter his apartment so I went to the forth floor to administer medication to another resident. Unfortunately I met the resident in help of ADL's and distress waving, so I help her (Room 4008) and with five (Resident #1) medications in my hand. Later in the written statement, Staff #1 stated "though responding to the request, I literally forget that the medication of Mr. Paul was still in the medication cup in my hands and accidentally threw the cups in the trash can by the right side of the medication cart." |
| Plan of Correction: | It is duly noted that the facility failed to ensure that medications shall remain in the pharmacy issued container with the prescription label or direction label attached, until administered to resident. The Resident Services Director, or designee, will re-educate medication aides on the standards of practice outlined in the current registered medication aide curriculum approved by the Virginia Board of Nursing. |
| Standard #: | 22VAC40-73-680-D |
| Description: | Based upon the staff member's written statement and interview with administration, 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 medication aide curriculum approved by the Virginia Board of Nursing.

Evidence: According to the November 2020 Medication Administration Record ([MAR](#)), Resident #1 is scheduled to receive the following medications at approximately 6 am and 6:30 am: Esomeprazole, Levothyroxine, Nifedipine ER, and Oxycontin. On 11/18/2020 at approximately 8:30 am, Resident #1 reported to staff that he had not received his 6 am and 6:30 am medications. The [MAR](#) was reviewed by staff and the [MAR](#) indicated that all medications were administered. The staff member assigned to administer medications was contacted and the staff member reported that she had administered the medications to Resident #1. Upon a second interview, the staff member indicated that she had not administered the 6 am and 6:30 am medications. The staff member provided a written statement on 11/20/2020 in which she stated "though responding to the request, I literally forgot that the medication of Mr. Paul was still in the medication cup in my hands and accidentally threw the cups in the trash can by the right side of the medication cart." The staff member explained to the administrator that she was asked to help with other residents when trying to administer medications to Resident #1, got distracted, and failed to administer the 6 am and 6:30 am medications to Resident #1.

Plan of Correction: It is duly noted that the facility failed to ensure that medications were administered in accordance with the prescriber's instructions and consistent with the standards of practice outlined in the current registered medication aide curriculum by the Virginia Board of Nursing. The Resident Services Director, or designee, will re-educate medication aides on the standards of practice outlined in the current registered medication aide curriculum by the Virginia Board of Nursing.

Standard #: 22VAC40-73-680-H

Description: Based upon a review of records, the facility failed to ensure that at the time the medication is administered, the facility shall document on a medication administration record ([MAR](#)) all medications administered to residents, including over-the-counter medications and dietary supplements.

Evidence: The Medication Administration Record ([MAR](#)) for 10/9/2020 and 10/14/2020 did not contain the initials of the staff member administering medication that would indicate that Resident #1 had been administered the 6 am dosage of Oxycontin 15mg (milligrams) 1 Tablet every 8 hours. However, the Individual Resident's Controlled Substance Record states that at approximately 9:40 am on 10/9/2020 and at approximately 6 am on 10/14/2020, Resident #1 was administered the prescribed order of Oxycontin 15mg 1 Tablet every 8 hours. The [MAR](#) for 11/15/2020 did not contain the initials of the staff member administering medication that would indicate that Resident #1 had been administered as "as needed" prn dosage of Oxycodone 5/325mg (milligrams). The Individual Resident's Controlled Substance Report Record has documented that at approximately 09:30 am on 11/15/2020 Resident #1 was administered 1 Tablet Oxycodone 5/325mg.

Plan of Correction: It is duly noted that the facility failed to ensure that at the time the medication is administered, the facility documents on a [MAR](#) (Medication Administration Record) all medications administered to residents, including over-the-counter medications and dietary supplements. The Resident Services Director, or designee, will re-educate medication aides on the standards of practice outlined in the current registered medication aide curriculum approved by the Virginia Board of Nursing.

Standard #: 22VAC40-73-680-I

Description: Based upon a review of records, the facility failed to ensure that the Medication Administration Record ([MAR](#)) shall include for "as needed" (prn) medications the following: symptoms for which medication was given, exact dosage given, and effectiveness.

Evidence: The Individual Resident's Controlled Substance Record document for Resident #1 indicates that on 11/15/2020 at approximately 9:30 am, Resident #1 was administered 1 Tablet of Oxycodone 5/325mg (milligrams) as needed (prn). The Medication Administration Record ([MAR](#)) for 11/15/2020 does not contain the initials of the staff member who administered the physician's order of Oxycodone 5/325 mg (milligrams) 1 Tablet every 6 hours prn for Resident #1, nor does the [MAR](#) include the symptoms for which the medication was given, the exact dosage given, and the effectiveness of the Oxycodone 5/325 mg that was administered at approximately 9:30am to Resident #1.

Plan of Correction: It is duly noted that the facility failed to ensure that the [MAR](#) (Medication Administration Record) included for "as needed" ([PRN](#)) medications the following: symptoms for which the medication was given, exact dosage given and effectiveness. The Resident Services Director, or designee, will re-educate medication aides on the standards of practice outlined in the current registered medication aide curriculum approved by the Virginia Board of Nursing.

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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