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Viva Memory Care at Chesapeake

130 Great Bridge Blvd.
Chesapeake, VA 23320
(757) 436-2109

Current Inspector: Donesia Peoples (757) 353-0430

Inspection Date: Sept. 17, 2020 , Sept. 18, 2020 , Sept. 21, 2020 and Sept. 22, 2020

Complaint Related: No

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 monitoring inspection was initiated on 09-17-2020 and concluded on 09-22-2020. Several self-reported incidents were received by the department pertaining to Administration and Administrative Services and Resident Care and Related Services. 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 self-report of non-compliance with standards or law, and violations were issued. Any violations not related to the self-reports but identified during the course of the investigation can be found on the violation notice.

Violations:

Standard #: 22VAC40-73-40-A

Description: Based on record review and interview, the licensee failed to ensure compliance with the facility's own policies and procedures.

Evidence:

1. On 08-31-2020, staff #2 emailed an incident report involving resident #1, which documented, "[On 08-28-2020 at approximately 5:05 PM] Resident allegedly [allegedly] repeatedly struck Direct Care Manger during ADL care being attempted. Another Direct Care Manager states that she saw 1st care giver [identified by staff #2 as 'staff #3?'] strike the resident on her right shoulder??"
2. Staff #1 provided a copy of the facility's ?GP12- Abuse Prevention, Intervention, Reporting, and Investigation (10-30-2019)? which documented ?Should any resident experience abuse (by staff, residents, family, or others) or when abuse is suspected, staff is required to immediately notify the Resident Care Director or designee and any other persons/agencies as described in this policy? Residents are to be free from ? physical, emotional/mental abuse? at all times? If such incidents occur or are discovered after normal working hours, the Manager on Duty is notified? Resident and staff are to be protected during incident investigations by ensuring accused employees are removed from resident contact immediately and suspended pending investigation??
3. Staff #1 provided signed and typed statements from staff #2, #3, #4 & #5 regarding the aforementioned incident involving resident #1:
 - A. Staff #2's statement dated 09-02-2020 documented ?On 8/31/2020? staff #1 informed me that staff #4 had called her early that morning stating that she thinks she may have witnessed abuse to a resident at the hand of her co-worker? I called staff #4 and she explained that she saw staff #3 hit resident #1 in her right upper arm/shoulder area ...?
 - B. Staff #4's statement documented ?On 08/28/2020 at approximately 5:04 pm? As I looked up, I saw staff #3 struck her [resident #1] in her right arm/shoulder area? The resident? did say to me, ?Don?t let her touch me! How could you let her do this to me??? After I went home for the weekend, I couldn?t get the situation off of my mind? So, on Monday morning I called staff #1 and told her what happened.?
 - C. Staff #3's statement documented ?On 08/28/2020? We started changing her and she [resident #1] punched me in my eye. In a reflex, I hit her arm??
 - D. Staff #5's statement documented ?On Friday evening staff #3 came up to me and told me that resident #1 had punched her in her eye? She [staff #3] never mentioned that she had struck resident.?
4. Staff #1 provided a copy of staff #3's ?Timecard Editor? [timesheet] that documented staff #3 worked from 2:52 PM until 11:02 PM on 08-28-2020. Staff #3 was not removed from resident contact immediately after the incident involving resident #1 that occurred on 08-28-2020 at approximately 5:05 PM; per the facility's ?GP12-Abuse Prevention,

Intervention, Reporting, and Investigation (10-30-2019)? policy.

5. Staff #1 acknowledged, staff did not follow the facility's policy labeled "GP12-Abuse Prevention, Intervention, Reporting, and Investigation (10-30-2019)" with regard to the aforementioned incident.

Plan of Correction:

1. Staff #4 was educated on our reporting policies and being a mandated reporter. Completed 09/02/2020.
2. Staff # 5 was involved in a different self-report. Staff # 5 was involved in violation :22VAC40-73-(3)-130-A
3. Executive Director, Business Office Manager and/or designee to assign the following Relias training to all staff:
 - a. Effective Communication
 - b. Preventing, recognizing, and reporting abuse
 - c. Handling Aggressive Behaviors
 - d. Dementia Care: Preventing catastrophic reactions
4. Staff # 3 was immediately suspended pending investigation. Completed 8/31/2020

Standard #: 22VAC40-73-130-A

Description: Based on record review and interview, the facility failed to ensure staff who are mandated reporters under "63.2-1606 of the Code of Virginia report suspected abuse of residents in accordance with that section.

Evidence:

1. On 09-17-2020, staff #2 emailed two incident reports which documented:
 - A. "On 09/17/2020 Direct Care Manager (staff #5) reported that she heard Direct Care Manager (staff #6) speaking loudly to resident [resident #3] in a disrespectful manner and felt that it was verbal abuse." The documented date of the incident was "09/15/20."
 - B. "On 09/17/2020 Direct Care Manger (staff #5) reported that she heard Direct Care Manager (staff #6) speaking loudly to resident [resident #4] in a disrespectful manner and felt that it was verbal abuse." The documented date of the incident was "09/15/20."
2. Staff #1 acknowledged staff #5 did not report the aforementioned suspected verbal abuse involving resident #3 and resident #4 after the incident's occurred.

Plan of Correction:

1. Staff #5 was educated on our reporting policies and being a mandated reporter. Completed 9/18/20
2. Executive Director, Business Office Manager and/or designee to assign the following Relias training to all staff:
 - a. Effective Communication
 - b. Preventing, recognizing, and reporting abuse
 - c. Handling Aggressive Behaviors
 - d. Dementia Care: Preventing catastrophic reactions
3. Staff # 6 was immediately suspended pending investigation. Investigation proved not valid; employee returned to work. Completed 9/17/2020

Standard #: 22VAC40-73-650-F

Description: Based on record review and interview, the facility failed to ensure whenever a resident is admitted to a hospital for treatment of any condition, the facility should obtain new orders for all medications and treatments prior to or at the time of the resident's return to the facility.

Evidence:

1. On 08-20-2020, staff #2 emailed an incident report involving resident #2 which documented, "[On 08-14-2020 at approximately 6:30 PM] Resident returned to community during the evening shift with no discharge summary. The only paperwork the resident had upon return was the unfilled COVID form, med list, hospital transfer form, and face sheet sent by [hospital]?"
2. Staff #1 provided a copy of resident #2's hospital "After Visit Summary" dated 08-14-2020, which documented the resident, had a diagnosis of "Acute deep vein thrombosis (DVT) of femoral vein of right lower extremity" and started on "Apixaban (Eliquis) 5mg. Take 1 tab by mouth two (2) times a day. 10mg BID daily for first 7 days. 5mg BID until stopped by primary care doctor..."
3. Resident #2's August 2020 Medication Administration Record (MAR) documented Eliquis was first administered by facility staff on 08-19-2020. The MAR did not document that facility staff administered Eliquis to the resident on 08-15-2020 through 08-18-2020.
4. Staff #1 provided a copy of resident #2's "Notes" which documented:
 - A. "08/18/2020 3:58 PM- Late Entry for 8/17/2020 11:25 AM: RCD called [hospital] medical records to fax over discharge orders as resident did not have paperwork at time of coming back to community?"
 - B. "08/18/2020 4:02 PM- " received discharge summary via fax at 3:26 PM. Upon review of d/c [discharge] summary, it was discovered that resident had an order to start Eloquis [Eliquis]?"
5. Staff #2 stated resident #2 did not receive the Eliquis 5mg for "3 days" after returning from the hospital on 08-14-2020 however, the resident did not receive the medication for 4 days (8-15-20, 8-16-20, 08-17-20 & 08-18-20).
6. Staff #1 acknowledged, "the facility did not obtain the new Eliquis order for resident #2's prior to or at the time resident #2 returned to the facility on 08-14-2020."

Plan of Correction:

1. Resident Care Director, Assistant Resident Care Director and/or designee will ensure upon resident return to speak with medical transport about retrieving discharge paperwork prior to leaving community. Ongoing
2. Resident Care Director, Assistant Resident Care Director and/or designee to notify Emergency Room/ Hospital within 24 hours of resident return if discharge paperwork not received upon residents' return to community. Ongoing
3. Resident Care Director, Assistant Resident Care Director and/or designee will review Yardi (medication administration system) daily for new orders, to ensure all medications are started within 24 hours. Ongoing

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.

