Search for an Assisted Living Facility

SHARE

|Return to Search Results | New Search |

Dominion Village at Poquoson
531 Wythe Creek Road
Poquoson, VA 23662
(757) 868-0335

Current Inspector: Alyshia E Walker (757) 670-0504

Inspection Date: May 6, 2021 , May 7, 2021 and May 17, 2021

Complaint Related: No

Areas Reviewed:

22VAC40-73 PERSONNEL
22VAC40-73 STAFFING AND SUPERVISION
22VAC40-73 ADMISSION, RETENTION, AND DISCHARGE OF RESIDENTS
22VAC40-73 RESIDENT CARE AND RELATED SERVICES
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 monitoring inspection was initiated on 5-6-21 and concluded on date 5-17--21. The administrator was contacted by telephone to initiate the inspection. The administrator reported that the current census was thirty-two. The inspector emailed the administrator a list of items required to complete the inspection. The inspector reviewed three staff records, three resident records, staff schedule, health and fire inspection, fire drills and health care oversight documents, sworn disclosure and criminal record history for new hires since last inspection, nutrition report and pharmacy report.
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.

Violations:

Standard #:	22VAC40-73-250-D
Description:	Based on record review and staff interview, the facility failed to ensure the risk assessment for staff was no older than 30 days. Evidence: 1. On 5-7-21, staff #6?s risk assessment submitted was dated 11-9-20. Staff?s date of hire was documented as 12-10-20 and the first day of employment was 12-15-20. 2. On 5-17-21, staff #1 acknowledged staff?s TB was greater than 30 days.
Plan of Correction:	Steps to correct the noncompliance with the standard Staff #6 had an updated TB risk assessment completed on 5/24/2021 TB risk assessment will be repeated if employees start day is delayed greater than 30 days Measures to prevent the noncompliance from occurring again BOM will audit team members hired in the last 90 days employee files to ensure that the TB risk assessment was completed within 30 days of hire. Business Office Manager will notify ED and DRC if employee start date exceeds 30 days Person(s) responsible for implementation of each step and/or monitoring preventative measures Business Office Manager Executive Director Director of Resident Care

---

Standard #:	22VAC40-73-450-C
Description:	Based on record review and staff interview, the facility failed to ensure the individualized service plan (ISP) included all assessed needs for two of three residents. Evidence:

	1. On 5-7-21, resident #1?s uniformed assessment instrument (UAI) dated 3-17-21 documented bladder assessed as independent/ no assistance needed. The individualized service plan (ISP) dated 4-7-21 documented resident incontinent less than weekly and use of protective undergarments used and incontinent care provided. Mobility assessed as mechanical help/human help (Supervision). The ISP did not include mechanical help assessed. Behavior was assessed as appropriate on the UAI but the ISP on 4-23-21 documented resident wandered weekly or more. 2. Resident #3?s physical examination dated 7-27-20 documented resident is legally blind. This information is not documented on the 4-30-21 ISP. 3. On 5-17-21, staff #1and #2 acknowledged all of resident #1 and #3?s assessed needs were not included on the ISP.
Plan of Correction:	Steps to correct the noncompliance with the standard Resident #1?s UAI updated to show resident incontinent less than weekly, needs help with toileting. And behavior pattern updated to show that resident wandered weekly or more Resident 1?s ISP will be updated to mobility with supervision and walker. Resident #3?s ISP will be updated to include resident is legally blind Measures to prevent the noncompliance from occurring again ED will re-educate DRC to UAI manual to ensure all resident assessed needs are documented on the UAI and ISP ED will review UAIs and ISPs weekly for 3 months to ensure all needs assessed and documented on UAI and ISP. Person(s) responsible for implementation of each step and/or monitoring preventative measures Executive Director Director of Resident Care

---

Standard #:	22VAC40-73-650-B
Description:	Based on record review and staff interview, the facility failed to ensure the physician or other prescriber?s orders, both written and oral, for administration of all prescription and over-the-counter medications?shall identify the diagnosis, condition, or specific indications for administering each drug. Evidence: 1 On 5-7-21, resident #3?s Lisinopril documented on the physician?s order dated 4-30-21, did not include the diagnosis, condition, or specific indications for the medication. 2. On 5-17-21, staff #1 acknowledged, resident #3?s physician?s order for Lisinopril did not include a diagnosis, condition, or specific indications for the medication.
Plan of Correction:	Steps to correct the noncompliance with the standard Res #3 had the diagnosis or indication for use for Lisinopril clarified with the physician. The DRC/Designee will complete a 100% audit of all ordered medications to ensure diagnosis or indication for use is present Measures to prevent the noncompliance from occurring again Current LPNs and CMAs will be reeducated to the medication management plan, specifically on obtaining a diagnosis or indication for use for each medication when order given The DRC/designee will audit new physician orders 3 times a week for 4 weeks than weekly for 8 weeks to ensure each medication order has a diagnosis or indication for use. Person(s) responsible for implementation of each step and/or monitoring preventative measures Executive Director Director of Resident Care

---

Standard #:	22VAC40-73-680-K
Description:	Based on record review and staff interview, the facility failed to ensure the physicians or other prescriber?s order for use of PRN medications included the exact dosage for a medication administered by the medication aides. Evidence: 1. On 5-7-21, resident #1?s physician?s order dated 5-5-21 prescribed Miralax as needed (PRN). The order documented ? 17 gm mixed with liquid of choice?? The April 2021 medication administration record (MAR) documented, ?give 17 g of powder mixed with 4 to 8 oz. of water?. 2. On 5-17-21, staff #1 acknowledged the PRN for Miralax did not include the exact dosage.
Plan of Correction:	Steps to correct the noncompliance with the standard Res. #1?s order for Miralax was clarified with the physician on 5/25/2021 to show the specific amount of fluid to administered DRC/designee will review all current residents with orders for Miralax to ensure that the order indicates the specific amount of fluid to be administered Measures to prevent the noncompliance from occurring again Current LPNs and CMAs will be reeducated to the medication management plan, specifically to the requirements for a complete order and to clarify and incomplete orders to inform physician?s that ranges are not permitted. The DRC/designee will audit new physician orders 3 times a week for 4 weeks than weekly for 8 weeks to ensure each medication order is complete. Person(s) responsible for implementation of each step and/or monitoring preventative measures Executive Director Director of Resident Care

---

Standard #:	22VAC40-90-40-B

Description:	Based on documents reviewed and staff interview, the facility failed to ensure the criminal history record report shall be obtained on or prior to the 30th day employment for each employee. Evidence: 1. On 5-7-21, staff #6?s record did not document a criminal history record report from the Virginia Department of State Police, Central Criminal Records Exchange. Staff #6?s date of hire was documented as 12-10-20 and first day of employment was 12-15-20. 2. On 5-17-21, staff #1 and #3 acknowledged the facility did not obtain on or prior to the 30th day of employment a criminal history record for staff #6 from the Virginia Department of State Police prior to the 30th day of employment.
Plan of Correction:	Steps to correct the noncompliance with the standard Staff #6?s VA State Police Background check was obtained on 5/25/2021 Business Office Manager will audit current employee files to ensure facility in compliance with standards. Measures to prevent the noncompliance from occurring again ED/designee will re-educate the Business Office Manager to 22VAC40?90-(BC3)-40-B obtaining a VA State Police Background check on or prior to the 30th day of employment Facility will delay employees start date until background check secured from Virginia Department of State Police. ED/Designee will audit all new hire paperwork weekly for 4 weeks than 2 times a month for 2 months to ensure a VA State Police Background Check was completed on or prior to the 3oth day of employment Person(s) responsible for implementation of each step and/or monitoring preventative measures ED/ Business Office Manager