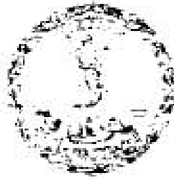


COMMONWEALTH *of* VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

March 29, 2001

CERTIFIED MAIL

Dr. Nazir Chaudhary, President
Forest Hill Manor
7806 Forest Hill Avenue
Richmond, Virginia 23225

Re: Revocation of License
Forest Hill Manor
7806 Forest Hill Avenue
Richmond, Virginia 23225

Dear Dr. Chaudhary:

This letter is to inform you that, based on findings by staff of the Division of Licensing Programs, Department of Social Services, it has been determined that you are in violation of the Virginia requirements for operation of a licensed assisted living facility as detailed hereafter. Therefore, pursuant to the authority vested in the Department under the *Code of Virginia*, Title 63.1, Section 63.1-179.1, you are hereby notified of the Department's decision to revoke your license to operate an assisted living facility.

You have the right to appeal this decision pursuant to the Administrative Process Act, *Code of Virginia*, Section 9-6.14:1 et seq. If you decide to exercise that right, you may the initiate this process by requesting an informal conference. Your request for an informal conference must be received within fifteen (15) days of your signature on the return receipt for this letter.

Theater Row Building • 730 East Broad Street • Richmond, Virginia 23219-1849
http://www.dss.state.va.us • 804-692-1900 • TDD 800-828-1120

If you should choose to appeal this decision, your request must be made in writing to the following person:

Ms. Beverly Kirby
Hearings Coordinator
Division of Licensing Programs
Virginia Department of Social Services
730 East Broad Street
Richmond, Virginia 23219-1849
Telephone: (804) 692-1760

Should you decide to file a request for an informal conference, you will be notified by the Department of the time, place and date of the conference. If you fail to request for the conference within the time period allowed, this letter will constitute the Department's final decision. The decision will take effect thirty (30) days after the receipt of this letter.

The matters of fact and law, which form the basis for the decision to revoke your license to operate Forest Hill Manor, are as follows:

Pursuant to the history of repeated violations found on renewal studies, monitoring inspections, and complaint investigations documented by a licensing inspector of the Division of Licensing Programs of Forest Hill Manor, located at 7806 Forest Hill Avenue, Richmond, Virginia 23225, from August 14, 2000 through January 23, 2001, it has been determined that you failed to meet the requirements of the *Code of Virginia*, Chapter 9, Title 63.1-174.B, and the following *Standards and Regulations for Licensed Adult Care Residences.*

1. **STANDARD:**

The licensee shall ensure compliance with all regulations for licensed adult care residences and terms of the license issued by the department; with other relevant federal, state or local laws and regulations; and with the facility's own policies. (Part II, Personnel and Staffing Requirements, 50. A)

STANDARD:

An adult care residence shall comply with the Virginia Statewide Fire Prevention Code as determined by at least an annual inspection by the appropriate fire prevention official.

An adult care residence shall comply with any fire ordinance. (Part V, Building and Grounds, 560.A & B)

VIOLATION:

During an inspection by the Fire Marshal and building inspectors on January 11, 2001, violations were cited in reference to the Virginia Statewide Fire Prevention Code. As a result of the inspection, a fire watch was ordered by the Fire Marshal due to finding a defective fire detection and suppression system. Specifically, two individuals were required to walk through the buildings on a continuous cycle, checking each room and space for any sign of smoke. The Fire Marshal required that this fire watch be carried out 24 hours per day, 7 days per week until the fire detection system was installed and approved. A log was to be initialed by the staff every one-half hour indicating the date, time of day and conditions found through the building. During a monitoring inspection on January 23, 2001, there was no documentation that the fire watch walk through was done from 7:00 a.m. to 8:45 a.m. in the one-story and two-story buildings.

2. **STANDARD:**

An adult care residence shall have a fire plan approved by the appropriate fire prevention official. The plan shall consist of the following:

1. Written procedures to be followed in the event of a fire. The local fire department or fire prevention bureau shall be consulted in preparing such a plan, if possible; (Part V, Buildings and Grounds, 570.A.1)

VIOLATION:

During the monitoring inspection conducted on January 11, 2001, the inspection revealed violations of the Virginia Statewide Fire Prevention Code. There was no approved fire plan by fire officials for the facility. The Fire Marshal mandated that there be in effect, and available to all supervisory personnel, written copies of a plan of protection for all persons in the event of a fire. The plan was to include procedures to ensure the safety of all residents and staff, to show evacuation routes and areas of refuge for residents and staff to gather. This facility could not provide a copy of this plan for the review and approval by the fire prevention official.

3. STANDARD:

No resident shall be admitted or retained for whom the facility cannot provide or secure appropriate care, or who requires a level of service or type of service for which the facility is not licensed or which the facility does not provide, or if the facility does not have, or if the facility does not have the staff appropriate in numbers and with appropriate skill to provide such services.

Adult care residences shall not admit an individual before a determination has been made that the facility can meet the needs of the resident. The facility shall make the determination based upon:

1. The completed UAI;
2. The physical examination report;
3. An interview between the administrator or a designee responsible for admission and retention decisions, the resident and his personal representative, if any. (Part III, Admission, Retention and Discharge of Residents, 150.A. & B.1, 2 & 3)

VIOLATION:

During a complaint investigation conducted on November 15, 2000, it was determined that on November 13, 2000, the facility admitted resident #1 inappropriately. He was admitted without the necessary documentation for admission. On November 15, 2000, resident #1, who suffers from dementia, was found in a nearby apartment complex and was returned to the facility by police.

It must be noted that this resident had been a resident of a nursing home prior to hospitalization. During the investigation, it was determined that this resident was admitted to the facility from a hospital without completing the required admission process and documentation.

4. **STANDARD:**

Heat shall be supplied from a central heating plant or by an approved electrical heating system.

Provided their installation or operation has been approved by the state or local fire authorities, space heaters, such as but not limited to, wood burning stoves, coal burning stoves, and oil heaters, or portable heating units either vented or unvented, may be used only to provide or supplement heat in the event of a power failure or similar emergency. These appliances may be used in accordance with the manufacturer's instructions.

When outside temperatures are below 65 F, a temperature of at least 72 shall be maintained in all areas used by residents during hours when residents are normally awake. During night hours, when residents are asleep, a temperature of at least 68 F shall be maintained. This standard applies unless mandated by federal or state authorities. (Part V, Buildings and Grounds, 510.C.1, 2 & 3)

VIOLATION:

According to a copy of an official inspection report provided to the licensing office by Mr. Cleavester Ferrell, building inspector for the City of Richmond, on January 11, 2001, the inspection found no permanent heat in rooms #2, #10, #13, #16, #17, #21, #23, and #24 in the one-story building. Also, portable electric heaters were being used in other rooms.

During a monitoring inspection conducted on December 21, 2000, the heating system was totally inoperable in the two-story building. Space heaters were approved for use for one week, beginning December 11, 2000 and ending December 18, 2000. The licensing inspector found these heaters still being used on December 21, 2000. All residents were observed sleeping in clothes. Residents reported to the inspector that they were cold.

During a complaint investigation conducted on December 12, 2000, portable electric heaters were being used in rooms #13, #16, #19, and #24 in the one-story building. There was no heat in rooms #17, #21, and #23. These rooms were visited by the licensing inspector and were found to be cold. Residents also stated to the inspector that the rooms were cold.

5. **STANDARD:**

The facility shall document all medications administered to residents, including over-the counter medications. This documentation shall include:

8. Date and time given and initials of staff administering the medication;

10. Any medication errors or omissions;

12. The name and initials of all staff administering medications (Part IV, Resident Accommodates, Care and Related Services, 400.F.8, 10 & 12)

VIOLATION:

During a monitoring inspection conducted on October 24, 2000, the medication administration records (MAR) for residents #1 and #2 failed to indicate whether or not medications were given and who administered the medications for the dates of October 2, 2000 and October 18, 2000.

6. **STANDARD:**

When any portion of an adult care residence is subject to inspection by the State Department of Health, the residence shall be in compliance with those regulations, as evidenced by a report from the State Department of Health. (Part IV, Resident Accommodations, Care and Related Services, 330.A)

VIOLATION:

Violations of health standards were noted on the last health inspection report in September 29, 2000, by the State Department of Health. During the monitoring inspection conducted on October 24, 2000, the inspector found that the violations cited by health inspectors on September 29, 2000 had not been corrected. Some of these violations were absence of thermometers in refrigerators, dirty can openers, no hand towels at sink, and spillage of garbage and cans in the parking lot.

7. **STANDARD:**

The interior and exterior of all buildings shall be maintained and in good repair.

The interior and exterior of all buildings shall be kept clean and free of rubbish.

All furnishings and equipment, including sinks, toilets, bathtubs, and showers, shall be kept clean and in good repair.

Each room shall have walls, ceiling, and floors or carpeting that may be cleaned satisfactorily. (Part V, Buildings and Grounds, 500.A, B, F & G)

VIOLATION:

According to a copy of an official inspection report provided to the licensing office by Mr. Cleavester Ferrell, on January 11, 2001, the inspection found the building to be "unsafe, unfit for habitation, and hazardous to life." The following building code violations relating to this standard were found in the two-story building: trash and flammable/combustible rubbish being stored in basement, an open sewer condition in two locations in basement, and a floor in state of collapse in a bathroom. The licensing inspector was present during Mr. Ferrell's inspection and also observed these violations.

During a monitoring inspection conducted in the one-story building on October 24, 2000, the following problems were found: the rug at the front entrance was unraveling and dirty. Pieces of paper and cigarette butts were observed along the front entrance of the facility. A rusted doorframe leading into the bathroom of room # 20 was found (a repeated violation). A broken ceiling light in bathroom of room #13 was found (a repeated violation). A broken window blind was observed in room #16. There was a dirty wall area at the corner of the west hall. Dirty bathroom walls were seen in room #20.

During the monitoring inspection conducted in the two-story building on October 24, 2000, the following problems were found: floor tiles were missing in the first floor bathroom, near the office; walls were dirty in a bathroom on the 1st floor, near the office, and a sign was posted outside of the bathroom stating that it was out of order due to a broken pipe; stained ceiling panels were observed in room #2.

8. STANDARD:

All areas shall be well lighted for safety and comfort of the residents according to the nature of the activities.

Hallways, stairwells, foyers, doorways, and exits utilized by residents shall be kept well lighted at all times residents are present in the building.

If used, fluorescent lights shall be replaced if they flicker or make noise. (Part V, Buildings and Grounds, 520.B, D, & G)

VIOLATION:

During the monitoring inspection conducted on October 24, 2000, in the one-story building, there was a dim bathroom light in room #22, and the light to the right of the stairwell leading to the two-story building was inoperable. There was an inoperable wall light at the end of the west hallway in the one-story building. Also, two flickering fluorescent lights were observed in the dining room in the one-story building.

9. **STANDARD:**

All furnishings and equipment, including sinks, toilet, bathtubs, and showers, shall be kept clean and in good repair. (Part V, Buildings and Grounds, 500. F)

VIOLATION:

During a complaint inspection on December 7, 2000, in room #21, a loud, rattling noise was coming from the heating unit, and it was the licensing inspector's opinion that it needed repairs.

10. **STANDARD:**

Glare shall be kept at a minimum in rooms used by residents. When necessary to reduce glare, coverings shall be used for windows and lights. (Part V, Buildings and Grounds, 520. F)

VIOLATION:

During the monitoring visit on December 21, 2000, room #6 in the two-story building was without lights and heat.

During the complaint inspection conducted on December 7, 2000, there was no light cover over the exposed bed light in room #1.

The overall management of this facility has continued to deteriorate despite efforts from the licensing office to assist in making needed corrections. Ten complaints were received from July 5, 2000 through August 7, 2000. Of these, five were founded. Five additional complaints were received from November 2, 2000 through January 18, 2001. Of these, three were founded.

A letter, dated September 21, 2000, was sent by the licensing inspector to inform you that if violations and complaints continue, further corrective actions would be considered.

The Code of Virginia requires the Department of Social Services to perform an investigation when it receives an application for licensure as an assisted living facility. One aspect of investigation is "the applicant's financial responsibility." (*Code of Virginia*, Title 63.1, Section 63.1-176) In addition, as part of ongoing compliance with licensing standards, all licensees of assisted living facilities are required to "give evidence of financial responsibility." (Part II, Personnel and Staffing Requirements, 50. B.1)

Dogwood Realty, Incorporated ("Dogwood Realty") currently owns and operates eleven (11) assisted living facilities. The facilities are as follows:

Forest Hill Manor (7806 Forest Hill Avenue, Richmond, Virginia 23225)
Chippendale Retirement Center (4931 Ridgedale Parkway, Richmond, Virginia 23234)
Chippendale Assisted Living (6701 Courtyard Road, Chester, Virginia 23831)
Warsaw Village (42 Mitchell Avenue, Warsaw, Virginia 22572)
Community Living Homes (12 & 14 Hartman Avenue, Onancock, Virginia 23417)
Mallory Woods (40 Hunt Club Boulevard, Hampton, Virginia 23666),
Oaktree Point Retirement Center (6115 Tidewater Drive, Norfolk, Virginia 23509)
Patriot Retirement Center (251 Patriot Lane, Williamsburg, Virginia 23185)
Commonwealth Assisted Living Center (9300 Onyx Court, Fredericksburg, Virginia 22407)
Dogwood Retirement Center (1001 Northside Drive, Fredericksburg, Virginia 222405)
Dogwood North Retirement Center (30 Kings Crest Drive, Stafford, Virginia 22554)

Pursuant to the above referenced code and regulation, an extensive review by the Department of the operations of the facilities, covering the past year, has found a pattern of wide-spread and serious violations that strongly suggest corporate level performance failures in compliance. In general, our investigations discovered serious problems surrounding inappropriate medication administration and documentation; inadequate staffing and training; poor physical care of residents; excessive delays or failures in providing personal spending funds to residents who receive an auxiliary grant; poor recordkeeping; inadequate housekeeping, food,

and personal care supplies; and neglect of the physical plant and environment at several facilities.

According to evidence already gathered, and giving consideration to information recently provided from ongoing investigations, the Department has determined that Dogwood Realty's fiscal management has significantly contributed to the problems found within the facilities. Of the eleven facilities, six were found over the past year to have significant difficulties in paying their debts (i.e., Dogwood North Retirement Center, Commonwealth Assisted Living Center, Warsaw Village, Chippendale Assisted Living, Forest Hill Manor, and Community Living Homes). Known debts have been calculated to the amount of $141,698.13. There are also numerous companies, agencies, and individuals from which an exact amount owed has not been obtained.

In addition to the above-mentioned obligations, Dogwood Realty has an outstanding debt with Suffolk Retirement Center, a facility that is now leased to another licensee. Dogwood Realty also has failed to pay two fines, amounting to a total of $1500.00, owed to the Department. According to information obtained from renewal studies and complaint investigations over the past year, Dogwood Realty has accrued outstanding bills from the following parties: Housing and Urban Development, county and town tax office, city utilities, employees and residents at various facilities, and providers of the following services: electricity, telephone, cable, waste management, pharmacy, plumbing, and newspaper. The Department's investigations also revealed that three Dogwood Realty owned and operated facilities (Patriot Retirement Center, Oaktree Point Retirement Center, and Mallory Woods) have submitted renewal applications, but the processing of the applications was delayed due to late or unpaid application fees.

The Department's investigations found a diverse range of violations in other facilities that not only suggested a link to the financial difficulties of Dogwood Realty, but also revealed a systemic problem with appropriate management oversight of daily operations. These facilities were Chippendale Retirement Center, Mallory Woods, Oaktree Point Retirement Center, Patriot Retirement Center, and Dogwood Retirement Center. The violations found related to the general problems referenced above, e.g., staffing shortages, medication errors, poor resident care (as evidenced by clothing, hygiene, and food supplies), poor maintenance of the physical plant and environment. Currently, these facilities, along with those referenced with having serious financial difficulties, are being recommended for adverse enforcement actions that range from the imposition of a civil penalty to the revocation of license.

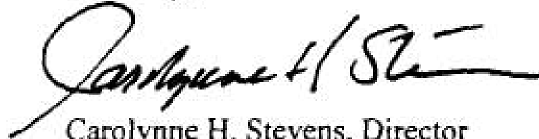
Based on the findings from multiple monitoring inspections and complaint investigations. the Department has determined that Dogwood Realty is not demonstrating proper management of its facilities. The unresolved and pervasive problems in the facilities place residents at risk of suffering serious to extreme harm. It is, therefore, the decision of the Department to revoke your license to operate Forest Hill Manor.

In accordance with Standard 3.7.G.4 of the General Procedures and Information for Licensure, you are directed to post the enclosed public notice, along with a copy of this letter, in a prominent place at each public entrance to your facility.

The right to amend and expand the grounds for revocation set forth above is expressly reserved.

Operation without a license issued by the Department of Social Services and required by law can result in a fine or imprisonment as well as action to enjoin the illegal operation.

Sincerely,



Carolynne H. Stevens, Director
Division of Licensing Programs

CHS/are

c: Siran Faulders, Senior Assistant Attorney General
Anne Chesney, Assistant Attorney General
Operations Manager, Division of Licensing Programs
DeNyce Bonaparte, Licensing Administrator, Central Regional Office
Senora B. Bennett, Licensing Inspector, Central Regional Office