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Bickford of Suffolk

6860 Harbour View Boulevard
Suffolk, VA 23435
(757) 215-0058

Current Inspector: Darunda Flint (757) 807-9731

Inspection Date: July 8, 2021 , July 9, 2021 , July 20, 2021 and July 21, 2021

Complaint Related: No

Areas Reviewed:

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 BUILDING AND GROUNDS
22VAC40-73 EMERGENCY PREPAREDNESS
22VAC40-73 ADDITIONAL REQUIREMENTS FOR FACILITIES THAT CARE FOR ADULTS WITH SERIOUS COGNITIVE IMPAIRMENTS

Article 1
Subjectivity
22VAC40-90 The Criminal History Record Report

Comments:

A renewal inspection was initiated on 07-08-2021 and concluded on 07-21-2021. The Administrator was contacted by telephone to initiate the inspection. The Administrator reported that the current census was 47. The inspector emailed the Administrator a list of items required to complete the remote documentation review portion of the inspection. The inspector reviewed 3 resident records, 3 staff records, activities calendar, menus, staff schedules, fire and health inspection reports, fire drills, healthcare oversight, and dietary oversight submitted by the facility to ensure documentation was complete. The inspector conducted the on-site portion of the inspection on 07-20-2021. An exit interview was conducted with the Administrator on the date of inspection, 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-compliances 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 on record review and interview, the facility failed to ensure the Individualized Service Plan (ISP) included a description of the residents' identified needs. Evidence: 1. Resident #2's current Uniform Assessment Instrument (UAI) dated 03-28-2021 documented the need for physical and mechanical assistance with eating and dressing. The resident also had a physician's order dated 09-24-2020 which documented, "Hospice eval and treat;" and a physician's order dated 11-04-2020 for 2 Liters of oxygen as needed daily. 2. Resident #2's current ISP dated 05-06-2021 did not include documentation of the resident's need for oxygen; the type of mechanical device needed for eating and dressing, or a description of the type of services that are provided by hospice. 3. Resident #3's current UAI dated 02-08-2021 documented the need for supervision and mechanical assistance with transferring; however, the resident's current ISP dated 02-08-2021 did not include the type of supervision needed for transferring. 4. Staff #1 and staff #2 acknowledged the aforementioned ISP's did not include a description of the residents' identified needs.
Plan of Correction:	The insufficiency will be corrected as follows: Resident #2 ISP has been updated to reflect the use of Oxygen, type of mechanical device needed for eating and dressing, and type of services provided by Hospice. Resident #3 ISP has been updated to include the type of supervision needed for transferring.

The following measures will be taken to ensure problems do not occur again:

The following measures will be taken to ensure problems do not occur again:

RN Coordinator will audit residents that are on oxygen to ensure instructions are reflected on their [ISP](#).

RN Coordinator will audit all residents that need feeding assistance [ISPs](#). [ISPs](#) are to include the type of mechanical device needed for eating and dressing, or a description of the type of services that are provided by hospice.

RN Coordinator will audit all residents that need transferring assistance [ISPs](#). [ISPs](#) are to include the type of assistance.

Persons responsible to implement and monitor corrective measure to ensure compliance:

RN Coordinator/Director

Standard #: 22VAC40-73-660-B

Description: Based on observation, record review, and interview, a resident was permitted to keep medications in their room when the Uniform Assessment Instrument ([UAI](#)) indicated that the resident was not capable of self-administering medication.

Evidence:

1. On 07-20-2021, during a tour of the facility with staff #1, the following medications were observed in residents' rooms:
A. Afrin nasal spray was located on a nightstand in resident #5 and resident #6's shared bedroom (Room #114);
B. Calmoseptine Ointment, skin Protective Ointment; and Pain Relieving Cream was located on the bathroom counter in resident #3 and resident #4's shared bathroom (Room #206).
2. Resident #3's current [UAI](#) dated 02-08-2021, resident #4's current [UAI](#) dated 02-05-2021, resident #5's current [UAI](#) dated 05-03-2021, and resident #6's current [UAI](#) dated 04-29-2021 documented medications are to be administered by professional nursing staff. The residents' [UAI](#)'s did not document that the aforementioned medications could be self-administered.
3. Staff #1 observed and acknowledged that resident #3, resident #4, resident #5, and resident #6 were not permitted to keep medications in their room for self-administration based on their current [UAI](#)'s.

[Plan of Correction](#): The insufficiency will be corrected as follows:
All OTC medications were removed from residents' apartment. Contacted resident family to notify of procedures of having OTC medications.

The following measures will be taken to ensure problems do not occur again:

RN Coordinator will perform bi-weekly room checks of all residents' room for the next 3 months. Any OTC medication will be removed and family will be contacted to follow procedures for resident to have OTC medications.
Director will send out monthly e-mail to families regarding OTC Medications.

Persons responsible to implement and monitor corrective measure to ensure compliance:

RN Coordinator/Director

Standard #: 22VAC40-73-680-D

Description: Based on record review and interview, the facility failed to ensure medications are administered in accordance with the physician's instructions, and in accordance with the standards of practice outlined in the current registered medication aide curriculum approved by the Virginia Board of Nursing.

Evidence:

1. Resident #1's signed physician's orders dated 06-01-2021 and 07-01-2021 documented, ?Lactobacillu Tab- Take one tablet by mouth twice daily for general health.?
2. Resident #1's June 2021 and July 2021 Medication Administration Record ([MAR](#)) documented staff administered one tablet of Lactobacillu once daily on 06-01-2021 through 07-07-2021, and not twice daily as ordered by the physician.
3. Resident #2's signed physician's orders dated 06-01-2021 documented, ?Acetamin 500mg- Take two tablets (1000mg) by mouth every eight hours for pain;? and ?Amlodipine 10mg- Take 1 tablet by mouth every day for HTN *Hold for SBP [Systolic Blood Pressure] <120.?
4. Resident #2's June 2021 [MAR](#) documented:
A. Staff administered Acetamin 500mg on 06-01-2021 through 06-27-2021, at 8:00 AM, 3:00 PM, and 11:00 PM; and
B. Staff administered Amlodipine 10mg on 06-18-2021 (Blood Pressure 104/60).
5. Resident #3's signed physician's orders dated 06-01-2021 documented:
A. ?Humalog Kwik Inj 100/ML ? Inject per s/s before meals and at bedtime for DMII? 201-240= 4U, 251-300=6U??
B. Eliquis 5mg and Metoprol 25mg ?every 12 hours? and Floranex ?every 8 hours;? and
C. ?Trulicity Inj 4.5/0.5 ? Inject-0.5ML (4.5MG) subcutaneously once weekly for DM2.?
6. According to the current Virginia Board of Nursing registered medication aide curriculum ?18VAC90-60-110. Standards of practice. A medication aide shall not: Administer by subcutaneous route, except for insulin medications, glucagon, or auto-injectable epinephrine.? Resident #3's June 2021 and July 2021 [MAR](#) documented:
A. Staff administered 4 units of insulin on 06-15-2021 with a blood sugar reading of 271;
B. Staff administered the following medications on 06-01-2021 through 06-30-2021: Eliquis 5mg at 9:00 AM and 8:00 PM; Floranex at 9:00 AM, 3:00 PM, and 11:00 PM; and Metoprol 25mg at 9:00 AM and 8:00 PM; and
C. Trulicity Inj 4.5/0.5 injections were administered by Registered Medication Aides (RMA) on 06-03-2021, 06-24-2021, 07-01-2021, and 07-08-2021 by staff #3, and 06-10-2021 and 06-17-2021 by staff #4.
7. Staff #3 stated the ?RMA's administer the Trulicity Injections? to resident #3.
8. Staff #1 and staff #2 acknowledged resident #1, resident #2, and resident #3's aforementioned medications were not administered as ordered by the physician.

[Plan of Correction](#): The insufficiency will be corrected as follows:

Resident's [MAR](#) have been updated to reflect current physician orders

RN/LPN staff to administer Trulicity

The following measures will be taken to ensure problems do not occur again:

RN Coordinator will perform audits on all current resident's physician orders and will ensure orders correctly reflect the [MAR](#)

RN Coordinator will reeducate with staff regarding POS and parameters and when to hold medications per physician orders

Persons responsible to implement and monitor corrective measure to ensure compliance:
Director/RN Coordinator

Standard #: 22VAC40-90-50-B

Description: Based on record review and interview, the operator of the facility failed to ensure that each criminal history record report was verified by matching the name to establish that all information pertaining to the individual cleared through the Central Criminal Records Exchange is exactly the same as another form of identification such as a driver's license.

Evidence:

1. Staff #1 provided a list of newly hired staff with dates of hire; to include staff #5 (date of hire 06-22-2021) and staff #6 (date of hire 08-06-2020), as well as a copy of their driver's licenses.
2. Staff #5's last name was entered at the first name, and first name was entered as the last name on the criminal history record report dated 06-14-2021. The name did not match what was shown on staff #5's driver's license.
3. Staff #6's middle name (as shown on the driver's license) was entered in as the last name on the criminal history record report dated 07-21-2020.
4. Staff #1 acknowledged the names on the aforementioned criminal history record reports did not match the name shown on the driver's license.

Plan of Correction: The insufficiency will be corrected as follows:
Background checks were re-submitted to match staff drivers license.

The following measures will be taken to ensure problems do not occur again:
Director will ensure all new hires background checks are to match Driver's License.

Persons responsible to implement and monitor corrective measure to ensure compliance:
Director

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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