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Bickford of Virginia Beach
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Virginia beach, VA 23456
(757) 821-0198

Current Inspector: Willie Barnes (757) 439-6815

Inspection Date: Jan. 13, 2021 , Jan. 14, 2021 , Jan. 15, 2021 , Jan. 28, 2021 and Jan. 29, 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 EMERGENCY PREPAREDNESS
22VAC40-73 ADDITIONAL REQUIREMENTS FOR FACILITIES THAT CARE FOR ADULTS WITH SERIOUS COGNITIVE IMPAIRMENTS

Article 1
Subjectivity

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 01-13-2021 and concluded on 01-29-2021. The Administrator was contacted by telephone to initiate the inspection. The Administrator reported that the current census was 57. The inspector emailed the Administrator a list of items required to complete the inspection. The inspector reviewed 4 resident records, 4 staff records, criminal background checks and sworn disclosures of newly hired staff, staff schedules, fire drills, fire and health inspection reports, dietary oversight, and healthcare oversight.

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-F
Description:	Based on record review and interview, the facility failed to ensure the Individualized Service Plan (ISP) was reviewed and updated as needed as the condition of the resident changes. Evidence: 1. Resident #3?s signed physician?s orders labeled ?Hospice IDG Comprehensive Assessment and Plan of Care Update Report? dated 11-12-2020 documented, the resident is on 2L of continuous oxygen at night, and 2L PRN [as needed] during the day. 2. Resident #3?s current ISP dated 06-15-2020 was not updated to reflect the need for oxygen, per the physician?s order dated 11-12-2020. 3. Staff #1 and staff #2 acknowledged the resident?s ISP was not updated to reflect the need for oxygen.
Plan of Correction:	*Residents #3s ISP was updated to reflect the current Provider O2 orders. *The RNC conducted a 100% audit to reconfirm all Provider orders for any Residents on O2 and updated those ISPs, if needed. *The RNC/ACC to audit all ISPs, at the time of admission, to assure that all O2 orders are reflected on the initial ISP.
Standard #:	22VAC40-73-650-B
Description:	Based on record review and interview, the facility failed to ensure physician orders, both written and oral, for administration of all prescription and over-the-counter medications, identified the diagnosis or specific indications for administering each drug. Evidence: 1. Resident #1 and resident #4?s signed physician?s orders did not include a diagnosis or specific indications for

	administering each of the following medications: A. Resident #1?s order dated 11-04-2020 for Pregabalin 150mg; order dated 09-30-2020 for Prednisone 40mg; and order dated 12-02-2020 for Lyrica200mg; and B. Resident #4?s order dated 12-02-2020 for Trulicity .75mg and Vit. D 5,000 units. 2. Staff #1 and staff #2 acknowledged resident #1 and resident #4?s physician?s orders did not include the diagnosis or specific indications for administering the aforementioned medications.
Plan of Correction:	*Resident #1 and #4 both had their Physician?s Order Sheets updated to reflect the diagnosis for each medication ordered. *The RNC/ACC conducted a 100% audit of all Physician Order Sheets to assure that all Resident medication orders also contain a diagnosis. *The Physical Examination Form, given to Providers prior to admission, was modified/highlighted to remind the Provider to include a diagnosis for each medication ordered. *All new medication orders will be reviewed by the RNC/ACC/LPN or RMA, prior to sending to the pharmacy, to assure that the orders also contain a diagnosis. *RNC/ACC to audit the Physician Order Sheets monthly to assure that all ordered medications have a diagnosis.

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. Evidence: 1. Resident #4 has three (3) separate insulin orders (1 sliding scale & 2 routine). The resident?s signed physician?s orders dated 11-25-2020 documented, ?Humalog Kwik Inj 100/ML- Inject per S/S [sliding scale] three times a day: 201-250=2U? 301-350=6U? 401-450=10U, >450 Contact NP.? The resident?s December 2020 Medication Administration Record (MAR) documented: A. 12-01-2020 at 12:00 PM, blood glucose reading was 346, 8 units of Humalog administered; B. 12-09-2020 at 5:00 PM, blood glucose reading was 158, 2 units of Humalog administered; and C. 12-23-2020 at 8:00 AM, blood glucose reading was 112, 15 units of Humalog administered. 2. In addition, resident #4?s signed physician?s orders dated 11-25-2020 documented, ?Humalog Kwik Inj 100/ML- Inject 5 units subcutaneously with dinner?? The December 2020 MAR documented Humalog 5 units with dinner not administered fourteen (14) times to include the following dates with the following reasons: A. 12-04-2020 & 12-07-2020 - ?withheld per DR/RN orders?; and B. 12-10-2020, 12-11-2020, 12-23-2020, 12-24-2020 & 12-28-2020 - ?outside order parameters?. C. Staff #3 stated ?personal nursing judgement? was used to hold the routine insulin; and did not notify the physician. 3. The resident signed physician?s order dated 12-02-2021 documented, ?Increase Humalog with breakfast to 10 units.? The December 2020 documented Humalog 10 units was not administered with breakfast on 12-08-2020. The reason: ?? outside order parameters?. 4. Staff #1 did not provide a physician?s order to hold the 5 units and/or 10 units of Humalog on the aforementioned dates. 5. Resident #1 current signed physician?s orders dated 09-02-2020 documented ?Aspercreme Pad Lido 4%- Apply to lower back every morning and remove 12 hours later. [Equiv To: Apply at 8AM and Remove at 8PM].? Resident #1?s October 2020 and December 2020 MARs documented staff applied the Aspercreme Pad 4% at 7:00 AM and removed at 9:00 PM. 6. Resident 1?s signed physician?s order dated 09-30-2020 documented ?Prednisone 40mg x6 days PO QAM.? Resident #1?s October 2020 MAR documented Prednisone 40mg was administered 10-03-2020 through 10-07-2020 (5days). 7. Staff #1 and staff #2 acknowledged resident #1 and resident #4?s aforementioned medications were not administered in accordance with the physician?s instructions.
Plan of Correction:	*RNC notified the Provider of the LPN?s/Staff #3 decision to withhold the routine insulin due to concerns of Resident #4 becoming Hypoglycemic. The Provider stated that her plan is to D/C all insulin orders for Resident #4 and continue with Trulicity only, affective 3/11/21. *RNC re-educated the LPN/Staff #3 on the need to notify the Provider anytime nursing judgement results in a decision to not follow Provider orders. *There are no other insulin dependent residents residing at Bickford of Virginia Beach, at this time. *In the future, all sliding scale insulin administration is to be double checked by the RNC/ACC/LPN or another RMA prior to administration. *The RNC/ACC will conduct weekly medication audits, utilizing QuickMar, to assure that the sliding scale insulin is being properly administered and signed off by getting a double check prior to administration.

Standard #:	22VAC40-73-680-E
Description:	Based on record review and interview, the facility failed to ensure treatments ordered by a physician or other prescriber are provided according to his instructions and documented. The documentation should be maintained in the resident's record. Evidence: 1. Resident #3?s signed physician?s orders labeled ?Hospice IDG Comprehensive Assessment and Plan of Care Update Report? dated 11-12-2020 documented, ?02- Oxygen, Reason: Dyspnea, Instructions: Continuous 2L at night, 2L PRN During Day.? 2. Staff #1 and staff #2 could not provide documentation indicating resident #3 received continuous 2L of oxygen at night in November 2020 and December 2020; nor could staff provide a discontinued order. 3. Resident #3?s ?Hospice IDG Comprehensive Assessment and Plan of Care Update Report? dated 11-12-2020 also documented ?? the staff do not always remember to place the oxygen on [resident] at night?? 4. Staff #1 and staff #3 acknowledgement the aforementioned regarding resident #3?s oxygen.
Plan of Correction:	*The ACC contacted the Provider for Resident #3 and clarified the O2 orders, reviewed those orders with Hospice and then updated the ISP accordingly. * The RNC conducted a 100% audit to reconfirm all Provider orders for any Resident on O2 and updated those ISPs, if needed. *The RNC/ACC then profiled/approved the O2 orders in QuickMar to assure that this service is being provided to Resident

*The RNC/ACC then profiled/approved the O2 orders in QuickMar to assure that this service is being provided to Resident #3, and any other Resident on O2, as ordered by the Provider.

*The RNC/ACC educated the BFMs/Staff about this change in QuickMar and the need to document that the task was completed.
*The RNC/ACC/DIR to conduct weekly medication audits, utilizing QuickMar, to assure that the care is being properly signed off on as ordered by the Provider.