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Brookdale Bristol
375 Liberty Place
Bristol, VA 24201
(276) 669-1111

Current Inspector: Rebecca Berry (276) 608-3514

Inspection Date: March 21, 2021

Complaint Related: No

Areas Reviewed:

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 03/21/2021 and concluded on 03/24/2021. A self-reported incident was received by the department regarding allegations in the areas of resident care. The Director of Nursing was contacted by telephone to conduct the investigation. The licensing inspector emailed the Director of Nursing 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-report but identified during the course of the investigation can be found on the violation notice.

Violations:

Standard #:	22VAC40-73-680-D
Description:	Based on interviews with staff and documentation review, the facility failed to ensure medications were administered in accordance with physician's or other prescribers instructions and consistent with standards of practice outlined in the current registered medication aide curriculum approved by the Virginia Board of Nursing. EVIDENCE: 1. Resident # 1 was admitted to the facility on 02/27/2014. 2. According to documentation submitted by the facility as part of a self-reported incident, resident # 1 is prescribed Carboxymethylcellulose Sod PF Solution 0.5% to instill one drop in both eyes four times a day for dry eyes. 3. On the evening of March 21, 2021 at approximately 8:30 pm, staff # 1 went into resident #1's room to administer her fourth dose of the prescribed eye drops. According to documentation and an interview with the Director of Nursing staff # 1 placed the medication on the resident's nightstand to assist the resident with personal care needs. Staff # 1 retrieved what she thought was the resident's prescribed eye drops and without paying attention instilled one drop of artificial nail glue into resident #1's left eye. Resident # 1 immediately complained of a burning sensation and staff # 1 realized she had used the artificial nail glue instead of the resident's eye drops. Staff # 1 immediately flushed resident # 1's eye and notified 911 for transport to the ER. 4. On March 22, 2021 resident # 1's eye was still glued shut. Resident # 1 was referred to an eye specialist and the appointment took place at 2 pm on this date. Resident # 1 was prescribed an antibiotic and artificial tears to be placed in resident # 1's left eye three times a day for 10 days. A protective lens was also placed in resident # 1's eye and she will continue to follow up with the eye specialist to ensure there are no long term effects.
Plan of Correction:	1. Follow-up visits with medical personnel scheduled for resident to monitor and prevent potential negative effect. 2. On 3/22/2021, Follow-up discussion was held with staff # 1 and additional information was gathered regarding the occurrence. Staff # 1 was notified of her suspension pending an investigation into the matter. 3. Based on outcome of incident investigation, decision was made terminate staff members employment effective 03/24/2021. 4. Retraining will be conducted for licensed and registered staff completed by the HWD/designee regarding the community's mediation administration guidelines no later than 04/03/2021. 5. Random audits/monitoring will be conducted by the Health and Wellness Director/designee for three months to verify compliance with the community's medication administration guidelines. [sic]

information is complete. It should not be used as the sole source in evaluating and/or selecting a facility.