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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on February 5 - 7, 2020.	D 000		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure foods being stored, prepared, and served to residents were protected from contamination related to exposed and expired food items and opened and undated food containers. The findings are: Observation of the stove in the kitchen on 02/05/20 at 2:21pm revealed: -There was a sauce pan on the warming shelf above the stove containing melted butter that was uncovered. -There was a sign the above saucepan that indicated the liquid butter was used for dinner rolls or biscuits. Observation of a kitchen cabinet beside the refrigerator on 02/05/20 at 2:37pm revealed: -There was a plastic container of cereal that was not dated. -There was a bowl of dried cereal covered in plastic wrap that was not dated.	D 283		

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D 283	Continued From page 1 -There was a plastic container with small holes on the lid that contained a white powdered substance that was not labeled or dated. -There was a 12-ounce clear squeeze bottle containing a brown liquid that was not labeled or dated. Observation of the refrigerator in the kitchen on 02/05/20 at 2:50pm revealed: -There was a 5-pound container of sour cream that had expired with "best if used by 01/28/2020" imprinted on the container. -On the top shelf, there was a ready to use whipped topping pastry bag stored in a plastic bag that was not dated. Observation of the freezer on 02/05/20 at 2:57pm revealed there was an unsecured clear bag containing cookies that was not dated. Observation of the kitchen pantry on 02/05/20 at 2:59pm revealed: -There was a box of cornbread mix that contained an opened and exposed bag of cornbread mix. -There was a clear bag that contained dried pasta that was not dated. -There were 3 decaying onions in a clear container. Interview with the Kitchen Manager (KM) on 02/05/20 at 3:00pm revealed: -She knew that all food should be labeled with the name and date of when an item was opened. -She did not know that all food was not labeled and stored correctly in the kitchen cabinet, pantry, refrigerators and freezer. -She and dietary staff were responsible for discarding expired food items. Interview with a Dietary Aide on 02/06/20 at	D 283		

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D 283	Continued From page 2 4:43pm revealed: -She knew that all food should be labeled with the name and date when opened. -She knew that she was responsible for discarding any expired foods during her shift. Interview with the Executive Director on 02/07/20 at 3:30pm revealed: -The KM was responsible for overseeing the dietary department. -The KM was responsible for ensuring that the dietary staff were trained on proper food storage. -The dietary staff were expected to maintain food storage with labels and dates on all opened items. -He expected all items in the pantry, refrigerator and freezer to be labeled with the name of the item and the date it was opened. -He expected expired items to be discarded.	D 283		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a prescribing practitioner to 2 of 5 residents (#9, #10) observed during the morning medication pass on	D 358		

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02/06/2020 who were prescribed ear drops (#9) and eye drops (#10).

The findings are:

The medication error rate was 11% as evidenced by the observation of 3 errors out of 27 opportunities during the 4:00pm medication pass on 02/05/2020 and the 8:00am medication pass on 02/06/2020.

1. Review of Resident #10's current FL-2 dated 06/28/2019 revealed:
-Diagnoses included anemia, hyperlipidemia, major depression, malnourished, muscle weakness of lower extremity, noncompliance with medications, Parkinson's disease, stage 3 chronic kidney disease, urinary frequency, and vitamin D deficiency.
-There was an order for artificial tears (used to treat dry eyes) instill one drop in each eye every twelve hours for dry eyes.

Review of a subsequent physician order dated 12/02/2019 revealed the order for artificial tears instill one drop in each eye every twelve hours was continued.

Observation of the 8:00am medication pass on 02/06/2020 at 7:50am-7:55am revealed:
-The medication aide (MA) prepared and administered one tablet to Resident #10 in her room.
-The MA did not administer any eye drops to Resident #10.

Interview with the MA on 02/06/2020 at 7:50am revealed Resident #10's artificial tear drops must not have been delivered to the facility "last night" (02/05/2020).

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D 358	Continued From page 4 Interview with Resident #10 on 02/07/2020 at 9:10am revealed: -She had not been administered any eye drops the morning of 02/07/2020. -She was administered her carb/levo (used to treat Parkinson's disease) tablet this morning (02/07/2020). -Her eyes felt like sand was in them. -Her eyes did not feel right. -She did not see good. -"One of the girls came and got them last night"(02/06/2020). -She was not sure, but thought she used the eye drops the morning of 02/06/2020. -She knew how to put the eye drops in her eyes because she put them in before being admitted to the facility. Observation of Resident #10 on 02/07/2020 at 9:16am revealed the resident activated the call system from her room and stated she needed her eye drops when the call system was answered. Observation of Resident #10 on 02/07/2020 at 9:22am revealed the MA arrived at the residents' room and administered Refresh eye drops in each eye. Review of Resident #10's electronic medication administration record (eMAR) for February 2020 revealed: -There was an entry for artificial tear instill one application in both eyes scheduled for administration at 8:00am and 8:00pm daily. -There was documentation for administration of the artificial tears daily at 8:00am and 8:00pm from 02/01/2020 through 02/05/2020, 8:00pm on 02/06/2020, and 8:00am on 02/07/2020. -There was a chart code of 09 (other/see nurse	D 358		

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notes) documented for the 8:00am scheduled dose for 02/06/2020.

Interview with a MA on 02/06/2020 from 4:23pm revealed:
-Resident #10 kept her artificial tears in her room.
-She administered the artificial tears to Resident #10 when she worked as the MA.
-She did not see anything in the eMAR for Resident #10 to self-administer the artificial tear drops.
-She had seen the artificial tear drops in Resident #10's room.
-She did not see any artificial tear drops on the medication cart for Resident #10.
-The eye drops were usually kept in the top drawer of the medication cart.

Interview with the same MA on 02/06/2020 at 4:58pm revealed:
-The MA presented an unlabeled bottle of refresh eye drops and stated the eye drops were Resident #10's eye drops.
-The Resident Care Coordinator (RCC) told her the eye drops belonged to Resident #10 and had been removed from the resident's room because the resident was not supposed to have them.
-She would have to find the labeled box for the eye drops but would put them in a plastic bag and label the bag.

Telephone interview with a Pharmacist from the provider pharmacy on 02/06/2020 at 6:10pm revealed:
-There was a current order for artificial tears one drop each eye every twelve hours for Resident #10.
-The artificial eye drops had been processed as a refill on 02/06/2020.
-The only dispense date from the pharmacy for

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the artificial tears was for 02/06/2020.
-When the artificial tears were originally put on file at the pharmacy on 07/18/2019 a note was written to "send no medication now - getting medication clarified".
-He did not know if the pharmacy was ever told to dispense the artificial tears.
-If there were missed doses of administering the eye drops the resident may have dry eyes.

Interview with a MA on 02/07/2020 at 9:47am revealed:
-She last administered eye drops to Resident #10 on 02/05/2020.
-She put the eye drops back in the box labeled for the resident after administering them, and placed the box in the top drawer of the medication cart.
-The resident's eye drops were kept in the top drawer of the medication cart and labeled with Resident #10's name.
-She ordered Resident #10's eye drops from the pharmacy on 02/05/2020 but the eye drops had not been delivered to the facility yet.
-Reordered medications were delivered to the facility the same day during the 11:00pm-7:00am shift, unless the medication was out of stock at the pharmacy.
-If a resident did not have a medication scheduled for administration, the MA was supposed to call the pharmacy to find out where the medication was.
-If the pharmacy needed a refill prescription, the MA was supposed to contact the physician.
-The pharmacy also would contact the physician for refill medication orders.

Interview with the Health and Wellness Director (HWD) on 02/07/2020 at 9:55am revealed:
-Resident #10's refresh eye drops had been found in the residents' room.

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-When a physician order was needed for medication refills, the MAs were responsible to contact the physician for the order.
-The pharmacy would call the physician for refill orders so the pharmacy could expedite the refill.

Telephone interview on 02/07/2020 at 12:56pm with the nurse for the Otorhinolaryngologist (a specialized doctor who treats disorders of the ears, nose, and throat and abbreviated ENT) prescribing the eye drops for Resident #10 revealed:
-The ENT did not want Resident #10 to miss having the artificial tear drops administered.
-Resident #10 was supposed to be administered one drop of the artificial eye drops to each eye two times a day.
-The resident had "dry eyes really bad".
-The resident would come to the doctor with complaints of burning eyes.

2. Review of Resident #9's current FL-2 dated 05/30/2019 revealed:
-Diagnoses included anxiety, benign prostatic hypertrophy, gastro-esophageal reflux disease, hypertension, hypothyroidism, history of pacemaker, atrial fibrillation, dementia, history of transient ischemic attack, coronary artery disease, and seizure disorder.
-The resident was intermittently disoriented.

Review of physician orders for Resident #9 dated 01/08/2020 revealed there was an order for Flucinolone Acetonide (used to treat a variety of skin disorders such as eczema, dermatitis, allergies, and rashes) 0.01% instill two drops in both ears one time a day Monday and Thursday for eczema.

Observation of the 8:00am medication pass on

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02/06/2020 from 8:15am-8:18am revealed:
-The medication aide (MA) removed a plastic bag from the medication cart, labeled with Resident #9's room number written on the bag, which was in another room of the medication area.
-The MA returned to the exterior room of the medication area, where the resident was seated, with the plastic bag of medication containers.
-The MA was not observed to review the eMAR instructions prior to administering the ear drops. The eMAR remained in the interior room of the medication area.
-The MA looked through the plastic bag and removed from the plastic bag a medication container of Fluocinolone Acetonide Oil 0.01% ear drops.
-The MA read aloud the instructions from the pharmacy printed label for the Fluocinolone Acetonide Oil stating the resident was supposed to get 3 to 4 drops of the medication in each ear two times a week.
-The MA administered four drops of the Fluocinolone Acetonide Oil in the resident's left ear at 8:17am as she counted each drop.
-The MA then administered four drops of the Fluocinolone Acetonide Oil in the resident's right ear at 8:18am as she counted each drop.

Review of Resident #9's electronic medication administration record (eMAR) for February 2020 revealed:
-There was an entry for fluocinolone acetonide oil 0.01% instill two drops in both ears one time a day every Monday and Thursday for eczema and scheduled for administration at 8:00am.
-There was documentation for administration of the fluocinolone acetonide oil at 8:00am on 02/03/2020 and 02/06/2020.

Interview with the MA on 02/06/2020 at 3:05pm

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revealed:
-She administered the ear drops according to the instructions printed on the medication container.
-She had not administered the ear drops according to the printed instructions on the eMAR.
-The medication label was incorrect.
-There should have been a direction change label sticker placed on the pharmacy printed label when the order changed.
-When the order changed, the MA on duty was responsible for placing the direction change sticker on the ear drops.

Telephone interview with a Pharmacist from the provider pharmacy on 02/06/2020 at 6:00pm revealed:
-The last pharmacy order for Resident #9's Fluocinolone Acetonide 0.01% was dated 12/11/2019 with instructions for 3 or 4 drops in each ear two times a week.
-He did not see another order in the pharmacy profile for the ear drops since the 12/11/2019 order and that did not mean there had not been another order.
-He would not think four drops of the ear drop in each ear would present a problem.

Interview with the Health and Wellness Director (HWD) on 02/07/2020 at 7:50am revealed:
-The MAs were responsible for inputting new orders to the eMAR.
-The MAs received new orders for residents, input the order to the eMAR, and faxed the orders to the pharmacy.
-Sometimes the physician sent orders directly to the pharmacy.
-The medications were delivered to the facility the same night the order was sent to the pharmacy.
-The backup pharmacy was contacted for orders

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received after 4:30pm or 5:00pm.
-The facility used an order tracking form.
-The evening or night MA rechecked new orders.
-The Resident Care Coordinator rechecked orders after the night shift MA checked them.
-If there was need for an order clarification, the MA was responsible for contacting the physician.

Interview with Resident #9 on 02/07/2020 at 9:33am revealed:
-He thought he was supposed to have three drops of the ear drops administered in each ear but was not certain and he did "not know if there was a firm how many".
-He did not know the names of the medications he was prescribed.

Second interview with the HWD on 02/07/2020 at 10:13am revealed:
-He expected the MAs to look at the eMAR, look at the medication, and look back at the eMAR before administering medication.
-He expected the MAs to verify the residents were being administered the right medications and dosage.

Interview with the same MA on 02/07/2020 at 10:19am revealed:
-When there was a discrepancy with the eMAR instructions and the medication label, she was supposed to get the resident record and check the order.
-She did not check the physician order for Resident #9's Fluocinolone Acetonide Oil because she thought the medication label was correct.
-She looked at the Fluocinolone Acetonide Oil and the dosage but did not go back and check the eMAR a second time because she thought the medication label and the eMAR had the same

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D 358	Continued From page 11 instructions. Telephone interview on 02/07/2020 at 1:38pm with the nurse for the Otorhinolaryngologist (a specialized doctor who treats disorders of the ears, nose, and throat and abbreviated ENT) prescribing the Fluocinolone Acetonide Oil ear drops for Resident #9 revealed: -It had "been a while" since the ENT had prescribed the ear drops. -The last order she found was dated 01/22/2019 for Fluocinolone Acetonide Oil ear drops three drops each ear twice a day on Monday and Thursday. -The ear drops were normally prescribed for one time a day unless there was flakiness and itchiness. -She saw an order to discontinue the ear drops on 05/14/2019. -She did not think the ENT would have a concern with Resident #9 being administered Fluocinolone Acetonide Oil ear drops fours drops in each ear. -Resident #9 usually had a lot of dry skin when he came for physician visits. -The dry skin mixed with the ear wax would stop up the resident's ear making his hearing worse.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.	D 371		

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D 371	Continued From page 12 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record review, the facility failed to assure medications were administered in accordance with infection control measures for 1 of 5 residents (Resident #9) observed during the 8:00am medication pass on 02/06/2020 who was administered a nasal spray from an opened container labeled for another resident. The findings are: Review of Resident #9's current FL-2 dated 05/30/2019 revealed: -Diagnoses included anxiety, benign prostatic hypertrophy, gastro-esophageal reflux disease, hypertension, hypothyroidism, history of pacemaker, atrial fibrillation, dementia, history of transient ischemic attack, coronary artery disease, and seizure disorder. -The resident was intermittently disoriented. Review of Resident #9's physician's orders dated 01/08/2020 revealed an order for azelastine HCL solution (a nasal spray used to relieve nasal symptoms caused by allergies) 137 micrograms/spray one spray in both nostrils two times a day. Observation of the medication aide (MA) on 02/06/2020 at 8:15am revealed: -The MA went into the medication room and returned with a clear plastic bag labeled with Resident #9's room number, with multiple containers inside the plastic bag. -The MA immediately gave one of the medication containers to Resident #9 and instructed the	D 371		

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resident to squirt one spray in each nostril.
-The resident immediately placed the medication container in the left nostril and then the right nostril, squirting one spray in each nostril.
-The resident handed the medication container back to the MA and remained seated in the medication room.
-The MA immediately began to return the medication container inside the plastic bag.

Observation of the medication label on the nasal spray container on 02/06/2020 at 8:15am revealed:
-The medication name on the medication bottle was azelastine HCL.
-The pharmacy label on the medication was for another resident with the first three letters of the other residents last name being the same as the first three letters of the first name for Resident #9.

Interview with the MA on 02/06/2020 at 8:15am revealed:
-She had made a mistake.
-She was "a little nervous" but "normally" she was not.
-She just looked at the container, saw the first two letters of the other resident's last name printed on the medication label and thought the medication was for Resident #9.
-The other resident was deceased.
-It was the responsibility of the MA working at the time the resident was discharged from the facility, to remove that residents' medications from the medication cart.
-She "double check[ed]" the medication cart when she worked weekends but did not get a chance to do so when she last worked a weekend.

Second interview with the MA on 02/06/2020 at 3:05pm revealed she did not know how the other

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	HAL025012	A. BUILDING: _____ B. WING _____	02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE NEW BERN	1336 SOUTH GLENBURNIE ROAD NEW BERN, NC 28562

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 371	Continued From page 14	D 371		

resident's nasal spray got in the plastic bag of medications labeled with Resident #9's room number.

Review of a Physician/Healthcare Provider Visit Form dated 01/28/2020 for Resident #9 revealed a current finding for nasal drainage.

Interview with the Health and Wellness Director (HWD) and Executive Director on 02/06/2020 at 3:40pm revealed:
-The MAs were supposed to administer medications according to the instructions on the medication administration record.
-The MAs were expected to look at the medication three times before administering the medication.
-The MA did get nervous.
-There had been previous concerns that the MA needed to slow down.

Interview with a Pharmacist with the provider pharmacy on 02/06/2020 at 6:00pm revealed:
-It was not sanitary to use another resident's nasal spray unless it was a new bottle of nasal spray.
-If the bottle of nasal spray was new, it should be relabeled with the resident's name who would be administered the nasal spray.

Review of a previous FL-2 dated 11/14/2018 for the other resident revealed the diagnoses included allergic rhinitis.

Review of a Physician/Healthcare Provider Visit Form dated 01/16/2020 for the other resident revealed: -The resident was found to have nasal congestion.
-The resident was prescribed Mucinex twice daily for 7 days.

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D 371	Continued From page 15 -The Provider wrote instructions of "be sure she is getting Azelastine nasal spray 2 sprays each nostril twice daily". Review of the hospital discharge dated 01/27/2020 for the other resident revealed: -The resident presented with complaints of increasing shortness of breath with associated cough and mild congestion. -The resident was found to have an Escherichia coli (a bacteria that can cause respiratory illnesses) urinary tract infection. -The resident had a further decline in her mental status and became less responsive each day. -The resident was discharged to hospice care. -Discharge diagnoses included metabolic encephalopathy, dementia, chronic respiratory failure with hypoxia, urinary tract infection - e coli, and acute on chronic systolic heart failure. Review of the facility medication administration policy revealed the policy included the following: -The five rights of medication, including the right patient, should be observed. -The resident's medication record should be checked. -Medications administered by other routes, including nasal, should be administered according to generally accepted standards of practice. Review of the MA's training record revealed: -The MA had received training on infection control on 01/14/2019. -The MA had completed and performed correctly a medication administration skills performance training (10/15-hour training course)on nasal sprays on 06/27/2017. Interview with Resident #9 on 02/07/2020 at	D 371		

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D 371	Continued From page 16 9:33am revealed: -His nasal issues were a "chronic thing", and he had "gotten so accustomed to it". -He was doing pretty good with the nose spray. -His nose would "clog up off and on, but today it's very good". -He did not know the names of his medications. Telephone interview with the Medical Assistant at the Primary Care Providers (PCP) office on 02/07/2020 at 11:50am revealed: -The resident was prescribed the Azelastine nasal spray by the ear, nose, and throat doctor (ENT) for chronic rhinitis. -The PCP had been contacted by the facility on 02/06/2020 regarding Resident #9 being administered another resident's Azelastine. -The PCP did not voice any concerns. _____ The facility failed to assure Resident #9 was administered his own Azelastine nasal spray, instead, used another resident's nasal spray who had a history of upper respiratory problems. The facility's failure to administer the nasal spray according to acceptable infection control measures was unsanitary and was detrimental to the health and safety of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with GS 131D-34 on 02/06/2020 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 23, 2020.	D 371		
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

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D912	Continued From page 17 G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration infection control measures. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer nasal spray according to acceptable infection control measures and in accordance with the facility's policies as ordered by a prescribing practitioner to 1 of 5 residents (#9) observed during the morning medication pass on 02/06/2020. [Refer to Tag 371 10A NCAC 13F.1004 (n) Medication Administration (Type B Violation)]	D912		