Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034016	A. BUILDING: _____ B. WING _____	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIENNA VILLAGE	6601 YADKINVILLE ROAD PFAFFTOWN, NC 27040

(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 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 03/13/24 and 03/14/24.	D 000	**Plan of correction for D358**	
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, record reviews and interviews, the facility failed to administer medication as ordered for 1 of 3 residents observed during the morning medication pass (#6 who had an order for a blood pressure medication and a potassium supplement. The findings are: The medication error rate was 7% as evidenced by 2 errors out of 28 opportunities during the 8:00am medication pass on 03/14/24. Review of Resident #6's current FL2 dated 04/12/23 revealed diagnoses included cerebral palsy, hypertension, edema, hypercholesterolemia, and reflux. a. Review of Resident #6's physician's order dated 11/30/23 revealed an order to increase the dose of metoprolol succinate (a medication used to lower blood pressure) from 25mg to 50mg	D 358	Actions taken and measures put in place to correct and to ensure will not occur again: On 3/14/24, for Resident #6, NP changed Metoprolol Succinate ER to Metroprolol Tartrate which is OK to crush. On 3/14/24, for Resident #6, NP changed potassium chloride ER to KDUR 10mEq which is dissolvable / OK to crush. On 3/14/24 pharmacy was alerted to "do not crush" missing from MAR for Metoprolol Succinate ER for Resident #6. Pharmacy said they would investigate and do additional training to ensure this does not happen in the future. On 3/14/24 additional protocols were put into place with our in-house monthly review of MARs to help ensure that all meds that are "Do not crush" are appropriately listed on MAR. Policy further enhanced on 3/26/24 when April MARs were being reviewed and prepared for distribution. *(continued on next page)*	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: D. Chris Parker — TITLE: ADMINISTRATOR — (X6) DATE: 4-3-2024

Reviewed and Acknowledged K.M. 04/05/24

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D 358	Continued From page 1 daily hold for systolic blood pressure (SBP) less than 110 or pulse less than 56. Review of Resident #6's signed medication orders dated 04/12/23 and 03/13/24 revealed metoprolol succinate ER tablets should not be crushed. Observation of the morning medication pass on 03/14/24 at 8:17am revealed: - The medication aide (MA) obtained Resident #6's blood pressure of 194/70 and pulse of 57. -The MA removed 10 medication bingo cards from the medication cart and compared each medication label to the medications due for administration on the medication administration record (MAR). -The MA popped each medication tablet from the medication card and placed it into a medication cup. -The MA transferred the tablets, including metoprolol succinate ER 50mg, into a clear plastic pouch and crushed the medications using a pill crushing device. -The medications were transferred back to the medication cup and mixed with applesauce. -The MA administered the medications to Resident #6 with a spoon and the resident consumed the entire cup of crushed medications and applesauce along with a cup of water. Review of Resident #6's March 2024 MAR revealed: -There was an entry for metoprolol succinate extended release (ER) 50mg take 1 tablet once daily scheduled at 8:00am; hold for SBP less than 110 or pulse less than 56. -There was no indication on the MAR not to crush metoprolol succinate ER. -There was documentation Resident #6's blood	D 358	On 3/14/24 and 3/15/24 ALL med aides cautioned and re-trained to follow procedures concerning crushable meds and reminded to notify their supervisors of any concerns about residents having issues with swallowing "Do not crush" meds so that they can follow up with MD to see if medicine can be changed. In addition to the above training, on 3/15/24 MA who failed to follow procedures on "Do not crush" meds was required to repeat 5 hour and 10 hour Med Aide Training courses along with Diabetes & Insulin Administration and Bloodborne Pathogens courses by the end of the following week (3/22/24). MA completed all of these courses by 3/22/24. Who will monitor the situation: Administrator and RCC developed plan along with assistance from MA supervisors, pharmacy and NP. Administrator and RCC will continue to monitor with assistance from MA supervisors and pharmacist reviewing the charts. How will monitoring take place: MA supervisors, RCC and pharmacists reviewing charts will monitor on an ongoing basis. MA training and monitoring will continue and be enhanced as needed.	

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D 358	Continued From page 2 pressure was 194/70 and pulse was 57. -There was documentation metoprolol was administered at 8:00am on 03/14/24. Observation of medications on hand for Resident #6 on 03/14/24 at 9:43am revealed: -There was one medication card for metoprolol succinate ER 50mg to take 1 tablet daily and hold for SBP less than 110 or pulse less than 56. -There was a dispensed date of 03/01/24 and 22 out of 30 tablets remaining. -There was no indication on the medication bingo card to not crush the medication. Telephone interview with a representative from the facility's contracted pharmacy on 03/14/24 at 9:20am revealed: -Resident #6 had an order for metoprolol succinate ER 50mg daily. -Metoprolol succinate ER should not be crushed or it would negate the extended release quality of the medication. -The pharmacy usually entered instructions of "do not crush" onto the MAR for medications that should not be crushed, but it was missed on Resident #6's metoprolol entry. Interview with the MA on 03/14/24 at 9:45am revealed: -She was aware that some of Resident #6's medications had instructions not to be crushed. -Resident #6's metoprolol medication card and entry on the MAR did not say it could not be crushed so she was not aware metoprolol should not be crushed. -She crushed all of Resident #6's medications because if Resident #6 was eating a meal, sometimes her medication tablets would get stuck in her mouth, and she was not able to properly swallow them.	D 358		

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D 358	Continued From page 3 -She thought she remembered telling a supervisor about Resident #6 having trouble swallowing her medications if they were not all crushed a couple of months prior, but she could not remember which supervisor she had notified and she had not followed up on it since. Telephone interview with Resident #6's primary care provider (PCP) on 03/14/24 at 9:57am revealed: -Metoprolol succinate ER should not be crushed. -If an ER medication was crushed, it would release the medication into the resident's body immediately instead of being an extended release which would cause the medication to work faster. -There was no risk of Resident #6 having adverse effects from receiving metoprolol succinate ER crushed on 03/14/24. Interview with the MA supervisor on 03/14/24 at 10:40am revealed: -She completed audits of the MARs every month when the new paper MARs were received from the pharmacy. -To audit, she compared the previous month's MAR to the new MAR to ensure they were accurate. -She did not compare the new MAR with the physician's orders to ensure that all medications that should not be crushed were indicated on the MAR. -She had not noticed there were no instructions on Resident #6's metoprolol succinate ER entry not to crush. Refer to interview with the Resident Care Coordinator (RCC) on 03/14/24 at 10:25am. Refer to interview with the MA supervisor on 03/14/24 at 10:40am.	D 358		

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D 358	Continued From page 4 Refer to interview with the Administrator on 03/14/24 at 10:55am. b. Review of Resident #6's current FL2 dated 04/12/23 revealed an order for potassium chloride (a potassium supplement) 10 milliequivalents (mEq) daily, do not crush. Observation of the morning medication pass on 03/14/24 at 8:17am revealed: -The medication aide (MA) removed 10 medication bingo cards from the medication cart and compared each medication label to the medications due for administration on the medication administration record (MAR). -The MA popped each medication tablet from the medication card and placed it into a medication cup. -The MA transferred the tablets, including potassium chloride 10 mEq, into a clear plastic pouch and crushed the medications using a pill crushing device. -The medications were transferred back to the medication cup and mixed with applesauce. -The MA administered the medications to Resident #6 with a spoon and the resident consumed the entire cup of crushed medications and applesauce along with a cup of water. Review of Resident #6's March 2024 MAR revealed: -There was an entry for potassium chloride extended release (ER) 10mEq daily; do not crush and scheduled at 8:00am. -There was documentation potassium chloride ER was administered at 8:00am on 03/14/24. Observation of medications on hand for Resident #6 on 03/14/24 at 9:44am revealed:	D 358		

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D 358	Continued From page 5 -There was one medication bingo card for potassium chloride ER 10mEq to take 1 tablet daily; do not crush. -There was a dispensed date of 02/12/24 and 3 out of 30 tablets remaining. Telephone interview with a representative from the facility's contracted pharmacy on 03/14/24 at 9:20am revealed: -Resident #6 had an order for potassium chloride ER 10mEq daily. -Potassium chloride ER could be dissolved into water and administered but it should not be crushed or it would no longer be an extended release. Interview with the MA on 03/14/24 at 9:45am revealed: -She was aware that some of Resident #6's medications had instructions not to be crushed, including her potassium supplement. -She crushed all of Resident #6's medications because if Resident #6 was eating a meal, sometimes her medication tablets would get stuck in her mouth, and she was not able to properly swallow them. -She thought she remembered telling a supervisor about Resident #6 having trouble swallowing her medications if they were not all crushed a couple of months prior, but she could not remember which supervisor she had notified and she had not followed up on it since. Telephone interview with Resident #6's primary care provider (PCP) on 03/14/24 at 9:57am revealed: -Potassium chloride ER should not be crushed. -If an ER medication was crushed, it would release the medication into the resident's body immediately instead of being an extended	D 358		

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D 358	Continued From page 6 release. -There was no risk of Resident #6 having adverse effects from receiving potassium chloride ER crushed on 03/14/24. Refer to interview with the Resident Care Coordinator (RCC) on 03/14/24 at 10:25am. Refer to interview with the MA supervisor on 03/14/24 at 10:40am. Refer to interview with the Administrator on 03/14/24 at 10:55am. Interview with the RCC on 03/14/24 at 10:25am revealed: -Any medication that should not be crushed would be indicated as such on the MAR. -She was responsible for typing up Resident #6's medication list. -Any medication that included instructions for the medication not be crushed on the pharmacy's online profile, she typed "do not crush" next to that medication on the medication list. -The PCP signed the medication lists that she prepared. -One of the MA supervisors was responsible for checking the MARs for accuracy against the previous month's MAR and the physician's orders each month. -She was aware that Resident #6 received some of her medications crushed, but thought the MAs were setting aside the medications that could not be crushed to administer whole. -The MAs were responsible for reporting to the MA supervisor any concerns regarding a resident not being able to swallow their medications whole. Interview with the MA supervisor on 03/14/24 at	D 358		

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D 358	Continued From page 7 10:40am revealed: -She was aware that the MAs sometimes crushed Resident #6's medications. -None of the MAs had requested she get order changes for Resident #6's medications that could not be crushed. -She was not aware that Resident #6 was receiving all of her medications crushed. -If a medication had instructions not to crush it, she expected the MAs to set it aside to administer to Resident #6 whole, or to notify her so she could get the order changed to a crushable version of that medication. Interview with the Administrator on 03/14/24 at 10:55am revealed: -He expected the MAs to read each medication order prior to administering the medication. -If a medication entry on the MAR or the medication label had instructions not to crush the medication, he expected the MAs not to crush it. -If a MA thought a resident needed their medications crushed and a medication had an order not to crush it, the MA should notify the MA supervisor so it could be addressed with the PCP. -He was not aware that the MAs were crushing medications for Resident #6 that should not be crushed. -The MA supervisor should be making sure each medication that should not be crushed had written instructions not to crush the medication on the medication card and the medication entry on the MAR.	D 358		