STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL067008	A. BUILDING: _____ B. WING _____	R-C 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEMPTON OF JACKSONVILLE	3045 HENDERSON DRIVE EXTENSION JACKSONVILLE, NC 28546

(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 and follow-up survey and a complaint investigation on 06/18/24 through 06/21/24. The complaint investigation was intitated by the Onslow County Depatment of Social Services on 05/24/24.	D 000		
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 ensure medications were administered as ordered for 2 of 4 residents (#7 and #9) observed during the medication pass including errors with a topical medication used to relieve pain (#7) and an extended-release medication used to treat high blood pressure (#9). The findings are: The medication error rate was 7% as evidenced by 2 errors out of 28 opportunities during the 8:00am morning medication pass on 06/19/24. Review of the facility's Medication Administration policy dated December 2019 revealed: -All orders must include components of a complete order.	D 358		

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D 358	Continued From page 1 -The medication name. -The strength of the medication, -The dosage of the medication. -The route of administration. -The specific directions for use. -The frequency of administration. -The reason for administration of the medication. -The medication aide (MA) or supervisor should clarify any orders that are unclear to include components of a complete order. -Staff referred to the community "Do Not Crush" list and consulted a pharmacist as needed to determine if a medication could be crushed. -A "Do Not Crush" list should be on each medication cart for reference. -MAs should follow the seven rights of medication administration including, right resident, right medication, right dose, right route, right time, right recording and right reason. -All medication labels were checked three times with the electronic medication administration record (eMAR) prior to administration. -The MAs were to check the medication label before or on pulling the medication from the medication cart, before the medication was placed in the medication cup and prior to placing the blister pack back into the medication cart. 1. Review of Resident #7's current FL-2 dated 07/27/23 revealed: -Diagnosis included Poly osteoarthritis. -She was non ambulatory. Review of Resident #7's signed physician's order sheet dated 05/01/24 revealed: -There was an order for Diclofenac Sodium External Gel 1%, apply to both knees topically every 12 hours for knee pain (Diclofenac is topical medication used to treat pain.). -Apply 4 grams using the dosing card.	D 358		

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D 358	Continued From page 2 Observation of the 8:00am medication pass on 06/19/24 at 7:25 am revealed: -The medication aide (MA) donned gloves and squeezed a pea sized amount of Diclofenac gel directly on to her gloved finger and rubbed the gel onto Resident #7's right knee and squeezed another pea sized amount on her gloved finger and rubbed the gel onto Resident #7's left knee. -The MA did not use the dosing card to dispense the Diclofenac gel to Resident #7. Review of Resident #7's electronic medication administration record (eMAR) for June 2024 revealed: -There was an entry for Diclofenac Sodium 1% gel, apply to both knees two times per day for arthritic pain at 8:00am and 8:00pm. -There was documentation Diclofenac Sodium 1% gel was applied at 8:00am 06/01/24 through 06/19/24 and at 8:00pm 06/01/24 through 06/18/24. Observation of Resident #7's medications on hand on 06/19/24 at 12:05pm revealed: -There was a box containing a 100gram tube of Diclofenac Sodium 1% gel. -The box containing the Diclofenac Sodium 1% gel was labeled with the resident's name and to apply 4 grams topically every 12 hours for pain. -The box containing the Diclofenac Sodium 1% gel had instructions to use the enclosed dosing card to measure a dose and the box contained a dosing card. -2.25 inches long was 2 grams. -4.5 inches long was 4 grams. Interview with the MA on 06/19/24 at 12:03pm revealed: -She applied enough of the Diclofenac 1% gel	D 358		

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that she thought would cover each of Resident #7's knees.
-She did not know she should measure the Diclofenac topical gel to ensure 4 grams of the medication was applied.
-She was never taught how much Diclofenac gel to administer.
-She did not know there was a dosing card with the Diclofenac gel.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/19/24 at 2:19pm revealed:
-Diclofenac should be measured by using the clear plastic measuring tool that came with the medication.
-A ribbon of gel is to be squeeze down the measuring tool to the ordered dose.
-There was little risk of a resident receiving too much medication but too little could cause pain to not be as well controlled.

Interview with Resident #7 on 06/19/24 at 11:00am revealed:
-She used Diclofenac gel twice daily for knee pain.
-Diclofenac gel helped her knee pain but sometimes the pain relief did not last.

Interview with the Resident Care Coordinator (RCC) on 06/19/24 at 12:12pm revealed:
-Diclofenac gel should be administered using the dose card provided.
-The MA should have used the dose card provided with the Diclofenac gel to ensure Resident #7 received the correct dose.
-She was not aware that the MA did not know how to measure the Diclofenac gel.
-Receiving too little of the Diclofenac gel could cause Resident #7 to have inadequate pain relief.

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D 358	Continued From page 4 Interview with the Director of Services (DOS), a Registered Nurse, on 06/19/24 at 12:18pm revealed: -The MA should use the dosing card provided with the Diclofenac gel to ensure Resident #7 received the accurate dose. -If the MA was unsure how to administer the Diclofenac gel, she should have asked the RCC or her, the DOS for clarification. Interview with the Administrator on 06/21/24 at 9:45am revealed: -The MAs were to administer medications as ordered by the provider. -Resident #7's Diclofenac gel should have been measured using the dosing card provided with the product to ensure she received the accurate dose. Telephone interview with the Registered Nurse from Resident #7's primary care provider's (PCP) office on 06/19/24 at 2:11pm revealed: -Resident #7 was prescribed Diclofenac gel for arthritic pain. -Diclofenac gel came with a dosing card to measure the amount of Diclofenac ordered, either 2 grams or 4 grams. -Resident #7 was to receive 4 grams of Diclofenac gel which should be measured on the provided dosing card. -Not using the provided dosing card for the Diclofenac gel could result in Resident #7 receiving too much Diclofenac gel or not enough Diclofenac gel, causing inadequate pain relief. 2. Review of Resident #9's current FL-2 dated 02/19/24 revealed diagnosis included hypertension.	D 358		

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Review of Resident #9's signed Physicians Order Sheet dated 05/01/24 revealed there was an order for Toprol XL Extended Release 24-hour 25mg, take one tablet one time a day. (Toprol XL is used to treat high blood pressure, regulate the heart rate and/or treat heart failure), Do Not Crush.

Observation of the 8:00am medication pass on 06/19/24 at 7:40am revealed:
-The medication aide (MA) prepared morning medications for Resident #9 and included one Metoprolol Succinate ER 25mg tablet (Metoprolol Succinate ER is a generic form of Toprol XL).
-The MA crushed 7 of Resident #9's oral medications, including the Metoprolol Succinate ER 25mg (Metoprolol Succinate ER is a generic form of Toprol XL Extended Release) tablet and mixed them in applesauce and administered the medications to Resident #9 at 7:42am.

Observation of Resident #9's medications on hand on 06/19/24 at 12:01pm revealed:
-There was a bubble package of Metoprolol Succinate ER 25mg tablets dispensed on 05/23/24 for a quantity of 30 with eleven tablets remaining.
-There were instructions on the upper right side of the medication label indicating Metoprolol Succinate ER 25mg should not be chewed or crushed.

Review of Resident #9's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Toprol XL Extended Release 25mg (Metoprolol Succinate) take one tablet every day scheduled for 8:00am.
-Toprol XL Extended Release 25mg (Metoprolol Succinate) was documented as administered

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D 358	Continued From page 6 daily from 06/01/24 through 06/19/24 at 8:00am. -There were instructions to Do Not Crush Toprol XL. Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 06/19/24 at 12:37pm revealed: -Metoprolol Succinate ER 25mg tablets were last dispensed for Resident #9 on 05/23/24 for a quantity of 30 tablets for a 30-day supply. -Metoprolol Succinate ER 25mg tablets should not be crushed due to the release mechanism. -Crushing the Metoprolol Succinate ER 25mg tablets could cause immediate release of the medication and could potentially lower the resident's blood pressure and heart rate and could result in dizziness Interview with Resident #9 on 06/19/24 at 11:47am revealed: -Staff administered her medications daily. -Some of her medications were crushed. -She was not sure exactly what medications she took. -She felt fine and denied feeling dizzy or lightheaded. Interview with the MA on 06/19/24 at 12:03pm revealed: -She always crushed some of Resident #9's medications. -There was a "Do Not Crush" sticker on the medication label if a medication could not be crushed. -There were instructions on the eMARS indicating if a medication should not be crushed. -Long-acting medications should not be crushed. -She was not sure why she crushed the Metoprolol Succinate ER, she usually did not crush Resident #9's Metoprolol but forgot to	D 358		

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remove it from the crushed medications during this morning medication pass.
-She was not aware of a medication Do Not Crush (DNC) list.
-Crushing an extended-release medication could cause the medication to be released too quickly.

Interview with the Resident Care Coordinator (RCC) on 06/19/24 at 12:12pm revealed:
-Extended-release medications should never be crushed because being crushed affects how the medication is absorbed
-The facility had a DNC list that was kept on the medication cart in the narcotics count binder.
-There were instructions on the eMARs and the medication labels indicated if a medication should not be crushed.
-The MAs were expected to review the eMARS and the medication label for instructions such as Do Not Crush.

Interview with the Director of Services (DOS), a Registered Nurse, on 06/19/24 at 12:18pm revealed:
-The MAs were expected to compare the medication label to the eMAR prior to administering medications.
-Any medications that were not to be crushed, were labeled by the pharmacy as Do Not Crush.
-There also was a DNC list in the medication room and the narcotics count binder.
-Extended-Release medications should not be crushed as crushing may allow for the medication to be released too quickly.

Resident #9's blood pressure was checked by the MA on 06/19/24 at 2:10pm and was reported as 110/61 with a heart rate of 76.

Interview with the Administrator on 06/21/24 at

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D 358	Continued From page 8 9:45am revealed: -The pharmacy labeled all medications that were not to be crushed. -The eMARS specified if a medication should not be crushed. -The MAs were taught to compare the eMARS to the medication label for each residents' medications. -Extended-Release medications should not be crushed, as this would cause the medication to be immediately released. Telephone interview with a representative at Resident #9's Primary Care Provider's (PCP) office on 06/19/24 at 12:45pm revealed: -Metoprolol Succinate ER was prescribed to Resident #9 for hypertension. -Crushing the tablet would affect the absorption of the medication. -Metoprolol Succinate ER should have been administered as a whole tablet and not crushed. Attempted telephone interview with Resident #9's PCP on 06/19/24 at 12:29pm was unsuccessful.	D 358		