STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045126	A. BUILDING: ______ B. WING ______	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA RESERVE OF LAUREL PARK	1825 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 on August 22, 2018 to August 23, 2018.	D 000		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to assure at least one staff person was on the premises at all times that had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) for 3 of 3 sampled staff (Staff C, D and E) who worked from 11:00 pm to 7:00 am. The findings are: Review of the facility's staffing schedule revealed:	D 167		

Reviewed and accepted 10/1/18 RP

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D 167	Continued From page 1	D 167		

-The date on the schedule was documented as "updated 08/17/18".
-Staff C, D and E were the only staff listed who worked 11:00pm to 7:00am.
-Staff C, D or E were the only staff on the schedule from 08/01/18 through 08/30/18.

1. Review of Staff C's personnel file revealed:
-Staff A was hired as a Supervisor/Medication Aide (MA) on 05/30/18.
-There was no documentation of CPR training.

Telephone interview with Staff C on 08/23/18 at 3:08 pm revealed:
-She worked third shift.
-Her CPR certification had expired.
-She did not know the expiration date.
-She did not have a copy of the expired CPR card.

Refer to the interview with the Business Office Manager (BOM) on 08/22/18 at 3:55pm and on 08/23/18 at 1:35pm.

Refer to interview with the Resident Care Coordinator (RCC) on 08/23/18 at 2:25pm.

Refer to the interview with the Registered Nurse from the facility's contracted pharmacy on 08/23/18 at 2:28pm.

Refer to the interview with the Director of Clinical Services (DCS) on 08/23/18 at 2:10pm.

Refer to the interview with the Administrator on 08/23/18 at 2:35pm.

2. Review of Staff D's personnel file revealed:
-Staff D was hired as a personal care aide (PCA) on 05/22/18.

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D 167	Continued From page 2 -There was no documentation of CPR training. Attempted telephone interview with Staff D on 08/23/18 at 2:55pm was unsuccessful. Refer to the interview with the BOM on 08/22/18 at 3:55pm and on 08/23/18 at 1:35pm. Refer to interview with the RCC on 08/23/18 at 2:25pm. Refer to the interview with the Registered Nurse from the facility's contracted pharmacy on 08/23/18 at 2:28pm. Refer to the interview with the DCS on 08/23/18 at 2:10pm. Refer to the interview with the Administrator on 08/23/18 at 2:35pm. 3. Review of Staff E's personnel file revealed: -Staff E was hired as a PCA on 07/25/18. -There was no documentation of CPR training. Attempted telephone interview with Staff E on 08/23/18 at 2:57pm was unsuccessful. Refer to the interview with the BOM on 08/22/18 at 3:55pm and on 08/23/18 at 1:35pm. Refer to interview with the RCC on 08/23/18 at 2:25pm. Refer to the interview with the Registered Nurse from the facility's contracted pharmacy on 08/23/18 at 2:28pm. Refer to the interview with the DCS on 08/23/18 at 2:10pm.	D 167		

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D 167	Continued From page 3 Refer to the interview with the Administrator on 08/23/18 at 2:35pm. ________________ Interview with the BOM on 08/22/18 at 3:55pm and on 08/23/18 at 1:35pm revealed: -About 1-2 weeks ago one third shift staff, who was CPR certified, had quit working at the facility. -She did not know if the other third shift staff had CPR training. -The RCC and DCS completed the staff schedule and tracked what staff were CPR certified. Interview with the RCC on 08/23/18 at 2:25pm revealed: -She was responsible for scheduling staff. -She was not aware of the CPR rule. -She did not know what staff had their CPR certification. -It was the former DCS who tracked staff certifications. Interview with the Registered Nurse from the facility's contracted pharmacy on 08/23/18 at 2:28pm revealed neither Staff C, D or E were on his records for having completed CPR with him. Interview with the DCS on 08/23/18 at 2:10pm revealed: -"Ultimately it is my responsibility" to assure there was one staff per shift with CPR training. -She did not know if Staff C, D or E were CPR certified. -She was not aware of the CPR rule. -She would assure there was a staff person on third shift who had their CPR training. Interview with the Administrator on 08/23/18 at 2:35pm revealed: -She was aware of the CPR rule.	D 167		

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D 167	Continued From page 4 -She did not know if Staff C, D or E had been trained in CPR. -The BOM was responsible for tracking staff trainings. -The BOM used to track the certifications until the previous DCS started tracking staff trainings. -Since the hire of the current DCS and RCC, no one has tracked the certifications. -The RCC and DCS were responsible to assure there was a CPR trained staff on each shift. ________________ The facility failed to assure there was a staff person on third shift who had completed a course on CPR within the previous 24 months. This failure was detrimental to the health, safety and welfare of the residents by not having adequately trained staff available in the event of cardiopulmonary arrest or choking, which constitutes a Type B Violation. ________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/23/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 9, 2018.	D 167		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by:	D 273		

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D 273	Continued From page 5	D 273		

Based on observations, interviews and record reviews, the facility failed to notify the physician of 1 of 5 sampled residents (Resident #1) related to refusal of antidepressant medication, who expressed suicidal ideation.

The findings are:

Review of Resident #1's current FL2 dated 04/16/18 revealed diagnoses included mood disorder, post-traumatic stress disorder, autism, chronic back pain, sleep apnea, and insomnia.

Review of Resident #1's psychiatrist's notes dated 07/26/18 revealed a physician order for fluoxetine 20mg/5ml solution take 5 ml daily (used to treat depression).

Review of Resident #1's July 2018 electronic Medication Administration Record (eMAR) revealed:
-A computer generated entry for fluoxetine 20mg/5ml solution take 5ml (20mg) by mouth every day, okay to mix in resident's food to be administered at 8:00am.
-Fluoxetine had been documented as refused for 2 of 5 opportunities from 07/27/18 to 07/31/18.

Review of Resident #1's August 2018 eMAR revealed:
-A computer generated entry for fluoxetine 20mg/5ml solution take 5ml (20mg) by mouth every day, okay to mix in resident's food to be administered at 8:00am.
- Fluoxetine had been documented as refused for 9 of 24 opportunities from 08/01/18 to 08/24/18.

Observation of Resident #1's medications on hand on 08/22/18 at 2:14pm revealed a partially used bottle of fluoxetine 20mg/5ml solution

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D 273	Continued From page 6 dispensed on 07/26/18 available to be administered. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 08/23/18 at 9:47pm revealed: -A 150ml bottle of fluoxetine 20mg/5ml was last dispensed to Resident #1 on 07/26/18 with directions take 5ml daily, okay to mix in food. -The bottle of fluoxetine had a 30 day supply based on the directions on the order. -This was the first time the pharmacy had dispensed fluoxetine solution to Resident #1. Interview with Resident #1 on 08/22/18 at 9:01am revealed: -He did not like taking a lot of medications so he refused his medications sometimes. -"It is terrible here and there will be a point that I am going to hang myself." Review of Resident #1's Resident Service Notes dated 07/24/18 revealed: -"Resident refused his medication this morning, stated that he just wanted to die." -Primary care physician (PCP) was notified at 3:10pm "of resident stating that he wanted to die." -Resident was told the facility would be doing hourly checks and his knife would need to be removed from his room. -"Resident stated that he was not suicidal and was not having any thoughts of harming himself or others." Review of Resident #1's Resident Service Notes dated 07/25/18 revealed: -The resident's psychiatrist was notified regarding the resident making the statement "that he wanted to die." -Sleep log and copy of eMAR was sent to	D 273		

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D 273	Continued From page 7 Resident #1's psychiatrist for review. Interview with the Medication Aide (MA) 08/22/18 at 2:14pm revealed: -Resident #1 refused his medications for "different reasons each time." -He mixed Resident #1's fluoxetine solution in "drink or food so he will take it." -He had not contacted Resident #1's psychiatrist about his multiple refusals of fluoxetine. -He thought the psychiatrist knew that Resident #1 was refusing his medications because they had changed his antidepressant medication from escitalopram (used to treat depression) to fluoxetine. -He contacted a physician for any resident that refused a medication for 3 days in a row. -He had not contacted Resident #1's psychiatrist because the resident had not refused the fluoxetine 3 days in a row. -He documented all refusals on a 24 hour summary report that was reviewed by the "RCC or nurse." Interview with the Resident Care Coordinator (RCC) on 08/23/18 at 11:32am revealed: -She was not aware that Resident #1 was refusing fluoxetine. -She had not contacted Resident #1's psychiatrist about resident refusing fluoxetine. Interview with the Director of Clinical Services (DCS) on 08/23/18 at 11:22am revealed: -She did not know that Resident #1 was refusing medications. -The facility policy was to notify the physician after a resident refused a medication 3 times. -The MA should be notifying the physician regarding medication refusals.	D 273		

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D 273	Continued From page 8 Telephone interview with Resident #1's care manager/power of attorney on 08/23/18 at 1:58pm revealed: -She did not know that Resident #1 had been refusing his fluoxetine. -She had noticed a change in Resident #1's behavior but thought it was because of a recent change in pain medication. -Resident #1 had previously refused his antidepressant "because it would not help with his insomnia." Interview with the Administrator on 08/23/18 at 2:00pm revealed: -She thought the psychiatrist had been notified about Resident #1 refusing medications. -She was worried about Resident #1's safety in the facility because of his past psychiatric history. -If a resident made a claim about harming themselves, the staff needed to be notified. -The incident would be taken seriously and investigated. Telephone interview with a Certified Medical Assistant (CMA) from Resident #1's Psychiatrist's Office on 08/23/18 at 12:57pm and 4:08pm revealed: -The facility had not contacted the psychiatrist about Resident #1 refusing fluoxetine. -The psychiatrist had switched Resident #1 from escitalopram to fluoxetine to stop the resident from refusing his antidepressant. -The last office visit for Resident #1 was on 06/26/18. Review of facility policy on medication refusals on 08/23/18 revealed: -The MA should contact the RCC, DCS or Administrator after a resident missed two doses of medication in a row.	D 273		

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D 273	Continued From page 9 -The RCC, DCS, or Administrator should notify the prescriber or responsible party for follow up.	D 273		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (Resident #1) related to medications for depression and mood disorder. The findings are: Review of Resident #1's current FL2 dated 04/16/18 revealed: -Diagnoses included mood disorder, post-traumatic stress disorder, autism, chronic back pain, sleep apnea, and insomnia. -There was a physician order for escitalopram 10 mg take 1 and a half tablets (15mg) every evening (used to treat depression). -There was a physician order for olanzapine oral dissolving tablet (ODT) 5mg every night at	D 358		

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D 358	Continued From page 10 bedtime (used to treat mood disorders, including depression and bipolar). -There was a physician order for olanzapine ODT 5mg take every 6 hours as needed for anxiety/agitation/psychosis. a. Review of Resident #1's psychiatrist's notes dated 04/15/18 revealed a physician order to increase escitalopram to 20mg daily. Review of Resident #1's psychiatrist's notes dated 07/26/18 revealed a physician order to discontinue escitalopram. Review of Resident #1's July 2018 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry for escitalopram 20mg take 1 and half tablets (30mg) daily to be administered at 8:00am. -Escitalopram had been documented as administered from 07/26/18 to 07/31/18. Review of Resident #1's August 2018 eMAR revealed: -A computer generated entry for escitalopram 20mg take 1 and half tablets (30mg) daily to be administered at 8:00am. -Escitalopram had been documented as administered from 08/01/18 to 08/22/18. Observation of Resident #1's medications on hand on 08/22/18 at 2:14pm revealed a partially used medication card of escitalopram 20mg dispensed on 05/31/18 containing 38 whole tablets and 38 half tablets to be administered Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 08/23/18 at 9:47am revealed:	D 358		

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D 358	Continued From page 11 -Escitalopram was last dispensed to Resident #1 on 08/08/18 with the directions 20mg daily for a 30 day supply. -A physician order for Resident #1 dated 04/15/18 for escitalopram 20mg daily had been faxed to the pharmacy by the facility on 08/08/18. -The pharmacy had previously dispensed escitalopram to Resident #1 on 06/23/18 with the directions 30mg daily from an order dated 05/01/18 for a 30 day supply. -The pharmacy had sent a clarification request to the facility on 08/08/18 to determine the correct dose of escitalopram for Resident #1 but had not received a response. -The facility was responsible for clarifying all medication orders with the physician. -The facility had faxed over the order to discontinue the escitalopram on 07/26/18 but the pharmacy had missed the order. -The escitalopram order remained on the eMAR until the pharmacy processed the order for facility approval. Interview with the Medication Aide (MA) on 08/22/18 at 2:14pm and 08/23/18 at 11:00am revealed: -He did not know that the escitalopram had been discontinued by the psychiatrist. -He had not seen the discontinuation order for escitalopram. -He had been administering the escitalopram to Resident #1 as directed on eMAR. -The MA, Resident Care Coordinator (RCC), or Director of Clinical Services (DCS) would fax new medication or discontinuation orders to the pharmacy. -The order had to be approved by a MA, RCC, or DCS before the change occurred on the eMAR. -He never looked at the original orders. -He approved "new orders if the label on the new	D 358		

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D 358	Continued From page 12 medication matched the order in the computer." Interview with the RCC on 08/22/18 at 2:25pm and 08/23/18 at 11:35am revealed: -She faxed the order dated 04/15/18 for escitalopram to the pharmacy on 08/08/18 because she had found it in Resident #1's record during an audit. -She had not faxed the discontinuation order for escitalopram to the pharmacy, but it was noted on the order in Resident #1's record that someone from the facility had faxed the order. -She did not know why no one from the facility had followed up on the discontinuation order for escitalopram with the pharmacy. -She had faxed the discontinuation order to the pharmacy on 08/23/18. -The discontinued order had to be approved by a MA, RCC, or DCS before the changes were made on the eMAR. Telephone interview with a Certified Medical Assistant (CMA) from Resident #1's Psychiatrist's Office on 08/23/18 at 4:08pm revealed the resident could have increased anxiety and insomnia from taking escitalopram and fluoxetine together. Refer to interview with Resident #1 on 08/22/18 at 9:01am. Refer to interview with the DCS on 08/23/18 at 11:22am. b. Review of Resident #1's psychiatrist's notes dated 07/26/18 revealed a physician order to start fluoxetine 20mg/5ml solution 5ml daily (used to treat depression). Review of Resident #1's July 2018 electronic	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA RESERVE OF LAUREL PARK	1525 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 358	Continued From page 13 Medication Administration Record (eMAR) revealed: -There was a computer generated entry for fluoxetine 20mg/5ml solution take 5ml (20mg) by mouth every day (okay to mix in food) to be administered at 8:00am. -Fluoxetine had been documented as administered on 07/27/18, 07/28/18, and 07/30/18 and documented as refused on 07/29/18 and 07/31/18. Review of Resident #1's August 2018 eMAR revealed: -There was a computer generated entry for fluoxetine 20mg/5ml solution take 5ml (20mg) by mouth every day (okay to mix in food) to be administered at 8:00am. - Fluoxetine had been documented as refused for 9 of 24 opportunities from 08/01/18 to 08/24/18. Observation of Resident #1's medications on hand on 08/22/18 at 2:14pm revealed -A partially used bottle of fluoxetine 20mg/5ml solution dispensed 07/26/18 was available to be administered. -The pharmacy had dispensed 150ml of solution to Resident #1. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 08/23/18 at 9:47am revealed: -A 150ml bottle of fluoxetine 20mg/5ml was last dispensed to Resident #1 on 07/26/18 with directions take 5ml daily okay to mix in food. -The bottle of fluoxetine had a 30 day supply based on the directions on the order. -This was the first time the pharmacy had dispensed fluoxetine solution to Resident #1. Interview with the Medication Aide (MA) on	D 358		

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	HAL045126	A. BUILDING: ______ B. WING ______	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA RESERVE OF LAUREL PARK	1825 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 358	Continued From page 14 08/22/18 at 2:14pm and 08/23/18 at 11:00am revealed: -He had been administering fluoxetine and escitalopram to Resident #1 since 07/27/18. -The MA, Resident Care Coordinator (RCC), or Director of Clinical Services (DCS) would fax new medication or discontinuation orders to the pharmacy. -The order had to be approved by a MA, RCC, or DCS before the change occurred on the eMAR. -He never looked at the original orders. -He approved "new orders if the label on the new medication matched the order in the computer." Interview with the RCC on 08/22/18 at 2:25pm and 08/23/18 at 11:35am revealed: -She faxed the order dated 04/15/18 for escitalopram to the pharmacy on 08/08/18 because she had found it in Resident #1's record during an audit. -She had not faxed the discontinuation order for escitalopram to the pharmacy, but it was noted on the order that someone from the facility had faxed the order. -She did not know why no one from the facility had followed up on the discontinuation order for escitalopram with the pharmacy. -She had faxed the discontinuation order for escitalopram to the pharmacy on 08/23/18. -The discontinued order had to be approved by a MA, RCC, or DCS before the changes were made on the eMAR. -She was not aware that Resident #1 was receiving fluoxetine and escitalopram from 07/27/18 to 08/23/18. Telephone interview with a CMA from Resident #1's Psychiatrist's Office on 08/23/18 at 4:08pm revealed: -The resident could have increased anxiety and	D 358		

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D 358	Continued From page 15 insomnia from taking escitalopram and fluoxetine together. -The psychiatrist office was not aware that Resident #1 had any side effects from taking medications together. Refer to interview with Resident #1 on 08/22/18 at 9:01am. Refer to interview with the DCS on 08/23/18 at 11:22am. c. Review of Resident #1's psychiatrist's notes dated 08/23/18 revealed a clarification order for olanzapine 5mg every night scheduled along with olanzapine 5mg every six hours as needed. Review of Resident #1's psychiatrist's notes dated 04/15/18 revealed a physician order to increase olanzapine to 7.5mg every night. Review of Resident #1's July 2018 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry for olanzapine ODT 5mg tablet take 1 tablet at bedtime to be administered at 8:00pm. -Olanzapine 5mg was documented as administered from 07/01/18 to 07/17/18 at 8:00pm. -The olanzapine order was documented as discontinued on 07/18/18. -A scheduled dose of olanzapine at bedtime was not documented as administered from 07/18/18 to 07/31/18. Review of Resident #1's August 2018 eMAR revealed: -There was a computer generated entry for olanzapine ODT 5mg tablet take 1 and half	D 358		

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NAME OF PROVIDER OR SUPPLIER: CAROLINA RESERVE OF LAUREL PARK

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D 358	Continued From page 16 tablets (7.5mg) at bedtime with a start date of 08/10/18. -Olanzapine 7.5mg was documented as administered from 08/10/18 to 08/21/18 at 8:00pm. -A scheduled olanzapine dose at bedtime was not documented as administered from 08/01/18 to 08/09/18. Observation of Resident #1's medications on hand on 08/22/18 at 2:14am revealed: -A medication card containing olanzapine 5mg with 1 and half tablets in every bubble with the directions 7.5mg at bedtime available to be administered. -A medication card containing olanzapine 5mg with the directions 1 tablet every six hours as needed available to be administered. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 08/23/18 at 9:47am revealed: -Olanzapine was last dispensed to Resident #1 on 08/08/18 with the directions 7.5mg every night. -The original order was dated 04/15/18. -Resident #1 had an order for olanzapine 5mg every six hours as needed. -The pharmacy dispensed 90 tablets of olanzapine 7.5mg to Resident #1 on 08/08/18 for a 17 day supply, including the scheduled and as needed orders. -The pharmacy dispensed 90 tablets of olanzapine 5mg to Resident #1 on 04/26/18 and 07/13/18 for a 17 day supply, including the scheduled and as needed orders. Telephone interview with Resident #1's care manager/power of attorney on 08/23/18 at 1:58pm revealed: -She did not know that Resident #1 had missed	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL046126	A. BUILDING: ______ B. WING ______	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER: CAROLINA RESERVE OF LAUREL PARK

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D 358	Continued From page 17 multiple doses of olanzapine. -She had noticed a change in Resident #1's behavior but thought it was because of a recent change in pain medication. -Resident #1 was more agitated recently and had begun to use a walker. Interview with the MA on 08/23/18 at 11:00am revealed: -He did not know why Resident #1 had not received a scheduled daily dose of olanzapine from 07/18/18 to 08/09/18. -He did not know who had discontinued the scheduled olanzapine order on the eMAR. -He did not know if a new order was written for olanzapine in August. -No information was documented in the eMAR software to explain the missed doses of medication. Interview with the Resident Care Coordinator (RCC) on 08/23/18 at 11:35am revealed: -She had faxed an order dated 04/15/18 to increase olanzapine to 7.5mg daily to the pharmacy on 08/08/18. -She had found the order in the chart during an audit. -She did not know why Resident #1 did not receive his schedule daily dose of olanzapine from 07/18/18 to 08/09/18. -She was not aware of a discontinuation order dated 07/18/18 for a scheduled daily dose of olanzapine. -She had recently stopped monitoring "missed dose reports" because it was now the responsibility of the DCS. -The missed doses of olanzapine for Resident #1 were not "showing up on the missed dose report." -Reports were reviewed weekly for all medications that were not administered to a	D 358		

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D 358	Continued From page 18 resident at the appropriate time. Telephone interview with a CMA from Resident #1's Psychiatrist's Office on 08/23/18 at 4:08pm revealed: -The psychiatrist had added a bedtime dose of olanzapine to help with sleep. -The resident could have mood changes and increased insomnia from missing his scheduled olanzapine. -The resident complained of not sleeping on a regular basis but the facility would report that the resident was sleeping. Refer to interview with Resident #1 on 08/22/18 at 9:01am. Refer to interview with the DCS on 08/23/18 at 11:22am. ____________ Interview with Resident #1 on 08/22/18 at 9:01am revealed: -He did not like taking a lot of medications. -He had been having trouble sleeping. -"It is terrible here and there will be a point that I am going to hang myself." Interview with the DCS on 08/23/18 at 11:22am revealed: -The RCC was responsible for faxing new orders to the pharmacy. -The MA or DCS was responsible if the RCC was not in the facility. -The medication orders were approved when the medication was delivered to the facility after the 5:00pm or 11:00pm pharmacy delivery by the MA on duty. -The MA would "double check the order in the computer" with the medication the pharmacy	D 358		

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D 358	Continued From page 19 sent. -A new procedure was started recently that a new order was attached to a "follow up checklist" to make sure each order was faxed to the pharmacy and processed. -She did not know about specific order changes for Resident #1. ______________________ The failure of the facility to administer medications as ordered, related to taking escitalopram, fluoxetine, and olanzapine to Resident #1 placed him at risk for increased anxiety and insomnia, which was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. ______________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/23/18 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 9, 2018.TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (Resident #1) related to medications for depression and mood disorder. The findings are: Review of Resident #1's current FL2 dated 04/16/18 revealed: -Diagnoses included mood disorder, post-traumatic stress disorder, autism, chronic back pain, sleep apnea, and insomnia. -There was a physician order for escitalopram 10	D 358		

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D 358	Continued From page 20 mg take 1 and a half tablets (15mg) every evening (used to treat depression). -There was a physician order for olanzapine oral dissolving tablet (ODT) 5mg every night at bedtime (used to treat mood disorders, including depression and bipolar). -There was a physician order for olanzapine ODT 5mg take every 6 hours as needed for anxiety/agitation/psychosis. a. Review of Resident #1's psychiatrist's notes dated 04/15/18 revealed a physician order to increase escitalopram to 20mg daily. Review of Resident #1's psychiatrist's notes dated 07/26/18 revealed a physician order to discontinue escitalopram. Review of Resident #1's July 2018 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry for escitalopram 20mg take 1 and half tablets (30mg) daily to be administered at 8:00am. -Escitalopram had been documented as administered from 07/26/18 to 07/31/18. Review of Resident #1's August 2018 eMAR revealed: -A computer generated entry for escitalopram 20mg take 1 and half tablets (30mg) daily to be administered at 8:00am. -Escitalopram had been documented as administered from 08/01/18 to 08/22/18. Observation of Resident #1's medications on hand on 08/22/18 at 2:14pm revealed a partially used medication card of escitalopram 20mg dispensed on 05/31/18 containing 38 whole tablets and 38 half tablets to be administered	D 358		

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D 358	Continued From page 21 Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 08/23/18 at 9:47am revealed: -Escitalopram was last dispensed to Resident #1 on 08/08/18 with the directions 20mg daily for a 30 day supply. -A physician order for Resident #1 dated 04/15/18 for escitalopram 20mg daily had been faxed to the pharmacy by the facility on 08/08/18. -The pharmacy had previously dispensed escitalopram to Resident #1 on 06/23/18 with the directions 30mg daily from an order dated 05/01/18 for a 30 day supply. -The pharmacy had sent a clarification request to the facility on 08/08/18 to determine the correct dose of escitalopram for Resident #1 but had not received a response. -The facility was responsible for clarifying all medication orders with the physician. -The facility had faxed over the order to discontinue the escitalopram on 07/26/18 but the pharmacy had missed the order. -The escitalopram order remained on the eMAR until the pharmacy processed the order for facility approval. Interview with the Medication Aide (MA) on 08/22/18 at 2:14pm and 08/23/18 at 11:00am revealed: -He did not know that the escitalopram had been discontinued by the psychiatrist. -He had not seen the discontinuation order for escitalopram. -He had been administering the escitalopram to Resident #1 as directed on eMAR. -The MA, Resident Care Coordinator (RCC), or Director of Clinical Services (DCS) would fax new medication or discontinuation orders to the pharmacy.	D 358		

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D 358	Continued From page 22	D 358		

-The order had to be approved by a MA, RCC, or DCS before the change occurred on the eMAR.
-He never looked at the original orders.
-He approved "new orders if the label on the new medication matched the order in the computer."

Interview with the RCC on 08/22/18 at 2:25pm and 08/23/18 at 11:35am revealed:
-She faxed the order dated 04/15/18 for escitalopram to the pharmacy on 08/08/18 because she had found it in Resident #1's record during an audit.
-She had not faxed the discontinuation order for escitalopram to the pharmacy, but it was noted on the order in Resident #1's record that someone from the facility had faxed the order.
-She did not know why no one from the facility had followed up on the discontinuation order for escitalopram with the pharmacy.
-She had faxed the discontinuation order to the pharmacy on 08/23/18.
-The discontinued order had to be approved by a MA, RCC, or DCS before the changes were made on the eMAR.

Telephone interview with a Certified Medical Assistant (CMA) from Resident #1's Psychiatrist's Office on 08/23/18 at 4:08pm revealed the resident could have increased anxiety and insomnia from taking escitalopram and fluoxetine together.

Refer to interview with Resident #1 on 08/22/18 at 9:01am.

Refer to interview with the DCS on 08/23/18 at 11:22am.

b. Review of Resident #1's psychiatrist's notes dated 07/26/18 revealed a physician order to start

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D 358	Continued From page 23 fluoxetine 20mg/5ml solution 5ml daily (used to treat depression). Review of Resident #1's July 2018 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry for fluoxetine 20mg/5ml solution take 5ml (20mg) by mouth every day (okay to mix in food) to be administered at 8:00am. -Fluoxetine had been documented as administered on 07/27/18, 07/28/18, and 07/30/18 and documented as refused on 07/29/18 and 07/31/18. Review of Resident #1's August 2018 eMAR revealed: -There was a computer generated entry for fluoxetine 20mg/5ml solution take 5ml (20mg) by mouth every day (okay to mix in food) to be administered at 8:00am. - Fluoxetine had been documented as refused for 9 of 24 opportunities from 08/01/18 to 08/24/18. Observation of Resident #1's medications on hand on 08/22/18 at 2:14pm revealed -A partially used bottle of fluoxetine 20mg/5ml solution dispensed 07/26/18 was available to be administered. -The pharmacy had dispensed 150ml of solution to Resident #1. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 08/23/18 at 9:47am revealed: -A 150ml bottle of fluoxetine 20mg/5ml was last dispensed to Resident #1 on 07/26/18 with directions take 5ml daily okay to mix in food. -The bottle of fluoxetine had a 30 day supply based on the directions on the order.	D 358		

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D 358	Continued From page 24 -This was the first time the pharmacy had dispensed fluoxetine solution to Resident #1. Interview with the Medication Aide (MA) on 08/22/18 at 2:14pm and 08/23/18 at 11:00am revealed: -He had been administering fluoxetine and escitalopram to Resident #1 since 07/27/18. -The MA, Resident Care Coordinator (RCC), or Director of Clinical Services (DCS) would fax new medication or discontinuation orders to the pharmacy. -The order had to be approved by a MA, RCC, or DCS before the change occurred on the eMAR. -He never looked at the original orders. -He approved "new orders if the label on the new medication matched the order in the computer." Interview with the RCC on 08/22/18 at 2:25pm and 08/23/18 at 11:35am revealed: -She faxed the order dated 04/15/18 for escitalopram to the pharmacy on 08/08/18 because she had found it in Resident #1's record during an audit. -She had not faxed the discontinuation order for escitalopram to the pharmacy, but it was noted on the order that someone from the facility had faxed the order. -She did not know why no one from the facility had followed up on the discontinuation order for escitalopram with the pharmacy. -She had faxed the discontinuation order for escitalopram to the pharmacy on 08/23/18. -The discontinued order had to be approved by a MA, RCC, or DCS before the changes were made on the eMAR. -She was not aware that Resident #1 was receiving fluoxetine and escitalopram from 07/27/18 to 08/23/18.	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 25 Telephone interview with a CMA from Resident #1's Psychiatrist's Office on 08/23/18 at 4:08pm revealed: -The resident could have increased anxiety and insomnia from taking escitalopram and fluoxetine together. -The psychiatrist office was not aware that Resident #1 had any side effects from taking medications together. Refer to interview with Resident #1 on 08/22/18 at 9:01am. Refer to interview with the DCS on 08/23/18 at 11:22am. c. Review of Resident #1's psychiatrist's notes dated 08/23/18 revealed a clarification order for olanzapine 5mg every night scheduled along with olanzapine 5mg every six hours as needed. Review of Resident #1's psychiatrist's notes dated 04/15/18 revealed a physician order to increase olanzapine to 7.5mg every night. Review of Resident #1's July 2018 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry for olanzapine ODT 5mg tablet take 1 tablet at bedtime to be administered at 8:00pm. -Olanzapine 5mg was documented as administered from 07/01/18 to 07/17/18 at 8:00pm. -The olanzapine order was documented as discontinued on 07/18/18. -A scheduled dose of olanzapine at bedtime was not documented as administered from 07/18/18 to 07/31/18.	D 358		

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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
	HAL045126	A. BUILDING: ______ B. WING ______	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA RESERVE OF LAUREL PARK	1825 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 358	Continued From page 26 Review of Resident #1's August 2018 eMAR revealed: -There was a computer generated entry for olanzapine ODT 5mg tablet take 1 and half tablets (7.5mg) at bedtime with a start date of 08/10/18. -Olanzapine 7.5mg was documented as administered from 08/10/18 to 08/21/18 at 8:00pm. -A scheduled olanzapine dose at bedtime was not documented as administered from 08/01/18 to 08/09/18. Observation of Resident #1's medications on hand on 08/22/18 at 2:14am revealed: -A medication card containing olanzapine 5mg with 1 and half tablets in every bubble with the directions 7.5mg at bedtime available to be administered. -A medication card containing olanzapine 5mg with the directions 1 tablet every six hours as needed available to be administered. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 08/23/18 at 9:47am revealed: -Olanzapine was last dispensed to Resident #1 on 08/08/18 with the directions 7.5mg every night. -The original order was dated 04/15/18. -Resident #1 had an order for olanzapine 5mg every six hours as needed. -The pharmacy dispensed 90 tablets of olanzapine 7.5mg to Resident #1 on 08/08/18 for a 17 day supply, including the scheduled and as needed orders. -The pharmacy dispensed 90 tablets of olanzapine 5mg to Resident #1 on 04/26/18 and 07/13/18 for a 17 day supply, including the scheduled and as needed orders.	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 27 Telephone interview with Resident #1's care manager/power of attorney on 08/23/18 at 1:58pm revealed: -She did not know that Resident #1 had missed multiple doses of olanzapine. -She had noticed a change in Resident #1's behavior but thought it was because of a recent change in pain medication. -Resident #1 was more agitated recently and had begun to use a walker. Interview with the MA on 08/23/18 at 11:00am revealed: -He did not know why Resident #1 had not received a scheduled daily dose of olanzapine from 07/18/18 to 08/09/18. -He did not know who had discontinued the scheduled olanzapine order on the eMAR. -He did not know if a new order was written for olanzapine in August. -No information was documented in the eMAR software to explain the missed doses of medication. Interview with the Resident Care Coordinator (RCC) on 08/23/18 at 11:35am revealed: -She had faxed an order dated 04/15/18 to increase olanzapine to 7.5mg daily to the pharmacy on 08/08/18. -She had found the order in the chart during an audit. -She did not know why Resident #1 did not receive his schedule daily dose of olanzapine from 07/18/18 to 08/09/18. -She was not aware of a discontinuation order dated 07/18/18 for a scheduled daily dose of olanzapine. -She had recently stopped monitoring "missed dose reports" because it was now the responsibility of the DCS.	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045126	A. BUILDING: ______ B. WING ______	R 08/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA RESERVE OF LAUREL PARK	1825 PISGAH DRIVE HENDERSONVILLE, NC 28791

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D 358	Continued From page 28	D 358		

-The missed doses of olanzapine for Resident #1 were not "showing up on the missed dose report."
-Reports were reviewed weekly for all medications that were not administered to a resident at the appropriate time.

Telephone interview with a CMA from Resident #1's Psychiatrist's Office on 08/23/18 at 4:08pm revealed:
-The psychiatrist had added a bedtime dose of olanzapine to help with sleep.
-The resident could have mood changes and increased insomnia from missing his scheduled olanzapine.
-The resident complained of not sleeping on a regular basis but the facility would report that the resident was sleeping.

Refer to interview with Resident #1 on 08/22/18 at 9:01am.

Refer to interview with the DCS on 08/23/18 at 11:22am.

____

Interview with Resident #1 on 08/22/18 at 9:01am revealed:
-He did not like taking a lot of medications.
-He had been having trouble sleeping.
-"It is terrible here and there will be a point that I am going to hang myself."

Interview with the DCS on 08/23/18 at 11:22am revealed:
-The RCC was responsible for faxing new orders to the pharmacy.
-The MA or DCS was responsible if the RCC was not in the facility.
-The medication orders were approved when the medication was delivered to the facility after the

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NAME OF PROVIDER OR SUPPLIER: CAROLINA RESERVE OF LAUREL PARK

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D 358	Continued From page 29 5:00pm or 11:00pm pharmacy delivery by the MA on duty. -The MA would "double check the order in the computer" with the medication the pharmacy sent. -A new procedure was started recently that a new order was attached to a "follow up checklist" to make sure each order was faxed to the pharmacy and processed. -She did not know about specific order changes for Resident #1. ______ The failure of the facility to administer medications as ordered, related to taking escitalopram, fluoxetine, and olanzapine to Resident #1 placed him at risk for increased anxiety and insomnia, which was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. ______ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/23/18 for this violation. CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 9, 2018.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights 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.	D912		

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D912	Continued From page 30 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 cardio-pulmonary resuscitation training and medication administration. The findings are: 1. Based on interviews and record reviews, the facility failed to assure at least one staff person was on the premises at all times that had training within the past 24 months in Cardio-Pulmonary Resuscitation (CPR) for 3 of 3 sampled staff (Staff C, D, and E) who worked from 11:00pm to 7:00am. [Refer to Tag D167, 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation (Type B Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (Resident #1) related to medications for depression and mood disorder. [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]	D912		

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The following is a summary of the Plan of Correction for Carolina Reserve of Laurel Park. This Plan of Correction is in regard to the Corrective Action Report dated September 10, 2018. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors.

10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation
Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation.

- Current associates were contacted requesting that they bring in a current copy of their CPR Certification by the Executive Director/ Designee.
- The schedule was reviewed for the presence of someone being in the community with a current CPR Certification all 3 shifts by the Director of Clinical Services/ Resident Care Coordinator.
- There were 2 subsequent CPR Trainings offered, on 8/23/18 & 8/31/18, with a total of 13 current associates becoming CPR Certified at that time.
- Going forward, the Executive Director/ Director of Clinical Services/ Resident Care Coordinator will have routine scheduled CPR Trainings being offered throughout the year.
- A tracker was developed for tracking the date CPR Certification was obtained, as well as the expiration date of that certification.
- Going forward, the tracker will be reviewed on a regular basis for compliance by the Executive Director/ Director of Clinical Services/ Designee reviewing for compliance.

10A NCAC 13F .0902 HEALTH CARE
(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.

- The eMAR will be reviewed for refusal of meds on at least a weekly basis for the next 30 days by the Executive Director/Director of Clinical Services/Resident Care Coordinator/Designee assuring proper follow up notification.
- Any frequent refusals noted will be followed up on with notification of the physician for further instructions by the Executive Director/Director of Clinical Services/Resident Care Coordinator/Designee
- Thereafter, the eMAR will be reviewed randomly, but at least on a bimonthly basis for refusal of meds, to include appropriate follow through.
- Appropriate associates were retrained regarding notification of the MD for meds that have been refused by the resident on 8/29/18.

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.

- Current resident charts have been reviewed for any order changes since 7/1/18 and completed by the Health and Wellness Director/Executive Director/Resident Care Coordination/ Designee.
- Any discrepancies noted during the review were clarified with the resident physician at that time with appropriate follow up and documentation by the Health and Wellness Director/Executive Director/Resident Care Coordination/ Designee.
- Re-training of appropriate associates on the use of the "New Order Tracking" form was completed on 8/29/18 by the Health and Wellness Director/Executive Director.
- Going forward, any new/changed order will have a "New Order Tracking" form completed at the time it was received by the person receiving the order.
- Each "New Order Tracking" form will be reviewed by the Health and Wellness Director/Executive Director/Designee daily for next 30 days, then minimally on a weekly basis thereafter.

G.S. 131D-21(2) Declaration of Resident Rights
2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.

- Associates were retrained no later than 9/21/18 regarding resident rights with receiving care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.

Above items will be ready for review no later than 10/1/18.