STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL088011	A. BUILDING: _____ B. WING _____	C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TORE'S HOME # 7	15 TORE DRIVE BREVARD, NC 28712

(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
C 000	Initial Comments The Adult Care Licensure Section and the Transylvania County Department of Social Services conducted a complaint investigation on 08/02/23, 08/03/23 with a telephone exit on 08/04/23. The complaint investigation was initiated by the Tranysvania County Department of Social Services on 07/31/23.	C 000		
C 131	10A NCAC 13G .0403(a) Qualifications of Medication Staff 10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure staff who administered medications had taken and successfully passed the written State medication aide exam within the 60 days after completion of the clinical skills checkoff for 2 of 5 staff (Staff C and E). The findings are: Review of Staff C's personnel record revealed: -There was documentation Staff C completed the clinical skills checkoff on 04/18/23. -Staff C should have completed the State written medication aide exam by 06/16/23. -There was no documentation Staff C had taken the State written medication aide exam within 60	C 131		

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C 131	Continued From page 1 days of completing the clinical skills checkoff. Review of the medication administration records (MAR) for June 2023 and July 2023 revealed documention Staff C continued to administer medications after 06/16/23 without having taken the State written medication aide exam. Telephone interview with Staff C on 08/03/23 at 10:00am revealed: -She was unaware of the 60 day rule. -She had been told by the facility management she would need a state issued identification (ID) in order to take the exam. -She had been waiting on the Division of Motor Vehicles (DMV) to obtain a state issued ID as she had lost her license and needed to obtain another one prior to taking the exam. Interview with the Facility Manager on 08/02/23 ay 2:30pm revealed: -If staff were waiting to obtain an ID and it was close to the 60 days the facility would move the staff member to a sister facility to start their 60 days over again. -She was unaware the facility would need complete a new hire folder for each facility to include a criminal background check, drug test and a Health Care Personnel Registry check. -She stated it was hard for staff to obtain an ID from the DMV as there were no appointments available. -The facility will hire staff without a state issued ID. -She was aware Staff C was administering medications in the facility and it was past the 60 days after she had taken her clinical skills checkoff. 2. Review of Staff E's personnel record revealed:	C 131		

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C 131	Continued From page 2 -There was documentation Staff E completed the clinical skills checkoff on 05/19/23. -Staff E should have completed the State written medication aide exam by 07/16/23. -There was no documentation Staff E had taken the State written medication aide exam within 60 days of completing the clinical skills checkoff. Review of the medication administration records (MAR) for May 2023, June 2023 and July 2023 revealed documention Staff E continued to administer medications after 05/19/23 without having taken the State written medication aide exam. Interview with the Facility Manager on 08/02/23 at 2:30pm revealed she was aware Staff E was administering medications in the facility and it was past the 60 days after she had taken her clinical skills checkoff. Attempted interview with Staff E on 08/03/23 was unsuccessful.	C 131		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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 record reviews and interviews the	C 330		

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facility failed to follow physicians orders for a resident (Resident #2) by not holding Losartan 100mg (used to treat high blood pressure) one tablet daily when the residents systolic (the top number) blood pressure was less than 110.

The findings are:

Review of Resident #2's current FL2 dated 06/30/23 revealed:
-Diagnoses of hypertension, type II diabetes, hypothyroidism, hypoxia and hydronephrosis.
-There was an order for Losartan 100mg one tablet daily, hold for systolic blood pressure less than 110.

Review of the electronic medication administration record (eMAR) for June 2023 for Resident #2 revealed:
-A computer generated entry for Losartan 100mg one tablet daily, hold for systolic blood pressure (SBP) less than 110.
-Losartan 100mg was scheduled for administration at 8:00am.
-There was documentation on 06/03/23 at 8:00am of a blood pressure of 84/71 and Losartan 100mg was not held.
-There was documentation on 06/04/23 at 8:00am of a blood pressure of 105/49 and Losartan 100mg was not held.

Review of the eMAR for July 2023 for Resident #2 revealed:
-A computer generated entry for Losartan 100mg one tablet daily, hold for systolic blood pressure less than 110.
-Losartan 100mg was scheduled for administration at 8:00am.
-There was documentation on 07/2/23 at 8:00am of a blood pressure of 84/56 and Losartan 100mg

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was not held.
-There was documentation on 07/03/23 at 8:00am of a blood pressure of 100/56 and Losartan 100mg was not held.
-There was documentation on 07/10/23 at 8:00am of a blood pressure of 103/58 and Losartan 100mg was not held.
-There was documentation on 07/13/23 at 8:00am of a blood pressure of 109/62 and Losartan 100mg was not held.
-There was documentation on 07/22/23 at 8:00am of a blood pressure of 103/51 and Losartan 100mg was not held.
-There was documentation on 07/26/23 at 8:00am of a blood pressure of 108/56 and Losartan 100mg was not held.
-There was documentation on 07/31/23 at 8:00am of a blood pressure of 108/67 and Losartan 100mg was not held.

Interview with a medication aide (MA) on 08/03/23 at 9:32am revealed:
-If there are any exceptions to why a medication is not given/held it would be circled on the eMAR and there would be a note under the exceptions section at the end of the eMAR.
-The MA who held the medication will have her initials circled.
-She confirmed her initials on 07/03/23, 07/10/23, 07/13/23, 07/26/23 and 07/31/23 where she had not held the Losartan 100mg for Resident #2.
-She had not held it for Resident #2 as she did not know what SBP was and she did not realize she needed to hold it.

Interview with the Property Manager on 08/03/23 at 10:05am revealed:
-If staff hold a medication then there will be a circle around their initials on the eMAR.
-There would be a note under the exception

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section at the end of the eMAR why staff held the medication.
-In Resident #2's case staff would note "held per MD orders".
-After reviewing the eMAR for June and July 2023 for Resident #2 she confirmed staff should have held the medication for Resident #2 on 06/03/23, 06/04/23, 07/02/23, 07/03/23, 07/10/23, 07/13/23, 07/22/23, 07/26/23, 07/31/23 per the physicians order.
-The supervisor for the facility was supposed to check each month to ensure accuracy, orders being correct and checking those orders against the eMAR for accuracy.
-The contracted facility nurse is also to be checking behind the facility supervisor.
-The facility supervisor began on 7/4/23 and was still learning her role.

Interview with the facility contracted pharmacy pharmacist on 08/03/23 at 10:25am revealed:
-If Resident #2 was given Losartan 100mg when she had a low blood pressure she could experience blurry vision, confusion, dizziness especially when standing up, syncope, headache or nausea or vomiting.
-In severe cases it could cause less blood flow to the kidneys.

Attempted interview with primary care physician for Resident #2 on 08/03/23 at 10:00am and 11:21am was unsuccessful.