STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL045122	A. BUILDING: _____ B. WING _____	R 10/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TORE'S HOME HENDERSON # 21	2408 SPARTANBURG HWY EAST FLAT ROCK, NC 28726

(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 conducted an annual and follow up survey on 10/12/23.	C 000		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 (Resident #1) resident rights were maintained related to the resident's television being removed from the resident's room. The findings are: Review of Resident #1's current FL2 dated 05/31/23 revealed there were no diagnoses listed. Review of Resident #1's record revealed diagnoses included bipolar disorder, anxiety, and traumatic brain injury (TBI). Observation of Resident #1's room during the initial tour on 10/12/23 at 8:47am revealed there was no television in the room. Interview with Resident #1 on 10/12/23 at 8:48am revealed: -He grabbed a staff's groin area and staff removed his television. -Staff removed the television from his room 10 days earlier (10/02/23). -He would like his television back because he was bored without his television.	C 311		

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C 311	Continued From page 1 -He slept to pass the time. Interview with the Supervisor in Charge (SIC) on 10/12/23 at 9:50am revealed: -Resident #1 had a history of groping, hitting, and talking in a sexually inappropriate manner to staff. -About 2 to 3 months earlier, facility management and Resident #1's guardian discussed the adverse behaviors and made the decision to take away his television for a length of time after each incident. -It was not discussed for how long to remove the television, but she would usually remove it for two days. -It was an incentive for Resident #1 to "act proper" and get his television back. -She thought it was ok to remove the television. -Staff removed the television on Sunday, 10/07/23, after Resident #1 grabbed a staff's groin area and made sexually inappropriate comments to the staff. -Resident #1 had multiple medication changes to address the adverse behaviors. Interview with the facility Manager on 10/12/23 at 11:15am revealed: -Resident #1 was sexually inappropriate, groped, and hit staff. -She reported to his mental health provider weekly regarding his adverse behaviors. -Resident #1 had multiple medication changes to address the behaviors. -She, the SIC, Resident #1's guardian, and his mental health Nurse Practitioner (NP) agreed to use the television as an intervention to address the adverse behaviors but it did not always work. -The television was removed from Resident #1's room on 10/09/23 at 7:49pm after he groped a staff and made sexually inappropriate comments.	C 311		

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C 311	Continued From page 2 Telephone interview with Resident #1's on call mental health Physician Assistant (PA) on 10/12/23 at 2:15pm revealed: -Adverse behaviors were managed with medications, not taking away personal property. -There was documentation of medication changes to address Resident #1's behaviors. -There was no documentation that removing the television was to be used as an intervention. Telephone interview with the Administrator on 10/12/23 at 12:45pm revealed: -He did not know the television was removed from Resident #1's room. -He agreed on using interventions that the mental health provider and guardian decided upon. Attempted telephone interview with Resident #1's guardian on 10/12/23 at 11:05am was unsuccessful.	C 311		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.	C 315		

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C 315	Continued From page 3 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to obtain clarification for 1 of 3 sampled residents (Resident #1) related to an order for a medication used to treat high blood glucose. The findings are: Review of Resident #1's current FL2 dated 05/31/23 revealed there were no diagnoses listed. Review of Resident #1's record revealed diagnoses included Type 2 diabetes (a chronic condition that affects the way the body processes blood sugar (glucose)). Review of Resident #1's laboratory results dated 08/29/23 revealed a hemoglobin A1c of 6.9 (a measure of blood sugar levels over the past 3 months, normal level is below 5.7) Review of an Emergency Department (ED) discharge instructions dated 09/26/23 revealed a medication order for Lantus insulin (medication used to decrease blood glucose) 100 unit/ml, inject 10 units under the skin nightly and to discuss this medication with the primary care provider. Review of Resident #1's electronic Medication Administration Record (eMAR) for 09/26/23 - 10/12/23 revealed: -There was not an entry for Lantus insulin 10 units nightly under the skin. -There was no documentation Lantus insulin 10 units nightly under the skin was administered. Interview with the facility Manager on 10/12/23 at 11:15am revealed:	C 315		

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C 315	Continued From page 4 -She did not know Lantus insulin was included in the ED discharge instructions for Resident #1. -Lantus was not being administered because "he was not on insulin". Interview with the Supervisor in Charge (SIC) on 10/12/23 at 11:50am revealed: -She was responsible for notifying the facility's contracted NP of new orders on hospital and ED discharge instructions. -She "usually" reviews the discharge instructions looking for new orders. -She should have received clarification of the Lantus order from the NP but she just missed it. Telephone interview with the facility's contracted NP on 10/12/23 at 11:25am revealed: -Resident #1 was a diabetic and had an order for an oral medication to treat his diabetes. -He did not know Resident #1 was discharged from the ED with an order for Lantus insulin. -No one from the facility contacted him for clarification of the Lantus order and he should have been notified. Telephone interview with the Administrator on 10/12/23 at 12:45pm revealed the SIC should have contacted the facility's contracted NP for clarification of the Lantus insulin order.	C 315		