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
	FCL088011	A. BUILDING: _____ B. WING _____	R 12/05/2023

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

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C 000	Initial Comments The Adult Care Licensure Section completed an annual and follow up survey on 12/05/23.	C 000	SEE ENCLOSED PLAN OF CORRECTION FOR PLC PREFIX TAGS	
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .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: Based on interviews, and record reviews, the facility failed to ensure the Primary Care Provider was notified for 1 of 3 sampled residents (Resident #3) related to blood pressures and heart rates. Review of Resident #3's current FL2 dated 07/27/23 revealed diagnosis included hypertension. a. Review of Resident #3 physician's orders dated 07/23/23 revealed: -An order for Amiodarone (used for cardiac function) 100mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -An order for amlodipine (used to treat hypertension) 5mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -An order for Chlorthalidone (used to treat hypertension) 25mg, 1/2 tablet daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -An order for lisinopril (used to treat hypertension) 40mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider.	C 246		

LSB Reviewed and acknowledged 12-22-23

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C 246	Continued From page 1 Review of Resident #3's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Amiodarone 100mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was an entry for amlodipine 5mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was an entry for Chlorthalidone 25mg, 1/2 tablet daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was an entry for lisinopril 40mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was documentation on 10/03/23 blood pressure was 134/52 and heart rate was 53. -There was documentation on 10/04/23 heart rate was 53. -There was documentation on 10/06/23 heart rate was 56. -There was documentation on 10/09/23 heart rate was 59. -There was documentation on 10/10/23 heart rate was 58. -There was documentation on 10/13/23 heart rate was 59. -There was documentation on 10/14/23 heart rate was 59. -There was documentation on 10/15/23 heart rate was 59. -There was documentation on 10/16/23 heart rate was 55. -There was documentation on 10/18/23 heart rate was 55. -There was documentation on 10/22/23 heart rate was 59. -There was documentation on 10/27/23 heart rate	C 246		

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C 246	Continued From page 2 was 54. -There was no documentation the provider was notified for out of range blood pressures or heart rates during October 2023. Review of Resident #3's November 2023 eMAR revealed: -There was an entry for Amiodarone 100mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was an entry for amlodipine 5mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was an entry for Chlorthalidone 25mg, 1/2 tablet daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was an entry for lisinopril 40mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was documentation on 11/01/23 blood pressure was 134/54. -There was documentation on 11/02/23 blood pressure was 161/53. -There was documentation on 11/05/23 blood pressure was 115/55. -There was documentation on 11/06/23 blood pressure was 144/74 and heart rate was 56. -There was documentation on 11/08/23 heart rate was 59. -There was documentation on 11/10/23 blood pressure was 124/54 and heart rate was 53. -There was documentation on 11/11/23 blood pressure was 124/52. -There was documentation on 11/13/23 blood pressure was 132/54. -There was documentation on 11/14/23 blood pressure was 130/57. -There was documentation on 11/15/23 heart rate was 53.	C 246		

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C 246	Continued From page 3 -There was documentation on 11/20/23 heart rate was 59. -There was documentation on 11/22/23 heart rate was 59. -There was documentation on 11/25/23 heart rate was 53. -There was documentation on 11/28/23 blood pressure was 136/54 and heart rate was 58. -There was documentation on 11/29/23 blood pressure was 134/53. -There was documentation on 11/30/23 blood pressure was 134/54. -There was no documentation the provider was notified for out of range blood pressures or heart rates during November 2023. Review of Resident #3's December 2023 eMAR revealed: -There was an entry for Amiodarone 100mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was an entry for amlodipine 5mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was an entry for Chlorthalidone 25mg, 1/2 tablet daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was an entry for lisinopril 40mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was documentation on 12/04/23 blood pressure was 164/53. -There was documentation on 12/05/23 heart rate was 58. -There was no documentation the provider was notified for out of range blood pressures or heart rates during December 2023. Interview with the SIC on 12/05/23 at 12:58pm	C 246		

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C 246	Continued From page 4 revealed: -She was a trained medication aide. -Resident #3 never had blood pressures or heart rates out of range. -When the SIC was shown the documented out of range blood pressures and heart rates she said she always contacted the Primary Care Provider (PCP). -She only documented in the eMAR system if she called the PCP and he instructed her to hold the medication. Interview with the facility Manager on 12/05/23 at 1:16pm revealed: -She did not review the eMARs when she reviewed resident files quarterly. -The SIC should document each time she called the PCP. -She did not know how the SIC was trained because the SIC was employed at the facility before she started working at the facility. Telephone interview with the Administrator on 12/05/23 at 1:59pm revealed he expected all his SICs who were medication aides to provide care as they were trained. Attempted telephone interview with Resident #3's PCP on 12/05/23 at 1:12pm was unsuccessful.	C 246		
C 288	10A NCAC 13G .0905(a) Activities Program 10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. This Rule is not met as evidenced by:	C 288		

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C 288	Continued From page 5 Based on observations and interviews, the facility failed to develop and implement an activity program that promoted active involvement for all 4 residents who resided in the facility. The findings are: Review of the facility's December 2023 activity calendar revealed: -The calendar was posted on a dry erase board in the hallway by the kitchen. -There was documentation a movie and a snack was scheduled from 1:00pm to 3:00pm on 12/05/23. Interview with one resident on 12/05/23 at 9:00am revealed: -She wished there were more activities in the facility. -"We really don't do anything here". -She only watched TV as an activity. Interview with a second resident on 12/05/23 at 1:45pm revealed she only sat in the dining room and looked at magazines. Interview with a third resident on 12/05/23 at 1:50pm revealed: -Staff did not provide her with any activities. -She would just watch TV and sleep to pass the time. Observations in the facility on 12/05/23 from 8:45am to 2:15pm revealed no activities occurred. Interview with the facility Manager on 12/05/23 at 2:00pm revealed: -She knew that a lot of times there were not any activities in the facility.	C 288		

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C 288	Continued From page 6 -It depended on whether or not there were enough staff to conduct the activities. -The facility had an activity director but she was on a leave of absence so staff should conduct the activities. Interview with the Supervisor in Charge (SIC) on 12/05/23 at 2:20pm revealed: -She did not conduct the afternoon activity because she was too busy. -She tried to follow the activity calendar and offered coloring and baking to the residents. Telephone interview with the administrator on 12/05/23 at 1:59pm revealed: -His main focus at the facility was providing resident care and having adequate staff. -Once the facility consistently had adequate staff they would worry about things like conducting activities.	C 288		
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 observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 3 sampled residents (#1, #2, and #3) related to a medication	C 330		

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C 330	Continued From page 7 used to decrease inflammation (#1), a medication used to treat fungal or yeast infections of the skin (#2), and 4 medications to treat blood pressure (#3). The findings are: 1. Review of Resident #1's current FL2 dated 07/13/23 revealed diagnoses included fibromyalgia (chronic disease of widespread pain and fatigue), diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), and degenerative joint disease (inflammation of the joints). Review of Resident #1's physician's orders dated 10/06/23 revealed prednisone (a medication used to decrease inflammation) 5mg daily. Review of Resident #1's physician's orders dated 10/13/23 revealed discontinue prednisone. Review of Resident #1's electronic Medication Administration Record (eMAR) for 10/13/23 - 10/31/23 revealed: -There was an entry for prednisone 5mg daily with an administration time of 10:00am and documentation the prednisone was administered daily at 10:00am from 10/13/23 - 10/31/23. Review of Resident #1's eMAR for November 2023 revealed: -There was an entry for prednisone 5mg daily with an administration time of 10:00am and there was documentation the prednisone was administered daily at 10:00am from 11/01/23 - 11/30/23. Review of Resident #1's eMAR for 12/01/23 - 12/05/23 revealed:	C 330		

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C 330	Continued From page 8 -There was an entry for prednisone 5mg daily with an administration time of 10:00am and there was documentation the prednisone was administered daily at 10:00am from 12/01/23 - 12/05/23. Review of Resident #1's medications available for administration on 12/05/23 at 1:27pm revealed: -There was one bubble pack labeled prednisone 5mg daily. -There were 30 tablets dispensed on 10/30/23 and 4 tablets remained. Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/05/23 at 10:20am revealed: -The pharmacy received a faxed physician's order for prednisone 5mg daily on 07/18/22 for Resident #1. -The pharmacy received faxed physician's orders which included prednisone 5mg daily on 10/06/23. -The pharmacy did not receive the physician's order dated 10/13/23 to stop the prednisone for Resident #1 and it continued to be an active order. Interview with the Supervisor in Charge (SIC) on 12/05/23 at 10:24am revealed: -She was responsible for faxing all physician's orders to the pharmacy. -She did not recall reviewing the physician's orders dated 10/13/23. -She did not know why she did not fax the physician's orders dated 10/13/23. Interview with the facility Manager on 12/05/23 at 10:26am revealed: -The SIC was responsible for faxing all physician orders to the pharmacy.	C 330		

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C 330	Continued From page 9 -The Manager did not know why the orders were not faxed. -She conducted medication cart audits every 90 days. Telephone interview with Resident #1's primary care provider (PCP) on 12/05/23 at 3:30pm revealed: -Resident #1 was prescribed prednisone to decrease inflammation caused by arthritis and fibromyalgia. -The medication should have been stopped because it can cause an increase in blood sugar levels. 2. Review of Resident #2's current FL2 dated 07/17/23 revealed diagnoses included hypertension and diabetes. Review of a physician's order for Resident #2 dated 11/07/23 revealed Nystatin (a medication used to treat fungal or yeast infections of the skin) 100,000 unit/gram topical powder apply to affected area three times daily. Review of Resident #2's electronic Medication Administration Record (eMAR) for November 2023 revealed: -There was an entry for Nystatin powder three times daily with administration times of 8:00am, 2:00pm, and 8:00pm with documentation the Nystatin powder was administered 11/01/23 - 11/07/23 at 8:00am, 2:00pm, and 8:00pm. -There was documentation the Nystatin powder was discontinued on 11/07/23. -There was an additional entry for Nystatin powder three times daily, ordered 11/07/23, with an administration time of prn (as needed) and no documentation it was administered.	C 330		

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C 330	Continued From page 10 Review of Resident #2's eMAR for 12/01/23 - 12/05/23 revealed there was an entry for Nystatin powder three times daily, ordered 11/07/23, with an administration time of prn and no documentation it was administered. Observation of Resident #2's medications available for administration revealed there was not any Nystatin powder available to administer. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/05/23 at 11:57am and 1:45pm revealed: -The pharmacy had received an electronic physician's order for a refill of Nystatin 100,000 unit/gram topical powder to affected area three times daily on 11/07/23. -The medication was dispensed on 11/07/23 and should have lasted 30 days. -The pharmacy only entered the medication orders exactly as written into the eMAR. -It was the facility's responsibility to enter the administration times. Interview with the SIC on 12/05/23 at 1:30pm revealed: -She was responsible for approving medication orders on the eMAR that were entered by the pharmacy. -She mistakenly entered prn instead of administration times. -She thought the Manager might review the eMAR to see if medication orders were correct. -She did not know why there was not any Nystatin powder available to administer. -She knew Resident #2 did not have any redness. Interview with the facility Manager on 12/05/23 at 11:35am revealed:	C 330		

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C 330	Continued From page 11 -The SIC was responsible for reviewing the orders and ensuring it matched the order on the eMAR. -Once the medication is reviewed it is approved and available for administration. -She did not know why the SIC entered the administration time as prn. Attempted telephone interview with Resident #2's PCP on 12/05/23 at 12:00pm was unsuccessful. 3. Review of Resident #3's current FL2 dated 07/27/23 revealed diagnosis included hypertension. a. Review of Resident #3 physician's orders dated 07/23/23 revealed an order for Amiodarone (used for cardiac function) 100mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. Review of Resident #3's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Amiodarone 100mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was documentation Amiodarone 100mg was administered on 10/03/23 and blood pressure was 134/52 and heart rate was 53. -There was documentation Amiodarone 100mg was administered on 10/04/23 and heart rate was 53. -There was documentation Amiodarone 100mg was administered on 10/06/23 and heart rate was 56. -There was documentation Amiodarone 100mg was administered on 10/09/23 and heart rate was 59. -There was documentation Amiodarone 100mg	C 330		

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C 330	Continued From page 12 was administered on 10/10/23 and heart rate was 58. -There was documentation Amiodarone 100mg was administered on 10/13/23 and heart rate was 59. -There was documentation Amiodarone 100mg was administered on 10/14/23 and heart rate was 59. -There was documentation Amiodarone 100mg was administered on 10/15/23 and heart rate was 59. -There was documentation Amiodarone 100mg was administered on 10/16/23 and heart rate was 55. -There was documentation Amiodarone 100mg was administered on 10/18/23 and heart rate was 55. -There was documentation Amiodarone 100mg was administered on 10/22/23 and heart rate was 59. -There was documentation Amiodarone 100mg was administered on 10/27/23 and heart rate was 54. -There was no documentation the provider was notified for out of range blood pressures or heart rates during October 2023. Review of Resident #3's November 2023 eMAR revealed: -There was an entry for Amiodarone 100mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was documentation Amiodarone 100mg was administered on 11/01/23 and blood pressure was 134/54. -There was documentation Amiodarone 100mg was administered on 11/02/23 and blood pressure was 161/53. -There was documentation Amiodarone 100mg was administered on 11/05/23 and blood	C 330		

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C 330	Continued From page 13 pressure was 115/55. -There was documentation Amiodarone 100mg was administered on 11/06/23 and blood pressure was 144/74 and heart rate was 56. -There was documentation Amiodarone 100mg was administered on 11/08/23 and heart rate was 59. -There was documentation Amiodarone 100mg was administered on 11/10/23 and blood pressure was 124/54 and heart rate was 53. -There was documentation Amiodarone 100mg was administered on 11/11/23 and blood pressure was 124/52. -There was documentation Amiodarone 100mg was administered on 11/13/23 and blood pressure was 132/54. -There was documentation Amiodarone 100mg was administered on 11/14/23 and blood pressure was 130/57. -There was documentation Amiodarone 100mg was administered on 11/15/23 and heart rate was 53. -There was documentation Amiodarone 100mg was administered on 11/20/23 and heart rate was 59. -There was documentation Amiodarone 100mg was administered on 11/22/23 and heart rate was 59. -There was documentation Amiodarone 100mg was administered on 11/25/23 and heart rate was 53. -There was documentation Amiodarone 100mg was administered on 11/28/23 and blood pressure was 136/54 and heart rate was 58. -There was documentation Amiodarone 100mg was administered on 11/29/23 and blood pressure was 134/53. -There was documentation Amiodarone 100mg was administered on 11/30/23 and blood pressure was 134/54.	C 330		

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 _____	R 12/05/2023

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 330	Continued From page 14 -There was no documentation the provider was notified for out of range blood pressures or heart rates during November 2023. Review of Resident #3's December 2023 eMAR revealed: -There was an entry for Amiodarone 100mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was documentation Amiodarone 100mg was administered on 12/04/23 and blood pressure was 164/53. -There was documentation Amiodarone 100mg was administered on 12/05/23 and heart rate was 58. -There was no documentation the provider was notified for out of range blood pressures or heart rates during December 2023. Observation of Resident #3's medications on hand revealed Amiodarone 100mg was available to administer. Interview with the SIC on 12/05/23 at 12:58pm revealed: -She was a trained medication aide. -Resident #3 never had blood pressures or heart rates out of range so she never held the medication. -When the SIC was shown the documented out of range blood pressures and heart rates she said she always contacted the Primary Care Provider (PCP) and was instructed to administer the medications -She only charted in the eMAR system if she called the PCP and he instructed her to hold the medication. -The PCP told her to not worry about heart rates unless they were less than 40 or 50. -She did not know why the PCP did not change	C 330		

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C 330	Continued From page 15 the parameters. Interview with the facility Manager on 12/05/23 at 1:16pm revealed: -She did not review the eMARs when she reviewed resident files quarterly. -The SIC should document each time she called the PCP. -She did not know how the SIC was trained because the SIC was employed at the facility before she started working at the facility. -The SIC should have requested the PCP change the blood pressure and heart rate parameters if he was not concerned about all the low rates. Telephone interview with the Administrator on 12/05/23 at 1:59pm revealed he expected all his SICs who are medication aides to administer medications as they were trained. Attempted telephone interview with Resident #3's PCP on 12/05/23 at 1:12pm was unsuccessful. b. Review of Resident #3 physician's orders dated 07/23/23 revealed an order for amlodipine (used to treat hypertension) 5mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. Review of Resident #3's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for amlodipine 5mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was documentation amlodipine 5mg was administered on 10/03/23 and blood pressure was 134/52 and heart rate was 53. -There was documentation amlodipine 5mg was administered on 10/04/23 and heart rate was 53.	C 330		

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C 330	Continued From page 16 -There was documentation amlodipine 5mg was administered on 10/06/23 and heart rate was 56. -There was documentation amlodipine 5mg was administered on 10/09/23 and heart rate was 59. -There was documentation amlodipine 5mg was administered on 10/10/23 and heart rate was 58. -There was documentation amlodipine 5mg was administered on 10/13/23 and heart rate was 59. -There was documentation amlodipine 5mg administered on 10/14/23 and heart rate was 59. -There was documentation amlodipine 5mg was administered on 10/15/23 and heart rate was 59. -There was documentation amlodipine 5mg was administered on 10/16/23 and heart rate was 55. -There was documentation amlodipine 5mg was administered on 10/18/23 and heart rate was 55. -There was documentation amlodipine 5mg was administered on 10/22/23 and heart rate was 59. -There was documentation amlodipine 5mg was administered on 10/27/23 and heart rate was 54. -There was no documentation the provider was notified for out of range blood pressures or heart rates during October 2023. Review of Resident #3's November 2023 eMAR revealed: -There was an entry for amlodipine 5mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was documentation amlodipine 5mg was administered on 11/01/23 and blood pressure was 134/54. -There was documentation amlodipine 5mg was administered on 11/02/23 and blood pressure was 161/53. -There was documentation amlodipine 5mg was administered on 11/05/23 and blood pressure was 115/55. -There was documentation amlodipine 5mg was administered on 11/06/23 and blood pressure	C 330		

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C 330	Continued From page 17 was 144/74 and heart rate was 56. -There was documentation amlodipine 5mg was administered on 11/08/23 and heart rate was 59. -There was documentation amlodipine 5mg was administered on 11/10/23 and blood pressure was 124/54 and heart rate was 53. -There was documentation amlodipine 5mg was administered on 11/11/23 and blood pressure was 124/52. -There was documentation amlodipine 5mg was administered on 11/13/23 and blood pressure was 132/54. -There was documentation amlodipine 5mg was administered on 11/14/23 and blood pressure was 130/57. -There was documentation amlodipine 5mg was administered on 11/15/23 and heart rate was 53. -There was documentation amlodipine 5mg was administered on 11/20/23 and heart rate was 59. -There was documentation amlodipine 5mg was administered on 11/22/23 and heart rate was 59. -There was documentation amlodipine 5mg was administered on 11/25/23 and heart rate was 53. -There was documentation amlodipine 5mg was administered on 11/28/23 and blood pressure was 136/54 and heart rate was 58. -There was documentation amlodipine 5mg was administered on 11/29/23 and blood pressure was 134/53. -There was documentation amlodipine 5mg was administered on 11/30/23 and blood pressure was 134/54. -There was no documentation the provider was notified for out of range blood pressures or heart rates during November 2023. Review of Resident #3's December 2023 eMAR revealed: -There was an entry for amlodipine 5mg daily, hold if blood pressure is less than 100/60 or heart	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 330	Continued From page 18 rate is less than 60 and notify the provider. -There was documentation amlodipine 5mg was administered on 12/04/23 and blood pressure was 164/53. -There was documentation amlodipine 5mg was administered on 12/05/23 and heart rate was 58. -There was no documentation the provider was notified for out of range blood pressures or heart rates during December 2023. Observation of Resident #3's medications on hand revealed amlodipine 5mg was available to administer. Interview with the SIC on 12/05/23 at 12:58pm revealed: -She was a trained medication aide. -Resident #3 never had blood pressures or heart rates out of range so she never held the medication. -When the SIC was shown the documented out of range blood pressures and heart rates she said she always contacted the Primary Care Provider (PCP) and was instructed to administer the medications -She only charted in the eMAR system if she called the PCP and he instructed her to hold the medication. -The PCP told her to not worry about heart rates unless they were less than 40 or 50. -She did not know why the PCP did not change the parameters. Interview with the facility Manager on 12/05/23 at 1:16pm revealed: -She did not review the eMARs when she reviewed resident files quarterly. -The SIC should document each time she called the PCP. -She did not know how the SIC was trained	C 330		

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C 330	Continued From page 19 because the SIC was employed at the facility before she started working at the facility. -The SIC should have requested the PCP change the blood pressure and heart rate parameters if he was not concerned about all the low rates. Telephone interview with the Administer on 12/05/23 at 1:59pm revealed he expected all his SICs who are medication aides to administer medications as they had been trained. Attempted telephone interview with Resident #3's PCP on 12/05/23 at 1:12pm was unsuccessful. c. Review of Resident #3 physician's orders dated 07/23/23 revealed an order for Chlorthalidone (used to treat hypertension) 25mg, 1/2 tablet daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. Review of Resident #3's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Chlorthalidone 25mg, 1/2 tablet daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was documentation Chlorthalidone 25mg, 1/2 tablet daily was administered on 10/03/23 and blood pressure was 134/52 and heart rate was 53. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 10/04/23 and heart rate was 53. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 10/06/23 and heart rate was 56. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 10/09/23 and	C 330		

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C 330	Continued From page 20 heart rate was 59. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 10/10/23 and heart rate was 58. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 10/13/23 and heart rate was 59. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 10/14/23 and heart rate was 59. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 10/15/23 and heart rate was 59. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 10/16/23 and heart rate was 55. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 10/18/23 and heart rate was 55. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 10/22/23 and heart rate was 59. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 10/27/23 and heart rate was 54. -There was no documentation the provider was notified for out of range blood pressures or heart rates during October 2023. Review of Resident #3's November 2023 eMAR revealed: -There was an entry for Chlorthalidone 25mg, 1/2 tablet daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 11/01/23 and blood pressure was 134/54. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 11/02/23 and	C 330		

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C 330	Continued From page 21 blood pressure was 161/53. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 11/05/23 and blood pressure was 115/55. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 11/06/23 and blood pressure was 144/74 and heart rate was 56. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 11/08/23 and heart rate was 59. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 11/10/23 and blood pressure was 124/54 and heart rate was 53. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 11/11/23 and blood pressure was 124/52. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 11/13/23 and blood pressure was 132/54. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 11/14/23 and blood pressure was 130/57. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 11/15/23 and heart rate was 53. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 11/20/23 and heart rate was 59. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 11/22/23 and heart rate was 59. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 11/25/23 and heart rate was 53. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 11/28/23 and blood pressure was 136/54 and heart rate was 58.	C 330		

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C 330	Continued From page 22 -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 11/29/23 and blood pressure was 134/53. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 11/30/23 and blood pressure was 134/54. -There was no documentation the provider was notified for out of range blood pressures or heart rates during November 2023. Review of Resident #3's December 2023 eMAR revealed: -There was an entry for Chlorthalidone 25mg, 1/2 tablet daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 12/04/23 and blood pressure was 164/53. -There was documentation Chlorthalidone 25mg, 1/2 tablet was administered on 12/05/23 and heart rate was 58. -There was no documentation the provider was notified for out of range blood pressures or heart rates during December 2023. Observation of Resident #3's medications on hand revealed Chlorthalidone 25mg, 1/2 tablet was available to administer. Interview with the SIC on 12/05/23 at 12:58pm revealed: -She was a trained medication aide. -Resident #3 never had blood pressures or heart rates out of range so she never held the medication. -When the SIC was shown the documented out of range blood pressures and heart rates she said she always contacted the Primary Care Provider (PCP) and was instructed to administer the	C 330		

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C 330	Continued From page 23 medications -She only charted in the eMAR system if she called the PCP and he instructed her to hold the medication. -The PCP told her to not worry about heart rates unless they were less than 40 or 50. -She did not know why the PCP did not change the parameters. Interview with the facility Manager on 12/05/23 at 1:16pm revealed: -She did not review the eMARs when she reviewed resident files quarterly. -The SIC should document each time she called the PCP. -She did not know how the SIC was trained because the SIC was employed at the facility before she started working at the facility. -The SIC should have requested the PCP change the blood pressure and heart rate parameters if he was not concerned about all the low rates. Telephone interview with the Administer on 12/05/23 at 1:59pm revealed he expected all his SICs who are medication aides to administer medications as they had been trained. Attempted telephone interview with Resident #3's PCP on 12/05/23 at 1:12pm was unsuccessful. d. Review of Resident #3 physician's orders dated 07/23/23 revealed an order for lisinopril (used to treat hypertension) 40mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. Review of Resident #3's October 2023 electronic medication administration record (eMAR) revealed: -There was an entry for lisinopril 40mg daily, hold	C 330		

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C 330	Continued From page 24 if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was documentation lisinopril 40mg was administered on 10/03/23 and blood pressure was 134/52 and heart rate was 53. -There was documentation lisinopril 40mg was administered on 10/04/23 and heart rate was 53. -There was documentation lisinopril 40mg was administered on 10/06/23 and heart rate was 56. -There was documentation lisinopril 40mg was administered on 10/09/23 and heart rate was 59. -There was documentation lisinopril 400mg administered on 10/10/23 and heart rate was 58. -There was documentation lisinopril 40mg was administered on 10/13/23 and heart rate was 59. -There was documentation lisinopril 40mg was administered on 10/14/23 and heart rate was 59. -There was documentation lisinopril 40mg was administered on 10/15/23 and heart rate was 59. -There was documentation lisinopril 40mg was administered on 10/16/23 and heart rate was 55. -There was documentation lisinopril 400mg administered on 10/18/23 and heart rate was 55. -There was documentation lisinopril 40mg was administered on 10/22/23 and heart rate was 59. -There was documentation lisinopril 400mg administered on 10/27/23 and heart rate was 54. -There was no documentation the provider was notified for out of range blood pressures or heart rates during October 2023. Review of Resident #3's November 2023 eMAR revealed: -There was an entry for lisinopril 40mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was documentation lisinopril 40mg was administered on 11/01/23 and blood pressure was 134/54. -There was documentation lisinopril 40mg was	C 330		

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C 330	Continued From page 25 administered on 11/02/23 and blood pressure was 161/53. -There was documentation lisinopril 400mg administered on 11/05/23 and blood pressure was 115/55. -There was documentation lisinopril 40mg was administered on 11/06/23 and blood pressure was 144/74 and heart rate was 56. -There was documentation lisinopril 40mg was administered on 11/08/23 and heart rate was 59. -There was documentation lisinopril 400mg was administered on 11/10/23 and blood pressure was 124/54 and heart rate was 53. -There was documentation lisinopril 400mg was administered on 11/11/23 and blood pressure was 124/52. -There was documentation lisinopril 400mg was administered on 11/13/23 and blood pressure was 132/54. -There was documentation lisinopril 400mg was administered on 11/14/23 and blood pressure was 130/57. -There was documentation lisinopril 400mg was administered on 11/15/23 and heart rate was 53. -There was documentation lisinopril 400mg was administered on 11/20/23 and heart rate was 59. -There was documentation lisinopril 400mg was administered on 11/22/23 and heart rate was 59. -There was documentation lisinopril 400mg was administered on 11/25/23 and heart rate was 53. -There was documentation lisinopril 400mg was administered on 11/28/23 and blood pressure was 136/54 and heart rate was 58. -There was documentation lisinopril 400mg was administered on 11/29/23 and blood pressure was 134/53. -There was documentation lisinopril 400mg was administered on 11/30/23 and blood pressure was 134/54. -There was no documentation the provider was	C 330		

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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 330	Continued From page 26 notified for out of range blood pressures or heart rates during November 2023. Review of Resident #3's December 2023 eMAR revealed: -There was an entry for lisinopril 40mg daily, hold if blood pressure is less than 100/60 or heart rate is less than 60 and notify the provider. -There was documentation lisinopril 400mg administered on 12/04/23 and blood pressure was 164/53. -There was documentation lisinopril 400mg administered on 12/05/23 and heart rate was 58. -There was no documentation the provider was notified for out of range blood pressures or heart rates during December 2023. Observation of Resident #3's medications on hand revealed lisinopril 40mg was available to administer. Interview with the SIC on 12/05/23 at 12:58pm revealed: -She was a trained medication aide. -Resident #3 never had blood pressures or heart rates out of range so she never held the medication. -When the SIC was shown the documented out of range blood pressures and heart rates she said she always contacted the Primary Care Provider (PCP) and was instructed to administer the medications -She only charted in the eMAR system if she called the PCP and he instructed her to hold the medication. -The PCP told her to not worry about heart rates unless they were less than 40 or 50. -She did not know why the PCP did not change the parameters.	C 330		

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 _____	R 12/05/2023

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C 330	Continued From page 27 Interview with the facility Manager on 12/05/23 at 1:16pm revealed: -She did not review the eMARs when she reviewed resident files quarterly. -The SIC should document each time she called the PCP. -She did not know how the SIC was trained because the SIC was employed at the facility before she started working at the facility. -The SIC should have requested the PCP change the blood pressure and heart rate parameters if he was not concerned about all the low rates. Telephone interview with the Administer on 12/05/23 at 1:59pm revealed he expected all his SICs who are medication aides to administer medications as they had been trained. Attempted telephone interview with Resident #3's PCP on 12/05/23 at 1:12pm was unsuccessful. Interview with the SIC on 12/05/23 at 12:58pm revealed: -She was a trained medication aide. -Resident #3 never had blood pressures or heart rates out of range so she never held his medications. -She never charted in the eMAR system when she called the Primary Care Provider (PCP), unless she was told to hold a medication. -Every time she called the PCP about Resident #3's medications she was instructed to administer them. -The PCP told her to not worry about heart rates unless they were less than 40 or 50. Interview with the facility Manager on 12/05/23 at 1:16pm revealed: -She did not review the eMARs when she reviewed resident files quarterly.	C 330		

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 _____	R 12/05/2023

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(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 330	Continued From page 28 -The SIC should document each time she called the PCP. -She did not know how the SIC was trained because the SIC was employed at the facility before she started working at the facility. -The SIC should have requested the PCP change the blood pressure and heart rate parameters if he was not concerned about all the low rates. Telephone interview with the Administer on 12/05/23 at 1:59pm revealed he expected all his SICs who are medication aides to administer medications as they had been trained. Attempted telephone interview with Resident #3's PCP on 12/05/23 at 1:12pm was unsuccessful.	C 330		

December 21, 2023, 2023

Lisa S. Bartholomew
Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation
2708 Mail Service Center
Raleigh, NC 27699-2708

Re:	Plan of Correction
Facility:	Tore's Home # 7
Facility License Number:	FCL –088-011
County:	Transylvania

Dear Ms. Bartholomew
Below you will find a Plan of Correction from the visit to our facility Tore's Home, Inc, #7 on December 5, 2023.

Plan of Correction for Prefix Tag C246

1. Correction of deficiency: Manager is to train all staff in the facility on how to contact supervisor when doctor's order state to contact doctor when vital signs drop below certain levels.
2. Measures to prevent problem from occurring: Train Supervisor in each home to follow up with doctor when vitals signs drop below certain levels as stated on doctor's orders. When orders to contact the doctor when vital signs drop below certain levels are received, contact doctor if they can add to the order to hold medication in case doctor is not able to respond quickly enough.
3. Who will monitor the situation to make sure it does not happen again: Supervisor and Manager of facilities
4. Frequency of monitoring: The monitoring will be done weekly by supervisor in each home.
5. Completion date: January 3, 2024

Plan of Correction for Prefix Tag C288

1. Correction of deficiency: Train staff to do activities during the slower part of the day but still during hours when residents are awake.
2. Measures to prevent problem from occurring: Engage support staff such as drivers, floaters, Supervisor on Call to engage in activities as available
3. Who will monitor the situation to make sure it does not happen again: Supervisor and Manager of facilities
4. Frequency of monitoring: The monitoring will be done monthly by supervisor in each home.
5. Completion date: January 3, 2024

Plan of Correction for Prefix Tag C330

1. Correction of deficiency: Train all staff on how to hold medication when vitals signs fall below certain limits per doctor's **written** orders.
2. Measures to prevent problem from occurring:
    a. Manager to review resident's eMAR quarterly.
    b. Train supervisor to document each time PCP is contacted
    c. If PCP changes the parameters of an order verbally have PCP give a written change order.
3. Who will monitor the situation to make sure it does not happen again: Supervisor and Manager of facilities
4. Frequency of monitoring: The monitoring will be done upon admission of a new resident and upon returning from the hospital and monthly by supervisor in each home.
5. Completion date: January 3, 2024