STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL045127	A. BUILDING _____ B. WING _____	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TORE'S HOME # 22	41 TORE'S DRIVE 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 survey on 04/29/25.	C 000		
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 administer medications as ordered for 1 of 3 sampled residents (Resident #2) related to a vitamin supplement. The findings are: Review of Resident #2's current FL2 dated 02/28/25 revealed diagnoses included Alzheimer's Disease and anemia. Review of Resident #2's physician's orders dated 02/06/25 revealed vitamin B12 (supplement) 500mcg daily. Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed there was an entry for vitamin B12 500mcg daily at 9:00am and documentation the B12 500mcg was administered 03/01/25 -	C 330	C330 10 NCAC 13G: *Tore's Home sends all medication orders to Blue Ridge Pharmacy, Tunnell Rd., Asheville NC. We encourage residents and resident's POA to allow us to use this pharmacy for all medication needs, which cut down on this type of error. We spoke with Resident #2's POA, he refuses to allow us to have the pharmacy fill this medication due to the cost. *Change in procedure-When accepting medication from an outside party we will have the med. tech and a witness check the medication into the med. cart. *Witness added to procedue to check in outside meds.when pharmacy not used. *Monitoring of the med cart will be completed by the supervisor of the facility, manager of the facility and the pharmacy representative. *Supervisor of the facility will review the med cart each morning, Monday thur Friday. Manager to the facility will monitor the med cart quarterly along with the representative's quarterly monitoring. *Plan of correction has been completed as of April 30, 2025.	

Reviewed and acknowledged 5/13/25

RP

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C 330	Continued From page 1 03/31/25 at 9:00am. Review of Resident #2's eMAR for 04/01/25 - 04/29/25 revealed there was an entry for vitamin B12 500mcg daily at 9:00am and documentation the B12 500mcg was administered 04/01/25 - 04/29/25 at 9:00am. Observation of Resident #2's medications available for administration on 04/29/25 at 9:53am revealed: -There was one over the counter bottle labeled B12 1000mcg, 180 tablets. -There were 53 tablets remaining in the bottle. Telephone interview with a representative from the facility's contracted pharmacy on 04/29/25 at 10:24am revealed: -The pharmacy received an order via fax for vitamin B12 500mcg daily on 01/09/25. -The pharmacy did not dispense the medication because they were instructed by the facility just to enter the medication into the eMAR system. Interview with the medication aide (MA) on 04/29/25 at 9:55am revealed: -Resident #2 was administered one tablet from the vitamin B12 bottle daily. -She always administered one tablet to the resident. -Resident #2's family member brought in the bottle of vitamin B12. -She did not read the label closely enough and did not know the tablets were 1000mcg. Telephone interview with Resident #2's family member on 04/29/25 at 10:28am revealed: -He brought the bottle of B12 1000mcg to the facility a couple of months earlier. -He did not know what dosage of B12 Resident	C 330		

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C 330	Continued From page 2 #2 was ordered. -He assumed she was getting the correct dose. Interview with the Manager on 04/29/25 at 10:18am revealed: -The MA should be paying more attention to the labels on the medication bottles and comparing to the eMAR. -The Supervisor-in-Charge (SIC) were responsible for auditing the medication carts. -All the MAs were trained to read the medications labels and compare it with the eMAR. Telephone interview with Resident #2's Primary Care Provider (PCP) on 04/29/25 at 10:32am revealed: -Resident #2 was prescribed vitamin B12 500mcg due to a deficiency. -She expected staff to administer the medications as ordered and contact her if there were issues.	C 330		