STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL088010	A. BUILDING: _____ B. WING _____	R 04/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TORE'S HOME #3	65 TORE'S 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 conducted an annual survey and a follow-up survey on April 23, 2015 with an exit conference via telephone on April 28, 2015.	C 000		
C 105	10A NCAC 13G .0317(d) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain the hot water temperatures in 6 of 6 resident rooms (Rooms 1-6) and 1 of 1 common half bath at a minimum of 100 degrees F (38 degrees C). The findings are: Observations during the facility tour on 4/23/15, between 9:00am and 9:27am, revealed: -The hot water temperatures at the sink in the half bathroom on the right end of the building measured 98 degrees Fahrenheit (F). -The hot water temperature in Rooms 1 and 2, across from the half bathroom, measured 96 degrees F. -The hot water temperature in Room 3, 4, 5 and 6 on the left side of the building measured 78-80 degrees F.	C 105		

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C 105	Continued From page 1 Interview on 4/23/15 at 9:30am with the Supervisor-In-Charge/Medication Aide (SIC/MA) revealed: -She was not aware the hot water temperatures in the resident's rooms and in the half bathroom in the hallway were between 78 and 98 degrees F. -No residents had complained of the hot water temperature being too cold. -The facility had a thermometer for testing water temperatures but she did not know exactly where it was located at the current time. -She did not routinely check water temperatures. -The facility had a hot water temperature log on the wall of the office, but it had not been kept up to date. -All residents currently residing in the home had diagnoses of dementia. -She had just called the Administrative Assistant/Operations Manager (AA/OM) and informed him about the water temperatures and hot water heaters. Interview on 4/23/15 at 10:00am with the AA/OM revealed: -He had just checked the hot water temperature in the half bathroom and it had been 98 degrees F. -He then checked the hot water temperature in Room 4 and it had been 82 degrees F. -The facility had 2 hot water heaters, one of which he found not working and the other he turned up the thermostat. -The resident rooms with hot water temperatures in the 80's were getting the water from the hot water heater holding tank. -After checking the water temperatures and the hot water heaters, he called a plumber who was due to arrive shortly to "trouble shoot/repair". -The facility did not have a maintenance log.	C 105		

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C 105	Continued From page 2 -The staff texted or called him if there was a problem. -He was not aware there was a problem until the SIC called him. Re-check of the hot water temperatures on 4/23/15 at 12:20pm and 2:10pm revealed: -The hot water temperatures at the sink in the half bathroom on the right end of the building measured 104 degrees Fahrenheit (F) and 112 degrees F. -The hot water temperature in Room 2, across from the half bathroom, measured 104 degrees F and 112 degrees F. -The hot water temperature in Room 4 remained at 80 degrees F. -The hot water temperature in Room 5 remained at 80 degrees F. Interview on 4/23/15 at 2:15pm with a MA/PCA (Personal Care Aide) revealed: -She had been working 3:00pm-11:00pm on 4/22/15. -The wind had been blowing very hard and the lights flickered. -Later in the evening, she noticed the hot water didn't seem to be as hot as it usually was. -The facility did not have a maintenance log. -The staff would call or text the AA/OM if problems came up. -She did not text or call the AA/OM regarding her concerns the hot water temperatures did not seem as warm as usual. -She had a training in the facility the morning of 4/23/15, and knew she would see the AA/OM and planned on telling him at that time. -She had not seen him prior to the SIC/MA calling him in to check water temperatures and hot water heaters.	C 105		

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C 105	Continued From page 3 Interview on 4/28/15 at 7:45am with the Administrator revealed: -The non-functioning water heater had been replaced. -An extra water heater had been purchased to "have on hand".	C 105		
C 247	10A NCAC 13G .0902(c) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (1) facility contacts with the resident's physician, physician service, other licensed health professional, including mental health professional, when illnesses or accidents occur and any other facility contacts with a physician or licensed health professional regarding resident care; This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to assure documentation in the resident's record related to one of three sampled residents (#2) receiving physician's services in the Emergency Department. The findings are: Review of Resident #2's current FL2 dated 3/9/15 revealed: -Diagnoses included Dementia and Chronic Brain Syndrome. -An admission date of 5/21/14. -He was constantly confused. -He was ambulatory and a wanderer.	C 247		

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C 247	Continued From page 4 Review of an Upper GI Endoscopy report dated 4/4/15 and located in the resident's record revealed: -The procedure had taken place on 4/4/15 at 7:50pm. -The resident had been an Outpatient admit. -Indications for the procedure were dysphagia (difficulty swallowing), foreign body in the esophagus and suspected esophageal obstruction due to food bolus impaction (a rounded mass of food packed into the esophagus). -Findings: Food had been found in the entire esophagus and removal had been successful. -Mildly severe esophagitis was noted after the food bolus was removed. -A benign appearing esophageal stricture was identified and biopsied. -Stenosis (narrowing) of the esophagus was identified. -Moderate mucosal (the membrane lining the intestinal tract) abnormality was identified in the duodenum (the first portion of the small intestine) and biopsied. Continued review of the resident's record revealed there was no documentation in the nurses notes or progress notes of Resident #2's record regarding the 4/4/15 Upper GI Endoscopy. Interview with Staff C (Medication Aide/Personal Care Aide) on 4/23/15 at 2:55pm revealed: -She had been on duty the evening of 4/4/15. -Resident #2 had left the facility with family for dinner. -Around 7:15pm, Resident #2's family member called and told her the resident was choking and the family was taking him to the local Emergency Room (ER).	C 247		

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C 247	Continued From page 5 -She notified the Supervisor-on-Call who called the family to tell them she would meet them at the ER. The family declined. -The resident returned to the facility with his family. -She did not document this incident in the nurses notes or progress notes. -She did not notify Resident #2's physician about the incident. Interview with Staff A, Supervisor-in -Charge/Medication Aide (SIC/MA) on 4/23/15 at 3:00pm revealed: -She had been notified Resident #2 was choking and going to the ER but did not document the incident in the nurses notes or progress notes. -She did not have Staff C document in the chart. -She did not notify Resident #2's physician of the incident. Interview with the Administrator on 4/28/15 at 7:45am revealed: -Documention regarding Resident #2's choking, evaluation and treatment in the ED should have been done in the Resident's record. -He did not know why the documentation had not occurred. -He would find out what happened, why it happened and make the necessary changes to prevent it from happening again.	C 247		
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:	C 330		

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C 330	Continued From page 6 (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 and interviews, the facility failed to assure medication was administered as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (#2) related to Prilosec. The findings are: Review of Resident #2's current FL2 dated 3/9/15 revealed: -Diagnoses included Dementia and Chronic Brain Syndrome. -An admission date of 5/21/14. Further review of the resident's record revealed: -An Upper Gastro-Intestinal Endoscopy (visualization of the esophagus, stomach and the first portion of the small intestine) report from 4/4/15 at 7:50pm. -Indications for the procedure were dysphagia (difficulty swallowing), foreign body in the esophagus and suspected esophageal obstruction due to food bolus impaction (a rounded mass of food packed into the esophagus). -Findings: Food had been found in the entire esophagus and removal had been successful. -Mildly severe esophagitis was noted after the food bolus was removed. -A benign appearing esophageal stricture was identified and biopsied. -Stenosis (narrowing) of the esophagus was identified. -Moderate mucosal (the membrane lining the	C 330		

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C 330	Continued From page 7	C 330		

intestinal tract) abnormality was identified in the duodenum and biopsied.
-Post procedure recommendations included a mechanical soft diet, indefinitely and Prilosec 20mg daily, indefinitely.
-The report, with recommendations, had been signed electronically and with the physicians hand written signature.

Review of Resident #2's Medication Administration Record (MAR) for April 2014 revealed no order for Prilosec 20mg daily.

Interview with Staff C, Medication Aide/Personal Care Aide (MA/PCA), on 4/23/15 at 2:55pm revealed:
-She had been on duty the evening of 4/4/15.
-Around 7:15pm, Resident #2's family member called and told her the resident was choking and the family was taking him to the local Emergency Room (ER).
-She notified the Supervisor-on-Call (SOC).
-The resident returned to the facility with a copy of the Upper Gastro-Intestinal Endoscopy report.
-She starred and highlighted the recommendations and left them for the weekday Supervisor-in-Charge (SIC) to review in the morning.
-The SOC and the Supervisor-in-Charge (SIC) were the only staff who could transcribe orders.

Interview with Staff A, SIC, on 4/23/15 at 3:00pm revealed:
-She had not seen the report sheet from Resident #2"s Upper GI Endoscopy prior to the interview.
-She knew the Resident was on a mechanical soft diet because a family member had told her.
-She was not aware the physician had also ordered Prilosec 20mg daily, indefinitely.
-She would call the physician and see what he

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C 330	Continued From page 8 wanted to do about the medication order. -The facility did not have a policy or procedure for reviewing reports coming from the hospital prior to their being filed in the chart. -She and the SOC were the only staff who could transcribe physician's orders. Interview with the Administrator on 4/28/15 at 7:45am revealed: -He was not aware Resident #2 had orders from the Gastro-Enterologist who had performed the Upper GI Endoscopy. -He did not know why the staff had not followed through on the orders. -He would find out what happened, why it happened and make the necessary changes to prevent it from happening again. A telephone call to the Gastro-Enterologist on 4/28/15 at 11:15am was not returned prior to exit.	C 330		