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
	FCL045127	A. BUILDING: _____ B. WING _____	12/06/2023

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 12/06/23.	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: TYPE A1 VIOLATION Based on observation, interviews and record reviews, the facility failed to ensure 1 of 3 sampled residents (Resident #2) was free from mental abuse and neglect related to staff disallowing or restricting telephone communication with his family member and utilizing a geriatric chair (Geri-chair) as forms of disciplinary action. The findings are: Review of Resident #2's current FL2 dated 11/28/23 revealed diagnoses included dementia with behavioral disorder and bi-polar disorder. Review of Resident #2's Resident Register revealed: -He was admitted to the facility on 02/25/20. -He had a legal guardian. Review of Resident #2 care plan dated 10/16/23 revealed: -There was documentation he was a fall risk. -There was documentation he was sometimes disoriented.	C 311	SEE ENCLOSED ATTACHMENT FOR PLAN OF CORRECTION	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: PRESIDENT — (X6) DATE: 12-22-23

Reviewed and acknowledged 12/28/23 RP

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C 311	Continued From page 2 himself on the floor in a seated position and scoot over to the call light by the toilet and activate the call light. -She responded to the call light, and he told her he fell. -She and another staff member helped him up and assessed him, determining he was not injured. -She informed Resident #2 his telephone privileges would be taken away for a week because when he pretended to be hurt it scared staff. -Resident #2's Primary Care Provider (PCP) reviewed and signed the Accident Report on 08/15/23. -There was documentation the incident was reviewed and discussed with Resiudent #2's legal guardian. Interview with the SIC on 12/06/23 at 10:25am revealed: -Resident #2 had a history of "ignoring us and pretending to fall". -Receiving telephone calls from his family member was taken away as discipline. -She knew staff were not allowed to discipline residents, but they took his telephone privileges away as discipline because it stopped his behavior. -Staff "do what they have to do". -Staff had been disciplining him by taking his telephone privileges away since before she started in October 2022. -Whether or not Resident #2 was allowed to receive telephone calls from his family member was dependent upon his behavior. -His legal guardian knew about the incident on 08/13/23 and initially agreed with staff taking away telephone privileges, but in October 2023 she told staff they could no longer take away his	C 311		

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C 311	Continued From page 3 telephone privileges as a disciplinary action. -Instead of taking away telephone privileges staff now used a Geri-Chair to prevent him from falling. Interview with the facility Manager on 12/06/23 at 11:58am revealed: -Resident #2's behaviors increased after he talked with his family member on the telephone. -His agitation continued after he had a telephone conversation with his family member. -In order to reduce behaviors, the telephone calls were limited to one call per day. -Staff removed the telephone privileges when Resident #2 had negative behaviors such as throwing himself on the floor, not taking his medications or screaming at staff. -Staff started taking away telephone privileges about a year ago. -Taking the telephone away helped with his behavior at first but it eventually stopped working. - Effective October 2023 the guardian said taking away his telephone privileges was no longer allowed. -The facility manager did not think taking telephone privileges away was discipline. -She knew staff were not allowed to discipline residents. Telephone interview with Resident #2's legal guardian on 12/06/23 at 12:29pm revealed: -Resident #2 talked with his family member at 3:00pm each day. -She was aware staff at the facility had been using Resident #2's telephone privileges as a disciplinary tool and had been doing it for more than a year. -In October 2023 it was decided by the guardian telephone privileges would not be used as a discipline tool anymore because using it had	C 311		

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C 311	Continued From page 4 gotten out of hand and it was being used too frequently and for minor behavior infractions such as taking "too long to eat dinner". -On 11/29/23 she spoke with Resident #2's Mental Health Provider (MHP) about giving Resident #2 the opportunity to earn privileges with good behaviors rather than taking things away such as telephone calls. Telephone interview with Resident #2's MHP on 12/06/23 at 3:24pm revealed: -She was not aware Resident #2's telephone privileges were being used as a disciplinary tool. -She talked in the past with staff about modifying behaviors through use of a consistent schedule and using de-escalation techniques. -Adverse behaviors were managed with medications, not taking privileges away. Telephone interview with the Administrator on 12/06/23 at 2:58pm revealed: -He was not aware staff were removing Resident #2's telephone calls with his family member when he had negative behaviors. -He recently was informed that even if the facility had permission from the guardian, the PCP and the MHP, removing privileges and personal property was unacceptable. -He told staff last week that resident discipline was not appropriate or approved. Attempted telephone interview with Resident #2's PCP on 12/06/23 at 2:59pm was unsuccessful. b. Observation of Resident #2 on 12/06/23 at 8:40am revealed he was seated in his bedroom in a Geri-chair with a lap tray. Interview with Resident #2 on 12/06/23 at 8:40 and 10:45am revealed:	C 311		

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C 311	Continued From page 5 -He needed to use a walker because he had a hard time walking. -He was sitting in a Geri-chair with a lap tray because he fell on the way to breakfast earlier in the morning when he was using his walker. -He never pretended to fall; if he fell it was because he was weak, which he did frequently because of his medication changes. -He was put in the Geri-chair whenever he fell. Interview with the SIC on 12/06/23 at 10:25am revealed: -Resident #2 had a history of "ignoring us and pretending to fall". -Instead of taking away telephone privileges staff now used a Geri-chair to prevent him from falling. -Staff started using a Geri-chair with Resident #2 on 11/29/23. -The Geri-chair was originally ordered in February 2023, but it was never used. -Resident #2 was placed in a Geri-chair whenever he had behaviors such as pretending to fall, which he did frequently. Interview with the facility manager on 12/06/23 at 11:58am and 2:44pm revealed: -The Geri-chair was used when Resident #2 had behaviors. -The facility requested the use of a Geri-chair as a restraint for behaviors, on an as needed basis. -The staff had been using a facility owned Geri-chair with Resident #2 even before the February 2023 request to purchase one for him was completed. -When the Geri-chair was first purchased in February 2023, Resident #2 needed it frequently, but his he told MHP made medication adjustments and his behavior improved so the staff did not have to place him in the Geri-chair except on rare occasions.	C 311		

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C 311	Continued From page 6 -Since 11/29/23, Resident #2 was placed in the Geri-chair if he threw himself on the floor three or more times. Telephone interview with Resident #2's legal guardian on 12/06/23 at 12:29pm revealed: -She thought staff started using a Geri-chair, for safety, with Resident #2 on 11/29/23. -The Geri-chair was being used if Resident #2 repeatedly threw himself on the floor. -She was with staff when he had a tele-health appointment with his PCP on 11/29/23 and the PCP requested staff speak with Resident #2's MHP about using the Geri-chair if he threw himself on the floor. Telephone interview with Resident #2's MHP on 12/06/23 at 3:25pm revealed: -The first time she remembered seeing Resident #2 in a Geri-chair was in mid-November 2023, prior to his hospitalization, but he did not have a tray attached to it. -She talked in the past with staff about modifying behaviors through use of a consistent schedule and using de-escalation techniques. -Adverse behaviors were managed with medications, not taking privileges away. Telephone interview with the Administrator on 12/06/23 at 2:58pm revealed staff last week that resident discipline was not appropriate or approved. Attempted telephone interview with Resident #2's PCP on 12/06/23 at 2:56pm was unsuccessful. The facility failed to ensure Resident #2 was free from mental abuse and neglect when staff restricted telephone communication with his family member by disallowing the resident to	C 311		

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C 311	Continued From page 7 receive telephone calls and obtaining an order for and inappropriately utilizing a Geri-chair without guardian consent as a form of discipline for behaviors by placing Resident #2 in the Geri-chair which was equipped with a lap tray that prevented the resident from exiting the Geri-chair without staff assistance. This failure resulted in mental abuse and neglect of Resident #2 and constitutes a Type A1 Violation. _____ A Plan of Protection was obtained according to G.S. 131D-34 on December 06, 2023. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 05, 2023.	C 311		
C 444	10A NCAC 13G .1213 Reporting Of Accidents And Incidents 10A NCAC 13G .1213 Reporting of Accidents and Incidents (a) A family care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the county department of social services (DSS) for 1 of 3 sampled residents (#1) after the resident sustained a fall with injury in her room requiring an emergency	C 444		

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C 444	Continued From page 8 department (ED) visit and hospitalization for a fractured leg. The findings are: Review of Resident #1's current FL2 dated 11/22/23 revealed a diagnosis of acute right femur fracture. Review of Resident #1's Resident Register revealed an admission date of 06/26/23. Review of Resident #1's hospital discharge summary dated 11/24/23 revealed Resident #1 was admitted to the hospital on 11/20/23 for a fractured femur requiring surgical repair and was discharged back to the facility on 11/24/23. Review of a facility accident report for Resident #1 dated 11/20/23 revealed: -Resident #1 rang her call light. -When staff went into the resident's room she was on the floor crying and her right leg was twisted over her left leg. -Resident #1 was unable to stand. -Emergency Medical Services (EMS) was notfied and Resident #1 was transported to the ED. -There was documentation the family and physician was notified. -There was no documentation the local county DSS was notified. Telephone interview with the local county DSS Adult Home Specialist (AHS) on 12/06/23 at 11:34am revealed DSS did not receive notification that Resident #1 was sent to the ED on 11/20/23 for an injury. Interview with the Supervisor in Charge (SIC) on 12/06/23 at 11:43am revealed:	C 444		

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C 444	Continued From page 9 -She knew she was supposed to notify DSS when a resident was sent to the ED requiring treatment for an injury. -She was going to notify DSS after the PCP signed the Accident Report. -She did not know she was to notify DSS immediately after an accident. Interview with the facility Manager on 12/06/23 at 12:00pm revealed: -She knew that DSS was to be notified immediately after a resident was sent to the ED for treatment. -The SIC was responsible for the notification. -She should have followed up with the SIC to ensure it was done.	C 444		
C 453	10A NCAC 13G .1301(a) Use of Physical Restraints and Alternatives 10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (a) A family care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential	C 453		

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C 453	Continued From page 10 decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a restraint was used only after a written physician order, a team assessment and care planning process occurred, and alternatives were tried prior to the restraint being implemented for 1 of 1 sampled resident (#2) who had a geriatric chair (Geri-chair) and was placed in the Geri-chair by staff for "behaviors". The findings are: Review of Resident #2's current FL2 dated	C 453		

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C 453	Continued From page 11 11/28/23 revealed diagnoses included dementia with behavioral disorder and bi-polar disorder. Observation of Resident #2 on 12/06/23 at 8:40am revealed he was sitting in his room in a Geri-chair with a tabletop. Interview with Resident #2 on 12/06/23 at 8:40am and 10:45 revealed: -He was in the Geri-chair because he fell going to breakfast earlier in the morning. -He was put in the Geri-chair whenever he fell. -He needed to use a walker because he had a hard time walking. -Staff say he pretends to fall but he never pretended to fall; if he fell it was because he was weak, which he did frequently because of his medications. Review of Resident #2 care plan dated 10/16/23 revealed: -There was documentation he was at high risk for falls. -There was documentation he was sometimes disoriented. -There was documentation he had limited ability to ambulate and needed a walker. Review of Resident #2's Request for Physician's Orders to Obtain Medical Equipment dated 02/01/23 revealed: -The request was for a Geri-chair with a detachable tray. -There was documentation the Geri-chair was needed for behaviors. -There was documentation the resident was at high risk for falls. -There was documentation the tray may be used as barrier to prevent the resident from exiting the chair without assistance while providing some	C 453		

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C 453	Continued From page 12 freedom of movement. -The request was signed by Resident #2's Primary Care Provider (PCP). Interview with Resident #2's PCP on 12/06/23 at 11:50am revealed: -He was the PCP on 02/01/23 when the Geri-chair request was signed. -He was no longer Resident #2's PCP. -He did not remember why staff requested a Geri-chair. Review of Resident #2's record revealed: -There was no documentation of an assessment, or a care planning process occurred before use of the restraint. -There was no documentation of guardian consent for use of the restraint. -There was no documentation any alternatives were tried prior to use of the restraint. Interview with the Supervisor in Charge (SIC) on 12/06/23 at 10:25am and 2:34pm revealed: -Staff started using a Geri-chair with Resident #2 on 11/29/23. -It was originally ordered in February 2023, but it was never used. -Resident #2 was placed in a Geri-chair whenever he had behaviors such as pretending to fall, which he did frequently. -Resident #2's guardian was aware of the Geri-chair use, but she was not sure if a consent was ever signed. -The facility manager was responsible for obtaining all paperwork related to restraint use. Interview with the facility manager on 12/06/23 at 11:58am and 2:44pm revealed: -The Geri-chair was used when Resident #2 had behaviors.	C 453		

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C 453	Continued From page 13 -The facility requested the use of a Geri-chair as a restraint for behaviors, on an as needed basis, in February 2023 and thought all the paperwork was obtained at that time. -The staff had been using a facility owned Geri-chair with Resident #2 even before the February 2023 request to purchase one for him was completed. -She did not know why all the documents were no longer in his record. -When the Geri-chair was first purchased in February 2023, Resident #2 needed it frequently, but his Mental Health Provider (MHP) made medication adjustments and his behavior improved so the staff did not have to place him in the Geri-chair except on rare occasions. -Since 11/29/23, Resident #2 was placed in the Geri-chair if he threw himself on the floor three or more times. Telephone interview with Resident #2's legal guardian on 12/06/23 at 12:29pm revealed: -Staff started using a Geri-chair, for safety, with Resident #2 on 11/29/23. -The Geri-chair was being used if Resident #2 repeatedly threw himself on the floor. -She never signed a consent for the use of a Geri-chair. -She was with staff when he had a tele-health appointment with his PCP on 11/29/23 and the PCP requested staff speak with Resident #2's MHP about using the Geri-chair if he threw himself on the floor. Telephone interview with Resident #2's MHP on 12/06/23 at 3:25pm revealed the first time she remembered seeing Resident #2 in a Geri-chair was in mid-November 2023, prior to his hospitalization, but he did not have a tray attached to it at that time.	C 453		

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C 453	Continued From page 14 Telephone interview with the Administrator on 12/06/23 at 2:58pm revealed: -If a restraint was being used with Resident #2, the facility Manager knew to complete all necessary restraint paperwork prior to use of the restraint. -All staff were trained in the proper use of restraints. -He was ultimately responsible for ensuring the facility Manager completed all restraint paperwork prior to use. Attempted telephone interview with Resident #2's PCP on 12/06/23 at 2:56pm was unsuccessful.	C 453		

December 22, 2023

Team Leader
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 # 22
Facility License Number:	FCL –045-127
County:	Henderson

Dear Team Leader
Below you will find a Plan of Correction from the visit to our facility Tore's Home, Inc, #22 on December 6, 2023.
This Plan of Correction is not an acknowledgement that the findings in the report issued by the surveyor are correct.

Plan of Correction for Prefix Tag C311

1. Correction of deficiency: Train staff to never use personal property or restraints to manage resident's behavior and to only restraints according to state regulations.
2. Measures to prevent problem from occurring: Train staff to make sure residents' personal property is always allowed to be used by Resident and that personal property is not used to manage a resident's behavior. Whenever a Geri chair is used to keep a resident safe from falling (in this case the resident's behavior was such that he was at risk from falling) staff will be trained to secure proper paperwork for restraints and trained to follow state regulations with regard to restraints.
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 the first time such restraints are used for any resident by supervisor and manager and weekly by supervisor in each home.
5. Completion date: January 3, 2024

Plan of Correction for Prefix Tag C444

1. Correction of deficiency: Train supervisors on how and when to send accident reports to DSS
2. Measures to prevent problem from occurring: Manager will follow up with supervisor to make sure an accident report is filed with DSS every time a resident has an accident.
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 every time a resident has an accident.
5. Completion date: January 3, 2024

Plan of Correction for Prefix Tag C453

1. Correction of deficiency: Manager is to train all supervisors on how to obtain orders for a restraint, obtain all the correct paperwork with required signatures and how to use such restraints according to state regulations.
2. Measures to prevent problem from occurring: Any time a restraint is ordered and used the supervisor in each home is to contact the Manager to make sure proper orders are obtained and uses of such restraints are performed per state regulations.
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 the first time such restraints are used for any resident by supervisor and manager and weekly by supervisor in each home.
5. Completion date: January 3, 2024