		AND HUMAN SERVICES			0		APPROVED 0938-0391
				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
34G072		B. WING			04/09/2019		
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
T.L.C. HOME, INC.					775 HAWKINS AVENUE ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 125			W 1	25			
	 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 3 of 6 audit clients (#1, #5, #9) had the right to be treated with dignity regarding the use of disposable incontinence pad placed underneath them as they sat. The findings are: Clients #1, #5, and #9 dignity was not considered regarding the use of a disposable incontinence pad placed underneath them as they sat. a. During evening observations in the home on 4/8/19 from 4:53pm until 5:20pm, client #1 was seated in a recliner with a disposable incontinence pad underneath him; it was visible to anyone in the home. b. During afternoon observations in the home on 4/8/19 from 11:30am though 1:05pm, client #9 was seated in his wheelchair with a disposable incontinence pad underneath her. c. During afternoon observations in the home on 4/8/19 from 11:30am though 1:05pm, client #9 was seated in his wheelchair with a disposable incontinence pad underneath her. 						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

(X6) DATE

PRINTED: 04/10/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 04/10/2019 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		. ,		(X3) DAT	(X3) DATE SURVEY COMPLETED	
		34G072	B. WING		04/	09/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
T.L.C. HOME, INC.				1775 HAWKINS AVENUE SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 125	pads are used just their clothes and the are also soiled. Fue #1, #5 and #9 are med to use the bat their clothing. Addi clients residing in th hours regarding the Review on 4/9/19 o plan (IPP) dated 4/2 Dependent on staff Review on 4/9/19 o revealed, "Toileting" staff"	in case the clients soil though en their wheelchair or recliner rther interview revealed clients not able to indicate when they hroom or if they have soiled tional interview revealed all the ne home are checked every 2 eir toileting. f client #5's individual program 23/18 stated, "Toileting: " f client #9's IPP dated 8/7/18 c [Client #9] is dependent on	W 125			
W 249	Director revealed sl disposable incontin wheelchair. Furthe Executive Director v disposable incontin and should have oc revealed the home rounds" which mea changed at least ev needed. PROGRAM IMPLE CFR(s): 483.440(d) As soon as the inte formulated a client's each client must re- treatment program interventions and so and frequency to su		W 249			

Facility ID: 922685

If continuation sheet Page 2 of 6

		AND HUMAN SERVICES				FORM	04/10/2019 APPROVED 0938-0391		
		. ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
34G072		B. WING			04/09/2019				
NAME OF PROVIDER OR SUPPLIER				S	STREET ADDRESS, CITY, STATE, ZIP CODE				
T.L.C. HOME, INC.			1775 HAWKINS AVENUE SANFORD, NC 27330						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE		
W 249	Continued From pa plan.	ge 2	W 2	249					
	Based on observat reviews, the facility received a continuo consisting of neede identified in the indi the area of impleme an adaptive switch	s not met as evidenced by: tions, interviews and record failed to assure each client bus active treatment plan ed interventions and services ividual program plan (IPP) in enting a formal objective using for communication. This t clients (#10). The findings							
		encouraged to utilize her ing mealtimes as described in e.							
	12:30pm, client #10 at the dining room t had chicken, potato beans for lunch. As talked with her and would like to try ney switch sat on the di At no time during th	s of lunch on 4/8/19 at b was seated in her wheelchair table. Staff #D told her that she bes, pineapple and green a staff #D sitting next to her asked her which food she kt, an adaptive switch mack ning room table in front of her. he meal did staff #D reach for ient #10 to activate the switch.							
	asked about the ad the switch is used to	meal on 4/8/19, staff #D was aptive switch. Staff #D stated o assist client #10 to she would like another bite of r meal.							
	7:40am client #10 v	s of breakfast on 4/9/19 at was seated in her wheelchair able. Staff #E told her she had							

If continuation sheet Page 3 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURV COMPLETED NAME OF PROVIDER OR SUPPLIER 34G072 B. WING 04/09/20' NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1775 HAWKINS AVENUE			AND HUMAN SERVICES				FORM	04/10/2019 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE T.I.C. HOME, INC. 1775 HAWKINS AVENUE			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
T.L.C. HOME, INC. 1775 HAWKINS AVENUE			34G072	B. WING			04/09/2019	
	NAME OF	PROVIDER OR SUPPLIER						
	T.L.C. H	OME, INC.				ANFORD, NC 27330		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPI	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	(X5) COMPLETION DATE
W 249 Continued From page 3 W 249 breakfast. A small adaptive switch ast on the table in front of her place setting. Staff #E offered bites of each food and asked her if she wanted additional spoonfuls. At no time during the meal did staff #E reach for the switch or ask client #10 to activate the switch. Interview on 4/9/19 with staff #E revealed the adaptive switch is used to help client #10 to communicate if she would like another bite. When asked is used at all meals, staff #E stated, "Yes, if she does not respond to our questions." Review on 4/9/19 of client #10's IPP dated 3/20/19 revealed a need to be offered choices throughout her day. Further review revealed a formal objective T1: Will press Big Mack switch to request another bite to eat. This objective was implemented on 3/11/19. It is to be trained at meals and data is collected on second shift Monday through Friday. Interview on 4/9/19 with the qualified intellectual disabilities professional (QIDP) revealed this objective for client #10 to use a switch to communicate at mealis. W 460 COO D AND NUTRTION SERVICES W 460 COO DAND NUTRTION SERVICES W 460 CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by:		cream of wheat, ap breakfast. A small a table in front of her bites of each food a additional spoonfuls did staff #E reach fo to activate the switch Interview on 4/9/19 adaptive switch is u communicate if she When asked is the staff #E stated, "Ye our questions." Review on 4/9/19 o 3/20/19 revealed a throughout her day formal objective 11 to request another implemented on 3/2 meals and data is of Monday through Fr Interview on 4/9/19 disabilities profession objective for client a communicate at me be integrated at all FOOD AND NUTRI CFR(s): 483.480(a) Each client must re well-balanced diet i specially-prescribed	plesauce and sausage for adaptive switch sat on the place setting. Staff #E offered and asked her if she wanted s. At no time during the meal or the switch or ask client #10 ch. with staff #E revealed the used to help client #10 to e would like another bite. switch is used at all meals, s, if she does not respond to f client #10's IPP dated need to be offered choices . Further review revealed a f: Will press Big Mack switch bite to eat. This objective was 11/19. It is to be trained at collected on second shift iday. with the qualified intellectual onal (QIDP) revealed this #10 to use a switch to ealtime is current and should meals. TION SERVICES (1) ceive a nourishing, ncluding modified and d diets.					

Facility ID: 922685

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		AND HUMAN SERVICES				FORM	04/10/2019 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G072	B. WING			04/	09/2019
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
T.L.C. HOME, INC.					775 HAWKINS AVENUE ANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 460	Based on observatively clients (#10) received diet as indicated. The client (#10) did not indicated. The client (#10) did not indicated. During observation 12:30pm, client #10 at the dining room the she had chicken, probeans for lunch. As talked with her and would like to try new small lumps throug During interview afted as asked about cl Staff #D answered consistency was to about the small lum staff #D stated the freferred the survey investigation, the consistency of the fish, potatoes, toma consistency of the fish throughout. All other interview on 4/819 #10's diet consistency the texture should the should the texture should the t	tions, interviews and record failed to ensure 1 of 6 audit ed her specially-prescribed The findings are: a receive her pureed diet as of lunch on 4/8/19 at 0 was seated in her wheelchair table. Staff #D told her that otatoes, pineapple and green a staff #D sitting next to her asked her which food she at. Her pureed chicken had hout the consistency. ther the meal on 4/8/19 staff #D lient #10's diet consistency. I that client #10's food be pureed. When asked nps in the chicken consistency, texture should be smooth and or to the cook. Upon further book was not available for s of supper on 4/8/19 at was seated in her wheelchair table. Staff #F told her she had atoes for supper. The fish had small lumps er textures were smooth. with staff #F revealed client hcy should be pureed and that	W 4	60			

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		AND HUMAN SERVICES			FORM	04/10/2019 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
34G072		B. WING		04/09/2019		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
T.L.C. HOME, INC.				1775 HAWKINS AVENUE SANFORD, NC 27330		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 460	2/22/19 revealed sh diet with regular ca liquids with Ensure between meals thre of this evaluation in risk for aspiration a Observation on 4/8 the dining room rev pureed diet with ne picture of the diet to textures next to the Interview on 4/9/19 responsible for coo revealed she had b cook that all pureed mechanically in the texture is smooth th #C stated you could reprocess until the stated it should be When asked if the preparing of food te not certain." Interview on 4/9/19 disabilities professi Dietician has monit kitchen. Further inter receive a pureed di confirmed the pure	age 5 he receives a pureed textured lories with nectar thickened Plus or Boost pudding ee times daily. Further review adicates that client #10 is at and that she is edentulous. (19 of client #10's diet card in vealed she is to receive a actar thickened liquids. A extures revealed smooth e description of Pureed. with staff #C, who is king meals in the kitchen, been inserviced by the other d foods are to be processed food processor until the hroughout with no lumps. Staff d add water to the mixture and texture was smooth. She like pudding or baby food. dietician monitors the extures, staff #C stated, "I am with the qualified intellectual onal (QIDP) revealed the tored meal preparation in the erview revealed client #10 is to iet. Additional interview ed diet should have a smooth od or pudding with no lumps.	W 460			

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