STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G072	A. BUILDING _____ B. WING _____	11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
T.L.C. HOME, INC.	1775 HAWKINS AVENUE SANFORD, NC 27330

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E 036	EP Training and Testing CFR(s): 483.475(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain	E 036	E036 The facility will maintain an emergency preparedness training and testing program that is based on the emergency plan including the risk assessment. All staff will be trained on the emergency preparedness plan and how to implement procedures. Facility Trainer will monitor monthly to ensure that all staff are trained on the emergency preparedness plan upon hire and at least annually. RECEIVED DEC 01 2021 DHSR-MH Licensure Sect	1/14/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Rita H. Wadsbee | Executive Director | 11/23/2021

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.

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E 036	Continued From page 1 an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure direct care staff were trained on the facility's Emergency Preparedness (EP) plan. The finding is: Review on 11/15/21 of the facility's EP plan (last updated 9/2020) did not reveal direct care staff had received recent training on the plan. Additional review of the EP plan manual did not include training for all staff working at the home. During an interview on 11/16/21, the facility's Director indicated no current training on the facility's EP plan had been completed. Additional	E 036		

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E 036	Continued From page 2 interview revealed she could not be sure of the last time staff working in the home had been trained on the plan.	E 036		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all nursing staff were sufficiently trained to implement general nursing practices and procedures. This affected 1 of 4 audit clients (#1). The findings are: A. During observations of medication administration in the home on 11/15/21 at 4:15pm, Nurse B dispensed client #1's medications into three separate pill cups. The pills were crushed and capsules opened and returned to the individual pill cups. The nurse then added water to each cup and poured the contents into client #1's G-tube. Afterwards, one of the three pill cups was noted to contain an undetermined amount of pill residue at the bottom and on one side of the cup. The nurse threw the pill cups in the trash. During an interview on 11/15/21 with Nurse B, when asked what she usually does when pill residue is left in the pill cup, she indicated she generally would add water to the pill cup containing the residue and give it to the client via	W 340	W340 The facility will ensure that nursing services implement appropriate protective and preventive health measure to include training staff as needed in appropriate health and hygiene methods. A. When administering medications via G-tube and medication residue is remaining in the cup, Nursing staff and medication technicians will be trained to add water to the pill cup and administer via G-tube to ensure all medication is administered and ingested as ordered.	1/14/22

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W 340	Continued From page 3 the G-tube. Interview on 11/16/21 with the facility's Director confirmed during medication administration via G-tube, when a medication's residue is left over in a pill cup, water would generally be added to the cup and the contents added to the G-tube. The Director acknowledged failure to do so could affect the actual amount of medication a client ingests. B. During observations of medication administration in the home on 11/15/21 from 4:15pm - 4:37pm, Nurse B dispensed medications for two separate clients. After placing pills into pill cups, the nurse immediately signed the Medication Administration Record (MAR) and then ensured each client ingested their medications. Interview on 11/15/21 with Nurse B revealed she normally signs the MAR "after I pull it". The nurse indicated this was how she was trained. Review on 11/16/21 of the facility's Nursing Policy and Procedures Manual (last reviewed on 4/26/21) revealed the nurse should document on the MAR "immediately after the drug is given." During an interview on 11/16/21, the Director acknowledged signing the MAR after ingestion of medications is a standard nursing practice/protocol. C. During observations of medication administration in the home on 11/16/21 at 7:16am, Nurse C left the medication cart unlocked as she went into the kitchen. At 8:09am, Nurse C left the medication cart unlocked as she	W 340	B. Nursing staff and medication technicians will be trained to sign the MAR once medication has been ingested by the client.	1/14/22

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W 340	Continued From page 4 went down the hall to obtain paper towels. At these times, medications were unlocked and accessible to anyone in the home. Interview on 11/16/21 with Nurse C revealed having the medication cart is new to the home and nursing staff have only been using it since the summer. She noted locking it before leaving the area has taken time to get used to. Additional interview confirmed the cart should be locked before leaving the area. Review on 11/16/21 of the facilty's Nursing Policy and Procedures manual (last reviewed on 4/26/21) revealed no information regarding the security of medications. Interview on 11/16/21 with the facility's Director confirmed the medication cart should "always be locked" unless the nurse is "right there at it" dispensing medications.	W 340	C. Nursing staff and medication technicians will be trained to lock the medication closet/cart when leaving the immediate area to ensure safety of all medications and safety of individuals served. QP will monitor weekly to ensure that medications are administered/ingested as ordered, MAR is signed after client ingests medication and medication closet/cart is locked when nursing staff/medication technician is not in the immediate area.	1/14/22
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all medications remained locked except when being administered. The finding is: During observations of medication administration in the home on 11/16/21 at 7:16am, Nurse C left the medication cart unlocked as she went into the kitchen. At 8:09am, Nurse C left the medication cart unlocked as she went down the hall to obtain paper towels. At these times, medications were	W 382		

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W 382	Continued From page 5 unlocked and accessible to anyone in the home. Interview on 11/16/21 with Nurse C revealed having the medication cart is new to the home and nursing staff have only been using it since the summer. She noted locking it before leaving the area has taken time to get used to. Additional interview confirmed the cart should be locked before leaving the area. Review on 11/16/21 of the facilty's Nursing Policy and Procedures manual (last reviewed on 4/26/21) revealed no information regarding the security of medications. Interview on 11/16/21 with the facility's Director confirmed the medication cart should "always be locked" unless the nurse is "right there at it" dispensing medications.	W 382	W382 D. The facility will ensure that all drugs and biologicals are locked except when being prepared for administration. Nursing staff and medication technicians will be trained to lock the medication closet/cart when leaving the immediate area to ensure safety of all medications and safety of individuals served. QP will monitor weekly to ensure that the medication closet/cart is locked when nursing staff/medication technician is not in the immediate area.	1/14/22