STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-274	A. BUILDING: _____ B. WING _____	09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENDER LOVING CARE HOMES, INC	10 HOLLY RIDGE DRIVE ASHEVILLE, NC 28803

(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
V 000	INITIAL COMMENTS An annual and complaint survey was completed on September 8, 2023. The complaint was substantiated (Intake #NC00206361). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. The facility is licensed for 3 and currently has a census of 1 client. The survey sample consisted of audits of 1 current client and 1 deceased client.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-274	A. BUILDING: _____ B. WING _____	09/08/2023

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on interview and record review, the facility failed to implement treatment plan strategies to meet the needs of 1 of 1 deceased client (DC #1). The findings are:

Review on 8/24/23 of DC #1's record revealed:
- admitted 7/6/09.
- age 69.
-deceased 8/19/23.
- diagnoses of Moderate Intellectual Developmental Disability, Intermittent Explosive Disorder, Schizoaffective Disorder, Hyponatremia and Polydipsia.
-1/1/23 - Individual Support Plan (ISP) - DC #1 " ...benefits from promoting to slow down turning mealtimes to chew to his food. He eats and drink quickly putting himself at risk of choking. He requires monitoring at mealtimes and to have his food cut into small pieces ..."
-ISP signed by DC #1's legal guardian and Licensee/Chief Executive Officer/Qualified Professional/Alternative Family Living Provider #1 (L/CEO/QP/AFL #1) on 11/29/22; Local Management Entity/Managed Care Organization (LME/MCO) Care Manager on 11/30/22.

Review on 8/30/23 of the local fire department's "Full Data Incident Report" dated 8/19/23 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 112	Continued From page 2 -"Call Date/Time 08/19/2023 16:21:21 (4:21 p.m.) ...10 HOLLY RIDGE DR, ASHEVILLE, NC, 28803 [DC #1] ...Patient...Age 69 years ...responded to a call for choking ...arrived on the scene to find the male patient lying in the middle of the living room, unresponsive ...There was some food that had cleared out of his (DC #1's) airway prior to ...arrival ...started compressions. The patient did not have a pulse ...working a cardiac arrest ...After a few minutes of CPR additional food was visible and able to be removed out of the patient's (DC #1's) mouth ...A nasal airway was then inserted to attempt in helping establish the airway. It was apparent that there was still a large amount of food blocking the patient's (DC #1's) airway. CPR was continued throughout the call ...There was no success in regaining a pulse. EMS talked to the Emergency Room doctor who advised that CPR efforts could be ceased, and the patient (DC #1) was pronounced deceased at 17:06 (5:06 p.m.)." Interview on 8/24/23 and 8/31/23 with the L/CEO/QP/AFL #1 revealed: -he was responsible for completing the treatment plan. -DC #1's treatment plan meetings included himself, the LME/MCO, and the client's legal guardian. -measures put into place for DC #1 due to his risk of choking included "put away food, monitor him, he can get up and go the bathroom by himself ...part of his rights ...privacy ...just kind of monitor ...[DC #1]..when gets a chance tries to help himself ..." -to prevent DC #1 from getting food he "put food away ...put where he (DC #1) can't see it ...sometimes he see it ...and that's how he gets it ...he steals anything and everything, not just food."	V 112		

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V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on observation, interview, and record review, 2 of 2 Alternative Family Living staff (Licensee/Chief Executive Officer/Qualified Professional/Alternative Family Living Provider #1 (L/CEO/QP/AFL #1) and AFL Provider #2) neglected 1 of 1 deceased client (DC #1). The findings are: Review on 8/24/23 of L/CEO/QP/AFL #1's	V 512		

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V 512	Continued From page 4	V 512		

personnel record revealed:
-date of hire 2006.
-QP job description signed January 2008: " ...to assist in supervision of team and direct care staff. Initiate and implement specific clinical interventions; assessment and reassessment, person centered planning, crisis planning ..."

Review on 9/5/23 of AFL #2's personnel record revealed:
-date of hire 2006.

Review on 8/24/23 of DC #1's record revealed:
- admitted 7/6/09.
-deceased 8/19/23.
- age 69.
- diagnoses of Moderate Intellectual Developmental Disability, Intermittent Explosive Disorder, Schizoaffective Disorder, Hyponatremia and Polydipsia.
-1/1/23 - Individual Support Plan (ISP) - DC #1 " ...benefits from promoting to slow down turning mealtimes to chew to his food. He eats and drink quickly putting himself at risk of choking. He requires monitoring at mealtimes and to have his food cut into small pieces ..."
-ISP signed by DC #1's legal guardian and L/CEO/QP/AFL #1 on 11/29/22; Local Management Entity/Managed Care Organization Care Manager on 11/30/22.

Review on 8/24/23 of an Incident Response Improvement System (IRIS) report for DC #1 last submitted 8/22/23 revealed:
-completed by L/CEO/QP/AFL #1 "Title "CEO (Chief Executive Officer)."
-incident occurred on 8/19/23 at 4:45 p.m. at the facility.
-"Cause of Death: Accident ...Associated Injuries: Airway Obstructed ...Due To: Choking ...Describe

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	MHL011-274	A. BUILDING: _____ B. WING _____	09/08/2023

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TENDER LOVING CARE HOMES, INC	10 HOLLY RIDGE DRIVE ASHEVILLE, NC 28803

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V 512	Continued From page 5 the cause of this incident ...Staff believed the staff took the banana without the staff's knowledge and went to the bedroom and ate the banana ...Client came back to living to sit on couch and the staff noticed that the client was choking ... [L/CEO/QP/AFL #1] laid a client (DC #1) on the floor and attempted to clear his airway by removing food from his throat. [L/CEO/QP/AFL #1] also started CPR (cardiopulmonary resuscitation) ...[AFL #2] simultaneously called 911 ...They (Emergency Medical Services (EMS)) pronounced him dead around 6:30 PM ... -Incident Prevention ...Bananas are hidden and food is placed out of sight." Review on 8/30/23 of the local fire department's "Full Data Incident Report" dated 8/19/23 revealed: -"Call Date/Time 08/19/2023 16:21:21 (4:21 p.m.) ...10 HOLLY RIDGE DR, ASHEVILLE, NC, 28803 [DC #1] ...Patient...Age 69 years ...responded to a call for choking ...arrived on the scene to find the male patient lying in the middle of the living room, unresponsive ...There was some food that had cleared out of his (DC #1's) airway prior to ...arrival ...started compressions. The patient did not have a pulse ...working a cardiac arrest ...After a few minutes of CPR additional food was visible and able to be removed out of the patient's (DC #1's) mouth ...A nasal airway was then inserted to attempt in helping establish the airway. It was apparent that there was still a large amount of food blocking the patient's (DC #1's) airway. CPR was continued throughout the call ...There was no success in regaining a pulse. EMS talked to the Emergency Room doctor who advised that CPR efforts could be ceased, and the patient (DC #1) was pronounced deceased at 17:06 (5:06 p.m.)."	V 512		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-274	A. BUILDING: _____ B. WING _____	09/08/2023

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V 512	Continued From page 6 Review on 9/5/23 of DC #1's Certificate of Death revealed: -myocardial infarction (heart attack) and coronary artery disease. Interview and observation on 8/24/23 at 3:21 p.m. with the L/CEO/QP/AFL #1 revealed: -this was a one level facility with the living/family room on left side when facing the house, the kitchen and dining room were in the middle, and DC #1's bedroom was on the other end of the house on the right side. -a video camera was in the living room, which faced the living room and love seats/sofas. -L/CEO/QP/AFL #1 was not sure if the camera recorded the incident on 8/19/23; he would check. -L/CEO/QP/AFL #1 showed where he "usually hid the bananas" on the dining room chair and pushed the chair under the dining room table so DC #1 "can't see them." -this chair was on the opposite side of where the walk through was when going to the living room and/or client bedrooms. -one would have to pass the kitchen counter in order to get to the client bedrooms or the living room. -the pantry had pad locks hanging on the knobs, the pad locks were unlocked. -the pantry was on the right side as passed through the kitchen toward the client bedrooms. -the locks "aren't because of [DC #1] ...he never snuck food out of the pantry ...locks on pantry to monitor stuff in there ..." -L/CEO/QP/AFL #1 was in his bedroom at the time of the incident (8/19/23) which was right outside the living room. -AFL #2 was in the living room on a love seat/sofa which faced L/CEO/QP/AFL #1's bedroom. -DC #1 was in the living room as well, then he got up, went to his bedroom, and came back to the	V 512		

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	MHL011-274	A. BUILDING: _____ B. WING _____	09/08/2023

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V 512	Continued From page 7	V 512		

living room.
-"[DC #1] had a history of choking."
-the last time DC #1 choked was "several years ago ...on peanut butter" and he (L/CEO/QP/AFL #1) was able to take his "finger and clear the airway and he (DC #1) survived ..."
-this was when he (L/CEO/QP/AFL #1) " ...started taking his (DC #1's) food and blending it ...always try to keep close eye as possible (when DC #1 was eating) ..."
-"Saturday (8/19/23) he (DC #1) got up (from the living room) and went to his room, because he picks up food he's not supposed to have, went to his room and came back (to the living room) ..."
-" ...he (DC #1) sat up and [AFL #2] said '[DC #1]' ...
-"I (L/CEO/QP/AFL #1) came in and put my finger in his mouth ...pulling out all kinds of things out of his (DC #1's) throat ...[AFL #2] called 911 ...
-he pulled out "Banana ...some was mushy ...not the peel ..."
-to prevent DC #1 from getting food he "put food away ...put where he (DC #1) can't see it ...sometimes he see it ...and that's how he gets it ...he steals anything and everything, not just food."
-DC #1 "like bananas and peanut butter ...he doesn't chew food hardly at all, he gulps it down, have to say chew up and put spoon down ...just have to slow him down ...sits with him at meals ..."
-there was a " ...lot of stuff in his throat ...stuffing it down ...happened quickly ...mushy stuff ..."

Interview on 8/25/23 with DC #1's legal guardian revealed:
-she did "have questions surrounding his (DC #1's) death ...he was healthy ..."
-DC #1 "has choked before ...several years ago ...not recently ...they (L/CEO/QP/AFL #1 and AFL

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V 512	Continued From page 8 #2) didn't let him eat food alone ...never allowed him (DC #1) to have food by himself ...wondering how he (DC #1) got a banana without them (L/CEO/QP/AFL #1 and AFL #2) knowing ..." Interview on 8/28/23 with L/CEO/QP/AFL #1 and AFL #2 revealed: -On Saturday (8/19/23) they did not go anywhere, they had lunch around 1:00 p.m., soup and crackers, and had not eaten dinner yet. -"Around 3:00 p.m. I (AFL #2) was watching tv (television) in the family room...[DC #1] was out here with us (AFL #2 and Client #1)...4:00 p.m ... [DC #1] got up and went to his room ...wasn't there too long ...came back ...sat down ...on love seat ...across from her (AFL #2) ...he [DC #1] looked like he was choking on something ...[AFL #2] asked [DC #1] what do you got ...[AFL #2] called for him [L/CEO/QP/AFL #1] ...he [L/CEO/QP/AFL #1] was in bedroom right behind love seat where [DC #1] was sitting ... [L/CEO/QP/AFL #1] put him on floor ...tried to clear his airway ..." -AFL #2 "try to put it (food) away because he's back and forth from living room to bedroom ...he [DC #1] always did that (walking back and forth from living room to his bedroom) ...wasn't anything (food) laying out (day of incident) ...goes back and forth constantly moving ..." -DC #1 "had a habit of not chewing and shoving food in his mouth ...one bite and tried to swallow ...break food up real tiny and blend it ...sit at table and eat with clients ..." -L/CEO/QP/AFL #1 said EMS " ...put a machine on that does chest compressions and pulled out a lot of stuff ...bananas ...mush ...didn't notice chunks ...could be corn bread ...round corn bread cakes from (a local grocery store) ...we could have ...we could have (had corn bread at the house) ...don't know (DC #1) will get food and	V 512		

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	MHL011-274	A. BUILDING: _____ B. WING _____	09/08/2023

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V 512	Continued From page 9	V 512		

store it ..."
-AFL #2 said there were "only canned goods in pantry ...corn bread ...can get it (food) anytime when not looking ...he (DC #1) stores it ..."
-L/CEO/QP/AFL #1 said he did not know if the camera recorded video; "I'm not going through all that ..."

Interview on 8/31/23 with the L/CEO/QP/AFL #1 revealed:
-measures he put into place for DC #1 due to his risk of choking included "put away food, monitor him, he can get up and go the bathroom by himself ...part of his rights ...privacy ...just kind of monitor ...[DC #1]..when gets a chance tries to help himself ..."

Review on 9/7/23 of the Plan of Protection dated 9/7/23 written and signed by L/CEO/QP/AFL #1/"owner" revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care?
-We will continue to provide extreme close monitor of all our clients as we have for the last over 22 years.
-Describe your plans to make sure the above happens.
-We will provide extreme close supervision!"

DC #1 was 69 years old and diagnosed with Moderate Intellectual Developmental Disability, Intermittent Explosive Disorder, Schizoaffective Disorder, Hyponatremia and Polydipsia. DC #1 had a history of choking. Food was supposed to be put away and cut up or blended. DC #1 was able to access food without the facility's knowledge and choked. EMS on the scene was able to get some food out of DC #1's airway but noted there was still a large amount of food blocking the airway. DC #1 was not able to be

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V 512	Continued From page 10 revived and pronounced dead on 8/19/23. This deficiency constitutes a Type A1 rule violation for serious neglect and harm and must be corrected within 23 days. An administrative penalty of $8,000 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day is imposed for failure to correct within 23 days.	V 512		