		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
	MHL072-008					R 04/02/2025
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	•	
TLC ADI	ILT CARE HOME		NDWARD LAN RD, NC 27944			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 000	INITIAL COMMEN	TS	V 000			
	An annual and follow up survey was completed on April 2, 2025. Deficiencies was cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability					
		sed for six and currently has a e survey sample consisted of ent clients.				
V 290	27G .5602 Supervi	sed Living - Staff	V 290			
	numbers specified of this Rule shall be enable staff to resp needs. (b) A minimum of of present at all times premises, except w habilitation plan do capable of remaining without supervision as needed but not the client continues the home or comm specified periods of (c) Staff shall be p following client-staff child or adolescent (1) children of abuse disorders sh of one staff presen clients present. H present during slee	bes above the minimum in Paragraphs (b), (c) and (d) e determined by the facility to bond to individualized client one staff member shall be when any adult client is on the when the client's treatment or cuments that the client is ng in the home or community n. The plan shall be reviewed less than annually to ensure is to be capable of remaining in unity without supervision for f time. resent in a facility in the ff ratios when more than one client is present: or adolescents with substance hall be served with a minimum t for every five or fewer minor owever, only one staff need be eping hours if specified by the p procedures determined by				

SMO411

Division	of Health Service Re	egulation			FURIN	APPROVED	
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL072-008	B. WING			R 02/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
	ULT CARE HOME	210 SOU	NDWARD LAN	IE			
		HERTFO	RD, NC 27944				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE	
V 290	Continued From pa	ge 1	V 290				
	developmental disa one staff present fo present and two sta more clients preser need be present du specified by the em determined by the g (d) In facilities whic diagnosis is substa (1) at least or duty shall be trained withdrawal symptor secondary complica drug addiction; and (2) the service	th serve clients whose primary nce abuse dependency: ne staff member who is on d in alcohol and other drug ns and symptoms of ations to alcohol and other d es of a certified substance nall be available on an					
	failed to ensure 1 o treatment plan docu remaining in the co specified periods of	view and interview the facility f 3 audited clients (#4) umented they were capable of mmunity unsupervised for times. The findings are: 5 of client #4's record					
	 Diagnoses of Mild Disability, Dementia Hyponatremia, Hyp Bronchitis. Person-Centered No documentation 	Intellectual Developmental a, Psoriasis, Seizure Disorder, ertension, Schizophrenia and Profile (PCP) dated 12/03/24. a client #6 was capable of mmunity unsupervised for					

Division of Health Service Regulation STATE FORM

Division	of Health Service Re	egulation				APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL072-0		B. WING			R 04/02/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
	ILT CARE HOME	210 SOU	NDWARD LAN	IE			
		HERTFO	RD, NC 27944	1		1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 290	Continued From pa	ge 2	V 290				
	specified periods of	time.					
	 He loved his Chur He attended Chur No staff went with The Pastor or othe bring him back to the Interview on 04/01/2 Client #4 went to 0 Client #4 had no is Church independer 	the facility for many years. ch. ch every Sunday. him to Church. er people from the Church he group home. 25 Staff #2 stated: Church unsupervised. ssues when he attended htly.					
	supervision. - Staff dropped clier	25 staff #3 stated: I a local Church without staff nt #4 off and the Pastor would s to meet staff after Church.					
	 Client #4 attended supervision. Client #4 had unset the past. Client #4 had atten years. There had been n he attended the Ch 	25 the Licensee stated: I a local Church without staff upervised time in his PCP in Inded the Church for may o issues with client #4 when urch unsupervised by staff. client #4's unsupervised time CP as applicable.					
V 736		ty and Grounds Maintenance	V 736				
	EXTERIOR REQUI (c) Each facility and	03 LOCATION AND REMENTS I its grounds shall be e, clean, attractive and orderly					

If continuation sheet 3 of 5

Division	of Health Service Re	gulation					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL072-008	B. WING		R 04/02/2025		
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	TATE, ZIP CODE			
	ILT CARE HOME	210 SOU	NDWARD LAN	IE			
TLC ADU		HERTFO	RD, NC 27944	l .			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 736	Continued From pa	ge 3	V 736				
	manner and shall be kept free from offensive odor.						
	This Rule is not met as evidenced by: Based on observation and interviews the facility was not maintained in a safe, clean and attractive manner. The findings are:						
	approximately 9:35a - 3 bags of trash on - The living room/dii bits of white paper a surface. The bluish sized light faded are - A chair at the kitch fabric peeled away - The linoleum floor waves on the surface appear to adhere to - The carpet was to the kitchen and livin - The air return vent ceiling on two sides - The area rug in the small bits of white d - The hallway sitting of the top layer of d fan had a layer of d - Client #2's bedroo threshold of the doo an approximately 3 the edge of the arm - Client #1 and clier stains on the carpet by 4 inches and one inches.	the front porch. ning room carpet had small and debris scattered on the carpet had many various eas. nen table had the top layer of from the surface. in the kitchen had small ce. The linoleum did not the subfloor. rn in the transition between ag room. t was bent away from the approximately 2 inches. e hallway sitting area had lebris on the surface. g area had various sized areas eiling pulled away. The ceiling ust on the blades. m had carpet torn at the prway. A chair in the room had inch by 3 inch torn area on					

SMO411

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOMBER.	A. BUILDING:			
		MHL072-008	B. WING			R 02/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	ILT CARE HOME		JNDWARD LAN DRD, NC 27944			
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT	TION SHOULD BE	(X5) COMPLET
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENC		DATE
V 736	Continued From pa	age 4	V 736			
	Interview on 04/01/25 the Licensee stated: - The trash on the front porch was to be picked up. - She would follow up on identified issues					
	reviewed for repair.					

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