STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G039	A. BUILDING _____ B. WING _____	R 12/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER-ADULT RESIDENTIAL	737 CHAPPELL DRIVE RALEIGH, NC 27606

(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) COMPLETION DATE
W 000	INITIAL COMMENTS A revisit was conducted on 12/5/18, for all previous deficiencies cited on 8/20-21/18. All deficiencies have not been corrected, and W125 was re-cited. The facility is not in compliance with all regulations surveyed.	W 000		
{W 125}	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 interview, the facility failed to assure client #10 had the right to freedom of movement in his environment. This affected 1 of 5 audit clients. The finding is: Client #10's wheelchair was locked while in the home. During morning observations in the home on 12/5/18, client #10's wheelchair was locked while he was at the table eating his breakfast. During an interview on 12/5/18, staff revealed client #10's wheelchair is locked while he is eating "for his safety." Additional interview with a second staff revealed client #10's wheelchair is kept locked due to the fact another client will "wheel herself" into client #10's wheelchair. Further interview revealed there is another client, who is ambulatory, will come up and "just push" wheelchairs of the clients, if they get in her way.	{W 125}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G039	A. BUILDING _____ B. WING _____	R 12/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER-ADULT RESIDENTIAL	737 CHAPPELL DRIVE RALEIGH, NC 27606

(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) COMPLETION DATE
{W 125}	Continued From page 1 Review on 12/5/18 of client #10's individual program plan (IPP) did not indicate that his wheelchair should be locked for his safety. During an interview on 12/5/18, the qualified intellectual disabilities professional (QIDP) was not aware if client #10's wheelchair should be unlocked or locked for his safety.	{W 125}		