DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/06/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G039	B. WING			1	R / 05/2018
NAME OF PROVIDER OR SUPPLIER TAMMY LYNN CENTER-ADULT RESIDENTIAL				737	EET ADDRESS, CITY, STATE, ZIP CODE CHAPPELL DRIVE LEIGH, NC 27606	1 12	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 000	000 INITIAL COMMENTS		W	000			
{W 125}	previous deficiencies deficiencies have no	LIENTS RIGHTS	{W 1	25}			
	Therefore, the facility individual clients to e of the facility, and as including the right to to due process. This STANDARD is Based on observation interview, the facility had the right to freed	ure the rights of all clients. must allow and encourage exercise their rights as clients citizens of the United States, file complaints, and the right not met as evidenced by: ons, record reviews, and failed to assure client #10 lom of movement in his ffected 1 of 5 audit clients.					
	Client #10's wheelch home.	air was locked while in the					
		ervations in the home on wheelchair was locked while eating his breakfast.					
	client #10's wheelcha eating "for his safety second staff revealed kept locked due to th "wheel herself" into of Further interview rev who is ambulatory, w	on 12/5/18, staff revealed air is locked while he is ." Additional interview with a d client #10's wheelchair is the fact another client will client #10's wheelchair. ealed there is another client, vill come up and "just push" itents, if they get in her way.					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUI	RE		TITLE		(X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/06/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G039	B. WING _			R 12/05/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE I	12/03/2010	
TAMMY LYNN CENTER-ADULT RESIDENTIAL				737 CHAPPELL DRIVE			
IAWWIT L	INN CENTER-ADOLT RE	SIDENTIAL		RALEIGH, NC 27606			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
{W 125}	Continued From page 1		{VV 1	25}			
	program plan (IPP) di wheelchair should be During an interview o intellectual disabilities	n 12/5/18, the qualified s professional (QIDP) was D's wheelchair should be					