STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G124	A. BUILDING ______ B. WING ______	03/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER/CHILDREN	743 & 745 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
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.	E 039		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G124	A. BUILDING ______ B. WING ______	03/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER/CHILDREN	743 & 745 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
E 039	Continued From page 1 *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure a facility/community-based or tabletop exercise was conducted to test their emergency plan. The finding is: The facility's Emergency Preparedness (EP) plan did not include completion of facility/community-based exercise or tabletop exercise over the past twelve months. Review on 3/12/19 of the facility's EP plan updated on 3/1/19 revealed the facility had conducted a table top exercise on 10/4/17 to test their EP plan. Additional review of the plan did not include a current full-scale community-based or individual facility-based exercise or a tabletop exercise to test their emergency plan. Interview on 3/12/19 with the Property Manager confirmed the facility has not conducted a	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G124	A. BUILDING ______ B. WING ______	03/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER/CHILDREN	743 & 745 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
E 039	Continued From page 2 full-scale facility/community-based exercise or a tabletop exercise to test the effectiveness of their current emergency plan since 2017.	E 039		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure nursing staff, including agency personnel, in the Tucker Residence, were sufficiently trained to perform their medication administration duties. The findings is: Proper medication administration procedures were not followed. During observation of medication administration in the home on 3/12/19 at 8:05 am, the nurse removed the 3/12/19 tablet a client's blister pack. When the package was examined, there was still a small round white pill sealed in the blister pack on 3/3/19, 3/4/19 and 3/8/19. The pills on 3/3/19 had the initials of one of the agency nurse's.. The only other signature on the blister back was 2/23/19. Review on 3/12/19 of the nursing supervisor's written instructions from the sign read, "When giving meds from a blister pack, please punch out of the blister that correlates with the current date its being given. For example, today is 11/15/18:	W 189		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G124	A. BUILDING ______ B. WING ______	03/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER/CHILDREN	743 & 745 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 189	Continued From page 3 punch meds out of blister 5, add date and initials to the blister pack...If you do not understand this process or you have questions, please call nursing supervisor for clarification." Interview on 3/12/19 with nursing supervisor revealed that she had experienced issues last year, mainly the agency staff not following their protocol to start the pill cycle on the 15 th of the month. When the protocol was not followed because staff were punching the blister cards out of order. The nursing supervisor offered that she responded to the issue by providing written instructions on how to "punch the cards" and hung a sign on the wall in the nurse's station. The agency staff was supposed to get 1:1 training with the lead nurse, but at the present time, the Tucker House was without supervisor on 2nd shift. The nursing supervisor left to bring a copy of the sign, hung in the med room for review.	W 189		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 1 of 3 audit clients (#1) in the Civitan Residence received a	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G124	A. BUILDING ______ B. WING ______	03/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER/CHILDREN	743 & 745 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 249	Continued From page 4 continuous active treatment plan consisting of needed interventions as identified in the Individual Support Plan (IPP) in the area of self-help skills, domestic skills and meal preparation skills. The findings are: 1. Client #1 was not afforded the opportunity to participate with meal preparation tasks to her maximum potential. During observations in the home throughout the survey on 3/11 - 3/12/19, staff completed all meal preparation tasks such as setting the table, preparing pitchers of drink, placed chopped and/or pureed food onto plates, and reheating food in a microwave. Client #1 was not prompted or encouraged to participate with these tasks. Staff interview on 3/12/19 revealed client #1 will throw items across the floor if placed in her hand. Review on 3/11/19 of client #1's ISP dated 8/28/18 revealed a Mealtime Prep Checklist dated 10/11/18. The checklist noted, "[Client #1] successfully completed formal objectives for the Meal time prep listed below. To ensure that [Client #1] is given the opportunity to participate in these skills on a daily basis, a checklist has been developed." Additional review of the mealtime checklist indicated client #1 can prepare a pitcher of ice water for the dinner table, assist in making a smoothie, pour smoothie into a cup, use the microwave to make popcorn, pour juice into a pitcher, pour cold foods into the serving dish and place food into the food processor. Interview on 3/12/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1 should be afforded the opportunity to	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G124	A. BUILDING ______ B. WING ______	03/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER/CHILDREN	743 & 745 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 249	Continued From page 5	W 249		

participate in meal preparation tasks as indicated in her IPP.

2. Client #1 was not afforded the opportunity to participate with self-help and domestic tasks to her maximum potential.

During 3 of 3 mealtime observations in the home throughout the survey on 3/11 - 3/12/19, client #1 consumed her food independently utilizing adaptive dining equipment. At the meals, staff consistently poured the client's drinks and wiped her mouth. After the meal, staff cleared client #1's dishes from the table, wiped the table, sweep the floor and loaded the dishwasher. Client #1 was not prompted or encouraged to participate in these tasks.

Staff interview on 3/11/19 revealed client #1 can pour and clear her place with hand-over-hand assistance.

Review on 3/11/19 of client #1's ISP dated 8/28/18 revealed a Domestic Skills Checklist dated 10/11/18. The checklist noted, "[Client #1] successfully completed formal objectives for the domestic skills listed below. To ensure that [Client #1] is given the opportunity to participate in these skills on a daily basis, a checklist has been developed." Additional review of the domestic skills checklist indicated client #1 can push the button to start the dishwasher, assist staff with cleaning the table, sweep her room and place her cup in the dishwasher.

Interview on 3/12/19 with the QIDP confirmed client #1 can complete tasks on the domestic skills checklist given assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G124	A. BUILDING ______ B. WING ______	03/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER/CHILDREN	**743 & 745 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 263	Continued From page 6	W 263		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure written informed consent was obtained from both guardians for client #1's restrictive Behavior Support Plan (BSP). This affected 1 of 3 audit clients in the Civitan Residence. The finding is: Written informed consent was not obtained from both parents for a restrictive behavior plan. Review on 3/12/19 of client #1's record revealed both her parents are her legal guardians. Additional review of the client's BSP dated 11/8/18 revealed an objective to exhibit appropriate, calm behavior throughout her day. Review of the plan included restrictive medications and other techniques used to address the client's inappropriate behaviors. Further review of a consent for the BSP indicated only one of two guardians had given their written informed consent for the plan on 8/28/18. Interview on 3/12/19 with the Qualfied Intellectual Disabilities Professional (QIDP) confirmed only client #1's father had signed the BSP consent form. The QIDP acknowledged both guardian's should be signing the consent forms.	W 263		
W 361	PHARMACY SERVICES	W 361		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G124	A. BUILDING ______ B. WING ______	03/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER/CHILDREN	743 & 745 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 361	Continued From page 7 CFR(s): 483.460(i) The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to pursue pharmacy services to ensure that 1 of 1 audited clients (#15) in the Tucker Residence, did not miss a dose of medication at the time of refill. The findings is: Client #15 missed doses of a prescribed antacid (Famotidine) because the order was not refilled. During observations of medication administration in the home on 3/12/19 at 8:47 am, the nurse discovered that the bottle of Famotidine was not available on the med cart. When the MAR notes were checked by the nurse, there was a note on 3/10/19 that the order was refilled. There was another nurse in the med room, who joined the nurse with searching both med carts and the med room but the bottle of client #15's Famotidine medication was not located. The second nurse made a phone call to pharmacy to check the status of the Famotidine and learned that it was out of stock, on back order and should be delivered to the Tucker Residence today. Review on 3/12/19 of client #15's current physician's orders revealed an order for Famotidine (Pepcid) 40 mg/5 ml susp; take 2.5	W 361		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G124	A. BUILDING ______ B. WING ______	03/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER/CHILDREN	743 & 745 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 361	Continued From page 8 ml (20 mg) per tube every day at 8 am. Additional review on 3/12/19 of the facility's 11/2013 policy for "How to Order or Reorder Medications was reviewed. It read, "All medications shall be ordered for clients on a monthly and as needed basis from the provider pharmacy... If the order is received after the provider pharmacy hours and is not stocked in the emergency box: order will be called to back-up pharmacy. Back up pharmacy will provide enough medication to last until next pharmacy tote box delivery." Interview on 3/12/19 with nursing supervisor revealed that the pharmacy issue had not been reported to her by any of the nurses and she had an expectation of staff to make her aware. The nursing supervisor checked the med cart and shared that no deliveries had been made by pharmacy today but there were options to use a local pharmacy or contact the physician for a new order.	W 361		
W 363	DRUG REGIMEN REVIEW CFR(s): 483.460(j)(2) The pharmacist must report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility's pharmacy failed to recognize duplication of drug therapy, in order to prevent unnecessary medications for 1 of 3 audited clients (#19) in the Tucker Residence. The finding is:	W 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G124	A. BUILDING ______ B. WING ______	03/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER/CHILDREN	743 & 745 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 363	Continued From page 9 Client #19 had a new laxative order written and the old order was never discontinued, thus leaving two orders on MAR to administer at the same time. During a medication administration observation in the home on 3/11/19 at 5:23 pm, the nurse poured a clear liquid 8 oz substance into the gastronomy tube of client #19, that she identified at Miralax. Interview on 3/11/19 with the nurse revealed that she was not aware client #19 was getting the medication daily, instead of every other day. The nurse responded that she was not able to access the previous entries on the electronic MAR and that the meds that the nurse needed to administere would automatically pop up on the screen. Review on 3/11/19 of client #19's current MAR revealed an 11/29/18 order for Gavilax Powder (Miralax), mix 17 grams in 8 oz beverage of choice and take per tube every other day at 6:00 pm. Plus a 6/6/2018 order for Peg 3350 powder take 17 grams in 8 oz beverage of choice and give via tube every other day at 6:00 pm. Review on 3/12/19 of client #19's Consultant Pharmacist Medication Regimen Review on 2/6/19 did not note any problems or irregularities and had zero recommendations for the physician. A look back of the MARS from Nov, 2018 until present, revealed client #19 had received both laxatives at 6 pm, 44 out of 103 times. Interview on 3/12/19 with the nursing supervisor revealed she was not aware that there were two	W 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G124	A. BUILDING ______ B. WING ______	03/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER/CHILDREN	743 & 745 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 363	Continued From page 10 laxatives orders on the physician's order for client #19 to receive at 6 pm. The nursing supervisor commented that she thought the pharmacy should have discontinued Peg 3350 before changing order over to Gavilax. She went onto say, that the pharmacy reviews were done every 90 days.	W 363		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure client #16's medication was administered in accordance with physician's orders. This affected 1 of 3 clients observed receiving medications in the Civitan Residence. The finding is: Client #16's Reglan was not administered in accordance with physician's orders. During observations of medication administration in the home on 3/11/19 at 4:25pm, client #16 ingested Metoclopramide (Reglan) 10mg via his g-tube. The client did not consume his dinner meal until 5:35pm. Review on 3/11/19 of client #16's current physician's orders revealed an order for Metclopramide (Reglan) 10 mg. The order noted, "Take 1 tablet per tube four times daily 30 minutes before meals..."	W 368		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G124	A. BUILDING ______ B. WING ______	03/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER/CHILDREN	**743 & 745 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 368	Continued From page 11 Interview on 3/11/19 with the facility's nurse confirmed the Reglan should be given 30 minutes before meals. Additional interview indicated client #16 usually eats at 5:00pm. Interview on 3/12/19 with the nursing supervisor confirmed client #16's Reglan is ordered to be given 30 minutes before meals.	W 368		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure all medications were given as ordered and without error for 1 of 3 audited clients (#19) in the Tucker Residence. The finding is: Client #19's Gavilax Powder was not administered in accordance to physician's orders. During a medication administration observation in the home on 3/11/19 at 5:23 pm, the nurse poured a clear liquid 8 oz substance into the gastronomy tube of client #19, that she identified as Miralax. Review of client #19's physician orders revealed an order for Gavilax Powder (Miralax), mix 17 grams in 8 oz beverage of choice and take per tube every other day at 6:00 pm. Upon review, the current medication administration record (MAR) had another nurse's initials in 3/10/19 box	W 369		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G124	A. BUILDING ______ B. WING ______	03/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER/CHILDREN	**743 & 745 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 369	Continued From page 12 and this nurse's initials in the slot for 3/11/19. Interview on 3/11/19 with the nurse to determine if she was aware that client was getting the medication daily, instead of every other day. The nurse responded that she wasn't able to access the previous entries on the MAR and that the meds that she needed to administered would automatically pop up on screen and those were the only meds that she reviewed. Interview on 3/12/19 with the nursing supervisor who commented that she was surprised the order wasn't originally written for daily use since constipation is problematic in this population.	W 369		
W 489	DINING AREAS AND SERVICE CFR(s): 483.480(d)(5) The facility must ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to maintain 1 of 2 audited clients (#19) with gastronomy tubes in the Tucker Residence, in an upright position during feeding. The finding is: Client #19 did not maintain safe body alignment during feeding, in accordance to the facility's policy. During observations in the home on 3/12/19 at 10:00 am in the dayroom, client #19 was not placed in an upright position in her wheelchair,	W 489		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G124	A. BUILDING ______ B. WING ______	03/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER/CHILDREN	743 & 745 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 489	Continued From page 13 receiving feeding through G-tube. Client #19's chin was tucked and almost touching her chest. Review on 3/12/19 of client's #19 current physician's order revealed an order for Promote with Fiber 240 ml via G-tube at 9 am. The facility's 11/2013 Enteral Nutrition Administration Policy was reviewed on 3/12/19. It read, "Position client so their head is elevated at a 30 to 45 degree angle before feeding unless otherwise contraindicated or unless alternate position is prescribed." An interview on 3/19/19 with the nursing supervisor led to an inquiry if client #19 was seated at the proper angle for feeding. The nursing supervisor responded that when a client gets tube fed, the client should be at a 30 degree angle; client #19 was using a fitted wheelchair. The nursing supervisor responded that she did not know how she would determine if client #19 was at the proper angle, however visually it appeared that the chair was at a 30 degree angle. The nursing supervisor acknowledged that she did not have a measuring device to check client #19's wheelchair and would contact therapy. Interview on 3/12/19 with the physical therapist confirmed that the chair was at the proper angle, "right below 40 degree" but client #19 had to be pulled up in the chair and her seatbelt needed to be tightened. The physical therapist mentioned that client #19's seat was fitted because she did not have a lot of hip flexibility to increase the angle. An additional observation on 3/12/19 on client #19 was made after the physical therapist repositioned client #19, the back of her head was	W 489		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G124	A. BUILDING ______ B. WING ______	03/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER/CHILDREN	**743 & 745 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 489	Continued From page 14 aligned with the headrest on the wheelchair.	W 489		