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 _____	08/21/2019

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 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to maintain accuracy in client #2's list of food allergies. This affected 1 of 6 audited clients. The finding is: Client #2's individual program plan (IPP) referred to food preferences as food allergies. During lunch observation on 8/20/19 at 12:00 pm, client #2 was fed beefaroni, a tomato based product by staff L. Client #2 had spit most of the contents of his meal onto his clothing protector. Review on 8/20/19 of client #2's IPP dated 4/24/19, revealed that he had listed food allergies to caffeine, tuna, tomatoes eggs, citrus and milk. An additional review on 8/21/19 of the Nutritional Evaluation dated 4/2/19 revealed that milk and milk products were food allergies. It was further noted that client #2's guardian had advised the facility that citrus, tomatoes, eggs and caffeine contributed to reflux in the past. The foods were now a routine part of client #2's diet with no noted negative effects. Client #2 reportedly disliked cold tuna entrees which were thus avoided. Interview with staff L on 8/20/19 at 12:00 pm, revealed that she did not know that client #2 had food allergies to tomatoes.	W 111		

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 _____	08/21/2019

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 111	Continued From page 1 Interview with nurse A on 8/21/19 at 7:07 am regarding food allergies revealed that many of the food allergies had been listed on the clients charts for many years, with no explanation of their origins. The nurse suggested that the food allergies were mainly food preferences or certain foods to be avoided due to medical conditions. Interview with the qualified developmental professional (QIDP) on 8/21/19 at 11:00 am, regarding client #2's food allergies to tomatoes, after observing him eating beefaroni yesterday. The QIDP responded that "Everyone knows that he can have those foods, it's still a preference." Then the QIDP skimmed client #2's chart and saw where the current individual program plan (IPP) still recorded that client #2 had food allergies to tomatoes. The QIDP responded that it was her fault to list food allergies when it had been determined that they were not true allergies. The IPP should have been revised.	W 111		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure relevant interventions or instructions to staff were addressed in the individual program plan (IPP.) This affected 1 of 6 audit clients (#5). The finding is: Client #5's IPP did not include interventions for	W 240		

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 _____	08/21/2019

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 240	Continued From page 2	W 240		

staff to use in order to redirect a shirt pulling/tearing behavior.

Throughout observations on 8/20/19, client #5 walked around with his left arm through a hole in his shirt under his sleeve. He continuously pulled at that sleeve of his shirt and was not redirected to correct this or to change shirts. On 8/21/19, he wore a shirt that had a tiny hole under his left arm. He pulled at sleeve continuously throughout observations without staff redirection.

Review of client #5's record on 8/21/19 revealed an individual program plan (IPP) dated 4/19/19. The IPP did not indicate an active plan to address his shirt tearing behaviors. There was nothing noted in the IPP as to how the staff should address the shirt tearing behaviors. However it was noted that a goal to wear a jumpsuit due to these behaviors was discontinued "due to infrequency of behaviors."

An interview 8/21/19 with staff B, C, E, F and G revealed all staff let him do this because this is what he does. Staff B and the DSC lead for first shift both indicated client #5 had been on a program to address shirt tearing previously (a few years ago) but the program was discontinued. Both indicated there is nothing to address the behavior in place now.

Interview on 8/21/19 with the qualified intellectual disabilities professional (QIDP) confirmed that he tears his shirt and is not on a program to address it. The QIDP further confirmed client #5 had been on a program in the past but it was discontinued because he was easy to redirect thus the redirection should have continued. The psychologist during a phone interview on 8/21/19

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 _____	08/21/2019

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 240	Continued From page 3 confirmed this as well. Both professionals confirmed there is nothing documented in the IPP at this time to address the behaviors or inform staff of redirection needs.	W 240		
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 reviews and interviews, the facility failed to assure a pattern of interactions supported the individual program plans (IPP) in the area of meaningful activity choices and behavior program implementation. This affected 1 of 6 audited clients (#5). The findings are: 1. Client #5's behavior program was not consistently implemented as written. Throughout observations on 8/20/19, client #5 walked around with his left arm through a hole in his shirt under his sleeve. He continuously pulled at that sleeve of his shirt and was not redirected to correct this or to change shirts. On 8/21/19, he wore a shirt that had a tiny hole under his left arm. He pulled at sleeve continuously throughout observations.	W 249		

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 _____	08/21/2019

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 249	Continued From page 4	W 249		

Review of client #5's record on 8/21/19 revealed an individual program plan (IPP) dated 4/19/19. The IPP did not indicate an active plan to address his shirt tearing behaviors. There was nothing noted in the IPP as to how the staff should address the shirt tearing behaviors. However it was noted that a goal to wear a jumpsuit due to these behaviors was discontinued "due to infrequency of behaviors."

An interview 8/21/19 with staff B, C, E, F and G revealed all staff let him do this because this is what he does. Staff B and the DSC lead for first shift both indicated client #5 had been on a program to address shirt tearing previously (a few years ago) but the program was discontinued. Both indicated there is nothing to address the behavior in place now.

Interview on 8/21/19 with the qualified intellectual disabilities professional (QIDP) confirmed that he tears his shirt and is not on a program to address it. The QIDP further confirmed client #5 had been on a program in the past but it was discontinued because he was easy to redirect.

Interview via phone with the psychologist on 8/21/19 revealed client #5 should be redirected. She also confirmed that redirection to a variety of activities would be important.

5. Client #5 was not consistently offered choices of meaningful activities.

Throughout all observations on 8/20/19-8/21/19, client #5 paced by walking up and down the hall and in and out of various rooms pulling on his shirt sleeve. Other than necessary healthcare

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 _____	08/21/2019

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 249	Continued From page 5 needs, he was not redirected to any other activities. No leisure choices were provided to him during observations other than handing him a toy/stuffed animal. He did periodically sit in a room with a television on in it but did not appear to engage in watching it. Review on 8/20/19 of client #5's IPP dated 4/19/19 revealed he often avoids group activities but can make choices by reaching out for a desired item when presented items. It also noted that he should be presented with a list of activities noted in the sensory plan. Review on 8/20/19 of client #5's sensory plan dated 4/4/18 indicated, "Please try to select enjoyable activities for [client #5] or allow him to choose between two activities....expose him to new activities and different types of stimulation as well...." Interview on 8/21/19 with staff B, C, E and H all confirmed client #5 doesn't participate in activities. Staff indicated he just walks around. Interview on 8/21/19 with the QIDP confirmed client #5 should be offered leisure choices. Further interview via phone on 8/21/19 with the psychologist confirmed client #5 should be redirected to a variety of leisure choices.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.	W 252		

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 _____	08/21/2019

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 252	Continued From page 6	W 252		

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to ensure data was recorded for 1 of 6 audited clients (#3), when engaged in self biting behaviors. The finding is:

Staff did not record the targeted behavior after each incident of occurrence, with client #3.

a. During lunch observation of client #3 at the group home on 8/20/19 at 11:30 am, revealed she was independent with eating and drinking. After the meal, staff A approached client #3, who immediately showed agitation and bit her left forearm twice, with no response from staff A. Client #3 who's edentulous (no teeth) bit her arm again, then staff A, softly told client #3, "no, no." Client #3 became more agitated, when she got up from the table to transfer from the chair to the wheelchair. Client #3 pulled up her shirt, revealing a sports bra, then continued to repeatedly bite her arm, becoming very verbal, as she moved toward the dirty linen cart. After client #3 tossed the clothing protector in the cart, staff A was observed, rubbing the tob of client #3's head.

b. During dinner observation of client #3 at the group home on 8/20/19 at 5:15 pm, the 1st shift direct care staff leader was observed to transfer three bowls of food for client #3 onto her plate. Client #3 immediately started to bite her left arm, with no response from 1st shift direct care staff leader. Client #3 finished her meal by 5:22 pm and was in the process of getting up from her dining chair, when she accidentally knocked over her beverage, which spilled on the floor. Client #3

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 _____	08/21/2019

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 252	Continued From page 7	W 252		

immediately started to bite her left arm. Staff J walked toward client #3 to assist her, since the wheelchair was out of reach and staff D. got up to assist client #3 as well. Client #3 slid down and sat on the floor. Both staff J and D helped client #3 get up, into the chair. Once seated, client #3 was observed to steadily bite her left arm then rolled self to dirty linen cart, to toss out clothing protector. Afterwards, client #3 was observed to continuously bite her left arm, as she wheeled herself out of the dining room. Staff were not observed to verbally or physically intervene with client #3's targeted behavior.

Review of client #3's individual program plan (IPP) dated 6/22/19 revealed that she had a behavior support plan (BSP) due to self injurious behaviors (SIB) to hands, chew-bites clothes, aggression, non-compliance and some agitation mainly associated with haircuts. Her objective was to decrease self injurious behaviors to 0 incidents per month, over 6 consecutive months. An additional review of client #3's targeted behavior data sheet, dated 1/28/19, revealed that target behaviors were listed as SIB, nipping/gumming, aggression, and chewing on clothes. Staff were to record data, as target behaviors occur and the frequency of documentation was based on, as the target behavior occurred. Staff were to describe what was going on before the behavior occurred as well as describe the SIB incident. The data sheet instructed staff to record what they did in response to the individual's behavior and the individual's response to the intervention. If a T-hold was used, the start and stop time needed to be recorded as well as description of possible factors affecting the incident. The last electronic targeted behavior data sheet was recorded on

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 _____	08/21/2019

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 252	Continued From page 8 8/16/19. Interview with the qualified intellectual disabilities professional (QIDP) on 8/21/19 at 11:40 am regarding client #3's SIB revealed that staff hardly had to complete the data sheet because client #3 could be redirected. When asked if copies of yesterday's incident could be secured, the QIDP responded that staff might still be using a manual method to record data. There was no type of data sheets for client's #3's SIB on 8/20/19 provided.	W 252		