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

PRINTED: 09/22/2021
FORM APPROVED
OMB NO. 0938-0391

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 _____	09/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAMMY LYNN CENTER/CHILDREN	743 & 745 CHAPPELL DRIVE RALEIGH, NC 27606

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W 194	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(4) Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, direct care staff failed to demonstrate specific skills in positioning. This affected 1 of 4 audit clients (#2). The finding is: During observations on 9/20/21 from 10:00am-12:05pm, client #2 was lying in his bedroom with bedrails up, positioned on his back. Client #2 was noted to have bleeding and redness coming from his gastronomy tube due to him hitting and pulling at it. Staff E explained he was still in bed due to being very active/agitated at this time and placing him in his chair may not be safe until he settles down. Staff E assisted client #2 by refreshing his clothing and ensuring his gastrostomy tube was in place but he remained in his bedroom. During continued observations in the facility on 9/20/21 from 2:05pm-4:15pm, client #2 remained in his bed, positioned on his back. At 4:15pm, client #2 was brought into the dayroom and transferred to a bed lying on his stomach. No other signs of agitation were noted at this time and client #2 slept soundly until the end of observations on 9/20/21 at 6:00pm. Interview on 9/21/21 with Staff B revealed staff are expected to turn clients every two hours even while they are sleeping.	W 194	TLC acknowledges that staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. On October 8th, all staff will receive an in-service training on positioning clients in accordance to our policy (NPP Section VIII-K). This policy states that all non-ambulatory clients will be actively repositioned every two hours. All position changes will be documented on the Position Change documents, located in each client's training file. Going forward, the QA/QI manager and Medical records manager will pull the position change documents to ensure that they are complete and being done every 2 hours each month as policy dictates. Any deficiencies will be reported to the house manager and/or residential services director along with a written summary. This will also be reviewed during the quarterly peer reviews conducted by the medical records manager. Also, the QA/QI manager will implement a new policy and procedure to address how direct service professionals are to complete position changes and document accordingly. The current policy is geared toward our nursing personnel and not the direct service professionals.	11/21/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rakisha Perry-Green	QA/QI MGR	10/1/2021

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.

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W 194	Continued From page 1 Record review on 9/21/21 of client #2's individual program plan (IPP) dated 3/1/21 indicates client #2 is non-ambulatory and non-verbal. He has been diagnosed with hypotonic cerebral palsy, bilateral anophthalmia, partial neurosensory deafness and intellectual disabilities. Client #2's IPP revealed a comfort needs checklist when he is agitated to prevent crying and thrashing which can lead to injuries. Check/change position is listed as an intervention. Record review on 9/21/21 of the facility's policy for Basic Care- Positioning for Well Being dated 10/1997 reveals all non-ambulatory clients will be actively repositioned every two hours. Interview on 9/21/21 with the Residential and Community Services Director confirmed clients should be repositioned every two hours.	W 194		
W 352	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(2) Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure each client received comprehensive dental services including periodic examinations at least annually. This affected 1 of 4 audit clients (#2). The finding is: Review on 9/21/21 of client #2's record revealed his last dental examination and cleaning occurred	W 352	TLC will ensure that dental examinations occur no less frequently than annually. We acknowledge that during 2020 the pandemic caused us to push back services that were from outside contractors as have residents who were not vaccinated against Covid-19. The clinical nurse manager has client #2 scheduled for the next dental day in November 2021. The house manager going forward, will ensure that all clients in the home receive their examinations at least annually.	11/21/2021

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W 352	Continued From page 2 on 10/03/19 and a recommendation was made for follow up in six months. No current dental examinations could be located. Interview on 9/21/21 with the Clinical Lead Nurse confirms client #2 is in need of a dental examination at this time.	W 352		
W 435	SPACE AND EQUIPMENT CFR(s): 483.470(g)(1) The facility must provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services as required by this subpart and as identified in each client's individual program plan. This STANDARD is not met as evidenced by: Based on observation, record review and confirmed by interviews with staff, the facility failed to ensure leisure materials used for active treatment for 3 of 4 audit clients (#2, #4 and #6) and two non-audit clients (#1 and #9) were appropriate for client identified needs. The findings are: A. During observations in the facility on 9/20/21 from 2:45pm-4:30pm clients #4 and #6 were in the activity room. Client #6 was sitting in his wheelchair and was being assisted by staff E manipulating his right hand to color a picture. At one point staff E stepped away to assist another client for about 10-15 minutes. Client #6 was left sitting in his wheelchair holding a crayon. The tray	W 435	TLC will ensure that staff and clients have the space, materials and equipment needed to implement formal and informal active treatment plans that reflect their interests, physical abilities and chronological age of the clients. TLC will work with our professional staff (OT, SLP) to ensure that we are adequately equipped with active treatment (leisure) activities that are suited for those that have auditory or sight impairment. Once these are identified, all staff will be trained on their implementation and usage by the SLP and OT. TLC will ensure sufficient space is available to accommodate group activities for those in wheelchairs which the majority of the residents in the Tucker residence. The QP (Tucker) will be in contact with the school of the blind and hearing impaired for additional activities that they can be conducted with the applicable residents in that facility. Going forward, the QA/QI Manager with the medical records manager, will conduct observations at least monthly to ensure that leisure activities (active treatment) are appropriate for the clients and staff. If there are areas of deficiency, the QA/QI manager will discuss directly with QP/House Manager and supervisor along with a summary that will be shared with the Residential Services Director as well.	11/21/2021

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W 435	Continued From page 3 that held the coloring book was several inches away from him, out of his reach. No other leisure activities were made available to him. Review on 9/20/21 of client #6's individual program (IPP) plan dated 7/16/21 revealed he has diagnoses of Profound intellectual Disability, Cerebral Palsy, Spastic Quadriplegia and Microcephaly. Further review of the IPP confirmed client #6 is non-verbal and depends on staff for all of daily living and active treatment needs. B. During further observations in the facility on 9/20/21 at 2:55pm-4:30pm, client #4 was seated in his wheelchair in front of the television in the activity room with several other clients. The TV picture was on but the sound was off. Non audit client #7 had an IPAD on her tray in front of her wheelchair which was out of client #4's reach. The program on the IPAD had a cartoon with the sound and picture activated. The IPAD program was only directly visible to client #7 and not to client #4. No other leisure options were available to client #4, who is visually impaired. Review on 9/20/21 of client #4's IPP dated 9/16/21 revealed he has Profound Intellectual Disabilities, Quadriplegia, and Cone Rod Dystrophy. C. During observations in the facility on 9/21/21 from 9:30am-10:05am, two non-audit clients (#1 and #9) were seated in their wheelchairs at a table in the activity room. Staff G gave each of the three clients playing cards. Two of the clients sitting at the table (#1 and #9) were not able to hold onto their playing cards. Staff G laid one of the playing cards on non audit client #1's lap.	W 435		

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W 435	Continued From page 4 Several times staff G had to step away for 10-15 minutes and clients were left with the playing cards on the table, out of their reach. Client #1, who is visually impaired, sat in her wheelchair with no other leisure activities offered. Review on 9/21/21 of client #1's IPP dated 10/22/21 revealed she has Profound Intellectual Disabilities, is non-verbal and has Cortical Visual Impairment. Further review of client #1's IPP confirms she depends on staff for all of her daily living and active treatment needs. Review on 9/21/21 of client #9's IPP dated 12/3/20 revealed he uses a wheelchair for mobility, that he is communication impaired and depends on staff for all of his daily living and active treatment needs. D. During observations in the facility on 9/21/21 from 9:00am-9:50am, client #2 who is visually and hearing impaired, was seated in his wheelchair in the activity room in front of the television with no other leisure activities offered to him. Review on 9/20/21 of client #2's IPP dated 3/1/21 revealed he has Profound Intellectual disabilities and that he is completely blind. Interview on 9/21/21 with the qualified intellectual disabilities professional (QIDP) confirmed that clients #1 and #9 could not reach the playing cards and that client #1 had significant visual limitations which limited her ability to participate. The QIDP also stated client #2 is blind and hearing impaired. The QIDP explained there were several leisure activities in the Tucker residence which included puzzles, coloring books, blocks	W 435		

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W 435	Continued From page 5 and games. When asked if The Division of Blind Services or other resources had been contacted to locate leisure activities for visually impaired clients, the QIDP stated, "No."	W 435		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure fire drills were conducted at varying times and conditions. This potentially affected all clients residing in the home (client's #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10). The finding is: Review on 9/20/21 of facility fire drill reports for June 2020-August 2021 on third shift revealed the following: 7/9/20: 11:00pm (3rd shift) 10/14/20: 6:45am (3rd shift) 4/30/21: 11:00pm (3rd shift) Interview on 9/21/21 with the Qualified Intellectual Disabilities Professional (QIDP) acknowledged the fire drills should be varied throughout the shift, however she acknowledged staff had not conducted any fire drills during the time when clients are sleeping from 11:30pm-6:00am.	W 441	An annual drill schedule has been implemented to ensure that all facilities conduct unannounced drills occur on a monthly basis. The calendar details which shift to complete the drill for each month. The specific date and time are left to the house manager to determine. These drills include Fire, Natural Disasters (hurricane, tornado, earthquakes, flooding), Utility Failure, Bomb threats, Violent Situations and Medical Emergencies. An in-service training will be completed with all staff on October 8th as refresher on conducting drills at various times and exits from the facility. Staff submit these drills to the property manager and the QA/QI Manager by the 10th of the following month. The QA/QI manager will analyze each drill to ensure that the facility holds monthly evacuation drills under varied conditions. The analysis will include the findings, recommendations for improvement, actions that need to be taken either by staff or manager and when follow up will occur by the QA/QI manager. If staff are found to be out of compliance (times not varied, lack of staff participation, etc.), the QA/QI manager will direct them to hold an additional drill, within 7 days, using the feedback given. On a quarterly basis, the drills for that quarter are analyzed and then discussed with the Residential Programs Director and the house managers on trends (such as same time, or time to conduct drill is excessive or unrealistic), and any areas of improvement (such as not following the drill schedule, not conducted on the shift scheduled, not submitted on time).	11/21/2021