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

PRINTED: 04/13/2022
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
	34G039	A. BUILDING _____ B. WING _____	04/12/2022

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 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 and interviews, the facility failed to ensure all staff were sufficiently trained to secure wheelchairs on the facility van. This affected 6 of 6 clients (#2, #6, #7, #8, #9 and #10) utilizing wheelchairs in the home. The finding is: During morning observations at the home on 4/12/22 at 10:25am, various staff began loading and securing clients onto three vans in preparation for transport to a local park. Six clients in wheelchairs were secured in the vans using wheelchair tie downs with two tie downs attached to the front frame of each chair and two tie downs attached to the back frame of each wheelchair. One van used to transport two of the six wheelchairs was observed to have a seat belt secured around the chairs. Although wheelchair seat belts were available in the other two vans, the four remaining clients did not have seat belts secured around their wheelchairs prior to transport. Interview on 4/12/22 with the Physical Therapist Assistant (PTA) confirmed staff have been trained to secure wheelchairs on the facility vans using two tie downs secured to the front and back of each wheelchair and a seat belt secured around each wheelchair. The PTA noted if all components are not provided to secure each wheelchair, then the van should not leave the facility.	W 189	TLC acknowledges that we need to provide a refresher course to all staff at ICF Moore on wheelchair tie downs and securing the safety belt across the wheelchair. Staff will have this training on three dates, 4/20/2022, 5/11/2022 and 5/18/2022. These refreshers will include the QDDP and all shift supervisors to ensure that staff are competent to properly load residents in the van and ensure their safety. Once completed, the scores will be loaded into our requirements tracker by the instructor. The QDDP will ensure that all staff are re-trained by 5/18/2022. On 6/1/2022 a report will compiled by the QA/QI manager to confirm that all staff have completed the refresher course. Going forward, the QA/QI Manager will alert the QDDP on a monthly basis of any expirations as well as she will receive an email from Relias's requirement tracker on any upcoming expirations 30 days in advance. The QA/QI Manager along with the Records manager will complete monthly observations using the updated checklist to ensure staff are loading and unloading residents into each van using tie-downs and the safety belts across each wheelchair. All observations will be typed up and submitted to the House Manager and the Director of Residential services.	6/10/2022
W 249	PROGRAM IMPLEMENTATION	W 249		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tahesha Berg-Green, QA, QI Mgr | TITLE | (X6) DATE: 4/22/2022

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 249	Continued From page 1 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 ensure 2 of 4 audit clients (#1 and #2) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of objective implementation, leisure and mealtime guidelines. The findings are: A. During evening observations in the home on 4/11/22 from 3:25pm - 5:00pm, client #1 was seated outside on the patio with various staff and other clients. During this time, several staff verbally interacted with client #1 without providing any physical interactions or activities. Throughout the observations, the client wore a splint on her left hand. At 5:01pm, the splint was removed as staff sanitized the client's hands and prepared her for the dinner meal. During morning observations in the home on 4/12/22 from 6:45am - 8:04am, client #1 was seated in a recliner in her bedroom. During this time, client #1 did not wear a thumb splint and the client was not provided with any activities to	W 249	TLC will ensure that all staff who have interactions with the resident are re-trained on the use of the splint. This in-service will be provided by the Therapy Department along with the QDDP (house manager). Staff will be in-serviced on providing her with manipulation activities when she is not wearing the splint. We will add a comment box in Therap to note the time the splint is removed since we can not shorten the time increments in Therap. To ensure the comment boxes are being completed, the QA/QI Manager will review on the 1st and 15th of each month, Therap, to ensure that documentation is being completed daily. Any days that are not accounted for will be reported to the QDDP and Director of Residential Services. The Records Manager will review a random sample of dates to ensure that the documentation has been entered during the quantitative record reviews completed each quarter.	6/10/2022

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W 249	Continued From page 2 manipulate. Interview on 4/11/22 with Staff C revealed client #1 wears her thumb splint to prevent her from rubbing her fingers together and she wears the splint when "she is not eating, doing an activity or one-on-one with staff". Additional interview on 4/12/22 with Staff A revealed client #1 likes stuffed animals and has several in her room. Additional interview on 4/12/22 with Staff A indicated client #1's thumb splint should be applied in the morning after she gets dressed and is worn up to lunch time. Review on 4/11/22 of client #1's Behavior Management Program (BMP) dated 4/14/20 revealed an objective, "When engaged in manual activities, [Client #1] will exhibit 0 incidents of finger-rubbing behavior (rubbing between the 4th and 5th fingers of her left hand with her thumb) per data session for 6 consecutive months..." Additional review of the BMP noted, "[Client #1] should be engaged in activities in which she uses her hands as much as possible. She will need physical prompts to keep her hands engaged with objects and materials, and to keep them out of her mouth...As much as possible, staff should encourage [Client #1] to use her left hand to work with materials, and should present objects to her left hand." Further review of the plan indicated, "Whenever staff is not one-on-one (meals, bathing, toothbrushing) with [Client #1] or working with her, they should place the thumb splint on her left hand...To help prevent sleep difficulties at night, provide [Client #1] with motivating and stimulating activities during the day..." Interview on 4/12/22 with the Psychologist	W 249		

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W 249	Continued From page 3 confirmed client #1 wears a thumb splint on her left hand to prevent her from rubbing between her two fingers with her thumb. Additional interview also confirmed staff should provide physical prompts and assistance to manipulate the client to participate with activities using her hands as much as possible to help prevent this behavior. B. During 3 of 3 mealtime observations in the home on 4/11 - 4/12/22, various staff assisted client #1 with consuming her meal. No staff were observed to encourage the client to reach for her spoon with the hand she preferred to use. Interview on 4/12/22 with Staff C indicated client #1 can feed herself with her left or her right hand but she has "more efficiency" using her right hand. Review on 4/11/22 of client #1's Mealtime Program (dated 3/7/22) revealed, "When [Client #1] is offered the spoon at midline, she does not reach for the spoon with either hand. She requires a physical prompt. Usually a small nudge of either elbow and she will reach out." Interview on 4/12/22 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1 should be given a physical prompt to reach for her spoon with the hand she chooses and her meal guidelines were recently revised to reflect this change. C. During observations of mealtime on 4/11/22 at 5:45pm, staff A took client #2's plate to the dining room table which had several small covered containers on it. Further observations revealed client #2 was sitting in his wheelchair at the dining room table being fed by staff A. After client #2	W 249	Staff will be trained by our feeding team on her meal time plan. The QDDP will have clarification noted on how staff are to prompt her to chose which hand she will hold the spoon in. If revisions are needed, the feeding team will make those changes and distribute to the home after training the staff on any updates and additions made. The QDDP will conduct mealtime monitoring at least 3 times a week for 4 weeks to ensure all guidelines are being followed for each meal observed. The QDDP will note her observations on the supervision logs. During monthly observations from the QA/QI Manager and Records manager, we will utilize the meal plan as a guide. Any detours from the prescribed plan will be given to the house QDDP and the Director of Residential Services in a written summary. Staff will be retrained on the mealtime routine for the resident reviewed during the survey. Staff will trained on the goal where he is to place the meal item on the table before or in the sink after meals. This will be added to the observation checklist.	6/10/2022

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W 249	Continued From page 4 finished his meal, staff A took client #2's plate, cups and silverware to the kitchen. During observations on 4/12/22 at 8:45am, staff B took client #2's plates, cups to the dining room table. Staff B fed client #2 and when the meal was finished, staff B took client #2's plates, cups and silverware to the kitchen at 8:50am. Review on 4/11/22 of client #2's IPP dated 4/20/21 revealed he has a formal objective to place one mealtime item on the dining room table before meals or in the sink after meals with 30% accuracy for 12 consecutive months. Interview on 4/12/22 with the QIDP revealed client #2's formal objective is current and should be trained consistently at meals.	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. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure data relative to the accomplishment of objective criteria was documented in measurable terms. This affected 2 of 3 audit clients (#1 and #2). The findings are: A. Throughout observations on 4/11/22 from 11:15am-12:30pm and 3:25pm-6:00pm, client #2	W 252	For all residents, staff will receive training on the importance of consistent documentation. The data will be monitored by the shift supervisors prior to the end of their shift. The QDDP/House Manager will monitor the data entered weekly to ensure that the staff are consistently documenting.	6/10/2022

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W 252	Continued From page 5 wore a compression edema glove on his right hand. During these observations he wore this glove during leisure activities and dining. There were minimal attempts by client #2 to bite his right hand. During observations on 4/12/22 after staff assisted client #2 with grooming and dressing from 7:10am until he was assisted with loading on the van outside at 10:25am, client #2 was observed to wear a compression edema glove on his right hand. There were minimal attempts by client #2 to bite his right hand. Review on 4/12/22 of client #2's behavior modification program (BMP) updated on 9/21/21 revealed he has target behaviors of self injurious behaviors which consists of biting his right hand, biting his right upper arm, hitting his head and attempts to hit any part of his face. Further review of this BMP revealed he wears an edema compression glove to decrease possible tissue damage to the skin on his right hand. Additional review revealed direct care staff are to document the use of the edema compression glove with breaks noted at mealtimes, grooming, hygiene and at nighttime. Review on 4/12/22 of the Habilitation Documentation Record revealed missing data for the following dates: March 1-2, 2022 March 4-5, 2022 March 9, 2022 March 13-16, 2022 March 18, 2022 March 20, 2022 March 24-25, 2022 March 29-31, 2022	W 252	On the 1st and 15th of each month, a review of documentation that requires daily entries will be reviewed by the QA/QI Manager. Any dates that do not have documentation will be reported to the QDDP/House Mgr and the Director of Residential Services. After each report, a follow up will occur within 48 hours to ensure that the documentation has been added to the Therap system. The Records Manager will review a random sample of dates to ensure that the documentation has been entered during the quantitative record reviews completed each quarter. This information will be shared during the quarterly Quality Improvement Committee as well.	6/10/2022

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W 252	Continued From page 6 April 1-2, 2022 April 4, 5 and April 9, 2022 Interview on 4/12/22 with the qualified intellectual disabilities professional (QIDP) and the facility Psychologist revealed direct care staff are to document the use of client #2's compression edema glove daily. Further review with the QIDP revealed she was unaware direct care staff had failed to document data for client #2's BMP. B. During evening observations in the home on 4/11/22 from 3:25pm - 5:00pm, client #1 wore a splint on her left hand. Additional review on 4/12/22 of the client's data collection sheet for her Protective Device Order (the thumb splint) indicated no documentation for 4/11/22. In addition, no documentation was noted for 4/3/22, 4/6/22 and 4/9/22. Further review of client #1's Behavior Management Program (BMP) dated 4/14/20 revealed an objective, "When engaged in manual activities, [Client #1] will exhibit 0 incidents of finger-rubbing behavior (rubbing between the 4th and 5th fingers of her left hand with her thumb) per data session for 6 consecutive months..." The BMP noted, "Use of the thumb splint will be recorded on a Protective Device Form..." Interview on 4/12/22 with Staff A revealed they do not document the use of client #1's thumb splint. The staff later indicated they should be documenting when the splint is utilized. Interview on 4/12/22 with the Psychologist confirmed client #1's thumb splint should be utilized daily and documented as indicated in the plan.	W 252		

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W 252	Continued From page 7 C. Review on 4/12/22 of client #1's Protective Device Form for 4/1/22 - 4/10/22 revealed the client's thumb splint was worn consistently between 8:00am - 12:30pm and between 3:30pm - 8:00pm for seven of the ten days. Additional review of the form did not indicate the splint had been removed for 10 minutes during these times. Additional review of client #1's Behavior Management Program (BMP) dated 4/14/20 revealed an objective, "When engaged in manual activities, [Client #1] will exhibit 0 incidents of finger-rubbing behavior (rubbing between the 4th and 5th fingers of her left hand with her thumb) per data session for 6 consecutive months..." The BMP noted, "Document thumb splint use on a Protective Device form...Check after each 30 minute interval and remove for 10 minutes if used for one hour and 59 minutes." Interview on 4/12/22 with Staff A revealed they do not document the use of client #1's thumb splint. The staff later indicated they should be documenting when the splint is utilized. Interview on 4/12/22 with the Psychologist confirmed client #1's thumb splint should be removed for 10 minutes as indicated in the plan and the removal of the splint should be documented. Interview on 4/12/22 with the Qualified Intellectual Disabilities Professional (QIDP) indicated the forms used to document client #1's use of her thumb splint do not include the removal of the client's splint for 10 minutes. The QIDP noted the form needed to be revised.	W 252		