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 _____	C 08/04/2022

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 000	INITIAL COMMENTS A complaint survey was completed on August 4, 2022 for intake #NC0091536. The complaint was not substantiated, however a deficiency was cited.	W 000		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observations, records review and interviews, the facility failed to provide nursing services in accordance with the needs for 1 of 10 clients (#6) relative to assessment and documentation of a hip injury. The finding is: Review on 8/4/22 of an internal investigation completed by the facility dated 1/14/22 revealed direct care staff A discovered a large bruise on client #6's right hip on 1/13/22 about 6:45pm when he was preparing client #6 for a bath. Staff A immediately told the shift charge person and notified Nurse A. Further review of the incident report dated 1/13/22 and the investigation revealed Nurse A documented a large bruise on client #6's hip but there was no documentation of any assessment of client 6's pain, any possible causes of the bruise and no one else was notified on 1/13/22. Additional review of the facility's investigation revealed the following morning on 1/14/22, staff B discovered a large bruise on client #6's hip and staff B immediately notified Nurse B. Review of staff statements revealed Nurse B assessed client #6, took vital signs and immediately notified the physician who ordered a mobile x ray crew to come to the center to x ray client #6's hip. Review on 8/4/22 of the xray	W 331		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 331	Continued From page 1	W 331		

report and hospital record confirmed a fracture of client #6's hip. Further review of the facility's internal investigation revealed following the x ray report, the physician ordered staff to call 911 and have client #6 transported to a local hospital where he was admitted for treatment of the fractured hip. The summation of the facility's internal investigation determined there was no evidence of abuse or neglect but recommendations were made to modify client #6's wheelchair so that he could not "throw his leg over the arm rest". Modifications to the wheelchair were completed. Documentation also confirmed physical therapy immediately re-evaluated client after his discharge from the hospital to help facilitate recovery from his fractured hip.

Interview on 8/4/22 with Nurse B revealed she was immediately notified by staff B of the large bruise on client #6's right hip when she arrived at work on 1/14/22. Further interview revealed she was puzzled by a lack of documentation on 1/13/22 of this injury and saw only an incident report completed by staff and Nurse on 1/13/22 indicating client #6 had a large bruise. She stated there was no additional assessment of this injury that she could locate on 1/14/22. Further interview revealed her focus on 1/14/22 was to facilitate prompt, appropriate assessment of client #6 and notify his physician as soon as possible.

Interview on 8/4/22 with staff B confirmed he saw the bruise on client #6 when he arrived at work and that it was "huge." Further interview confirmed that he immediately notified Nurse B and she immediately notified the physician.

Interview on 8/4/22 with the Director of Nursing,

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W 331	Continued From page 2 Director of Quality Assurance and the Residential Director confirmed there was not adequate documentation on 1/13/22 of client #6's bruising to his hip by Nursing. Further interview confirmed there should have been an assessment to determine client #6's comfort level, if any additional notifications needed to be made and an overall assessment of client #6's physical status when this injury was discovered on 1/13/22.	W 331		