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	34G124	A. BUILDING _____ B. WING _____	02/07/2023

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 120	SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3) The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure outside services were coordinated to meet each client's needs. This affected 1 of 5 audit clients (#16). The finding is: During observations at the school on 2/6/23, client #16 was located in a classroom with one other client, a public school teacher and two assistants. Review on 2/6/23 of client #16's record confirmed she is provided a public school education. Interview on 2/6/23 with the classroom teacher indicated she is responsible for implementing client #16's Individualized Education Plan (IEP) from the public school system. The teacher revealed she was not aware of any residential training programs for client #16 and did not have a copy of the client's current Individual Program Plan (IPP). Interview on 2/7/23 with the Qualified Intellectual Disabilities Program (QIDP) revealed communication between the school and the home was usually coordinated by a staff who no longer works for the facility; therefore, some things may have not have been done. The QIDP acknowledged she had not relayed any client specific information to the classroom teacher and a copy of client #16's IPP had not been provided.	W 120		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)	W 249		

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

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W 249	Continued From page 1	W 249		

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 each client received a continuous active treatment plan consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of implementing mealtime guidelines. This affected 3 of 5 audit clients (#9, #13 and #16). The findings are:

A. During dinner observations in the Tucker Residence on 2/6/23 from 5:17pm - 6:15pm, Staff D assisted client #16 to consume her meal. The client picked up her milk at the beginning of the meal and independently drank from the spouted cup. During the remaining time, the client consumed numerous bites of food without drinking. Although the staff verbally prompted client #16 to pick up her cup, the client was not assisted to obtain her cup and drink after beginning to eat her food.

Interview on 2/6/23 with Staff D revealed client #16 will pick up her cup on her own when she is ready to drink.

Review on 2/7/23 of client #16's Mealtime

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W 249	Continued From page 2 Program guidelines dated 10/26/22 revealed, "...Assist her with taking small bites...Alternate food and liquid every 2 - 3 bites. Allow her to drink 1 - 2 oz every 2 - 3 bites..." Interview on 2/7/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #16's mealtime guidelines should be followed as written. B. During dinner observation in the Civitan Residence on 2/6/23 from 5:10pm to 5:25pm, Civitan 2nd shift supervisor (C2SS) transferred client #13 from sofa to an anti-tip dining chair. Client #13 was observed to sit with her lap belt unfastened throughout her meal. The C2SS was observed to initially provide hand over hand assistance with client #13 scooping, but he started to feed her the rest of her meal. Client #13 was not observed showing resistance to eating, before the C2SS began to feed her exclusively. Review on 2/6/23 of client #13's Mealtime Program guidelines dated 8/24/22 revealed anti-tip chair with lap belt, plus use hand over hand assistance to scoop. Interview on 2/7/23 with the Qualified Intellectual Disabilities Professional (QIDP) revealed client #13's meal guidelines required her to secured in anti-tip dining chair due to seizures. C. During dinner observation in the Civitan Residence on 2/6/23 at 5:27pm, C2SS was observed re-applying client #9's chest harness after she finished eating. Her dinner plate had already been cleared by unknown staff. Client #9 began to self-propel her wheelchair down the	W 249		

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W 249	Continued From page 3 hallway, without any prompting from staff to wipe her table area. Staff B was observed at 5:29pm, to push client #9 back to her bedroom. An additonal breakfast observation in the Civitan Residence on 2/7/23 at 9:00am, revealed client #9 finishing her meal, without wiping the table area and then self-propelled herself away from the table, with dishes left behind. Review on 2/6/23 of client #9's individual program plan (IPP) dated 3/8/22 revealed mealtime goals to wipe her area of the table after meal 25% of all trials and place her cup in the dishwasher after meals 30% of trials. Interview on 2/7/23 with the QIDP revealed client #13's goals included encouraging her to wipe off her table and take her cup to the dishwasher.	W 249		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure staff were sufficiently trained to wear face masks appropriately. The findings are: A. Upon entry into a classroom at the facility on 2/6/23 at 12:35pm, three staff were observed not wearing face masks. At this time, two clients were also in the classroom. After the surveyor entered	W 340		

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W 340	Continued From page 4	W 340		

the classroom, the three staff retrieved a face mask and placed it over their nose and mouth.

Interview on 2/7/23 with the Director indicated the classroom staff may be following the public school system policies for wearing masks and not the facility's mask policy. However, face masks are still required to be worn at the facility.

B. During dinner observations in the Civitan Residence on 2/6/23 from 3:30pm to 5:45pm, Staff A and Staff C were observed to wear a disposable surgical face mask, resting underneath their nostrils, while providing active treatment and feeding assistance with all of the clients. Staff B wore a lose fitting cloth face mask, that fell beneath her nose. Occasionally Staff A, Staff B and Staff C would pull up their face masks but it would not stay on top the bridge of their noses.

An additional observation of Nurse A on 2/6/23 from 3:30pm to 5:30pm, revealed the disposable face mask was worn across her chin. The face mask allowed Nurse A's mouth and nose to be exposed while administrating medications and feeding assistance.

Interview on 2/7/23 with the Director of Human Resources revealed staff were expected to wear a face mask covering their mouth and nose, while present with clients.

Interview on 2/6/23 with the Director revealed the facility had experienced a COVID-19 outbreak in January, 2023 and had ended quarantine two weeks ago. The Director indicated that all staff were expected to wear a face mask covering their nose and mouth, while providing care to clients.

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W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) and under varied conditions to- This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted at varying times and conditions. The finding is: Review on 2/7/23 of the Civitan Residence fire drill reports for February 2022 to January 2023 revealed the following: 1st Shift Drills 2/8/22 at 9:13am 4/16/22 at 2:00pm 9/12/22 at 9:00am 11/1/22 at 2:15pm 2nd Shift Drills 5/4/22 at 6:30pm 8/1/22 at 6:10pm 1/4/23 at 6:15pm 3rd Shift Drills 3/31/22 at 2:30am 6/13/22 at 2:45am 8/23/22 at 2:13am 10/2/22 at 2:17am Interview on 2/7/23 with the Qualified Intellectual Disabilities Professional (QIDP), she acknowledged a failure to vary the times of the fire drills had been a problem before. The QIDP indicated that it had been stressed to staff to perform a drill for every shift, but they did not concentrate on the times the drills were	W 441		

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W 441	Continued From page 6 conducted.	W 441		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 5 audit clients (#4 and #16) received their modified diets as ordered. The finding is: During breakfast observations in the Tucker Residence at 7:45am and 9:05am, client #4 and client #16 consumed grits and eggs. While the eggs were pureed smooth, the grits were also pureed but dry and lumpy. Both clients consumed their meal without difficulty. Interview on 2/7/23 with the Shift Supervisor revealed the grits were pureed; however, they "sat for a while" which made them lumpy. Review on 2/7/23 of client #4's Mealtime Program guidelines dated 8/22/22 revealed he consumes "smooth blended/pureed foods". Review on 2/7/23 of client #16's Mealtime Program guidelines dated 10/26/22 revealed she consumes a pureed diet. The guidelines noted, "pureed food (no chunks, or lumps, foods only)..." Interview on 2/7/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed pureed foods should be served "smooth" with "no lumps"	W 460		

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W 460	Continued From page 7 and may resemble mashed potatoes.	W 460		
W 488	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #4 ate in a manner which was not stigmatizing. This affected 1 of 5 audit clients. The finding is: During breakfast observations in the Tucker Residence on 2/7/23 at 7:45am, client #4 sat at the table with a clothing protector around his neck. Closer observation of the clothing protector revealed the upper portion was secured around his neck while the lower portion was spread across the table in front of him with his plate on top of it. Client #4 consumed his breakfast meal with his clothing protector positioned in this manner. Minimal food spillage was observed during the meal. Interview on 2/7/23 with Staff H revealed client #4 normally wears his clothing protector positioned in this manner to "catch the food" and keep food and liquids from spilling onto the his clothing. Review on 2/7/23 of client #4's Mealtime Program guidelines dated 8/22/22 did not reveal his clothing protector should be positioned in this manner at meals. Interview on 2/7/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4's clothing protector should not be positioned in	W 488		

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W 488	Continued From page 8 this manner at meals.	W 488		
W 508	COVID-19 Vaccination of Facility Staff CFR(s): 483.430(f)(1)-(3)(i)-(x) § 483.430 Condition of Participation: Facility staffing. (f) Standard: COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or client contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its clients: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its clients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of	W 508		

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W 508	Continued From page 9 the facility setting and who do not have any direct contact with clients and other staff specified in paragraph (f)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (f)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its clients; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (f)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff	W 508		

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W 508	Continued From page 10 COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: (ii) A process for ensuring that all staff specified in paragraph (f)(1) of this section are fully	W 508		

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W 508	Continued From page 11 vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure their COVID-19 policy and procedures were implemented as written. The finding is: During morning observations in the Tucker Residence on 2/7/23, Staff G was noted wearing a face mask while providing care and services for various clients in the home. Review on 2/7/23 of the facility's COVID-19 employee vaccination list revealed Staff G was hired on 9/12/22 had received approval for a religious exemption from the COVID-19 vaccine and was currently not vaccinated. Additional review of the facility's COVID-19 Vaccination Policy (no date) revealed, "Employees in need of an exemption from this policy due to a medical reason, or because of a sincerely held religious belief must submit a completed Request for Accommodation form to the human resources department to begin the interactive accommodation process as soon as possible after vaccination deadlines have been announced and a required to continue weekly COVID teasing, wear a face covering at the workplace...Employees who are non-compliant for three (3) consecutive weeks by not submitting COVID-19 test results to human resources will be subject to disciplinary action up to and including termination."	W 508		

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W 508	Continued From page 12 Interview on 2/7/23 with the Director of Human Resources confirmed Staff G was not vaccinated against COVID-19 and has an approved religious exemption. Additional interview indicated the staff has not been compliant with weekly COVID-19 testing provided by the facility as indicated in the policy; however, continues to work directly with clients at the facility with no additional safeguards in place.	W 508		