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 _____	05/23/2023

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
E 037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.	E 037	TLC will conduct agency training regarding EP for all staff. We will review all policies and procedures for employees and will have documentation of the training. We will ensure that we follow state/federal guidelines with the following: 1) ensure policy manual is updated. TLC will show that manual is updated. 2) All staff will be in-serviced on policy and procedures regarding EP within our agency by conducting training. 3) all units will have an updated EP plan on site.	7/22 7/22 7/22

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

Jeffrey Chell-Ivey Senior Director Programs 5/5/23

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.

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 _____	05/23/2023

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
E 037	Continued From page 1 (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness	E 037		

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 _____	05/23/2023

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
E 037	Continued From page 2 policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 037		

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 _____	05/23/2023

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
E 037	Continued From page 3 (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.	E 037		

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 _____	05/23/2023

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
E 037	Continued From page 4 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure all staff were trained on the facility's Emergency Preparedness (EP) plan. The finding is: Review on 5/22/23 of the facility's EP plan (dated 2022 - 2023) did not indicate all new and/or existing staff had received training and/or retraining on the EP plan. During an interview on 5/23/23, the Associate Director (AD) indicated training on the EP had not been completed and no documentation of any recent training was available for review.	E 037		
W 129	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure each client had the right to personal privacy. This potentially affected all clients in the home (#1, #2, #3, #4, #5, #6, #7, #8, #9 and #10). The findings are:	W 129	All staff will be in-serviced regarding client's rights. QP, AD, and AM will do in total 8 observations on the unit to ensure client's rights are being followed. All client's IPP will be updated to ensure all client rights issues are being addressed within their IPP.	7/22 7/22

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 _____	05/23/2023

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 129	Continued From page 5 A. During observations in the home throughout the survey on 5/22 - 5/23/23, various staff disregarded the privacy of clients by failing to knock on the doors of bedrooms and bathrooms which were occupied by clients before entering. For example, on 5/23/23 between 7:15am - 8:00am, various staff entered bedrooms and bathrooms where clients were located without knocking on the door. On at least one occasion, a client was having her morning bath as staff entered the bathroom without knocking to retrieve various items. B. During observations in the home on 5/23/23 from 6:58am - 7:15am, client #10 entered the bedrooms of various clients without their permission while the clients were having private time in their room. Review on 5/23/23 of client #10's IPP dated 9/26/22 revealed, "Personal Space: [Client #10] will refrain from invading other's space. This will be an ongoing service." The IPP indicated, "[Client #10] will tend to get very close to things or people, at times invading their personal space. When staff see this happen, they should calmly redirect [Client #10]." Interview on 5/23/23 with the Qualified Intellectual Disabilities Professional (QIDP) and Associate Director (AD) indicated staff should be knocking on bedroom and bathroom to ensure privacy for all clients. Additional interview revealed client #10 used to wander in/out of rooms at his previous placement and he should be redirected by staff.	W 129	Issued discussed: 1) privacy issues 2) knocking before entering bedrooms and bathrooms. Staff will work with psychologist regarding client # 10 helping with redirection and guidance when client #10 is invading others personal space. Once the training is completed QP, AD, and AM will do several observations to ensure client # 10 is being redirected when he tries to enter others room's without being invited or asked.	7/22 7/22
W 130	PROTECTION OF CLIENTS RIGHTS	W 130		

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 _____	05/23/2023

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 130	Continued From page 6 CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure clients were afforded privacy during personal care. This affected 3 of 6 audit clients (#2, #6 and #7). The findings are: A. During observations in the home on 5/22/23 at 12:30pm, the first shift supervisor brushed client #2's teeth in his bedroom with his door open and visible from hallway. Client #6 was also in the bedroom. At no time was a privacy curtain drawn or bedroom door closed. Review on 5/23/23 of client #2's Individualized Program Plan (IPP), dated 4/18/23, revealed no requirement for assurance of privacy. Further review on 5/23/23 of client #2's records revealed no information for privacy assurance. Interview on 5/23/23 with Staff B revealed the staff try to ensure privacy during care. When asked if the privacy curtains or doors were used to ensure privacy, Staff B stated both are utilized to ensure privacy. Interview on 5/23/23 with the Associate Director (AD) revealed staff should be using privacy curtains and closing doors during all personal care because all clients in the facility need assistance with privacy. B. During observations in the home on 5/23/23 at	W 130	All staff will be in-serviced regarding client's rights. QP, AD, and AM will do in total 8 observations on the unit to ensure client's rights are being followed. All client's IPP will be updated to ensure all client rights issues are being addressed within their IPP. Staff will ensure they are using privacy screens/curtains and closing doors during ADL's at all times. Privacy and clients rights will all be discussed at the all staff meeting across the agency.	7/22

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 _____	05/23/2023

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 130	Continued From page 7 9:10am, the first shift supervisor brushed client #6's teeth in the bathroom with the door open and visible from hallway. Review on 5/23/23 of client #6's IPP, dated 3/7/23, revealed no requirement for assurance of privacy. Review on 5/23/23 of client #6's records revealed no information for privacy assurance. Interview on 5/23/23 with Staff B revealed the staff try to ensure privacy during care. When asked if the privacy curtains or doors were used to ensure privacy, Staff B stated staff utilized both to ensure privacy. Interview on 5/23/23 with the AD revealed staff should be using privacy curtains and closing doors during all personal care because all clients in the facility need assistance with privacy. C. During observations in the home on 5/22/23 at 12:30pm, Staff B brushed client #7's teeth in his bedroom with his door open and visible from hallway. At no time was a privacy curtain drawn or bedroom door closed. Review on 5/23/23 of client #7's IPP, 11/29/22, revealed no requirement for assurance of privacy. Review on 5/23/23 of client #7's records revealed no information for privacy assurance. Interview on 5/23/23 with Staff B revealed the staff try to ensure privacy during care. When asked if the privacy curtains or doors were used to ensure privacy, Staff B stated staff utilized both to ensure privacy.	W 130		

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 _____	05/23/2023

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 130	Continued From page 8 Interview on 5/23/23 with the AD revealed staff should be using privacy curtains and closing doors during all personal care because all clients in the facility need assistance with privacy.	W 130		
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #10 had the right to access his personal belongings. This affected 1 of 6 audit clients. The finding is: During observations in the home on 5/23/23 at 11:31am, client #10's bedroom closet was noted to be secured using a latch hook. Closer observation of the closet revealed the client's clothing, shoes, toys and other personal items inside. Interview on 5/23/23 with Staff D indicated all closets in the home contain latch hooks and the closets are kept locked. Additional interview revealed client #10's closet my be locked to keep him from getting into things inside. The staff also indicated it could likely be done for safety reasons. Review on 5/23/23 of client #10's IPP dated 9/26/22 revealed the client requires "full support" in the area of advocacy except for making choices which can be done with partial physical assistance for choosing foods, drink, clothing,	W 137	All locks on closets will be removed so clients may access their clothing. Client #10 will be redirected safely out of client's rooms once he enters, the psychologist will in-service staff on Moore unit to give them guild lines and redirection techniques to help manage client #10 wandering behavior it will be reflected in his IPP and behavioral plan. Any gates or barriers will be removed so clients can move around their living environment freely. Staff will be in-serviced regarding safe re-direction instead of using gates or barriers to prevent client's from entering an area of their living environment. 5 observations will be completed by the QP and AM	7/22 7/22

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 _____	05/23/2023

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 137	Continued From page 9 etc. Immediate interview with the Qualified Intellectual Disabilities Professional (QIDP) revealed she did not know why the closet was locked. The QIDP acknowledged if the closet door was secured client #10 would not be able to retrieve his personal items.	W 137		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure all allegations including injuries of unknown origin are thoroughly investigated. This affected 1 of 6 audit clients. The finding is: Review of an incident report dated 4/25/23 revealed an injury to client #8's right ankle. The report noted the cause of the injury was "unknown" and the client "possibly bumped her foot onto/into something". Additional review of a hospital exam report dated 4/25/23 revealed, "...fractures of the distal tibial metaphysis..." Further review of documentation regarding the injury indicated only four staff had been interviewed regarding the injury with no explanation for the injury. No other interviews or documentation regarding an investigation into the cause of client #8's fracture was provided. Interview on 5/23/23 with the Associate Director (AD) revealed, "the ball was dropped" regarding an investigation into client #8's injury. The AD acknowledged the investigation was not thorough.	W 154	All manager, directors, supervisors will go through investigation training to ensure all policy and procedures are being followed in-case of an injury of unknown origin. We will review the incident again and make corrections to our policy and procedures.	7/22

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 _____	05/23/2023

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 staff were sufficiently trained to perform their duties while demonstrating respect and dignity during client care. This affected 2 of 6 audit clients (#4 and #7). The findings are: A. Observations in the home on 5/22/23 at 12:35pm revealed Staff B preparing to brush client #7's teeth in his bedroom with the door open. Staff B tied a toileting pad around client #7's neck and then brushed his teeth. Staff B then removed the toileting pad and threw it away. Interview on 5/23/23 with Staff B revealed pads are used to protect clients' clothing while brushing teeth. Interview on 5/23/23 with the Associate Director (AD) revealed toileting pads should not be used for brushing teeth as the facility has towels and clothing protectors. B. Observations in the home on 5/23/23 at 9:24am revealed Staff B preparing to brush client #4's teeth in her bedroom with the door open. Staff B tied a toileting pad around client #4's neck and then brushed her teeth. Staff B then removed the toileting pad and threw it way. Interview on 5/23/23 with Staff B revealed pads are used to protect clients' clothing while brushing teeth.	W 189	QP & AD will review with all staff policy and procedures of dignity and rights with all staff. QP will model appropriate ways to do tooth brushing and proper use of incontinent pads inside the milieu. AD and QI personal will do 3 morning and evening observations to ensure policies are being followed.	7/22

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 _____	05/23/2023

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	Continued From page 11 Interview on 5/23/23 with the AD revealed toileting pads should not be used for brushing teeth as the facility has towels and clothing protectors.	W 189		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 6 audit clients (#7 and #10) had the opportunity to choose their personal preference regarding the manner in which they consumed their food, freedom of movement and were provided with alternative choices of foods after refusals. The finding is: A. During breakfast observations in the home on 5/23/23 from 7:55am - 8:53am, staff served scrambled eggs and grits into individual bowls, mixed the two food items together and assisted clients to consume the mixture. Clients were not afforded the opportunity to choose not to have their breakfast food items mixed together prior to consumption. Interview on 5/23/23 with Staff E revealed they normally mix grits and eggs together because only bowls are used at breakfast, not plates. The staff indicated breakfast has been done this way since she started working in the home about 5 months ago. Review on 5/23/23 of client #10's Individual Program Plan (IPP) dated 9/26/22 revealed,	W 247	QP will do 6 mealtime morning and evening observations. focusing on routines and freedom of choice. This will ensure staff are following client's rights regarding choice in foods, clothing, and activities. All staff will be trained in client rights of choice. This will be an in-person training session not computer-based training to ensure staff understand choice and why it is so important. Also the Moore house will ensure we have alternative food choices for clients when they do not like what is served for the meal. All meals times should be documented by staff after each meal and what the alternative was given if the client refused to eat. The Moore house should have a list of foods for each client's preferences of food when refusing a meal. All clients should have at least two choices on hand within the living enviroment. .	7/22

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 _____	05/23/2023

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 247	Continued From page 12 "[Client #10] requires support with making choices but likes to be part of making choices (e.g. what to wear and what to eat) in his daily life....Communicating his desires and needs is very important to him." Interview on 5/23/23 with the Qualified Intellectual Disabilities Professional (QIDP) and Associate Director (AD) confirmed clients should be given the opportunity to choose if they want their food mixed together. Additional interview noted food should be served separately since it was delivered to the home in separate containers. B. During lunch and dinner observations in the home on 5/22 - 5/23/23, client #10 refused food items served to him. The client was not offered an alternative food choice. Interview on 5/23/23 with Staff B revealed if clients refuse food items they can call the kitchen for other options for the client. Review on 5/23/23 of client #10's IPP dated 9/26/22 revealed, "[Client #10] requires support with making choices but likes to be part of making choices (e.g. what to wear and what to eat) in his daily life....Communicating his desires and needs is very important to him." Interview on 5/23/23 with the QIDP and AD indicated a food preference list needs to be developed for each client. Additional interview confirmed alternative food choices should be offered when clients refuse food items. C. During evening activity observations on 5/22/23 on the home patio, client #7 rolled his	W 247		

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 _____	05/23/2023

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 247	Continued From page 13 wheelchair in a circle with his right hand. Staff D walked behind client #7's wheelchair and locked it to prohibit his movement. On 5/23/23 at 7:45am, client #7 was observed sitting in his bedroom attempting to move his wheelchair with his right hand. The wheelchair was observed to be locked. Review on 5/22/23 of client #7's IPP, dated 11/29/22, revealed client #7 can propel himself with his right hand, and his ability to move is important to him. In addition, client #7 has a training objective to propel his chair in the hallway independently daily. Staff are to assist client #7 by pushing to destinations. Review on 5/23/23 of client #7's physical therapy evaluation, dated 11/30/17, revealed client #7 should have opportunity to push his wheelchair. Interview on 5/23/23 with Staff B revealed client #7 likes to rock back and forth to music and staff lock the wheelchair to ensure he doesn't run into furniture or hurt himself. Interview on 5/23/23 with the AD revealed independence should be promoted throughout the day for clients. The AD stated client #7 should be able to move freely.	W 247	All staff will be in-serviced regarding client's rights to move freely within their living environment. Staff will learn not to lock client #7 wheelchair unless specified on his behavioral plan. The QP will review his plan and ensure all staff are trained on client #7 wheelchair procedures and guidelines within the home environment.	7/22
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	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 _____	05/23/2023

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 14 plan. This STANDARD is not met as evidenced by: and Based on observations, record reviews, and interviews, the facility failed to ensure 3 of 6 audit clients (#7, #8, and #10) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of leisure, mealtime skills and objective implementation. The findings are: A. During observations throughout the survey in the home on 5/22/23 from 10:50am - 12:48pm and on 5/23/23 from 6:45am - 10:11am, client #10 was not provided meaningful activities. For example, the client walked throughout the home holding a small toy in one hand while intermittently placing the other hand in his mouth or layed on his bed asleep and at times awake holding the same small toy as music played in the background. During the survey, various staff infrequently interacted with client #10. The client was not provided with alternative activites or choices and was not prompted or encouraged to participate in group activities. Interview on 5/23/23 with Staff B and Staff E revealed client #10 likes to play on the piano, tambourines, or anything with noises. Additional interview indicated he also likes to watch television. Review on 5/22/23 of client #10's IPP dated 9/26/22 revealed, "He requires a great deal of hands on assistance in order to meet his personal care needs, encourage independence	W 249	Client #8 IPP was reviewed, updated and completed for October 2022. Ongoing compliance will be ensured by the QP. At the time of survey, we were unable to locate the proper documentation ensuring the meeting was held in October of 2022. Documentation has since been located and the IPP has been updated accordingly.	7/22

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 _____	05/23/2023

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 15 and provide structure and opportunities in order to participate in meaningful activities." Additional review of the IPP identified an objective to participate in a group activity for 3 minutes without fleeing 40% of trials for 12 consecutive months. Further review of the client's Behavior Intervention Plan (BIP) dated 9/16/22 noted, "Provide [Client #10] with stimulating activities during the day so he is less likely to sleep from boredom during the day. Examples include: Playing games, listening to music, physical activity to keep him focused and occupied, turn taking activities with peers, learning and communication activities, interactive stories, adaptive switch use, self-help tasks and domestic tasks." Interview on 5/23/23 with the Qualified Intellectual Disabilities Professional (QIDP) and Associate Director (AD) revealed "he can do a lot". Additional interview indicated he likes music and being outside or playing with other personal items in his bedroom. B. During lunch observations in the home on 5/22/23 at 11:43am, client #8 was fed by staff using a built-up handle spoon. The client was not prompted or encouraged to assist with feeding herself. During breakfast observations in the home on 5/23/23 at 8:16am, client #8 was fed grits and eggs by staff. With the exception of bringing her spoon to her mouth on one occasion, the client was not prompted or encouraged to feed herself. Interview on 5/23/23 with Staff E revealed they follow mealtime guidelines for each client which are posted in the kitchen.	W 249	In-service will be reviewed with staff on a monthly basis. QP, AM and Supervisor's will be expected to do 2 observations a piece. Active treatment stations will be set up to encourage clients to engage daily with support staff. Examples of stations will be music, sensory and self-care.	7/22

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 _____	05/23/2023

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 16 Review on 5/23/23 of client #8's Mealtime Program guidelines (dated 4/12/23) posted in the kitchen revealed, "Offer [Client #8] a spoon to hold in her hand if needed...All [Client #8] to assist with self-feeding for part of her meal (3 bites)...Place the loaded spoon in her right hand. She requires full assistance to bring the spoon to her mouth...Let [Client #8] assist with self-feeding ONLY with food that adhere to the spoon (grits, potatoes, etc)..." Interview on 5/23/23 with the QIDP confirmed staff should be following the mealtime guidelines posted in the kitchen. C. During lunch observation on 5/22/23 at 12:20pm in the dining room, Staff B used an adaptive spoon to feed client #7 his meal. Staff B used a handled cup to offer hand over hand prompting. At no time was client #7 prompted to feed himself with hand over hand prompting. During dinner observation at 5:00pm, Staff A briefly attempted hand over hand prompting to feed client #7. Staff A then used the adaptive spoon to feed client #7 his meal with no further hand over hand prompting. Staff A used a handled cup to pour beverage into client #7's mouth with no hand over hand prompting. Review on 5/22/23 of client #7's Individual Program Plan (IPP), dated 11/29/22, revealed client #7 can feed himself a portion of meals and drink independently. In addition, client #7 has two objective training goals to drink his beverage independently and feed himself with hand over hand assistance. Review on 5/23/23 of client #7's mealtime	W 249	[redacted] M.ED. CCC-SLP and [redacted] MA, OTR/L will facilitate an in-service to review the newest meal plans and appropriate use of adaptive equipment. QP and SLP/ OT will be expected to observe mealtimes during all three shifts to ensure staff are following proper procedure. Staff will work closely with the meal preparation staff to ensure additional choices (or alternatives) are available for those who show a lack of interest in the meals provided.	7/22

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 _____	05/23/2023

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 17 program guidelines revealed staff should use and over hand feeding prompts during client #7's meals. In addition, the guidelines state client #7 can get cup to his mouth with assistance. Interview on 5/23/23 with Staff B revealed client #7 can eat independently with hand over hand assistance. Interview 5/23/23 with the AD revealed staff should be training throughout meals and promoting independence throughout the day. The AD stated that staff should have used hand over hand prompting for client #7.	W 249		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the Individual Program Plan (IPP) was revised at least annually. This affected 1 of 6 audit clients (#8). The finding is: Review on 5/23/23 of client #8's record revealed an IPP dated 10/30/21. No current IPP was available for review. Interview on 5/23/23 with the Associate Director of Residential Services confirmed client #8's 2022 planning meeting had not been held; therefore, her updated IPP was not available for review.	W 260		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3)	W 288		

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 _____	05/23/2023

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 288	Continued From page 18 Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure techniques to manage client #10's behaviors were included in a formal active treatment program. This affected 1 of 6 audit clients. The findings are: A. During observations in the home throughout the survey on 5/22 - 5/23/23, a gate blocked the entryway into the kitchen of the home. Various staff were noted to go in and out the kitchen while securing the gate behind them. The gate was periodically secured while staff and clients were in and out of the dining room area. Interview on 5/22/23 with the Shift Supervisor indicated the gate was put in place due to client #10 to keep him from getting into anything in the kitchen area. B. During observations in the home on 5/23/23 at 11:31am, client #10's bedroom closet was noted to be secured using a latch hook. Closer observation of the closet revealed the client's clothing shoes, toys and other personal items inside. Interview on 5/23/23 with Staff D indicated all closets in the home contain latch hooks and the closets are kept locked. Additional interview revealed client #10's closet my be locked to keep him from getting into the kitchen and getting into anything. The staff also indicated it could likely be done for safety reasons.	W 288	Staff will participate in an in-service over rights restrictions annually. Client #10 IPP did not include any rights restriction thus locks will be removed from closets and gate from kitchen until supporting documentation provides that it is a safety concern for the individual approved by psychologist [redacted]	7/22

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 _____	05/23/2023

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 288	Continued From page 19 Review on 5/23/23 of client #10's Behavior Intervention Plan (BIP) dated 9/16/22 revealed goals to address sleep behaviors, making transitions, self-stimulatory behaviors, self-injurious behaviors and non-compliance. Additional review of the BIP did not include a technique of using a secured gate to prevent client #10 from entering the kitchen or the use of a latch hook to secure his closet door due to his inappropriate behaviors. Interview on 5/23/23 with the Qualified Intellectual Disabilities Professional (QIDP) and Associate Director (AD) revealed the gate should not be in place and client #10's bedroom door should not be secured denying him access to his personal items.	W 288		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct fire drills, per shift, at least quarterly. The finding is: Review on 5/22/23 of the facility's fire drill evacuation reports revealed for the time period of May 2022 through April 2023, the following fire drills were not conducted: Quarter 1 first and third shift Quarter 2 second and third shift Quarter 3 first shift Quarter 4 second shift Interview with the Qualified Intellectual Disabilities Professional (QIDP) revealed that the fire drills that were reviewed were the only drills completed	W 440	In-service Supervisors regrading procedures around fire drills and on quarterly bases ensuring compliance with monthly drills.	7/22

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 _____	05/23/2023

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 440	Continued From page 20 to her knowledge.	W 440		