STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G272	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST ROAD GROUP HOME	**114 GREENHOUSE LANE SOUTHERN PINES, NC 28387**

(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 9/19/19 for Intake #NC00155302. A deficiency was cited. The complaint allegation was unsubstantiated.	W 000		
W 203	ADMISSIONS, TRANSFERS, DISCHARGE CFR(s): 483.440(b)(5)(i) At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a final summary of former client #1's (FC#1) status at the time of discharge was developed. This affected 1 of 2 discharged clients. The finding is: A discharge summary was not completed for FC#1. Review on 9/19/19 of FC#1's record revealed he was admitted to the facility on 11/28/19 from a local regional center. Review of his individual program plan (IPP) dated 12/28/18 revealed he had diagnoses of Severe intellectual disabilities and Autism. Review on 9/19/19 Nursing notes for FC#1 revealed the following:: 8/14/19: Attacking staff and attacked client. 8/15/19: Spoke with Department of Social services (DSS) Case manager possible increased level of care. Made appointment with	W 203		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G272	A. BUILDING _____ B. WING _____	C 09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST ROAD GROUP HOME	114 GREENHOUSE LANE SOUTHERN PINES, NC 28387

(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 203	Continued From page 1 Physician on 8/16/19. 8/16/19: Seen by Physician for increased aggression. Several medication changes. 8/27/19: Spoke with LME/MCO (Local managed care entity/managed care organization) regarding increased level of care; program director and QIDP (qualified intellectual disabilities professional)on call. 8/30/19: Transported to hospital via EMS (emergency medical services). Interview on 9/19/19 with the QIDP confirmed a letter had been sent to the legal guardian for FC#1 on 8/12/19 regrading him being discharged from the facility within the next 30 days. Additional interview confirmed when FC#1 was transported from the facilty to the hospital on 8/30/19 that he was considered discharged from the facility. The QIDP and Nurse contacted the guardian by phone but did not get a return call to confirm their message had been received. Additional interview with the QIDP confirmed following this discharge from the facility, she did not complete a discharge summary for FC#1.	W 203		