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

PRINTED: 09/20/2019
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
	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(a): 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	By 10-10-19 a final summary will be completed for discharged client #1. Completion of all discharges will be monitored by administration/QA QI for implementation of regulation pertaining to to discharges.	10/10/19

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

Print Name QIDP MA LCAS CCSI — 10/1/19

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.

GREATER IMAG E HEALTHCARE CORP
401 ROBESON STREET
FAYETTEVILLE, NC 28301
(910) 321-0069 Fax: (910) 491-1000

Fax Cover Sheet

Send To: Kim McCashill	From: Jeane Rhone
Attention:	Date: 10/2/19
RE:	Office Location:
Fax Number:	Phone Number: 910 491-1000

- ☐ Urgent
- ☐ Reply ASAP
- ☐ Please Comment
- ☐ Please Review
- ☐ For your Information

Total pages, including cover:

RECEIVED
By DHRS-Mental Health Licensure at 10:35 am, Oct 02, 2019

Comments: Plan of Correction
Please call if you questions

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