| DEPARTMENT OF HEALTH AND HUMAN SERVICES | | | | | | | | |
|--|---|--|--|--|--|--|--|--|
| FOR MEDICARE | & MEDICAID SERVICES | T | | OMB N | IO. 0938-0391 | | | |
| DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | |
| | 34G081 | B. WING _ | | (| 01/06/2021 | | | |
| NAME OF PROVIDER OR SUPPLIER | | | | DE | | | | |
| FANJOY HOME #2 | | | 450 TWIN OAKS ROAD STATESVILLE, NC 28625 | | | | | |
| SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | (EACH CORRECTIVE ACTION | SHOULD BE | (X5) COMPLETION DATE | | | |
| INITIAL COMMENTS | | W 00 | 000 | | | | | |
| INITIAL COMMENTS A complaint survey was completed on 1/6/21 in addition to the recertification survey. No deficiencies were cited as a result of the complaint survey for intake #NC169386. A deficiency was cited as a result of the recertification survey. 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 assure a final discharge summary was completed for 1 of 1 closed record reviewed (#7). The finding is: Review of the closed record for client #7 on 1/5/21 revealed the client was admitted to the hospital on 8/19/20 due to severe abdominal area pain. A subsequent nursing note dated 8/19/20 revealed hospice services were ordered for the client while in the hospital. Continued review of the record did not reveal any further notes regarding client status or client record. No discharge summary was available. Nursing staff was able to provide evidence of communication with the guardian regarding status of the client, and the team decision not to re-admit the client due to a new medical diagnoses and a need for an increased level of care. | | W 20 | 03 | | | | | |
| | FOR MEDICARE DEFICIENCIES CORRECTION DVIDER OR SUPPLIER DME #2 SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS A complaint survey ddition to the recent eficiencies were ci- complaint survey for eficiency was cited eficiency was cited ecertification survey DMISSIONS, TRA FR(s): 483.440(b) t the time of the di- evelop a final sum- evelopmental, beh- utritional status. his STANDARD is Based on record re- illed to assure a fin- pompleted for 1 of 1 he finding is: eview of the close (5/21 revealed the ospital on 8/19/20 ain. A subsequent evelop a final sum- evelop a final sum- as able to provide it the guardian re- d the team decisi- ue to a new medic | FOR MEDICARE & MEDICAID SERVICES POFICIENCIES FORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G081 WIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) NITIAL COMMENTS A complaint survey was completed on 1/6/21 in ddition to the recertification survey. No efficiencies were cited as a result of the pomplaint survey for intake #NC169386. A efficiency was cited as a result of the scertification survey. 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WING WIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CC 450 TWIN OAKS ROAD STATESVILLE, NC 28625; USUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) NITIAL COMMENTS W 000 V000 D PREFIX TAG V000 INTIAL COMMENTS W 000 V000 D PREFIX V000 INTIAL COMMENTS W 000 V000 V000 D PREFIX V000 INTIAL COMMENTS W 000 V000 V000 V000 V000 V000 D PREFIX D PREFIX V000 V000 <td>FOR MEDICARE & MEDICAID SERVICES OMB N DEFICIENCIES (1) PROVIDERSUPPLIERCLA (2) MULTIPLE CONSTRUCTION (X) I A. BUILDING A. BUILDING (A) BUING (X) I WIDER OR SUPPLIER B. WING (X) I (X) I ME #2 STREET ADDRESS.CITY.STATE, ZIP CODE 450 TWIN OAKS ROAD STATESVILLE, NC 28625 STATESVILLE, NC 28625 STATESVILLE, NC 28625 ITAL COMMENTS IN PREVENTION OR USE DEPTICIONES ID PREVENTION OR USE DEPTICIONES ID PREVENTION OR USE DEPTICIONES ITAL COMMENTS W 000 IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEPTICIENCY) ID PREVENTION ITAL COMMENTS W 000 ITAL COMMENTS W 000 Action to the recertification survey. No afficiencies were cited as a result of the organist survey for intake #NC169386. A ficiency was cited as a result of the certification survey. DMISSIONS, TRANSFERS, DISCHARGE FR(s): 483.440(b)(5)(i) W 203 It the time of the discharge the facility must sevelop a final summary of the client's sevelopamental, behavioral, social, health and utritional status. 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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 01/08/2021

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.

| | | AND HUMAN SERVICES | | | | FORM | 01/08/2021 APPROVED 0938-0391 | |
|---|---|--|---|---------|---|-------------------------------|-------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | (X3) DATE SURVEY COMPLETED | | |
| | | 34G081 | | B. WING | | | 01/06/2021 | |
| NAME OF PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | |
| FANJOY HOME #2 | | | 450 TWIN OAKS ROAD STATESVILLE, NC 28625 | | | | | |
| (X4) ID PREFIX TAG | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| W 203 | the client was diagr admitted to the hos indicated that based from the hospital, th provide the level of the client based on medical needs. Th was discharged from an increased level of the qualified intelled on 1/5/21 confirmed completed for client | acility nurse on 1/5/21 revealed nosed with cancer after being pital in 8/2020. The nurse d on the information received ney did not feel they could medical care necessary for the new diagnoses and client e nurse indicated the client m the hospital to a facility with of medical care. Interview with ctual disabilities professional d no discharge summary was t #7, and therefore no y was sent to the facility the | W 2 | 203 | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 921836

If continuation sheet Page 2 of 2