STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G081	A. BUILDING _____ 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	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 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.	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 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 203		

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

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.

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FANJOY HOME #2	**450 TWIN OAKS ROAD STATESVILLE, NC 28625**

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W 203	Continued From page 1 Interview with the facility nurse on 1/5/21 revealed the client was diagnosed with cancer after being admitted to the hospital in 8/2020. The nurse indicated that based on the information received from the hospital, they did not feel they could provide the level of medical care necessary for the client based on the new diagnoses and client medical needs. The nurse indicated the client was discharged from the hospital to a facility with an increased level of medical care. Interview with the qualified intellectual disabilities professional on 1/5/21 confirmed no discharge summary was completed for client #7, and therefore no discharge summary was sent to the facility the client was discharged to.	W 203		