DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM						M APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
		34G137	B. WING			C /10/2025	
NAME OF PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE			
				6113 BLUE LANTERN ROAD			
SUMMERI	_YN			GIBSONVILLE, NC 27249			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	SHOULD BE COMPLETION		
W 000	INITIAL COMMENTS		w oc	0			
	A complaint investigation was completed on 6/10/25 for CINV Intake No. NC00231298. The complaint was substantiated and deficiencies were cited.						
W 201			W 20	11			
	If a client is to be either transferred or discharged, the facility must have documentation in the client's record that the client was transferred or discharged for good cause. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure there was documentation in the client's record that the facility prepared to discharge client #1 for good cause. The finding is:						
	text messages betwee #1's guardian betwee 6/6/25, the President have been trying to gu it has not been. We a forward with client #1 effective this coming a Further review reveal indicated she could n Sunday, the Presiden dated 6/7/25 that, "Th until Monday. He mus Please confirm the tin Monday. It will need t review revealed an en requesting a timefram discharge from the gr	6/10/25 revealed a series of en the President and client n 6/6/25 and 6/9/25. On stated to the guardian, "I et the situation resolved but re going to have to move 's discharge into your care Sunday, June 8, 2025." ed that when the guardian ot pick the client up on it responded in an email the latest we can keep him is st be picked up by then. ne he will be picked up o be by 5 PM." Continued mail dated 6/8/25 again ne for picking client #1 up for oup home on 6/9/25, and 25 again requesting a time					
		SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

PRINTED: 06/13/2025

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 06/13/2025 1 APPROVED 0. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		-	(X3) DATE SURVEY COMPLETED			
34		34G137	B. WING		_	C 06/10/2025			
NAME OF PF	ROVIDER OR SUPPLIER		\$	STREET ADDRESS, CITY, S	TATE, ZIP CODE				
SUMMERLYN				6113 BLUE LANTERN ROAD GIBSONVILLE, NC 27249					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
W 201	revealed that she had provider's office on or they were not receivin client #1 and that, if th that situation that day client #1. Further inter revealed that she had referred to above and with the facility to rem The guardian also stat care for client #1 in he disabled by a recent st Interview on 6/10/25 w that the facility was at Medicaid billing issue Further interview reve believes that the guar and has transferred c county which is outsic area and that this is th When asked why the discharge client #1 an previously set, the Pro- billing was denied, it to continuing to provide support the services r ADMISSIONS, TRAN CFR(s): 483.440(b)(4	ck up client #1 that at 's legal guardian on 6/9/25 a gotten a call from the around 6/4/25 indicating ng Medicaid payments for ne guardian did not remedy at the facility would discharge rview with the guardian a received each of the emails at that she was trying to work hedy the payment situation. Atted that she is unable to ar home since she was stroke. With the President revealed ttempting to resolve a concerning client #1. ealed that the President rdian is being uncooperative lient #1's Medicaid to a de of the MCO's catchment he cause of the denial. facility was attempting to head of the 6/18/25 date esident replied, "When his became an issue of a service with no revenue to heeded." ISFERS, DISCHARGE)(ii) er transferred or discharged, de a reasonable time to	W 201		DEFICIENCY)				
	prepare the client and								

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Facility ID: 922670

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 06/13/2025 RM APPROVED IO. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DAT	(X3) DATE SURVEY COMPLETED	
34G137		34G137	B. WING		0'	C 6/10/2025	
NAME OF PI	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP COD			
			611	3 BLUE LANTERN ROAD			
SUMMERI	LYN		GIE	BSONVILLE, NC 27249			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
W 202	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		W 202				

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Facility ID: 922670

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 06/13/2025 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G137	B. WING			C 06/10/2025	
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
SUMMER	LYN				113 BLUE LANTERN ROAD GIBSONVILLE, NC 27249		
	CLIMMADY CT	ATEMENT OF DEFICIENCIES		G	PROVIDER'S PLAN OF CORRECTIO		(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 202	Continued From page	e 3	w	202			
	The guardian also stated that she is unable to care for client #1 in her home since she was disabled by a recent stroke.						
	The guardian also stated that she is unable to care for client #1 in her home since she was						

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