STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G137	A. BUILDING _____ B. WING _____	C 06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERLYN	6113 BLUE LANTERN ROAD GIBSONVILLE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint investigation was completed on 6/10/25 for CINV Intake No. NC00231298. The complaint was substantiated and deficiencies were cited.	W 000		
W 201	ADMISSIONS, TRANSFERS, DISCHARGE CFR(s): 483.440(b)(4)(i) 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: Review of records on 6/10/25 revealed a series of text messages between the President and client #1's guardian between 6/6/25 and 6/9/25. On 6/6/25, the President stated to the guardian, "I have been trying to get the situation resolved but it has not been. We are going to have to move forward with client #1's discharge into your care effective this coming Sunday, June 8, 2025." Further review revealed that when the guardian indicated she could not pick the client up on Sunday, the President responded in an email dated 6/7/25 that, "The latest we can keep him is until Monday. He must be picked up by then. Please confirm the time he will be picked up Monday. It will need to be by 5 PM." Continued review revealed an email dated 6/8/25 again requesting a timeframe for picking client #1 up for discharge from the group home on 6/9/25, and another email on 6/9/25 again requesting a time	W 201	We have implemented a new system of documenting all contacts between the guardian and the facility. Each party retains a copy of all documentation associated with all: incidents, update communication, and any changes related to the cosumer and his ongoing care. We have also requested that the guardian communicate any changes that she is implementing without our involvement, so that we can adjust as needed and avoid further complications while the consumer remains in our care. The QP will communicate with the guardian on a monthly basis or as needed when certain situations present themselves and require an immedite response.	08/09/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE Aug. 8, 25

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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W 201	Continued From page 1 for the guardian to pick up client #1 that afternoon. Interview with client #1's legal guardian on 6/9/25 revealed that she had gotten a call from the provider's office on or around 6/4/25 indicating they were not receiving Medicaid payments for client #1 and that, if the guardian did not remedy that situation that day, the facility would discharge client #1. Further interview with the guardian revealed that she had received each of the emails referred to above and that she was trying to work with the facility to remedy the payment situation. The guardian also stated that she is unable to care for client #1 in her home since she was disabled by a recent stroke. Interview on 6/10/25 with the President revealed that the facility was attempting to resolve a Medicaid billing issue concerning client #1. Further interview revealed that the President believes that the guardian is being uncooperative and has transferred client #1's Medicaid to a county which is outside of the MCO's catchment area and that this is the cause of the denial. When asked why the facility was attempting to discharge client #1 ahead of the 6/18/25 date previously set, the President replied, "When his billing was denied, it became an issue of continuing to provide a service with no revenue to support the services needed."	W 201	See response on page 1	08/09/2025
W 202	ADMISSIONS, TRANSFERS, DISCHARGE CFR(s): 483.440(b)(4)(ii) If a client is to be either transferred or discharged, the facility must provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in	W 202	See page 3 for response	

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W 202	Continued From page 2 emergencies). This STANDARD is not met as evidenced by: The facility failed to provide a reasonable time to prepare client #1 and his parent or guardian for discharge on 6/8/25 and again on 6/9/25. The finding is: Review of records on 6/10/25 revealed a series of text messages between the President and client #1's guardian between 6/6/25 and 6/9/25. On 6/6/25, the President stated to the guardian, "I have been trying to get the situation resolved but it has not been. We are going to have to move forward with client #1's discharge into your care effective this coming Sunday, June 8, 2025." Further review revealed that when the guardian indicated she could not pick the client up on Sunday, the President responded in an email dated 6/7/25 that, "The latest we can keep him is until Monday. He must be picked up by then. Please confirm the time he will be picked up Monday. It will need to be by 5 PM." Continued review revealed an email dated 6/8/25 again requesting a timeframe for picking client #1 up for discharge from the group home on 6/9/25, and another email on 6/9/25 again requesting a time for the guardian to pick up client #1 that afternoon. Interview with client #1's legal guardian on 6/9/25 revealed that she had gotten a call from the provider's office on or around 6/4/25 indicating they were not receiving Medicaid payments for client #1 and that, if the guardian did not remedy that situation that day, the facility would discharge client #1. Further interview with the guardian revealed that she had received each of the emails referred to above and that she was trying to work with the facility to remedy the payment situation.	W 202	As advised by by Lillian a new letter of discharge with adequate notice was mailed and emailed to the guardian. A new agreed upon discharge date of 8/11/2025 was given. This meets the minimum 60 day requirement. We will continue to monitor the situation and keep the guardian updated as to the consumers discharge. If the situation present itself that placement is not found by the agreed deadline. The facility will contact DHSR for further advisement and work with the LMEs to expedite placement for the consumer. All of our efforts will be well documented and the guardian will have copies mailed to her with any informaiton that is deemed necessary. We will continue to work with the gaurdian. If she needs to extend his stay that can be discussed 10 days prior to the deadline of his discharge. The QP will communicate with the guardian on a monthly basis or as needed when certain situations present themselves and require an immedite response.	08/09/2025

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W 202	Continued From page 3 The guardian also stated that she is unable to care for client #1 in her home since she was disabled by a recent stroke. Interview on 6/10/25 with the President revealed that the facility was attempting to resolve a Medicaid billing issue concerning client #1. Further interview revealed that the President believes that the guardian is being uncooperative and has transferred client #1's Medicaid to a county which is outside of the MCO's catchment area and that this is the cause of the denial. When asked why the facility was attempting to discharge client #1 ahead of the 6/18/25 date previously set, the President replied, "When his billing was denied, it became an issue of continuing to provide a service with no revenue to support the services needed."	W 202	See page 3 for response	08/09/2025