PRINTED: 07/19/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		MHL026-855	B. WING		07/10/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			AND DRIVE	,		
JOYFUL L	IVING #1		/ILLE, NC 2830	04		
(VA) ID	SI IMMADV ST	ATEMENT OF DEFICIENCIES	<del></del>	PROVIDER'S PLAN OF CORRECTIO	N (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	An annual and follow on July 10, 2019. De	up survey was completed ficiencies were cited.				
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.					
V 108	√ 108 27G .0202 (F-I) Personnel Requirements		V 108			
	10A NCAC 27G .0202 PERSONNEL REQUIREMENTS  (f) Continuing education shall be documented.  (g) Employee training programs shall be provided and, at a minimum, shall consist of the following:  (1) general organizational orientation;  (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;  (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and  (4) training in infectious diseases and bloodborne pathogens.  (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their					
	equivalence for reliev (i) The governing bodimplement policies ar reporting, investigating	ing airway obstruction.				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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DIVISION OF FERNING FOR REGULATION		(VO) MULTIPLE	Take All II TIPLE CONCERNATION		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING: _		COWII LL IED	
					R
MHL026-855		B. WING	<del></del>	07/10/2019	
			I .		0111012010
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
JOYFUL L	IVING #4	1951 IRE	LAND DRIVE		
JOTFULL	IVING #1	FAYETTE	VILLE, NC 2830	04	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
V 108	Continued From page	1	V 108		
	Continued From page				
	clients.				
	This Rule is not met	as evidenced by:			
	Based on record review	ew and interview, the facility			
	failed to ensure staff v	were currently trained in			
	cardiopulmonary resuscitation (CPR), Heimlich				
	maneuver, and other first aid techniques provided				
	by the Red Cross, the American Heart				
	Association, or their equivalence for 2 of 3 staff audited (Licensee and Staff #1). The findings are:				
	Review on 07/10/19 of	of the Staff #1's personnel			
	file revealed:				
	-Hired 12/31/08.				
	-Documentation of CF	PR and first aid training			
	dated 01/21/17 had expired and no current training was available for review.				
	Review on 07/10/19 of the Licensee's personnel file revealed:				
	-Hired 06/2008.				
	-Documentation of CPR and first aid training				
	dated 01/21/17 had e	xpired and no current			
	training was available	for review.			
	Interview on 07/10/19	the Licensee stated:			
	-She would have the	training completed.			
		-			
V 114	27G .0207 Emergenc	y Plans and Supplies	V 114		
V 117	ZIO .UZUI LIIIGIYGIIU	y i lans and oupplies	' ' ' '		
	10A NCAC 27G 0207	7 EMERGENCY PLANS			
	AND SUPPLIES	LVILITOLITOTI LAND			
	(a) A written fire plan	for each facility and			
		an shall be developed and			
	area-wide disaster pro	an anali be developed and	- 1		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			D 14/11/0		R	
		MHL026-855	B. WING		07/1	0/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
JOYFUL L	IVING #1		AND DRIVE			
			VILLE, NC 2830			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 114	Continued From page 2		V 114			
	and evacuation proce posted in the facility. (c) Fire and disaster of shall be held at least repeated for each shi under conditions that	made available to all staff dures and routes shall be drills in a 24-hour facility				
	This Rule is not met as evidenced by: Based on record review and interviews the facility failed to have fire and disaster drills held at least quarterly and repeated on each shift. The findings are:					
	- No documented fire November 2018-Marc					
	at the facility.  - She understood the to be completed quar shift.  - She would complete	some fire and disaster drills fire and disaster drills had terly and repeated on each e drills as required. tutes a re-cited deficiency				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
THE PERIOD CONTROL			A. BUILDING:			
MI		MHL026-855	B. WING		R 07/10/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADD			RESS, CITY, STA	TE, ZIP CODE		
JOYFUL L	IVING #1		AND DRIVE			
			ILLE, NC 2830			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 736	Continued From page 3		V 736			
V 736	27G .0303(c) Facility and Grounds Maintenance		V 736			
		EMENTS				
	This Rule is not met as evidenced by: Based on observations and interview, the licensee failed to maintain the facility in a clean, attractive and orderly manner. The findings are:  Observation on 07/10/19 at approximately 10:30 am revealed: - Client #1 and client #4's bedroom had broken blind slates The carpet in the downstairs sitting area was worn and dirty The hall bathroom had peeling paint on the walls, the linoleum floor had tears in front of the sink and the floor was soft and squishy when walking on the floorClient #3's bedroom had a tear in the carpet and she used a walker causing a fall hazard for client #3The air return in the hall was dirty and dusty.  Interview on 07/10/19 the Licensee stated: -She was in the process of making repairs to the facility.					

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