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: COMPLETED A. BUILDING: _ R MHL026-855 B. WING 07/10/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1951 IRELAND DRIVE JOYFUL LIVING #1 **FAYETTEVILLE, NC 28304** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual and follow up survey was completed on July 10, 2019. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised DHSR - Mental Health Living for Adults with Developmental Disabilities. AUG 2 2 2019 V 108 27G .0202 (F-I) Personnel Requirements V 108 10A NCAC 27G .0202 PERSONNEL Lic. & Cert. Section 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

Division of Health Service Regulation

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

equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and

TITLE

(X6) DATE

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:** COMPLETED A. BUILDING: __ R MHL026-855 B. WING 07/10/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1951 IRELAND DRIVE **JOYFUL LIVING #1 FAYETTEVILLE, NC 28304** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) V 108 Continued From page 1 V 108 clients This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff 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 Just Aid & CPR Iraining was conjuded in all stop 7/12/19.

Ricenses and or Q.P.

Will minition to maintain conjudence Review on 07/10/19 of the Staff #1's personnel file revealed: -Hired 12/31/08. -Documentation of CPR 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 expired and no current training was available for review. Interview on 07/10/19 the Licensee stated: -She would have the training completed.

AND SUPPLIES

V 114 27G .0207 Emergency Plans and Supplies

10A NCAC 27G .0207 EMERGENCY PLANS

(a) A written fire plan for each facility and area-wide disaster plan shall be developed and V 114

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ R B. WING _ MHL026-855 07/10/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

(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) COMPLETE DATE
	Continued From page 2 shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use.	V 114		
	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: Review on 07/10/19 of facility records revealed: - No documented fire or disaster drills from November 2018-March 2019 No documented disaster drill in December 2019-June 2019, Interview on 07/10/19 the Licensee stated: - She had completed some fire and disaster drills at the facility She understood the fire and disaster drills had to be completed quarterly and repeated on each shift She would complete drills as required. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.		Jul & plinaster dulls will be completed as required and documented Linewer & O.P. will winder quaterly to maintain Curpliance.	ć.

Division of Health Service Regulation

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: COMPLETED MHL026-855 B. WING 07/10/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **JOYFUL LIVING #1** 1951 IRELAND DRIVE **FAYETTEVILLE, NC 28304** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE (X5)TAG **PREFIX** COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 736 Continued From page 3 V 736 V 736 27G .0303(c) Facility and Grounds Maintenance V 736 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS Clients # 124 hunds (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly were replaced 7/13/19 manner and shall be kept free from offensive Carpet in downstains odor. setting area well be Cleaned and or replaced This Rule is not met as evidenced by: Based on observations and interview, the licensee failed to maintain the facility in a clean, l hathroom will 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 floor. -Client #3's bedroom had a tear in the carpet and she used a walker causing a fall hazard for client -The 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. proper working order and cleaned in a