| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL026-856 | A. BUILDING: _____ B. WING _____ | R 01/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JOYFUL LIVING #2 | 6125 LOUISE STREET FAYETTEVILLE, NC 28314 |

| (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 |
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| V 000 | INITIAL COMMENTS<br><br>An annual and follow up survey was completed on January 7, 2022. Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.<br><br>The survey sample consisted of audits of 3 current clients. | V 000 | | |
| V 112 | 27G .0205 (C-D)<br>Assessment/Treatment/Habilitation Plan<br><br>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN<br>(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.<br>(d) The plan shall include:<br>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;<br>(2) strategies;<br>(3) staff responsible;<br>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;<br>(5) basis for evaluation or assessment of outcome achievement; and<br>(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. | V 112 | | |

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| V 112 | Continued From page 1 | V 112 | | |

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement strategies to address needs and behaviors for 3 of 3 audited clients (#1, #2, #4) and failed to assure the treatment plans were reviewed at least annually. The findings are:

Finding #1
Review on 1/6/22 of client #1's record revealed:
-43 year old male.
-Admitted on 10/12/10.
-Diagnoses of Impulse Control Disorder, Borderline Intellectual Functioning, Allergic Rhinitis, Diabetes and Hypertension.
-Treatment plan effective 3/2/21 was not signed by client #1's guardian.

Interview on 1/6/22 client #1 stated:
-His guardian was a local Department of Social Services.
-Staff worked with him on his goals.
-He attended his medical appointments.

Finding #2
Review on 1/6/22 of client #2's record revealed:
-60 year old male.
-Admitted on 7/29/08.
-Diagnoses of Moderate Intellectual Disability, Intermittent Explosive Disorder, Social Phobia and Hypertension.
-Last treatment plan completed on 1/13/19.
-There was no current treatment/habilitation plan.

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| V 112 | Continued From page 2<br><br>Interview on 1/6/22 client #2 stated:<br>-He had not attended the Psychosocial Rehabilitation Program (PSR) program since COVID (Coronavirus Disease 2019).<br>-Staff worked with him on his goals.<br>-Staff worked with him on boundaries and took him shopping.<br><br>Finding #3<br>Review on 1/6/22 of client #4's record revealed:<br>-43 year old male.<br>-Admitted on 7/1/09.<br>-Diagnoses of Schizoaffective Disorder, deferred and Hypertension.<br>-Treatment plan effective 2/28/21 was not signed by client #4.<br><br>Interview on 1/6/22 client #4 stated:<br>-Staff worked with him on his goals of practicing patience and exercising.<br>-Staff took clients to their medical appointments.<br><br>Interview on 1/6/22 the Qualified Professional (QP) stated:<br>-The PSR completed the treatment plans before COVID.<br>-She completed the treatment plans.<br>-She was unsure why the treatment plans had not been signed by clients or guardians.<br>-Some of the clients cannot write to sign the treatment plan.<br><br>Interview on 1/6/22 the Licensee stated:<br>-The clients no longer attended the PSR due to COVID.<br>-The clients last attended the PSR in March 2020.<br>-The PSR or the QP completed the treatment plans.<br>-There was "no excuse" for the treatment plans not signed. | V 112 | | |

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| V 113 | 27G .0206 Client Records<br><br>10A NCAC 27G .0206 CLIENT RECORDS<br>(a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to:<br>(1) an identification face sheet which includes:<br>(A) name (last, first, middle, maiden);<br>(B) client record number;<br>(C) date of birth;<br>(D) race, gender and marital status;<br>(E) admission date;<br>(F) discharge date;<br>(2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV;<br>(3) documentation of the screening and assessment;<br>(4) treatment/habilitation or service plan;<br>(5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician;<br>(6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician;<br>(7) documentation of services provided;<br>(8) documentation of progress toward outcomes;<br>(9) if applicable:<br>(A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM);<br>(B) medication orders;<br>(C) orders and copies of lab tests; and<br>(D) documentation of medication and administration errors and adverse drug reactions.<br>(b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed | V 113 | | |

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| V 113 | Continued From page 4<br>only in accordance with the communicable disease laws as specified in G.S. 130A-143.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews the facility failed to maintain documentation of services provided and progress towards outcomes for 3 of 3 audited clients (#1, #2, #4). The findings are:<br><br>Finding #1<br>Review on 1/6/22 of client #1's record revealed:<br>-43 year old male.<br>-Admitted on 10/12/10.<br>-Diagnoses of Impulse Control Disorder, Borderline Intellectual Functioning, Allergic Rhinitis, Diabetes and Hypertension.<br>-There was no documentation of progress towards client goals.<br><br>Finding #2<br>Review on 1/6/22 of client #2's record revealed:<br>-60 year old male.<br>-Admitted on 7/29/08.<br>-Diagnoses of Moderate Intellectual Disability, Intermittent Explosive Disorder, Social Phobia and Hypertension.<br>-There was no documentation of services provided or progress towards client goals.<br><br>Finding #3<br>Review on 1/6/22 of client #4's record revealed:<br>-43 year old male.<br>-Admitted on 7/1/09. | V 113 | | |

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| V 113 | Continued From page 5<br>-Diagnoses of Schizoaffective Disorder, deferred and Hypertension.<br>-There was no documentation of progress towards client goals.<br><br>Interview on 1/6/22 - 1/7/22 the Licensee stated:<br>-There were no client progress notes in the client records.<br>-Staff had not completed progress notes since "clients were home every day all day."<br>-The clients had not attended the Psychosocial Rehabilitation Program (PSR) since March 2020.<br>-She would ensure progress notes were completed. | V 113 | | |