STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING		R		
		MHL026-856	D. WING		01/0	7/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
JOYFUL	LIVING #2		ISE STREET VILLE, NC 2			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	-S	V 000			
	on January 7, 2022 This facility is licens	w up survey was completed . Deficiencies were cited. sed for the following service C 27G .5600C Supervised				
	Living for Adults with Developmental Disabilities.  The survey sample consisted of audits of 3 current clients.					
V 112	112 27G .0205 (C-D) Assessment/Treatment/Habilitation Plan		V 112			
	10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN  (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.  (d) The plan shall include:  (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;  (2) strategies;  (3) staff responsible;  (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;  (5) basis for evaluation or assessment of outcome achievement; and  (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.					

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

(X6) DATE TITLE

DIVISION	of Health Service Re					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
				R		
		MHL026-856	B. WING			7/2022
NAME OF			DDECC OILY	STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
JOYFUL	LIVING #2		JISE STREET			
		FAYETTE	VILLE, NC 2	88314		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
				· ·		
V 112	Continued From pa	ge 1	V 112			
	This Rule is not me					
	Based on record re	views and interviews, the				
	facility failed to deve	elop and implement strategies				
	to address needs and behaviors for 3 of 3 audited					
	clients (#1, #2, #4)	and failed to assure the				
		re reviewed at least annually.				
	The findings are:					
	The infamge are.					
	Finding #1					
		f client #1's record revealed:				
	-43 year old male.	Client #1 S record revealed.				
	•	/10				
	-Admitted on 10/12					
		Ilse Control Disorder,				
		ual Functioning, Allergic				
	Rhinitis, Diabetes a					
		ective 3/2/21 was not signed				
	by client #1's guard	ian.				
	Interview on 1/6/22					
		a local Department of Social				
	Services.					
	-Staff worked with h					
	-He attended his me	edical appointments.				
	Finding #2					
		f client #2's record revealed:				
	-60 year old male.					
	-Admitted on 7/29/0	98.				
	-Diagnoses of Mode	erate Intellectual Disability,				
		ve Disorder, Social Phobia				
	and Hypertension.	•				
		n completed on 1/13/19.				
		ent treatment/habilitation plan.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		R		
		MHL026-856	D. WING		01/0	7/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
JOYFUL	LIVING #2		ISE STREET			
			VILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
V 112	Continued From pa	ge 2	V 112			
	COVID (Coronaviru -Staff worked with h	ed the Psychosocial ram (PSR) program since s Disease 2019).				
	Finding #3 Review on 1/6/22 of client #4's record revealed: -43 year old maleAdmitted on 7/1/09Diagnoses of Schizoaffective Disorder, deferred and HypertensionTreatment plan effective 2/28/21 was not signed by client #4.					
	Interview on 1/6/22 client #4 stated: -Staff worked with him on his goals of practicing patience and exercisingStaff took clients to their medical appointments.					
	Interview on 1/6/22 the Qualified Professional (QP) stated: -The PSR completed the treatment plans before COVIDShe completed the treatment plansShe was unsure why the treatment plans had not been signed by clients or guardiansSome of the clients cannot write to sign the treatment plan.					
	-The clients no long COVID. -The clients last atte -The PSR or the QP plans.	the Licensee stated: per attended the PSR due to ended the PSR in March 2020. Completed the treatment use" for the treatment plans				

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not signed.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		A. BUILDING:					
MHL026-856		B. WING			R <b>01/07/2022</b>		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
IOVEIII	LIVING #2	6125 LOU	ISE STREET	ī			
JOTFOL	LIVING #2	FAYETTE	VILLE, NC 2	8314			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
V 113	27G .0206 Client R	ecords	V 113				
	10A NCAC 27G .02 (a) A client record sindividual admitted contain, but need n (1) an identification (A) name (last, first (B) client record nu (C) date of birth; (D) race, gender ar (E) admission date (F) discharge date; (2) documentation developmental disadiagnosis coded ac (3) documentation assessment; (4) treatment/habilit (5) emergency inforshall include the nanumber of the personal sudden illness or an and telephone numphysician; (6) a signed statem responsible personemergency care from (7) documentation (8) documentation (9) if applicable: (A) documentation diagnosis according of Diseases (ICD-9 (B) medication order (C) orders and cop (D) documentation administration error (b) Each facility shall	contacted in case of coident and the name, address and telephone on to be contacted in case of coident and the name, address ber of the client's preferred the client or legally granting permission to seek on a hospital or physical disorders g to International Classification -CM); ers; ies of lab tests; and					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE COMP	SURVEY LETED
				R		
MHL026-856		B. WING		01/0	7/2022	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S JISE STREET	STATE, ZIP CODE •		
JOYFUL	LIVING #2		VILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 113	only in accordance disease laws as sp  This Rule is not me Based on record re	with the communicable ecified in G.S. 130A-143.  et as evidenced by: views and interviews the	V 113			
	facility failed to maintain documentation of services provided and progress towards outcomes for 3 of 3 audited clients (#1, #2, #4). The findings are:  Finding #1 Review on 1/6/22 of client #1's record revealed: -43 year old maleAdmitted on 10/12/10Diagnoses of Impulse Control Disorder, Borderline Intellectual Functioning, Allergic Rhinitis, Diabetes and HypertensionThere was no documentation of progress towards client goals.					
	-60 year old maleAdmitted on 7/29/0 -Diagnoses of Mod Intermittent Explosi and HypertensionThere was no door provided or progres Finding #3	erate Intellectual Disability, ve Disorder, Social Phobia umentation of services as towards client goals.  f client #4's record revealed:				

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C54S11 If continuation sheet 5 of 6

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  6125 LOUISE STREET FAYETTEVILLE, NC 28314  [X4) ID SUMMARY STATEMENT OF DEFICIENCES TAGS  SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FILL (FACH DEFICIENCY MUST BE PRECEDED BY FILL (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE  DATE  V 113  Conflued From page 5 -Diagnoses of Schizoaffective Disorder, deferred and HypertensionThere was no documentation of progress towards client goals.  Interview on 1/6/22 - 1/7/22 the Licensee stated: -There were no client progress notes in the client recordsStaff had not completed progress notes since "clients were home every day all day." -The clients had not attended the Sychosocial Rehabilitation Program (PSR) since March 2020She would ensure progress notes were completed.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  6125 LOUISE STREET FAYETTEVILLE, NC 28314   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 113  Continued From page 5  -Diagnoses of Schizoaffective Disorder, deferred and HypertensionThere was no documentation of progress towards client goals.  Interview on 1/6/22 - 1/7/22 the Licensee stated: -There were no client progress notes in the client recordsStaff had not completed progress notes since "clients were home every day all day." -The clients had not attended the Psychosocial Rehabilitation Program (PSR) since March 2020She would ensure progress notes were					R		
SUMMARY STATEMENT OF DEFICIENCIES   FAYETTEVILLE, NC 28314			MHL026-856	B. WING		01/0	7/2022
CX4) ID   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPLETE DATE    V 113   Continued From page 5   V 113    -Diagnoses of Schizoaffective Disorder, deferred and HypertensionThere was no documentation of progress towards client goals.  Interview on 1/6/22 - 1/7/22 the Licensee stated: -There were no client progress notes in the client recordsStaff had not completed progress notes since "clients were home every day all day." -The clients had not attended the Psychosocial Rehabilitation Program (PSR) since March 2020She would ensure progress notes were	NAME OF F	PROVIDER OR SUPPLIER					
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	V 113	-Diagnoses of Schiz and HypertensionThere was no doct towards client goals Interview on 1/6/22 -There were no clie recordsStaff had not comp "clients were home -The clients had no Rehabilitation Programs.	zoaffective Disorder, deferred umentation of progress s.  - 1/7/22 the Licensee stated: nt progress notes in the client pleted progress notes since every day all day." t attended the Psychosocial ram (PSR) since March 2020.				

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