PRINTED: 01/10/2022 FORM APPROVED

(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED R B. WING MHL026-856 01/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6125 LOUISE STREET JOYFUL LIVING #2 FAYETTEVILLE, NC 28314** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual and follow up survey was completed on January 7, 2022. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. The survey sample consisted of audits of 3 current clients. V 112 27G .0205 (C-D) V 112 Assessment/Treatment/Habilitation Plan 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 TITLE (X6) DATE STATE FORM 6899 C54S11 If continuation sheet 1 of 6

Division of Health Service Regulation

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER.		A. BUILDING:		
		MHL026-856	B. WING		R <b>01/07/2022</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE		
JOYFUL	LIVING #2	6125 LOU	IISE STREE	T		
		FAYETTE	VILLE, 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	:
V 112	facility failed to deve to address needs an clients (#1, #2, #4)		V 112			
	The findings are:  Finding #1 Review on 1/6/22 of -43 year old maleAdmitted on 10/12/2 -Diagnoses of Impuls Borderline Intellectua Rhinitis, Diabetes an -Treatment plan effe by client #1's guardia  Interview on 1/6/22 of -His guardian was a ServicesStaff worked with hir -He attended his med Finding #2 Review on 1/6/22 of -60 year old maleAdmitted on 7/29/08 -Diagnoses of Moder Intermittent Explosive and HypertensionLast treatment plan	client #1's record revealed:  10. se Control Disorder, al Functioning, Allergic d Hypertension. ctive 3/2/21 was not signed an.  lient #1 stated: local Department of Social m on his goals. dical appointments.  client #2's record revealed:		Client # 1's treatment plans be founded to the guar for a signature. Licensed AP will monitor quarterly ensure compliance.  Client #2's treatment plan was be updated I completed. Licensed AP will monitor quart to ensure compliance.		

Division of Health Service Regulation

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

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		MHL026-856	B. WING		01/	07/2022
NAME OF	PROVIDER OR SUPPLIER	STATE, ZIP CODE				
JOYFUL LIVING #2 6125 LO FAYETTE			VILLE, NC			
(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 APPROPED DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 112	Continued From page	ge 2	V 112			
	COVID (Coronavirus -Staff worked with h	d the Psychosocial am (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.			Client #4's tradmont plan De signed and updated. L and ap will monitor and quarterly to ensure comp	will iconsic	03/01/2022
	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.			company to endure con-		
	(QP) stated: -The PSR completed COVIDShe completed the second completed completed the second completed comp	y the treatment plans had not				
	COVIDThe clients last atter -The PSR or the QP plans.	ne Licensee stated: or attended the PSR due to nded the PSR in March 2020. completed the treatment se" for the treatment plans				

(X2) MULTIPLE CONSTRUCTION

Division of Health Service Regulation

C54S11

Division of Health Service Regulation

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  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)  V 113  27G .0206 Client Records  V 113  10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		
NAME OF PROVIDER OR SUPPLIER  JOYFUL LIVING #2  SUMMARY STATEMENT OF DEFICIENCIES FAYETTEVILLE, NC 28314  [X4) ID PREFIX TAG TAG  V 113  27G .0206 Client Records  10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness,			
JOYFUL LIVING #2  6125 LOUISE STREET FAYETTEVILLE, NC 28314  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 113  27G .0206 Client Records  V 113  10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness,	MHL026-856		
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X44   ID   PREFIX   CEACH 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)   OAT    V 113   27G .0206 Client Records   V 113    10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness,	2	FUL LIV	JOYFL
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 113  27G .0206 Client Records  10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness,	CUMMARY CTATEMENT OF DESIG		040.15
10A NCAC 27G .0206 CLIENT RECORDS  (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to:  (1) an identification face sheet which includes:  (A) name (last, first, middle, maiden);  (B) client record number;  (C) date of birth;  (D) race, gender and marital status;  (E) admission date;  (F) discharge date;  (2) documentation of mental illness,	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		
diagnosis coded according to DSM IV;  (3) documentation of the screening and assessment;  (4) treatment/habilitation or service plan; (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; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed	AC 27G .0206 CLIENT RE ent record shall be maintain al admitted to the facility, we but need not be limited to: lentification face sheet while e (last, first, middle, maide at record number; of birth; , gender and marital status ission date; harge date; mentation of mental illness mental disabilities or substance is coded according to DSM mentation of the screening hent; ment/habilitation or service regency information for each lude the name, address an of the person to be contact illness or accident and the behone number of the client on; hed statement from the client contact of the person granting permis lacy care from a hospital or mentation of services provi- mentation of physical disor is according to International ses (ICD-9-CM); cation orders; is and copies of lab tests; a mentation of medication ar ration errors and adverse of facility shall ensure that inf	10 (a) inco (1) (A) (B) (C) (D) (B) (C) (B) (C) (D) adn (b)	V 11

(X2) MULTIPLE CONSTRUCTION

Division of Health Service Regulation

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	DENTILICATION NOWIDER.		A. BUILDIN	A. BUILDING:		
		MHL026-856	B. WING _		R <b>01/07/2022</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE		
JOYFUL	LIVING #2	6125 LOL	JISE STREE	ET .		
			VILLE, NC	28314		
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V 113	Continued From page	ge 4	V 113			
		with the communicable ecified in G.S. 130A-143.				
	facility failed to main services provided ar	riews and interviews the tain documentation of				
	Review on 1/6/22 of -43 year old maleAdmitted on 10/12/2 -Diagnoses of Impuls Borderline Intellectual Rhinitis, Diabetes and	se Control Disorder, al Functioning, Allergic d Hypertension. mentation of progress		Staff Will do Weekly progress towards geals, Lironson Will Workly to ensure company	monidar	
	-60 year old maleAdmitted on 7/29/08 -Diagnoses of Moder Intermittent Explosive and HypertensionThere was no docur provided or progress	client #2's record revealed:  a. rate Intellectual Disability, e Disorder, Social Phobia mentation of services towards client goals.		Shaff Will do wheth progress. notes to document progress. goals. Licensee and QP will Weekly to ensure compliance	ess odalzozz townds monitor	
	Finding #3 Review on 1/6/22 of 6 -43 year old maleAdmitted on 7/1/09. alth Service Regulation	client #4's record revealed:				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	N OF CORRECTION	IDENTIFICATION NUMBER:		G:	(X3) DATE S COMPL			
		MHL026-856	B. WING	-	R 01/07	7/2022		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE				
JOYFUL	JOYFUL LIVING #2 6125 LOUISE STREET FAYETTEVILLE, NC 28314							
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V 113	and HypertensionThere was no docutowards client goals Interview on 1/6/22 -There were no client recordsStaff had not composite the clients were home of the clients had not composite the clients had not composit	coaffective Disorder, deferred amentation of progress  - 1/7/22 the Licensee stated: nt progress notes in the client leted progress notes since every day all day."  attended the Psychosocial am (PSR) since March 2020.	V 113	Shaff will do Weekly progretoward goals, Litensee and will monitor weekly to compliance.	55	3/0/2022		