PRINTED: 03/28/2025 FORM APPROVED

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G081	B. WING			2/20/202
FANJOY I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 450 TWIN OAKS ROAD STATESVILLE, NC 28625	1 0:	3/26/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RF	(X5) COMPLETION DATE
	CFR(s): 483.475(d)(1); §403.748(d)(1), §416. §441.184(d)(1), §460. §483.73(d)(1), §485.4 §485.68(d)(1), §485.5; §491.12(d)(1). *[For RNCHIs at §403. Hospitals at §482.15, I at §484.102, REHs at under §485.727, OPO: RHC/FQHCs at §491. (1) Training program. the following: (i) Initial training in emerolicies and procedure staff, individuals provide arrangement, and volu expected roles. (ii) Provide emergency least every 2 years. (iii) Maintain document preparedness training. (iv) Demonstrate staff is procedures. (v) If the emergency procedures are significant tonduct training of procedures. *[For Hospices at §418 hospice must do all of the composition of the procedures and	54(d)(1), §418.113(d)(1), 84(d)(1), §482.15(d)(1), 75(d)(1), §482.15(d)(1), 75(d)(1), §485.625(d)(1), 920(d)(1), §486.360(d)(1), 920(d)(1), §486.360(d)(1), 920(d)(1), §486.360(d)(1), 920(d)(1), 920(E 037	The Qualified Professional and Chairperson will update the Emergency Preparedness Plan. Qualified Professional will train a staff on the plan. The Regional Administrator will monitor the Emergency Preparedness Plan 6 months to ensure it remains updated and staff are trained. The Program Manager and Safety Chairperson will organize and complete a tabletop exercise. The Safety Chairperson will monitor to ensure tabletop exercises are completed at least on an annual basis. In the future, the Regional Administrator will ensure tabletop exercises are completed on an annual basis. The Qualified Professional will ensure the Emergency Preparedness Plan is updated and staff are trained on current plan and training conduct annually.	The all every see	5/25/25
INTERNITORY IN	MEGIOR S OR PROVIDER/SU	PPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DD Regional Administrator 4/1/25

STATEMENT	OF DEFICIENCIES				OMB	NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME		34G081	B. WING _			03/26/2025
FANJOY	PROVIDER OR SUPPLIER HOME #2			STREET ADDRESS, CITY, STATE, ZIP COD 450 TWIN OAKS ROAD STATESVILLE, NC 28625	DE	33/20/2023
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
E 037	(ii) Demonstrate staff procedures. (iii) Provide emergency least every 2 years. (iv) Periodically review emergency preparedremployees (including special emphasis place procedures necessary others. (v) Maintain document preparedness training (vi) If the emergency procedures are significant training procedures. *[For PRTFs at §441.* program. The PRTF maintenance of the procedures and procedures staff, individuals provide arrangement, and voluex procedures. (ii) After initial training preparedness training (iii) Demonstrate staff procedures. (iv) Maintain document preparedness training. (v) If the emergency procedures are significant training. (v) If the emergency procedures are significant training. (vi) If the emergency procedures. *[For PACE at §460.84] organization must do as	expreparedness training at and rehearse its less plan with hospice nonemployee staff), with sed on carrying out the art to protect patients and station of all emergency coreparedness policies and cantly updated, the hospice on the updated policies and less to all new and existing ding services under unteers, consistent with their provide emergency every 2 years. knowledge of emergency tation of all emergency every 2 years. knowledge of emergency every 2 years. knowledge of emergency tation of all emergency every 2 years. knowledge of emergency tation of all emergency every 2 years. It is a support of the updated, the PRTF on the updated policies and less the less than the updated policies and less than the	EO	37		

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				ОМВ	NO. 0938-0391
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCT	FION	The state of the s	ATE SURVEY OMPLETED
NAME OF S		34G081	B. WING				03/26/2025
FANJOY I				450 TWIN OAK	ESS, CITY, STATE, ZIP CODE KS ROAD .E, NC 28625		33/20/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	K (E.	PROVIDER'S PLAN OF CORRECT EACH CORRECTIVE ACTION SHOL DSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	staff, individuals proviarrangement, contract volunteers, consistent (ii) Provide emergency least every 2 years. (iii) Demonstrate staff procedures, including what to do, where to go case of an emergency (iv) Maintain document (v) If the emergency procedures are signific must conduct training procedures. *[For LTC Facilities at Program. The LTC fact following: (i) Initial training in empolicies and procedures staff, individuals provide arrangement, and volue expected role. (ii) Provide emergency least annually. (iii) Maintain document preparedness training. (iv) Demonstrate staff if procedures. *[For CORFs at §485.6] CORF must do all of the (i) Provide initial training preparedness policies and existing staff, individuals staff, individuals procedures.	ding on-site services under tors, participants, and with their expected roles. The preparedness training at knowledge of emergency informing participants of too, and whom to contact in the contact in the preparedness policies and control updated, the PACE on the updated policies and control updated polici	E	037			

STATEMENT	OF DEFICIENCIES	(VA) PROMPERIOR			OMB	NO. 0938-0391
AND DI AN OF CODDECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TPLE CONSTRUCTION	The second secon	OATE SURVEY OMPLETED
		34G081	B. WING			02/26/2025
FANJOY	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 450 TWIN OAKS ROAD STATESVILLE, NC 28625	DE	03/26/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	least every 2 years. (iii) Maintain documer (iv) Demonstrate staff procedures. All new p and assigned specific the CORF's emergency their first workday. The include instruction in t alarm systems and sig equipment. (v) If the emergency procedures are signific must conduct training procedures. *[For CAHs at §485.62 The CAH must do all of (i) Initial training in em policies and procedure reporting and extinguis and where necessary, personnel, and guests cooperation with firefig authorities, to all new a individuals providing so and volunteers, consis roles. (ii) Provide emergency least every 2 years. (iii) Maintain document (iv) Demonstrate staff l procedures. (v) If the emergency procedures are signific	tation of the training. knowledge of emergency ersonnel must be oriented responsibilities regarding by plan within 2 weeks of e training program must the location and use of gnals and firefighting preparedness policies and cantly updated, the CORF on the updated policies and cantly updated policies and cantly including: ergency preparedness es, including prompt shing of fires, protection, evacuation of patients, fire prevention, and whiting and disaster and existing staff, ervices under arrangement, tent with their expected	EO	37		

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		OMB NO. 0938-0391
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD			(X3) DATE SURVEY COMPLETED
NAME OF I	PROVIDED OF SUPERIOR	34G081	B. WING			03/26/2025
FANJOY	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 450 TWIN OAKS ROAD STATESVILLE, NC 28625	CODE	00/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(TION SHOULD BE THE APPROPRIAT	
E 037	*[For CMHCs at §485 CMHC must provide i preparedness policies and existing staff, indi under arrangement, a with their expected ro documentation of the demonstrate staff kno procedures. Thereaft emergency preparednyears. This STANDARD is not be a seed on record revietable to ensure direct the facility's Emergency (EPP) at least biennia.	i.920(d):] (1) Training. The nitial training in emergency and procedures to all new ividuals providing services and volunteers, consistent les, and maintain training. The CMHC must wledge of emergency er, the CMHC must provide ness training at least every 2 not met as evidenced by: ew and interview, the facility care staff were trained on cy Preparedness Plan	E	037		
E 039	professional on 3/26/2 evidence of initial and EPP. EP Testing Requireme CFR(s): 483.475(d)(2) §416.54(d)(2), §418.1 §460.84(d)(2), §482.1 §483.475(d)(2), §484.5 §485.542(d)(2), §485.6 §485.920(d)(2), §491.4 §485.542, OPO, "Or	13(d)(2), §441.184(d)(2), 5(d)(2), §483.73(d)(2), 102(d)(2), §485.68(d)(2), 625(d)(2), §485.727(d)(2), 12(d)(2), §494.62(d)(2). -, CORFs at §485.68, REHs rganizations" under §485.920, RHCs/FQHCs at	ΕO	E 039 Cross reference E 03	37	5/25/25

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				OWR M	O. 0938-0391	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		1000	(X3) DATE SURVEY COMPLETED	
NAME OF		34G081	B. WING			02	126/2025	
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 03	3/26/2025	
FANIOV	HOME "							
FANJOY	HOME #2				TWIN OAKS ROAD			
(V4) ID	OUB MADY OF			STA	ATESVILLE, NC 28625			
(X4) ID PREFIX	(FACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECTION		W. W.	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFI	X	(EACH CORRECTIVE ACTION SHOULD B)	E	(X5) COMPLETION	
	What is sometimes and a second	THO IN ORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	ATE	DATE	
					DEFICIENCY)			
E 039	0 "							
⊏ 039	Continued From page	5	E	039				
	(2) Testing. The [facilit	ty] must conduct exercises					1	
	to test the emergency	plan annually. The [facility]						
	must do all of the follo	wing:						
	made ad all of the follo	willig.		- 1				
	(i) Participate in a full							
	(i) Participate in a full-	scale exercise that is						
	community-based eve	ry 2 years; or						
	(A) when a communit	ty-based exercise is not						
	accessible, conduct a	facility-based functional						
	exercise every 2 years							
	(B) If the [facility]	experiences an actual					1	
	natural or man-made e	emergency that requires						
-	activation of the emerg	gency plan, the [facility] is						
	exempt from engaging	in its next required						
	community-based or in	ndividual facility-based						
	functional exercise follo	Owing the onset of the						
	actual event.	owing the onset of the						
		nal exercise at least every 2					1	
	Vears especife the ver	and exercise at least every 2						
	years, opposite the year	ar the full-scale or						
- 1	this as a time in the control of the	ler paragraph (d)(2)(i) of						
	this section is conducte	ed, that may include, but is						
	not limited to the follow							
	(A) A second full-scale	exercise that is						
	community-based or in	dividual, facility-based						
	functional exercise; or							
	(B) A mock disaster dri							
	(C) A tabletop exercise	or workshop that is led by						
	a facilitator and include	s a group discussion using						
	a narrated, clinically-rel	evant emergency					1	
	scenario, and a set of p	problem statements						
	directed messages, or	prepared questions						
	designed to challenge a	an emergency plan						
	(iii) Analyze the [facility	an emergency plan.						
	maintain documentation	of all drills, table to						
	maintain documentation	or all drills, tabletop						
	facility of an emerger	ncy events, and revise the						
1	[facility's] emergency pl	an, as needed.						
	+r= 11 ·							
	*[For Hospices at 418.1	13(d):]						
6:								

STATEMENT	OF DEFICIENCIES	(X1) PROMPERIOUS ISSUED		westing it has a second	OMB	NO. 0938-0391
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
NAME OF S		34G081	B. WING _			03/26/2025
FANJOY	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 450 TWIN OAKS ROAD STATESVILLE, NC 28625	DE	03/26/2025
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	patient's home. The revercises to test the en annually. The hospica (i) Participate in a full community based ever (A) When a community accessible, conduct an functional exercise ever (B) If the hospice experiment and emergency the emergency plan, the emergency plan, the emergency plan, the emergency plan its next recommunity-based exertions onset of the emergency (ii) Conduct an addition opposite the year the free exercise under paragrasis conducted, that may to the following: (A) A second full-scale community-based or an exercise; or (B) A mock disaster did (C) A tabletop exercise a facilitator and include a narrated, clinically-rescenario, and a set of directed messages, or designed to challenge (3) Testing for hospices care directly. The hospice must a facilitator must be exercises to test the end of the exercise to t	es that provide care in the nospice must conduct emergency plan at least emust do the following: escale exercise that is ry 2 years; or y based exercise is not in individual facility based ery 2 years; or eriences a natural or y that requires activation of the hospital is exempt from equired full scale rcise or individual fall exercise following the exp event. In the second of the hospital is exempt from experiences and individual fall exercise following the expression of the following the expression of the hospital is exempt from experiences and individual fall exercise following the expression functional formulation in the facility based functional formulation in the facility based functional formulation in the facility based functional formulations are mergency plan. The facility based functions are mergency plan twice per set do the following: in the following: in the facility scale exercise that in the following: in the facility scale exercise that in the following: in the facility scale exercise that in the facility scale exercise in the facility scale exercise that in the facility scale exercise in the facil	E 03	39		

STATEMENT	OF DEFICIENCIES	(X1) PROVIDED OUR PROVIDED OF	Vanish and the second		OMB	NO. 0938-0391	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING _	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF F	PROVIDER OR SUPPLIER	34G081	B. WING			03/26/2025	
FANJOY			4	TREET ADDRESS, CITY, STATE, ZIP COD 50 TWIN OAKS ROAD TATESVILLE, NC 28625	E	00/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	(A) When a commur accessible, conduct facility-based function (B) If the hospice expansion made emergenthe emergency plan, engaging in its next abased or facility-based following the onset of (ii) Conduct an addition may include, but is not (A) A second full-sear community-based or exercise; or (B) A mock disaster (C) A tabletop exercifacilitator that include narrated, clinically-reand a set of problem messages, or preparate challenge an emerge (iii) Analyze the hospimaintain documentate exercises, and emergency hospice's emergency *[For PRFTs at §441. §482.15(d), CAHs at (2) Testing. The [PRT conduct exercises to fit twice per year. The [Indo the following: (i) Participate in an an is community-based; of the following: (ii) Participate in an an is community-based; of the following: (iii) Participate in an an is community-based; of the following: (iii) Participate in an an incommunity-based; of the following: (iii) Participate in an an incommunity-based; of the following: (iii) Participate in an an incommunity-based; of the following: (iiii) Participate in an an incommunity-based; of the following: (iiii) Participate in an an incommunity-based; of the following: (iiii) Participate in an an incommunity-based; of the following: (iiiii) Participate in an an incommunity-based; of the following: (iiiiii) Participate in an an incommunity-based; of the following: (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	anity-based exercise is not an annual individual anal exercise; or periences a natural or cy that requires activation of the hospice is exempt from required full-scale community ed functional exercise from the emergency event. In a facility based functional exercise that the emergency event. In a facility based functional exercise that is a facility based functional exercise exercise that exercise is not annual individual,	E 039				

PRINTED: 03/28/2025 FORM APPROVED OMB NO. 0938-0391

AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF F	PROVIDED OF SUPERIOR	34G081	B. WING		03/26/2025	
FANJOY			450	EET ADDRESS, CITY, STATE, ZIP CODE TWIN OAKS ROAD TESVILLE, NC 28625	03/20/2025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D.RE COMPLETION	
	(B) If the [PRTF, Hoactual natural or mai requires activation o [facility] is exempt for required full-scale of facility-based function onset of the emerger (ii) Conduct an and that may include following: (A) A second full-scale or functional exercise; or (B) A mock (C) A tabletop existed by a facilitator and discussion, using a nemergency scenario, statements, directed questions designed to plan. (iii) Analyze the [maintain documentate exercises, and emergency if [facility's] emergency *[For PACE at §460.8 (2) Testing. The PACE of following: (i) Participate in an a is community-based; (A) When a community accessible, conduct a facility-based function (B) If the PACE experiments.	spital, CAH] experiences an n-made emergency that if the emergency plan, the omengaging in its next ommunity based or individual, nal exercise following the ney event. [additional] annual exercise or expected by the new power of the plane and the plane and the plane are the plane and the plane are the plane as needed. [additional] annual exercise or exercise that is individual, a facility-based for disaster drill; or exercise or workshop that is dincludes a group arrated, clinically-relevant and a set of problem messages, or prepared to challenge an emergency of facility's] response to and the plane, as needed. [additional] annual drills, tabletop gency events and revise the plane, as needed. [additional] exercise that for exercise plane at least or ganization must do the nual full-scale exercise is not nannual individual,	E 039			

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		and a supplication of the	OM	<u>B NO. 0938-0391</u>
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF	DDOUBLE	34G081	B. WING _			00/00/000
portugation and	PROVIDER OR SUPPLIER HOME #2			STREET ADDRESS, CITY, STATE, ZIP 450 TWIN OAKS ROAD STATESVILLE, NC 28625	CODE	03/26/2025
(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	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	the emergency plan, the engaging in its next resistance of individual, fall exercise following the event. (ii) Conduct an act years opposite the years opposite the years opposite the years conducted that may the following: (A) A second full-scale community-based or infunctional exercise; or (B) A mock disaster discommunity-based or infunctional exercise; or (C) A tabletop exercise a facilitator and include using a narrated, clinic scenario, and a set of directed messages, or designed to challenge (iii) Analyze the PACE maintain documentatio exercises, and emerge PACE's emergency planticluding unannounced emergency procedures ICF/IID] must do the following unantous demergency procedures ICF/IID]	the PACE is exempt from equired full-scale community icility-based functional onset of the emergency diditional exercise every 2 for the full-scale or functional aph (d)(2)(i) of this section include, but is not limited to exercise that is individual, a facility based will; or every or workshop that is led by estanging a group discussion, ally-relevant emergency problem statements, prepared questions an emergency plan. It is response to and in of all drills, tabletop incy events and revise the in, as needed. 1483.73(d): It is using the interest to mat least twice per year, staff drills using the interest. The [LTC facility, lowing: interest has not annual individual, exercise. It is according to the interest and individual, exercise. It is according to the exercise is not annual individual, exercise.	E 03	39		

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IDI E CON	STRUCTION	0.0000/2000	NO. 0938-0391
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN		STRUCTION		OATE SURVEY OMPLETED
		34G081	B. WING				
NAME OF P	ROVIDER OR SUPPLIER	040001	B. WING_				03/26/2025
					T ADDRESS, CITY, STATE, ZIP CODE		
FANJOY H	IOME #2				VIN OAKS ROAD		
(X4) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES		STATE	ESVILLE, NC 28625		
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX	,	PROVIDER'S PLAN OF CORRECTI	NC	(X5)
TAG	REGULATORY OR	SC IDENTIFYING INFORMATION)	TAG	`	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE PRIATE	COMPLETION DATE
					DEFICIENCY)		
E 039	Continued France	10					
L 003	Continued From page		E 0	39			
	TC facility is exempt	the emergency plan, the					
	required a full-scale c	from engaging its next					
	individual facility-has	ed functional exercise					
	following the onset of	the emergency event.					
	(ii) Conduct an addition	onal annual exercise that					
	may include, but is no	t limited to the following:					
	(A) A second full-scal	e exercise that is					
	community-based or a	an individual, facility based					
	functional exercise; or						
	(B) A mock disaster d	eriii; or se or workshop that is led by					
	a facilitator includes a	group discussion, using a					
	narrated, clinically-rele	evant emergency scenario,					
	and a set of problem s	statements, directed					
-	messages, or prepare	d questions designed to					
19	challenge an emergen	cy plan.					
	(iii) Analyze the [LTC	facility] facility's response to					
	and maintain documer	ntation of all drills, tabletop					
	ILTC facility! facility's a	ency events, and revise the					
	[LTO lacility] lacility's e	emergency plan, as needed.					
	*[For ICF/IIDs at §483.	475(d)1:					
	(2) Testing. The ICF/III	D must conduct exercises					
	to test the emergency	plan at least twice per year.					
1	The ICF/IID must do th	e following:					
	(i) Participate in an anr	nual full-scale exercise that					
	s community-based; o	r					
	accessible, conduct an	-based exercise is not					
f	acility-based functiona	l exercise: or					
		iences an actual natural or					
r	man-made emergency	that requires activation of					
t	he emergency plan, th	e ICF/IID is exempt from					
6	engaging in its next red	quired full-scale					
(community-based or in	dividual, facility-based					
	unctional exercise follo	owing the onset of the					
e	emergency event.						

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			ON	<u>/IB NO. 0938-0391</u>
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3	B) DATE SURVEY COMPLETED
NAME		34G081	B. WING			02/20/2005
FANJOY I	ROVIDER OR SUPPLIER		4	STREET ADDRESS, CITY, STATE, ZIP COD 150 TWIN OAKS ROAD STATESVILLE, NC 28625	E	03/26/2025
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	may include, but is no (A) A second full-scale community-based or a functional exercise; or (B) A mock disaster dr (C) A tabletop exercise a facilitator and include using a narrated, clinic scenario, and a set of directed messages, or designed to challenge (iii) Analyze the ICF/III maintain documentatio exercises, and emerge ICF/IID's emergency p *[For HHAs at §484.10 (d)(2) Testing. The HH (i) Participate in a full-s community-based; or (A) When a comm accessible, conduct an facility-based functiona or. (B) If the HHA exp or man-made emergency plan, engaging in its next req community-based or in functional exercise follo emergency event. (ii) Conduct an addition opposite the year the full exercise under paragra	anal annual exercise that the limited to the following: exercise that is an individual, facility-based or ill; or every an every an exercise that is led by es a group discussion, cally-relevant emergency problem statements, prepared questions an emergency plan. D's response to and on of all drills, tabletop ency events, and revise the lan, as needed. 22] A must conduct exercises plan at lA must do the following: scale exercise that is cale exercise that is unity-based exercise is not annual individual, all exercise every 2 years; periences an actual natural cy that requires activation the HHA is exempt from quired full-scale dividual, facility based owing the onset of the lateral exercise every 2 years, and exercise eve	E 039			

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G081	B. WING				100/000	
NAME OF P	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 0;	3/26/2025	
FANJOY	HOME #2				TWIN OAKS ROAD			
				STA	TESVILLE, NC 28625			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	10075	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(X5) COMPLETION DATE	
	community-based or functional exercise; (B) A mock disa: (C) A tabletop exited by a facilitator and discussion, using a nemergency scenario, statements, directed questions designed to plan. (iii) Analyze the HHA documentation of all emergency events, a emergency plan, as referred to test the emergency following: (i) Conduct a paper-b workshop at least and led by a facilitator and discussion, using a nemergency scenario, statements, directed in questions designed to plan. If the OPO experimental emergency plan, if the emergency plan, if the emergency plan, if the opposition of all to occumentation of all to the statements of the emergency plan, if the opposition of all to occumentation of all to the statements of the emergency plan, if the opposition of all to occumentation of all to the statements of the emergency plan, if the opposition of all to occumentation occurred to occumentation occurred to occurred the occurred to o	I-scale exercise that is an individual, facility-based or ster drill; or exercise or workshop that is d includes a group parrated, clinically-relevant and a set of problem messages, or prepared or challenge an emergency 's response to and maintain drills, tabletop exercises, and and revise the HHA's needed. 360] PO must conduct exercises or plan. The OPO must do the exercise or nually. A tabletop exercise is d includes a group parrated, clinically relevant and a set of problem messages, or prepared or challenge an emergency eriences an actual natural or by that requires activation of the OPO is exempt from equired testing exercise the emergency event. Its response to and maintain abletop exercises, and and revise the [RNHCl's and	E	039				

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/28/2025 CENTERS FOR MEDICARE & MEDICAID SERVICES **FORM APPROVED** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 34G081 B. WING 03/26/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **FANJOY HOME #2** 450 TWIN OAKS ROAD STATESVILLE, NC 28625 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) E 039 Continued From page 13 E 039 *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct biennial testing of the facility's Emergency Preparedness Plan (EPP). The finding is: Review of the facility's EPP on 3/25/25 revealed a table top exercise dated 3/15/24. Continued review revealed no evidence of an additional full-scale community/facility-based exercise. Interview with the qualified intellectual disability professional on 3/26/25 confirmed the facility has not conducted a full-scale community/facility-based exercise within the last two years. W 249 PROGRAM IMPLEMENTATION W 249

CFR(s): 483.440(d)(1)

As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G081	B. WING			0.3	3/26/2025
FANJOY I	PROVIDER OR SUPPLIER			45	TREET ADDRESS, CITY, STATE, ZIP CODE 50 TWIN OAKS ROAD TATESVILLE, NC 28625	1 03	0/20/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE .	(X5) COMPLETION DATE
W 249	interventions and servand frequency to supply objectives identified in plan. This STANDARD is in Based on observation interviews, the facility clients (#1) received a treatment program as Person-Centered Plan supervision. The finding Evening observations 3/25/25 revealed client evening meal which corrice, and collard green revealed client #1 to coindependently. Continuently, and actively monitoring client which is staff to slow his rate of or swallow before taking the swallow before taking observations 3/26/25 revealed client which toast and banana. Fur client #1 to consume to Continued observation were present in the dia techis breakfast, there	vices in sufficient number port the achievement of the in the individual program and the individual program are to the individ	W	249	The Qualified Professional will in-service all staff one diet orders. People Supported. The clinical to will monitor through meal time assessments 2x a week for a peof 30 days and then on a routine basis to ensure diet orders are followed properly. In the future, to Qualified Professional will ensure staff are trained on diet orders of People Supported.	riod he e all	5/25/25

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENT		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		34G081	B. WING		0:	3/26/2025	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	JI LOI LO LO	
FANJOY	HOME #2		- 1	50 TWIN OAKS ROAD STATESVILLE, NC 28625			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID				
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 249	Continued From page well, or swallow befor		W 249				
W 368	Review of records reversible in the physician's orders. This STANDARD is no Based on observation interview, the facility fawere administered in a orders. This affected 1 during medication the medications admir Mupirocin 2% cream. If revealed staff to apply client #3's left and other facility fawere admired medication admired to the medication admired medication admired medication admired medication 2% cream. If revealed staff to apply client #3's left and right.	realed a Person-Centered 7/25 which states, "Diet is asistency meats, 1" foods. 1:1 monitoring while in to chew and swallow well bite." lified intellectual disabilities confirmed that client #1's at staff should have for of client #1 and this rate of eating. TION dministration must assure inistered in compliance with the confirmed that client #1 and this rate of eating. TION dministration must assure inistered in compliance with the confirmed that client #3 observed to ensure medications accordance with physician's client (#3) observed inistration. The finding is: the home on 3/26/25 at the cobserved to participate in a administration. Among distered at that time was further observation the Mupirocin cream to the great to cleanse the area the amount of the state of the	W 368	W 368 The nurse will in-service all staff proper medication passes when applying topicals and following doctor's orders. The clinical team monitor through medication pass assessments 2x a week for a period of 30 days and then on a routine basis to ensure medication passes are completed per policy. In the future, the nurse will ensure all sare trained on proper medication passes.	n will s riod es	5/25/25	

STATEMENT	OF DEFICIENCIES	(X1) PROVIDENCIAN (X1)			OMB N	NO. 0938-0391
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G081	B. WING			2/20/2005
	PROVIDER OR SUPPLIER HOME #2		1 .	STREET ADDRESS, CITY, STATE, ZIP CODE 450 TWIN OAKS ROAD STATESVILLE, NC 28625	1 0	03/26/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBF	(X5) COMPLETION DATE
W 436	physician's order which cream should be applied to and that the area peroxide. Interview with the faci confirmed that the physician's should he to before applying the the cream should not left big toe. SPACE AND EQUIPM CFR(s): 483.470(g)(2). The facility must furnist and teach clients to us choices about the use hearing and other command other devices ider interdisciplinary team at the straightful teach of the facility facility facility for the facility	ch states that the Mupirocin lied to the client's right big should first be cleansed with should first be cleansed with should first be cleansed with lity nurse on 3/26/25 ysician's order is current have cleaned the right big e Mupirocin cream and that have been applied to the MENT Sh, maintain in good repair, se and to make informed of dentures, eyeglasses, munications aids, braces, nitified by the as needed by the client. The state of the se record review and sailed to ensure adaptive lients (#5) was furnished desirents (#5) was furnished desirents (#5) was furnished desirents (#5) to engage in a variety of sining, skipping, swinging observations revealed client this leg with his hands. The revealed client #5 to wear to the protective is or arms.	W 436	W 436 The Behavior Analyst will purch soft mitts and in-service all staff the use for Client #5. The clinical team will monitor through interal assessments 2x a week for a portion of 30 days and then on a routing basis to ensure the BSP is following the future, the behavior analytic ensure all staff are trained on Box.	f on al action eriod e wed.	5/25/25

STATEMENT	OF DEFICIENCIES	OVAL PROPERTY OF THE PROPERTY			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	(X3) DATE SURVEY COMPLETED		
		34G081	B. WING		02/26/2025
	PROVIDER OR SUPPLIER HOME #2			STREET ADDRESS, CITY, STATE, ZIP CODE 450 TWIN OAKS ROAD STATESVILLE, NC 28625	03/26/2025
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
	as soft helmet, soft m shirt protector and sm review revealed a Bel 9/26/24 which indicate be offered whenever of head or legs or otherw. Interview with the Horn 3/25/25 revealed that for approximately 6 m soft mitts for client #5. intellectual disabilities revealed that the PCP that the facility should available for client #5 self-injurious behavior EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each finding is: A review of the facility revealed March, 2024 facility conducted 6 fire drills occurred on first second shift and 1 drill Interview with the quality professional (QIDP) co	itts, high sided divided dish, all spoon. Continued record havior Support Plan dated set that the soft mitts should client #5 begins to hit his vise attempts self-injury. The Manager (HM) on she has been in the home onths and had not seen any Interview with the qualified professional (QIDP) and BSP are current and have made soft mitts in the event he engages in the event he engages in the event he engages in the shift of personnel. The strength of the personnel. The fire drill reports on 3/25/25 and March 2025, the endrills and that, of those, 3 shift, 2 drills occurred on	W 440		l ety ety agers