STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G081	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FANJOY HOME #2	**450 TWIN OAKS ROAD , STATESVILLE, North Carolina, 28625**

(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) COMPLETION DATE
E0004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.	E0004		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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E0004	Continued from page 1 . This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure that the Emergency Preparedness Plan (EPP) was reviewed and updated at least every two years. The finding is: Throughout the recertification survey on 3/30/26 and 3/31/26, the facility was unable to produce an Emergency Preparedness Plan (EPP) for the group home. Interviews with 5 staff on 3/30/26 and 3/31/26 revealed that none of the staff was aware of an EPP being in the home and none could state the evacuation location assigned to this group home in the event of an emergency. Interview with the qualified intellectual disabilities professional (QIDP) confirmed that the EPP could not be located and that she had no information about when the EPP had last been reviewed and updated.	E0004		
W0104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is NOT MET as evidenced by: Based on observations, record review and interview, the governing body and management failed to exercise general policy and operating direction over the facility by failing to ensure repairs and maintenance at the group home were completed in a timely manner, affecting 6 out of 6 clients (#1, #2, #3, #4, #5, #6). The finding is: Observations throughout the 3/30/26 - 3/31/26 survey revealed several repairs needed inside the group home to include blinds on doors, broken kitchen cabinets and drawer fronts, a broken oven door, inoperable outdoor lighting, peeling and moldy caulking around sinks and bathtub, vent covers which are bent and extremely dirty, broken track lighting in the living room, missing chair and dresser in client #3's bedroom, missing window covering in client #3's bedroom and painting and repair of walls throughout the home. Review of records on 3/31/26 revealed maintenance work orders submitted by the facility staff as follows:	W0104		

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W0104	Continued from page 2 11/11/25: "House in general needs walls fixed and painted, side door, kitchen door and dining room doors need blinds, kitchen cabinets need painted, fence in the front is bent inwards and broken, broken tile in shower in big bathroom, client #3 needs chair in room. Utilizing dining room chair in room," 11/19/25: "kitchen drawer is broken - a member had pulled it all the way out and broke the drawer in pieces, oven door is broken," 11/24/25: "Bathroom shower is stopped up, toilet is stopped up." Several additional items are noted on a maintenance work order dated 3/25/26. Continued review of records revealed no evidence that any of the requested repairs and maintenance has been completed as of 3/31/26. Interview with the qualified intellectual disabilities professional (QIDP) on 3/31/26 confirmed these items are broken and/or in need of cleaning, repair or replacement and that work orders have been submitted to the provider but no action has been taken on them.	W0104		
W0130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to assure that privacy was maintained for 2 of 6 clients (#2, #5) during personal care. The findings are: A. Observations in the group home on 3/31/26 at 5:15 AM revealed client #2 to be naked in the shower with no door or curtain and with the bathroom door open. Continued observation revealed staff to leave the bathroom, leaving the door open with the client visible from the hallway. Review of records for client #2 on 3/31/26 revealed an adaptive behavior inventory dated 6/6/25. Continued record review revealed that client #2 was found to be partially independent in the area of closing the bathroom door for privacy, indicating that improving on this skill presents a need for client #2. B. Observations in the group home on 3/31/26 at 6:30 AM revealed client #5 to be in his bedroom along with staff. Continued observation revealed client #5 to remove his pajamas and put on clothes with staff	W0130		

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W0130	Continued from page 3 assistance while the bedroom door was open and client #5 was visible from the hallway. Review of records for client #5 on 3/31/26 revealed a program goal initiated on 3/4/26 to ensure privacy for himself and housemates, to include bathroom use and dressing in private. Interview with the qualified intellectual disabilities professional (QIDP) on 3/31/26 confirmed that all clients should be given privacy during care and treatment.	W0130		
W0249	PROGRAM IMPLEMENTATION 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 interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is NOT MET as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure that 2 of 6 clients (#3, #5) received a continuous active treatment program as identified in the Person-Centered Plan (PCP) relative to maintaining a calm environment in the home and appropriate use of adaptive equipment. The findings are: Throughout observations in the home on 3/30/26 and 3/31/26 client #3 was observed to be wearing a gait belt and staff were observed several times to pull client #3 around the home and yard by pulling on the gait belt, sometimes causing the client to change direction. Further observation in the home on 3/31/26 between 6:00 AM and 8:00 AM revealed staff D to use an unnecessarily loud and forceful voice when speaking with clients. Staff D's voice could be heard from all areas of the home and at one point, client #1 was observed to cover his ears when staff D was speaking from the adjoining room. Continued observation in the home revealed client #3 to become agitated several times, leading to hitting himself in the head with his hands. Review of records for client #3 revealed a behavior support plan (BSP) dated 11/15/23 which includes several Rules of Interaction, including "Attempt to	W0249		

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W0249	Continued from page 4 moderate stimulation in the environment, as loud noise and too much action in the home can cause client #3 to become agitated," and "client #3 should wear his gait belt during awake hours to assist staff with physically guiding client #3 in a respectful manner as needed." Review of records for client #5 revealed a BSP dated 10/1/25 which includes several Prevention Strategies, one of which reads, "Client #5 appears hypersensitive to loud noises, and staff will monitor him in loud or busy environments so that they can intervene quickly if needed," and "Seek to offer environments and activities that are soothing to client #5." Interview on 3/31/26 with the qualified intellectual disabilities professional (QIDP) confirmed that client #3's gait belt should not be used to pull him around the home or yard and that the staff should work to maintain a calm environment and avoid loud noise in the home.	W0249		
W0260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2) At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure the person-centered plan (PCP) was revised at least annually for 4 of 6 clients (#1, #3, #5, #6). The findings are: A. Review of records on 3/31/26 revealed a PCP dated 1/17/25 for client #1. There was no additional documentation provided to show evidence that client #1's PCP meeting had taken place, nor the plan updated since 1/17/25. Interview on 3/31/26 with the qualified intellectual disabilities professional (QIDP) confirmed that client #1's PCP has not been reviewed or revised since 1/17/25. B. Review of records on 3/31/26 revealed a PCP dated 12/12/24 for client #3. There was no additional documentation provided to show evidence that client #3's PCP meeting had taken place, nor the plan updated since 12/12/24. Interview on 3/31/26 with the qualified intellectual	W0260		

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W0260	Continued from page 5 disabilities professional (QIDP) confirmed that client #3's PCP has not been reviewed or revised since 12/12/24. C. Review of records on 3/31/26 revealed a PCP dated 7/24/24 for client #5. There was no additional documentation provided to show evidence that client #5's PCP meeting had taken place, nor the plan updated since 7/24/24. Interview on 3/31/26 with the qualified intellectual disabilities professional (QIDP) confirmed that client #5's PCP has not been reviewed or revised since 7/24/24. D. Review of records on 3/31/26 revealed a PCP dated 12/17/24 for client #6. There was no additional documentation provided to show evidence that client #6's PCP meeting had taken place, nor the plan updated since 12/17/24. Interview on 3/31/26 with the qualified intellectual disabilities professional (QIDP) confirmed that client #6's PCP has not been reviewed or revised since 12/17/24.	W0260		
W0262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is NOT MET as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure that restrictive interventions were reviewed and approved by the Human Rights Committee (HRC) for 6 of 6 clients (#1, #2, #3, #4, #5, #6). The findings are: A. Observations throughout the recertification survey period from 3/30/26 through 3/31/26 revealed that the refrigerator and pantry in the home are locked due to food seeking behaviors by one client. Review of records on 3/31/26 revealed no evidence that the restrictive intervention was reviewed and approved by the HRC. Interview with the qualified intellectual disabilities	W0262		

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W0262	Continued from page 6 professional (QIDP) on 3/31/26 revealed that no signed HRC consents for the locked refrigerator and pantry could be located during the survey. B. Review of records on 3/31/26 revealed a behavior support plan (BSP) for client #2 dated 8/1/25 which includes prescriptions for the behavior medications Clonidine, Vyvanse, Depakote and Lexapro. Continued review of records for client #3 revealed a medication administration record (MAR) dated 3/31/26 which indicates that client #2 receives the following behavior management medications daily: Clonidine, Focalin, Depakote and Lexapro. Further review revealed no HRC consent for the use of behavior management medications. Interview with the QIDP revealed that no signed HRC consent for client #2's behavior medications could be located during the survey. C. Review of records on 3/31/26 revealed a BSP for client #3 dated 11/15/23 which includes prescriptions for the behavior medications Tegretol, Abilify, Clonazepam, Fluoxetine, Inderal, Naltrexone and Vistaril. Continued review of records for client #3 revealed a MAR dated 3/31/26 which indicates that client #3 receives the following behavior management medications daily: Abilify, Tegretol, Klonopin, Naltrexone, Inderal and Zoloft. Further review revealed no HRC consent for the use of any behavior management medications. Interview with the QIDP revealed that no signed HRC consent for client #3's behavior medications could be located during the survey. D. Review of records on 3/31/26 revealed a BSP for client #4 dated 10/1/24 which includes prescriptions for the behavior medications Invega and Trazadone. Continued review of records for client #4 revealed a MAR dated 3/31/26 which indicates that client #4 receives Invega and Trazadone daily. Further review revealed no HRC consent for the use of any behavior management medications. Interview with the QIDP revealed that no signed HRC consent for client #4's behavior medications could be located during the survey. E. Review of records on 3/31/26 revealed a BSP for client #5 dated 10/1/25 which includes prescriptions for the behavior medications Catapres, Vistaril and Risperdal. Continued review of records for client #5 revealed a MAR dated 3/31/26 which indicates that	W0262		

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W0262	Continued from page 7 client #5 receives Catapres, Vistaril, Invega and Trazadone daily. Further review revealed no HRC consent for the use of any behavior management medications. Interview with the QIDP revealed that no signed HRC consent for client #5's behavior medications could be located during the survey. F. Review of records on 3/31/26 revealed a BSP for client #6 dated 1/1/26 which includes prescriptions for the behavior medications Buspar and Inderal. Continued review of records for client #6 revealed a MAR dated 3/31/26 which indicates that client #6 Buspar, Invega and Inderal daily. Further review revealed no HRC consent for the use of any behavior management medications. Interview with the QIDP revealed that no HRC guardian consent for client #6's behavior medications could be located during the survey.	W0262		
W0263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is NOT MET as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure that restrictive interventions were reviewed and approved by the legal guardians of 6 of 6 clients (#1, #2, #3, 34, #5, #6). The findings are: A. Observations throughout the recertification survey period from 3/30/26 through 3/31/26 revealed that the refrigerator and pantry in the home are locked due to food seeking behaviors by one client. Review of records on 3/31/26 revealed no evidence that the restrictive intervention was reviewed and approved by the guardians of clients #1, #2, #3, #4, #5 or #6. Interview with the qualified intellectual disabilities professional (QIDP) on 3/31/26 revealed that no guardian signed consents for the locked refrigerator and pantry could be located during the survey. B. Review of records on 3/31/26 revealed a behavior support plan (BSP) for client #2 dated 8/1/25 which	W0263		

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W0263	Continued from page 8 includes prescriptions for the behavior medications Clonidine, Vyvanse, Depakote and Lexapro. Continued review of records for client #3 revealed a medication administration record (MAR) dated 3/31/26 which indicates that client #2 receives the following behavior management medications daily: Clonidine, Focalin, Depakote and Lexapro. Further review revealed no guardian consent for the use of behavior management medications. Interview with the QIDP revealed that no signed guardian consent for client #2's behavior medications could be located during the survey. C. Review of records on 3/31/26 revealed a BSP for client #3 dated 11/15/23 which includes prescriptions for the behavior medications Tegretol, Abilify, Clonazepam, Fluoxetine, Inderal, Naltrexone and Vistaril. Continued review of records for client #3 revealed a MAR dated 3/31/26 which indicates that client #3 receives the following behavior management medications daily: Abilify, Tegretol, Klonopin, Naltrexone, Inderal and Zoloft. Further review revealed no guardian consent for the use of any behavior management medications. Interview with the QIDP revealed that no signed guardian consent for client #3's behavior medications could be located during the survey. D. Review of records on 3/31/26 revealed a BSP for client #4 dated 10/1/24 which includes prescriptions for the behavior medications Invega and Trazadone. Continued review of records for client #4 revealed a MAR dated 3/31/26 which indicates that client #4 receives Invega and Trazadone daily. Further review revealed no guardian consent for the use of any behavior management medications. Interview with the QIDP revealed that no signed guardian consent for client #4's behavior medications could be located during the survey. E. Review of records on 3/31/26 revealed a BSP for client #5 dated 10/1/25 which includes prescriptions for the behavior medications Catapres, Vistaril and Risperdal. Continued review of records for client #5 revealed a MAR dated 3/31/26 which indicates that client #5 receives Catapres, Vistaril, Invega and Trazadone daily. Further review revealed no guardian consent for the use of any behavior management medications. Interview with the QIDP revealed that no signed	W0263		

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W0263	Continued from page 9 guardian consent for client #5's behavior medications could be located during the survey. F. Review of records on 3/31/26 revealed a BSP for client #6 dated 1/1/26 which includes prescriptions for the behavior medications Buspar and Inderal. Continued review of records for client #6 revealed a MAR dated 3/31/26 which indicates that client #6 Buspar, Invega and Inderal daily. Further review revealed no guardian consent for the use of any behavior management medications. Interview with the QIDP revealed that no signed guardian consent for client #6's behavior medications could be located during the survey.	W0263		
W0440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure evacuation drills were held at least quarterly for each shift of personnel. The finding is: A review of facility fire drill reports for the period of April, 2025 through March, 2026 revealed that there were no fire drills for the months of June, July, August and September of 2025. This resulted in a total of 3 fire drills for the first and third shifts of personnel and 2 for the second shift during the survey year. Interview with the qualified intellectual disabilities professional (QIDP) on 3/31/26 confirmed no other fire drill reports could be located and that drills should have been conducted quarterly for each shift of personnel.	W0440		