

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>FCL081032</b>           | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/03/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>JOYFUL HOME FAMILY CARE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>113 BEACON HILL<br/>ELLENBORO, NC 28040</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| C 000                                                              | Initial Comments<br><br>The Adult Care Licensure Section conducted a<br>Annual survey on February 2, 2017 with an exit<br>conference via telephone on February 3, 2017.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | C 000                                                                                   |                                                                                                                          |                                                        |
| C 153                                                              | 10A NCAC 13G .0501 (a) Personal Care Training<br>And Competency<br><br>10A NCAC 13G .0501 Personal Care Training<br>And Competency<br><br>(a) The facility shall assure that personal care<br>staff and those who directly supervise them in<br>facilities without heavy care residents<br>successfully complete a 25-hour training<br>program, including competency evaluation,<br>approved by the Department according to Rule<br>.0502 of this Section. For the purposes of this<br>Subchapter, heavy care residents are those for<br>whom the facility is providing personal care tasks<br>listed in Paragraph (i) of this Rule. Directly<br>supervise means being on duty in the facility to<br>oversee or direct the performance of staff duties.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews the facility<br>failed to assure 1 of 3 sampled (Staff C) personal<br>care staff successfully completed a 25-hour<br>training program, including competency<br>evaluation within six months of hire.<br><br>The findings are:<br><br>Review of Staff C's personnel record revealed:<br>- He was hired on 10/8/15.<br>- His title was Relief Supervisor in Charge.<br>- There was no documentation of personal care | C 153                                                                                   |                                                                                                                          |                                                        |

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Service Regulation

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| C 153                                                              | <p>Continued From page 1</p> <p>training.</p> <p>Staff C was not available for interview during the survey.</p> <p>Interview on 2/2/17 at 11:20am with Staff B, Supervisor-In-Charge (SIC) revealed:</p> <ul style="list-style-type: none"> <li>- She worked from 6:00am to 2:00pm.</li> <li>- Staff C was hired only to work at night and did not give medications.</li> <li>- Staff C would call her or the other med aide if a medicine needed to be given or if a resident was having a problem.</li> <li>- She lived less than a mile from the facility.</li> </ul> <p>Interview on 2/2/17 at 3:30pm with Staff A, SIC revealed:</p> <ul style="list-style-type: none"> <li>- She stated Staff C was hired only for night shift.</li> <li>- If there was an emergency or someone did require medications Staff C would call Staff A or Staff B.</li> </ul> <p>Interview on 2/3/17 at 1:53pm with the Administrator revealed:</p> <ul style="list-style-type: none"> <li>- Staff C was hired as night shift relief worker from 10:00pm until 6:00am.</li> <li>- Staff C "does not give medications, baths or anything like that, he is here at night for relief".</li> <li>- Staff C was to call Staff A or Staff B if he required assistance for a resident.</li> <li>- Staff C had a current cardio-pulmonary resuscitation card.</li> <li>- She did not have any documentation of Staff C's personal care training.</li> <li>- "The responsibility falls on me" for making sure it was done.</li> <li>- "I will get it taken care of as soon as possible."</li> </ul> | C 153                                                                         |                                                                                                                          |  |                                                        |