STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL081032	A. BUILDING: _____ B. WING _____	02/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYFUL HOME FAMILY CARE	113 BEACON HILL ELLENBORO, NC 28040

(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) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted a Annual survey on February 2, 2017 with an exit conference via telephone on February 3, 2017.	C 000		
C 153	10A NCAC 13G .0501 (a) Personal Care Training And Competency 10A NCAC 13G .0501 Personal Care Training And Competency (a) The facility shall assure that personal care staff and those who directly supervise them in facilities without heavy care residents successfully complete a 25-hour training program, including competency evaluation, approved by the Department according to Rule .0502 of this Section. For the purposes of this Subchapter, heavy care residents are those for whom the facility is providing personal care tasks listed in Paragraph (i) of this Rule. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to assure 1 of 3 sampled (Staff C) personal care staff successfully completed a 25-hour training program, including competency evaluation within six months of hire. The findings are: Review of Staff C's personnel record revealed: - He was hired on 10/8/15. - His title was Relief Supervisor in Charge. - There was no documentation of personal care	C 153	Administrator scheduled necessary training for staff ASAP 2/22/17 to be completed on 2/28/17 Administrator will be more diligent in meeting training requirements for staff	2/3/17 2/28/17 2/15/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joy Cooper-Williams TITLE: Admin (X6) DATE: 2/22/17

STATE FORM 6899 T6ZM11 If continuation sheet 1 of 2

Reviewed and Accepted RM 2/27/17